Dissector

Grant's

FIFTEENTH EDITION

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Grant’s Dissector was originally designed as an instruction manual for dissection by the regional approach. The 15th edition continues this tradition. It has been rewritten to make the dissection instructions more concise and more appropriate to today’s gross anatomy curriculum. However, Grant’s Dissector is not an anatomical atlas, nor is it a textbook of anatomy. It is only intended to provide dissection instructions and enough anatomical details to make the student observe and recognize the important relationships that have been revealed. The student is encouraged to rely upon Grant’s Dissector only for dissection instructions and to use a textbook such as Clinically Oriented Anatomy and a quality atlas such as Grant’s Atlas to provide anatomical details.

**KEY FEATURES**

**Consistent Organization**

Each chapter in the 15th edition begins with a brief study of surface anatomy. Next, an overview of osteology is presented in a concise way to provide the student with important foundational structures that will aid in localization of soft tissue structures. Additional osteology is presented throughout each chapter when appropriate to support the dissection.

Each dissection activity begins with a section called “Dissection Overview.” This section is a thumbnail sketch of what is to be accomplished during the dissection session. It is followed by a section entitled “Dissection Instructions.” The Dissection Instructions lead the student through the dissection in a logical sequence by use of a series of numbered steps. The numbering sequence allows the student to return quickly to the appropriate place on the page to get the next dissection instruction. Each dissection concludes with a section called “Dissection Follow-up.” The Dissection Follow-up is a numbered list of tasks for the students to perform in the lab following the dissection. These tasks illustrate the important features of the dissection and encourage the synthesis of information.

**Improved Dissection Instructions**

The best way to evaluate a dissector is by use in the dissecting laboratory. Through use, small changes in wording (often at the suggestion of students and teaching faculty) may be identified that will clarify and improve the dissection experience. These small changes may be difficult to recognize in the final product but they make a world of difference in the quality of the dissection experience.

**New Head Removal Instructions**

A new head removal method is presented in the 15th edition. The change is intended to make removal of the head and the study of internal features of the cranial cavity easier and faster for students.

**New Illustrations**

A total of 69 new illustrations appear in the 15th edition of Grant’s Dissector. These illustrations are scattered through all seven chapters and are a continuation of the art program that was begun with the 13th edition. Some of these new illustrations are replacements for existing illustrations and are intended to clarify the intent of the original drawing. Many original illustrations have been added to support the descriptions in the text and to assist the student in making correct incisions.

**References to Atlas Illustrations**

The illustrations included in the 15th edition are not intended to take the place of atlas figures. To aid the students in finding atlas illustrations to support their dissection, the dissection instructions contain references to appropriate illustrations in five anatomical atlases:

- Lippincott Williams & Wilkins Atlas of Anatomy, 1st edition, by Patrick W. Tannk and Thomas R. Gest

Curricula are constantly changing, and the modifications described previously are intended to increase the adaptability of Grant’s Dissector to a variety of dissection needs. Since the chapters are written to stand alone, the dissection sequence can be modified or regional units may be eliminated with a minimum amount of effort. These features are intended to make Grant’s Dissector a flexible yet comprehensive dissection guide for a changing curricular environment.
CONTENTS

1: THE BACK 5

SURFACE ANATOMY 5

SKELETON OF THE BACK 5

SKIN AND SUPERFICIAL FASCIA 8

Dissection Overview 8
Dissection Instructions 8
• Skin Incisions 8
• Superficial Fascia 9
Dissection Follow-up 9

SUPERFICIAL MUSCLES OF THE BACK 9

Dissection Overview 9
Dissection Instructions 9
• Trapezius Muscle 9
• Latissimus Dorsi Muscle 11
• Rhomboid Major and Rhomboid Minor Muscles 11
• Levator Scapulae Muscle 11
Dissection Follow-up 12

INTERMEDIATE MUSCLES OF THE BACK 12

DEEP MUSCLES OF THE BACK 12

Dissection Overview 12
Dissection Instructions 12
• Splenius Muscle 12
• Erector Spinae Muscle 13
• Transversospinal Group of Muscles 13
• Semispinalis Capitis Muscle 14
Dissection Follow-up 14

SUBOCcipital REGION 14

Dissection Overview 14
Dissection Instructions 14
Dissection Follow-up 15

VERTEBRAL CANAL, SPINAL CORD, AND MENINGES 15

Dissection Overview 15
Dissection Instructions 16
• Spinal Meninges 17
Dissection Follow-up 19

2: THE UPPER LIMB 21

SURFACE ANATOMY 21

SUPERFICIAL VEINS AND CUTANEOUS NERVES 21

Dissection Overview 21
Dissection Instructions 22
• Skin Incisions 22
• Superficial Veins 22
• Cutaneous Nerves 23
Dissection Follow-up 24

SUPERFICIAL MUSCLES OF THE BACK 24

SCAPULAR REGION 24

Dissection Overview 24
Dissection Instructions 24
Dissection Follow-up 26

PECTORAL REGION 26

Dissection Overview 26
Dissection Instructions 26
• Breast 26
• Superficial Fascia 27
Dissection Follow-up 28

MUSCLES OF THE PECTORAL REGION 28

Dissection Overview 28
Dissection Instructions 29
Dissection Follow-up 30

AXILLA 30

Dissection Overview 30
Dissection Instructions 31
• Axillary Artery 31
• Brachial Plexus 32
Dissection Follow-up 34

ARM AND CUBITAL FOSSA 34

Dissection Overview 34
• Skeleton of the Arm and Cubital Region 35
Dissection Instructions 35
• Anterior Compartment of the Arm 35
• Cubital Fossa 37
• Posterior Compartment of the Arm 38
Dissection Follow-up 39

FLEXOR REGION OF THE FOREARM 40

Dissection Overview 40
• Skeleton of the Forearm 40
CONTENTS

Dissection Instructions 41
• Superficial Layer of Flexor Muscles 41
• Intermediate Layer of Flexor Muscles 42
• Vessels and Nerves of the Anterior Forearm 44
• Deep Layer of Flexor Muscles 46
Dissection Follow-up 47

PALM OF THE HAND 46
Dissection Overview 46
• Skeleton of the Hand 47
Dissection Instructions 47
• Skin Incisions 47
• Superficial Palm 47
• Carpal Tunnel 49
• Thenar Muscles 50
• Hypothenar Muscles 51
• Deep Palm 51
Dissection Follow-up 52

EXTENSOR REGION OF THE FOREARM AND DORSUM OF THE HAND 53
Dissection Overview 53
Dissection Instructions 53
• Superficial Layer of Extensor Muscles 53
• Deep Layer of Extensor Muscles 55
Dissection Follow-up 55

JOINTS OF THE UPPER LIMB 57
Dissection Overview 57
Dissection Instructions 57
• Sternoclavicular Joint 57
• Acromioclavicular Joint 58
• Glenohumeral Joint 58
• Elbow Joint and Proximal Radioulnar Joint 60
• Intermediate Radioulnar Joint 61
• Distal Radioulnar Joint 61
• Wrist Joint 61
• Metacarpophalangeal Joints 61
• Interphalangeal Joints 62

3: THE THORAX 63

SURFACE ANATOMY 63
SKELETON OF THE THORAX 63
PECTORAL REGION 64
INTERCOSTAL SPACE AND INTERCOSTAL MUSCLES 65
Dissection Overview 65
Dissection Instructions 65
Dissection Follow-up 66
REMOVAL OF THE ANTERIOR THORACIC WALL 66
Dissection Overview 66
Dissection Instructions 67
Dissection Follow-up 67

PLEURAL CAVITIES 68
Dissection Overview 68
Dissection Instructions 69
Dissection Follow-up 69

LUNGS 69
Dissection Overview 69
Dissection Instructions 69
• Lungs in the Thorax 69
• Removal of the Lungs 70
Dissection Follow-up 72

MEDIASTINUM 72
Dissection Overview 72
Dissection Instructions 73
Dissection Follow-up 73

MIDDLE MEDIASTINUM 73
Dissection Overview 73
Dissection Instructions 73
• Heart in the Thorax 73
• Removal of the Heart 75
Dissection Follow-up 76

EXTERNAL FEATURES OF THE HEART 76
Dissection Overview 76
Dissection Instructions 76
• Surface Features 76
• Cardiac Veins 76
• Coronary Arteries 77
Dissection Follow-up 78

INTERNAL FEATURES OF THE HEART 78
Dissection Overview 78
Dissection Instructions 78
• Right Atrium 78
• Right Ventricle 79
• Left Atrium 80
• Left Ventricle 81
Dissection Follow-up 82

SUPERIOR MEDIASTINUM 82
Dissection Overview 82
Dissection Instructions 82
Dissection Follow-up 84

POSTERIOR MEDIASTINUM 85
Dissection Overview 85
Dissection Instructions 85
Dissection Follow-up 87

4: THE ABDOMEN 89

SURFACE ANATOMY 89
SUPERFICIAL FASCIA OF THE ANTEROLATERAL ABDOMINAL WALL 90
Dissection Overview 90
**Dissection Instructions**

- Skin Incisions 90
- Superficial Fascia 90

**MUSCLES OF THE ANTEROLATERAL ABDOMINAL WALL** 91

- Dissection Overview 91
- Skeleton of the Abdominal Wall 92
- External Oblique Muscle 92
- Internal Oblique Muscle 93
- Transversus Abdominis Muscle 94
- Deep Inguinal Ring 95
- Rectus Abdominis Muscle 95

**Reflection of the Abdominal Wall** 98

- Dissection Overview 98
- Dissection Instructions 98

**Peritoneum and Peritoneal Cavity** 99

- Dissection Overview 99
- Abdominal Viscera 99
- Peritoneum 101

**Celiac Trunk, Stomach, Spleen, Liver, and Gallbladder** 102

- Dissection Overview 102
- Dissection Instructions 102
- Celiac Trunk 103
- Spleen 105
- Liver 106
- Gallbladder 107

**Superior Mesenteric Artery and Small Intestine** 107

- Dissection Overview 107
- Dissection Instructions 108
- Superior Mesenteric Artery 108
- Small Intestine 110

**Inferior Mesenteric Artery and Large Intestine** 110

- Dissection Overview 110
- Dissection Instructions 111
- Inferior Mesenteric Artery 111
- Large Intestine 111

**Duodenum, Pancreas, and Hepatic Portal Vein** 112

- Dissection Overview 112
- Dissection Instructions 112
- Duodenum 112
- Pancreas 113
- Hepatic Portal Vein 114

**Removal of the Gastrointestinal Tract** 114

- Dissection Overview 114
- Dissection Instructions 114
- Dissection Follow-up 116

**Posterior Abdominal Viscera** 116

- Dissection Overview 116
- Dissection Instructions 117
- Kidneys 117
- Suprarenal Glands 119
- Abdominal Aorta and Inferior Vena Cava 120

**Posterior Abdominal Wall** 121

- Dissection Overview 121
- Dissection Instructions 121
- Lumbar Plexus 122
- Abdominal Part of the Sympathetic Trunk 122

**Diaphragm** 123

- Dissection Overview 123
- Dissection Instructions 123
- Dissection Follow-up 124

**5: The Pelvis and Perineum** 125

**Skeleton of the Pelvis** 125

**Anal Triangle** 127

- Dissection Overview 127
- Dissection Instructions 127
- Skin and Superficial Fascia Removal 127
- Ischioanal Fossa 128

**Male External Genitalia and Perineum** 129

- Dissection Overview 129
- Dissection Instructions 129
- Scrotum 129
- Spermatic Cord 130
- Testis 131

**Male Pelvic Cavity** 137

**Male Urogenital Triangle** 132

- Dissection Overview 132
- Dissection Instructions 132
- Skin Removal 132
- Superficial Perineal Pouch 132
- Penis 134
- Spongy Urethra 135
- Deep Perineal Pouch 136

**Male Pelvic Cavity** 137

- Dissection Overview 137
- Dissection Instructions 137
CONTENTS

Dissection Instructions 137
• Peritoneum 137
• Section of the Pelvis 138
• Male Internal Genitalia 138
Dissection Follow-up 140

URINARY BLADDER, RECTUM, AND ANAL CANAL 140
Dissection Overview 140
Dissection Instructions 141
• Urinary Bladder 141
• Rectum and Anal Canal 141
Dissection Follow-up 142

INTERNAL ILIAC ARTERY AND SACRAL PLEXUS 143
Dissection Overview 143
Dissection Instructions 143
• Blood Vessels 143
• Nerves 144
Dissection Follow-up 145

PELVIC DIAPHRAGM 145
Dissection Overview 145
Dissection Instructions 145
Dissection Follow-up 147

FEMALE EXTERNAL GENITALIA AND PERINEUM 147
Labium Majus 147
Dissection Overview 147
Dissection Instructions 148
Dissection Follow-up 148

FEMALE UROGENITAL TRIANGLE 148
Dissection Overview 148
Dissection Instructions 148
• External Genitalia 148
• Skin Removal 149
• Superficial Perineal Pouch and Clitoris 149
• Deep Perineal Pouch 151
Dissection Follow-up 152

FEMALE PELVIC CAVITY 152
Dissection Overview 152
Dissection Instructions 153
• Peritoneum 153
• Section of the Pelvis 154
• Female Internal Genitalia 154
Dissection Follow-up 156

URINARY BLADDER, RECTUM, AND ANAL CANAL 156
Dissection Overview 156
Dissection Instructions 156
• Urinary Bladder 156
• Rectum and Anal Canal 158
Dissection Follow-up 159

INTERNAL ILIAC ARTERY AND SACRAL PLEXUS 159
Dissection Overview 159
Dissection Instructions 159
• Blood Vessels 159
• Nerves 160
Dissection Follow-up 161

PELVIC DIAPHRAGM 161
Dissection Overview 161
Dissection Instructions 163
Dissection Follow-up 163

6: THE LOWER LIMB 165

SURFACE ANATOMY 165
SUPERFICIAL VEINS AND CUTANEOUS NERVES 165
Dissection Overview 165
Dissection Instructions 165
• Skin Incisions 165
• Superficial Fascia of the Posterior Lower Limb 166
• Superficial Fascia of the Anterior Lower Limb 168
Dissection Follow-up 169

ANTERIOR COMPARTMENT OF THE THIGH 169
Dissection Overview 169
Dissection Instructions 170
• Saphenous Opening 170
• Femoral Triangle 171
• Adductor Canal and Sartorius Muscle 173
• Quadriceps Femoris Muscle 173
Dissection Follow-up 175

MEDIAL COMPARTMENT OF THE THIGH 175
Dissection Overview 175
Dissection Instructions 175
Dissection Follow-up 176

GLUTEAL REGION 176
Dissection Overview 176
Dissection Instructions 177
Dissection Follow-up 180

POSTERIOR COMPARTMENT OF THE THIGH AND POPLITEAL FOSSA 181
Dissection Overview 181
Dissection Instructions 181
• Posterior Thigh 181
• Popliteal Fossa 183
Dissection Follow-up 184

LEG AND DORSUM OF THE FOOT 184
Skeleton of the Leg 185

POSTERIOR COMPARTMENT OF THE LEG 185
Dissection Overview 185
Dissection Instructions 186
Dissection Follow-up 189

LATERAL COMPARTMENT OF THE LEG 190
Dissection Overview 190
Dissection Instructions 190
Dissection Follow-up 190
CONTENTS

ANTERIOR COMPARTMENT OF THE LEG AND DORSUM OF THE FOOT 190
Dissection Overview 190
Dissection Instructions 191
Dissection Follow-up 193

SOLE OF THE FOOT 193
Dissection Overview 193
Dissection Instructions 194
• Plantar Aponeurosis and Cutaneous Nerves 194
• First Layer of the Sole 195
• Second Layer of the Sole 196
• Third Layer of the Sole 197
• Fourth Layer of the Sole 197
Dissection Follow-up 198

JOINTS OF THE LOWER LIMB 198
Dissection Overview 198
Dissection Instructions 198
• Hip Joint 198
• Knee Joint 200
• Ankle Joint 202
• Joints of Inversion and Eversion 203

7: THE HEAD AND NECK 205

NECK 205
Skeleton of the Neck 205

ORGANIZATION OF THE NECK 206
Dissection Overview 206
Dissection Instructions 206
• Skin Removal 206
• Posterior Triangle of the Neck 207
Dissection Follow-up 209

ANTERIOR TRIANGLE OF THE NECK 209
Dissection Overview 209
• Bones and Cartilages 209
Dissection Instructions 210
• Superficial Fascia 210
• Muscular Triangle 210
• Submandibular Triangle 211
• Submental Triangle 212
• Carotid Triangle 212
Dissection Follow-up 214

THYROID AND PARATHYROID GLANDS 215
Dissection Overview 215
Dissection Instructions 215
Dissection Follow-up 216

ROOT OF THE NECK 216
Dissection Overview 216
Dissection Instructions 216
Dissection Follow-up 218

HEAD 218
Skull 219
• Anterior View of the Skull 219
• Lateral View of the Skull 219
• Superior View of the Skull 220

FACE 221
Surface Anatomy 221
Dissection Overview 221
Dissection Instructions 222
• Skin Incisions 222
• Superficial Fascia and Facial Nerve 222
• Facial Artery and Vein 224
• Muscles Around the Orbital Opening 224
• Muscles Around the Oral Opening 224
• Sensory Nerves of the Face 225
Dissection Follow-up 226

PAROTID REGION 226
Dissection Overview 226
Dissection Instructions 226
Dissection Follow-up 228

SCALP 228
Dissection Overview 228
Dissection Instructions 228
Dissection Follow-up 229

TEMPORAL REGION 230
Dissection Overview 230
• Skeleton of the Temporal Region 230
Dissection Instructions 231
• Masseter Muscle and Removal of the Zygomatic Arch 231
• Temporal Region 232
• Infratemporal Fossa 232
• Temporomandibular Joint 234
Dissection Follow-up 235

INTERIOR OF THE SKULL 235
Dissection Overview 235
Dissection Instructions 235
• Removal of the Calvaria 235
• Cranial Meninges 236
Dissection Follow-up 238

REMOVAL OF THE BRAIN 238
Dissection Overview 238
Dissection Instructions 238

DURAL INFOLDINGS AND DURAL VENOUS SINUSES 239
Dissection Overview 239
Dissection Instructions 239
• Dural Infoldings 239
• Dural Venous Sinuses 239
Dissection Follow-up 240

GROSS ANATOMY OF THE BRAIN 240
Dissection Overview 240
Dissection Instructions 240
Dissection Follow-up 242
CONTENTS

CRANIAL FOSSAE 242
  Dissection Overview 242
  • Skeleton of the Cranial Base 242
  Dissection Instructions 243
  • Anterior Cranial Fossa 243
  • Middle Cranial Fossa 243
  • Posterior Cranial Fossa 245
  Dissection Follow-up 245

ORBIT 245
  Dissection Overview 245
  • Skeleton of the Orbit 246
  • Surface Anatomy of the Eyeball, Eyelids, and Lacrimal Apparatus 246
  Dissection Instructions 247
  • Eyelid and Lacrimal Apparatus 247
  • Right Orbit from the Superior Approach 248
  • Left Orbit from the Anterior Approach 251
  Dissection Follow-up 252

DISARTICULATION OF THE HEAD 252
  Dissection Overview 252
  • Skeleton of the Suboccipital Region 252
  Dissection Instructions 253
  • Retropharyngeal Space 253
  • Disarticulation of the Head 253
  • Prevertebral and Lateral Vertebral Regions 254
  Dissection Follow-up 254

PHARYNX 255
  Dissection Overview 255
  Dissection Instructions 255
  • Muscles of the Pharyngeal Wall 255
  • Bisection of the Head 257
  • Internal Aspect of the Pharynx 258
  Dissection Follow-up 259

NOSE AND NASAL CAVITY 259
  Dissection Overview 259
  • Skeleton of the Nasal Cavity 259
  Dissection Instructions 260
  • External Nose 260
  • Nasal Cavity 260
  • Nasal Septum 260
  • Lateral Wall of the Nasal Cavity 261
  Dissection Follow-up 263

HARD PALATE AND SOFT PALATE 263
  Dissection Overview 263
  • Skeleton of the Palate 263
  Dissection Instructions 264
  • Soft Palate 264
  • Tonsillar Bed 266
  • Sphenopalatine Foramen and Pterygopalatine Fossa 266
  Dissection Follow-up 267

ORAL REGION 268
  Dissection Overview 268
  • Surface Anatomy of the Oral Vestibule 268
  • Surface Anatomy of the Oral Cavity Proper 268
  Dissection Instructions 268
  • Tongue 268
  • Bisection of the Tongue and Mandible 269
  • Sublingual Region 270
  Dissection Follow-up 271

LARYNX 271
  Dissection Overview 271
  • Skeleton of the Larynx 271
  Dissection Instructions 272
  • Intrinsic Muscles of the Larynx 272
  • Interior of the Larynx 274
  Dissection Follow-up 274

EAR 274
  Dissection Overview 274
  • Temporal Bone 275
  Dissection Instructions 275
  • External Ear 275
  • Middle Ear (Tympanic Cavity) 275
  • Internal Ear 278
  Dissection Follow-up 278

INDEX 279
Modified from Moore KL, Agur AMR, Dalley AF. *Essential Clinical Anatomy*, 4E. Baltimore: Lippincott Williams & Wilkins, 2011. Figure 6.24.


**Chapter 7**


Modified from Woodburne RT, Burkel WE. *Essentials of Human Anatomy*, 9E, Oxford University Press, 1994. Figure 7.3.


Modified from Hansen JT. *Essential Anatomy Dissector*, 2E. Baltimore: Lippincott Williams & Wilkins, 2002. Figure 7.71.

Modified from Moore KL, Dalley AF. *Clinically Oriented Anatomy*, 4E. Baltimore: Lippincott Williams & Wilkins, 1999. Figure 7.75.

Modified from Moore KL, Dalley AF, Agur AMR. *Clinically Oriented Anatomy*, 6E. Baltimore: Lippincott Williams & Wilkins, 2010. Figure 7.82.

Modified from Bailey FR. *Bailey’s Textbook of Histology*, 16E. Baltimore: Williams & Wilkins, 1978. Figure 7.89.
INTRODUCTION

YOUR FIRST PATIENT

The opportunity to dissect a human body is a once in a lifetime opportunity. The cadaver that you will use for dissection was donated by a person who wished to make a contribution to your education as a physician. It is not possible to put into words the emotions experienced by that individual as he or she made the decision to become a body donor. It goes without saying that the value of the gift that the donor has made to you cannot be measured, and can only be repaid by the proper care and use of the cadaver. The cadaver must be treated with the same respect and dignity that are usually reserved for the living patient.

CADAVER CARE

Upon entering the laboratory, you will find that the cadaver has been embalmed with a strong fixative. The veins are sometimes full of clotted blood and sometimes empty. In some schools, the arteries are injected with red dye. The whole body has been kept moist by wrappings or by submersion under preservative fluid. Dessication of the cadaver will quickly render the specimen useless for study because once a part has been allowed to become dry, it can never be fully restored. Therefore, expose only those parts of the body to be dissected. Inspect every part of the body periodically and moisten the wrappings during each dissection session.

DISSECTION INSTRUMENTS

It is generally true that large dissection equipment (hammers, chisels, saws, etc.) is provided for you, but personal dissection instruments must be purchased. The well-equipped dissector should have the following instruments (FIG. 1.1):

- **Probe** – the primary dissecting tool, after your fingers. A probe is designed to tear connective tissue and allow the user to feel nerves and vessels before they are damaged.
- **Forceps** – used to lift and hold vessels, nerves, and other structures while blunt dissecting with a probe. Two pairs of forceps are needed. One pair should have tips that are blunt and rounded, and the gripping surfaces should be corrugated. The second pair should have teeth (also known as tissue forceps or rat-toothed forceps) for gripping tissue.

![Figure I.1](https://example.com/figure1.png)

• **Scalpel** – primarily used as a skinning tool. Scalpels are not recommended for general dissection because they cut small structures without allowing you to feel them. The scalpel handle should be made of metal (not plastic). The blade should be about 3.5 to 4 cm long. The cutting edge must have some convexity near the point. A sharp blade must be used at all times because no one can do good work with a dull scalpel. Therefore, a sufficient supply of blades will be needed.

• **Scissors** – useful in cutting, blunt dissection, and transection. Two pairs of scissors are recommended: a large, heavy pair of dissecting scissors (about 15 cm in length) and a small pair of scissors with two sharp points for the dissection of delicate structures.

• **Hemostat** – a powerful grasping tool that is helpful in skin removal. The hemostat has two disadvantages: First, it crushes delicate structures. Second, it cannot be repositioned quickly like forceps can, thereby slowing progress.

**GLOSSARY OF DISSECTION TERMS**

This dissection manual repeatedly uses a number of dissection terms. Before beginning to dissect, learn the meaning of the following:

• **Dissect** – to cut apart. In the context of this dissection manual, the meaning of dissect is to tear apart. The dissection approach throughout this manual is to dissect as much as possible with the fingers, to next use a probe, and to then use scissors. A scalpel is used only as a tool of last resort for crude cuts or to dissect extremely tough connective tissues.

• **Blunt dissection** – to separate structures with your fingers, a probe, or scissors by tearing (not cutting) connective tissues.

• **Scissors technique** – a method of blunt dissection in which the tips of a closed pair of scissors are inserted into connective tissue and then opened, tearing the connective tissue with the back edge of the tips (FIG. I.2). The scissors technique is an effective way to dissect vessels and nerves.

• **Sharp dissection** – to dissect by use of a scalpel. Sharp dissection is discouraged and will be recommended only in rare situations.

• **Clean** – to remove fat and connective tissue by means of blunt dissection (preferred) or sharp dissection.

  Clean the surface of a muscle – to remove all fat and connective tissue so that the muscle fascicles become obvious and the direction of force can be understood.

  Clean the border of a muscle – to define the border by using fingers or a probe to break the loose connective tissue that binds the muscle to surrounding structures.

  Clean a nerve – to use a probe (or scissors technique) to tear the connective tissue around the nerve for purposes of observing its relationships and branches.

  Clean a vessel – to use a probe (or scissors technique) to strip the fat and connective tissue off the surface of a vessel and its branches to illustrate its relationships.

• **Define** – to use blunt dissection to enhance a structure to better illustrate its relationships. Defining a structure usually involves bluntly dissecting the loose connective tissue away from it by use of a probe.

• **Retract** – to pull a structure to one side to visualize another structure that lies more deeply. Retraction is a temporary displacement and is not intended to harm the retracted structure.

• **Transect** – to cut in two in the transverse plane, as in transection of a muscle belly or tendon.

• **Reflect** – to fold back from a cut edge, as in folding back a transected muscle to view what is beneath it. The reflected tissue should remain attached to the specimen.

• **Strip a vein** – to remove a vein and its tributaries from the dissection field so that the artery and related structures can be seen more clearly. Veins are stripped by blunt dissection using a probe.

**ANATOMICAL POSITION**

Anatomists describe structures with the body in the anatomical position. In the anatomical position the person stands erect with the feet together, arms by the sides, and the palms facing forward (FIG. I.3). During dissection, structures are described as though the body was in the anatomical position, even though the cadaver is lying on the dissection table. When encountering a
structure during dissection, be aware of its position, its relationship to other structures, its size and shape, its function, its blood supply, and its nerve supply. Learn to give an accurate account of each important structure in an orderly and logical fashion by describing it to your lab partners. Always base your descriptions on the anatomical position.

Before beginning to dissect, consult your textbook for a description of anatomical planes and a definition of terms of relationship and comparison, terms of laterality, and terms of movement. These terms form the language of anatomy, and it is not possible to understand anatomical descriptions without being able to understand these terms and use them in your own descriptions.

ANATOMICAL VARIATION

All bodies have the same basic architectural plan but no two bodies are identical. Minor variations commonly occur and should be expected. You should learn normal (average) anatomy rather than the variation unless specifically instructed to do otherwise. Take time during each dissection period to view several dissections on neighboring cadavers so that you can learn to appreciate anatomical variations.

DAILY DISSECTION ROUTINE

To get the most out of a dissection, it is recommended that you establish a routine approach to each day’s dissection. Some suggestions are offered:

• Prepare before the lab. Read the dissection assignment in this book and become familiar with the new vocabulary, the structures to be dissected, and the dissection approach. You must deliberately search for structures, and a small amount of advance preparation will make the exercise go more quickly.

• Use a good atlas in the dissection lab. This dissection manual provides references to five excellent atlases to help you quickly find illustrations that support the dissection.

• Palpate bony landmarks and use them in the search for soft tissue structures.

• Remove fat, connective tissue, and smaller veins to clean up the dissection.

• Review the completed dissection at the end of the dissection period and again at the start of the next dissection period. To help you do this, review exercises are included at strategic points in each chapter.

• Complete each dissection before proceeding to the next because each new dissection is an extension of the previous dissection.

LAB SAFETY

While in the laboratory, protect your clothing by wearing a long laboratory coat or apron. For sanitary reasons, this outer layer of clothing should not be worn outside of the dissection laboratory. Do not wear sandals or open-toed shoes in the laboratory because a dropped scalpel can seriously injure your foot. Gloves must be worn to prevent contact with human tissue and fixatives. When cutting bones, wear glasses or goggles to protect your eyes against flying chips.

SKIN REMOVAL

Skin removal is the first step in dissection and a few suggestions are offered to help you get started. A variable amount of subcutaneous tissue (also called superficial fascia) lies immediately deep to the skin. The subcutaneous tissue contains fat, cutaneous nerves, and superficial blood vessels. Throughout this dissection manual, when you are instructed to skin a region, the skin should be removed and the subcutaneous tissue should be left behind. Subsequent dissection instructions will be provided for dissection and removal of the subcutaneous tissue.
To begin skinning, make incision lines of the appropriate depth as instructed in this manual. Then, use toothed forceps to grasp the skin at the intersection of two incision lines and begin to remove it from the underlying subcutaneous tissue with the scalpel blade. Once a skin flap has been raised, place traction on the skin as it is being removed and direct the scalpel blade toward the deep surface of the skin to cut the taut collagen fibers (FIG. I.4). To steady your scalpel hand, rest it against the cadaver and hold the scalpel as you would hold a pencil (FIG. I.5). Make short (5 to 10 cm), sweeping motions. To prevent accidents, do not work too close to your lab partners.

The thickness of skin varies from region to region. For example, the skin is relatively thin on the anterior surface of the forearm and it is considerably thicker over the posterior surface of the forearm. Generally, skin incisions should not extend into the subcutaneous tissue, therefore a general understanding of regional skin thickness is important.
The Back

The back region contains the superficial muscles of the back, the intermediate muscles of the back, and the deep muscles of the back. All of these muscles attach to the vertebral column. The vertebral column serves the dual purpose of forming the axis of the body and providing a protective bony covering for the spinal cord.

SURFACE ANATOMY

The surface anatomy of this region may be studied on a living subject or on a cadaver. In the cadaver, fixation may make it difficult to distinguish bone from well-preserved soft tissues. Turn the cadaver to the prone position (face down) and attempt to palpate the following structures (FIG. 1.1): [G 322; L 5; N 149; C 325]

- External occipital protuberance
- Superior border of the trapezius muscle
- Spinous process of the seventh cervical vertebra (vertebra prominens)
- Spine of the scapula (at vertebral level T3)
- Acromion of the scapula
- Medial (vertebral) border of the scapula
- Inferior angle of the scapula (at vertebral level T7)
- Spinous processes of thoracic vertebrae
- Erector spinae muscle (most noticeable in the lumbar region)
- Median furrow
- Lateral border of the latissimus dorsi muscle (posterior axillary fold)
- Iliac crest (at vertebral level L4)
- Posterior superior iliac spine

SKELETON OF THE BACK

Refer to a skeleton. On the scapula, identify (FIG. 1.2): [G 483; L 32; N 408; R 371; C 112]

- Acromion
- Spine
- Superior angle
- Medial (vertebral) border
- Inferior angle

ATLAS REFERENCES:

G = Grant’s Atlas, 13th ed., page number
L = LWW Atlas of Anatomy, 1st ed., page number
N = Netter’s Atlas, 5th ed., plate number
R = Color Atlas of Anatomy, 7th ed., page number
C = Clemente’s Atlas, 6th ed., plate number
The vertebral column (FIG. 1.2) consists of 33 vertebrae: 7 cervical (C), 12 thoracic (T), 5 lumbar (L), 5 sacral (S), and 4 coccygeal (Co). The upper 24 vertebrae (cervical, thoracic, and lumbar) allow flexibility and movement of the vertebral column, whereas the sacral vertebrae are fused to provide rigid support of the pelvic girdle. A typical thoracic vertebra will be described, and the cervical and lumbar vertebrae will be compared to it. [G 292; L 6; N 150; R 193; C 392]

Refer to a disarticulated thoracic vertebra and identify (FIG. 1.3): [G 104; L 9; N 151; R 190; C 393]

- **Body**
  - **Vertebral arch** – formed by the combination of pedicles and laminae
  - **Pedicle** (2)
  - **Lamina** (2)
  - **Vertebral foramen**
  - **Transverse process** (2)
  - **Transverse costal facet**
  - **Spinous process**
  - **Articular processes** – superior and inferior
  - **Vertebral notches** – superior and inferior
  - **Costal facets** – superior and inferior

The spinous process of a thoracic vertebra is long, slender, and directed inferiorly over the spinous process of the vertebra that is inferior to it. Articulation with ribs is a characteristic of thoracic vertebrae. The head of a

**FIGURE 1.2** Skeleton of the back and vertebral column.

On the ilium, identify (FIG. 1.2): [G 317; L 5; N 474; R 188; C 323]

- Iliac crest
- Posterior superior iliac spine

On the occipital bone, identify (FIG. 1.2):

- External occipital protuberance (inion)
- Superior nuchal line

On the temporal bone, identify (FIG. 1.2):

- Mastoid process

**FIGURE 1.3** Typical thoracic vertebra in lateral and superior view.
The sacrum is formed by five fused vertebrae and it does not have identifiable spines or transverse processes. On the posterior surface of the sacrum, identify (FIG. 1.6): [G 314; L 12; N 154; R 191; C 399]

- **Median sacral crest**
- **Posterior (dorsal) sacral foramina**
- **Sacral hiatus**

The **coccyx** is a small triangular bone formed by four rudimentary coccygeal vertebrae that are fused together (FIG. 1.6).
SKIN AND SUPERFICIAL FASCIA

Dissection Overview

The order of dissection will be as follows: The skin will be removed from the back, the posterior surface of the neck, and the posterior surface of the proximal upper limb. Posterior cutaneous nerves will be studied. The superficial fascia will then be removed.

Dissection Instructions

Skin Incisions

1. Refer to FIGURE 1.7.
2. Use a scalpel to make a skin incision in the midline from the external occipital protuberance (X) to the tip of the coccyx (S). The skin is approximately 6-mm thick in this region.
3. Make an incision from the tip of the coccyx (S) to the midaxillary line (T). This incision should pass approximately 3 cm inferior to the iliac crest.
4. Make a transverse skin incision from the external occipital protuberance (X) laterally to the base of the mastoid process (M).
5. Make a skin incision along the lateral surface of the neck and superior border of the trapezius muscle (M to B). Extend this incision to point F, about halfway down the arm.
6. At point F, make an incision around the anterior and posterior surfaces of the arm, meeting on the medial side (G). If the upper limb has been dissected previously, this incision has already been made.
7. Make a skin incision that begins at G on the medial surface of the arm and extends superiorly to the axilla. Extend this incision inferiorly along the lateral surface of the trunk, through V to T.
8. Make a transverse skin incision from R to B superior to the scapula and superior to the acromion.
9. At the level of the inferior angle of the scapula, make a transverse skin incision from the midline (U) to the midaxillary line (V).
10. To facilitate skinning, make several parallel transverse incisions above and below the one described in step 9. The strips of skin that result should be about 7.5-cm wide to make skinning easier.
11. Remove the skin from medial to lateral. Detach the skin and place it in the tissue container.
CHAPTER 1: THE BACK

Superficial Fascia

1. In the superficial fascia, locate the occipital artery and the greater occipital nerve (FIG. 1.8). First, find the occipital artery and then look on its medial side for the greater occipital nerve. The greater occipital nerve is the posterior (dorsal) ramus of spinal nerve C2. The greater occipital nerve pierces the trapezius muscle about 3 cm inferolateral to the external occipital protuberance. The deep fascia in this area is very dense and tough. Therefore, it may be difficult to find the greater occipital nerve, even though it is a large nerve. [G 323; L 16; N 172; R 226; C 382]

2. Read a description of the posterior (dorsal) ramus of a spinal nerve. The posterior cutaneous branches of the posterior rami pierce the trapezius muscle or the latissimus dorsi muscle to enter the superficial fascia (FIG. 1.9) [G 22; L 21; N 185; R 229]. To save time, make no deliberate effort to display posterior cutaneous branches of the posterior rami.

3. Reflect the superficial fascia of the back from medial to lateral. Detach the superficial fascia by cutting it along the skin incision lines and place it in the tissue container.

4. In the neck, reflect the superficial fascia only as far laterally as the superior border of the trapezius muscle. Do not cut the deep fascia along the superior border of the trapezius muscle. The accessory nerve is superficial at this location and it is in danger of being cut.

Dissection Follow-up

1. Review the branching pattern of a typical spinal nerve and understand that cutaneous branches of the posterior rami innervate the skin of the back.

2. Study a dermatome chart and become familiar with the concept of segmental innervation. [G 348; L 27; N 159; C 372]

Superficial Muscles of the Back

Dissection Overview

The superficial muscles of the back are the trapezius, latissimus dorsi, rhomboid major, rhomboid minor, and levator scapulae.

The order of dissection will be as follows: The superficial surface and borders of the trapezius muscle will be cleaned. The trapezius muscle will be examined and reflected. The latissimus dorsi muscle will be studied and reflected. The rhomboid major muscle, rhomboid minor muscle, and levator scapulae muscle will be identified. Dissection of the superficial back muscles should be performed bilaterally.

Dissection Instructions

Trapezius Muscle [G 323; L 17; N 168; R 226; C 373]

1. Clean the fat and connective tissue from the surface of the trapezius muscle (L. trapezoideus, an irregular four-sided figure) (FIG. 1.10). Clearly define its inferolateral border but do not disturb the superolateral border of the trapezius muscle. Observe the medial attachment of the trapezius muscle on the external occipital protuberance, the nuchal ligament, and the spinous processes of vertebrae C7 to T12.

2. Observe the lateral attachments of the trapezius muscle on the clavicle and scapula. The trapezius muscle has three parts, each of which has a distinctly different action:

   • Superior part – attaches to the lateral one-third of the clavicle and it elevates the scapula.
3. Prepare the trapezius muscle for reflection. First, insert your fingers deep to the inferolateral border of the muscle (medial to the inferior angle of the scapula) and move them superiorly as far as possible to break the connective tissue that lies between the trapezius muscle and the deeper muscles of the back.

4. Next, use scissors to detach the trapezius muscle from its medial attachment on the spinous processes and the nuchal ligament (FIG. 1.10, dashed line). Start at the inferior end of the muscle and continue the cut superiorly as far as the external occipital protuberance.

5. Use scissors to make a short transverse cut (2.5 cm) across the superior end of the trapezius muscle to detach it from the superior nuchal line. Spare the greater occipital nerve, and do not extend the transverse cut beyond the superolateral border of the trapezius muscle.

6. Use scissors to cut the trapezius muscle from its lateral attachments on the spine and acromion of the scapula (FIG. 1.10, dashed line). Make this cut very close to the scapular spine. Leave the
CHAPTER 1: THE BACK

11

Latissimus Dorsi Muscle  [G 323; L 17; N 168; R 226; C 373]
1. Clean the surface and borders of the latissimus dorsi muscle (L. latissimus, widest) (FIG. 1.10).
2. The medial attachments of the latissimus dorsi muscle are the spines of vertebrae T7 to T12, the thoracolumbar fascia, and the iliac crest. The latissimus dorsi muscle also has a medial attachment to ribs 9 to 12, lateral to their angles.
3. Note that the lateral attachment of the latissimus dorsi muscle is the floor of the intertubercular sulcus on the anterior side of the humerus but do not dissect this attachment. The latissimus dorsi muscle receives the thoracodorsal nerve and artery on its anterior surface near its lateral attachment. The lateral attachment of the latissimus dorsi muscle, its nerve, and its artery will be dissected with the upper limb.
4. To reflect the latissimus dorsi muscle, insert your fingers deep to the inferior border of the rhomboid major muscle and separate it from deeper muscles.
5. The dorsal scapular artery and vessels course parallel to the medial border of the scapula.
6. On the deep surface of the two rhomboid muscles near their lateral attachments, use blunt dissection to find the dorsal scapular nerve and dorsal scapular vessels. The dorsal scapular nerve and vessels may branch directly from the subclavian artery, or it may arise from the transverse cervical artery, in which case it is also known as the deep branch of the transverse cervical artery.

Rhomboid Major and Rhomboid Minor Muscles  [G 324; L 17; N 171; R 226; C 373]
1. Clean the surface and borders of the rhomboid (rhomboideus) minor muscle and the rhomboid major muscle (Gr. rhombus, shaped like a kite).
2. The medial attachments of the rhomboid minor muscle are the nuchal ligament and the spinous processes of vertebrae C7 and T1. The lateral attachment of the rhomboid minor muscle is the medial border of the scapula at the level of the scapular spine.
3. The medial attachments of the rhomboid major muscle are the spinous processes of vertebrae T2 to T5. The lateral attachment of the rhomboid major muscle is the medial border of the scapula inferior to the scapular spine.
4. Typically, the separation between the rhomboid muscles is not very obvious and the two muscles must be separated from each other using their lateral attachments as a guide.
5. The rhomboid muscles retract the scapula, rotate the scapula to depress the glenoid cavity, and hold the scapula close to the thoracic wall.
6. To reflect the rhomboid muscles, insert your fingers deep to the inferior border of the rhomboid major muscle and separate it from deeper muscles.
7. Working from inferior to superior, use scissors to detach the rhomboid major muscle from its medial attachments on the spinous processes. Continue the cut superiorly and detach the rhomboid minor muscle from its medial attachments on the spinous processes. Reflect these two muscles laterally.
8. The dorsal scapular artery may branch directly from the subclavian artery, or it may arise from the transverse cervical artery, in which case it is also known as the deep branch of the transverse cervical artery.

Levator Scapulae Muscle  [G 324; L 17; N 168; R 226; C 373]
1. Identify the levator scapulae muscle (L. levare, to raise). At this stage of the dissection, the levator scapulae muscle can be seen only near its attachment on the scapula.
2. Note that the superior attachments of the levator scapulae muscle are the transverse processes of the upper four cervical vertebrae. Do not dissect its superior attachments.

Trapezius Muscle attached to the clavicle and the cervical fascia.
7. Reflect the trapezius muscle superolaterally. Leave the cervical fascia attached along the superior border of the trapezius muscle to act as a hinge.
8. Study the deep surface of the reflected trapezius muscle. Find the plexus of nerves formed by the accessory nerve (cranial nerve XI) and branches of the anterior (ventral) rami of spinal nerves C3 and C4. The accessory nerve provides motor innervation to the trapezius muscle; the branches of nerves C3 and C4 are sensory (proprioception). The superficial branch of the transverse cervical artery accompanies the nerves. The transverse cervical vein may be removed to clear the dissection field.
9. The accessory nerve passes through the posterior triangle at this time. The posterior triangle will be dissected with the neck.

Rhomboid Major and Rhomboid Minor Muscles
1. Clean the surface and borders of the rhomboid (rhomboideus) minor muscle and the rhomboid major muscle (Gr. rhombus, shaped like a kite).
2. The medial attachments of the rhomboid minor muscle are the nuchal ligament and the spinous processes of vertebrae C7 and T1. The lateral attachment of the rhomboid minor muscle is the medial border of the scapula at the level of the scapular spine.
3. The medial attachments of the rhomboid major muscle are the spinous processes of vertebrae T2 to T5. The lateral attachment of the rhomboid major muscle is the medial border of the scapula inferior to the scapular spine.
4. Typically, the separation between the rhomboid muscles is not very obvious and the two muscles must be separated from each other using their lateral attachments as a guide.
5. The rhomboid muscles retract the scapula, rotate the scapula to depress the glenoid cavity, and hold the scapula close to the thoracic wall.
6. To reflect the rhomboid muscles, insert your fingers deep to the inferior border of the rhomboid major muscle and separate it from deeper muscles.
7. Working from inferior to superior, use scissors to detach the rhomboid major muscle from its medial attachments on the spinous processes. Continue the cut superiorly and detach the rhomboid minor muscle from its medial attachments on the spinous processes. Reflect these two muscles laterally.
8. The dorsal scapular artery may branch directly from the subclavian artery, or it may arise from the transverse cervical artery, in which case it is also known as the deep branch of the transverse cervical artery.

Levator Scapulae Muscle
1. Identify the levator scapulae muscle (L. levare, to raise). At this stage of the dissection, the levator scapulae muscle can be seen only near its attachment on the scapula.
2. Note that the superior attachments of the levator scapulae muscle are the transverse processes of the upper four cervical vertebrae. Do not dissect its superior attachments.
The inferior attachment of the levator scapulae muscle is on the superior angle of the scapula.

4. The dorsal scapular nerve and artery supply the levator scapulae muscle. The dorsal scapular nerve and artery pass anterior (deep) to the inferior end of the levator scapulae muscle.

5. The levator scapulae muscle elevates the scapula and rotates the scapula to depress the glenoid cavity.

Dissection Follow-up

1. Replace the superficial muscles of the back in their correct anatomical positions.
2. Use the dissected specimen to review the attachments, action, innervation, and blood supply of each muscle that you have dissected.
3. Review the movements that occur between the scapula and the thoracic wall.
4. Use an illustration to observe the origin of the transverse cervical artery and the origin of the dorsal scapular artery.
5. Observe two triangles associated with the latissimus dorsi muscle: the triangle of auscultation and the lumbar triangle (FIG. 1.10).

CLINICAL CORRELATION

**TRIANGLES OF THE BACK** [G 323, 324; L 17; N 248; C 373]

The triangle of auscultation is bounded by the latissimus dorsi muscle, the trapezius muscle, and the rhomboid major muscle. Within the triangle of auscultation, intercostal space 6 has no overlying muscles. This area is particularly well suited for auscultation (listening to sounds produced by thoracic organs, particularly the lungs).

The lumbar triangle is bounded by the latissimus dorsi muscle, the external oblique muscle, and the iliac crest. The floor of the lumbar triangle is the internal oblique muscle of the abdomen. On rare occasions, the lumbar triangle is the site of a lumbar hernia.

**INTERMEDIATE MUSCLES OF THE BACK** [G 324; L 17, 18; N 168; R 228; C 374]

The intermediate muscles of the back are the serratus posterior superior muscle and the serratus posterior inferior muscle. The serratus posterior superior and inferior muscles are very thin muscles, which may have been accidentally reflected with the rhomboid muscles or the latissimus dorsi muscle. If you do not see the serratus posterior muscles, look for them on the deep surface of the reflected rhomboid muscles or the reflected latissimus dorsi muscle.

1. The medial attachments of the serratus posterior superior muscle are the nuchal ligament and the spinous processes of vertebrae C7 to T3. Its lateral attachments are the superior borders of ribs 2 to 5, lateral to their angles.
2. The medial attachments of the serratus posterior inferior muscle are the spinous processes of vertebrae T11 to L2. Its lateral attachments are the inferior borders of ribs 9 to 12, lateral to their angles.
3. The serratus posterior muscles are respiratory (inspiratory) muscles, and they are innervated by intercostal nerves.

DEEP MUSCLES OF THE BACK

**Dissection Overview**

The deep muscles of the back act on the vertebral column. There are many deep muscles of the back (FIG. 1.11) and only a few will be dissected: splenius capitis muscle, splenius cervicis muscle, semispinalis capitis muscle, and erector spinae muscle. All of the deep muscles of the back are innervated by posterior rami of spinal nerves.

The order of dissection will be as follows: The deep muscles of the posterior neck (splenius capitis and cervicis) will be studied and reflected. The semispinalis capitis muscle will be identified. The erector spinae muscle will be dissected and the three columns of muscle that comprise its component parts will be identified.

**Dissection Instructions**

**Splenius Muscle** [G 325; L 18; N 168; R 226; C 376]

1. Detach the serratus posterior superior muscle from the spines of vertebrae C7 to T3 and reflect it laterally. Leave it attached to the ribs.
2. Identify the splenius muscle (Gr. splenion, bandage) (FIG. 1.10). The fibers of the splenius muscle course obliquely across the neck. The inferior attachment of the splenius muscle is the nuchal ligament and the spinous processes of vertebrae C7 to T6.
3. The splenius muscle has two parts that are named according to their superior attachments:
   - **Splenius capitis muscle** (L. caput, head) – attached to the mastoid process of the temporal bone and the superior nuchal line of the occipital bone
   - **Splenius cervicis muscle** (L. cervix, neck) – attached to the transverse processes of vertebrae C1 to C4
2. Use a scalpel to incise the posterior surface of the thoracolumbar fascia beginning at the midthoracic level and extending to the sacrum. This fascia is very thin at thoracic levels but becomes very thick at lumbar and sacral levels. Use blunt dissection to separate the thoracolumbar fascia from the posterior surface of the erector spinae muscle. Remove the thoracolumbar fascia and place it in the tissue container.

3. Beginning at the midthoracic level, use your fingers to separate the three columns of the erector spinae. Continue to separate the columns inferiorly as far as possible. The columns of the erector spinae muscle are fused to each other at the level of the sacrum and ilium and they cannot easily be separated at lower levels.

4. Identify (FIG. 1.11):
   - **Spinalis muscle** – the most medial column of the erector spinae muscle. The inferior attachments of the spinalis muscle are on spinous processes. Its superior attachments are also on spinous processes. The spinalis muscle is present at lumbar, thoracic, and cervical vertebral levels.
   - **Longissimus muscle** (L. longissimus, the longest) – the intermediate column of the erector spinae muscle. Its inferior attachment is on the sacrum and its superior attachments are the transverse processes of the thoracic and cervical vertebrae. Note that its most superior portion, the longissimus capitis muscle, attaches to the mastoid process of the temporal bone.
   - **Iliocostalis muscle** – the lateral column of the erector spinae muscle. Its inferior attachment is the ilium (iliac crest), and its superior attachments are on ribs (L. costa, rib).

5. All three columns of the erector spinae muscle extend the vertebral column when both sides work together. If only one side of the erector spinae muscle is active, it bends the vertebral column laterally toward the side that is active.

Transversospinal Group of Muscles [G 328; L 19; N 170; R 223; C 378]

The transversospinal group of muscles is located deep to the erector spinae muscle. The muscles in the transversospinal group attach to transverse processes and spinous processes (FIG. 1.11). The muscles of the transversospinal group cause rotational and lateral bending movements between adjacent vertebrae and act to stabilize the vertebral column. A number of muscles comprise this group: the semispinalis, the multifidus, and more deeply, the rotatores.
The semispinalis capitis muscle will be reflected. The muscles that bound the suboccipital triangle will be identified. The contents of the suboccipital region (vertebral artery and suboccipital nerve) will be studied.

Dissection Instructions

1. One again, identify the semispinalis capitis muscle (FIGS. 1.11, 1.13). [G 330; L 19, 20; N 170; R 238; C 377]

2. Find the greater occipital nerve where it penetrates the semispinalis capitis muscle. Use blunt dissection to follow the greater occipital nerve deeply through the semispinalis capitis muscle. Detach the semispinalis capitis muscle close to the occipital bone and reflect it inferiorly. Preserve the greater occipital nerve.

3. Deep to the semispinalis capitis muscle, follow the greater occipital nerve to the lower border of the obliquus capitis inferior muscle. Note that the greater occipital nerve (posterior ramus of C2) emerges between vertebrae C1 and C2.

4. Identify and clean the three muscles that form the boundaries of the suboccipital triangle (FIG. 1.13): [G 333; L 20; N 172; R 238; C 385]

- Obliquus capitis inferior muscle forms the inferior boundary of the suboccipital triangle. Verify that the medial attachment of the obliquus capitis inferior muscle is the spinous process of the axis (C2). Its lateral attachment is on the transverse process of the atlas (C1).

- Rectus capitis posterior major muscle forms the medial boundary of the suboccipital triangle. Confirm that the medial attachment of the rectus capitis posterior major muscle is the spinous process of the axis. Its lateral attachment is the inferior nuchal line of the occipital bone.
CHAPTER 1: THE BACK

Note that the suboccipital nerve (posterior ramus of C1) emerges between the occipital bone and the atlas (C1 vertebra). The suboccipital nerve supplies motor innervation to the muscles of the suboccipital region. The suboccipital nerve is the only posterior ramus of a cervical spinal nerve that has no cutaneous distribution.

7. Identify the vertebral artery. Use an illustration to study the course of the vertebral artery through the neck and into the skull.

Dissection Follow-up

1. Review the actions of the suboccipital muscles.
2. Review the distribution of the branches of a thoracic posterior ramus and compare the thoracic pattern to the distribution of the posterior rami of spinal nerves C1 to C3.

VERTEBRAL CANAL, SPINAL CORD, AND MENINGES

Dissection Overview

The vertebral canal is a bony tube formed by the stacked vertebral foramina of the cervical vertebrae, thoracic vertebrae, lumbar vertebrae, and sacral canal (FIG. 1.14). The vertebral canal encloses and protects the spinal cord, its membranes (spinal meninges), and blood vessels.

The spinal cord begins at the foramen magnum of the occipital bone and usually terminates in the adult at the level of the second lumbar vertebra. Because the spinal cord is shorter than the vertebral canal, the spinal cord segments are found at higher vertebral levels than their names would suggest (FIG. 1.14).

The spinal cord is not uniform in diameter throughout its length. It has a cervical enlargement (FIG. 1.14) that corresponds to spinal cord segments C4 to T1 and a lumbar enlargement that corresponds to spinal cord segments L2 to S3. There are 31 pairs of spinal nerves (8 cervical, 12 thoracic, 5 lumbar, 5 sacral, and 1 coccygeal) (FIG. 1.14), which emerge between adjacent vertebrae. Most spinal nerves are numbered according to the vertebra above them as they pass through the intervertebral foramen (i.e., spinal nerve T1 exits the vertebral canal below vertebra T1). However, in the cervical region, spinal nerves are numbered differently—they are numbered according to the vertebra below. For example, spinal nerve C1 exits the vertebral canal above vertebra C1, and the C8 spinal nerve does not have a correspondingly numbered cervical vertebra.

The order of dissection will be as follows: The erector spinae muscles will be removed to expose the laminae of the vertebrae. The laminae will then be cut and removed (laminectomy) to expose the spinal meninges.
Laminectomy will begin at thoracic levels and will be extended inferiorly. The spinal meninges will be examined and will be opened to expose the spinal cord. The spinal cord will then be studied.

**Dissection Instructions**

1. **Wear eye protection for all steps that require the use of a chisel, bone saw, or bone cutters.**
2. Use a scalpel to remove the erector spinae muscles bilaterally from vertebral levels T4 to S3. The laminae must be cleanly exposed. Use scraping motions with a chisel to clean the muscle fragments off the laminae after the muscles have been removed.

3. Use a chisel or power saw to cut the laminae of vertebrae T6 to T12 on both sides of the spinous processes. Make this cut at the lateral end of the laminae to gain wide exposure to the vertebral canal. The cutting instrument should be angled at 45° to the vertical (FIG. 1.15).
4. Use a scalpel to cut the interspinous ligament between vertebrae T6 and T7 and between vertebrae T12 and L1. Preserve the interspinous ligaments between these levels to keep the intervening spines together.
5. Use a chisel to pry the six spinous processes and their laminae out as a unit. The dura mater will...
CLINICAL CORRELATION

VERTEBRAL VENOUS PLEXUSES

The veins of the vertebral venous plexuses are valveless, permitting blood to flow superiorly or inferiorly depending on blood pressure gradients. The vertebral venous plexuses can serve as routes for metastasis of cancer from the pelvis to the vertebrae, vertebral canal, and cranial cavity.

1. Identify the dura mater. The dural sac ends inferiorly at vertebral level S2 (FIG. 1.16A). [G 338; L 22, 24; N 157; R 230; C 403]

2. On the deep surface of the removed spinous specimen, observe the ligamenta flava. The ligamenta flava connect the laminae of adjacent vertebrae.

6. Continue the laminectomy procedure inferiorly. Use direct observation of the vertebral canal to help you make the cuts correctly. Exercise caution in lower lumbar and sacral regions, as the vertebral canal curves sharply posteriorly (superficially) (FIG. 1.16A). Do not drive the chisel or push the saw through the sacrum as the tool will penetrate the rectum.

8. When finished with the laminectomy, you should see the posterior surface of the dura mater from vertebral levels T6 to S2.

Spinal Meninges

1. Once the laminectomy is completed, the epidural (extradural) space is exposed. It contains fat and veins. Use blunt dissection to remove the epidural fat and the posterior internal vertebral venous plexus from the epidural space. [L 26; N 163; C 481]
The tip of the conus medullaris. It ends at vertebral level S2, where it becomes encircled by the lower end of the dural sac. 

- **Filum terminale externum (coccygeal ligament)** (FIG. 1.16A, B) is made of dura mater and it contains the continuation of the filum terminale internum below vertebral level S2. The filum terminale externum passes through the sacral hiatus and ends by attaching to the coccyx.

7. The pia mater forms two denticulate ligaments, one on each side of the spinal cord (FIG. 1.17A, B). Each denticulate ligament has 21 teeth and each midline and observe the **subarachnoid space**. The subarachnoid space contains cerebrospinal fluid in the living person but not in the cadaver. [G 339; L 23; N 162; R 232; C 404] 

5. Retract the arachnoid mater and observe the **spinal cord**. The spinal cord is completely invested by the **pia mater**, which is on the surface of the spinal cord and cannot be dissected from it.

6. Identify the following features of the spinal cord: [G 336; L 22, 24; N 157; R 230; C 403]

- **Lumbar enlargement** (spinal cord segments L2 to S3) provides nerves to the lower limb. The lumbar enlargement is located at lower thoracic vertebral levels.
- **Conus medullaris (medullary cone)** is the end of the spinal cord located between vertebral levels L1 and L2.
- **Cauda equina** (L., tail of horse) is a collection of anterior and posterior roots in the lower vertebral canal (FIG. 1.16B).
- **Filum terminale internum** (FIG. 1.16A, B) is a delicate filament of pia mater that arises from the tip of the conus medullaris. It ends at vertebral level S2, where it becomes encircled by the lower end of the dural sac.

7. The pia mater forms two **denticulate ligaments**, one on each side of the spinal cord (FIG. 1.17A, B). Each denticulate ligament has 21 teeth and each midline and observe the **subarachnoid space**. The subarachnoid space contains cerebrospinal fluid in the living person but not in the cadaver. [G 339; L 23; N 162; R 232; C 404] 

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CHAPTER 1: THE BACK

19

10. In the thoracic region, expose one spinal nerve. Place a probe into an intervertebral foramen to protect the nerve within it. Use bone cutters to remove the posterior wall of the intervertebral foramen and expose the spinal ganglion (dorsal root ganglion) (FIG. 1.17A). Distal to the spinal ganglion, identify the spinal nerve and follow it distally to the point where it divides into a posterior ramus and an anterior ramus.

CLINICAL CORRELATION

LUMBAR PUNCTURE

Cerebrospinal fluid (CSF) can be obtained from the subarachnoid space inferior to the conus medullaris (FIG. 1.18). At this level, there is no danger of penetrating the spinal cord with the puncture needle.

Dissection Follow-up

1. Review the formation and branches of a typical spinal nerve.
2. Describe the way that the deep back muscles receive their innervation.
3. Review the coverings and parts of the spinal cord and study an illustration that shows the blood supply to the spinal cord.
4. Consult a dermatome chart and relate this pattern of cutaneous innervation to the spinal cord segments. [G 348; L 27; N 159; C 372]
The function of the upper limb is to place the hand in a position to be effective as a grasping tool. As such, the upper limb has adapted into a body part with great freedom of motion. Some of the muscles that control this motion extend across the front and back of the thorax. If the back has previously been dissected, the superficial muscles of the back have been studied. If the upper limb is your first dissection unit, you will be instructed to dissect the superficial muscles of the back at the appropriate time.

**SURFACE ANATOMY**

[G 482, 483; L 30; N 400; R 401, 402; C 34]

The upper limb is divided into four regions: shoulder, arm (brachium), forearm (antebrachium), and hand (manus). The surface anatomy of the upper limb can be studied on a living subject or on the cadaver. Place the cadaver in the supine position (face up) and palpate the following superficial structures (FIG. 2.1):

- Jugular notch
- Xiphisternal junction
- Costal margin
- Clavicle
- Acromion
- Anterior axillary fold
- Posterior axillary fold
- Deltoid muscle
- Biceps brachii muscle
- Triceps brachii muscle
- Cubital fossa
- Medial epicondyle

**ATLAS REFERENCES:**

G = Grant’s Atlas, 13th ed., page number
L = LWW Atlas of Anatomy, 1st ed., page number
N = Netter’s Atlas, 5th ed., plate number
R = Color Atlas of Anatomy, 7th ed., page number
C = Clemente’s Atlas, 6th ed., plate number

**SUPERFICIAL VEINS AND CUTANEOUS NERVES**

**Dissection Overview**

The superficial fascia of the upper limb contains fat, superficial veins, and cutaneous nerves. In the living body, the superficial veins may be visible through the...
skin. They are frequently used for drawing blood and injecting medications. In the cadaver, the superficial veins are not conspicuous. The cutaneous nerves of the upper limb pierce the deep fascia to reach the superficial fascia and skin.

The order of dissection will be as follows: The anterior thoracic wall and the upper limb proximal to the wrist will be skinned. The objective is to remove only the skin, leaving the superficial fascia undisturbed. The superficial veins and selected cutaneous nerves will be dissected. The fat will then be removed so that the deep fascia may be observed. [G 490, 498; L 31; N 403, 404; R 400, 402; C 41]

Dissection Instructions

Skin Incisions
1. Place the cadaver in the supine position.
2. Refer to FIGURE 2.2A. Before cutting, realize that the skin is thin on the anterior thoracic wall.
3. Make a midline skin incision from the jugular notch (A) to the xiphisternal junction (C).
4. Make a skin incision from the jugular notch (A) along the clavicle to the acromion (B). Continue this incision down the lateral side of the arm to a point that is approximately halfway down the arm (F).
5. At point F, make an incision around the anterior and posterior surfaces of the arm, meeting on the medial side (G).
6. Make an incision from the xiphisternal junction (C) along the costal margin to the midaxillary line (V).
7. Make an incision that begins at G on the medial surface of the arm and extends superiorly to the axilla. Extend this incision inferiorly along the lateral surface of the trunk to V.
8. Make a transverse skin incision from the middle of the manubrium to the midaxillary line, passing around the nipple.
9. Make a transverse skin incision from the xiphisternal junction (C) to the G–V incision.
10. Make a transverse skin incision halfway between the A–B incision and the incision made in step 8.
11. Remove the skin from medial to lateral. Leave the nipple attached to the superficial fascia. Detach the skin along the midaxillary line and place it in the tissue container.
12. If the back has not been dissected previously go to page 8, follow the skinning instructions that are provided there, and return to this page.
13. Refer to FIGURE 2.2B.
14. Make an incision that encircles the wrist (E). The skin is very thin (2 mm) on the anterior surface of the wrist—do not cut too deeply.
15. Make a longitudinal incision on the anterior surface of the upper limb (E to G).
16. Remove the skin from the arm and forearm and place it in the tissue container. Do not damage the superficial veins and cutaneous nerves in the superficial fascia.

Superficial Veins [G 498; L 31; N 403, 404; R 398; C 41]
1. Use blunt dissection with a probe to demonstrate the superficial veins of the arm and forearm (FIG. 2.3).
2. Abduct the upper limb to about 45° and have your dissection partner hold it in the abducted position.
3. In the posterior forearm, demonstrate the basilic vein and cephalic vein.
4. Use a probe to follow the cephalic and basilic veins proximally, freeing them from the surrounding fat and connective tissue.
5. Demonstrate that the cephalic and basilic veins are joined across the cubital fossa by the median
CHAPTER 2: THE UPPER LIMB

6. Follow the cephalic vein proximally into the pectoral region where it courses in the deltopectoral groove between the deltoid muscle and the pectoralis major muscle. Near the clavicle, the cephalic vein passes deeply through the deltopectoral triangle to join the axillary vein.

7. Follow the basilic vein proximally. About halfway up the arm, it pierces the deep fascia to join the deep veins.

8. Use a probe to elevate the superficial veins (FIG. 2.3). Note that several perforating veins penetrate the deep fascia and connect the superficial veins to the deep veins.

Cutaneous Nerves [G 490; L 31; N 403, 404; R 400; C 36, 37, 68, 69]

1. Before dissecting, use an illustration to familiarize yourself with the course and distribution of the cutaneous nerves of the arm and forearm (FIG. 2.3):

- Superior lateral cutaneous nerve of the arm
- Inferior lateral cutaneous nerve of the arm
- Posterior cutaneous nerve of the arm
- Intercostobrachial nerve
- Medial cutaneous nerve of the arm
- Posterior cutaneous nerve of the forearm
- Lateral cutaneous nerve of the forearm
- Medial cutaneous nerve of the forearm
- Superficial branch of the radial nerve
- Dorsal branch of the ulnar nerve

2. Identify only four of the cutaneous nerves:

- **Lateral cutaneous nerve of the forearm** – located at the level of the elbow in the superficial fascia lateral to the biceps brachii tendon. Note its close relationship to the cephalic vein and the median cubital vein.
- **Medial cutaneous nerve of the forearm** – located on the medial side of the biceps brachii tendon. Note its close relationship to the basilic vein.
- **Superficial branch of the radial nerve** – located in the superficial fascia near the styloid process of the radius. Expose only 2 or 3 cm of this nerve.
- **Dorsal branch of the ulnar nerve** – located in the superficial fascia near the styloid process of the ulna. Expose only 2 or 3 cm of this nerve.

3. The cutaneous nerves to the digits will be studied when the hand is dissected.

4. Remove all remaining superficial fascia from the arm and forearm, preserving the superficial veins and nerves that you have dissected. Do not disturb the deep fascia. Place the superficial fascia in the tissue container.

5. Examine the deep fascia of the upper limb and note that it extends from the shoulder to the fingertips. It attaches to the bones of the upper limb and forms compartments that contain groups of muscles. The deep fascia of the upper limb is regionally named: brachial fascia in the arm and antebrachial fascia in the forearm. In the hand, the deep fascia is called palmar fascia on the palmar surface and dorsal fascia of the hand on the posterior surface.
Dissection Follow-up
1. Review the superficial fascia of the upper limb.
2. Use the dissected specimen to trace the course of the superficial veins from distal to proximal.
3. Review the location of the cephalic vein, basilic vein, and median cubital vein in the cubital fossa and recall that these are important for venipuncture.
4. Use the dissected specimen to review the four cutaneous nerves that you have dissected. Use an illustration to review the pattern of distribution of the cutaneous nerves that you did not dissect.
5. Compare this pattern of cutaneous nerve distribution to a dermatome chart.
6. Review the deep fascia of the upper limb and name its parts. [G 501; L 31; N 401, 402]

SUPERFICIAL MUSCLES OF THE BACK

Instructions for dissection of the superficial muscles of the back are found in Chapter 1, The Back. If you are dissecting the upper limb before the back, the superficial muscles of the back must be dissected now. Turn to pages 9 to 12, complete that dissection, and return to this page.

SCAPULAR REGION

Dissection Overview
There are six shoulder (scapulohumeral) muscles: deltoid, supraspinatus, infraspinatus, teres minor, teres major, and subscapularis. The order of dissection will be as follows: The deltoid muscle will be studied, and then it will be detached from its proximal attachment, and the course of its nerve and artery will be studied. Subsequently, the four muscles arising from the posterior surface of the scapula (supraspinatus, infraspinatus, teres major, teres minor) will be dissected and their nerves and blood vessels will be demonstrated. The subscapularis muscle will be dissected later, with the axilla.

Dissection Instructions
1. Place the cadaver in the prone position (face down). Abduct the upper limb to 45°. If a block is available, place it under the chest.
2. Reflect the trapezius muscle superiorly, leaving it attached along the “hinge” of cervical fascia that was created during the back dissection.
3. Clean the surface and borders of the deltoide muscle. Observe the proximal attachments of the deltoid muscle:
   - Spine of the scapula

Skeleton of the Scapular Region [G 526, 527; L 32; N 408; R 371, 373; C 112, 113]
Refer to a skeleton. On the scapula, identify (FIG. 2.4):
- Acromion
- Suprascapular notch
- Supraspinous fossa
- Spine
- Infraspinous fossa
- Supraglenoid tubercle
- Glenoid cavity
- Infraglenoid tubercle
- Coracoid process

On the humerus, identify (FIG. 2.4):
- Head
- Anatomical neck
- Greater tubercle
- Lesser tubercle
- Intertubercular sulcus (bicipital groove)
- Surgical neck
- Deltoid tuberosity
- Radial groove
• Acromion of the scapula
• Lateral one-third of the clavicle

Observe the distal attachment of the deltoid muscle on the deltoid tuberosity of the humerus. The deltoid muscle abducts the humerus. [G 521; L 36; N 411; R 382; C 62]

4. Use a scalpel to detach the deltoid muscle from its proximal attachments. Make your cuts close to the bone. Leave the muscle attached to its distal attachment on the humerus. Reflect the deltoid muscle laterally, taking care not to tear the vessels and nerve that course along its deep surface.

5. Observe the axillary nerve and the posterior circumflex humeral artery and vein on the deep surface of the deltoid muscle near its attachment to the humerus (FIG. 2.5). Use a probe to clean the nerve and vessels and trace them around the surgical neck of the humerus. [G 536; L 37; N 414; R 383; C 67]

6. Note that the axillary nerve innervates the deltoid muscle and that it also innervates the teres minor muscle.

7. Follow the axillary nerve and the posterior circumflex humeral artery and vein deeply. Push your finger parallel to the nerve and vessels to open the quadrangular space (FIG. 2.5). Define the borders of the quadrangular space:

- Superior border – inferior border of the teres minor muscle
- Lateral border – surgical neck of the humerus
- Medial border – lateral border of the long head of the triceps brachii muscle
- Inferior border – superior border of the teres major muscle

8. Identify the long head of the triceps brachii muscle and observe its relationships:

- It passes anterior to the teres minor muscle
- It passes posterior to the teres major muscle
- It passes medial to the axillary nerve and posterior humeral circumflex artery

9. Clean and define the borders of the teres minor muscle. The medial attachment of the teres minor muscle is on the lateral border of the scapula. The lateral attachment of the teres minor muscle is on the inferior facet of the greater tubercle of the humerus. The teres minor muscle laterally rotates the humerus.

10. Clean and define the borders of the teres major muscle. The medial attachment of the teres major muscle is the inferior angle of the scapula. The lateral attachment of the teres major muscle is the medial lip of the intertubercular sulcus of the humerus. The teres major muscle adducts and medially rotates the humerus.
11. Define the borders of the triangular space:
- **Superior border** – inferior border of the teres minor muscle
- **Lateral border** – medial border of the long head of the triceps brachii muscle
- **Inferior border** – superior border of the teres major muscle

12. Note that the circumflex scapular artery may be found deep within the triangular space.

13. Clean and define the borders of the **supraspinatus muscle**. Observe the medial attachment of the supraspinatus muscle on the supraspinous fossa of the scapula. The lateral attachment of the supraspinatus muscle is on the highest facet of the greater tubercle of the humerus. The supraspinatus muscle initiates abduction of the humerus.

14. Use a probe to define the borders of the **infraspinatus muscle**. Observe the medial attachment of the infraspinatus muscle on the infraspinous fossa of the scapula. The lateral attachment of the infraspinatus muscle is on the middle facet of the greater tubercle of the humerus. The infraspinatus muscle laterally rotates the humerus.

15. The **suprascapular artery** and the **suprascapular nerve** are found deep to the supraspinatus muscle (FIG. 2.5). To see them, the supraspinatus muscle must be reflected. [G 536; L 37; N 414; R 404; C 33]

16. Use a scalpel to transect the supraspinatus muscle about 5 cm lateral to the superior angle of the scapula but medial to the suprascapular notch (FIG. 2.5). If a disarticulated scapula is available, hold it over the scapula of the cadaver to help you locate the proper level of the cut.

17. Use blunt dissection to loosen, from the infraspinous fossa, the portion of the supraspinatus muscle that is distal to the transection. Reflect it laterally. Leave it attached to the humerus.

18. Identify the **suprascapular artery and nerve** that lie on the posterior surface of the scapula. Follow the artery and nerve superiorly. Observe that the suprascapular artery passes superior to the **superior transverse scapular ligament** and the suprascapular nerve passes inferior to it (FIG. 2.5). This relationship can be remembered by use of a mnemonic device: Army (artery) goes over the bridge; Navy (nerve) goes under the bridge. The “bridge” is the superior transverse scapular ligament.

19. Transect the **infraspinatus muscle** about 5 cm lateral to the medial border of the scapula (FIG. 2.5).

20. Use blunt dissection to loosen from the infraspinous fossa—the portion of the infraspinatus muscle that is distal to the transection. Reflect it laterally.

21. Now follow the **suprascapular artery** and the **suprascapular nerve** inferiorly. Observe that they reach the infraspinatus muscle by coursing deep (anterior) to the spine of the scapula (FIG. 2.5).

22. The suprascapular artery contributes to the collateral circulation of the scapular region. Use an illustration to study the **scapular anastomosis**. [G 512; L 38; N 415; R 404]

23. The four muscles of the **rotator cuff** are the **supraspinatus, infraspinatus, teres minor, and subscapularis**. The subscapularis muscle will be dissected with the axilla. Use an illustration to study the lateral attachments of the rotator cuff muscles. [G 524, 525, 542; L 45; N 407, 408; R 383; C 32, 54]

**Dissection Follow-up**

1. Replace the muscles of the scapular region in their correct anatomical positions.
2. Use an illustration and the dissected specimen to review the attachments of each muscle of the scapular region. List the action of each muscle and the combined action of the rotator cuff group of muscles.
3. Review the origin, course, and distribution of the transverse cervical artery, dorsal scapular artery, and suprascapular artery.
4. Review the scapular anastomosis.
5. Review the relationship of the suprascapular artery and the suprascapular nerve to the superior transverse scapular ligament.
6. Review the innervation of each muscle dissected.

**PECTORAL REGION**

**Dissection Overview**

The **pectoral region** (L. pectus, chest) covers the anterior thoracic wall and part of the lateral thoracic wall. The order of dissection will be as follows: The breast will be dissected in female cadavers. In cadavers of both sexes, the superficial fascia will be removed to expose the pectoral muscles.

**Dissection Instructions**

**Breast** [G 5, 6; L 39; N 176; R 290; C 4–6]

The breast is dissected in female cadavers only. Students with male cadavers must observe at another dissection table. Because of the advanced age of some cadavers, it may be difficult to dissect and identify all of the structures listed. Expect the lobes of the gland to be replaced by fat with advanced age.

The **breast** extends from the lateral border of the sternum to the midaxillary line, and from rib 2 to rib 6.
The mammary gland is a modified sweat gland that is contained within the superficial fascia of the breast (FIG. 2.6). The breast is positioned anterior to the pectoral fascia (the deep fascia of the pectoralis major muscle). The pectoral fascia is attached to the overlying skin by the suspensory ligaments of the breast that pass between the lobes of the mammary gland.

1. Identify the areola and the nipple (FIG. 2.6).
2. Use the handle of a forceps to scoop the fat out of several compartments between suspensory ligaments. These areas between suspensory ligaments once contained lobes of functional glandular tissue.
3. Make a parasagittal (superior to inferior) cut through the nipple that divides the breast into a medial half and a lateral half (FIG. 2.6).
4. On the cut edge of the breast, use a probe to dissect through the fat deep to the nipple. Conflne your search area to within 3-cm deep to the areola. Find and clean one of the 15 to 20 lactiferous ducts that converge on the nipple. Deep to the nipple identify a lactiferous sinus, which is an expanded part of the lactiferous duct.
5. Trace one lactiferous duct to the nipple and attempt to identify its opening.
6. Use an illustration to study the lymphatic drainage of the breast. [G 8; L 40; N 178; R 290; C 7, 8]
7. Insert your fingers behind the breast and open the retromammary space. Note that the normal breast can be easily separated from the underlying deep fascia of the pectoralis major muscle.
8. Remove the breast from the anterior surface of the pectoralis major muscle with the aid of a scalpel.
9. Store the breast in a plastic bag.

### CLINICAL CORRELATION

**BREAST**

For descriptive purposes, clinicians divide the breast into four quadrants. The superolateral (upper outer) quadrant contains a large amount of glandular tissue and is a common site for breast cancers to develop. From this quadrant, an “axillary tail” of breast tissue often extends into the axilla.

In advanced stages of breast cancer, the tumor may invade the underlying pectoralis major muscle and its fascia. When this happens, the tumor and breast become fused to the chest wall, a condition that can be detected by palpation during a physical examination. As the breast tumor enlarges, it places traction on the suspensory ligaments, resulting in dimpling of the skin overlying the tumor.

### Superficial Fascia

1. Dissection of the superficial fascia of the anterior thoracic wall must be performed on both male and female cadavers.
2. The platysma muscle is a muscle of facial expression that may extend inferior to the clavicle into the superficial fascia of the superior thorax. It is very thin but broad. If the platysma muscle is present in the thorax, dissect it from the superficial fascia that lies deep to it and reflect the muscle superiorly out of the dissection field. Do not extend the dissection field superior to the clavicles.
3. Make a vertical cut through the superficial fascia in the midline of the sternum. Make additional cuts through the superficial fascia corresponding to skin incisions A–B–F, C–V, and G–V (FIG. 2.2A).
4. Remove the superficial fascia, proceeding from medial to lateral.
5. Study an illustration of the cutaneous branches of a typical spinal nerve (FIG. 2.7). The anterior cutaneous branches are small and emerge from the intercostal space lateral to the border of the sternum. Do not attempt to find them. [G 22; L 170; N 185; R 214; C 10]
6. As you peel back the superficial fascia, identify an intercostal space by palpation. Palpate the lateral
cutaneous branches of the intercostal nerves near the midaxillary line where they leave the intercostal space and enter the superficial fascia. Identify one lateral cutaneous branch (from intercostal space 4, 5, or 6) while the superficial fascia is being removed. Trace its anterior and posterior branches for a short distance and preserve them.

7. Detach the superficial fascia along the midaxillary line and place it in the tissue container.

Dissection Follow-up
1. Review the location and parts of the breast.
2. Use an illustration to review the vascular supply to the breast.
3. Discuss the pattern of lymphatic drainage of the breast and identify by name the lymph node groups that are involved.

4. Use an illustration of the branching pattern of a typical spinal nerve to review the innervation of the anterior thoracic wall and breast (FIG. 2.7).

MUSCLES OF THE PECTORAL REGION

Dissection Overview
There are three muscles in the pectoral region: pectoralis major, pectoralis minor, and subclavius. The muscles of the pectoral region attach the upper limb to the axial skeleton. The pectoralis major muscle is positioned immediately deep to the superficial fascia (deep to the breast).

The dissection will proceed as follows: The pectoralis major muscle will be studied and reflected. The pectoralis minor muscle and clavipectoral fascia will be studied. The subclavius muscle will be identified. The pectoralis minor muscle will be reflected, and the branches of the thoracoacromial artery will be dissected.
Dissection Instructions

1. Clean the superficial surface of the **pectoralis major muscle** and use your fingers to define its borders (FIG. 2.8). Study an illustration and note that the deep fascia on the superficial and deep surfaces of the pectoralis major muscle is called **pectoral fascia** and that it is continuous with the **axillary fascia** that forms the base of the axilla. [G 506; L 41; N 411; R 406; C 17]

2. Identify the two heads of the pectoralis major muscle: **clavicular head** and **sternocostal head** (FIG. 2.8). Observe that the juncture of these two heads is at the sternoclavicular joint.

3. Use your fingers to trace the tendon of the pectoralis major muscle to its lateral attachment on the humerus. The pectoralis major muscle flexes, adducts, and medially rotates the humerus.

4. Identify the **deltoid muscle** (FIG. 2.8). It is located between the superior border of the clavicular head of the pectoralis major muscle and the inferior border of the deltoid muscle near the clavicle. Laterally, the deltopectoral triangle narrows to form the **deltoid muscle**. 

5. Using blunt dissection, follow the **cephalic vein** from the arm to the deltopectoral triangle where the vein passes deeply to enter the axilla. Preserve the cephalic vein in subsequent steps of this dissection.

6. To prepare the pectoralis major muscle for transection, relax the sternal head of the pectoralis major muscle by flexing and adducting the arm. Gently insert your fingers posterior to the inferior border of the pectoralis major muscle and create a space between the sternal head of the pectoralis major and the **clavicular fascia**. Push your fingers superiorly to open this space.

7. Beginning at the inferior border of the muscle, use scissors to detach the sternocostal head of the pectoralis major muscle from its attachment to the sternum (FIG. 2.8, dashed line).

8. Still working from inferior to superior, insert your fingers under the clavicular head and palpate the **medial and lateral pectoral nerves and vessels**.

9. Now use scissors to cut the clavicular head of the pectoralis major muscle close to the clavicle (FIG. 2.8, dashed line). Preserve the cephalic vein. Note that the **lateral pectoral nerve** and the **pectoral branch of the thoracoacromial artery** enter the deep surface of the clavicular head.

10. Reflect the pectoralis major muscle laterally, leaving it attached to the humerus. Attempt to preserve the nerves and vessels that enter its deep surface.

11. Deep to the pectoralis major muscle are the **clavicular fascia, pectoralis minor muscle**, and **subclavius muscle** (FIG. 2.8). [G 506; L 41; N 416; R 407]

12. Identify the **pectoralis minor muscle**. Its inferior attachment is on ribs 3 to 5 near their costal cartilages. Its superior attachment is on the coracoid process of the scapula. The pectoralis minor muscle draws the glenoid cavity of the scapula anteriorly and inferiorly.

13. Note that the **medial pectoral nerve** pierces the pectoralis minor muscle and then enters the deep surface of the pectoralis major muscle, innervating both.
14. Identify the subclavius muscle, which is located inferior to the clavicle (FIG. 2.8). The subclavius muscle is attached to the clavicle and the first rib, and it depresses the clavicle.

15. Read a description of the clavipectoral fascia and understand that it is immediately deep to the pectoralis major muscle. Superiorly, the clavipectoral fascia is attached to the clavicle. It lies both superficial and deep to the subclavius muscle and the pectoralis minor muscle. Inferiorly, the clavipectoral fascia is attached to the axillary fascia.

16. Note that the cephalic vein passes through the costocoracoid membrane (part of the clavipectoral fascia) on the medial side of the pectoralis minor muscle. The thoracoacromial artery and the lateral pectoral nerve also pass through the costocoracoid membrane.

17. Use scissors to detach the pectoralis minor muscle from its inferior attachments on ribs 3 to 5 (FIG. 2.8, dashed line).

18. Reflect the pectoralis minor muscle superiorly. Leave the muscle attached to the coracoid process of the scapula. [G 508; L 42; N 415; R 412; C 22]

19. Clean the branches of the thoracoacromial artery. Begin by finding the pectoral branch and trace it proximally to find the other branches. Identify the following (FIG. 2.9):

- **Pectoral branch** – descends between the pectoralis major muscle and the pectoralis minor muscle and supplies both. It is usually the largest branch of the thoracoacromial artery.
- **Deltoid branch** – courses laterally in the deltopectoral groove between the deltopectoral groove and pectoralis major muscle. The deltopectoral groove accompanies the cephalic vein.

20. Along the lateral border of the pectoralis minor muscle, identify the lateral thoracic artery (FIG. 2.9). Do not follow the lateral thoracic artery at this time.

21. Identify the serratus anterior muscle (FIG. 2.8). It covers the lateral surface of the thoracic wall. Note its extensive anterior attachments on the upper eighth or ninth ribs. The posterior attachment of the serratus anterior muscle is on the anterior surface of the scapula along the entire length of its medial border. You cannot see the posterior attachment at this time.

**Dissection Follow-up**

1. Replace the pectoral muscles into their correct anatomical positions.
2. Review the attachments of the pectoralis major, pectoralis minor, and subclavius muscles. Review their actions, innervations, and blood supply.
3. Review the relationship of the clavipectoral fascia to the muscles, vessels, and nerves of this region.
4. Be sure that you understand the role played by the clavipectoral fascia to support the base of the axilla.
5. Name all branches of the thoracoacromial artery and the structures supplied by each branch.

**AXILLA**

**Dissection Overview**

The axilla is the region between the pectoral muscles, the scapula, the arm, and the thoracic wall (FIG. 2.10). It is a region of passage for vessels and nerves that course from the root of the neck into the upper limb. The contents of the axilla are the axillary sheath, brachial plexus, axillary vessels and their branches; lymph nodes and lymphatic vessels; portions of three muscles; and a considerable amount of fat and connective tissue.

Note the following walls and boundaries of the axilla (FIG. 2.11): [G 510; N 416]

- **Apex of the axilla** – bounded by the clavicle anteriorly, the superior border of the scapula posteriorly, and the first rib medially
- **Base of the axilla** – skin and fascia of the armpit
CHAPTER 2: THE UPPER LIMB

31

• Anterior wall – anterior axillary fold (pectoralis major muscle), pectoralis minor muscle, and clavipectoral fascia
• Posterior wall – posterior axillary fold (teres major and latissimus dorsi muscles) and the subscapularis muscle that covers the anterior surface of the scapula
• Medial wall – upper portion of the thoracic wall and the serratus anterior muscle, which overlies this wall
• Lateral wall – intertubercular sulcus of the humerus

The order of dissection will be as follows: The pectoralis major muscle, the pectoralis minor muscle, and the clavipectoral fascia will be reflected to expose the contents of the axilla. The axillary vein and its tributaries will be removed to clear the dissection field. The branches of the axillary artery will be dissected. The brachial plexus will be studied.

Dissection Instructions
1. Review the pectoralis major muscle, the pectoralis minor muscle, and the clavipectoral fascia.
2. Reflect the pectoralis major muscle laterally.
3. Reflect the pectoralis minor muscle superiorly.
4. Abduct the arm to about 45°.
5. The axillary sheath is a connective tissue structure that surrounds the axillary vessels and brachial plexus. The axillary sheath extends from the lateral border of the first rib to the inferior border of the teres major muscle. It may be thin and almost unnoticeable.
6. Use scissors to open the anterior surface of the axillary sheath.
7. Identify the axillary vein. Note that the axillary vein is formed at the lateral border of the teres major muscle by the joining of the two brachial veins. The axillary vein ends at the lateral border of the first rib where its name changes to subclavian vein.
8. To enhance dissection of the arteries and nerves in the axilla, the axillary vein must be removed. First, cut the cephalic vein where it joins the axillary vein and preserve the cephalic vein. Next, cut the axillary vein at the lateral border of the first rib. Use a probe to dissect the axillary vein from the structures that lie posterior to it (axillary artery and brachial plexus), then cut the axillary vein at the lateral border of the teres major muscle and remove it. [G 509; N 417; R 411; C 20]
9. As the dissection proceeds, remove smaller veins that are tributary to the axillary vein. Preserve the accompanying arteries. Note the presence of lymph nodes that are associated with the veins.

Axillary Artery [G 516, 517; L 44; N 415; R 413; C 23, 24]
The axillary artery begins at the lateral border of the first rib where it is the continuation of the subclavian artery.
artery (FIG. 2.12). The axillary artery ends at the inferior border of the teres major muscle where its name changes to brachial artery. The axillary artery is surrounded by the brachial plexus. The brachial plexus must be retracted and preserved during dissection of the axillary artery and its branches.

1. Identify the three parts of the axillary artery (FIG. 2.12):
   - First part – extends from the lateral border of the first rib to the medial border of the pectoralis minor muscle
   - Second part – lies posterior to the pectoralis minor muscle
   - Third part – extends from the lateral border of the pectoralis minor muscle to the inferior border of the teres major muscle

Dissection note: The branching pattern of the axillary artery may vary from that which is commonly illustrated. If the pattern is different in your specimen, understand that the branches are named according to their region of distribution rather than by their pattern of origin.

2. The first part of the axillary artery has one branch, the superior thoracic artery. The superior thoracic artery arises near the apex of the axilla and supplies blood to the first and second intercostal spaces.

3. The second part of the axillary artery has two branches: thoracoacromial artery and lateral thoracic artery (FIG. 2.12).

4. Briefly return the pectoralis minor muscle to its anatomical position and identify the thoracoacromial artery on the medial side of the pectoralis minor muscle. Review the branches of the thoracoacromial artery that have been dissected previously:
   - Pectoral branch
   - Acromial branch
   - Deltoid branch
   - Clavicular branch

5. Identify the lateral thoracic artery, which arises at the lateral border of the pectoralis minor muscle and descends along the lateral border of the pectoralis minor muscle (FIG. 2.12). In a significant percentage of cases (35%), the lateral thoracic artery may arise from the subscapular artery or from the thoracoacromial artery. The lateral thoracic artery supplies the pectoral muscles, the serratus anterior muscle, the axillary lymph nodes, and the lateral thoracic wall. In females, the lateral thoracic artery also supplies the lateral portion of the breast.

6. The third part of the axillary artery has three branches: subscapular artery, posterior circumflex humeral artery, and anterior circumflex humeral artery (FIG. 2.12).

7. Identify the subscapular artery, which is the largest branch of the axillary artery. The subscapular artery courses inferiorly for a short distance before dividing into the circumflex scapular artery (to muscles on the posterior surface of the scapula) and the thoracodorsal artery (to the latissimus dorsi muscle). The subscapular artery also gives off several unnamed muscular branches and may be the origin of the lateral thoracic artery.

8. Find the anterior and posterior circumflex humeral arteries, which arise from the lateral surface of the axillary artery distal to the origin of the subscapular artery. Occasionally, these two arteries may arise from a short common trunk. They supply the deltoid muscle.

9. Observe that the posterior circumflex humeral artery is the larger of the two circumflex humeral arteries. Follow it as it passes posterior to the surgical neck of the humerus with the axillary nerve. Demonstrate that the posterior circumflex humeral artery and the axillary nerve pass through the quadrangular space together.

10. The anterior circumflex humeral artery courses around the anterior surface of the humerus at the surgical neck. It passes deep to the tendon of the long head of the biceps brachii muscle and anastomoses with the posterior circumflex humeral artery.

Brachial Plexus [G 516; L 43; N 417; R 413; C 20]

The brachial plexus begins in the root of the neck superior to the clavicle. It enters the apex of the ax-
illia then passes inferiorly toward the base of the axilla where its terminal branches arise. Only the infraclavicular part of the brachial plexus (divisions, cords, and branches) will be dissected at this time. The suprACLavicular part (roots and trunks) will be dissected with the neck.

The three cords of the brachial plexus (lateral, medial, and posterior) are named according to their relationship to the second part of the axillary artery (FIG. 2.13). All four of these structures lie close together posterior to the pectoralis minor muscle.

1. Identify the musculocutaneous nerve. It is the most lateral terminal branch of the brachial plexus and enters the coracobrachialis muscle.
2. To find the lateral cord, use your fingers to follow the musculocutaneous nerve proximally.
3. Observe that the lateral cord gives rise to one other large branch, the lateral root of the median nerve. Follow the lateral root distally and identify the median nerve.
4. To find the medial cord, trace the medial root of the median nerve proximally.
5. A portion of the medial cord continues distally as the ulnar nerve.
6. Note that the three terminal branches (musculocutaneous nerve, median nerve, and ulnar nerve) that you have just identified form the letter M anterior to the third part of the axillary artery (FIG. 2.13).
7. Trace the medial and lateral pectoral nerves from the reflected pectoral muscles to their origins from the medial and lateral cords, respectively.
8. Identify two nerve branches that arise from the inferior side of the medial cord. They are the medial cutaneous nerve of the forearm and the median cutaneous nerve of the arm (FIG. 2.13). Use your fingers to trace these nerves a short distance (7.5 cm) into the arm.
9. Retract the axillary artery, the lateral cord, and the medial cord in the superior direction to expose the posterior cord of the brachial plexus (FIG. 2.14). The branches of the posterior cord are the axillary nerve, radial nerve, and three subscapular nerves (upper, middle, and lower).
10. Use blunt dissection to clean the axillary nerve. Observe that the axillary nerve passes posterior to the humerus and courses through the quadrangular space with the posterior circumflex humeral artery (FIG. 2.14).
11. Use blunt dissection to clean the radial nerve and confirm that it leaves the axilla by passing posterior to the humerus but anterior to the latissimus dorsi and teres major muscles. The radial nerve is the only motor and sensory nerve to the posterior side of the upper limb.
12. Identify the subscapular nerves that arise from the posterior cord (FIG. 2.14) and verify that they run in the loose connective tissue on the anterior surface of the subscapularis muscle:

- **Upper subscapular nerve** – innervates the subscapularis muscle
- **Middle subscapular nerve (thoracodorsal nerve)** – innervates the latissimus dorsi muscle
- **Lower subscapular nerve** – innervates the subscapularis muscle and the teres major muscle
13. Identify the three muscles that form the posterior wall of the axilla: latissimus dorsi, teres major, and subscapularis (FIG. 2.14).

14. Examine the subscapularis muscle. The medial attachment of the subscapularis muscle is the subscapular fossa of the scapula. The lateral attachment of the subscapularis muscle is the lesser tubercle of the humerus. The subscapularis muscle medially rotates the humerus. The subscapularis muscle is a member of the rotator cuff group of muscles.

15. Verify that the medial wall of the axilla is formed by the serratus anterior muscle (FIG. 2.13). Because this muscle is not in clear view, use an illustration to study its attachments. The anterior attachments of the serratus anterior muscle are the external surfaces of ribs 1 to 8 or 9. Its posterior attachment is the anterior surface of the medial border of the scapula. The serratus anterior muscle protracts the scapula. The serratus anterior muscle also rotates the scapula, especially when the arm is abducted above the horizontal plane. [G 519; L 41; N 417; R 412; C 20]

16. Use your fingers to follow the serratus anterior muscle posteriorly toward the medial border of the scapula. On the superficial surface of this muscle, use a probe to free the long thoracic nerve (FIG. 2.13). Note the vertical course of this nerve. Observe its branches to the serratus anterior muscle. Follow the nerve superiorly toward the apex of the axilla as far as possible.

**Dissection Follow-up**

1. Replace the pectoralis major muscle and the pectoralis minor muscle into their correct anatomical positions and review their attachments.
2. Review the boundaries of the axilla.
3. Use the dissected specimen to observe the relationship of the three parts of the axillary artery to the pectoralis minor muscle.
4. Recite the names of all branches of the axillary artery and identify each branch on your dissected specimen.
5. Test your understanding of the brachial plexus by drawing a picture that shows its structure and branches. Extend this exercise demonstrating the divisions, cords, and terminal branches of the infraclavicular portion of the brachial plexus on the cadaver.
6. Review the motor nerve supply to the muscles of the scapular region. Name each muscle and the nerve that supplies it. Realize that some of these nerves arise from the supraclavicular portion of the brachial plexus and that they have not yet been dissected completely.
7. Review the movements of the scapula.
8. Examine other cadavers to gain an appreciation of variations in the branching patterns of arteries and nerves.
9. Use an illustration to review the lymphatic drainage of the axilla.

**CLINICAL CORRELATION**

**NERVE INJURIES**

The long thoracic nerve is vulnerable to stab wounds and to surgical injury during mastectomy. Injury of the long thoracic nerve affects the serratus anterior muscle. When a patient with paralysis of the serratus anterior muscle is asked to push with both hands against a wall, the medial border of the scapula protrudes on the affected side, a condition known as “winged scapula.”

The thoracodorsal nerve is vulnerable to compression injuries and surgical trauma during mastectomy. Injury of the thoracodorsal nerve affects the latissimus dorsi muscle resulting in a weakened ability to extend, adduct, and medially rotate the arm.

The axillary nerve courses around the surgical neck of the humerus and may be injured during a fracture or during an inferior dislocation of the shoulder joint. Injury of the axillary nerve affects the deltoid muscle and teres minor muscle, resulting in a weakened ability to abduct and laterally rotate the arm.

**Dissection Overview**

The brachial fascia (deep fascia of the arm) is a sleeve of tough connective tissue that is continuous at its proximal end with the pectoral fascia, the axillary fascia, and the deep fascia that covers the deltoid and latissimus dorsi muscles. Distally, the brachial fascia is continuous with the antebrachial fascia (deep fascia of the forearm). The brachial fascia is connected to the medial and lateral sides of the humerus by intermuscular septa (FIG. 2.15), creating an anterior (flexor) compartment and a posterior (extensor) compartment.
compartment for the muscles of the arm. The anterior compartment contains three muscles (biceps brachii, brachialis, and coracobrachialis) and the musculocutaneous nerve. The posterior compartment contains two muscles (triceps brachii and anconeus), the radial nerve, and the deep artery and vein of the arm.

The order of dissection will be as follows: The anterior compartment of the arm will be opened and its contents will be studied. Nerves and blood vessels will then be traced through the arm from the axilla to the elbow region. The cadaver will be turned to the prone position to complete the dissection of the posterior compartment of the arm.

Skeleton of the Arm and Cubital Region [G 552; L 32, 33; N 424; R 373, 374; C 113, 122]

Refer to a skeleton. On the humerus, identify (FIG. 2.16):

- Medial epicondyle
- Lateral epicondyle
- Olecranon fossa

On the radius, identify:

- Head
- Neck
- Tuberosity

On the ulna, identify:

- Olecranon
- Coronoid process

Dissection Instructions

Anterior Compartment of the Arm [G 530, 531; L 46; N 419; R 415; C 56, 57]

1. Place the cadaver in the supine position.
2. Use scissors to make a longitudinal incision in the anterior surface of the brachial fascia from the level of the pectoralis major tendon to the elbow.
3. Use your fingers to separate the brachial fascia from the underlying muscles. Work laterally and medially from the incision and note the presence of the lateral intermuscular septum and the medial intermuscular septum. Detach the brachial fascia from the intermuscular septa and place it in the tissue container.
4. Use your fingers to separate the three muscles in the anterior compartment of the arm: coracobrachialis, brachialis, and biceps brachii (FIG. 2.17).
5. The biceps brachii muscle has two proximal attachments on the scapula:
   - Short head of the biceps brachii muscle – attaches to the coracoid process of the scapula
   - Long head of the biceps brachii muscle – attaches to the supraglenoid tubercle of the scapula
6. The tendon of the long head of the biceps brachii muscle courses through the intertubercular sulcus of the humerus posterior to the transverse humeral ligament, then enters the shoulder joint.
10. Use your fingers to confirm that the proximal attachment of the coracobrachialis muscle is the coracoid process and that its distal attachment is on the medial side of the shaft of the humerus. The coracobrachialis muscle adducts and flexes the humerus.

11. Find the **musculocutaneous nerve** where it emerges from the coracobrachialis muscle. Follow the musculocutaneous nerve through the plane of loose connective tissue between the biceps brachii muscle and brachialis muscle.

12. After the musculocutaneous nerve gives off its muscular branches, it continues distally as the **lateral cutaneous nerve of the forearm**. Follow the lateral cutaneous nerve of the forearm to the cubital fossa where it emerges on the lateral side proximal to the biceps brachii tendon. Review the relationship of the lateral cutaneous nerve of the forearm to the cephalic vein.

13. Use scissors to transect the biceps brachii muscle about 5 cm proximal to the elbow (FIG. 2.17, dashed line). Do not cut the musculocutaneous nerve. Reflect the two portions of the biceps brachii muscle proximally and distally, respectively.

14. Observe the **brachialis muscle**, which is deep to the biceps brachii muscle. The proximal attachment of the brachialis muscle is the anterior surface of the distal half of the humerus and its distal attachment is on the coronoid process of the ulna. The brachialis muscle flexes the forearm.

15. Follow the **medial cutaneous nerve of the forearm** from the brachial plexus to the level of the elbow (FIG. 2.17). Note its relationship to the basilic vein at the level of the elbow.

16. Find the **median nerve** where it arises from the brachial plexus (FIG. 2.17). Use blunt dissection to follow the median nerve from the axilla to the cubital fossa. The median nerve courses distally within the **medial intermuscular septum**.

17. Use blunt dissection to follow the **ulnar nerve** from the medial cord of the brachial plexus to the medial epicondyle of the humerus (FIG. 2.17). Note that the ulnar nerve is in the medial intermuscular septum in the proximal arm, then comes to lie on the posterior surface of the medial intermuscular septum in the distal one-third of the arm. At the elbow, the ulnar nerve is in contact with the posterior surface of the medial epicondyle of the humerus. On yourself, palpate the ulnar nerve where it passes posterior to the medial epicondyle.
18. Identify the **brachial artery**. The brachial artery is the continuation of the axillary artery. The brachial artery begins at the inferior border of the teres major muscle and ends at the level of the elbow by branching into the ulnar artery and radial artery (FIG. 2.18). Verify that the brachial artery courses with the median nerve within the medial intermuscular septum, and that the median nerve is the only large structure to cross the anterior surface of the brachial artery.

19. Remove the brachial veins and their tributaries to clear the dissection field. Preserve the branches of the brachial artery.

20. The brachial artery has three named branches in the arm: **deep artery of the arm**, **superior ulnar collateral artery**, and **inferior ulnar collateral artery**. Several unnamed muscular branches also arise along the length of the brachial artery.

21. In the proximal arm, find the **deep artery of the arm** (deep brachial artery, profunda brachii artery) where it arises from the brachial artery (FIG. 2.18). The deep artery of the arm courses around the posterior surface of the humerus, where it accompanies the radial nerve in the radial groove. The course of the deep artery of the arm will be seen when the posterior compartment of the arm is dissected.

22. Identify the **superior ulnar collateral artery** (FIG. 2.17). It arises from the brachial artery about halfway down the arm. It courses distally with the ulnar nerve and passes posterior to the medial epicondyle of the humerus.

23. Find the **inferior ulnar collateral artery** (FIG. 2.17). It arises from the brachial artery about 3 cm above the medial epicondyle of the humerus and passes anterior to the medial epicondyle between the brachialis muscle and the pronator teres muscle.

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**CLINICAL CORRELATION**

**BRACHIAL ARTERY** [G 558; L 48, 75; N 422; R 397; C 59]

Use an illustration to study the collateral circulation around the elbow joint (FIG. 2.18). The brachial artery may become blocked at any level distal to the deep artery of the arm without completely blocking blood flow to the forearm and hand.

In the arm, the brachial artery lies medial to the biceps brachii muscle and close to the shaft of the humerus. The brachial artery is compressed at this location when taking a blood pressure reading.

**Cubital Fossa** [G 546–548; L 46; N 421; R 416–418; C 70–76]

The **cubital fossa** (L. cubitus, elbow) is the depression on the anterior surface of the elbow. The cubital fossa is clinically important because it contains superficial veins that are used for venipuncture. Large nerves and vessels pass through this region.

1. Note the **boundaries of the cubital fossa** (FIG. 2.19):
   - **Lateral boundary** – brachioradialis muscle
   - **Medial boundary** – pronator teres muscle
   - **Superior boundary** – an imaginary line connecting the medial and lateral epicondyles of the humerus
   - **Superficial boundary (roof of the cubital fossa)** – antebrachial fascia reinforced by the bicipital aponeurosis
   - **Deep boundary (floor of the cubital fossa)** – brachialis and supinator muscles

2. Review the positions of the cephalic vein, basilic vein, and median cubital vein anterior to the cubital fossa. To gain access to deeper structures, it may be necessary to cut the median cubital vein and retract its cut ends medially and laterally, respectively.
3. Use scissors to open the posterior compartment of the arm by making a longitudinal incision through the brachial fascia from the level of the olecranon of the ulna to the teres minor muscle. Use your fingers to open the brachial fascia widely, then detach it from the medial and lateral intermuscular septa. Place it in the tissue container.

4. Examine the triceps brachii muscle (FIG. 2.20). It has three heads:
   - **Long head of the triceps brachii muscle** – attaches to the infraglenoid tubercle of the scapula
   - **Lateral head of the triceps brachii muscle** – attaches to the posterior surface of the humerus lateral to the radial groove
   - **Medial head of the triceps brachii muscle** – attaches to the posterior surface of the humerus medial to the radial groove

5. Observe the distal attachment of the triceps brachii tendon on the olecranon of the ulna. The triceps brachii muscle extends the forearm.

6. Use your fingers to separate the **long head of the triceps brachii** from the **lateral head**. Observe
7. Inferior to the teres major muscle is an opening between the long head of the triceps brachii muscle and lateral head of the triceps brachii muscle (FIG. 2.20). Use a probe to widen this opening and identify the radial nerve and the deep artery of the arm.

8. Push a probe distally along the course of the radial nerve. The probe should be positioned between the lateral head of the triceps brachii muscle and the humerus (FIG. 2.20).

9. Use a scalpel to transect the lateral head of the triceps brachii muscle over the probe. This cut will separate the lateral head of the triceps brachii muscle from the medial head.

10. Use a probe to clean the radial nerve and the deep artery of the arm. Observe that the radial nerve and deep artery of the arm lie in the radial groove of the humerus in direct contact with the bone.

11. Follow the radial nerve distally toward the elbow. Return to the cubital fossa and on the lateral aspect of the forearm, identify the brachioradialis muscle (FIG. 2.19A). Use your fingers to open the connective tissue plane between the brachioradialis muscle and the brachialis muscle (FIG. 2.19B). Deep in this plane of connective tissue, find the radial nerve and follow it proximally to complete its dissection.

12. Note that the radial nerve passes on the flexor side of the elbow joint and that it is accompanied by the radial recurrent artery at that location (FIG. 2.19B).

13. Identify the anconeus muscle (FIG. 2.20). The proximal attachment of the anconeus muscle is the lateral epicondyle of the humerus. The distal attachment is the lateral surface of the olecranon and superior part of the posterior surface of the ulna. The anconeus muscle assists the triceps brachii muscle in extension of the forearm.

Dissection Follow-up

1. Replace the muscles of the anterior and posterior compartments of the arm in their correct anatomical positions.

2. Review the attachments, nerve supply, and action of each muscle.

3. Use the dissected specimen to review the origin, course, termination, and branches of the brachial artery.

4. Trace each nerve that you have dissected from the brachial plexus to the elbow, reviewing relationships.

5. Review a drawing of a cross section of the arm and notice the position of the brachial fascia and the intermuscular septa relative to the structures that you have dissected.

6. Review the nerve territories of the brachial region (FIG. 2.21).

7. Recall the rules of innervation of the muscles of the arm:

- All muscles in the anterior compartment of the arm are innervated by the musculocutaneous nerve. [L 76]
- All muscles in the posterior compartment of the arm are innervated by the radial nerve. [L 79]
- The median nerve and the ulnar nerve do not innervate muscles in the arm.
FLEXOR REGION OF THE FOREARM

Dissection Overview

The antebrachial fascia is a sleeve of connective tissue that invests the forearm. Intermuscular septa project inward from it and attach the antebrachial fascia to the radius and ulna (FIG. 2.22). The intermuscular septa, the interosseous membrane, the radius, and the ulna combine to divide the forearm into an anterior (flexor) compartment and a posterior (extensor) compartment.

The muscles in the anterior compartment of the forearm can be divided into a superficial, intermediate, and deep layer of flexor muscles. Muscles of the superficial flexor layer arise primarily from the medial epicondyle of the humerus and its supracondylar ridge. The muscle of the intermediate layer arises from the medial epicondyle of the humerus and the anterior surface of the radius. Muscles of the deep flexor layer arise from the anterior surfaces of the radius, ulna, and interosseous membrane. Study a transverse section through the midlevel of the forearm (FIG. 2.22) and note that the ulnar artery, ulnar nerve, and median nerve are in the connective tissue plane that separates the intermediate and deep layers of flexor muscles.

Skeleton of the Forearm  [G 560, 582; L 33; N 424, 427; R 375; C 113, 122]

Refer to a skeleton. On the humerus, identify (FIG. 2.23):

- Medial epicondyle
- Medial supracondylar ridge
- Lateral epicondyle
- Lateral supracondylar ridge
- Capitulum
- Trochlea
- Olecranon fossa

On the radius, identify (FIG. 2.23):

- Head
- Neck
- Tuberosity
- Anterior oblique line
CHAPTER 2: THE UPPER LIMB

Ulnar notch
Styloid process
Interosseous border for attachment of the interosseous membrane

On the ulna, identify (FIG. 2.23):

Olecranon
Trochlear notch
Radial notch
Head
Interosseous border for attachment of the interosseous membrane

On the palmar surface of the articulated hand, identify the pisiform bone (FIG. 2.23).

On a skeleton, examine the elbow joint. The elbow joint is the articulation between the trochlear notch of the ulna and the trochlea of the humerus, and the articulation between the head of the radius and the capitulum of the humerus. These two articulations account for the hinge action (flexion/extension) of the elbow joint.

On a skeleton, observe the proximal radioulnar joint between the head of the radius and the radial notch of the ulna. Observe the distal radioulnar joint between the head of the ulna and the ulnar notch of the radius. Pronate and supinate the hand of the skeleton and notice the rotational movements that occur in the proximal and distal radioulnar joints. In the position of supination (anatomical position) note that the the radius and the ulna are parallel. In the position of pronation, the radius crosses the ulna.

The order of dissection will be as follows: The structures in the superficial fascia of the forearm will be reviewed, then the superficial fascia and the antebrachial fascia will be removed. At the level of the wrist, the relative positions of tendons, vessels, and nerves will be studied. The superficial and intermediate layers of flexor muscles will be studied and then reflected. Vessels and nerves that lie between the intermediate and deep layers of flexor muscles will be studied. The deep layer of flexor muscles will be dissected.

Dissection Instructions

Superficial Layer of Flexor Muscles [G 562; L 52; N 434; R 422; C 70]

1. Place the cadaver in the supine position and abduct the upper limb. Forcefully supinate the hand and have your dissection partner hold it in this position.
2. Remove the remnants of the superficial fascia, taking care to preserve the cephalic and basilic veins.
3. Use scissors to incise the anterior surface of the antebrachial fascia from its attachments to the radius and ulna and place it in the tissue container.
4. There are four muscles in the superficial layer: pronator teres, flexor carpi radialis, palmaris longus, and flexor carpi ulnaris (FIG. 2.24).
5. Use your fingers to separate the tendons of the superficial layer of flexor muscles from each other and identify each. Observe that the bellies of these four muscles cannot be easily separated from each other.
6. Identify the common flexor tendon, which is attached to the medial epicondyle of the humerus. It forms part of the proximal attachment of the muscles of the superficial layer (FIG. 2.24).
7. Although you cannot see the distal attachments of all of these muscles at this time, note the following:

- **Pronator teres muscle** – attaches to the middle of the lateral surface of the radius. The pronator teres muscle pronates the hand and flexes the forearm.
- **Flexor carpi radialis tendon** – attaches to the base of the second metacarpal bone. The flexor carpi radialis muscle flexes and abducts the hand.
- **Palmaris longus tendon** – attaches to the palmar aponeurosis. The palmaris longus muscle flexes the hand.
- **Flexor carpi ulnaris tendon** – attaches to the pisiform bone, the hamate bone, and the base of the fifth metacarpal bone. The flexor carpi ulnaris muscle flexes and adducts the hand.

8. Examine the superficial structures on the anterior surface of the wrist (FIG. 2.25). From lateral to medial, identify:  

- Tendon of the **abductor pollicis longus muscle**
- **Radial artery**
- Tendon of the **flexor carpi radialis muscle**
- **Median nerve**
- Tendon of the **palmaris longus muscle** (absent in 13% of limbs)
- Four tendons of the **flexor digitorum superficialis muscle**
- **Ulnar artery and ulnar nerve**
- Tendon of the **flexor carpi ulnaris muscle**

9. Palpate the tendons listed previously in your own wrist. Feel the pulse of the radial artery between the abductor pollicis longus and flexor carpi radialis tendons. Note that the median nerve is superficial at the wrist and can be easily injured. Flex your wrist and palpate the distal attachment of the flexor carpi ulnaris tendon on the pisiform bone. Palpate the ulnar nerve and artery, which lie immediately lateral to the pisiform bone.

### Intermediate Layer of Flexor Muscles  

1. **The flexor digitorum superficialis muscle** is the only member of the intermediate layer of forearm flexor muscles (FIG. 2.26). To see it, several muscles of the superficial layer must be transected and reflected.

2. Use scissors to cut the tendon of the palmaris longus muscle about 3 cm proximal to the wrist (FIG. 2.24, cut 1) and reflect the muscle belly proximally.

3. Cut the tendon of the flexor carpi radialis muscle about 5 cm proximal to the wrist (FIG. 2.24, cut 2) and reflect it proximally.

4. The pronator teres muscle has two proximal heads—a superficial (humeral) head and a deep (ulnar) head. The median nerve passes between these two heads. Only the superficial head of the pronator teres muscle will be reflected at this time. Insert a probe through the pronator teres muscle along the anterior surface of the median nerve (FIG. 2.24, cut 3). Use scissors to transect the portion of the pronator teres muscle that lies anterior to the probe. Reflect the humeral head of the pronator teres medially along with the bellies of the palmaris longus and flexor carpi radialis muscles.

5. Observe the flexor digitorum superficialis muscle (FIG. 2.26). It has three proximal attachments—one on the humerus via the common flexor tendon, a small attachment to the ulna, and a long narrow
attachment on the anterior oblique line of the radius.

6. The attachments described previously create a ten-}

6. The attachments described previously create a ten-

dinous arch. The ulnar artery and median nerve pass posterior (deep) to this arch.

7. Distally, the flexor digitorum muscle gives rise to four tendons. Although you cannot see their attachments at this time, note that

8. Proximal to the wrist, observe that the four tendons attach to the middle phalanges of digits 2 to 5. The flexor digitorum superficialis muscle flexes the middle phalanx of digits 2 to 5. These four tendons attach to the middle phalanges of digits 2 to 5. The flexor digitorum superficialis muscle flexes the middle phalanx of digits 2 to 5.
Vessels and Nerves of the Anterior Forearm  [G 564; L 53, 54; N 435, 436; R 423; C 76–78]

1. On the lateral side of the proximal forearm, identify the brachioradialis muscle (FIG. 2.24). At the point where the pronator teres muscle passes deep to the brachioradialis muscle, use your fingers to open the connective tissue plane that is deep to the brachioradialis muscle. In this muscular plane, identify the superficial branch of the radial nerve, which courses distally on the deep surface of the brachioradialis muscle (FIG. 2.26). Follow the superficial branch of the radial nerve to the distal one-third of the forearm and confirm that it emerges on the posterior side of the brachioradialis tendon to become a cutaneous nerve.

2. Once again, identify the brachial artery in the cubital fossa (FIG. 2.26). Use blunt dissection to follow the brachial artery distally until it bifurcates into the radial artery and the ulnar artery.

3. Use a probe to clean the radial artery and follow it distally as far as the level of the wrist. The radial vein and its tributaries may be removed to clear the dissection field. Note that the radial artery gives rise to several unnamed muscular branches in the forearm.

4. Find the radial recurrent artery, which arises from the radial artery near its origin from the brachial artery (FIG. 2.26). The radial recurrent artery courses proximally in the connective tissue plane between the brachioradialis muscle and the brachialis muscle. The radial recurrent artery anastomoses with the radial collateral branch of the deep artery of the arm. Recall that the radial recurrent artery is part of the anastomotic network around the elbow (FIG. 2.18).

5. Once again find the median nerve in the cubital fossa. Observe that it is positioned medial to the brachial artery and that it passes deep to the flexor digitorum superficialis muscle (FIG. 2.26). The median nerve innervates most of the muscles of the flexor compartment of the forearm.

6. To expose the distal part of the median nerve, the flexor digitorum superficialis muscle must be cut and retracted medially. First, use scissors to cut the four tendons of the flexor digitorum superficialis muscle proximal to the wrist at the level shown in FIGURE 2.26 (cut 1). Next, use scissors to detach the flexor digitorum superficialis muscle from its attachment on the anterior oblique line of the radius (FIG. 2.26, cut 2). Do not cut the radial artery. Retract the muscle medially, leaving it attached to the ulna and medial epicondyle of the humerus.

7. Observe the median nerve coursing distally in the median plane of the forearm (FIG. 2.27). Use a probe to free the median nerve from the loose connective tissue that lies between the intermediate and deep layers of forearm flexor muscles. Observe that the median nerve gives small muscular branches to innervate the palmaris longus, flexor carpi radialis, flexor digitorum superficialis, and pronator teres muscles. The median nerve also gives rise to the anterior interosseous nerve that innervates the deep layer of forearm flexor muscles (FIG. 2.27).

8. Find the ulnar artery in the cubital fossa. Observe that the ulnar artery passes posterior to the deep head of the pronator teres muscle. To follow the ulnar artery distally, the deep head of the pronator teres must be transected. Insert a probe along the anterior surface of the ulnar artery, posterior to the deep head of the pronator teres muscle. Use scissors to cut the deep head of the pronator teres muscle. The pronator teres muscle is now completely transected and it may be reflected widely to broaden the dissection field.

9. Use a probe to clean the ulnar artery and follow it from the cubital fossa to the wrist (FIG. 2.27). The ulnar vein and its tributaries may be removed to clear the dissection field. Observe the following relationships of the ulnar artery (FIG. 2.27):

   - It passes posterior to the median nerve in the cubital fossa
   - It is layered between the flexor digitorum superficialis and the flexor digitorum profundus muscles in the proximal forearm
   - It is joined by the ulnar nerve about one-third of the way down the forearm
   - The ulnar artery and nerve lie deep to the flexor carpi ulnaris muscle in the distal forearm
   - The ulnar artery and nerve pass on the lateral side of the pisiform bone at the wrist

CLINICAL CORRELATION

HIGH BIFURCATION OF THE BRACHIAL ARTERY

In about 3% of upper limbs, the brachial artery bifurcates in the arm. When it does, the ulnar artery may course superficial to the superficial layer of flexor muscles. When this happens, the ulnar artery may be mistaken for a vein. When certain drugs are injected into an artery, the capillary bed is damaged, followed by gangrene. In the example of an injection into a superficial ulnar artery, the hand could be severely injured.
10. Find the **common interosseous artery**. It is a branch of the ulnar artery that arises about 3 cm distal to the origin of the ulnar artery. It passes posterolaterally toward the interosseous membrane before dividing into the **anterior interosseous artery** and the **posterior interosseous artery**. The common interosseous artery is usually quite short and may be absent (i.e., the anterior and posterior interosseous arteries may arise directly from the ulnar artery).

11. Identify the **anterior interosseous artery** and follow it distally. Note that the anterior interosseous artery lies on the anterior surface of the interosseous membrane, between the muscles of the deep layer of forearm flexor muscles. It supplies the deep layer of flexor muscles.

12. At the proximal end of the interosseous membrane, the **posterior interosseous artery** passes posteriorly to enter the posterior compartment of the forearm. The posterior interosseous artery supplies the extensor group of forearm muscles. Identify it, but do not attempt to follow it into the posterior compartment at this time.
13. Two other named vessels arise from the ulnar artery in the proximal forearm: anterior ulnar recurrent artery and posterior ulnar recurrent artery (FIG. 2.27). They anastomose with the inferior and superior ulnar collateral branches of the brachial artery, respectively (FIG. 2.18). Note that several unnamed muscular branches arise from the ulnar artery in the forearm.

14. Identify the ulnar nerve in the distal forearm and follow it proximally. Near the elbow, observe that the ulnar nerve penetrates the flexor carpi ulnaris muscle and courses posterior to the medial epicondyle of the humerus. The ulnar nerve innervates the flexor carpi ulnaris muscle and the medial half of the flexor digitorum profundus muscle.

Deep Layer of Flexor Muscles [G 565; L 54; N 436; R 423; C 72]

1. Three muscles comprise the deep layer of forearm flexor muscles: flexor digitorum profundus, flexor pollicis longus, and pronator quadratus (FIG. 2.27).

2. The proximal attachment of the flexor digitorum profundus muscle is on the anterior surface of the ulna and interosseous membrane. In the distal forearm, its four tendons lie deep to the four tendons of the flexor digitorum superficialis muscle. Although they cannot be seen at this time, note that the flexor digitorum profundus tendons attach to the distal phalanx of digits 2 to 5. The flexor digitorum profundus muscle flexes the distal phalanx of digits 2 to 5. Note that the flexor digitorum profundus muscle has two motor nerves: the lateral half of the muscle is innervated by the median nerve and the medial half is innervated by the ulnar nerve.

3. The proximal attachment of the flexor pollicis longus muscle is on the anterior surface of the radius and interosseous membrane. The distal attachment of the flexor pollicis longus tendon is the distal phalanx of digit 1 (thumb). The flexor pollicis longus muscle flexes digit 1.

4. The pronator quadratus muscle lies posterior to the tendons of the deep flexor muscles in the distal one-fourth of the forearm (FIG. 2.27). Retract the tendons of the superficial and deep layers of flexor muscles and find the pronator quadratus muscle. The fibers of the pronator quadratus muscle run transversely from the ulna to the radius. The pronator quadratus muscle pronates the hand.

5. Observe that the anterior interosseous artery and nerve pass deep (posterior) to the pronator quadratus muscle (i.e., between the pronator quadratus muscle and the interosseous membrane).

Dissection Follow-up

1. Replace the flexor muscles in their correct anatomical positions taking care to align the cut tendons correctly.
2. Use the dissected specimen to review the attachments and action of each muscle dissected.
3. Organize the flexor muscles into superficial, intermediate, and deep layers and recall that the nerves and vessels coursing through the forearm are found between the intermediate and deep layers.
4. Follow the brachial artery from its origin in the proximal arm to its bifurcation in the cubital fossa.
5. Review all of the branches of the radial and ulnar arteries. Trace the course of these two arteries from the elbow to the wrist.
6. Review the course of the median nerve from the brachial plexus to the wrist.
7. Review the course of the ulnar nerve from the brachial plexus to the wrist.
8. Recall the rule for innervation of the muscles in the anterior compartment of the forearm:

   • All muscles of the anterior compartment of the forearm are innervated by the median nerve except the flexor carpi ulnaris muscle and the medial half of the flexor digitorum profundus muscle, which are innervated by the ulnar nerve. [L 77, 78]

PALM OF THE HAND

Dissection Overview

The intrinsic hand muscles are those muscles that have both their proximal and distal attachments within the hand. There are two superficial groups of intrinsic hand muscles: the thenar group of muscles forms the thenar eminence, and the hypothenar group of muscles forms the hypothenar eminence. Deep in the hand is a third group of intrinsic hand muscles: the interosseous muscles and the adductor pollicis muscle.

In the middle of the palm, the palmar fascia is thickened to form the palmar aponeurosis. The palmar fascia over the thenar and hypothenar eminences is much thinner. Deep to the palmar aponeurosis are the tendons of the flexor digitorum superficialis and flexor digitorum profundus muscles. These tendons reach the palm through the carpal tunnel and are responsible for flexing the digits. In the deepest part of the palm are muscles that abduct and adduct the digits.

The palm is supplied with blood by two arterial arches. The superficial palmar arch is mainly derived from the ulnar artery and the deep palmar arch from the radial artery. The nerve supply of the palmar aspect of the hand is derived from the median and ulnar nerves.

The order of dissection will be as follows: The palmar aponeurosis will be studied and removed. The superficial palmar arch will be dissected, followed by the tendons of the muscles of the anterior compartment of the forearm.
The flexor retinaculum will be cut and the flexor tendons will be released from the palm. The muscles of the thenar group will be dissected, followed by the muscles of the hypothenar group. The deep palmar arch will be dissected along with the deep branch of the ulnar nerve. The adductor pollicis and interosseous muscles will be studied.

**Skeleton of the Hand** [G 560, 582; L 60, 61; N 444; R 376, 377; C 128, 129]

Refer to an articulated skeleton of the hand and identify (FIG. 2.28):

- Eight carpal bones (Gr. karpos, wrist)
- Five metacarpal bones
- Fourteen phalanges

Be able to identify the eight carpal bones in an articulated skeleton. Digit 1 (thumb) has two phalanges: proximal and distal. Digits 2 to 5 (fingers) have three phalanges: proximal, middle, and distal.

Identify the pisiform bone and the hook of the hamate on the medial side of the wrist. On the lateral side of the wrist, identify the tubercle of the scaphoid and the tubercle of the trapezium. The flexor retinaculum bridges these four bones (FIG. 2.29). The space between the carpal bones and the flexor retinaculum is the carpal tunnel, which allows passage of the flexor tendons and the median nerve into the hand.

**Dissection Instructions**

**Skin Incisions**

1. Refer to FIG. 2.30.
2. Force open the clenched hand and let your dissection partner hold it open.
3. Make a longitudinal incision across the palm (E to M).
4. Make a transverse incision at the level of the webs of the fingers (N to O).
5. Make a longitudinal incision along the palmar surface of the thumb (E to Q).
6. Make a longitudinal incision along the palmar surface of the digits (E to Q).
7. Remove the skin from the palmar and posterior surfaces of the hand and digits 1 to 5. When skinning the digits, proceed with caution. Note that the subcutaneous tissue on the palmar surface of the digits is very thin, especially at the skin creases. There are digital nerves, vessels, and fibrous digital sheaths immediately deep to the skin (FIG. 2.31).

**Superficial Palm** [G 568; L 62; N 447, 448; R 428; C 94]

1. Use scraping motions with a dull scalpel blade to clean the fat from the palmar aponeurosis.
GRANT’S DISSECTOR

the palmar aponeurosis during its removal. Do not cut too deeply because the superficial palmar arch is in contact with the deep surface of the palmar aponeurosis. Be careful to preserve the recurrent branch of the median nerve near the thenar eminence (FIG. 2.31).

7. Near the proximal end of digits 2 and 3, remove the band of longitudinal fibers of the palmar aponeurosis. Use blunt dissection to clean the fibrous digital sheath on the flexor surface of digit 3 (FIG. 2.31).

8. Find the ulnar artery in the forearm (FIG. 2.32). Use a probe to dissect the ulnar artery and follow it into the palm. The ulnar artery passes lateral to the pisiform bone with the ulnar nerve, then divides into a superficial branch and a deep branch. The superficial branch of the ulnar artery crosses the palm to form the superficial palmar arch. The superficial palmar arch is completed by a smaller contribution from the superficial palmar branch of the radial artery (FIG. 2.32) [G 574; L 63; N 448; R 428; C 107].

9. Use a probe to clean the superficial palmar arch and the three common palmar digital arteries that arise from it. Trace one common palmar digital artery (FIG. 2.31). Observe that the palmar aponeurosis has four bands of longitudinal fibers, one band to each of the digits 2 to 5. These longitudinal fibers end by attaching to the fibrous digital sheath near the base of the proximal phalanx of each digit.

2. Identify the palmar fascia covering the thenar muscles lateral to the palmar aponeurosis. Note that it is very thin compared to the palmar aponeurosis.

3. Identify the palmar fascia covering the hypothenar muscles medial to the palmar aponeurosis. The palmaris brevis muscle is found superficial to the hypothenar fascia (FIG. 2.31). It is a thin, fragile muscle. The proximal attachment of the palmaris brevis muscle is the medial aspect of the palmar aponeurosis. Its distal attachment is the skin over the hypothenar eminence.

4. Detach the palmaris brevis muscle from the palmar aponeurosis and reflect it medially.

5. Find the tendon of the palmaris longus muscle where you transected it in the forearm. Follow the palmaris longus tendon distally into the palm where it is attached to the palmar aponeurosis (FIG. 2.31). Although the palmaris longus muscle may be absent, the palmar aponeurosis is always present.

6. To remove the palmar aponeurosis, use a scalpel and skinning motions to detach the palmar aponeurosis from the underlying deep structures. Begin at its proximal end and proceed distally. Use the palmaris longus tendon to apply traction to the palmar aponeurosis during its removal. Do not cut too deeply because the superficial palmar arch is in contact with the deep surface of the palmar aponeurosis. Be careful to preserve the recurrent branch of the median nerve near the thenar eminence (FIG. 2.31).

7. Near the proximal end of digits 2 and 3, remove the band of longitudinal fibers of the palmar aponeurosis. Use blunt dissection to clean the fibrous digital sheath on the flexor surface of digit 3 (FIG. 2.31).

8. Find the ulnar artery in the forearm (FIG. 2.32). Use a probe to dissect the ulnar artery and follow it into the palm. The ulnar artery passes lateral to the pisiform bone with the ulnar nerve, then divides into a superficial branch and a deep branch. The superficial branch of the ulnar artery crosses the palm to form the superficial palmar arch. The superficial palmar arch is completed by a smaller contribution from the superficial palmar branch of the radial artery (FIG. 2.32) [G 574; L 63; N 448; R 428; C 107].
tal artery distally and note that it divides into two proper palmar digital arteries that supply the adjacent sides of two digits.

10. Find the ulnar nerve lateral to the pisiform bone (FIG. 2.32). Use a probe to dissect the superficial branch of the ulnar nerve, which supplies cutaneous innervation to digit 5 and the medial side of digit 4. The deep branch of the ulnar nerve disappears between the hypothenar muscles. Identify the initial portion of the deep branch of the ulnar nerve but do not follow it at this time.

Carpal Tunnel [G 575; L 63, 65; N 449; R 429; C 99]

1. Identify the flexor retinaculum between the thenar and hypothenar eminences (FIG. 2.32). Use an illustration to review the flexor retinaculum and its role in the formation of the carpal tunnel (FIG. 2.29).

2. Insert a probe from proximal to distal, deep to the flexor retinaculum (FIG. 2.33). Use a scalpel to cut through the flexor retinaculum anterior to the probe (FIG. 2.33, dashed line) and open the carpal tunnel.

3. Examine the contents of the carpal tunnel: median nerve, four tendons of the flexor digitorum superficialis muscle, four tendons of the flexor digitorum profundus muscle, and the tendon of the flexor pollicis longus muscle (FIG. 2.34).

4. Find the median nerve at the level of the wrist and follow it through the carpal tunnel. Identify the recurrent branch of the median nerve, which innervates the three thenar muscles (FIG. 2.34). The median nerve also innervates lumbrical muscles 1 and 2.

5. Follow the common palmar digital branches of the median nerve toward the lateral 3.5 digits (FIG. 2.34). Note that the common palmar digital nerves typically divide to give rise to two proper palmar digital nerves, which accompany the proper palmar digital arteries. Use an illustration to study the cutaneous distribution of the median nerve in the hand. [G 587; L 62; N 460; R 423]

6. Identify the flexor tendons that pass through the carpal tunnel. Observe that these tendons pass through the palm of the hand posterior to the superficial palmar arch and digital nerves. The flexor tendons enter the fibrous digital sheaths on the anterior surfaces of the digits (FIG. 2.34).

7. Use an illustration to study the extent of the synovial tendon sheaths deep to the flexor retinaculum and extending into the palm. There are four synovial sheaths associated with the tendons of the fingers: a common flexor synovial sheath (ulnar bursa) and three digital synovial sheaths. The tendon of the flexor pollicis longus muscle has its own synovial sheath (radial bursa). [G 576, 577; L 65; N 449, 450; R 390, 391; C 96]
CLINICAL CORRELATION

CARPAL TUNNEL SYNDROME
A swelling of the common flexor synovial sheath may encroach on the available space in the carpal tunnel. As a result, the median nerve may be compressed, resulting in pain and paresthesia of the thumb, index, and middle fingers, and weakness of the thenar muscles.

8. In the distal forearm, use your fingers to separate the tendons of the flexor digitorum superficialis muscle from the tendons of the flexor digitorum profundus muscle. Reflect the tendons of the flexor digitorum superficialis distally as follows: Cut the superficial palmar arch in the midline of the palm and retract the common digital branches of the median and ulnar nerves laterally and medially, respectively. Make a longitudinal incision in the palmar surfaces of the fibrous digital sheaths of digits 2 to 5. Now pull the tendons of the flexor digitorum superficialis muscle distally through the carpal tunnel (FIG. 2.35). During this procedure, the common flexor synovial sheath will be destroyed.

9. In the palm, observe the tendons of the flexor digitorum profundus muscle (FIG. 2.35). Identify four lumbrical muscles. The distal attachment of the lumbrical muscles is on the radial side of the extensor expansions of digits 2 to 5 (FIG. 2.35). The lumbrical muscles flex the metacarpophalangeal joints and extend the interphalangeal joints.

10. In digit 3, study the relationship of the tendons of the flexor digitorum superficialis and flexor digitorum profundus muscles (FIGS. 2.35 and 2.36). Note that the flexor digitorum profundus tendon passes through the flexor digitorum superficialis tendon. Verify that the flexor digitorum superficialis tendon attaches to the middle phalanx, whereas the flexor digitorum profundus tendon attaches to the distal phalanx. This pattern is true of digits 2 to 5.

11. Identify the flexor pollicis longus muscle in the forearm (FIG. 2.27). Follow its tendon distally through the carpal tunnel into the palm. Pull on the tendon to confirm that the flexor pollicis longus muscle flexes the distal phalanx of the thumb.

Thenar Muscles (G 576–578; L 63; N 453; R 428; C 98, 99)
1. Use blunt dissection to clean the thin layer of palmar fascia off the thenar muscles. Preserve the recurrent branch of the median nerve (FIG. 2.35).
2. The thenar group contains three muscles: **abductor pollicis brevis**, **flexor pollicis brevis**, and **opponens pollicis** (L. *pollex*, thumb; genitive, *pollicis*). The proximal attachments of the thenar muscles are the scaphoid, trapezium, and flexor retinaculum. Identify:

   - **Abductor pollicis brevis** (FIG. 2.35) – attaches to the lateral side of the proximal phalanx of the thumb and abducts the thumb
   - **Flexor pollicis brevis muscle** (FIG. 2.35) – attaches to the lateral side of the proximal phalanx of the thumb and flexes the thumb
   - **Opponens pollicis muscle** (FIG. 2.36) – attaches to the lateral side of the shaft of the first metacarpal bone and opposes the thumb

3. Examine the **recurrent branch of the median nerve**. The recurrent branch of the median nerve crosses the superficial surface of the flexor pollicis brevis muscle, then disappears deep to the abductor pollicis brevis muscle.

### CLINICAL CORRELATION

#### RECURRENT BRANCH OF THE MEDIAN NERVE

The recurrent branch of the median nerve is superficial and it can easily be severed by “minor” cuts over the thenar eminence. If the recurrent branch of the median nerve is injured, the thenar muscles are paralyzed and the thumb cannot be opposed.

4. Use a probe to separate the abductor pollicis brevis muscle from the flexor pollicis brevis muscle. Use the recurrent branch of the median nerve to help you locate the correct plane of separation.
5. Use a probe to elevate the abductor pollicis brevis muscle and transect it with scissors.
6. Observe the **opponens pollicis muscle** deep to the abductor pollicis brevis muscle (FIG. 2.36). Note that the opponens pollicis muscle attaches to the lateral side of the entire length of the shaft of the first metacarpal bone.

**Hypotenar Muscles** [G 576–578; L 64; N 453; R 428; C 98, 99]

1. Use blunt dissection to clean the thin layer of palmar fascia off the hypotenar muscles (FIG. 2.31). The hypotenar group contains three muscles: **abductor digiti minimi**, **flexor digiti minimi brevis**, and **opponens digiti minimi**. The proximal attachments of the hypothenar muscles are the pisiform, hamate, and flexor retinaculum. Identify:

   - **Abductor digiti minimi muscle** (FIG. 2.35) – attaches to the medial side of the base of the proximal phalanx of digit 5 and abducts digit 5
   - **Flexor digiti minimi brevis muscle** – (FIG. 2.35), attaches to the medial side of the base of the proximal phalanx of digit 5 and flexes digit 5
   - **Opponens digiti minimi muscle** – attaches to the medial border of the fifth metacarpal bone and opposes digit 5

2. Find the tendons of the abductor digiti minimi and flexor digiti minimi brevis muscles near their distal attachments on the base of the proximal phalanx. Use a probe to separate and define the borders of the muscles using their tendons to aid in this separation.
3. Use a probe to elevate the abductor digiti minimi brevis muscle and detach it from its proximal attachment on the flexor retinaculum. Preserve the deep branches of the ulnar artery and ulnar nerve. Reflect the muscle distally.
4. Observe the **opponens digiti minimi muscle**. Note that the opponens digiti minimi muscle attaches to the entire length of the shaft of the fifth metacarpal bone.

**Deep Palm** [G 578, 579; L 64; N 453, 454; R 429; C 108]

1. Transect the flexor digitorum profundus muscle in the distal forearm at the level shown in FIGURE 2.35. Reflect its tendons and the associated lumbrical muscles distally as far as possible. The deep palm is now exposed (FIG. 2.36).
2. Find the ulnar nerve and the ulnar artery on the lateral side of the pisiform bone.
3. The **deep branch of the ulnar nerve** and the **deep palmar branch of the ulnar artery** pass between the proximal attachments of the flexor digiti minimi brevis and abductor digiti minimi muscles (FIG. 2.36).
4. Push a probe parallel to the deep branch of the ulnar nerve where it pierces the opponens digiti minimi muscle. Use a scalpel to cut down to the probe and release the nerve. Now use blunt dissection to follow the deep branch of the ulnar nerve across the palm.
5. As it passes laterally, observe that the deep branch of the ulnar nerve lies on the anterior surface of the interosseous muscles (FIG. 2.36) then passes into the adductor pollicis muscle.
6. Observe the **deep palmar arch**. The deep palmar arch courses with the deep branch of the ulnar nerve. It arises from the *radial artery* on the lateral side of the palm and is completed by the
deep branch of the ulnar artery. Use an illustration to study the branches of the deep palmar arch (FIG. 2.36).

7. Identify the **adductor pollicis muscle** (FIG 2.36). Use blunt dissection to define its borders. The adductor pollicis muscle has two heads: **oblique** and **transverse**. The medial attachment of the transverse head is the anterior surface of the shaft of metacarpal bone 3. The medial attachments of the oblique head are the bases of metacarpal bones 2 and 3 and the adjacent carpal bones. Both heads attach to the medial side of the base of the proximal phalanx of the thumb. The adductor pollicis muscle draws the thumb toward digit 3 (adduction).

8. Use an illustration to study the three **palmar interosseous muscles** (FIG. 2.37A). The palmar interosseous muscles are unipennate muscles that attach to the metacarpal bones of digits 2, 4, and 5. Distally, each palmar interosseous muscle attaches to the base of the proximal phalanx and the extensor expansion of the same digit on which it originates. Do not attempt to dissect these muscles. [G 573; L 64; N 453; R 429; C 104]

9. Use an illustration to study the four **dorsal interosseous muscles** (FIG. 2.37B). The dorsal interosseous muscles are bipennate muscles that attach to metacarpal bones 1 to 5. Distally, the dorsal interosseous muscles attach to the bases of the proximal phalanges and the extensor expansions of digits 2, 3, and 4. Look at the dorsum of the dissected hand and note that the dorsal interosseous muscles occupy the intervals between the metacarpal bones. Do not dissect these muscles.

10. Study the actions of the interosseous muscles (FIG. 2.37A, B). The three Palmar interosseous muscles are **ADuctors** (PAD). They adduct digits 2, 4, and 5 toward an imaginary axial line drawn through the long axis of digit 3. The four Dorsal interosseous muscles are **ABductors** (DAB). They move digits 2, 3, and 4 away from the imaginary axial line. The two dorsal interosseous muscles that attach to digit 3 move it to either side of the imaginary axial line. The interosseous muscles are innervated by the deep branch of the ulnar nerve.

**Dissection Follow-up**

1. Place the muscles, tendons, and nerves that you have dissected back into their correct anatomical positions.
2. Review the movements of the fingers and thumb. Define flexion, extension, abduction, and adduction. Review the muscles that are responsible for each action.
3. Use the dissected specimen to follow the median nerve from the forearm into the hand. Review its recurrent branch and list the three muscles that the recurrent branch innervates.
4. Follow the ulnar artery from the elbow to the hand. In the hand, trace the superficial branch and deep palmar branch of the ulnar artery and review the formation of the palmar arterial arches.
5. Follow the ulnar nerve from the medial epicondyle of the humerus to the hand. In the hand, trace the superficial and deep branches of the ulnar nerve.
6. Review an illustration that demonstrates the cutaneous distribution of the ulnar and median nerves in the hand.
7. Recall the rule for innervation of the muscles in the hand:
   • All intrinsic muscles of the hand are innervated by the ulnar nerve except the muscles of the thenar group and the first two lumbrical muscles, which are innervated by the median nerve. [L 77, 78; N 460]

**EXTENSOR REGION OF THE FOREARM AND DORSUM OF THE HAND**

**Dissection Overview**
The posterior compartment of the forearm contains the extensor muscles of the hand and digits. They can be divided into a superficial layer and a deep layer (FIG. 2.22). The muscles of the superficial layer extend the wrist and the proximal phalanges. The muscles of the deep layer cause supination of the hand, extension of the index finger, and abduction and extension of the thumb. The deep branch of the radial nerve innervates the extensor muscles of the forearm. Nerves and vessels of the posterior compartment run in the connective tissue plane that divides the superficial layer of extensor muscles from the deep layer of extensor muscles (FIG. 2.22).

In the dorsum of the hand, the bones are superficial. There are no intrinsic muscles in the dorsum of the hand, so no motor innervation is required. The radial, ulnar, and median nerves share the cutaneous innervation of the dorsum of the hand.

The order of dissection will be as follows: The antebrachial fascia will be removed from the elbow to the wrist. The muscles of the superficial extensor layer will be identified and followed to their attachments in the hand. The tendons of the superficial extensor muscles will be released from the extensor retinaculum and retracted to expose the muscles of the deep extensor layer. The contents of the anatomical snuffbox will be identified.

**Dissection Instructions**

**Superficial Layer of Extensor Muscles** [G 584; L 58; N 432; R 421; C 80]
1. Place the cadaver in the supine position.
2. Use blunt dissection to remove the remnants of the superficial fascia from the posterior forearm and dorsum of the hand, taking care to preserve the dorsal venous arch.
3. Identify the extensor retinaculum, which is a specialization of the antebrachial fascia located on the posterior surface of the distal forearm (FIG. 2.38).
4. Use scissors to incise the posterior surface of the antebrachial fascia from the olecranon to the extensor retinaculum. Preserve the extensor retinaculum. Use your fingers or a probe to separate the antebrachial fascia from the muscles that lie deep to it. Detach the antebrachial fascia from its attachments to the radius and ulna and place it in the tissue container.
5. Six muscles comprise the superficial layer of extensor muscles: brachioradialis, extensor carpi radialis longus, extensor carpi radialis brevis, extensor digitorum, extensor digiti minimi, and extensor carpi ulnaris. Note that four of the muscles in the superficial extensor layer (extensor carpi radialis brevis, extensor digitorum, extensor digiti minimi, and extensor carpi ulnaris) attach to the lateral epicondyle of the humerus by way of a common extensor tendon (FIG. 2.38).
6. Use tendon patterns at the wrist and distal attachments to positively identify the muscles of the superficial extensor layer:
   • Brachioradialis tendon – attaches to the lateral surface of the distal radius
   • Extensor carpi radialis longus tendon – attaches to the base of metacarpal 2
   • Extensor carpi radialis brevis tendon – attaches to the base of metacarpal 3
   • Extensor digitorum tendons – attach to the extensor expansions of digits 2 to 5
   • Extensor digiti minimi tendon – attaches to the extensor expansion of digit 5
   • Extensor carpi ulnaris tendon – attaches to the base of metacarpal 5
7. Note that the tendons of the extensor digitorum muscle are tied together by intertendinous connections on the posterior surface of the hand. [G 590; L 58; N 458; R 424; C 92]
8. Observe the extensor expansion of digit 3 (FIG. 2.39). The extensor expansion is wrapped around the dorsum and the sides of the proximal phalanx and the distal end of the metacarpal bone. The hood-like expansion retains the extensor tendon in the midline of the digit. The tendons of the lumbrical and interosseous muscles attach to the extensor expansion. [G 591; L 59; N 452; R 421; C 69, 104]
9. Note that all of the extensor tendons are contained within individual osseofibrous tunnels. Synovial sheaths line these tunnels.
FIGURE 2.38  Superficial layer of extensor muscles in the right forearm. Posterior view.
Deep Layer of Extensor Muscles [G 585; L 59; N 433; R 421; C 82]

1. Five muscles comprise the deep layer of extensor muscles: supinator, abductor pollicis longus, extensor pollicis brevis, extensor pollicis longus, and extensor indicis (FIG. 2.38).

2. Cut through the extensor retinaculum to release the tendons of the extensor digitorum muscle (FIG. 2.38, dashed line). Retract the tendons medially (FIG. 2.40).

3. The proximal attachments of four of the muscles of the deep extensor layer (abductor pollicis longus, extensor pollicis brevis, extensor pollicis longus, and extensor indicis) are the posterior surfaces of the radius, ulna, and interosseous membrane. Three of these muscles (or their tendons) emerge from the interval between the extensor digitorum muscle and the extensor carpi radialis brevis muscle and for this reason they are often referred to as the “outcropping” muscles of the thumb (FIG. 2.38).

4. Identify the tendon of each of the following muscles and follow it to its distal attachment:
   - Abductor pollicis longus tendon – attaches to the base of metacarpal 1

5. Identify the anatomical snuffbox (FIG. 2.41A, B). The anatomical snuffbox is a depression on the posterior surface of the wrist that is bounded anteriorly by the abductor pollicis longus tendon and the extensor pollicis brevis tendon. The posterior boundary of the anatomical snuffbox is the extensor pollicis longus tendon. [G 593; L 58; N 457; R 424; C 111]

6. Within the anatomical snuffbox, find the radial artery (FIG. 2.41B). Use a probe to clean the radial artery and follow it distally until it disappears between the two heads of the first dorsal interosseous muscle. Note that the dorsal carpal arch receives a branch of the radial artery that arises in the anatomical snuff box. The dorsal carpal arch supplies arterial blood to the dorsum of the hand (FIG. 2.41A). Do not dissect its branches.

7. Near the elbow, use your fingers to retract the brachioradialis muscle and observe the supinator muscle (FIG. 2.40). The proximal attachments of the supinator muscle are the lateral epicondyle of the humerus, the radial collateral and annular ligaments of the elbow, and the lateral surface of the ulna. The distal attachment of the supinator muscle is the proximal one-third of the radius. The supinator muscle supinates the hand.

8. On the lateral aspect of the elbow, once again find the radial nerve in the connective tissue plane between the brachioradialis muscle and the brachialis muscle. Observe that the radial nerve divides into a superficial branch and a deep branch. The deep branch of the radial nerve enters the supinator muscle.

9. Look for the deep branch of the radial nerve where it emerges from the distal border of the supinator muscle. Its name changes to posterior interosseous nerve at this location (FIG. 2.40). The posterior interosseous nerve provides motor branches to the extensor muscles.

10. Observe that the posterior interosseous nerve is accompanied by the posterior interosseous artery, which is a branch of the common interosseous artery.

Dissection Follow-up

1. Replace the muscles of the posterior compartment of the forearm into their correct anatomical positions.

2. Use the dissected specimen to review the attachments of the extensor tendons.
FIGURE 2.40 Deep layer of extensor muscles in the right forearm. Lateral view.
3. Note that the tendons of three strong extensor muscles (extensor carpi radialis longus, extensor carpi radialis brevis, and extensor carpi ulnaris) attach to the proximal ends of metacarpal bones. These three extensors of the wrist work synergistically with the flexors of the digits: A firm grip requires an extended wrist.

4. Review the extensor expansion of digit 3. Recall the muscles that insert there and the action of each muscle.

5. Review the course of the common interosseous branch of the ulnar artery and observe how the posterior interosseous artery enters the posterior compartment of the forearm.

6. Review the course of the radial artery from the cubital fossa to the deep palmar arch.

7. Palpate the anatomical snuffbox on yourself. Feel the pulsations of the radial artery within its boundaries.

8. Recall the rule for innervation of the posterior compartment of the forearm:

- The radial nerve innervates all of the muscles in the posterior compartment of the forearm. [L 79]
- Note that there are no intrinsic muscles in the dorsum of the hand. Therefore, there are no muscles in the hand that are innervated by the radial nerve.

**JOINTS OF THE UPPER LIMB**

**Dissection Overview**

Dissect the joints in one upper limb. Keep the soft tissue structures of the other limb intact for review purposes. During this dissection, the muscles of one limb will be removed. Take advantage of this opportunity to review the attachments, innervation, and action of each muscle as it is removed.

The order of dissection will be as follows: The sternoclavicular and acromioclavicular joints will be dissected. The glenohumeral joint will be dissected. The elbow joint and radioulnar joints will be studied. The wrist joint will be dissected. Finally, the joints of the digits will be studied.

**Dissection Instructions**

**Sternoclavicular Joint** [G 514; L 71; N 406; C 140]

1. Use an articulated skeleton to observe the relationships between the sternum and clavicle. Identify the clavicular notch of the manubrium. The medial end of the clavicle articulates with the clavicular notch and the adjacent part of the first costal cartilage (FIG. 2.42).
2. Place the cadaver in the supine position. The tendon of the sternocleidomastoid muscle is attached to the anterior surface of the sternoclavicular joint. Detach the tendon and reflect the sternocleidomastoid muscle superiorly.

3. Identify the anterior sternoclavicular ligament, which spans from the sternum to the clavicle.

4. Use blunt dissection to clean the costoclavicular ligament, which runs obliquely from the first costal cartilage to the inferior surface of the clavicle near its medial end.

5. Use a scalpel to remove the anterior sternoclavicular ligament. Within the joint cavity, observe the articular disc. Inferiorly, the articular disc is attached to the first costal cartilage. Superiorly, the articular disc is attached in such a manner that it resists medial displacement of the clavicle.

6. Palpate the movements of the sternoclavicular joint on yourself. Place your left hand on your right sternoclavicular joint and circumduct your right upper limb through a large circle. Observe that the sternoclavicular joint allows a limited amount of movement in every direction.

Acromioclavicular Joint [G 540, 543; L 71; N 410; R 378; C 114]

1. Review the bony features that are relevant to the acromioclavicular joint (FIG. 2.43):
   - Acromion
   - Coracoïd process of the scapula
   - Lateral end of the clavicle

2. Detach the trapezius muscle from the lateral end of the clavicle. Detach the coracobrachialis and pectoralis minor muscles from the coracoïd process. The acromioclavicular joint is now exposed. The acromioclavicular joint is a plane synovial joint between the acromion and the distal end of the clavicle.

3. Identify the coracoclavicular ligament, which supports the acromioclavicular joint (FIG. 2.43). Use a probe to clean the ligament. Identify its two parts:
   - Conoid ligament
   - Trapezoid ligament

4. Open the acromioclavicular joint by completely removing the joint capsule. Separate the acromion from the lateral end of the clavicle.

5. Note the shape of the articulating surfaces. The angle of the articulating surfaces causes the acromion to slide inferior to the distal end of the clavicle when the acromion is forced medially. The conoid and trapezoid ligaments prevent the acromion from moving inferiorly relative to the clavicle, thus strengthening the joint.

Glenohumeral Joint [G 540–543; L 71; N 410; R 378; C 112, 114, 116, 118, 119]

The glenohumeral joint (shoulder joint) is a ball-and-socket synovial joint with a wide range of motion. The shoulder joint has a greater degree of movement than any other joint in the body. This is due to the small area of contact between the bones involved (head of the humerus and the glenoid fossa of the scapula) and the loose joint capsule. Stability of the shoulder joint depends on the proper function of the muscles of the rotator cuff.

1. Place the cadaver in the supine position.

2. Review the bony features pertinent to dissection of the glenohumeral joint (FIG. 2.4):
   - Glenoid fossa of the scapula
   - Head of the humerus
   - Anatomical neck of the humerus
3. To expose the **capsule of the glenohumeral joint**, the muscles and tendons that span the joint must be removed. Review the proximal attachment and distal attachment of each muscle as you remove it.

4. Remove the coracobrachialis muscle and the short head of the biceps brachii muscle. Leave the subscapularis muscle intact.

5. Place the cadaver in the prone position. Observe that the tendons of the supraspinatus, infraspinatus, and teres minor muscles blend with the joint capsule. Remove these tendons.

6. Remove the long head of the triceps brachii muscle.

7. The posterior surface of the **joint capsule** is now exposed. Verify that the joint capsule is attached to the anatomical neck of the humerus.

8. Use a scalpel to open the posterior surface of the joint capsule (**FIG. 2.44A**).

9. Use a saw or a chisel to remove the head of the humerus at the anatomical neck.

10. Use a probe to explore the **glenoid cavity**. Identify the **glenoid labrum** and attempt to demonstrate the three **glenohumeral ligaments**, which strengthen the anterior wall of the fibrous capsule (**FIGS. 2.43 and 2.44B**).

11. Observe that the **tendon of the long head of the biceps brachii muscle** passes through the glenoid cavity and is attached to the supraglenoid tubercle.
12. Place the cadaver in the supine position. Define and clean the **coracoacromial ligament**, which spans from the coracoid process to the acromion. The coracoacromial ligament, the acromion, and the coracoid process prevent superior displacement of the head of the humerus.

13. Use the dissected specimen to perform the movements of the glenohumeral joint: flexion, extension, abduction, adduction, and circumduction. Note that this freedom of motion is obtained at the loss of joint stability.

**Elbow Joint and Proximal Radioulnar Joint** [G 554, 555; L 72; N 426; R 379; C 123–126]

1. Review the bony features of the elbow region (FIG. 2.45A).

2. Use an articulated skeleton to verify that the elbow joint consists of two parts:
   - A **hinge joint** between the trochlea of the humerus and the trochlear notch of the ulna
   - A **gliding joint** between the capitulum of the humerus and the head of the radius

3. Remove the brachialis muscle from the anterior surface of the joint capsule.
4. Detach the triceps brachii tendon from the olecranon and the posterior surface of the joint capsule.

5. Remove the superficial flexor muscles of the forearm from their attachment to the medial epicondyle. Review the common flexor tendon and the five muscles that attach to it.

6. Identify the **ulnar collateral ligament** on the medial side of the elbow joint (FIG. 2.45D). Observe that it consists of a strong anterior cord and a fan-like posterior portion.

7. Remove the superficial extensor muscles of the forearm from their attachment to the lateral epicondyle of the humerus. Review the common extensor tendon and the muscles that attach to it.

8. Remove the supinator muscle.

9. Identify the **radial collateral ligament** (FIG. 2.45C). It fans out from the lateral epicondyle of the humerus to the radius and annular ligament.

10. The **proximal radioulnar joint** is a pivot joint that occurs between the head of the radius and the radial notch of the ulna. The **annular ligament** and the radial notch of the ulna completely encircle the head of the radius (FIG. 2.45B). Note that the radius can freely rotate in the annular ligament. Place the hand of the cadaver specimen into the pronated position. Now pull on the biceps brachii tendon. Note the strong supinating action of the biceps brachii muscle.

11. Open the elbow joint by making a transverse cut through the anterior surface of the joint capsule between the ulnar collateral ligament and the radial collateral ligament.

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**FIGURE 2.45** Elbow joint.
12. Use a probe to explore the extent of the synovial cavity. Observe the smooth articular surfaces of the humerus, ulna, and radius.
13. Use the dissected specimen to perform the movements of the elbow joint: flexion and extension. Observe the joint surfaces and the collateral ligaments during these movements.

**Intermediate Radioulnar Joint** [G 559; L 72, 73; N 427; R 380; C 126]

1. The radius and ulna are joined throughout their length by the interosseous membrane. This is a fibrous joint. Use an illustration to study this joint.

**Distal Radioulnar Joint** [G 598, 600; L 73; N 443; R 381; C 126]

1. The distal radioulnar joint is a pivot joint that occurs between the head of the ulna and the ulnar notch of the radius (FIG. 2.46).
2. Remove all tendons and soft tissue structures that cross the wrist. Review the distal attachment of each tendon and the action of each muscle.
3. Note that the anterior and posterior surfaces of the wrist joint are reinforced by radiocarpal ligaments.
4. To open the distal radioulnar joint, extend the hand. On the anterior surface of the joint capsule, cut transversely through the radiocarpal ligaments. This cut should be made proximal to the flexor retinaculum and carpal tunnel. Leave the hand attached to the forearm by the posterior part of the joint capsule.
5. Use a probe to explore the articulation between the radius and the ulna. Note that the distal radioulnar joint contains an articular disc. Verify that the articular disc holds the distal ends of the radius and the ulna together.

**Wrist Joint** [G 598, 599; L 73, 74; N 442, 443; R 380, 381; C 130, 131]

1. The wrist joint (radiocarpal joint) is the articulation between the distal end of the radius and the proximal carpal bones (FIG. 2.46). Note that the distal end of the radius articulates with only two carpal bones: scaphoid and lunate.
2. Identify the smooth proximal surfaces of the scaphoid, lunate, and triquetrum. Study the corresponding articular surface of the radius. Notice that the scaphoid and lunate bones transmit forces from the hand to the forearm. Therefore, these carpal bones are the ones most commonly fractured in a fall on the outstretched hand.
3. Once again, identify the articular disc. The articular disc articulates with the triquetrum when the hand is adducted.
4. Use the dissected specimen to perform the movements of the wrist joint: flexion, extension, abduction, and circumduction. Observe the articular surfaces during these movements.

**Metacarpophalangeal Joints** [G 602; L 74; N 446; R 381; C 130, 131]

1. Dissect digit 3 as a representative example.
2. Remove the tendons of the flexor digitorum superficiais and flexor digitorum profundus muscles. Note their attachments on the phalanges.
3. Remove the interosseous muscles and the extensor expansion to expose the metacarpophalangeal joint capsule.
4. Clean the collateral ligaments (FIG. 2.47A). Move the digit to confirm that the ligaments are slack during extension and taut during flexion. Therefore, the digits cannot be spread (abducted) unless they are extended.
5. Use the dissected specimen to perform the movements of the digit at the metacarpophalangeal joint: flexion, extension, abduction, and adduction. Confirm that the metacarpophalangeal joints are condyloid joints.
Interphalangeal Joints [G 602; L 74; N 446; R 381; C 131]

1. Clean the collateral ligaments of the interphalangeal joints of digit 3 (FIG. 2.47B).
2. Use a probe to explore the synovial cavity of one interphalangeal joint. Inspect the articular surfaces that are covered with smooth cartilage.

3. Use the dissected specimen to perform flexion and extension of the interphalangeal joint and confirm that the collateral ligaments limit the range of motion. Confirm that the interphalangeal joints are hinge joints.
The heart and lungs are fragile organs, and the main function of the thorax is to house and protect them. The protective function of the thoracic wall is combined with mobility to accommodate volume changes during respiration. These two dissimilar functions, protection and flexibility, are accomplished by the alternating arrangement of the ribs and intercostal muscles.

The superficial fascia of the thorax contains the usual elements that are common to superficial fascia in all body regions: blood vessels, lymph vessels, cutaneous nerves, and sweat glands. In addition, the superficial fascia of the anterior thoracic wall in the female contains the mammary glands, which are highly specialized organs unique to the superficial fascia of the thorax.

**SURFACE ANATOMY**

[G 2; L 160; N 175; C 139]

The surface anatomy of the thorax can be studied on a living subject or on the cadaver. Turn the cadaver to the supine position and palpate the following structures (FIG. 3.1):

- Jugular notch (suprasternal notch)
- Clavicle
- Acromion of the scapula
- Manubrium
- Sternal angle
- Body of the sternum
- Xiphoid process
- Costal margin
- Anterior axillary fold (lateral border of the pectoralis major muscle)

**SKELETON OF THE THORAX**

If you have previously dissected the back, review the parts of a thoracic vertebra. If you have not dissected the back, you must study the vertebrae now. Turn to pages 6 to 8, complete that exercise, and return to this page.

Refer to a skeleton. Examine a rib from the midthorax level and identify (FIG. 3.2): [G 15; L 164; N 180; R 197; C 142]

- Head
- Neck
- Tubercle
- Costal angle
- Shaft (body)
- Costal groove

On an articulated skeleton, note the following features:

- The first rib is the highest, shortest, broadest, and most sharply curved rib.
abdominal musculature and, because of this, these two false ribs are also called floating ribs.

Examine the sternum and identify (FIG. 3.4): [G 14; L 163; N 180; R 193; C 141]

- Jugular notch (suprasternal notch)
- Manubrium (L. manubrium, handle)
- Sternal angle (at the attachment of the second costal cartilage; also at the level of the T4/T5 intervertebral disc)
- Body
- Xiphoid process (Gr. xiphos, sword)

Examine a scapula and identify (FIG. 3.4): [G 487; L 32; N 179; R 189; C 112]

- Acromion
- Coracoid process

Observe that the medial end of the clavicle articulates with the manubrium of the sternum (sternoclavicular joint) and the lateral end of the clavicle articulates with the acromion of the scapula (acromioclavicular joint) (FIG. 3.4).

PECTORAL REGION

Instructions for dissection of the pectoral region are found in Chapter 2, The Upper Limb. If you are dissecting the thorax before the upper limb, the pectoral region must be...
INTERCOSTAL SPACE AND INTERCOSTAL MUSCLES

Dissection Overview
The interval between adjacent ribs is called the intercostal space. The intercostal space is truly a space only in a skeleton, as three layers of muscle fill the intercostal space in the living body and in the cadaver. From superficial to deep, the three layers of muscle are external intercostal muscle, internal intercostal muscle, and innermost intercostal muscle.

There are 11 intercostal spaces on each side of the thorax. Each is numbered according to the rib that forms its superior boundary. For example, the fourth intercostal space is located between ribs 4 and 5.

The order of dissection will be as follows: The external intercostal muscle will be studied in the fourth intercostal space and will be reflected. The internal intercostal muscle will then be studied in the fourth intercostal space and will be reflected. Branches of intercostal nerves and blood vessels will be identified. The innermost intercostal muscle will be identified.

Dissection Instructions

1. Detach the serratus anterior muscle from its proximal attachments on the upper eighth or ninth ribs and reflect it laterally.
2. Palpate the ribs and the intercostal spaces. Begin at the level of the sternal angle (attachment of the second costal cartilage) and identify each intercostal space by number.
3. Dissect intercostal space 4 (the space between ribs 4 and 5).
4. Identify the external intercostal muscle (FIG. 3.5). The external intercostal muscle attaches to the inferior border of the rib above and the superior border of the rib below. The external intercostal muscle elevates the rib below. Note that the fibers of the external intercostal muscles pass diagonally toward the anterior midline as they descend. [G 21; L 166; N 183; R 207; C 148]
5. Identify the external intercostal membrane, which is located at the anterior end of the intercostal space between the costal cartilages. Note that the fibers of the external intercostal muscle end at the lateral edge of the external intercostal membrane.
6. Insert a probe deep to the external intercostal membrane just lateral to the border of the sternum in the fourth intercostal space. Push the probe laterally and note that it passes deep to the external intercostal muscle.
7. With the probe as a guide, use scissors to cut the external intercostal muscle from the rib above and reflect it inferiorly (FIG. 3.5). Continue the cut laterally to the midaxillary line.
8. Identify the internal intercostal muscle. The internal intercostal muscle attaches to the superior border of the rib below and the inferior border of the rib above. The internal intercostal muscle depresses the rib above. Note that the fiber direction of the internal intercostal muscle is perpendicular to the fiber direction of the external intercostal muscle (FIG. 3.5).
9. Begin at the lateral border of the sternum and detach the internal intercostal muscle from its attachment on rib 5. Continue to detach the internal intercostal muscle as far laterally as the midaxillary line. Reflect the muscle superiorly (FIG. 3.5).
10. Identify the fourth intercostal nerve and the fourth posterior intercostal artery and vein inferior to rib 4. The intercostal nerve and vessels run in the plane between the internal intercostal muscle and innermost intercostal muscle (FIG. 3.6). The innermost intercostal muscle has the same fiber direction, attachments, and action as the internal intercostal muscle, but it does not extend as far anteriorly in the intercostal space. [G 22; L 170; N 185; R 214; C 10]
11. The intercostal nerve and vessels supply the intercostal muscles, the skin of the thoracic wall, and the parietal pleura. Use FIGURE 3.6 to study the course and distribution of a typical intercostal nerve.
12. The anterior end of the intercostal space is supplied by **anterior intercostal branches** of the **internal thoracic artery**. The internal thoracic artery runs a vertical course just lateral to the border of the sternum and crosses the deep surfaces of the costal cartilages. [G 24; L 167, 168; N 183; R 208; C 148]

**Dissection Follow-up**

1. Replace the internal and external intercostal muscles in their correct anatomical positions.
2. Review the muscles that lie in the intercostal space. Review their actions. Understand how they assist respiration by elevating and depressing the ribs.
3. Use an illustration and your dissected specimen to review the origin, course, and branches of the posterior intercostal artery and intercostal nerve.
4. Consult a dermatome chart and compare the dermatome pattern to the distribution of the intercostal nerves. [G 348; L 162; N 159; R 205; C 10]

**REMOVAL OF THE ANTERIOR THORACIC WALL**

**Dissection Overview**

To view the contents of the thoracic cavity, the anterior thoracic wall must be removed. The goal of this dissection is to remove the thoracic wall with the **costal pleura** attached to its inner surface. The structures to be removed include the...
proximal ends of both clavicles, the manubrium and body of the sternum, the anterior and lateral portions of ribs 1 through 5, and the contents of intercostal spaces 1 to 4.

The order of dissection will be as follows: The sternocleidomastoid muscle and infrahyoid neck muscles will be detached from their sternal and clavicular attachments. The clavicles will be cut at their midlength. The costal cartilages and sternum will be cut at the level of the xiphisternal joint. The ribs and contents of the intercostal spaces will be cut at the midaxillary line. The thoracic wall will be removed, and the inner surface of the thoracic wall will be studied.

**Dissection Instructions**  
[G 767; L 308; N 27, 28; R 174; C 519]

1. Reflect the pectoralis major muscle laterally. Reflect the pectoralis minor muscle superiorly. Reflect the serratus anterior muscle laterally.
2. Use scissors to cut the sternocleidomastoid muscle where it is attached to the superior margin of the sternum and the superior surface of the clavicle. Use blunt dissection to loosen the distal 5 cm of the sternocleidomastoid muscle and reflect it superiorly.
3. Use your fingers to push the infrahyoid muscles posteriorly with enough force to tear their attachments to the deep surface of the sternum.
4. Cut both clavicles at their midlength using a saw (Fig. 3.7, cuts 1 and 2).
5. At the level of the xiphisternal joint (approximately at the level of intercostal space 5), use a saw to make a transverse cut across the sternum and costal cartilages (Fig. 3.7, cut 3). Allow the saw to pass through the bone and cartilage, but not into the deeper tissues.

**Fig. 3.7** Cuts used to remove the anterior thoracic wall.

6. Use a saw or bone cutters to cut ribs 1 to 5 in the midaxillary line on both sides of the thorax.
7. With a scalpel, make a series of vertical cuts through the muscles in intercostal spaces 1 to 5 in the midaxillary line. The cuts should be aligned with the cut ribs. Make the cut deep enough to cut the parietal pleura.
8. Use scissors to cut the intercostal muscles and underlying costal pleura from the upper border of rib 6 on both sides of the thorax.
9. Gently, elevate the inferior end of the sternum along with the attached portions of the severed costal cartilages and ribs. Near the lower end of the sternum, identify the right and left internal thoracic vessels. Cut the internal thoracic vessels at the level of the fifth sternocostal joint.
10. Continue to elevate the inferior end of the thoracic wall and cut the parietal pleura with scissors where it reflects from the inner surface of the thoracic wall onto the mediastinum.
11. Cut the internal thoracic vessels at the level of the first rib. Remove the anterior thoracic wall with the internal thoracic vessels attached.
12. Observe the internal surface of the anterior thoracic wall and identify the costal pleura. Use blunt dissection to remove the parietal pleura from the inner surface of the anterior thoracic wall.
13. Identify the transversus thoracis muscle [G 25; L 168; N 184; R 206; C 147]. Observe that the inferior attachment of the transversus thoracis muscle is on the sternum and its superior attachments are on costal cartilages 2 to 6. The transversus thoracis muscle depresses the ribs.
14. The internal thoracic artery and veins are located between the transversus thoracis muscle and the costal cartilages.
15. Follow the internal thoracic artery inferiorly and identify at least one of the anterior intercostal branches. Note that posterior to the sixth or seventh costal cartilage, the internal thoracic artery divides into the superior epigastric artery and the musculophrenic artery. This division may be seen on the cadaver rather than on the thoracic wall specimen.

**Dissection Follow-up**

1. Replace the anterior thoracic wall in its correct anatomical position.
2. Replace the serratus anterior muscle in its correct anatomical position.
3. Replace the pectoralis minor muscle, making sure that its proximal attachments touch ribs 3, 4, and 5.
4. Replace the pectoralis major muscle in its correct anatomical position.
5. Review the attachments and the action of the pectoral muscles, the serratus anterior muscle, and the transversus thoracis muscle.

6. Study the course of the internal thoracic artery from its origin to its bifurcation and name its branches.

**CLINICAL CORRELATION**

**ANTERIOR THORACIC WALL**

The anterior and lateral approaches to the contents of the thorax are the two most common surgical approaches. In the anterior approach, the sternum is split vertically in the midline. This approach does not cross major vessels and allows good access to the heart. The incision through the sternum is closed with stainless steel wires. In the lateral approach, an intercostal space is incised to provide access to the lungs or to structures posterior to the heart.

**PLEURAL CAVITIES**

**Dissection Overview**

The thorax has two apertures (FIG. 3.4). The **superior thoracic aperture** (thoracic inlet) is relatively small and bounded by the manubrium of the sternum, the right and left first ribs, and the body of the first thoracic vertebra. Structures pass between the thorax, the neck, and the upper limb through the superior thoracic aperture (e.g., trachea, esophagus, vagus nerves, thoracic duct, major blood vessels).

The **inferior thoracic aperture** (thoracic outlet) is larger and bounded by the xiphisternal joint, the costal margin, ribs 11 and 12, and the body of vertebra T12. The **diaphragm** attaches to the structures that form the boundaries of the inferior thoracic aperture and it separates the thoracic cavity from the abdominal cavity. Several large structures (e.g., aorta, thoracic duct, inferior vena cava, esophagus, vagus nerves) pass between the thorax and abdomen through openings in the diaphragm.

The thorax contains two pleural cavities (right and left) and the **mediastinum**. The two pleural cavities occupy the lateral parts of the thoracic cavity and each contains one lung. The mediastinum (L. *quod per medium stat*, that which stands in the middle) is the region between the two pleural cavities. It contains the heart, aorta, trachea, esophagus, and other structures that pass to or from the head and neck. [G 30; L 173; N 190; R 243; C 149]

Each pleural cavity is lined by a serous membrane called the **parietal pleura** (FIG. 3.8). The parietal pleura has subdivisions that are regionally named:

- **Costal pleura** – lines the inner surface of the thoracic wall
- **Mediastinal pleura** – lines the mediastinum
- **Diaphragmatic pleura** – lines the superior surface of the diaphragm
- **Cervical pleura** (cupula) – extends superior to the first rib

The parietal pleura is sharply folded where the costal pleura meets the diaphragmatic pleura and where the costal pleura meets the mediastinal pleura. The folds are called **lines of pleural reflection**. The lines of pleural reflection are acute, and the inner surfaces of the parietal pleura are in contact with one another (FIG. 3.8). The areas where parietal pleura contacts parietal pleura are called **pleural recesses**. The two **costomediastinal recesses** (left and right) occur posterior to the sternum where costal pleura meets mediastinal pleura. The two **costodiaphragmatic recesses** (left and right) are located at the most inferior limits of the parietal pleura (FIG. 3.8). During quiet inspiration, the inferior border of the lung does not extend into the costodiaphragmatic recess. [G 30; L 172; N 190; R 265; C 152]

The **endothoracic fascia** is a small amount of connective tissue that attaches the costal pleura to the thoracic wall.

Each lung is completely covered with **visceral pleura** (pulmonary pleura). At the root of the lung, the visceral pleura becomes continuous with the mediastinal pleura.

The **pleural cavity** is the space between the visceral pleura and the parietal pleura (FIG. 3.8). In the living body, the pleural cavity is a potential space, and visceral pleura touches parietal pleura.
LUNGS

Dissection Overview

The order of dissection will be as follows: The surface features and relationships of the lungs that can be seen from an anterior view will be studied with the lungs in the thorax. Then the lungs will be removed, and the study of surface features and relationships of the lungs will be completed. The hilum of the lung will be studied.

Dissection Instructions

Lungs in the Thorax

1. Observe the lungs in situ (FIG. 3.9). [G 27; L 174, 175; N 192; R 268; C 152]

2. Each lung has three surfaces: costal, mediastinal, and diaphragmatic. You can see only the costal surface with the lung in situ.

3. Observe the oblique fissure on both lungs. Replace the anterior thoracic wall and observe that the oblique fissure lies deep to the fifth rib laterally and that it is deep to the sixth costal cartilage anteriorly. Clinicians may refer to the oblique fissure as the major fissure.

4. Remove the anterior thoracic wall and identify the horizontal fissure on the right lung. Replace the anterior thoracic wall and observe that the horizontal fissure lies deep to the fourth rib and fourth costal cartilage. Clinicians may refer to the horizontal fissure as the minor fissure or transverse fissure.

5. Note that the right lung has three lobes (superior, middle, and inferior). The left lung has two lobes (superior and inferior).

CLINICAL CORRELATION

PLEURAL CAVITY

Under pathologic conditions, the potential space of the pleural cavity may become a real space. For example, if air enters the pleural cavity (pneumothorax), the lung collapses due to the elasticity of its tissue.

Excess fluid may accumulate in the pleural cavity, compress the lung, and produce breathing difficulties. The fluid could be serous fluid (plural effusion) or blood resulting from trauma (hemothorax).

2. Use paper towels to remove fluid that may have collected in the pleural cavity.

3. Identify the parts of the parietal pleura: costal, diaphragmatic, mediastinal, and cervical. Part of the costal pleura was removed with the anterior thoracic wall.

4. Place your fingers in the costodiaphragmatic recess. Follow it posteriorly and notice the acute angle that the diaphragm makes with the inner surface of the thoracic wall.

5. Place your hand between the lung and the mediastinum and palpate the root of the lung. At the root of the lung, the mediastinal pleura is continuous with the visceral pleura. Palpate the pulmonary ligament, which extends inferior to the root of the lung.

6. The root of the lung is attached to the mediastinum. All other parts of the lung should slide freely against the parietal pleura. Pleural adhesions may occur between visceral and parietal pleurae. Pleural adhesions are the result of disease processes, and you should use your fingers to break them.

Dissection Follow-up

1. Replace the anterior thoracic wall in its correct anatomical position.

2. Use an illustration and the dissected specimen to project the lines of pleural reflection to the anterior thoracic wall.

3. Review the course of the intercostal nerves and understand that they provide somatic innervation (including pain fibers) to the costal pleura.

FIGURE 3.9 The lungs in situ. Anterior view.
6. Observe that the **apex** of the lung lies anterior to the neck of the first rib (superior to the body of the first rib). Therefore, the apex of the lung and the cervical pleura lie superior to the plane of the superior thoracic aperture and are actually located in the neck.

7. Identify the **pericardium** that occupies the midline between the lungs. The pericardium contains the heart.

8. Insert your hand into the pleural cavity between the heart and the lung and palpate the **root of the lung**. Feel the hard structures within the root of the lung. These are the pulmonary vessels filled with clotted blood and the main bronchus.

9. Observe that the **phrenic nerve** and **pericardiacophrenic vessels** pass anterior to the root of the lung and are medial to the mediastinal pleura. Use an illustration to observe that the **vagus nerve** passes posterior to the root of the lung. [G 82, 83; L 194, 195; N 224, 225; R 280, 281; C 166, 167]

### Removal of the Lungs

1. Preserve the phrenic nerve, pericardiacophrenic vessels, and vagus nerve during lung removal.

2. Place your hand into the pleural cavity between the lung and mediastinum. Retract the lung laterally to stretch the root of the lung.

3. While retracting the lung, use scissors to transect the root of the lung halfway between the lung and the mediastinum. Take care not to cut into the mediastinum or the lung. Remove both lungs.

4. Compare the two lungs (FIG. 3.10). Note that the right lung is shorter but has greater volume than the left lung. [G 34, 35; L 189; N 193; R 249; C 158]

5. Identify the **surfaces of the lung**: costal, mediastinal, and diaphragmatic.

6. Identify the **borders of the lung**: anterior, posterior, and inferior.

7. Recall that each lung has a **superior lobe** and an **inferior lobe** separated by the **oblique fissure**. Note that most of the inferior lobe lies posteriorly and that most of the superior lobe lies anteriorly in the thorax (FIG. 3.10).

8. Recall that the right lung has a **horizontal fissure**, which defines a small **middle lobe** (FIG. 3.10). Identify the middle lobe.

9. Identify the **cardiac notch** on the superior lobe of the left lung (FIGS. 3.9 and 3.10). The cardiac notch is located on the anterior border of the left lung, and in the anatomical position it is anterior to the heart.

10. Identify the **lingula** of the left lung. The lingula is the inferior, medial portion of the superior lobe of the left lung. It is the homolog of the middle lobe of the right lung.

11. Identify several **contact impressions** on the mediastinal surface of each lung (FIGS. 3.11 and 3.12). These impressions illustrate the close proximity of the mediastinal structures to the lung.

On the mediastinal surface of the **right lung**, identify: [G 36, 37; L 190; N 193; R 249; C 160]

- Cardiac impression
- Esophagus impression
- Arch of the azygos vein impression
- Superior vena cava impression

On the mediastinal surface of the **left lung**, identify:

- Cardiac impression
- Aortic arch impression
- Thoracic aorta impression
CHAPTER 3: THE THORAX

Apex
Arch of azygos vein impression
Right brachiocephalic vein impression
Superior vena cava impression
Cardiac impression

Anterior border
Horizontal fissure
Middle lobe

Diaphragmatic surface

Superior lobe
Oblique fissure
Inferior lobe

Structures of hilum:
- Pulmonary artery
- Bronchi
- Bronchial artery
- Bronchopulmonary lymph nodes
- Superior and inferior pulmonary veins

Posterior border
Esophagus impression
Pulmonary ligament

Inferior border

FIGURE 3.11 Mediastinal surface of the right lung.

Superior lobe
Oblique fissure
Inferior lobe

Aortic arch impression
Cardiac impression

Anterior border

Thoracic aorta impression
Pulmonary ligament

Diaphragmatic surface

Cardiac notch
Lingula

Inferior border

FIGURE 3.12 Mediastinal surface of the left lung.
12. Examine the hilum of the lung (FIGS. 3.11 and 3.12). Identify the main bronchus, pulmonary artery, and pulmonary veins. At the hilum, the main bronchus usually lies posterior to the pulmonary vessels, and the pulmonary artery is superior to the pulmonary veins. To help distinguish the arteries from the veins, compare the relative thickness of the walls of the vessels (arteries have thicker walls). To distinguish the main bronchus from the pulmonary vessels, look for cartilage in its wall.

13. At the hilum of each lung, use blunt dissection to follow the main bronchus into the lung.

14. In the left lung, identify the superior and inferior lobar (secondary) bronchi. [G 43; L 192; N 197; R 247; C 162]

15. In the right lung, identify the superior, middle, and inferior lobar bronchi. Note that the right superior lobar bronchus passes superior to the right pulmonary artery and, therefore, it is also called the "eparterial bronchus."

16. Use blunt dissection to follow one lobar bronchus approximately 3 to 4 cm deeper into the lung tissue until it branches into several segmental bronchi. The right lung contains 10 segmental bronchi and the left lung contains 9. Each segmental bronchus supplies one bronchopulmonary segment of the lung. In your textbook, read a description of the bronchopulmonary segments and the internal organization of the lung.

17. Identify the bronchial artery. The bronchial artery courses along the surface of the main bronchus. The lumen of the bronchial artery may be seen where the main bronchus was cut during lung removal (FIGS. 3.11 and 3.12).

18. The hilum of the lung contains lymph nodes, lymph vessels, and autonomic nerve fibers. Use an illustration to confirm this. [G 44, 45; L 190; N 202, 203; R 275; C 166, 167]

19. Note that the lungs have a rich nerve supply via the anterior and posterior pulmonary plexuses. Sympathetic contributions are received from the right and left sympathetic trunks, whereas parasympathetic contributions are received from the right and left vagus nerves.

Dissection Follow-up

1. Review the parts of the lungs.
2. Replace the lungs in their correct anatomical positions within the pleural cavities.
3. Replace the anterior thoracic wall. Project the borders, surfaces, and fissures of the lungs to the surface of the thoracic wall.
4. Review the relationship of the pleural reflections to the thoracic wall.
5. Review the costomediastinal and costodiaphragmatic recesses.

MEDIASTINUM

Dissection Overview

The region between the two pleural cavities is the mediastinum. The boundaries of the mediastinum are:

- Superior boundary – superior thoracic aperture
- Inferior boundary – diaphragm
- Anterior boundary – sternum
- Posterior boundary – bodies of vertebrae T1 to T12
- Lateral boundaries – mediastinal pleurae (left and right)

For descriptive purposes, the mediastinum is divided into four parts (FIG. 3.13). An imaginary transverse plane at the level of the sternal angle intersects the intervertebral disc between vertebrae T4 and T5. The plane of the sternal angle separates the superior mediastinum from the inferior mediastinum. The pericardium divides the inferior mediastinum into three parts:

- Anterior mediastinum – the part that lies between the sternum and the pericardium. In children and adolescents, part of the thymus may be found in the anterior mediastinum.
- Middle mediastinum – the part that contains the pericardium, the heart, and the roots of the great vessels.
- Posterior mediastinum – the part that lies posterior to the pericardium and anterior to the bodies of vertebrae T5 to T12. The posterior mediastinum contains structures that pass between the neck, thorax, and abdomen (esophagus, vagus nerves, azygos system of veins, thoracic duct, thoracic aorta).

The plane of the sternal angle is an important thoracic landmark that marks the level of the:

- Superior border of the pericardium
- Bifurcation of the trachea

![FIGURE 3.13 Boundaries and subdivisions of the mediastinum.](image-url)
CHAPTER 3: THE THORAX

3. Compare and contrast the structures that can be seen on the right side of the mediastinum to those that can be seen on the left side of the mediastinum.

4. Review the relationship of the phrenic nerve to the root of the lung and the pericardium.

MIDDLE MEDIASTINUM

Dissection Overview

The middle mediastinum contains the pericardium, the heart, and the roots of the great vessels. The pericardium is a sac that encloses the heart, and it is pierced by the great vessels (aorta, pulmonary trunk, superior vena cava, inferior vena cava, and four pulmonary veins). The outer surface of the pericardium is fibrous, whereas the inner surface of the pericardium is serous and smooth. The pericardium is attached to the central tendon of the diaphragm. Thus, the pericardium and the heart move up and down with the diaphragm during inspiration and expiration.

The order of dissection will be as follows: The pericardium will be opened and its relationship to the heart and great vessels will be explored. The characteristics of the parietal serous pericardium will then be studied. The heart will be removed by cutting the great vessels.

Dissection Instructions

Heart in the Thorax [G 51; L 177, 178; N 206; R 268; C 174]

1. Open the pericardium in the following manner (FIG. 3.14). Use forceps to elevate the anterior surface of the pericardium. Observe that, as you move from anterior to posterior, the mediastinal pleura is in contact with the pericardium and root of the lung, and either the esophagus (right side) or the thoracic aorta (left side).

Dissection Follow-up

1. Review the parts of the parietal pleura.

2. Note that the transition from parietal to visceral pleura occurs at the root of the lung.

3. Identify the left and right phrenic nerves and the left and right pericardiacophrenic vessels. The phrenic nerve and pericardiacophrenic vessels are located between the mediastinal pleura and the pericardium about 1.5 cm anterior to the root of the lung. Follow the phrenic nerve and pericardiacophrenic vessels to the diaphragm. Each phrenic nerve is the only motor innervation to half of the diaphragm.

Dissection Instructions

1. Observe the mediastinal pleura. You may be able to see structures through the mediastinal pleura.

2. Palpate the mediastinal structures through the mediastinal pleura. Observe that, as you move from anterior to posterior, the mediastinal pleura is in contact with the pericardium and root of the lung, and either the esophagus (right side) or the thoracic aorta (left side).

3. Follow the mediastinal pleura further posteriorly until it contacts the sides of the vertebral bodies. At this location, the mediastinal pleura becomes the costal pleura.

4. To examine the mediastinum more closely, the pleura must be removed bilaterally.

5. Use your fingers to pick up the costal pleura in the midaxillary line near the cut ends of ribs 1 to 5. Peel the costal pleura off the inner surface of the posterior thoracic wall, moving from lateral to medial. Note that the endothoracic fascia provides a natural cleavage plane for separation of costal pleura from the thoracic wall.

6. Continue to remove the costal pleura where it covers the vertebral column and the mediastinal pleura where it covers the esophagus or aorta and the pericardium.

7. Identify the left and right phrenic nerves and the left and right pericardiacophrenic vessels. The phrenic nerve and pericardiacophrenic vessels are located between the mediastinal pleura and the pericardium about 1.5 cm anterior to the root of the lung. Follow the phrenic nerve and pericardiacophrenic vessels to the diaphragm. Each phrenic nerve is the only motor innervation to half of the diaphragm.

Dissection Instructions

1. Observe the mediastinal pleura. You may be able to see structures through the mediastinal pleura.

2. Palpate the mediastinal structures through the mediastinal pleura. Observe that, as you move from anterior to posterior, the mediastinal pleura is in contact with the pericardium and root of the lung, and either the esophagus (right side) or the thoracic aorta (left side).

3. Follow the mediastinal pleura further posteriorly until it contacts the sides of the vertebral bodies. At this location, the mediastinal pleura becomes the costal pleura.

4. To examine the mediastinum more closely, the pleura must be removed bilaterally.

5. Use your fingers to pick up the costal pleura in the midaxillary line near the cut ends of ribs 1 to 5. Peel the costal pleura off the inner surface of the posterior thoracic wall, moving from lateral to medial. Note that the endothoracic fascia provides a natural cleavage plane for separation of costal pleura from the thoracic wall.

6. Continue to remove the costal pleura where it covers the vertebral column and the mediastinal pleura where it covers the esophagus or aorta and the pericardium.

7. Identify the left and right phrenic nerves and the left and right pericardiacophrenic vessels. The phrenic nerve and pericardiacophrenic vessels are located between the mediastinal pleura and the pericardium about 1.5 cm anterior to the root of the lung. Follow the phrenic nerve and pericardiacophrenic vessels to the diaphragm. Each phrenic nerve is the only motor innervation to half of the diaphragm.
a vertical cut through the pericardium from the diaphragm to the ascending aorta. Make the two transverse cuts as illustrated in FIGURE 3.14 and open the flaps widely.

2. Identify the following structures (FIG. 3.15): superior vena cava, ascending aorta, arch of the aorta, and pulmonary trunk.

3. Use your fingers to gently open the interval between the concavity of the aortic arch and pulmonary trunk, and identify the ligamentum arteriosum (FIG. 3.15). The ligamentum arteriosum connects the left pulmonary artery to the arch of the aorta.

4. Use a probe to dissect the left vagus nerve where it crosses the left side of the aortic arch (FIG. 3.15). Identify the initial portion of the left recurrent laryngeal nerve. The left recurrent laryngeal nerve is located inferior to the aortic arch and posterior to the ligamentum arteriosum.

5. Examine the heart and identify the chambers that can be seen from the anterior view: right atrium, right ventricle, and left ventricle (FIG. 3.15). Note that the right ventricle forms most of the anterior surface of the heart.

6. Identify the borders of the heart:
   - **Right border** – formed by the right atrium
   - **Inferior border** – formed by the right ventricle and a small part of the left ventricle
   - **Left border** – formed by the left ventricle

7. Identify the apex of the heart. Note that the apex of the heart is part of the left ventricle. The apex of the heart is normally located deep to the left fifth intercostal space, approximately 9 cm from the midline.

8. Identify the base of the heart. The left atrium and part of the right atrium form the base of the heart. Clinicians often refer to the emergence of the great vessels from the heart as its base.

9. Observe that the inner surface of the pericardium is lined by the smooth, shiny parietal layer of serous pericardium.

10. Use the cadaver and an illustration to observe that the parietal layer of serous pericardium is reflected onto the heart as the visceral layer of serous pericardium (epicardium). The line of reflection of parietal serous pericardium to visceral serous pericardium occurs at the roots of the great vessels. [G 51; L 178; N 206; R 269; C 174]

11. The pericardial cavity is a potential space between the parietal and visceral layers of the serous pericardium. Normally it contains only a thin film of fluid.
Inflammatory diseases can cause fluid to accumulate in the pericardial cavity (pericardial effusion). Bleeding into the pericardial cavity (hemopericardium) may result from penetrating heart wounds or perforation of a weakened heart muscle following myocardial infarction. Because the pericardium is composed of fibrous connective tissue, it cannot stretch, and fluids collected in the pericardial cavity compress the heart (cardiac tamponade).

**Removal of the Heart**

1. The heart will be detached from the great vessels along the lines of reflection of the serous pericardium (Fig. 3.16).
2. Place a probe through the transverse pericardial sinus.
3. Use scissors to cut the ascending aorta and the pulmonary trunk anterior to the probe, about 1.5 cm superior to the point where the aorta and pulmonary trunk emerge from the heart.
4. Use scissors to cut the superior vena cava about 1 cm superior to its junction with the right atrium.
5. Lift the apex of the heart superiorly and cut the inferior vena cava close to the surface of the diaphragm.
6. While lifting the apex of the heart, cut the four pulmonary veins where they form the boundary of the oblique pericardial sinus (Fig. 3.16). Cut the
pulmonary veins very close to the inner surface of the pericardial sac.

7. The heart is now held in place only by reflections of the serous pericardium from its posterior surface to the inner surface of the pericardial sac (FIG. 3.16). Cut these reflections and remove the heart.

8. Refer to FIGURE 3.16. Examine the posterior aspect of the pericardium and identify the openings of eight vessels and the lines of the pericardial reflections.

Dissection Follow-up

1. Review the parts of the mediastinum and state their boundaries.
2. Review the attachments of the pericardium to the diaphragm and to the roots of the great vessels.
3. Review the embryonic origin of the transverse and oblique pericardial sinuses.
4. Compare the appearance and functional properties of the parietal serous pericardium to those of the parietal pleura.

EXTERNAL FEATURES OF THE HEART

Dissection Overview

Dissection of the heart will proceed in two stages: The external features of the heart will be studied, including its vascular supply. The internal features of each chamber of the heart will then be studied.

Dissection Instructions

Surface Features

1. Examine the external surface of the heart. Identify the following (FIG. 3.15): [G 48, 49; L 180; N 208; R 252; C 176, 177]
   - Coronary (atrioventricular) sulcus (L. sulcus, a groove; pl. sulci) – runs around the heart, separating the atria from the ventricles.
   - Anterior interventricular sulcus and the posterior interventricular sulcus – the interventricular sulci indicate the location of the interventricular septum. The interventricular sulci join the coronary sulcus at a right angle.

2. Identify the surfaces of the heart:
   - Sternocostal (anterior) surface – formed mainly by the right ventricle
   - Diaphragmatic (inferior) surface – formed mainly by the left ventricle and a small part of the right ventricle
   - Left pulmonary surface – formed mainly by the left ventricle. The pulmonary surface of the heart is in contact with the cardiac impression of the left lung.

   - Right pulmonary surface – formed mainly by the right atrium

3. Note that the coronary sulcus and the interventricular sulci mark the boundaries of the four chambers of the heart.

4. On the surface of the heart, identify the chambers (FIG. 3.15):
   - Right atrium and right auricle
   - Right ventricle
   - Left ventricle
   - Left atrium and left auricle

5. Examine the heart in superior view. Identify:
   - Aorta and aortic valve
   - Pulmonary trunk and pulmonary valve
   - Superior vena cava

6. Examine the diaphragmatic surface of the heart and identify:
   - Opening of the inferior vena cava
   - Posterior interventricular sulcus

7. Note that the cardiac veins and coronary arteries are located in the coronary and interventricular sulci.

Cardiac Veins [G 57; L 183; N 211; R 262; C 176, 177]

1. As you study the vessels of the heart, realize that they (and the fat that surrounds them) are located between the visceral pericardium (epicardium) and the muscular wall of the heart.

2. The cardiac veins course superficial to the coronary arteries, so they will be dissected first. The coronary sulcus and the interventricular sulci are filled with fat that must be removed to observe the vessels. Use blunt dissection to remove the fat.

3. Identify the coronary sinus on the diaphragmatic surface of the heart (FIG. 3.17B). The coronary sinus is a dilated portion of the venous system of the heart that is located in the coronary sulcus. The coronary sinus is about 2 to 2.5 cm in length and opens into the right atrium. Its opening will be seen when the internal features of the right atrium are dissected.

4. Use a probe to clean the surface of the coronary sinus.

5. Follow the coronary sinus superiorly in the coronary sulcus to the point where it receives the great cardiac vein (FIG. 3.17B).

6. Use blunt dissection to follow the great cardiac vein onto the sternocostal surface of the heart. The great cardiac vein courses from the apex of the heart toward the coronary sinus in the anterior interventricular sulcus (FIG. 3.17A).

7. In the posterior interventricular sulcus, identify the middle cardiac vein and trace it to the coronary sinus.

8. Near the inferior end of the coronary sinus, identify the small cardiac vein. Use a probe to dissect...
1. Begin the dissection of the coronary arteries by observing the aortic valve in the lumen of the ascending aorta. Identify the right, left, and posterior semilunar cusps of the aortic valve. Behind each valve cusp is a small pocket called an aortic sinus (right, left, and posterior, respectively).

2. In the left aortic sinus, identify the opening of the left coronary artery. Insert the tip of a probe into the opening. On the surface of the heart, palpate the tip of the probe between the left auricle and the pulmonary trunk. This is the initial portion of the left coronary artery.

3. Use blunt dissection to clean the left coronary artery. The left coronary artery is quite short. In the coronary sulcus, the left coronary artery divides into the anterior interventricular branch and the circumflex branch (FIG. 3.18A).

4. Trace the anterior interventricular branch in the anterior interventricular sulcus to the apex of the heart. Clinicians call the anterior interventricular branch of the left coronary artery the left anterior descending (LAD) artery. Note that the anterior interventricular artery accompanies the great cardiac vein.

5. Follow the circumflex branch of the left coronary artery in the coronary sulcus and around the left border of the heart (FIG. 3.18B). The circumflex branch of the left coronary artery has several unnamed branches that supply the posterior wall of the left ventricle. The circumflex branch of the left coronary artery accompanies the coronary sinus in the coronary sulcus.

6. To begin the dissection of the right coronary artery, identify its opening in the right aortic sinus. Insert the tip of a probe into its opening. On the surface of the heart, palpate the tip of the probe in the coronary sulcus between the right auricle and the ascending aorta. This is the beginning of the right coronary artery.

7. Use blunt dissection to clean the right coronary artery and identify the anterior right atrial branch (FIG. 3.18A). The anterior right atrial branch arises close to the origin of the right coronary artery and ascends along the anterior wall of the right atrium toward the superior vena cava. The anterior right atrial branch gives rise to the sinuatrial nodal branch, which supplies the sinuatrial node.

8. Follow the right coronary artery in the coronary sulcus. If possible, preserve the anterior cardiac veins. The right marginal branch of the right coronary artery usually arises near the inferior border of the heart. The right marginal branch accompanies the small cardiac vein along the inferior border of the heart.

9. Continue to follow the right coronary artery in the coronary sulcus onto the diaphragmatic surface of the heart (FIG. 3.18B). When the right coronary artery

10. Note that most veins of the heart are tributaries to the coronary sinus. The anterior cardiac veins are the exceptions to this rule.

Coronary Arteries  [G 56; L 182; N 211; R 262; C 176]

1. Begin the dissection of the coronary arteries by observing the aortic valve in the lumen of the ascending aorta. Identify the right, left, and posterior semilunar cusps of the aortic valve. Behind each valve cusp is a small pocket called an aortic sinus (right, left, and posterior, respectively).

2. In the left aortic sinus, identify the opening of the left coronary artery. Insert the tip of a probe into the opening. On the surface of the heart, palpate the tip of the probe between the left auricle and the pulmonary trunk. This is the initial portion of the left coronary artery.

3. Use blunt dissection to clean the left coronary artery. The left coronary artery is quite short. In the coronary sulcus, the left coronary artery divides into the anterior interventricular branch and the circumflex branch (FIG. 3.18A).

4. Trace the anterior interventricular branch in the anterior interventricular sulcus to the apex of the heart. Clinicians call the anterior interventricular branch of the left coronary artery the left anterior descending (LAD) artery. Note that the anterior interventricular artery accompanies the great cardiac vein.

5. Follow the circumflex branch of the left coronary artery in the coronary sulcus and around the left border of the heart (FIG. 3.18B). The circumflex branch of the left coronary artery has several unnamed branches that supply the posterior wall of the left ventricle. The circumflex branch of the left coronary artery accompanies the coronary sinus in the coronary sulcus.

6. To begin the dissection of the right coronary artery, identify its opening in the right aortic sinus. Insert the tip of a probe into its opening. On the surface of the heart, palpate the tip of the probe in the coronary sulcus between the right auricle and the ascending aorta. This is the beginning of the right coronary artery.

7. Use blunt dissection to clean the right coronary artery and identify the anterior right atrial branch (FIG. 3.18A). The anterior right atrial branch arises close to the origin of the right coronary artery and ascends along the anterior wall of the right atrium toward the superior vena cava. The anterior right atrial branch gives rise to the sinuatrial nodal branch, which supplies the sinuatrial node.

8. Follow the right coronary artery in the coronary sulcus. If possible, preserve the anterior cardiac veins. The right marginal branch of the right coronary artery usually arises near the inferior border of the heart. The right marginal branch accompanies the small cardiac vein along the inferior border of the heart.

9. Continue to follow the right coronary artery in the coronary sulcus onto the diaphragmatic surface of the heart (FIG. 3.18B). When the right coronary artery

10. Note that most veins of the heart are tributaries to the coronary sinus. The anterior cardiac veins are the exceptions to this rule.
In approximately 75% of hearts, the right coronary artery gives rise to the posterior interventricular branch and supplies the left ventricular wall and posterior portion of the interventricular septum. In approximately 15% of hearts, the left coronary artery gives rise to the posterior interventricular branch. Other variations account for 10%.

**Dissection Follow-up**

1. Review the borders of the heart.
2. On the surface of the heart, review the boundaries of the four chambers.
3. Review the coronary sulcus and interventricular sulci of the heart and the vessels that course within these sulci.
4. Trace a drop of blood from the right aortic sinus to the coronary sinus, naming all vessels that are involved.
5. Trace a drop of blood from the left aortic sinus to the apex of the heart and its venous return to the coronary sinus, naming all vessels that are involved.

**INTERNAL FEATURES OF THE HEART**

**Dissection Overview**

The atria and ventricles of the heart will be opened and their internal features will be studied. The cuts that will be used are designed to preserve most of the vessels that you have previously dissected. The heart will contain clotted blood, which must be removed. The clots will be hard and may need to be broken before they can be extracted.

The chambers will be dissected in the sequence that blood passes through the heart: right atrium, right ventricle, left atrium, and left ventricle. All descriptions are based on the heart in the anatomical position.

**Dissection Instructions**

**Right Atrium** [G 62; L 184; N 214; R 258; C 182]

1. The cuts used to open the right atrium are illustrated in **FIGURE 3.19**.
2. Use scissors to make a cut through the tip of the right auricle. Insert one blade of the scissors through the opening and make a short horizontal cut toward the right (FIG. 3.19, cut 1).
3. Turn the scissors and cut through the anterior wall of the right atrium in an inferior direction. Stop superior to the inferior vena cava (FIG. 3.19, cut 2).
4. Make a horizontal cut toward the left, stopping just short of the coronary sulcus (FIG. 3.19, cut 3).
FOSSA OVALIS

The fossa ovalis is the remnant of the foramen ovale. In fetal life, blood from the placenta is delivered to the heart by way of the inferior vena cava. This oxygen-rich and nutrient-rich blood is directed toward the foramen ovale, which allows passage into the left atrium and out to the body without passing through the lungs.

5. Turn the flap of the atrial wall toward the left and open the right atrium widely (FIG. 3.20). Remove blood clots and take the heart to the sink to rinse it with water.

6. Observe the inner surface of the anterior wall of the right atrium. Identify (FIG. 3.20):
   - Pectinate muscles – horizontal ridges of muscle
   - Crista terminalis – a vertical ridge of muscle that connects the pectinate muscles

7. Observe the posterior wall of the right atrium. Identify (FIG. 3.20):
   - Opening of the superior vena cava
   - Opening and valve of the inferior vena cava
   - Opening and valve of the coronary sinus
   - Fossa ovalis and the limbus fossa ovalis (L. limbus, a border)

8. Parts of the conducting system of the heart are located in the walls of the right atrium, but cannot be seen in dissection. Familiarize yourself with their approximate locations in the dissected specimen (FIG. 3.20). The sinuatrial node (SA node) lies at the superior end of the crista terminalis at the junction between the right atrium and the superior vena cava. The atrioventricular node (AV node) is located in the interatrial septum, above the opening of the coronary sinus.

9. Identify the opening of the right atrioventricular valve, which leads into the right ventricle.

Right Ventricle [G 63; L 184; N 214; R 261; C 182]

1. The cuts used to open the right ventricle are illustrated in FIGURE 3.19.

2. Insert your finger into the pulmonary trunk and determine the level of the pulmonary valve. Immediately inferior to the level of the pulmonary valve, use scissors to make a short horizontal cut through the anterior wall of the right ventricle (FIG. 3.19, cut 4).

3. Insert one blade of the scissors into the right end of cut 4 and make a cut parallel to the coronary sulcus (FIG. 3.19, cut 5). This cut should be about 1 cm from the coronary sulcus and should end at the inferior border of the heart. Cut only the ventricular wall, not the atrioventricular valve cusp.

4. Insert your finger through the opening in the ventricular wall and palpate the interventricular septum. From the left end of cut 4, make a cut toward the inferior border of the heart (FIG. 3.19, cut 6). This cut should be about 2 cm to the right of the anterior interventricular sulcus and should parallel the right side of the interventricular septum.

5. Turn the flap of the right ventricular wall inferiorly (FIG. 3.21).

6. Remove blood clots. Use care to avoid damaging the chordae tendineae. Rinse the right ventricle with water.
7. Identify the **opening of the right atrioventricular valve**. The right atrioventricular valve is also called the **tricuspid valve**. Observe that the right atrioventricular valve has three cusps: anterior, septal, and posterior (FIG. 3.21).

8. Identify the **chordae tendineae**. Observe that these delicate tendons pass from the valve cusps to the apices of papillary muscles. The papillary muscles arise from the walls of the right ventricle.

9. Identify the **three papillary muscles**: anterior, septal, and posterior. The anterior papillary muscle is the largest. The septal papillary muscle is very small and may be multiple. Note that the chordae tendineae of each papillary muscle attach to the adjacent sides of two valve cusps.

10. Observe that the inner surface of the wall of the right ventricle is roughened by muscular ridges called **trabeculae carneae** (*L.* *trabs*, wooden beam; *carneus*, fleshy).

11. Identify the **septomarginal trabecula (moderator band)**. The septomarginal trabecula extends from the interventricular septum to the base of the anterior papillary muscle. The septomarginal trabecula contains part of the right bundle of the conducting system, the part that stimulates the anterior papillary muscle.

12. Identify the **opening of the pulmonary trunk** (FIG. 3.21). The conus arteriosus (infundibulum) is the cone-shaped portion of the right ventricle inferior to the opening of the pulmonary trunk. The inner wall of the conus arteriosus is smooth.

13. Observe that the **pulmonary valve** consists of three semilunar cusps: anterior, right, and left (FIG. 3.21). *G 66, 67; L 184; N 216; R 259; C 176*

14. Look into the pulmonary trunk from above and examine the superior surface of the semilunar valve. Observe that each semilunar valve cusp has one fibrous nodule and two lunules. The nodule and lunules help to seal the valve cusps and prevent backflow of blood during diastole.

**Left Atrium** *G 64; L 185; N 215; R 258; C 184*

1. Examine the posterior surface of the heart. Observe the openings of the four pulmonary veins into the left atrium. The pulmonary veins are usually arranged in pairs, two from the right lung and two from the left lung.

2. The cut used to open the left atrium is illustrated in **FIGURE 3.22A**.

3. Use scissors to make an inverted U-shaped cut through the posterior wall of the left atrium. Do not cut into the openings of the pulmonary veins; cut between them. Turn the flap inferiorly (FIG. 3.22B).
2. Look into the aorta from above and identify the aortic valve. Identify three semilunar valve cusps: right, left, and posterior. [G 66, 67; L 185; N 216, 217; R 259; C 176]

3. Insert one blade of the scissors between the left and right semilunar cusps (FIG. 3.19).

4. Make a cut through the anterior wall of the ascending aorta between the left and right semilunar cusps (FIG. 3.19, cut 7). This cut should be anterior and parallel to the left coronary artery.

5. Continue the cut to the apex of the heart. The cut should be about 2 cm to the left of the anterior interventricular sulcus and should be parallel to the left side of the interventricular septum. The cut will cross the anterior interventricular branch of the left coronary artery and the great cardiac vein.

6. Open the left ventricle and the ascending aorta widely (FIG. 3.23). Remove blood clots and rinse with water.

7. In the left ventricle, identify the left atrioventricular valve (bicuspid valve, mitral valve). Identify the anterior cusp and the posterior cusp (FIG. 3.23).

8. Identify the anterior papillary muscle and the posterior papillary muscle. Observe that the chordae tendineae of each papillary muscle attach to both valve cusps.

9. Observe that the inner surface of the wall of the left ventricle is roughened by trabeculae carnea.

10. Examine the aortic valve. Again identify its right, left, and posterior semilunar cusps. Observe that

4. Remove blood clots and rinse with water.

5. Note that the inner surface of the wall of the left atrium is smooth except for its auricle, which has a rough inner surface.

6. Observe the following features in the left atrium (FIG. 3.22):

- Valve of the foramen ovale on the interatrial septum
- Opening into the left auricle
- Opening of the left atrioventricular valve

**Left Ventricle** [G 65; L 185; N 215; R 258; C 185]

1. The cut used to open the left ventricle is illustrated in FIGURE 3.19. Note that the following procedure will cut the anterior interventricular branch of the left coronary artery and the great cardiac vein.

**FIGURE 3.22** The left atrium of the heart. A. Cuts used to open the left atrium. B. Interior of the left atrium. Posterior wall reflected inferiorly.
6. Review the connections of the great vessels to the heart.

7. Use an illustration to review the conducting system of the heart and relate the illustration to the dissected specimen.

**SUPERIOR MEDIASTINUM**

**Dissection Overview**

The superior mediastinum contains structures that pass between the thorax and the neck or the thorax and the upper limb. These structures include several of the great vessels and their primary branches, the trachea, the esophagus, and the thoracic duct.

The order of dissection will be as follows: The brachiocephalic veins will be studied and reflected superiorly to expose the aortic arch. The aortic arch and its branches will be dissected. Note that only the proximal ends of some of the large vessels will be seen in this dissection. The distal parts of these vessels will be dissected with the neck or the upper limb. The trachea and its bifurcation will be studied. The upper part of the esophagus and the vagus nerves will be dissected.

**Dissection Instructions**

1. Review the **boundaries of the superior mediastinum** (FIG. 3.13).
   - **Superior** – superior thoracic aperture
   - **Posterior** – bodies of vertebrae T1 to T4
   - **Anterior** – manubrium of the sternum
   - **Lateral** – mediastinal pleurae (left and right)
   - **Inferior** – plane of the sternal angle

2. Remove the anterior thoracic wall.

3. Identify the **thymus** [G 68–71; L 177; N 206; R 268].
   In the newborn, the thymus is an active lymphatic organ that can be visualized on a chest radiograph. The thymus is replaced by connective tissue and fat after puberty. In the adult, the thymus is a fatty mass that lies immediately posterior to the manubrium of the sternum. It may be difficult to recognize the thymus in the cadaver.

4. Remove the remnant of the thymus by blunt dissection.

5. Trace the superior vena cava superiorly until it bifurcates. Identify the **left brachiocephalic vein** (FIG. 3.24). Use blunt dissection to clean the left brachiocephalic vein and free it from the structures that lie posterior to it.

6. Identify the **right brachiocephalic vein**. The two brachiocephalic veins meet to form the **superior vena cava** posterior to the inferior border of the right first costal cartilage.

7. Follow the superior vena cava inferiorly. Note that the superior vena cava passes anterior to the root of the right lung. [G 82; L 179, 194; N 224; R 280; C 166]
8. Identify the **azygos vein** on the right side of the mediastinum. The **arch of the azygos vein** passes superior to the root of the right lung and drains into the posterior surface of the superior vena cava.

9. Cut the superior vena cava just superior to the entrance of the azygos vein. Reflect the superior vena cava and the attached brachiocephalic veins superiorly.

10. Identify the **right phrenic nerve** and the **left phrenic nerve** that pass posterior to the brachiocephalic veins (FIG. 3.24). The phrenic nerves were previously dissected in the middle mediastinum. Note that the right and left phrenic nerves pass anterior to the roots of the right and left lungs, respectively. Demonstrate that the phrenic nerves accompany the pericardiocophrenic vessels and that they enter the superior surface of the diaphragm.

11. Identify the **arch of the aorta** (FIG. 3.24). The arch of the aorta begins and ends at the level of the sternal angle.  

12. Identify the three arteries that arise from the arch of the aorta (FIG. 3.24). From anterior to posterior these arteries are:
   - Brachiocephalic trunk
   - Left common carotid artery
   - Left subclavian artery

13. Identify the **ligamentum arteriosum**. The ligamentum arteriosum is a fibrous cord that connects the concavity of the arch of the aorta to the left pulmonary artery (FIG. 3.24).

14. Identify the **left vagus nerve** and the **left recurrent laryngeal nerve** on the left side of the arch of the aorta (FIG. 3.24). Follow the left vagus nerve inferiorly and note that it passes posterior to the root of the left lung toward the esophagus. Review the relationship of the left recurrent laryngeal nerve to the ligamentum arteriosum.

15. On the right side, note that the **right vagus nerve** passes posterior to the root of the right lung (FIG. 3.25). The **right recurrent laryngeal nerve**
16. Identify the trachea. Note that the esophagus lies posterior to the trachea in the superior mediastinum, but do not attempt to dissect it.

17. Identify the bifurcation of the trachea. The trachea bifurcates at the plane of the sternal angle to form the right main bronchus and the left main bronchus. Note that the arch of the azygos vein passes superior to the right main bronchus and the arch of the aorta passes superior to the left main bronchus (FIG. 3.25).

18. Look for tracheobronchial lymph nodes located around the trachea near its bifurcation.

19. Palpate the anterior and posterior surfaces of the trachea near its bifurcation. Observe that the tracheal rings are C-shaped and that the open part of the “C” is located posteriorly.

20. Observe that the esophagus is located posterior to the trachea in close relationship to the open part of the tracheal cartilages.

21. Compare the right and left main bronchi. Observe that the right main bronchus is larger in diameter, shorter, and oriented more vertically than the left main bronchus.

22. Use a figure to study the inner surface of the tracheal bifurcation. Inside the tracheal bifurcation is a ridge of cartilage called the carina (L. carina, keel of a boat).

(a branch of the right vagus nerve) loops around the right subclavian artery.

BIFURCATION OF THE TRACHEA

During bronchoscopy, the carina serves as an important landmark because it lies between the superior ends of the right and left main bronchi. The carina is usually positioned slightly to the left of the median plane of the trachea. When foreign bodies are aspirated, they usually enter the right main bronchus because it is wider and more vertically oriented than the left main bronchus.

Dissection Follow-up

1. Replace the contents of the superior mediastinum into their correct anatomical positions.
2. Return the anterior thoracic wall to its correct anatomical position. Project the structures of the superior mediastinum to the surface of the thoracic wall.
3. Remove the anterior thoracic wall.
4. Review the formation of the superior vena cava and the position of the arch of the azygos vein.
5. Review the position of the ascending aorta and the position of the arch of the aorta.
6. Review the branches of the arch of the aorta.
7. Compare the positions of the phrenic and vagus nerves to the root of the lung.
8. Contrast the thoracic course of the left recurrent laryngeal nerve to the thoracic course of the right recurrent
laryngeal nerve. Relate this difference to the embryonic origin of the arteries.

**POSTERIOR MEDIASTINUM**

**Dissection Overview**

The posterior mediastinum contains structures that course between the thorax and the abdomen. The posterior mediastinum lies posterior to the pericardium. To emphasize their close relationship to the heart, the structures in the posterior mediastinum will be approached through the **posterior wall of the pericardium**.

The order of dissection will be as follows: The pericardium will be reviewed and its posterior wall will be removed. The close relationship of the pericardium to the esophagus will be studied and then the pericardium will be removed. The esophagus will be studied. The azygos vein and its tributaries will be studied. The thoracic duct will be identified. Then, the descending aorta and its branches will be dissected. Finally, the thoracic portion of the sympathetic trunk and its branches will be dissected.

**Dissection Instructions**

1. Review the boundaries of the posterior mediastinum (FIG. 3.13):
   - **Superior** – plane of the sternal angle
   - **Posterior** – bodies of vertebrae T5 to T12

2. Review the inner surface of the posterior wall of the pericardium (FIG. 3.16).
3. Place the heart back into the pericardium. From the right side of the thorax, examine the relationship of the heart to the esophagus. Note that the esophagus lies immediately posterior to the left atrium and part of the left ventricle. Remove the heart.
4. Remove the posterior wall of the pericardium in the **area of the oblique pericardial sinus** (FIG. 3.26). Identify the **esophagus**. The esophagus is a muscular tube that sits just to the right of the midline. To the left and slightly posterior to the esophagus is the **thoracic aorta**.
5. Use blunt dissection to remove the remainder of the posterior wall of the pericardium. Leave the portion adhering to the diaphragm undisturbed. Use scissors to cut the pericardium at its attachments to the great vessels and diaphragm, and place the pericardium in the tissue container. [G 84; L 196; N 226; R 274; C 202]
6. Use blunt dissection to clean the **esophagus**. Note that the surface of the esophagus is covered by the **esophageal plexus of nerves** (FIG. 3.26). The esophageal plexus innervates the inferior portion of the esophagus.
7. Find the **right vagus nerve** where it crosses the anterior surface of the right subclavian artery (FIG. 3.25). Follow it posterior to the root of the right lung. Confirm that the fibers of the right vagus nerve spread out on the surface of the esophagus.

8. Identify the **left vagus nerve** as it crosses the left side of the arch of the aorta (FIG. 3.25). Follow the left vagus nerve posterior to the root of the left lung and confirm that its fibers contribute to the esophageal plexus.

9. Note that the esophageal plexus forms the **anterior vagal trunk** and the **posterior vagal trunk** just superior to the diaphragm (FIG. 3.25). The vagal trunks are found on the inferior part of the esophagus just before it passes through the diaphragm and, due to the curvature of the diaphragm, they may not be visible at this stage of the dissection. The vagal trunks pass through the diaphragm with the esophagus and innervate a large part of the gastrointestinal tract.

10. Identify the **azygos vein** where it arches superior to the root of the right lung (FIGS. 3.25 and 3.27). Clean the azygos vein and follow it inferiorly to the level of the diaphragm. Note that the **posterior intercostal veins** on the right side are tributaries to the azygos vein. [G 80; L 194, 198; N 232; R 279; C 203]

11. Identify the **thoracic duct** (FIG. 3.27). To find the thoracic duct, retract the esophagus to the left and explore the area between the azygos vein and the **thoracic aorta**. The thoracic duct lies immediately to the left of the azygos vein and it is posterior to the esophagus. The thoracic duct is thin walled and easily torn. It has the appearance of a small vein without blood in it. [G 78; L 199; N 295; R 277; C 203]

12. Use a probe to free the thoracic duct from the surrounding connective tissue. The thoracic duct may be a network of several smaller ducts instead of a single duct. Inferiorly, the thoracic duct passes through the diaphragm with the thoracic aorta. Superiorly, the thoracic duct terminates by draining into the junction of the left internal jugular vein and left subclavian vein (FIG. 3.27). Do not attempt to demonstrate its termination at this time.

13. Note that the thoracic duct crosses the anterior surface of the **right posterior intercostal arteries**, the **hemiazygos vein**, and the **accessory hemiazygos vein**.

14. On the left side of the posterior mediastinum, observe that the left posterior intercostal veins drain into the **hemiazygos vein** or **accessory hemiazygos vein**. The hemiazygos and accessory hemiazygos veins cross the bodies of the eighth and ninth thoracic vertebrae, respectively, and...
CHAPTER 3: THE THORAX

22. Use a probe to dissect the greater splanchnic nerve on both the right and left sides (FIG. 3.27). Note that the greater splanchnic nerve receives contributions from the fifth through the ninth thoracic sympathetic ganglia and that it is not completely formed until lower thoracic levels. As an aid to identification, observe that the greater splanchnic nerve is found on the sides of vertebral bodies T5 to T9, whereas the sympathetic trunk crosses the heads of ribs 5 to 9 (i.e., the sympathetic trunk is located posterior to the greater splanchnic nerve).

23. The lesser splanchnic nerve arises from the 10th and 11th thoracic sympathetic ganglia. The least splanchnic nerve arises from the 12th thoracic sympathetic ganglion (FIG. 3.27). Due to the curvature of the diaphragm, these two nerves cannot be seen at this time.

Dissection Follow-up

1. Review the boundaries of the anterior, middle, and posterior mediastina.
2. Study a transverse section through the midlevel of the thorax and identify the contents of the posterior mediastinum. Note the relationship of the contents of the posterior mediastinum to the heart and vertebral bodies.
3. Review the course and function of an intercostal nerve, naming all structures that it innervates.
4. Review the parts of the aorta (ascending, arch, thoracic), naming all branches and describing their distribution.
5. Review the origin and course of the right and left posterior intercostal arteries.
6. Name the structures in the posterior mediastinum that cross anterior to the right posterior intercostal arteries.
The Abdomen

The abdomen is the portion of the trunk that lies between the thorax and the pelvis. The abdominal cavity is divided from the thoracic cavity by the diaphragm but it is continuous with the pelvic cavity. Viscera contained within the abdominal cavity are not bilaterally symmetrical. Therefore, it is worth noting that use of the words "right" and "left" in names and instructions refers to the right and left sides of the cadaver in the anatomical position.

SURFACE ANATOMY

Firm fixation of tissues in the cadaver may make it difficult to distinguish between bony landmarks and well-fixed soft tissue structures. Place the cadaver in the supine position and attempt to palpate the following structures (FIG. 4.1): [G 100; L 213; N 240]

- Xiphoid process
- Costal margin
- Pubic symphysis
- Pubic crest
- Pubic tubercle
- Anterior superior iliac spine
- Tubercle of the iliac crest

To prepare patient notes, you will need to understand the terminology used to describe the abdomen. The quadrant and regional systems are both in common use. The quadrant system divides the abdomen by means of the transumbilical plane and the median plane (FIG. 4.2). The quadrant system is suitable for general descriptions and will be used to describe the position of organs in this dissection guide. The regional system divides the

ATLAS REFERENCES:

G = Grant’s Atlas, 13th ed., page number
L = LWW Atlas of Anatomy, 1st ed., page number
N = Netter’s Atlas, 5th ed., plate number
R = Color Atlas of Anatomy, 7th ed., page number
C = Clemente’s Atlas, 6th ed., plate number
Dissection Instructions

Skin Incisions
1. Refer to FIGURE 4.5.
2. Make a midline skin incision from the xiphisternal junction (C) to the pubic symphysis (E), encircling the umbilicus.
3. Make an incision from the xiphoid process (C) along the costal margin to a point on the midaxillary line (V). If the thorax has been dissected previously, this incision has been made.
4. Make a skin incision beginning 3 cm below the pubic crest (E). Extend this incision laterally, 3 cm inferior to the inguinal ligament to a point 3 cm below the anterior superior iliac spine. Continue the incision posteriorly, 3 cm below the iliac crest to a point on the midaxillary line (F).
5. Make a vertical skin incision along the midaxillary line from point V to point F.
6. Make a transverse skin incision from the umbilicus to the midaxillary line.
7. Reflect the skin from medial to lateral, detach it along the midaxillary line, and place it in the tissue container.

Superficial Fascia
1. Use a probe to tear through the superficial fascia about 7.5 cm lateral to the midline (FIG. 4.6). The superficial epigastric artery and vein are in the superficial fascia in this area, but do not make a special effort to find them.
2. Dissect through the superficial fascia down to the aponeurosis of the external oblique muscle. On the medial side of the cut, use your fingers to separate the superficial fascia from the aponeurosis of the external oblique muscle (FIG. 4.6, arrow 1). As you remove the superficial fascia, observe that its deep surface is

abdomen based on the right and left midclavicular lines, the subcostal plane, and the transtubercular plane (FIG. 4.3). Clinical complaints may be more specifically described using the regional system.

SUPERFICIAL FASCIA OF THE ANTEROLATERAL ABDOMINAL WALL

Dissection Overview
The contents of the abdominal cavity are protected by the anterolateral abdominal wall. The organization of the layers forming the anterolateral abdominal wall is illustrated in FIGURE 4.4. The superficial fascia is unique in this region in that it has a superficial fatty layer called Camper's fascia and a deep membranous layer called Scarpa's fascia. The membranous layer is noteworthy because it attaches to the fascia lata of the thigh and is continuous with named fascias in the perineum. [G 109; L 218; N 246; R 213; C 230]
nerve. Clean the branches of one lateral cutaneous nerve.

5. Remove the superficial fascia in an inferior direction until the lower border of the external oblique muscle is exposed (approximately 2.5 cm into the proximal thigh).

6. Detach the superficial fascia from the midline, midaxillary line, and proximal thigh and place it in the tissue container.

**Dissection Follow-up**

1. Use an illustration to review the distribution of the superficial epigastric vessels.
2. Review the abdominal distribution of the anterior rami of spinal nerves T6 to L1.

**CLINICAL CORRELATION**

**SUPERFICIAL VEINS OF THE ABDOMINAL WALL**

The superficial epigastric vein anastomoses with the lateral thoracic vein in the superficial fascia. This is an important collateral venous channel from the femoral vein to the axillary vein. In patients who have an obstruction of the inferior vena cava or hepatic portal vein, the superficial veins of the abdominal wall may be engorged, and may become visible around the umbilicus (caput medusae).

**MUSCLES OF THE ANTEROLATERAL ABDOMINAL WALL**

**Dissection Overview**

Three flat muscles (external oblique, internal oblique, and transversus abdominis) form most of the anterolateral abdominal wall. The rectus abdominis muscle and the pyramidalis muscle complete the anterior abdominal wall near the midline. The three flat muscles have broad, fleshy proximal attachments (to the ribs, vertebrae, and pelvis) and broad, aponeurotic distal attachments (to the ribs, linea alba, and pubis). Each of the three flat muscles contributes to the formation of the rectus sheath and the inguinal canal.

In the male, the testes are housed in the scrotum, which is an outpouching of the anterior abdominal wall. Each testis passes through the abdominal wall during development, dragging its ductus deferens behind it. This passage occurs through the inguinal canal. The inguinal canal is located superior to the medial half of the inguinal ligament and extends from the superficial (external) inguinal ring to the deep (internal) inguinal ring. In the female, the inguinal canal is smaller in diameter.
GRANT’S DISSECTOR

It must be noted that the structures forming the inguinal canal are identical in the two sexes, but the contents of the inguinal canal differ. In the male, the inguinal canal contains the spermatid cord, whereas in the female the inguinal canal contains the round ligament of the uterus. Dissection instructions are designed for male cadavers, but these instructions also apply to female cadavers.

The order of dissection will be as follows: The three flat muscles of the abdominal wall will be studied. Emphasis will be placed on the inguinal region. The composition and contents of the rectus sheath will be explored. The anterior abdominal wall will be reflected.

Skeleton of the Abdominal Wall
Use a skeleton to identify the following structures (FIG. 4.7): [G 12, 200; L 215; N 241; R 189; C 140, 324]

- Xiphisternal junction
- Xiphoid process
- Costal margin
- Pubic symphysis
- Pubic crest
- Pubic tubercle
- Anterior superior iliac spine
- Iliac crest
- Tubercle of the iliac crest

Dissection Instructions

External Oblique Muscle [G 106; L 216; N 243; R 210; C 221]

1. Clean any remnants of the superficial fascia from the surface of the external oblique muscle and place them in the tissue container.
2. Observe the external oblique muscle and note that its fibers course from superolateral to inferomedial (FIG. 4.8A). The proximal attachments of the external oblique muscle are the external surfaces of ribs 5 to 12. It has a broad aponeurosis that forms distal attachments on the linea alba, pubic tubercle, and anterior half of the iliac crest.
3. In the inguinal region, use blunt dissection to clean the aponeurosis of the external oblique muscle. [G 110, 114; L 216, 220; N 243; R 217, 220; C 223]
4. Note that the external oblique aponeurosis splits to permit the spermatic cord (round ligament of the

**FIGURE 4.7** Skeleton of the anterior abdominal wall.

**FIGURE 4.8** Contributions of the flat abdominal muscles to the inguinal canal.
CHAPTER 4: THE ABDOMEN

93

5. Identify the following features of the external oblique aponeurosis:

- **Lateral (inferior) crus** – forms the lateral margin of the superficial inguinal ring. These fibers attach to the pubic tubercle.
- **Medial (superior) crus** – forms the medial margin of the superficial inguinal ring. These fibers attach to the pubic crest.
- **Intercrural fibers** – delicate fibers that span across the crura superolateral to the superficial inguinal ring. They prevent the crura from spreading apart.
- **Inguinal ligament** – the inferior border of the aponeurosis of the external oblique muscle. It spans from the anterior superior iliac spine to the pubic tubercle. Vessels and nerves exit the abdominal cavity and enter the lower limb by passing posterior to the inguinal ligament.
- The external oblique aponeurosis forms the anterior wall of the inguinal canal, and the inguinal ligament forms its floor.

6. At the margins of the superficial inguinal ring, observe the thin layer of fascia that extends from the external oblique aponeurosis onto the spermatic cord. This is the **external spermatic fascia**, which is the contribution of the external abdominal oblique muscle to the layers of the spermatic cord.

7. Note that a branch of the **ilioinguinal nerve** emerges at the superficial inguinal ring, anterior to the spermatic cord (round ligament of the uterus). The ilioinguinal nerve supplies sensory fibers to the skin on the anterior surface of the external genitalia and the medial surface of the thigh.

8. Use an illustration to study the **lacunar ligament**.

**Internal Oblique Muscle** [G 107; L 216; N 244; R 212; C 224]

The internal oblique muscle lies deep to the external oblique muscle and forms the intermediate layer of the anterolateral abdominal wall. To expose the internal oblique muscle, the external oblique muscle must be partially transected and a flap reflected inferiorly (FIG. 4.9). Perform this reflection bilaterally.

1. Make a vertical cut through the external oblique muscle beginning at the anterior superior iliac
spine and ending at the level of the umbilicus (FIG. 4.9A, cut 1). Insert your finger into cut 1 and direct it medially to separate the muscle layers. Use scissors to make a horizontal cut across the external oblique muscle (FIG. 4.9A, cut 2). Stop at the semilunar line.

2. Insert your fingers into cut 2 and direct them inferiorly toward the inguinal ligament. Separate the external oblique muscle from the underlying internal oblique muscle and note that your fingers cannot pass medial to the semilunar line because the external oblique aponeurosis is fused to the internal oblique aponeurosis at this location.

3. Use scissors to cut the external oblique aponeurosis along the semilunar line down to the superficial inguinal ring (FIG. 4.9A, cut 3). Only the external oblique aponeurosis should be cut.

4. Reflect the flap of external oblique muscle inferiorly (using the inguinal ligament as a hinge) to reveal the inguinal portion of the internal oblique muscle (FIG. 4.9B).

5. Use an illustration to study the attachments and fiber direction of the internal oblique muscle [G 108; L 216; N 244; R 212; C 225]. The proximal attachments of the internal oblique muscle are the thoracolumbar fascia, the iliac crest, and the lateral half of the inguinal ligament. The distal attachments of the internal oblique muscle are the inferior borders of ribs 10 to 12, the linea alba, the pubic crest, and the pecten pubis. Note that the fibers of the internal oblique muscle ascend from inferior lateral to superior medial (perpendicular to the fiber direction of the external oblique muscle).

6. Examine the exposed inguinal portion of the internal oblique muscle. The lowest fibers run transversely and arch over the spermatic cord (round ligament) to attach on the pecten pubis (FIG. 4.10). The arching fibers of the internal oblique muscle form part of the roof of the inguinal canal, and the aponeurotic insertion of these fibers form part of the posterior wall of the inguinal canal (conjoint tendon; FIG. 4.8B).

7. Observe the small bundle of muscle fibers that connects the internal oblique muscle to the superficial side of the spermatic cord or round ligament (FIG. 4.10). This is the cremaster muscle and fascia, which is the contribution of the internal oblique muscle to the coverings of the spermatic cord. In the female, the cremaster muscle and fascia surround the round ligament of the uterus.

8. In the intermuscular plane between the external oblique and the internal oblique muscles, two nerves may be found (FIG. 4.10):

- **Ilioinguinal nerve** – runs parallel to the ilioinguinal nerve and superior to it.

**Transversus Abdominis Muscle** [G 107; L 217; N 245; R 215; C 227]

The transversus abdominis muscle lies deep to the internal oblique muscle. In the inguinal region, the transversus abdominis muscle has attachments and fiber directions that are similar to the internal oblique muscle.

1. Use an illustration to study the proximal attachments, distal attachments, and fiber direction of the transversus abdominis muscle [G 108; L 216; N 245; R 215; C 227]. The proximal attachments of the transversus abdominis muscle are the internal surfaces of the costal cartilages of ribs 7 to 12, the thoracolumbar fascia, the iliac crest, and the lateral third of the inguinal ligament. The distal attachments of the transversus abdominis muscle are the linea alba, the pubic crest, and the pecten pubis.

**Dissection note:** The transversus abdominis muscle is difficult to separate from the internal oblique muscle because their tendons are fused near their distal attachments to form the conjoint tendon. If you are not required to expose the internal oblique muscle, go to the section entitled “Deep Inguinal Ring.” If you are required to separate the internal
oblique muscle from the transversus abdominis muscle, proceed with the next dissection step.

2. The ilioinguinal nerve will be followed laterally to find the plane of separation between the internal oblique muscle and the transversus abdominis muscle.

3. Locate the ilioinguinal nerve near the superficial inguinal ring and follow it laterally until it disappears into the surface of the internal oblique muscle (FIG. 4.10).

4. Using a probe, split the fibers of the internal oblique along the course of the ilioinguinal nerve.

5. Insert your finger through the split and into the plane between the internal oblique and transversus abdominis muscles. Push your finger inferiorly and medially to separate the muscle layers. Proceed medially until stopped by the arcuate line and conjoint tendon. Observe that the aponeuroses of the two muscles are inseparable near their attachment on the pecten pubis.

6. Note that the inferior free edge of the transversus abdominis muscle is slightly superior to the inferior free edge of the internal oblique muscle. As is true of the internal abdominal oblique muscle, the arching fibers of the transversus abdominis form part of the roof of the inguinal canal and its aponeurotic insertion forms part of the posterior wall (FIG. 4.8C).

7. Below the arching fibers of the internal oblique and transversus abdominis muscles, the abdominal wall is unsupported by muscle (FIG. 4.10). This is a natural weak point in the posterior wall of the inguinal canal.

Deep Inguinal Ring [G 113; L 217, 219, 220; N 253; R 218; C 222]

Transversalis fascia lines the inner surface of the abdominal muscles (FIG. 4.4). The deep inguinal ring is the point at which the gubernaculum passed through the transversalis fascia during development. The deep inguinal ring is located superior to the midpoint of the inguinal ligament. In the male, the ductus deferens passes through the deep inguinal ring. In the female, the round ligament of the uterus passes through the deep inguinal ring.

1. Retract the spermatic cord (or round ligament of the uterus) inferiorly (FIG. 4.10).

2. Use a probe to lift the arching fibers of the internal oblique and transversus abdominis muscles.

3. Observe the inferior epigastric vessels through the transversalis fascia (FIG. 4.10). The inferior epigastric vessels are located within the layer of extraperitoneal fascia.

4. The deep inguinal ring is lateral to the inferior epigastric vessels and is identified by the presence of the ductus deferens (or round ligament of the uterus) passing through this area.

5. To summarize, the boundaries of the inguinal canal are (FIG. 4.8):

   - **Deep** – deep inguinal ring
   - **Superficial** – superficial inguinal ring
   - **Anterior** – aponeurosis of the external oblique muscle
   - **Inferior** (floor) – inguinal ligament and lacunar ligament
   - **Superior** (roof) – the arching fibers of the internal oblique and transversus abdominis muscles
   - **Posterior** – transversalis fascia laterally and conjoint tendon medially

**CLINICAL CORRELATION**

**INGUINAL HERNIAS** [L 223; R 219]

The inguinal canal is a weak area of the abdominal wall through which abdominal viscera may protrude (inguinal hernia). An inguinal hernia is classified according to its position relative to the inferior epigastric vessels. An *indirect inguinal hernia* exits the abdominal cavity through the deep inguinal ring lateral to the inferior epigastric vessels, and it follows the inguinal canal (an indirect course through the abdominal wall) (FIG. 4.11B). In contrast, a *direct inguinal hernia* exits the abdominal cavity *medial* to the inferior epigastric vessels and it follows a relatively direct course through the abdominal wall (FIG. 4.11C).

**Rectus Abdominis Muscle** [G 106; L 217, 218; N 244; R 211; C 227]

The rectus sheath is formed by the aponeuroses of the three flat abdominal muscles. The rectus sheath contains the rectus abdominis muscle, the pyramidalis muscle, the superior and inferior epigastric vessels, and the terminal ends of the ventral rami of spinal nerves T7 to T12. The purpose of this dissection is to first open the anterior wall of the rectus sheath, observe the rectus abdominis muscle in situ, then transect the rectus abdominis muscle to expose the posterior wall of the rectus sheath.

1. Reposition the internal oblique and external oblique muscles.

2. Make the following cuts bilaterally. Use scissors to make a transverse cut across the anterior surface of the rectus sheath at the level of the umbilicus (FIG. 4.12, cut 1). Begin the cut approximately 2.5 cm lateral to the umbilicus and continue it laterally as far as the semilunar line.
3. Use scissors to cut the rectus sheath along the medial border of the rectus abdominis muscle (FIG. 4.12, cut 2). This cut should extend in a superior direction, about 2.5 cm from the midline. Stop at the costal margin.

4. Extend the vertical cut inferiorly along the medial border of the rectus abdominis muscle (FIG. 4.12, cut 3). Cut 3 should be about 1.2 cm from the midline and stop at the pubic crest.

5. Insert your fingers into the vertical cut and separate the anterior wall of the rectus sheath from the anterior surface of the rectus abdominis muscle. Observe that the anterior wall of the rectus sheath is firmly attached to the anterior surface of the rectus muscle by several tendinous intersections (FIG. 4.13). Lay the scissors flat against the body wall, insert them between the rectus sheath and the anterior surface of the rectus abdominis muscle, and cut the tendinous intersections to free the rectus sheath from the rectus abdominis muscle.

6. Observe the rectus abdominis muscle (FIG. 4.13). The inferior attachment of the rectus abdominis muscle is the symphysis and body of the pubis.
CHAPTER 4: THE ABDOMEN

THE ABDOMEN

CLINICAL CORRELATION

EPIGASTRIC ANASTOMOSES

The superior epigastric vessels anastomose with the inferior epi-

gastric vessels within the rectus sheath (FIG. 4.14). If the inferior

vena cava becomes obstructed, the anastomosis between the in-

ferior epigastric and superior epigastric veins provides a collateral

venous channel that drains into the superior vena cava. If the aorta

is occluded, collateral arterial circulation to the lower part of the

body occurs through the superior and inferior epigastric arteries.

11. Examine the posterior wall of the rectus sheath (FIG. 4.15). Identify the arcuate line, which is

located midway between the pubic symphysis and the

umbilicus. The arcuate line is the inferior limit of the

posterior wall of the rectus sheath, and it may be indistinct. At the level of the arcuate line, the

inferior epigastric vessels enter the rectus sheath.

12. Inferior to the arcuate line, observe the transversalis fascia. Deep to the transversalis fascia, observe

a layer of extraperitoneal fascia and the parietal

peritoneum (FIG. 4.15).

13. In the midline, identify the linea alba (FIG. 4.13). The linea alba is formed by the fusion of the aponeuroses

of the right and left flat abdominal muscles (external

oblique, internal oblique, and transversus abdominis).
2. Refer to FIGURE 4.16. On the left side of the umbilicus, use scissors to create a small hole (2.5 cm) through the posterior wall of the rectus sheath, extraperitoneal fascia, and parietal peritoneum.

3. Insert your finger through the hole into the abdominal cavity and pull the posterior wall of the rectus sheath anteriorly to create a space between the abdominal wall and the abdominal viscera.

4. Use scissors to make a vertical cut through the linea alba to the xiphoid process (FIG. 4.16, cut 1). Stay 1 cm to the left of the midline to preserve the falciform ligament.

5. Extend the cut inferiorly as far as the pubic symphysis (FIG. 4.16, cut 2). Stay 1 cm to the left of the midline to preserve the median umbilical fold.

6. Return the rectus abdominis muscle and the external oblique muscle to their correct anatomical positions.

7. At the level of the umbilicus, place one hand through the vertical cut and raise the abdominal wall from the abdominal contents.

8. On the right side of the abdomen, use scissors to cut the posterior wall of the rectus sheath, extraperitoneal fascia, and peritoneum in the transumbilical plane (FIG. 4.16, cut 3). The scissors should pass through the posterior wall of the rectus sheath, extraperitoneal fascia, and peritoneum.

Dissection Follow-up

1. Replace the muscles of the anterior abdominal wall in their correct anatomical positions.

2. Review the proximal attachment, distal attachment, and action of each muscle.

3. Review the structures that form the nine layers of the abdominal wall (FIG. 4.4).

4. Use the dissected specimen to review the rectus sheath just superior to the level of the umbilicus and just superior to the pubic symphysis (FIG. 4.15).

5. Review the blood and nerve supply to the anterior abdominal wall.

REFLECTION OF THE ABDOMINAL WALL

Dissection Overview

The anterior abdominal wall will be reflected in such a way that the contents of the abdominopelvic cavity can be accessed, but the abdominal wall can be repositioned for review. The cut lines will be similar to the quadrant lines illustrated in FIGURE 4.2. The cuts are designed to give direct reference to the position of the abdominal organs within the abdominal quadrants.

The order of dissection will be as follows: The anterior abdominal wall will be cut and opened. The inner surface of the anterior abdominal wall will be studied.

Dissection Instructions

1. Reflect the halves of the rectus abdominis muscles superiorly and inferiorly.

FIGURE 4.16 Cuts used to open the abdominal cavity.
Some abdominal organs develop behind the peritoneum and are called retroperitoneal (extraperitoneal) organs. The retroperitoneal organs are:

- Kidneys
- Ureters
- Suprarenal glands
- Rectum

Some parts of the gastrointestinal tract begin as intraperitoneal organs in the embryo and then become attached to the abdominal wall later in development. These organs are secondarily retroperitoneal. Examples of secondarily retroperitoneal organs include:

- Duodenum (2nd through 4th parts)
- Pancreas
- Ascending colon
- Descending colon

The order of dissection will be as follows: The abdominal viscera will be identified and localized by abdominal quadrant. The named specializations of the peritoneum will be studied. For a more complete understanding, review the development of the gastrointestinal tract before examining the peritoneal specializations.

### Dissection Instructions

**Abdominal Viscera**  
[G 123, 132; L 224, 225; N 261; R 291, 292; C 244, 245]

1. Use your hands to inspect the abdominal cavity. As you perform the inspection, you may encounter adhesions. If adhesions are present, tear them with your fingers to mobilize the organs.
2. Open the flaps of the abdominal wall. The cut lines correlate to the abdominal quadrant lines. As you examine the organs, you may close and open the flaps to help you relate the organs to the abdominal quadrants. Most of the organs to be identified are parts of the gastrointestinal tract.
3. Identify the liver (FIG. 4.17). The liver occupies the right upper quadrant and extends across the midline into the left upper quadrant. The liver lies against the inferior surface of the diaphragm. The attachment of the falciform ligament divides the liver into right and left lobes.
4. The gallbladder is also in the right upper quadrant. The gallbladder extends below the inferior border of the liver. It is usually found at the tip of the right ninth costal cartilage in the midclavicular line. Confirm this relationship.
5. Identify the stomach. It lies in the left upper quadrant. It is continuous with the esophagus proximally and the duodenum distally. The liver partially covers the anterior surface of the stomach.
6. Find the **spleen**. It is in the left upper quadrant. It is found posterior to the stomach and may be difficult to find unless it is enlarged. Reach around the left side of the stomach with your right hand and palpate the spleen.

7. Identify the **greater omentum** (FIG. 4.17). The greater omentum is attached to the greater curvature of the stomach. Reflect the greater omentum superiorly over the costal margin (FIG. 4.18).

8. Identify the **small intestine** (FIGS. 4.18 and 4.19). The small intestine begins at the pyloric end of the stomach. It has three parts:
   - **Duodenum**
   - **Jejunum**
   - **Ileum**

9. The duodenum lies posterior to the other parts of the gastrointestinal tract and will be dissected after the other parts. It will be studied with the pancreas.

10. The **jejunum** and **ileum** extend from the left upper quadrant to the right lower quadrant, but due to their length and mobility, they occupy all four quadrants. Beginning in the left upper quadrant, pass the jejunum and ileum between your hands and appreciate their length, position, and termination.

11. Identify the **large intestine**. The large intestine begins in the right lower quadrant at the ileocecal junction (FIGS. 4.18 and 4.19). It has six parts:
   - **Cecum** – located in the right lower quadrant. The **appendix** is attached to the inferior end of the cecum.
   - **Ascending colon** – extends from the right lower quadrant to the right upper quadrant. It ends at the **right colic (hepatic) flexure**.
• Transverse colon – extends from the right upper quadrant to the left upper quadrant. The transverse colon ends at the left colic (splenic) flexure.

• Descending colon – extends from the left upper quadrant to the left lower quadrant.

• Sigmoid colon – located in the left lower quadrant. The sigmoid colon ends in the pelvic cavity at the level of the third sacral vertebra.

• Rectum – located in the pelvis. The rectum will be dissected with the pelvic viscera.

12. Use your hands to trace the large intestine from the right lower quadrant to the left lower quadrant. Note the position (quadrant) and mobility of each of its parts.

Peritoneum [G 123; L 224–226; N 261; R 306; C 250]
1. Observe the visceral peritoneum on the surface of the stomach or small intestine (FIG. 4.20). Note that visceral peritoneum is smooth and slippery.

2. Observe the parietal peritoneum on the inner surface of the abdominal wall (FIG. 4.20). Note that parietal peritoneum is also smooth and slippery.

3. Observe the greater omentum (FIG. 4.17). Spread this apron-like structure to appreciate its size. The greater omentum normally lies between the intestines and the anterior abdominal wall (FIG. 4.20). [G 128; L 224; N 267; R 306; C 258]

4. Elevate the inferior border of the liver and identify the lesser omentum (FIG. 4.20). The lesser omentum passes from the lesser curvature of the stomach and first part of the duodenum to the inferior surface of the liver. The lesser omentum has two parts:

• Hepatogastric ligament – spans from the liver to the lesser curvature of the stomach.

• Hepatoduodenal ligament – spans from the liver to the first part of the duodenum.

5. Return the right upper quadrant flap to its anatomical position and review the falciform ligament. The falciform ligament passes from the parietal peritoneum on the anterior abdominal wall to the visceral peritoneum on the surface of the liver. The round ligament of the liver (ligamentum teres hepatis) is found in the inferior edge of the falciform ligament. It is the remnant of the umbilical vein.

6. Follow the falciform ligament superiorly and observe that it is one part of the coronary ligament that attaches the liver to the diaphragm. Two additional peritoneal ligaments are also parts of the coronary ligament:

• Left triangular ligament – located between the left lobe of the liver and the diaphragm.

• Right triangular ligament – located between the right lobe of the liver and the diaphragm.

7. The gastrophrenic ligament connects the superior part of the greater curvature of the stomach to the diaphragm. Slide your hand superiorly around the left side of the stomach to feel this ligament.

8. The gastroplenic (gastrolienal) ligament passes from the greater curvature of the stomach to the spleen, and the splenorenal (lienorenal) ligament attaches the spleen to the body wall anterior to the left kidney (FIG. 4.21).

9. Reflect the greater omentum superiorly over the costal margin and identify the transverse mesocolon (FIGS. 4.18 and 4.20). The transverse mesocolon attaches to the anterior surface of the duodenum and pancreas. At the left end of the transverse mesocolon is the phrenicocolic ligament, which attaches the left colic flexure to the diaphragm. [L 224; N 263; R 313; C 288]

10. Identify the mesentery (FIG. 4.20). The mesentery suspends the jejunum and ileum from the posterior abdominal wall. The root of the mesentery attaches
Development, the inferior recess extended between the layers of the greater omentum (review an embryology text). The highest part of the lesser peritoneal sac is the superior recess. The diaphragm lies posterior to the superior recess and the caudate lobe of the liver is anterior to the superior recess. [G 124; L 230; N 264, 265; R 313; C 249]

17. Posterior to the main part of the lesser peritoneal sac is the pancreas (FIG. 4.20). The peritoneum that covers the pancreas forms part of the posterior wall of the lesser peritoneal sac.

Dissection Follow-up

1. Use the cadaver specimen to review all parts of the gastrointestinal tract proximal to the distal order. State the quadrant(s) in which each abdominal organ normally is found.
2. Review all parts and specializations of the peritoneum listed on the preceding pages.
3. Review the embryology of the gut tube and mesenteries.

CELIAC TRUNK, STOMACH, SPLEEN, LIVER, AND GALLBLADDER

Dissection Overview

The order of dissection will be as follows: The ribs and diaphragm will be cut to allow the liver to be retracted superiorly, exposing the lesser omentum. The surface features of the stomach will be studied. The vessels and ducts in the hepatoduodenal ligament will be demonstrated. The branches of the celiac trunk that supply the stomach, spleen, liver, and gallbladder will be dissected. The remainder of the field of supply of the celiac trunk (to the duodenum and pancreas) will be dissected later. The hepatic portal vein will be studied. The spleen, liver, and gallbladder will be studied.

Dissection Instructions

1. Place the greater omentum in its correct anatomical position.
2. Identify the parts of the stomach (FIG. 4.22): [G 133; L 231; N 267; R 294; C 254]
   - Body
   - Greater curvature
   - Lesser curvature
   - Cardia
   - Cardial notch
   - Fundus
   - Body
   - Angular incisure (notch)
   - Pyloric part
   - Pylorus
3. Identify the following features of the liver (FIG. 4.23A, B): [G 150; L 233; N 277; R 298; C 271]
   - Right lobe
   - Left lobe
   - Diaphragmatic surface
   - Inferior border
4. Use your hand to raise the inferior border of the liver and identify the visceral surface of the liver (FIG. 4.23B). The visceral surface is in contact with the gallbladder and the peritoneum covering the stomach, duodenum, colon, right kidney, and right suprarenal gland.
5. Identify the porta hepatis on the visceral surface of the liver. It is the fissure through which vessels, ducts, lymphatics, and nerves enter the liver (FIG. 4.23B). [G 151; L 233; N 277; R 299; C 271]
6. Identify the gallbladder (FIG. 4.23B). The gallbladder may have been surgically removed.

Celiac Trunk [G 134; L 231; N 284; R 315; C 252]
As you dissect the branches of the celiac trunk, realize that arteries are named by their region of distribution, not by their origin or branching pattern.

1. On the left side only, use bone cutters to detach the costal cartilages of ribs 6 and 7 from the xiphisternal junction and lateral border of the sternum. Working through the opening just created, use scissors to make a vertical cut through the diaphragm. Extend this cut up to the level of the coronary ligament on the superior surface of the liver. Use your hands to retract the ribs, diaphragm, and liver superiorly to expose the lesser omentum.

2. Insert the index finger of your left hand into the omental foramen (FIG. 4.24). Anterior to your finger is the hepatoduodenal ligament and its contents:
   - Bile duct
   - Hepatic artery proper
   - Hepatic portal vein
   - Autonomic nerves
   - Lymphatic vessels
3. To aid dissection, you may place a strip of white paper into the omental foramen (FIG. 4.24).

**FIGURE 4.22** Parts of the stomach.

**FIGURE 4.23** Relationships of the gallbladder. A. Anterior view. B. Sagittal view.
4. Use blunt dissection to remove the peritoneum from the anterior surface of the hepatoduodenal ligament (anterior to the vessels and ducts).

5. Identify the three large structures that are contained within the hepatoduodenal ligament: **bile duct**, **hepatic artery proper**, and **hepatic portal vein** (FIG. 4.24). The bile duct is the most lateral of the three.

6. Use a probe to trace the bile duct superiorly. Identify the **cystic duct** and the **common hepatic duct** (FIG. 4.25).

7. Follow the common hepatic duct superiorly until it receives its tributaries: the **right hepatic duct** and the **left hepatic duct**. The right and left hepatic ducts exit the **porta hepatis**.

8. Clean the **hepatic artery proper**. The tough “connective tissue” around this vessel is an **autonomic nerve plexus**. To clear the dissection field, remove the autonomic nerve fibers. [G 134; L 231; N 283; R 315; C 252]

9. Follow the hepatic artery proper toward the liver through the hepatoduodenal ligament. Near the porta hepatis, the hepatic artery proper branches into the **left hepatic artery** and the **right hepatic artery** (FIG. 4.25).

10. Two other arteries arise in the hepatoduodenal ligament (FIG. 4.25):
    - **Cystic artery** – arises from the right hepatic artery. Follow it to the gallbladder.
    - **Right gastric artery** – arises from the hepatic artery proper. Follow it to the lesser curvature of the stomach.

11. **Lymphatics** are also contained within the hepatoduodenal ligament. The lymphatic vessels are too small to dissect but **hepatic lymph nodes** can be seen. The lymph nodes may be removed to clear the dissection field.

12. Follow the hepatic artery proper inferiorly and confirm that it is the continuation of the **common hepatic artery** (FIG. 4.25).

13. Observe that the common hepatic artery gives rise to the **gastroduodenal artery**. The gastroduodenal artery passes posterior to the first part of the duodenum (FIG. 4.26). Follow the gastroduodenal artery until it divides to give rise to the **right gastro-omental (gastroepiploic) artery** and the **anterior superior pancreaticoduodenal artery**.

**CLINICAL CORRELATION**

**ANATOMICAL VARIATION IN ARTERIES**

In about 12% of cases, the right hepatic artery arises from the superior mesenteric artery.

An aberrant left hepatic artery may arise from the left gastric artery. During surgical removal of the stomach (gastrectomy), blood flow to an aberrant left hepatic artery could be interrupted, endangering the left lobe of the liver.

The cystic artery usually arises from the right hepatic artery, but other origins are possible. The cystic artery may pass posterior (75%) or anterior (24%) to the common hepatic duct (FIG. 4.27).
of the stomach. Branches of the gastric arteries distribute to the anterior and posterior surfaces of the stomach.

16. Follow the **spleenic artery** to the left for about 5 cm and verify that it lies against the posterior abdominal wall. The splenic artery courses along the superior border of the pancreas and may be partially imbedded in it. Do not dissect the splenic artery from the pancreas at this time. Note that **short gastric arteries** arise from the distal end of the splenic artery to supply the fundus of the stomach (FIG. 4.26).

17. Find the **left gastro-omental** (gastroepiploic) artery in the greater omentum about 2 cm from the greater curvature of the stomach (FIG. 4.26). The left gastro-omental artery is a branch of the splenic artery.

18. Find the **right gastro-omental artery** in the greater omentum near the right end of the greater curvature of the stomach. The right gastro-omental artery anastomoses with the left gastro-omental artery. Follow the right gastro-omental artery to the right to find its origin from the gastroduodenal branch of the common hepatic artery.

19. Return to the hepatoduodenal ligament and identify the **hepatic portal vein**. The hepatic portal vein lies posterior to both the hepatic artery proper and the bile duct (FIG. 4.24). Follow the hepatic portal vein superiorly and observe that it passes into the porta hepatis, where it divides into **right and left portal veins**. The hepatic portal vein usually receives the left and right gastric veins as tributaries. Inferiorly, the hepatic portal vein passes posterior to the first part of the duodenum.

**Spleen**

The spleen is the largest hematopoietic organ in the body. Its size and weight may vary considerably depending on the blood volume that it contains. The spleen is covered by the visceral peritoneum except at the hilum where the splenic vessels enter and leave.

1. Use your left hand to retract the fundus of the stomach to the right. Use your right hand to gently pull the spleen anteriorly.

2. Observe that the spleen has a smooth **diaphragmatic surface**. The spleen has sharp anterior, inferior, and superior borders. The superior border of the spleen is often notched.

3. The **visceral surface of the spleen** is related to four organs:

   - **Stomach**
   - **Left kidney**
   - **Transverse colon (left colic flexure)**
   - **Pancreas**
3. Insert your fingers between the liver and the diaphragm and tear the connective tissue that attaches the liver to the diaphragm. Cut the posterior layer of the coronary ligament.

4. Use scissors to cut the inferior vena cava between the liver and the diaphragm. Elevate the inferior border of the liver and cut the inferior vena cava again as close to the inferior surface of the liver as possible. These two cuts will leave a short segment of the inferior vena cava within the liver (FIG. 4.29B).

5. The liver should now be freely mobile but attached to the other abdominal viscera by the bile duct, hepatic artery proper, and hepatic portal vein. Move the liver carefully to avoid tearing these structures.

6. Examine the liver and note that the right lobe is six times larger than the left lobe. The sharp inferior

**CLINICAL CORRELATION**

**Spleen**

The relationship of the spleen to ribs 9, 10, and 11 is of clinical importance in evaluating rib fractures and penetrating wounds. A lacerated spleen bleeds profusely into the abdominal cavity and may have to be removed surgically (splenectomy). It must be emphasized that there is a risk of puncturing the spleen during pleural tap (thoracentesis).

An enlarged spleen (splenomegaly) may be encountered during physical examination. The spleen is considered enlarged when it can be palpated inferior to the costal margin.

**Liver** [G 150; L 233; N 277; R 298; C 270, 271]

The liver is the largest gland in the body, comprising about 2.5% of the body weight of an adult. To study the surface features of the liver, it must be detached from the diaphragm.

1. Review the falciform ligament and the coronary ligament of the liver.

2. Use scissors to cut the falciform ligament along its attachment to the anterior abdominal wall. Extend the cut superiorly and cut the right and left triangular ligaments along the inferior surface of the diaphragm.

**FIGURE 4.28** Relationships of the spleen to the thoracic wall.

A. Frontal section. B. Lateral view. A penetrating wound through the ninth intercostal space, just posterior to the midaxillary line, will penetrate the pleural cavity, diaphragm, peritoneal cavity, and spleen.

**FIGURE 4.29** Posterior views of the liver. A. Fissures and sulci define the four lobes of the liver (right, left, quadrate, and caudate). B. Structures located in the H-shaped fissures.
border of the liver separates the visceral surface from the diaphragmatic surface.
7. Identify the bare area on the posterior aspect of the diaphragmatic surface. Here, the liver was adjacent to the diaphragm and not covered by peritoneum. Around the bare area, note the cut edges of the coronary ligament.
8. Examine the visceral surface of the liver (FIG. 4.29A). An H-shaped set of fissures and fossae defines four lobes. Identify the right lobe, left lobe, caudate lobe, and quadrate lobe. [G 151, 158; L 233; N 277; R 299; C 271]
9. Observe that the ligamentum venosum and falciform ligament occupy the left fissure of the “H” (FIG. 4.29B). The gallbladder and inferior vena cava occupy the fossae that form the right side of the “H.”
10. Identify the porta hepatitis. It forms the horizontal bar of the “H.” The structures passing through the hepatoduodenal ligament (bile ducts, hepatic arteries, hepatic portal vein, lymphatics, and autonomic nerves) enter or leave the liver at the porta hepatis.
11. Examine the small segment of the inferior vena cava that is attached to the liver. Note that several hepatic veins drain directly from the liver into the inferior vena cava (FIG. 4.29B).
12. Use a textbook to study the two conventions by which the liver may be divided into lobes. The falciform ligament divides the liver into right and left anatomical lobes. The pattern of its bile drainage and vascular supply are used to divide the liver into right and left functional lobes. [G 154; L 234, 235; R 299]
13. The liver has a substantial lymphatic drainage. At the porta hepatis, small lymph vessels drain into hepatic lymph nodes. From the hepatic lymph nodes, lymphatic vessels follow the hepatic arteries to celiac lymph nodes located around the celiac trunk. Lymph from the liver also drains posteriorly into phrenic nodes.

**GALLBLADDER [G 158; L 236; N 280; R 297; C 278]**

The gallbladder is a reservoir for the storage and concentration of bile. The gallbladder occupies a shallow fossa on the visceral surface of the liver (FIG. 4.29). The gallbladder is usually stained dark green by bile, which leaks through the wall of the gallbladder after death.

1. Replace the liver into its correct anatomical position.
2. Confirm that the gallbladder is located near the tip of the ninth costal cartilage in the midclavicular line.
3. Lift the inferior border of the liver to expose the visceral surface. Use blunt dissection to remove the gallbladder from its fossa.
4. Identify the parts of the gallbladder (FIG. 4.30):
   - Fundus
   - Body
   - Neck

5. Review the course of the cystic artery (FIG. 4.27). The cystic artery is stained green by bile and is often fragile, making it difficult to dissect.
6. Use scissors to make a longitudinal cut through the wall of the gallbladder, beginning at the fundus and continuing through the neck and into the cystic duct. If gallstones are present, remove them. Look for the spiral fold, which is a fold in the mucosal lining of the neck that continues into the cystic duct.

**Dissection Follow-up**

1. Replace the organs in their correct anatomical positions.
2. Review the location of each organ relative to the abdominal quadrant system.
3. Use an illustration and the dissected specimen to trace the branches of the celiac trunk.
4. Review the relationships of the structures in the hepatoduodenal ligament.
5. Review the boundaries of the omental foramen.
6. Review the parts of the organs dissected and their relationships to surrounding structures.
7. Use an embryology textbook to review the development of the liver, pancreas, and ventral mesogastrium.
8. Review all derivatives of the embryonic foregut.

**SUPERIOR MESENTERIC ARTERY AND SMALL INTESTINE**

**Dissection Overview**

The order of dissection will be as follows: The mesentery will be examined. The branches of the superior mesenteric artery that supply the jejunum, ileum, cecum, ascending
colon, and transverse colon will be dissected. The remainder of the field of supply of the superior mesenteric artery (to the duodenum and pancreas) will be dissected later because these structures lie behind the attachment of the transverse mesocolon. The external features of the jejunum and ileum will be studied.

Dissection Instructions

Superior Mesenteric Artery  [G 144; L 225; N 287, 288; R 303; C 292]

The superior mesenteric artery arises from the anterior surface of the abdominal aorta about 1 cm inferior to the celiac trunk (L1 vertebral level). At its origin, the superior mesenteric artery lies posterior to the neck of the pancreas. When the superior mesenteric artery emerges from posterior to the neck of the pancreas, it passes anterior to the uncinate process, the third part of the duodenum, and the left renal vein. The superior mesenteric artery then enters the mesentery. Within the mesentery, the superior mesenteric artery courses into the right lower quadrant, toward the terminal end of the ileum.

1. Return the liver to its correct anatomical position.
2. Turn the transverse colon and greater omentum superiorly over the costal margin. The posterior surface of the transverse mesocolon should face anteriorly (FIG. 4.31).
3. Move the coils of the jejunum and ileum to the left side of the abdomen so that the right side of the mesentery faces anteriorly (FIG. 4.31). Observe that the root of the mesentery is attached to the posterior abdominal wall along a line from the left upper quadrant to the right lower quadrant.
4. Remove the peritoneum on the right side of the mesentery to expose the branches of the superior mesenteric artery. To do this, use a probe to tear...
the peritoneum, and then grasp it between your thumb and index finger. Peel it slowly using the handle of a forceps to release the peritoneum from the underlying blood vessels.

5. Remove the parietal peritoneum from the posterior abdominal wall on the right side of the mesentery. Remove the peritoneum as far laterally as the ascending colon.

6. Identify the **superior mesenteric artery**. Use blunt dissection to trace the superior mesenteric artery proximally and observe that it crosses anterior to the third part of the duodenum. Note that the third part of the duodenum and the left renal vein can become compressed between the superior mesenteric vessels and the abdominal aorta.

7. Use blunt dissection to clean the branches of the superior mesenteric artery. As you dissect, note the dense autonomic nerve network surrounding the blood vessels. This is the **superior mesenteric plexus of nerves**. Remove the nerve fibers as necessary to clean the vessels.

8. Identify the **branches of the superior mesenteric artery** (FIG. 4.31):

- **Inferior pancreaticoduodenal artery** is usually the first branch of the superior mesenteric artery. The inferior pancreaticoduodenal artery will be dissected with the duodenum.

- **Intestinal arteries** are 15 to 18 arteries to the jejunum and the ileum (FIG. 4.31). Intestinal arteries end in straight terminal branches called arteriae rectae (straight arteries). Arterial arcades connect the intestinal arteries. Observe the blood supply to the proximal jejunum and note that only one or two arcades are found between adjacent intestinal arteries, resulting in relatively long arteriae rectae (FIG. 4.32A). Examine the distal ileum and note that four or five arcades occur between adjacent intestinal arteries, resulting in relatively short arteriae rectae (FIG. 4.32B).

- **Ileocolic artery** supplies the cecum. It arises from the right side of the superior mesenteric artery and courses toward the right in a retroperitoneal position. The ileocolic artery gives rise to the **appendicular artery** (FIG. 4.33) and anastomoses with intestinal branches and with the right colic artery.

- **Right colic artery** supplies the ascending colon. The right colic artery arises from the right side of the superior mesenteric artery and passes to the right in a retroperitoneal position. It divides into a superior branch and an inferior branch.

- **Middle colic artery** supplies the transverse colon. The middle colic artery arises from the anterior surface of the superior mesenteric artery and courses through the transverse mesocolon. It divides into a right branch and a left branch.
9. Identify the **superior mesenteric vein**. The superior mesenteric vein is usually positioned along the right side of the superior mesenteric artery. The superior mesenteric vein is formed by branches that correspond in name and position to the branches of the superior mesenteric artery. Posterior to the pancreas, the superior mesenteric vein joins the splenic vein to form the **hepatic portal vein**.

10. The mesentery may contain up to 200 **mesenteric lymph nodes**. Identify one or two of these lymph nodes along the branches of the superior mesenteric vessels. The mesenteric lymphatic channels follow the branches of the superior mesenteric artery and drain into the **superior mesenteric lymph nodes** near the origin of the superior mesenteric artery from the abdominal aorta. Lymph nodes may be removed to clear the dissection field.

**Small Intestine** [G 140, 141; L 225, 228; N 262; R 310; C 294]

The small intestine consists of the duodenum, jejunum, and ileum. The function of the small intestine is to absorb nutrients from food. It has elaborate folds of mucosa that increase surface area and a rich blood supply to transport the absorbed nutrients. The **jejunum** (approximately two-fifths of the small intestine) and **ileum** (distal three-fifths) will be studied together because the transition from one to the other is not obvious.

1. Move the small intestine to the left side of the abdominal cavity and follow the jejunum proximally (**FIG. 4.34A**). Find the **duodenojejunal junction**.

2. Note that the **suspending ligament of the duodenum** is a fibromuscular ligament that arises from the right crus of the diaphragm and anchors the small intestine at the duodenojejunal junction (**FIG. 4.34B**). The suspensory ligament passes posterior to the pancreas and cannot be seen at this time.

3. Palpate the small intestine and note that the wall of the jejunum is thicker than the wall of the ileum.

4. Identify the termination of the ileum where it empties into the **cecum** at the **ileocecal junction** (**FIG. 4.34A**).

5. Verify that the **root of the mesentery** crosses the posterior abdominal wall from the duodenojejunal junction to the ileocecal junction (**FIG. 4.34A**). The root of the mesentery is about 15 cm long. The intestinal attachment of the mesentery is nearly 6 m long.

**Dissection Follow-up**

1. Replace the small intestine in its correct anatomical position.

2. Review the location of the jejunum and ileum relative to the abdominal quadrant system.

3. Review the relationships of the jejunum and ileum to surrounding structures.

4. Use an illustration and the dissected specimen to review the branches of the superior mesenteric artery.

5. Use an embryology textbook to review the derivatives of the embryonic midgut.

**INFERIOR MESENTERIC ARTERY AND LARGE INTESTINE**

**Dissection Overview**

The **inferior mesenteric artery** arises from the anterior surface of the abdominal aorta at the L3 vertebral level. The objective of this dissection is to demonstrate the field of supply of the inferior mesenteric artery (left third of the transverse colon, descending colon, sigmoid colon, and most of the rectum). Except for the branches that pass through the sigmoid mesocolon to supply the sigmoid
colon, the inferior mesenteric artery and its branches lie retroperitoneally.

The order of dissection will be as follows: The inferior mesenteric artery and its branches will be dissected. The external features of the large intestine will be studied.

**Dissection Instructions**

**Inferior Mesenteric Artery** [G 146; L 226; N 288; R 305; C 294]

1. Turn the transverse colon and greater omentum superiorly over the costal margin to expose the posterior surface of the transverse mesocolon (FIG. 4.35).
2. Move the small intestine to the right so that the descending colon is visible from the left colic flexure to the sigmoid colon (FIG. 4.35).
3. The origin of the inferior mesenteric artery lies posterior to the third part of the duodenum. If you have trouble finding it, find one of its branches in the sigmoid mesocolon and trace that branch back to the main vessel. Then proceed with the dissection of the peripheral branches.

**Dissection note:** The left ureter could be mistaken for the inferior mesenteric artery or one of its branches. The inferior mesenteric artery and vein and the ureter all lie in the retroperitoneal space, but the vessels pass anterior to the ureter.

4. Use a probe to clean the branches of the inferior mesenteric artery (FIG. 4.35):

   - **Left colic artery** – supplies the descending colon and the left third of the transverse colon. The left colic artery anastomoses with the middle colic branch of the superior mesenteric artery and the ascending branch of the first sigmoid artery.
   - **Sigmoid arteries** – three or four arteries that supply the sigmoid colon. Sigmoid arteries pass through the sigmoid mesocolon. Note that they form arcades similar to those of the intestinal arteries.
   - **Superior rectal artery** – supplies the proximal part of the rectum. The superior rectal artery divides into a **right branch** and a **left branch**. The right and left branches of the superior rectal artery descend into the pelvis on either side of the rectum. Do not follow them into the pelvis.

5. Observe the tributaries of the **inferior mesenteric vein**. The tributaries of the inferior mesenteric vein correspond to the branches of the inferior mesenteric artery. The inferior mesenteric vein is a tributary of the hepatic portal vein. The inferior mesenteric vein ascends on the left side of the inferior mesenteric artery, passes posterior to the pancreas, and joins either the **spleenic vein** or (less frequently) the **superior mesenteric vein**.

6. The descending colon and sigmoid colon are drained by lymph vessels that accompany the branches of the inferior mesenteric artery. These lymphatic channels drain into the **inferior mesenteric nodes** located around the origin of the inferior mesenteric artery from the abdominal aorta.

**Large Intestine** [G 140, 141; L 224, 226; N 276; R 307; C 288, 290]

The large intestine consists of the **cecum** (with attached **appendix**), **colon** (ascending, transverse, descending, and sigmoid), **rectum**, and **anal canal**. Absorption of water from fecal material is a major function of the large intestine. The relatively smooth mucosal surface of the large intestine is well suited for this function, as a smooth surface is less likely to impede the movement of progressively more solid fecal material.

1. Return the small intestine and transverse colon to their correct anatomical positions.
2. In the right lower quadrant, identify the **cecum** (L. cæcum, blind) (FIG. 4.33). The length of its mesentery and the degree of its mobility vary considerably from individual to individual.
• Omental appendices (epiploic appendages) — small accumulations of fat covered by visceral peritoneum.

10. Review the branches of the superior mesenteric artery and inferior mesenteric artery that supply the large intestine. [G 149; L 226; N 288; R 308; C 292, 294]

Dissection Follow-up
1. Review the location of each part of the large intestine relative to the abdominal quadrant system.
2. Review the relationship of each part of the large intestine to surrounding structures.
3. Use an illustration and the dissected specimen to trace the branches of the inferior mesenteric artery.
4. Use an embryology textbook to review the derivatives of the embryonic hindgut.

DUODENUM, PANCREAS, AND HEPATIC PORTAL VEIN

Dissection Overview
The duodenum is the part of the small intestine between the stomach and the jejunum. The duodenum is the drainage point for the ducts of the liver and pancreas. The pancreas lies within the bend of the duodenum. The pancreas is both an endocrine and an exocrine organ and has a rich blood supply arising from the celiac trunk and the superior mesenteric artery.

The order of dissection will be as follows: The parts of the duodenum will be studied. The pancreas will be dissected. The formation of the hepatic portal vein will be demonstrated.

Dissection Instructions

Duodenum [G 137, 138; L 238, 239; N 270; R 316; C 282]
1. Turn the transverse colon and greater omentum superiorly over the costal margin.
2. Use blunt dissection to remove the connective tissue and peritoneum from the anterior surface of the duodenum and pancreas. Consult an atlas figure and note that you are removing the remnants of the transverse mesocolon when you do this.
3. Observe the four parts of the duodenum (FIG. 4.37):
   • Superior (first) part — at the L1 vertebral level. The superior part of the duodenum lies in the transverse plane and the hepatoduodenal ligament is attached to it. It is mostly intraperito-
neal and has an expanded initial part called the **ampulla**. Clinicians often call the ampulla the **duodenal cap** or **duodenal bulb**.

- **Descending (second) part** – at the L2 vertebral level. The descending part of the duodenum is positioned to the right of the midline and anterior to the hilum of the right kidney, right renal vessels, and inferior vena cava. It is retroperitoneal. The bile duct and the pancreatic duct drain into the descending part of the duodenum.
- **Horizontal (third) part** – at the L3 vertebral level. The horizontal part of the duodenum lies anterior to the inferior vena cava and the abdominal aorta. It is retroperitoneal. The horizontal part of the duodenum is crossed anteriorly by the superior mesenteric vessels and posteriorly by the inferior mesenteric vessels.
- **Ascending (fourth) part** – ascends to the L2 vertebral level. The ascending part of the duodenum is retroperitoneal throughout most of its length. The ascending part of the duodenum turns anteriorly to join the jejunum at the duodenojejunal junction.

**Pancreas**  

1. Identify the **pancreas** within the bend of the duodenum. Note that it is a secondarily retroperitoneal organ that lies across the midline and that it is positioned against vertebral bodies L1 to L3.

2. Identify the parts of the pancreas (**FIG. 4.37**):

   - **Head** – lies within the curve of the duodenum. The **uncinate process** is a small projection from the inferior margin of the head that passes posterior to the superior mesenteric vessels. The

   - **Body** – extends from right to left and slightly superiorly as it crosses the posterior abdominal wall. The abdominal aorta lies posterior to the body of the pancreas.

   - **Tail** – the narrow left end of the gland. The tip of the tail lies in the splenorenal ligament and contacts the hilum of the spleen.

3. Use a probe to dissect into the anterior surface of the head of the pancreas and find the **main pancreatic duct**. Follow the main pancreatic duct through the neck and into the body. The **accessory pancreatic duct** joins the superior side of the main pancreatic duct.

4. Observe that the main pancreatic duct is joined by the bile duct near the left side of the descending part of the duodenum.

5. Identify the **posterior and anterior superior pancreaticoduodenal arteries** (**FIG. 4.38**). Both are branches of the gastroduodenal artery.  

   - **Inferior pancreaticoduodenal artery** is usually the most proximal branch of the superior mesenteric artery, although its origin is variable (**FIG. 4.38**). The inferior pancreaticoduodenal artery enters the inferior portion of the head of the pancreas.

6. Return to the celiac trunk and follow the splenic artery as it passes to the left side of the descending part of the duodenum.
border of the pancreas (FIG. 4.38). Up to 10 small branches of the splenic artery supply the body and tail of the pancreas. Identify only two:

- **Dorsal pancreatic artery** – enters the neck of the pancreas.
- **Greater pancreatic (pancreatica magna) artery** – enters the pancreas about halfway between the neck and the tail.

8. Follow the splenic artery to the hilum of the spleen and identify the **left gastro-omental artery**. Complete the dissection of the left gastro-omental artery by following it through the greater omentum to its anastomosis with the right gastro-omental artery.

9. The veins of the pancreas correspond to the arteries. They drain into the superior mesenteric and splenic veins and ultimately are tributary to the hepatic portal vein.

**Hepatic Portal Vein** [G 164; L 240; N 291; R 303; C 253]

Use an illustration to review the hepatic portal venous system. The **superior mesenteric vein** and the **splenic vein** join to form the hepatic portal vein posterior to the neck of the pancreas. The **hepatic portal vein** carries venous blood to the liver from the abdominal portion of the gastrointestinal tract, the spleen, and the pancreas.

1. The **splenic vein** courses posterior to the pancreas and is inferior to the splenic artery. Use a probe to dissect posterior to the body of the pancreas and find the splenic vein.

2. Follow the splenic vein to the right, where it is joined by the superior mesenteric vein. This is the origin of the **hepatic portal vein**. Recall that the hepatic portal vein ascends in the hepatoduodenal ligament to the porta hepatis.

3. Return to the field of distribution of the inferior mesenteric vein. Find it and follow it superiorly. The inferior mesenteric vein usually joins the splenic vein but it may join either the superior mesenteric vein or the junction of the superior mesenteric and splenic veins.

4. Use a textbook or atlas to review the portal-systemic (portal-caval) anastomoses:

- **Gastroesophageal** – left gastric vein/esophageal veins/azygos vein.
- **Anorectal** – superior rectal vein/middle and inferior rectal veins.
- **Paraumbilical** – paraumbilical veins/superficial epigastric veins.
- **Retroperitoneal** – colic veins/retroperitoneal veins.

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**CLINICAL CORRELATION**

**PORTAL HYPERTENSION**

The hepatic portal system of veins has no valves. When the hepatic portal vein becomes blocked, blood pressure increases in the hepatic portal system (portal hypertension) and its tributaries become engorged. Portal hypertension causes hemorrhoids and varicose gastric and esophageal veins. Bleeding from ruptured gastroesophageal varices is a dangerous complication of portal hypertension.

**Dissection Follow-up**

1. Review the relationship of each part of the duodenum to surrounding structures.
2. Review the branches of the celiac trunk and superior mesenteric artery.
3. Use an illustration and the dissected specimen to reconstruct the blood supply to the pancreas and duodenum.
4. Review the formation and field of drainage of the hepatic portal vein.
5. Trace a drop of blood from the small intestine to the inferior vena cava, naming all veins that are encountered along the way. Repeat this exercise beginning at the descending colon.
6. Use an embryology textbook to review the development of the liver, pancreas, and duodenum.

**REMOVAL OF THE GASTROINTESTINAL TRACT**

**Dissection Overview**

The interior features of the various parts of the gastrointestinal tract and the posterior abdominal wall are best dissected with the gastrointestinal tract removed from the abdominal cavity. The order of dissection will be as follows: The arteries to the gastrointestinal tract (celiac trunk, superior mesenteric artery, and inferior mesenteric artery) will be cut close to the aorta. The esophagus and rectum will be cut, using ligatures to prevent spilling their contents. The gastrointestinal tract will then be removed and reviewed outside of the body. The gastrointestinal tract will be taken to a sink and selected areas will be opened and rinsed in order to study their internal features.

**Dissection Instructions**

1. Tie two strings 4 cm apart around the distal end of the sigmoid colon, close to the rectum. Use scissors to cut the sigmoid colon between the strings. Also cut the superior rectal artery.
2. Inferior to the diaphragm, tie one string around the esophagus and cut the esophagus superior to the string. Cut the vagus nerve trunks at the same level.
3. Use scissors to cut the celiac trunk close to the aorta, leaving no stump.
4. Use scissors to cut the superior mesenteric artery near the aorta, leaving a 1-cm stump.
5. Use scissors to cut the inferior mesenteric artery near the aorta, leaving a 1-cm stump.
6. Free the stomach from any peritoneal attachments it may still have to the posterior abdominal wall.
7. Grasp the spleen and gently pull it anteriorly and medially. Insert your fingers posterior to the spleen and carefully free the splenic vessels, tail of the pancreas, and body of the pancreas from the posterior abdominal wall.
8. Use scissors to cut the suspensory ligament of the duodenum close to the duodenojejunal junction.
9. Insert your fingers posterior to the duodenum and free it and the head of the pancreas from the posterior abdominal wall.
10. Use scissors to cut the parietal peritoneum lateral to the ascending colon and use your fingers to free the ascending colon from the posterior abdominal wall. Roll the ascending colon toward the midline and use your fingers to loosen its blood vessels from the posterior abdominal wall.
11. Cut the parietal peritoneum lateral to the descending colon and use your fingers to free the descending colon from the posterior abdominal wall. Roll the descending colon toward the midline and use your fingers to loosen its blood vessels from the posterior abdominal wall.
12. The gastrointestinal tract, liver, pancreas, and spleen should now be free of attachments. Remove them from the abdominal cavity. Support the liver and be careful not to twist or tear the structures in the hepatoduodenal ligament.
13. Arrange the abdominal viscera on the dissecting table in anatomical position and study the parts from the anterior view:
   - Trace the branches of the celiac trunk, superior mesenteric artery, and inferior mesenteric artery to their areas of distribution.
   - Observe the formation and termination of the hepatic portal vein.
   - Note the differences between the branching pattern of the arteries and the veins.
   - Turn the viscera and repeat the exercise from the posterior view.
14. To examine their internal features, carry the viscera to a sink and perform dissection steps 15 through 19 in the sink.
15. Use scissors to open the stomach along its anterior surface. Extend the cut into the first part of the duodenum. Rinse the mucosa and observe the following features (FIG. 4.39): [G 133; L 231; N 268; R 294; C 255]
   - Gastric folds (rugae)
   - Pyloric antrum
   - Pyloric canal
   - Pyloric sphincter
   - Pyloric orifice
   - Ampulla of duodenum
16. Use scissors to extend the longitudinal cut into the anterior wall of the duodenum. In the second part of the duodenum, identify the following (FIG. 4.40): [G 137; L 238; N 271; R 297; C 283]
   - Circular folds (plicae circulares)
19. Make a single cut approximately 5 cm long in the anterior surface of the transverse colon. Note the semilunar folds (plicae semilunares) between adjacent haustra. Observe that the mucosa of the large intestine is relatively smooth compared to the other parts of the gastrointestinal tract. [G 141; N 276; C 304]

20. The viscera may be stored in a large plastic bag or in the abdominal cavity. Wet these specimens frequently with mold-inhibiting solution.

**Dissection Follow-up**

1. Review the features of the gastrointestinal mucosa.
2. Compare the quantity and complexity of circular folds in the proximal and distal parts of the small intestine. Compare this arrangement to the mucosal features seen in the stomach and large intestine. Correlate your findings to the function of the organs dissected.
3. Recall the locations of valves in the gastrointestinal tract.

**POSTERIOR ABDOMINAL VISCERA**

**Dissection Overview**

The posterior abdominal viscera are located in an area that is referred to as the retroperitoneal space. The retroperitoneal space is not a real space. It is that part of the body between the posterior parietal peritoneum bounding the abdominal cavity and the muscles and bones of the posterior abdominal wall (FIG. 4.43). The retroperitoneal space contains the kidneys, ureters, suprarenal glands, aorta, inferior vena cava, and abdominal portions of the sympathetic trunks. [G 175; L 243; N 317; R 324; C 320]

The order of dissection will be as follows: The posterior abdominal viscera will be palpated. The renal fascia will be opened and the kidneys and suprarenal glands will be studied. The abdominal aorta and the inferior vena cava will be dissected. The muscles of the posterior abdominal
CHAPTER 4: THE ABDOMEN

Inferior vena cava
Superior mesenteric vessels
Abdominal aorta
Sympathetic trunks
Deep back muscles
Psoas major m.
Quadratus lumborum m.
Pararenal fat
Perirenal fat
Right kidney
Retroperitoneal space and pararenal fat
Peritoneum
Three flat abdominal muscles:
Transversus abdominis m.
Internal oblique m.
External oblique m.

FIGURE 4.43
Transverse section through the posterior abdominal wall at the level of the kidneys.

Dissection Instructions

1. Use a sponge or paper towels to clean the posterior abdominal wall.
2. Palpate the kidneys and the suprarenal (adrenal) glands. They lie lateral to the vertebral column between vertebral levels T12 and L3. [G 167; L 242; N 308; R 331]
3. Palpate the abdominal aorta.
4. To the right of the abdominal aorta, palpate the inferior vena cava.
5. Remove any remaining parietal peritoneum from the posterior abdominal wall.
6. If you are dissecting a female cadaver, go to step 10.
7. Identify the testicular artery and vein at the deep inguinal ring. The testicular artery is quite small and delicate. Follow the testicular vessels superiorly and note that they cross anterior to the ureter. Do not damage the ureter while following the vessels.
8. The right and left testicular arteries branch directly from the aorta at about vertebral level L2. This origin is inferior to the origin of the renal arteries.
9. Observe that the left testicular vein drains into the left renal vein. The right testicular vein drains directly into the inferior vena cava.

Clinical Correlation

TESTICULAR VARICOCELE

Testicular varicocele occurs when the pampiniform plexus of veins becomes engorged with blood due to restriction of venous return through these vessels. This condition is more common on the left side because the left testicular vein drains into the left renal vein, and the left renal vein is subject to compression where it passes inferior to the superior mesenteric artery.

10. In the female cadaver, identify the ovarian vessels. Their origin from the aorta is comparable to that of the testicular vessels in the male. Note that the ovarian vessels cross anterior to the ureter.
11. Inferiorly, the ovarian vessels end in the pelvic cavity. Follow the ovarian vessels inferiorly until they cross the external iliac vessels. Do not follow them into the pelvis at this time.

Kidneys [G 167; L 243, 244; N 308; R 331]
The retroperitoneal position of the kidneys is well illustrated in a transverse section (FIG. 4.43). The kidneys...
are well protected by their position within the body as well as by a cushioning layer of fat.

1. Note that the kidneys lie against the posterior abdominal wall. The anterior surface of the kidneys face anterolaterally (FIG. 4.43).

2. Use your fingers to tear through the renal fascia and separate the kidney from the perirenal fat (FIG. 4.43).

3. Observe that the superior pole of the kidney is separated from the suprarenal gland by a thin layer of renal fascia. Carefully insert your fingers between the kidney and the suprarenal gland and separate the two organs. Be careful not to remove the suprarenal gland with the fat.

4. Note the size and shape of the kidney.

5. Identify the left renal vein. Use a probe to trace the left renal vein from the left kidney across the midline to the inferior vena cava. Observe that it lies anterior to both renal arteries and the aorta.

6. Identify and clean the tributaries of the left renal vein:
   - Left testicular (or ovarian) vein
   - Left suprarenal vein

7. Use scissors to cut the left renal vein close to the inferior vena cava. Reflect the left renal vein toward the left. Do not detach the testicular (or ovarian) vein or the left suprarenal vein from the left renal vein.

8. Identify the left renal artery, which lies posterior to the left renal vein. Follow the left renal artery to the hilum of the kidney. The renal artery usually divides into several segmental arteries before it enters the kidney. Accessory renal arteries are common.

9. Branches of the left renal artery include:
   - Inferior suprarenal artery – to the left suprarenal gland
   - Ureteric branch – to the left ureter

10. Using the left renal artery as a hinge, turn the left kidney toward the right. Observe the posterior surface of the left kidney and identify the renal pelvis and its inferior continuation, the ureter.

11. Use blunt dissection to follow the ureter inferiorly. Observe that the abdominal part of the ureter passes posterior to the testicular (or ovarian) vessels and crosses the anterior surface of the psoas major muscle. Before the gastrointestinal tract was removed, the left ureter passed posterior to the branches of the inferior mesenteric artery. The pelvic part of the ureter will be dissected with the pelvic viscera.

12. Return the left kidney to its correct anatomical position.

13. Clean the relatively short right renal vein. Note that it has no tributaries.

14. To expose the right renal artery, reflect the inferior vena cava inferiorly and slightly toward the right. Observe that the right renal artery is longer than the left renal artery. Identify the branches of the right renal artery:
   - Inferior suprarenal artery – to the right suprarenal gland
   - Ureteric branch

15. The right renal pelvis lies posterior to the right renal artery. Follow the right ureter inferiorly from the right renal pelvis and observe that the ureter passes posterior to the right testicular (ovarian) vessels.

16. Use an illustration to review the relationships of each kidney: [G 166; L 241; N 308; R 318; C 308, 311]

   - The suprarenal gland is superior to the kidney.
   - Through the peritoneum, the right kidney is in contact with the right colic flexure, the visceral surface of the liver, and the second part of the duodenum.
   - Through the peritoneum, the left kidney is in contact with the tail of the pancreas, the left colic flexure, the stomach, and the spleen.
   - The hilum of the kidney faces anteromedially and the lateral border faces posterolaterally.

17. Divide the left kidney into anterior and posterior halves by splitting it longitudinally along its lateral border. Open the two halves of the kidney like a book using the renal pelvis as the hinge.

18. Identify (FIG.4.44): [G 170; L 244; N 311; R 326; C 312]

   - Renal capsule – a fibrous capsule that is firmly attached to the surface of the kidney.
   - Renal cortex – the outer zone of the kidney (about one-third of its depth).
   - Renal medulla – the inner zone of the kidney (about two-thirds of its depth) consisting of:
     - Renal pyramids
     - Renal columns
   - Renal sinus – the space within the kidney that is occupied by the renal pelvis, calices, vessels, nerves, and fat.
   - Renal papilla – the apex of the renal pyramid that projects into a minor calyx.
   - Minor calyx – a cup-like chamber that is the beginning of the extrarenal duct system. Several minor calyces combine to form a major calyx.
CHAPTER 4: THE ABDOMEN

• Major calyx – two or three per kidney that combine to form the renal pelvis.
• Renal pelvis – the funnel-like end of the ureter that begins within the renal sinus and emerges from the renal hilum.
• Ureter – the muscular duct that carries urine from the kidney to the urinary bladder.

CLINICAL CORRELATION

KIDNEY STONES

Kidney stones (renal calculi) may form in the calyces and renal pelvis. Small kidney stones may spontaneously pass through the ureter into the bladder. Larger kidney stones may lodge at one of three natural constrictions of the ureter: (1) where the renal pelvis becomes constricted to form the ureter; (2) where the ureter crosses the pelvic brim; and (3) at the entrance of the ureter into the urinary bladder.

1. Palpate the suprarenal glands within the pararenal fat. Use a probe to carefully expose the borders of each gland.
2. Observe that the right suprarenal gland is triangular in shape. Part of the right suprarenal gland lies posterior to the inferior vena cava.
3. Observe that the left suprarenal gland is semilunar in shape.
4. Each suprarenal gland receives multiple arteries (FIG. 4.45). Identify:
   • Superior suprarenal arteries – arise from the inferior phrenic artery.
   • Middle suprarenal artery – arises from the aorta near the celiac trunk.
   • Inferior suprarenal artery – arises from the renal artery.
5. Note that the left suprarenal vein empties into the left renal vein. The right suprarenal vein drains directly into the inferior vena cava.
6. The suprarenal glands receive numerous sympathetic nerve fibers.
**SUPRARENAL GLANDS**

The kidneys and suprarenal glands have different embryonic origins. If the kidney fails to ascend to its normal position during development, the suprarenal gland develops in its normal position lateral to the celiac trunk.

**Abdominal Aorta and Inferior Vena Cava [G 178; L 246; N 308; R 333; C 317]**

1. Use an illustration to study the abdominal aorta. The abdominal aorta begins at vertebral level T12 as the continuation of the thoracic aorta. It ends by bifurcating at vertebral level L4 to form two common iliac arteries.

2. Observe that the abdominal aorta has three types of branches:
   - **Unpaired visceral arteries** – to the gastrointestinal tract (celiac trunk, superior mesenteric artery, inferior mesenteric artery).
   - **Paired visceral arteries** – to the three paired abdominal organs (middle suprarenal arteries, renal arteries, testicular or ovarian arteries).
   - **Paired somatic arteries** – to the abdominal wall (lumbar arteries, inferior phrenic arteries).

3. The unpaired visceral arteries and paired visceral arteries have been dissected previously.

4. Four pairs of **lumbar arteries** supply the posterior abdominal wall. Identify at least one lumbar artery in the right side where it crosses the lumbar vertebral body (FIG. 4.46). Note that the right lumbar arteries pass posterior to the inferior vena cava. On both sides, the lumbar arteries pass deep to the psoas major muscle.

5. Identify the **inferior phrenic arteries** on the inferior surface of the diaphragm. These arteries arise from the aorta near the aortic hiatus. Recall that these arteries give rise to superior suprarenal arteries.

6. Identify the **common iliac arteries**, which arise at the bifurcation of the aorta. The common iliac arteries supply blood to the pelvis and lower limbs.

7. Observe the **inferior vena cava** and its tributaries. Note the following:
   - The inferior vena cava begins at the L5 vertebral level by the joining of the two common iliac veins.

**Dissection Follow-up**

1. Replace the kidneys in their correct anatomical positions.

2. Use an illustration and the dissected specimen to review the relationships of each kidney to surrounding structures.

3. Trace the path taken by a drop of urine from the renal papilla through the ureter to the level of the pelvic brim.
4. Review the shape, position, relationships, arterial supply, and venous drainage of each suprarenal gland.
5. Review the branches of the abdominal aorta.
6. Review the tributaries of the inferior vena cava.

**POSTERIOR ABDOMINAL WALL**

**Dissection Overview**

The posterior abdominal wall is composed of the vertebral column, muscles that move the vertebral column, muscles that move the lower limbs, and the diaphragm. The nerves that supply the abdominal wall and the lumbar plexus of nerves that innervate the lower limb will be dissected with the posterior abdominal wall.

The order of dissection will be as follows: Muscles that form the posterior abdominal wall will be dissected. The branches of the lumbar plexus will be studied. The abdominal part of the sympathetic trunk will be studied.

**Dissection Instructions**

1. Move the kidney and suprarenal gland toward the midline (do not cut their vessels) and use your hands to remove the remaining fat and the renal fascia from the posterior abdominal wall.

2. Identify the *psoas major muscle* (FIG. 4.47). The proximal attachments of the psoas major muscle are the lumbar vertebrae (bodies, intervertebral discs, and transverse processes). Its distal attachment is the lesser trochanter of the femur. The psoas major muscle is a strong flexor of the thigh and vertebral column. [G 176; L 245; N 256; R 331; C 314]

3. Look for the *psoas minor muscle*. The psoas minor muscle is absent in approximately 40% of cases and may be present on only one side of the cadaver. The psoas minor muscle has a long flat tendon that passes down the anterior surface of the psoas major muscle. Its distal attachment is on the iliopubic eminence and arcuate line of the ilium.

4. Identify the *iliacus muscle* (FIG. 4.47). The proximal attachment of the iliacus muscle is the iliac fossa. Its distal attachment is on the lesser trochanter of the femur. The iliacus muscle flexes the thigh. The iliacus and psoas major muscles form a functional unit and together they are called the *iliopsoas muscle*.

5. Identify the *quadratus lumborum muscle* (FIG. 4.47). The proximal attachments of the quadratus lumborum muscle are the 12th rib and lumbar transverse processes. Its distal attachments are the iliolumbar ligament and iliac crest. The quadratus lumborum muscle flexes the vertebral column.
column laterally and anchors the inferior end of the rib cage during respiration.

6. Review the transversus abdominis muscle. The transversus abdominis muscle forms the lateral part of the posterior abdominal wall. The transversus abdominis muscle lies posterior to the quadratus lumborum muscle.

7. Use an illustration and the dissected specimen to study the relationships between the kidneys and the posterior abdominal wall (FIG. 4.46). Verify that the posterior surface of each kidney is related, through the renal fat and fascia, to the diaphragm, psoas major muscle, quadratus lumborum muscle, and transversus abdominis muscle. The superior pole of the right kidney is near the 12th rib. The superior pole of the left kidney is slightly higher, near the 11th rib.

**Lumbar Plexus** [G 176, 177; L 250; N 260; R 333; C 317]

The nerves of the posterior abdominal wall arise from the anterior rami of spinal nerves T12 to L4. The lumbar plexus (L1 to L4) is formed within the psoas major muscle, and its branches can be seen as they emerge from the lateral border of this muscle. The lumbar plexus can be seen only after removal of the psoas major muscle.

Dissect the lumbar plexus on the left side only. Because each branch of the lumbar plexus passes through the psoas major muscle at a different depth, it is necessary to follow each nerve proximally into the psoas major muscle. The nerves of the lumbar plexus are variable in their branching. Use the peripheral relationships of the nerves (their region of distribution or a point of exit from the abdominal cavity) for positive identification.

1. Identify the genitofemoral nerve. It is found on the anterior surface of the psoas major muscle (FIG. 4.47). The genitofemoral nerve divides into two branches on the anterior surface of the psoas major muscle superior to the inguinal ligament:
   - **Genital branch** – passes through the deep inguinal ring and down the inguinal canal. It is the motor nerve to the cremaster muscle.
   - **Femoral branch** – passes under the inguinal ligament on the anterior surface of the external iliac artery. It supplies a small area of skin inferior and medial to the inguinal ligament.

2. Use blunt dissection to remove the extraperitoneal fascia from the posterior abdominal wall lateral to the psoas major muscle. The branches of the lumbar plexus are in the extraperitoneal fascia and care must be taken to move the dissection instrument parallel to the course of the nerves (FIG. 4.47).

3. To find the subcostal nerve, palpate rib 12 and look for the subcostal nerve about 1 cm inferior to it.

4. Find the iliohypogastric and ilioinguinal nerves. They descend steeply across the anterior surface of the quadratus lumborum muscle. Frequently, these two nerves arise from a common trunk and do not separate until they reach the transversus abdominis muscle. To positively identify the ilioinguinal nerve, follow it to the superficial inguinal ring.

5. Identify the lateral cutaneous nerve of the thigh. The lateral cutaneous nerve of the thigh passes deep to the inguinal ligament near the anterior superior iliac spine. The lateral cutaneous nerve of the thigh supplies the skin on the lateral aspect of the thigh.

6. Identify the femoral nerve. The femoral nerve lies on the lateral side of the psoas major muscle in the groove between the psoas major and iliacus muscles. The femoral nerve innervates the iliacus muscle. The femoral nerve passes deep to the inguinal ligament and provides motor and sensory branches to the anterior thigh.

7. To find the obturator nerve, insert your finger into the extraperitoneal fascia on the medial side of the psoas major muscle and move your finger parallel to the muscle, creating a gap between the psoas major muscle and the common iliac vessels. The obturator nerve supplies motor and sensory innervation to the medial thigh.

8. Identify the lumbosacral trunk, which is deep to the obturator nerve. The lumbosacral trunk is a large nerve that is formed by half of the anterior ramus of L4 and all of the anterior ramus of L5. The lumbosacral trunk passes into the pelvis to join the sacral plexus.

**Abdominal Part of the Sympathetic Trunk** [G 180; L 251–253; N 260; R 334]

1. Study the location of the sympathetic trunk on a transverse section of the abdomen (FIG. 4.43). Note that the abdominal part of the sympathetic trunk lies on the lumbar vertebral bodies between the crus of the diaphragm and the psoas major muscle.

2. Identify lumbar splanchnic nerves that pass anteriorly from the lumbar sympathetic ganglia to the aortic autonomic nerve plexus.

3. Identify rami communicantes that pass posteriorly from the sympathetic ganglia to the lumbar anterior rami. Note that each ramus communicans passes deep to the psoas major muscle against the lateral surface of the vertebral body. The gray rami of the lower lumbar region are the longest in the
4. Observe the left crus (FIG. 4.48). The proximal attachments of the left crus of the diaphragm are the bodies of vertebrae L1 and L2.

5. Identify the arcuate ligaments. The arcuate ligaments are thickenings of fascia that serve as proximal attachments for some of the muscle fibers of the diaphragm.
   - **Lateral arcuate ligament** – bridges the anterior surface of the quadratus lumborum muscle.
   - **Medial arcuate ligament** – bridges the anterior surface of the psoas major muscle.
   - **Median arcuate ligament** – (unpaired) bridges the anterior surface of the aorta at the aortic hiatus.

6. There are three large openings in the diaphragm (FIG. 4.48). Identify:
   - **Vena caval foramen** – passes through the central tendon (vertebral level T8).
   - **Esophageal hiatus** – passes through the right crus (vertebral level T10).
   - **Aortic hiatus** – passes behind the diaphragm (vertebral level T12).

7. The right and left phrenic nerves innervate the diaphragm. Each phrenic nerve provides motor innervation to one-half of the diaphragm (one hemidiaphragm). The phrenic nerves supply most of the sensory innervation to the abdominal (parietal peritoneum) and thoracic (parietal pleura) surfaces of the diaphragm. The pleural and peritoneal coverings of the peripheral part of the diaphragm receive sensory fibers from the lower intercostal nerves (T5 to T11) and the subcostal nerve.

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**Dissection Follow-up**

1. Use the dissected specimen to review the proximal and distal attachments, as well as the action of each of the muscles of the posterior abdominal wall.
2. Review the three muscles that form the anterolateral abdominal wall (external oblique, internal oblique, and transversus abdominis).
3. Follow each branch of the lumbar plexus peripherally. Review the region of innervation of each of these nerves.
4. Use an atlas drawing to review the abdominal part of the sympathetic trunk, the lumbar splanchnic nerves, and rami communicantes (both gray and white).

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**DIAPHRAGM**

**Dissection Overview**

The diaphragm forms the roof of the abdominal cavity and the floor of the thoracic cavity. It is the principal muscle of respiration. The diaphragm has a right half and a left half (the hemidiaphragms).

The order of dissection will be as follows: The parts of the diaphragm will be identified. The phrenic nerve will be reviewed. The greater splanchnic nerves that pass through the diaphragm will be studied.

**Dissection Instructions**

1. Use blunt dissection to strip the parietal peritoneum and connective tissue off the abdominal surface of the diaphragm.
2. Identify the parts of the diaphragm (FIG. 4.48):
   - **Central tendon** – the aponeurotic center of the diaphragm, which is the distal attachment of all of its muscular parts.
   - **Sternal part** – two small bundles of muscle fibers that attach to the posterior surface of the xiphoid process.
   - **Costal part** – the muscle fibers that attach to the inferior six ribs and their costal cartilages.
   - **Lumbar part** – formed by two crura (right and left) and the muscle fibers that arise from the medial and lateral arcuate ligaments.
3. Identify the right crus (FIG. 4.48). The proximal attachments of the right crus of the diaphragm are the bodies of vertebrae L1 to L3. The esophageal hiatus is an opening in the right crus.
The phrenic nerves arise from cervical spinal cord segments C3 to C5. Therefore, pain from the diaphragm is referred to the shoulder region (suprachlavicular nerve territory).

The diaphragm is paralyzed in cases of high cervical spinal cord injuries but it is spared in low cervical spinal cord injuries. A paralyzed hemidiaphragm cannot contract (descend), so it will be positioned higher than normal in the thorax on a chest radiograph.

8. Identify the greater splanchnic nerve in the thorax and follow it to the superior surface of the diaphragm. [G 180; L 251–253; N 260; R 280, 281; C 317]

9. Push a probe through the diaphragm parallel to the greater splanchnic nerve. Note that the greater splanchnic nerve penetrates the crus to enter the abdominal cavity.

10. Observe that the main portion of the greater splanchnic nerve distributes to the celiac ganglion where its sympathetic axons will synapse.

11. Find the celiac ganglia. They are found on the left and right sides of the celiac trunk near its origin from the aorta. The celiac ganglia are the largest of the sympathetic ganglia that are located on the surface of the aorta.

12. Use an illustration or textbook description to review the autonomic nerve supply of the abdominal viscera.

Dissection Follow-up

1. Review the attachments of the diaphragm to the skeleton of the thoracic wall.
2. Trace the course of the thoracic aorta as it passes through the aortic hiatus to become the abdominal aorta.
3. Review the course of the esophagus and the vagus nerve trunks through the esophageal hiatus.
4. Recall the position of the heart on the superior surface of the diaphragm and review the course of the inferior vena cava.
5. Study an illustration and observe that the thoracic duct passes through the aortic hiatus and that the splanchnic nerves (greater, lesser, and least) penetrate the crura.
The Pelvis and Perineum

The pelvis is the area of transition between the trunk and the lower limbs. The bony pelvis serves as the foundation for the pelvic region and provides strong support for the vertebral column upon the lower limbs. The pelvic cavity is continuous with the abdominal cavity, the transition occurring at the plane of the pelvic inlet (FIG. 5.1). The pelvic cavity contains the rectum, the urinary bladder, and the internal genitalia. [G 200]

The perineum is the region of the trunk located between the thighs. The pelvic diaphragm separates the pelvic cavity from the perineum (FIG. 5.1). The perineum contains the anal canal, the urethra, and the external genitalia (penis and scrotum in the male, vulva in the female).

This chapter begins with the dissection of structures in the anal triangle that are common to both sexes. Dissection of internal and external genitalia is divided into two sections: one for male cadavers and one for female cadavers. Students are expected to learn the anatomy of the male and female pelvis and perineum. Each dissection team, therefore, should partner with another team that is dissecting a cadaver of the opposite sex.

SKELETON OF THE PELVIS

Refer to an articulated bony pelvis. The pelvis (L. pelvis, basin) is formed by two hip bones (os coxae) joined posteriorly by the sacrum (FIG. 5.2A). Each hip bone is formed by three fused bones: pubis, ischium, and ilium. The point of fusion of these three bones is the acetabulum. The coccyx is attached to the sacrum. [G 200; L 261; N 335; R 436; C 324]

On the hip bone, identify: [G 201; L 260; N 336; R 433; C 324]

- Iliac fossa
- Iliopubic eminence
- Arcuate line
- Pecten pubis
- Superior pubic ramus
- Pubic symphysis
- Pubic arch
- Ischiopubic ramus – formed by the ischial ramus and the inferior pubic ramus
- Obturator foramen
- Ischiatic tuberosity
- Ischial spine

On the sacrum, identify: [G 200; L 261; N 335; R 434; C 399]

- Sacral promontory
- Anterior sacral foramina

ATLAS REFERENCES:

G = Grant’s Atlas, 13th ed., page number
L = LWW Atlas of Anatomy, 1st ed., page number
N = Netter’s Atlas, 5th ed., plate number
R = Color Atlas of Anatomy, 7th ed., page number
C = Clemente’s Atlas, 6th ed., plate number


Identify the coccyx.

The hip bone and sacrum are connected by strong ligaments. On a model with pelvic ligaments, identify (FIG. 5.2A, B): [G 205; L 263; N 336; R 444; C 327, 329]

- Sacrotuberous ligament
- Sacrospinous ligament

- Greater sciatic foramen
- Lesser sciatic foramen

Note that the sacrotuberous ligament and sacrospinous ligament convert the greater and lesser sciatic notches into the greater and lesser sciatic foramina.

The sacroiliac articulation is a synovial joint between the auricular surfaces of the sacrum and the ilium. It is
strengthened by an anterior sacroiliac ligament and a posterior sacroiliac ligament (FIG. 5.2A, B). The articulation between the ilium and the L5 vertebra is strengthened by the iliolumbar ligament.

Identify the pubic arch. Note that the subpubic angle (angle of the pubic arch) is wider in females than in males. [G 202, 203; L 262; N 334; R 436; C 326, 327]

Identify the pelvic inlet (superior pelvic aperture). The bony rim of the pelvic inlet is called the pelvic brim. From anterior to posterior, identify the structures that form the pelvic brim: [G 203; L 261; N 335; R 435; C 326]

• Superior margin of the pubic symphysis
• Posterior border of the pubic crest
• Pecten pubis
• Arcuate line of the ilium
• Anterior border of the ala (wing) of the sacrum
• Sacral promontory

Identify the pelvic outlet. The pelvic outlet is bounded on each side by: [G 206; L 260, 263; N 336; R 444; C 328]

• Inferior margin of the pubic symphysis
• Ischiopubic ramus
• Ischial tuberosity
• Sacrotuberous ligament
• Tip of the coccyx

In the erect posture (anatomical position), the anterior superior iliac spines and the anterior aspect of the pubis are in the same vertical plane. In this position, the plane of the pelvic inlet forms an angle of approximately 55° to the horizontal. [G 201; L 262; N 336; R 439]

ANAL TRIANGLE

Dissection Overview

The perineum is a diamond-shaped area between the thighs that is divided for descriptive purposes into two triangles (FIG. 5.3). The anal triangle is the posterior part of the perineum and it contains the anal canal and anus. The urogenital triangle is the anterior part of the perineum and contains the urethra and the external genitalia. At the outset of dissection, it is important to understand that the pelvic diaphragm separates the pelvic cavity from the perineum (FIG. 5.1).

The order of dissection will be as follows: Dissection of the anal triangle will begin with removal of skin from the gluteal region and retraction of the gluteus maximus muscle. The nerves and vessels of the ischioanal fossa will be dissected. The fat will be removed from the ischioanal fossa to reveal the inferior surface of the pelvic diaphragm.

Dissection Instructions

Skin and Superficial Fascia Removal

1. If the lower limb has been dissected previously, reflect the gluteus maximus muscle laterally and move ahead to the dissection of the ischioanal fossa. If the lower limb has not been dissected, continue with step 2.
2. Place the cadaver in the prone position.
3. Refer to FIGURE 5.4.
4. Make an incision that follows the lateral border of the sacrum and the iliac crest from the tip of the coccyx.
Retract the gluteus maximus muscle superiorly to broaden the dissection field and expose the fat of the ischioanal fossa.

**Ischioanal Fossa**

The **ischioanal (ischiorectal) fossa** is a wedge-shaped area on either side of the anus. The apex of the wedge is directed superiorly and the base is beneath the skin. The ischioanal fossa is filled with fat that helps accommodate the fetus during childbirth or the distended anal canal during the passage of feces. The ischioanal fat is part of the superficial fascia of this region. The goal of this dissection is to remove the fat and identify the nerves and vessels that pass through the ischioanal fossa.

1. Lateral to the anus, insert closed scissors into the ischioanal fat to a depth of 3 cm. Open the scissors in the transverse direction to tear the fat (**FIG. 5.6**, initial cut).
2. Insert your finger into this opening and move it back and forth (medial to lateral) to enlarge the opening.
3. Palpate the **inferior rectal (anal) nerve** and vessels (**FIG. 5.6**). Preserve the branches of the inferior rectal nerve and vessels but use blunt dissection to remove the fat that surrounds them. Dry the area with paper towels if necessary.
9. Place gentle traction on the inferior rectal vessels and nerve and observe that a ridge is raised in the obturator internus fascia. Carefully cut the obturator fascia along this ridge to open the pudendal canal. The inferior rectal vessels and nerve exit the pudendal canal to enter the ischioanal fossa.

10. Use a probe to elevate the contents of the pudendal canal. The pudendal canal contains the pudendal nerve and the internal pudendal artery and vein.

Dissection Follow-up

1. Review the boundaries of the true pelvis and the concept that the pelvic diaphragm separates the pelvic cavity from the perineum.
2. In the dissected specimen, review the inferior surface of the pelvic diaphragm and understand that this is the “roof” of the perineum.
3. Use the dissected specimen to review the lateral and medial walls of the ischioanal fossa.
4. Review the external anal sphincter muscle and its blood and nerve supply. Understand that the external anal sphincter muscle is skeletal muscle under voluntary control.

MALE EXTERNAL GENITALIA AND PERINEUM

Dissection Overview

If you are dissecting a female cadaver, go to the section entitled “Female External Genitalia and Perineum” located on page 147.

In the embryo, the scrotum forms as an outpouching of the anterior abdominal wall, and most layers of the abdominal wall are represented in the scrotum (FIG. 5.7). The superficial fascia of the scrotum contains no fat. The superficial fascia is represented by dartos fascia, which contains smooth muscle fibers (dartos muscle).

The order of dissection will be as follows: The scrotum will be opened by a vertical cut along its anterior surface. The spermatic cord will be followed from the superficial inguinal ring into the scrotum. The testis will be removed from the scrotum. The spermatic cord will be dissected. The testis will be studied.

Dissection Instructions

Scrotum [G 116; L 282, 288; N 367; R 217, 220; C 236]

This dissection corresponds to the dissection of the labium majus in female cadavers. Partner with a dissection team that has a female cadaver for the dissection of...
The spermatic cord contains the ductus deferens, testicular vessels, lymphatics, and nerves. The contents of the spermatic cord are surrounded by three fascial layers, the **coverings of the spermatic cord**, that are derived from layers of the anterior abdominal wall (FIG. 5.7). These coverings are added to the spermatic cord as it passes through the inguinal canal.

1. Study an illustration of a transverse section through the spermatic cord (FIG. 5.8).
2. Palpate the **ductus deferens (vas deferens)** within the spermatic cord. It is hard and cord-like.
3. Use a probe to open the **coverings of the spermatic cord**. The three coverings are fixed to each other at the time of embalming and cannot be separated. The coverings of the spermatic cord are (FIGS. 5.7 and 5.8):
   - **External spermatic fascia** – derived from the external oblique muscle.
   - **Cremasteric muscle and fascia** – derived from the internal oblique muscle.
   - **Internal spermatic fascia** – derived from the transversalis fascia.
4. Use a probe to separate the ductus deferens from the **pampiniform plexus of veins**.
5. Observe the **artery of the ductus deferens**, a small vessel located on the surface of the ductus deferens (FIG. 5.8)
6. Follow the ductus deferens superiorly through the inguinal canal and toward the deep inguinal ring. Note that the ductus deferens passes through the deep inguinal ring lateral to the inferior epigastric vessels.
7. Use a probe to separate the **testicular artery** from the pampiniform plexus of veins. The testicular artery is a branch of the internal iliac artery. You are expected to observe and learn the anatomy for both sexes.

1. Inferior to the superficial inguinal ring, insert your finger deep to the subcutaneous tissue of the lower anterior abdominal wall and push your finger into the scrotum.
2. Use scissors to make a cut down the anterior surface of the scrotum through the skin, dartos, and superficial fascia.
3. Use your fingers to free the testis and spermatic cord from the scrotum.
4. Observe a band of tissue that anchors the inferior pole of the testis to the scrotum. This is the **scrotal ligament** (the remnant of the gubernaculum testis). (G 116; N 367; R 343; C 237)
5. Use scissors to cut the scrotal ligament. Use your fingers to remove the testis from the scrotum, but leave the testis attached to the spermatic cord.
6. Observe that the **scrotal septum** divides the scrotum into two compartments.
2. Use scissors to cut the parietal layer of the tunica vaginalis along its anterior surface and open it widely. Observe that the visceral layer of the tunica vaginalis covers the anterior, medial, and lateral surfaces of the testis, but not its posterior surface.

3. Use a probe to follow the ductus deferens inferiorly until it joins the epididymis. Identify the parts of the epididymis (FIG. 5.9):
   - **Head** – superior expanded part that receives the efferent ductules.
   - **Body** – middle part that is narrower in diameter than the head.
   - **Tail** – inferior part that turns superiorly to join the ductus deferens.

4. Use a scalpel to section the testis longitudinally from its superior pole to its inferior pole. Make the cut along its anterior surface. Use the epididymis as a hinge, and open the halves of the testis as you would open a book.

5. Note the thickness of the tunica albuginea, which is the fibrous capsule of the testis. Observe the septa that divide the interior of the testis into lobules (FIG. 5.9).

6. Use a needle or fine-tipped forceps to tease some of the seminiferous tubules out of one lobule.

### CLINICAL CORRELATION

#### LYMPHATIC DRAINAGE OF THE TESTIS

Lymphatics from the scrotum drain to the superficial inguinal lymph nodes. Inflammation of the scrotum may cause tender, enlarged superficial inguinal lymph nodes.

In contrast, lymphatics from the testis follow the testicular vessels through the inguinal canal and into the abdominal cavity where they drain into lumbar (lateral aortic) lymph nodes and preaortic lymph nodes. Testicular tumors may metastasize to lumbar and preaortic lymph nodes, not to superficial inguinal lymph nodes.

### Dissection Follow-up

1. Review the course of the ductus deferens from the abdominal wall to the testis.
2. Review the coverings of the spermatic cord and recall the layers of the abdominal wall from which they are derived.
3. Use an illustration to trace the route of spermatozoa from their origin in the seminiferous tubule to the ejaculatory duct.
4. Visit a dissection table with a female cadaver and complete the Dissection Follow-up that follows the dissection of the labium majus (page 147).
MALE UROGENITAL TRIANGLE

Dissection Overview
The order of dissection of the male urogenital triangle will be as follows: The skin will be removed from the urogenital triangle. The superficial perineal fascia will be removed and the contents of the superficial perineal pouch will be identified. The skin will be removed from the penis and its parts will be studied. The contents of the deep perineal pouch will be described, but not dissected.

Dissection Instructions

Skin Removal
Partner with a dissection team that has a female cadaver for the dissection of the urogenital triangle. Usually, only one student can work on the urogenital triangle at a time. The dissector should be positioned between the thighs with the cadaver pulled to the end of the dissection table.

1. Place the cadaver in the supine position. Stretch the thighs widely apart and brace them.
2. Make a skin incision that encircles the proximal end of the penis (FIG. 5.10, blue dashed line). The skin is very thin.
3. Make a midline skin incision posterior to the proximal end of the penis that splits the scrotum along the scrotal septum. Carry the cut posteriorly as far as the anus (FIG. 5.10, blue dashed line).
4. Make an incision in the midline superior to the penis. Stop where the skin of the abdomen was removed previously.

5. Reflect the skin flaps from medial to lateral. Detach the scrotum and skin flaps along the medial thigh (FIG. 5.10, red dashed lines) and place them in the tissue container.
6. If the cadaver has a large amount of fat in the superficial fascia of the medial thighs, remove a portion of the superficial fascia starting at the ischiopubic ramus and extending down the medial thigh about 7 cm. Stay superficial to the fascia lata (deep fascia of the thigh) when removing the superficial fascia.

Superficial Perineal Pouch [G 265, 261; L 284; N 361; R 350; C 365]
The superficial perineal fascia has a superficial fatty layer and a deep membranous layer. The superficial fatty layer is continuous with the superficial fatty layer of the lower abdominal wall, ischioanal fossa, and thigh. The membranous layer of the superficial perineal fascia (Colles’ fascia) is continuous with the membranous layer of the superficial fascia of the anterior abdominal wall (Scarpa’s fascia) and the dartos fascia of the penis and scrotum (FIG. 5.11A). The membranous layer of the superficial perineal fascia is attached to the ischiopubic ramus as far posteriorly as the ischial tuberosity and to the posterior edge of the perineal membrane. The membranous layer of the superficial perineal fascia forms the superficial boundary of the superficial perineal pouch (space).

Clinical Correlation

Superficial Perineal Pouch
If the urethra is injured in the perineum, urine may escape into the superficial perineal pouch. The urine may spread into the scrotum and penis, and upward into the lower abdominal wall between the membranous layer of the abdominal superficial fascia (Scarpa’s fascia) and the aponeurosis of the external oblique muscle (FIG. 5.11B). The urine does not enter the thigh because the membranous layer of the superficial fascia attaches to the fascia lata, ischiopubic ramus, and posterior edge of the perineal membrane.

1. The contents of the superficial perineal pouch in the male are the (FIG. 5.12A, B):
   - Three pairs of muscles (left and right)
   - Ischiocavernosus
   - Bulbospongiosus
   - Superficial transverse perineal
   - Crura of the penis (paired: left and right)
CHAPTER 5: THE PELVIS AND PERINEUM

Superficial abdominal fascia:
- Peritoneum
- Rectum
- Bladder
- External urethral sphincter
- Perineal membrane
  - Membranous layer of superficial perineal fascia (Colles’)
  - Membranous layer of superficial abdominal fascia
- Bloody extravasation
- Perforation of spongy urethra
- External oblique m.
  - Deep fascia of penis (Buck’s)
- Deep fascia of penis (Buck’s)
- Dartos fascia
- Fatty layer (Camper’s)
- Membranous layer (Scarpa’s)

**FIGURE 5.11** Fasciae of the perineum. A. The membranous layer of the superficial perineal fascia (Colles’ fascia) is continuous with the superficial fascia (dartos fascia) of the scrotum and the penis. It is also continuous with the membranous layer of superficial fascia of the lower abdominal wall (Scarpa’s fascia) and is attached to the posterior border of the perineal membrane. B. Following injury to the urethra in the perineum, extravasated urine is contained in the superficial perineal pouch and spreads into the lower abdominal wall.

- **Bulb of the penis** (unpaired)
- **Arteries, veins, and nerves** that supply the structures listed previously

2. Note that the superficial branch of the perineal a. and n. enter the urogenital triangle by passing lateral to the external anal sphincter muscle

3. It is not necessary to identify the membranous layer of the superficial perineal fascia to complete the dissection. Use a probe to dissect through the superficial perineal fascia in the midline.

4. Use blunt dissection to find the bulbospongiosus muscle in the midline of the urogenital triangle (FIG. 5.12A). The bulbospongiosus muscle covers the superficial surface of the bulb of the penis. The posterior attachments of the bulbospongiosus muscle are the bulbospongiosus muscle of the opposite side (in a midline raphe) and the perineal body. The anterior attachment of the bulbospongiosus muscle is the corpus cavernosum penis. The bulbospongiosus muscle compresses the bulb of the penis to expel urine or semen.

5. Lateral to the bulbospongiosus muscle, use a probe to clean the surface of the ischiocavernosus muscle (FIG. 5.12A). The ischiocavernosus muscle covers the superficial surface of the crus of the penis. The posterior attachment of the ischiocavernosus muscle is the ischial tuberosity and the ischiopubic ramus. The anterior attachment of the ischiocavernosus muscle is the crus of the penis. The ischiocavernosus muscle forces blood from the crus of the penis into the distal part of the corpus cavernosum penis.

6. Using blunt dissection, attempt to find the superficial transverse perineal muscle at the posterior border of the urogenital triangle (FIG. 5.12A). The superficial transverse perineal muscle may be delicate and difficult to find; limit the time spent looking for it. The lateral attachments of the superficial transverse perineal muscle are the ischial tuberosity and the ischiopubic ramus. The medial attachment of the superficial transverse perineal muscle is the perineal body. The perineal body is a fibromuscular mass located anterior to the anal canal and posterior to the perineal membrane that serves as an attachment for several muscles. The superficial transverse perineal muscle helps to support the perineal body.

7. Use a probe to dissect between the three muscles of the superficial perineal pouch until a small triangular opening is created (FIG. 5.12A). The membrane that becomes visible through this opening is the perineal membrane. The perineal membrane is the deep boundary of the superficial perineal pouch, and the bulb of the penis and crura are attached to it.

8. Use a scalpel to divide the bulbospongiosus muscles along their midline raphe. This is a thin muscle and care must be taken not to cut too deeply. On the left
side of the cadaver, remove the bulbospongiosus muscle.

9. Identify the bulb of the penis (FIG. 5.12B). The bulb of the penis is continuous with the corpus spongiosum penis and contains a portion of the spongy urethra.

10. On the left side of the cadaver, use blunt dissection to remove the ischiocavernosus muscle from the crus of the penis (FIG. 5.12B) (L. crus, a leg-like part; pl. crura). The crus of the penis attaches the corpus cavernosum penis to the ischiopubic ramus and perineal membrane.

Penis [G 269; L 288, 289; N 361, 362; R 337, 339; C 237, 367]

In the anatomical position, the penis is erect. The surface of the penis that is closest to the anterior abdominal wall is the dorsal surface of the penis.

Study a drawing of a transverse section of the penis (L. penis, tail) (FIG. 5.13). The superficial fascia of the penis (dartos fascia) has no fat, and contains the superficial dorsal vessels of the penis. The deep fascia of the penis (Buck’s fascia) is an investing fascia. Contained within the deep fascia of the penis are the:

- Corpus spongiosum penis
- Corpus cavernosum penis (paired)
- Deep dorsal vein of the penis (unpaired)
- Dorsal artery of the penis (paired)
- Dorsal nerve of the penis (paired)

1. Identify the parts of the penis:

- Root – the part of the penis that is attached to the ischiopubic ramus and perineal membrane (bulb and crura).
- Body (shaft) – the part of the penis that is pendant (corpora cavernosa and corpus spongiosum penis).
- Glans penis
- Corona of the glans
- Prepuce
- Frenulum
- External urethral orifice

FIGURE 5.12 Contents of the superficial perineal pouch in the male. A. Superficial dissection. Skin has been removed on left side of figure to reveal fatty layer of superficial perineal fascia. Skin, fatty layer of superficial perineal fascia, and the membranous layer of superficial perineal fascia (Colles’ fascia) have been removed on the right side of the figure to show the muscles, vessels, and nerves. B. Deep dissection. Bulbospongiosus and ischiocavernosus muscles, vessels, and nerves have been removed to show the erectile tissues.
Deep dorsal vein of the penis (unpaired) – in the midline. Most of the blood from the penis drains through the deep dorsal vein into the prostatic venous plexus.

Dorsal artery of the penis (paired) – one artery on each side of the deep dorsal vein. The dorsal artery of the penis is a terminal branch of the internal pudendal artery.

Dorsal nerve of the penis (paired) – one nerve on each side of the midline, lateral to the deep dorsal artery. The dorsal nerve of the penis is a branch of the pudendal nerve.

5. Use a probe to trace the vessels and nerves of the penis proximally. Use an atlas illustration to study the course of the pudendal nerve and the internal pudendal artery [G 271; L 286; N 363; R 352; C 358]. Observe that the dorsal artery and nerve of the penis course deep to the perineal membrane before they emerge onto the dorsum of the penis. The deep dorsal vein passes between the pubic arch and the anterior edge of the perineal membrane to enter the pelvis. Note that the deep dorsal vein does not accompany the deep dorsal artery and dorsal nerve proximal to the body of the penis. [G 268, 271; N 383, 390; R 340; C 351]

Spongy Urethra [G 272; L 266; N 365; R 338, 339; C 356]
The male urethra consists of three portions: prostatic urethra, membranous urethra, and spongy urethra (FIG. 5.15). The spongy urethra is the portion that is located within the corpus spongiosum penis. The next objective is to longitudinally cut the spongy urethra and examine its internal features.

1. Examine the external urethral orifice at the tip of the glans penis. Push a probe into the external urethral orifice, and then use a scalpel to cut down to the probe from both the dorsal and ventral surfaces of the penis. Cut in the median plane of the penis. (It may not be a straight line.)

2. Advance the probe proximally, and continue to divide the penis in this manner. Dorsal to the probe, the cut should pass between the corpora cavernosa and may split the deep dorsal vein longitudinally. Stop inferior to the pubic symphysis where the two corpora cavernosa separate. Ventral to the probe the cut should divide the corpus spongiosum into equal halves. Proximally, stop at the bulb of the penis.

3. In the bulb of the penis, the urethra bends at a sharp angle and passes through the perineal membrane (FIG. 5.15). Carefully complete the cut through the bulb posterior to the urethra but do not cut through the perineal membrane.
4. Note that the **glans penis** (L. glans, acorn) is the distal expansion of the corpus spongiosum and that it caps the two corpora cavernosa penis. The spongy urethra terminates by passing through the glans.

5. Examine the interior of the spongious urethra. Identify the **navicular fossa**, a widening of the urethra in the glans penis.

6. The openings of the ducts of the **bulbourethral glands** are in the proximal part of the spongious urethra, but may be too small to see.

7. On the left side of the penis, make a transverse cut through the body of the penis about midway down its length.

8. On the cut surface of the transverse section of the penis, study the relationship of the **corpus cavernosum penis** and **corpus spongiosum penis**. Identify (FIG. 5.13): [G 271; L 289; N 361; R 339; C 237]
   - Tunica albuginea of the corpus cavernosum penis
   - Tunica albuginea of the corpus spongiosum penis
   - Septum penis

9. Study the erectile tissue within the corpus spongiosum penis. Confirm that the corpus spongiosum penis surrounds the spongy urethra.

10. Study the erectile tissue within the corpus cavernosum penis (FIG. 5.13). Identify the **deep artery of the penis** near the center of the erectile tissue. Review the origin of the deep artery of the penis from the internal pudendal artery.

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**Deep Perineal Pouch**

The deep perineal pouch (space) will not be dissected. The deep perineal pouch lies superior (deep) to the perineal membrane (FIG. 5.15). Note the **contents of the deep perineal pouch in the male** (FIG. 5.16):

- Membranous urethra
- External urethral sphincter muscle
- Bulbourethral glands
- Branches of the internal pudendal artery and vein (most notably, the dorsal artery of the penis)
- Branches of the pudendal nerve (most notably, the dorsal nerve of the penis)
MALE PELVIC CAVITY

Dissection Overview

The male pelvic cavity contains the urinary bladder anteriorly, male internal genitalia, and the rectum posteriorly (FIG. 5.17). The order of dissection will be as follows: The peritoneum will be studied in the male pelvic cavity. The pelvis will be sectioned in the midline and the cut surface of the sectioned pelvis will be studied. The ductus deferens will be traced from the anterior abdominal wall to the region between the urinary bladder and rectum. The seminal vesicles and prostate gland will be studied.

Dissection Instructions

Peritoneum  [G 213, 219; L 265; N 346; R 337; C 353]

1. Using FIGURE 5.17 as a reference, examine the peritoneum in the male pelvis. Note that the peritoneum:

- Passes from the anterior abdominal wall superior to the pubis
- Covers the superior surface of the urinary bladder
- Passes inferiorly along the posterior surface of the urinary bladder
- Has a close relationship to the superior ends of the seminal vesicles
- Passes inferiorly between the urinary bladder and the rectum to form the rectovesical pouch
- Contacts the anterior surface and sides of the rectum
- Forms the sigmoid mesocolon beginning at the level of the third sacral vertebra

2. The paravesical fossa (paired) is a shallow depression in the peritoneal cavity on the lateral side of the urinary bladder.

3. The deep perineal pouch contains branches of the pudendal nerve and internal pudendal artery. These structures supply the external urethral sphincter muscle, the deep transverse perineal muscle, and the penis (FIG. 5.16).

4. Collectively, the muscles within the deep perineal pouch plus the perineal membrane are known as the urogenital diaphragm. This older anatomical nomenclature is still in clinical use.

Dissection Follow-up

1. Return the muscles of the urogenital triangle to their correct anatomical positions.
2. Review the contents of the male superficial perineal pouch. Visit a dissection table with a female cadaver and view the contents of the superficial perineal pouch.
3. Use an atlas illustration to review the course of the internal pudendal artery from its origin in the pelvis to the dorsum of the penis.
4. Use an atlas illustration to review the course and branches of the pudendal nerve.
5. Study an atlas illustration showing the course of the deep dorsal vein of the penis into the pelvis to join the prostatic venous plexus.
6. Draw a cross section of the penis showing the erectile bodies, superficial fascia, deep fascia, vessels, and nerves.
7. Review the parts of the male urethra.

1. Use an atlas illustration to study the following: [G 261; L 285; N 363; C 358]

- Membranous urethra – extends from the perineal membrane to the prostate gland (FIG. 5.15). This is the shortest (about 1 cm), thinnest, narrowest, and least distensible part of the urethra.
- External urethral sphincter (sphincter urethrae) muscle – a voluntary muscle that surrounds the membranous urethra (FIG. 5.16). When the external urethral sphincter muscle contracts, it compresses the membranous urethra and stops the flow of urine.
- Deep transverse perineal muscle (paired) – has a lateral attachment to the ischial tuberosity and the ischiopubic ramus and a medial attachment to the perineal body (FIG. 5.16). Its fiber direction and function are identical to those of the superficial transverse perineal muscle, which is a content of the superficial perineal pouch.

2. The bulbourethral gland (paired) is located in the deep perineal pouch but its duct passes through the perineal membrane and drains into the proximal portion of the spongy urethra in the superficial perineal space.

3. The deep perineal pouch contains branches of the pudendal nerve and internal pudendal artery. These structures supply the external urethral sphincter muscle, the deep transverse perineal muscle, and the penis (FIG. 5.16).

4. Collectively, the muscles within the deep perineal pouch plus the perineal membrane are known as the urogenital diaphragm. This older anatomical nomenclature is still in clinical use.

FIGURE 5.17 Peritoneum in the male pelvis. The numbered features of the peritoneum are explained in the text.
3. The **pararectal fossa** (paired) is a shallow depression in the peritoneal cavity on the lateral side of the rectum.

### CLINICAL CORRELATION

#### PELVIC PERITONEUM

As the urinary bladder fills, the peritoneal reflection from the anterior body wall to the urinary bladder (**FIG. 5.17**, item 2) is elevated above the level of the pubis. A filled urinary bladder can be penetrated by a needle inserted just superior to the pubis without entering the peritoneal cavity.

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#### Section of the Pelvis

The pelvis will be divided in the midline. First, the pelvic viscera and the soft tissues of the perineum will be cut in the midline with a scalpel. The pubic symphysis and vertebral column (up to vertebral level L3) will be cut in the midline with a saw. Subsequently, the right side of the body will be transected at vertebral level L3. The left lower limb and left side of the pelvis will remain attached to the trunk.

Both halves of the pelvis will be used to dissect the pelvic viscera, pelvic vasculature, and nerves of the pelvis. One-half of the pelvis will be used to demonstrate the muscles of the pelvic diaphragm.

1. Begin this dissection with a new scalpel blade.
2. In the pelvic cavity make a midline cut, beginning posterior to the pubic symphysis. Carry this midline cut through the superior surface of the urinary bladder. Open the bladder and sponge the interior, if necessary.
3. Identify the internal urethral orifice in the bladder insert a probe into it. Use the probe as a guide and continue the midline cut inferior to the urinary bladder, dividing the urethra. Divide the prostate gland.
4. Extend the midline cut in the posterior direction. Cut through the anterior and posterior walls of the rectum and the distal part of the sigmoid colon. Sponge them clean.
5. In the perineum, insert the scalpel blade inferior to the pubic symphysis with the cutting edge directed posteriorly. Make a cut in the midline from the pubic symphysis to the coccyx passing through the perineal membrane, perineal body, and anal canal. Cut between the halves of the bulb of the penis (sectioned earlier).

6. Use a saw to make two cuts in the midline:
   - Pubic symphysis – With the cadaver in the supine position, cut through the pubic symphysis from anterior to posterior. Do not allow the saw to pass into the scalpel incision.
   - Sacrum – Turn the cadaver to the prone position. Cut through the sacrum from posterior to anterior. Do not allow the saw to pass between the soft tissue structures that were cut with the scalpel. Spread the opening and extend the midline cut as far superiorly as the body of the third lumbar vertebra.

7. Return the cadaver to the supine position. To mobilize the right lower limb, use a scalpel to cut the right common iliac vein, right common iliac artery, and right testicular vessels. Cut the right ureter and the branches of the right lumbar plexus.

8. In the transverse plane, use the scalpel to cut the right psoas major and quadratus lumborum muscles at vertebral level L3. Use the saw to cut horizontally through the right half of the intervertebral disc between L3 and L4. Now, the right lower limb can be removed.

9. Clean the rectum and anal canal.

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**Male Internal Genitalia**  
*G 213; L 270; N 346; R 337; C 355*

1. Study the cut surface of the sectioned specimen (**FIG. 5.18**).
2. Identify the **perineal membrane**. It is located deep to the bulb of the penis and can be identified as a thin line at the deep edge of the bulb (**FIG. 5.18**). Superior (deep) to the perineal membrane, the **external urethral sphincter muscle** surrounds the **membranous urethra**. The external urethral sphincter muscle may be difficult to see in the sectioned specimen.
3. On the sectioned pelvis, identify the three parts of the urethra: **prostatic urethra**, **membranous urethra**, and **spongy urethra** (**FIG. 5.16**).
4. Examine the **interior of the prostatic urethra**. The prostatic urethra is about 3 cm in length and is the part that passes through the prostate. On the posterior wall of the prostatic urethra, identify (**FIG. 5.19**):  
   - **Urethral crest** – a longitudinal ridge.
   - **Seminal colliculus** – an enlargement of the urethral crest.
   - **Prostatic sinus** – the groove on either side of the seminal colliculus.
   - **Prostatic utricle** – a small opening on the midline of the seminal colliculus.
   - **Opening of the ejaculatory duct** – one on either side of the prostatic utricle.
5. Near the inner surface of the anterior abdominal wall, find the ductus deferens where it enters the deep inguinal ring lateral to the inferior epigastric vessels (FIG. 5.18). Use a probe to break through the peritoneum near the deep inguinal ring. Use blunt dissection to peel the peritoneum off the lateral wall of the pelvic cavity. Strip the peritoneum from lateral to medial, stopping where it comes in contact with the rectum and urinary bladder. Detach the peritoneum and place it in the tissue container.

FIGURE 5.18 Sagittal section of the male pelvis.

FIGURE 5.19 Urinary bladder and proximal portion of the male urethra seen in frontal section.
6. Use blunt dissection to trace the ductus deferens from the deep inguinal ring toward the midline. Observe that the ductus deferens passes superior and then medial to the branches of the internal iliac artery. Note that the ductus deferens crosses superior to the ureter. [G 220; L 270; N 347; R 336; C 351]

7. Trace the ductus deferens into the rectovesical septum, which is the endopelvic fascia between the rectum and the urinary bladder (FIG. 5.18). Observe that the ductus deferens is in contact with the fundus (posterior surface) of the urinary bladder.

8. Identify the ampulla of the ductus deferens, which is the enlarged portion just before its termination (FIG. 5.20). [G 224; L 270; N 364; R 339; C 354]

9. Identify the seminal vesicle (FIG. 5.20). The seminal vesicle is located lateral to the ampulla of the ductus deferens in the rectovesical septum. Use blunt dissection to release the seminal vesicle from the rectovesical septum.

10. Close to the prostate, the duct of the seminal vesicle joins the ductus deferens to form the ejaculatory duct. The ejaculatory duct is delicate and easily torn when it enters the prostate. The ejaculatory duct empties into the prostatic urethra on the seminal colliculus.

11. Observe the prostate (FIG. 5.18). The apex of the prostate is directed inferiorly and the base of the prostate is located superiorly against the neck of the urinary bladder. Use an atlas illustration to study the lobes of the prostate.

Dissection Follow-up

1. Review the position of the male pelvic viscera within the lesser pelvis. Visit a dissection table with a female cadaver and observe the position of the female pelvic viscera.

2. Review the peritoneum in the male pelvic cavity. Visit a dissection table with a female cadaver and compare differences in the male and female peritoneum (FIGS. 5.17 and 5.32).

3. Follow the ductus deferens from the epididymis to the ejaculatory duct, recalling its relationships to vessels, nerves, the ureter, and the seminal vesicle.

4. Visit a dissection table with a female cadaver and follow the round ligament of the uterus from the labium majus to the uterus.

5. Compare the pelvic course of the ductus deferens with the pelvic course of the round ligament of the uterus.

URINARY BLADDER, RECTUM, AND ANAL CANAL

Dissection Overview

The urinary bladder is a reservoir for urine. When empty, it is located within the pelvic cavity. When filled, it extends into the abdominal cavity. The urinary bladder is a subperitoneal organ that is surrounded by endopelvic fascia. Between the pubic symphysis and the urinary bladder, there is a potential space called the retropubic space (prevesical space) (FIG. 5.17). The retropubic space is filled with fat and loose connective tissue that accommodates the expansion of the urinary bladder. The puboprostatic ligament is a condensation of fascia that ties the prostate to the inner surface of the pubis (FIG. 5.17). The puboprostatic ligament
defines the inferior limit of the retropubic space. The lower one-third of the rectum is surrounded by endopelvic fascia. The middle and upper thirds of the rectum are partially covered by peritoneum (FIG. 5.17).

The order of dissection will be as follows: The parts of the urinary bladder will be studied. The interior of the urinary bladder will be studied. The interior of the rectum and anal canal will be studied.

Dissection Instructions

Urinary Bladder [G 225; L 266, 267; N 350; R 337; C 355]

1. Identify the parts of the urinary bladder (FIG. 5.21):
   - Apex – the pointed part directed toward the anterior abdominal wall. The apex of the urinary bladder can be identified by the attachment of the urachus.
   - Body – between the apex and fundus.
   - Fundus – the inferior part of the posterior wall, also called the base of the urinary bladder. In the male the fundus is related to the ductus deferens, seminal vesicles, and rectum.
   - Neck – where the urethra exits the urinary bladder. In the neck of the urinary bladder, the wall thickens to form the internal urethral sphincter, which is an involuntary muscle.

2. Identify the four surfaces of the urinary bladder (FIG. 5.21):
   - Superior – covered by peritoneum.
   - Posterior – covered by peritoneum on its superior part and by the endopelvic fascia of the rectovesical septum on its inferior part.
   - Inferolateral (paired) – covered by endopelvic fascia.

3. Examine the wall of the urinary bladder and note its thickness. The wall of the urinary bladder consists of bundles of smooth muscle called the detrusor muscle (L. detrudere, to thrust out).

4. Identify the trigone on the inner surface of the fundus (FIG. 5.19). The angles of the trigone are the internal urethral orifice and the two orifices of the ureters. The internal urethral orifice is located at the most inferior point in the urinary bladder. The interureteric crest is a ridge that extends across the trigone between the orifices of the ureters. [G 225; L 267; N 350; R 338; C 354]

5. Observe that the mucous membrane over the trigone is smooth. The mucous membrane lining the other parts of the urinary bladder lies in folds when the bladder is empty but will accommodate expansion.

6. Insert the tip of a probe into the orifice of the ureter and observe that the ureter passes through the muscular wall of the urinary bladder in an oblique direction. When the urinary bladder is full (distended), the pressure of the accumulated urine flattens the part of the ureter that is within the wall of the bladder and prevents reflux of urine into the ureter.

7. Find the ureter where it crosses the external iliac artery or the bifurcation of the common iliac artery. Use blunt dissection to follow the ureter to the fundus of the urinary bladder.

Rectum and Anal Canal [G 213, 215; L 272, 273; N 346, 373; R 336; C 355, 359]

1. The rectum begins at the level of the third sacral vertebra. Observe the sectioned pelvis and note that the rectum follows the curvature of the sacrum (FIG. 5.18).

2. Identify the ampulla of the rectum (FIGS. 5.18 and 5.22). At the ampulla, the rectum bends approximately 80° posteriorly (anorectal flexure) and is continuous with the anal canal. Observe that the prostate and seminal vesicles are located close to the anterior wall of the rectum (FIG. 5.18).

KIDNEY STONES

Kidney stones pass through the ureter to the urinary bladder and they may become lodged in the ureter. The point where the ureter passes through the wall of the urinary bladder is a relatively narrow passage. If a kidney stone becomes lodged, severe colicky pain results. The pain stops suddenly once the stone passes into the bladder.
6. The anal sphincter muscles surround the anal canal. Identify the external anal sphincter muscle and the internal anal sphincter muscle in the sectioned specimen (FIGS. 5.18 and 5.22). The longitudinal muscle of the anal canal separates the two sphincter muscles. If you have difficulty identifying them, use a new scalpel blade to cut another section through the wall of the anal canal to improve the clarity of the dissection.

**CLINICAL CORRELATION**

**HEMORRHOIDS**

In the anal columns, the superior rectal veins of the hepatic portal system anastomose with middle and inferior rectal veins of the inferior vena caval system. An abnormal increase in blood pressure in the hepatic portal system causes engorgement of the veins contained in the anal columns, resulting in internal hemorrhoids. Internal hemorrhoids are covered by mucous membrane and are relatively insensitive to painful stimuli because the mucous membrane is innervated by autonomic nerves.

External hemorrhoids are enlargements of the tributaries of the inferior rectal veins. External hemorrhoids are covered by skin and are very sensitive to painful stimuli because they are innervated by somatic nerves (inferior rectal nerves).

**RECTAL EXAMINATION**

Digital rectal examination is part of the physical examination. The size and consistency of the prostate gland can be assessed by palpation through the anterior wall of the rectum.

3. Examine the inner surface of the rectum. Note that the mucous membrane is smooth except for the presence of transverse rectal folds (FIG. 5.18). There is usually one transverse rectal fold on the right side and two on the left side. The transverse rectal folds may be difficult to identify in some cadavers.

4. Observe that the anal canal is only 2.5 to 3.5 cm in length (FIG. 5.22). The anal canal passes out of the pelvic cavity and enters the anal triangle of the perineum.

5. Examine the inner surface of the anal canal (FIG. 5.22). The mucosal features of the anal canal may be difficult to identify in older individuals, but attempt to identify the following:

- **Anal columns** – 5 to 10 longitudinal ridges of mucosa in the proximal part of the anal canal. The anal columns contain branches of the superior rectal artery and vein.
- **Anal valves** – semilunar folds of mucosa that unite the distal ends of the anal columns. Between the anal valve and the wall of the anal canal is a small pocket called an anal sinus.
- **Pectinate line** – the irregular line formed by all of the anal valves.

**Dissection Follow-up**

1. Use the dissected specimen to review the features of the urinary bladder, rectum, and anal canal.
2. Review the relationships of the seminal vesicles, ampulla of the ductus deferens, and ureters to the rectum and fundus of the urinary bladder.
3. Visit a dissection table with a female cadaver and review the relationships of the uterus, vagina, and ureters to the rectum and fundus of the urinary bladder.
4. Review the kidney, the abdominal course of the ureter, the pelvic course of the ureter, and the function of the urinary bladder as a storage organ.
5. Review the parts of the female urethra. Visit a dissection table with a female cadaver and review the female urethra.
6. Review all parts of the large intestine and recall its function in absorption of water and in compaction and elimination of fecal material.
7. Recall that the external anal sphincter muscle is composed of skeletal muscle and is under voluntary control, whereas the internal anal sphincter muscle is composed of smooth muscle and is involuntary.
INTERNAL ILIAC ARTERY AND SACRAL PLEXUS

Dissection Overview

Anterior to the sacroiliac articulation, the common iliac artery divides to form the external and internal iliac arteries (FIG. 5.23). The external iliac artery distributes to the lower limb and the internal iliac artery distributes to the pelvis. The internal iliac artery has the most variable branching pattern of any artery, and it is worth noting at the outset of this dissection that you must use the distribution of the branches to identify them, not their pattern of branching.

The internal iliac artery commonly divides into an anterior division and a posterior division. Branches arising from the anterior division are mainly visceral (branches to the urinary bladder, internal genitalia, external genitalia, rectum, and gluteal region). Parietal branches arise from the posterior division (branches to the pelvic walls and gluteal region).

The order of dissection will be as follows: The branches of the anterior division of the internal iliac artery will be identified. The branches of the posterior division of the internal iliac artery will be identified. The nerves of the sacral plexus will be dissected. Subsequently, the pelvic portion of the sympathetic trunk will be dissected.

Dissection Instructions

Blood Vessels [G 228; L 274; N 382, 383; R 347]

1. The internal iliac vein is typically plexiform. To clear the dissection field, remove all tributaries to the internal iliac vein.

2. Identify the common iliac artery and follow it distally until it bifurcates.

3. Identify the internal iliac artery. Use blunt dissection to follow the internal iliac artery into the pelvis.

4. Identify the branches of the anterior division of the internal iliac artery (FIG. 5.23):

   - **Umbilical artery** – in the medial umbilical fold, find the medial umbilical ligament (the remnant of the umbilical artery) and use blunt dissection to trace it posteriorly to the umbilical artery. Note that several superior vesical arteries arise from the inferior surface of the umbilical artery and descend to the superolateral part of the urinary bladder.

   - **Obturator artery** – passes into the obturator canal. Find the obturator artery where it enters the obturator canal in the lateral wall of the pelvis and follow the artery posteriorly to its origin. In about 20% of cases, an aberrant obturator artery (a branch of the external iliac artery) crosses the pelvic brim and is at risk of injury during surgical repair of a femoral hernia.

   - **Inferior vesical artery** – courses toward the fundus of the urinary bladder to supply the bladder, seminal vesicle, and prostate. The inferior vesical artery is a named branch only in the male; in the female it is an unnamed branch of the vaginal artery.

   - **Middle rectal artery** – courses medially toward the rectum. It often arises in common with the inferior vesical artery, making positive identification difficult. Identify the middle rectal artery
by tracing it to the rectum. The middle rectal artery, like the inferior vesical artery, sends branches to the seminal vesicle and prostate.

- **Internal pudendal artery** — exits the pelvic cavity by passing through the greater sciatic foramen inferior to the piriformis muscle. The internal pudendal artery often arises from a common trunk with the inferior gluteal artery.
- **Inferior gluteal artery** — usually passes out of the pelvic cavity between ventral rami S2 and S3, but it may pass between ventral rami S1 and S2. The inferior gluteal artery exits the pelvis by passing through the greater sciatic foramen inferior to the piriformis muscle. The inferior gluteal artery may share a common trunk with the internal pudendal artery, or less commonly, with the superior gluteal artery.

5. Identify the branches of the posterior division of the internal iliac artery (FIG. 5.23):

- **Iliolumbar artery** — passes posteriorly, then ascends between the lumbosacral trunk and the obturator nerve. It may arise from a common trunk with the lateral sacral artery.
- **Lateral sacral artery** — gives rise to a superior branch and an inferior branch. Observe that the inferior branch passes anterior to the sacral ventral rami.
- **Superior gluteal artery** — usually exits the pelvic cavity by passing between the lumbosacral trunk and the ventral ramus of S1.

6. Use an atlas illustration to study the **prostatic venous plexus**, **vesical venous plexus**, and **rectal venous plexus**. All of these plexuses drain into the internal iliac vein.

7. On the dissected specimen, observe the **deep dorsal vein of the penis** just inferior to the pubic symphysis. Verify that the deep dorsal vein of the penis empties into the prostatic venous plexus.

**Nerves** [G 211, 234; L 275, 276; N 390, 487; R 471; C 362]

The somatic plexuses of the pelvic cavity are the **sacral plexus** and the **coccygeal plexus**. These plexuses are located between the pelvic viscera and the lateral pelvic wall within the endopelvic fascia. These somatic nerve plexuses are formed by contributions from anterior rami of spinal nerves L4 to S4.

The primary visceral nerve plexus of the pelvic cavity is the **inferior hypogastric plexus** (also called the **pelvic plexus**). It is formed by contributions from the hypogastric nerves, sacral splanchnic nerves (sympathetic), and pelvic splanchnic nerves (parasympathetic).

1. Use your fingers to free the rectum from the anterior surface of the sacrum and coccyx.
2. Retract the rectum medially and identify the **sacral plexus** of nerves. The sacral plexus is closely related to the anterior surface of the piriformis muscle. Verify the following (FIG. 5.24):

- The **lumbosacral trunk** (anterior rami of L4 and L5) joins the sacral plexus.

**FIGURE 5.24** Sacral plexus of nerves in the male.
• The anterior rami of S2 and S3 emerge between the proximal attachments of the piriformis muscle.

• The sciatic nerve is formed by the anterior rami of spinal nerves L4 through S3. The sciatic nerve exits the pelvis by passing through the greater sciatic foramen, usually inferior to the piriformis muscle.

• The superior gluteal artery usually passes between the lumbosacral trunk and the anterior ramus of spinal nerve S1, and exits the pelvis by passing superior to the piriformis muscle.

• The inferior gluteal artery usually passes between the anterior rami of spinal nerves S2 and S3 but it may pass between anterior rami S1 and S2. The inferior gluteal artery exits the pelvis by passing inferior to the piriformis muscle.

• The pudendal nerve is formed by contributions from the anterior rami of spinal nerves S2, S3, and S4. The pudendal nerve exits the pelvis by passing inferior to the piriformis muscle.

3. Identify the pelvic splanchnic nerves (nervi erigentes). Pelvic splanchnic nerves are branches of the anterior rami of spinal nerves S2, S3, and S4 (FIG. 5.24). Pelvic splanchnic nerves carry presynaptic parasympathetic axons for the innervation of pelvic organs and the distal gastrointestinal tract (from the left colic flexure through the anal canal). [G 211; L 276; N 390; R 349; C 362]

4. The sacral portion of the sympathetic trunk is located on the anterior surface of the sacrum, medial to the ventral sacral foramina. Identify the following:

• Sympathetic trunk – continues from the abdominal region into the pelvis. The sympathetic trunks of the two sides join in the midline near the level of the coccyx to form the ganglion impar.

• Gray rami communicantes – connect the sympathetic ganglia to the sacral anterior rami. Each gray ramus communicans carries postsynaptic sympathetic fibers to an anterior ramus for distribution to the lower extremity and perineum.

• Sacral splanchnic nerves – arise from two or three of the sacral sympathetic ganglia and pass directly to the inferior hypogastric plexus. Sacral splanchnic nerves carry sympathetic fibers that distribute to the pelvic viscera.

• The anterior rami of S2 and S3 emerge between the proximal attachments of the piriformis muscle.

• The sciatic nerve is formed by the anterior rami of spinal nerves L4 through S3. The sciatic nerve exits the pelvis by passing through the greater sciatic foramen, usually inferior to the piriformis muscle.

• The superior gluteal artery usually passes between the lumbosacral trunk and the anterior ramus of spinal nerve S1, and exits the pelvis by passing superior to the piriformis muscle.

• The inferior gluteal artery usually passes between the anterior rami of spinal nerves S2 and S3 but it may pass between anterior rami S1 and S2. The inferior gluteal artery exits the pelvis by passing inferior to the piriformis muscle.

• The pudendal nerve is formed by contributions from the anterior rami of spinal nerves S2, S3, and S4. The pudendal nerve exits the pelvis by passing inferior to the piriformis muscle.

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CLINICAL CORRELATION

PELVIC NERVE PLEXUSES

The inferior hypogastric plexus is located in the endopelvic fascia lateral to the rectum, bladder, seminal vesicles, and prostate. This autonomic nerve plexus could be injured during pelvic surgery, causing loss of bladder control and erectile dysfunction.

Dissection Follow-up

1. Review the abdominal aorta and its terminal branches.

2. Use the dissected specimen to review the branches of the internal iliac artery. Review the region supplied by each branch.

3. Visit a dissection table with a female cadaver and review the arteries that are unique to the female: uterine artery and vaginal artery. Note their relationship to the ureter.

4. Review the formation of the sacral plexus and the branches that were dissected in the pelvis.

5. Use the dissected specimen and an atlas illustration to review the course of the pudendal nerve from the pelvic cavity to the urogenital triangle.

PELVIC DIAPHRAGM

Dissection Overview

The pelvic diaphragm is the muscular floor of the pelvic cavity. The pelvic diaphragm is formed by the levator ani muscle and coccygeus muscle plus the fasciae covering their superior and inferior surfaces (FIG. 5.25A, B). The pelvic diaphragm extends from the pubic symphysis to the coccyx. Laterally, the pelvic diaphragm is attached to the fascia covering the obturator internus muscle. The urethra and anal canal pass through midline openings in the pelvic diaphragm called the urogenital hiatus and anal hiatus, respectively.

Dissection Instructions

1. Perform the dissection of the pelvic diaphragm on one side of the cadaver. Save the side with the best dissection of arteries and nerves for review. [G 206–208; L 278–279; N 340, 341; C 358]

2. Retract the rectum, urinary bladder, prostate, and seminal vesicles medially.

3. Use blunt dissection to remove any remaining fat and connective tissue from the superior surface of the pelvic diaphragm.
4. To find the tendinous arch of the levator ani muscle (FIG. 5.25A), palpate the medial surface of the ischial spine and then locate the obturator canal. The tendinous arch lies just inferior to a line connecting these two structures. Note that the tendinous arch is the superior edge of the levator ani muscle.

5. Identify the three muscles that form the levator ani muscle. The muscles are identified by their anterior attachments. Learn, but do not dissect, their posterior attachments. Identify the following:

- **Puborectalis muscle** – its anterior attachment is the body of the pubis. Its posterior attachment is the puborectalis muscle of the opposite side (in a midline raphe). The puborectalis muscle forms the margin of the urogenital hiatus (FIG. 5.25B). The two puborectalis muscles form a “puborectal sling,” which causes the anorectal flexure at the ampulla of the rectum (FIG. 5.22). During defecation, the puborectalis muscles relax, the anorectal flexure straightens, and the elimination of fecal matter is facilitated.

- **Pubococcygeus muscle** – its anterior attachment is the body of the pubis. Its posterior attachment is the coccyx and the anococcygeal raphe.

- **Iliococcygeus muscle** – its anterior attachment is the tendinous arch. Its posterior attachment is the coccyx and the anococcygeal raphe.

6. The levator ani muscle supports the pelvic viscera and resists increases in intra-abdominal pressure.

7. Identify the coccygeus muscle. The coccygeus muscle completes the pelvic diaphragm posteriorly. The anterior attachment of the coccygeus muscle is the ischial spine and its posterior attachment is the lateral border of the coccyx and the lowest part of the sacrum (FIG. 5.25A).

8. Place the fingers of one hand in the ischioanal fossa and the fingers of the other hand on the superior surface of the pelvic diaphragm. Palpate the pelvic diaphragm and appreciate its thinness.

9. Observe that the obturator internus muscle forms the lateral wall of the ischioanal fossa. The medial attachment of the obturator internus muscle is the margin of the obturator foramen and inner surface of the obturator membrane. The lateral attachment of the obturator internus muscle will be studied when the glutal region is dissected. Superior to the tendinous arch of the levator ani muscle, the obturator internus muscle forms the lateral wall of the pelvic cavity. Inferior to the tendinous arch, the obturator internus muscle forms the lateral wall of the perineum.

10. Use your textbook to learn the general pattern of lymphatic drainage of the pelvis and the location of each of the following groups of lymph nodes: [G 217, 232, 234; L 291; N 388]

- **Internal iliac nodes**
- **External iliac nodes**
- **Common iliac nodes**
- **Sacral nodes**
- **Lumbar nodes**

**Dissection Follow-up**

1. Use the dissected specimen to review the proximal attachment and action of each muscle of the pelvic diaphragm.

2. Review the relationship of the branches of the internal iliac artery to the pelvic diaphragm.

3. Review the relationship of the sacral plexus to the pelvic diaphragm.

4. Use an atlas illustration to review the role played by the pelvic diaphragm in forming the boundary between the pelvic cavity and the perineum. Review the function of the pelvic diaphragm and perineal body in supporting the pelvic and abdominal viscera.

5. Use an atlas illustration to review the lymphatic drainage from the pelvis and perineum. Realize that structures in the perineum (including the scrotum and the lower part of the anal canal) drain into superficial inguinal lymph nodes. The lymphatic drainage of the testis follows the testicular vessels to the lumbar chain of nodes, bypassing the perineal and pelvic drainage systems.

6. Review the formation of the thoracic duct to complete your understanding of the lymph drainage from this region.

7. Visit a dissection table with a female cadaver and perform a complete review of the dissected female pelvis.

**FEMALE EXTERNAL GENITALIA AND PERINEUM**

**Labium Majus**

**Dissection Overview**

In the female, the round ligament of the uterus passes through the superficial inguinal ring and descends into the fat that forms the labium majus. The layers of the scrotum that are identified in the male are not found in the labium majus.

The order of dissection will be as follows: The anterior surface of the labium majus will be opened by a vertical incision. The round ligament of the uterus will be followed from the superficial inguinal ring for a short distance into the superior part of the labium majus.
Review the adult structures that are formed from the gubernaculum in both sexes.

3. Visit a dissection table with a male cadaver and complete the Dissection Follow-up that follows the dissection of the spermatic cord and testis (page 131).

**FEMALE UROGENITAL TRIANGLE**

**Dissection Overview**

The order of dissection of the female urogenital triangle will be as follows: The external genitalia will be examined. The skin will be removed from the labia majora. The superficial perineal fascia will be removed and the contents of the superficial perineal pouch will be identified. The contents of the deep perineal pouch will be described, but not dissected.

**CLINICAL CORRELATION**

**LYMPHATIC DRAINAGE OF THE LABIUM MAJUS**

Lymphatics from the labium majus drain to the superficial inguinal lymph nodes. Inflammation of the labium majus may cause tender, enlarged superficial inguinal lymph nodes.

**Dissection Follow-up**

1. Review the course of the round ligament from the abdominal wall to the labium majus.
2. Review the embryology of the ovary and testis and compare the role of the gubernaculum in each case.

**Dissection Instructions**

Partner with a dissection team that has a male cadaver for the dissection of the urogenital triangle. Usually, only one student can work on the urogenital triangle at a time. The dissector should be positioned between the thighs with the cadaver pulled to the end of the dissection table.

1. Place the cadaver in the supine position. Stretch the thighs widely apart and brace them.
2. Examine the **vulva** (female external genitalia) *(FIG. 5.26)*. Identify the following structures:

   - Mons pubis
   - Anterior labial commissure

![Female external genitalia](image)
of the superficial fascia that corresponds to the skin that was removed.

Superficial Perineal Pouch and Clitoris [G 257, 273–276; L 283, 284; N 357, 358; R 363, 364; C 347, 348]
The superficial perineal fascia has a superficial fatty layer and a deep membranous layer. In the female, the superficial fatty layer provides the shape of the labium majus and is continuous with the fat of the lower abdominal wall, ischioan fossa, and thigh. The membranous layer of the superficial perineal fascia (Colles’ fascia) is attached to the ischiopubic ramus as far posteriorly as the ischial tuberosity and to the posterior edge of the perineal membrane (FIG. 5.28). The membranous layer of the superficial perineal fascia forms the superficial boundary of the superficial perineal pouch (space).

1. The contents of the superficial perineal pouch in the female are (FIG. 5.29):
   - Three pairs of muscles (left and right)
   - Ischiocavernosus
   - Bulbospongiosus
   - Superficial transverse perineal
   - Crura of the clitoris (paired)
   - Bulbs of the vestibule (paired)
   - Greater vestibular glands (paired)
   - Arteries, veins, and nerves, that supply the structures listed previously

2. Note that the posterior labial nerve and vessels enter the urogenital triangle by passing lateral to the external anal sphincter muscle (FIG. 5.30). The posterior labial nerve and vessels supply the posterior part of the labium majus and are superficial contents of the urogenital triangle. Look for them before continuing to step 3.

3. It is not necessary to identify the membranous layer of the superficial perineal fascia to complete the dissection. Use a probe to dissect through the superficial perineal fascia about 2 cm lateral to the labium minus. Remove the fat that forms the labium majus and place it in the tissue container.

4. Identify the bulbospongiosus muscle, which is lateral to the labium minus (FIG. 5.29). The bulbospongiosus muscle covers the superficial surface of the bulb of the vestibule. The posterior attachment of the bulbospongiosus muscle is the perineal body. The anterior attachment of the bulbospongiosus muscle is the corpus cavernosum clitoris. The bulbospongiosus muscle in the female does not join the bulbospongiosus muscle of the opposite side across the midline as it does in the male.
5. Lateral to the bulbospongious muscle, use blunt dissection to clean the surface of the ischiocavernosus muscle (FIG. 5.29). The ischiocavernous muscle covers the superficial surface of the crus of the clitoris. The posterior attachments of the ischiocavernous muscle are the ischial tuberosity and the ischiopubic ramus. The anterior attachment of the ischiocavernous muscle is the crus of the clitoris. The ischiocavernous muscle forces blood from the crus of the clitoris into the distal part of the corpus cavernosum clitoris.

6. The superficial transverse perineal muscle is difficult to find. Using blunt dissection, attempt to find the superficial transverse perineal muscle at the posterior border of the urogenital triangle (FIG. 5.29). Limit the time spent looking for it. The lateral attachment of the superficial transverse perineal muscle is the ischial tuberosity and the ischiopubic ramus. The medial attachment of the superficial transverse perineal muscle is the perineal body. The perineal body is a fibromuscular mass located between the anal canal and the posterior edge of the perineal membrane that serves as an attachment for several muscles. The superficial transverse perineal muscle helps to support the perineal body.

7. To find the perineal membrane, use a probe to dissect between the three muscles of the superficial
Deep Perineal Pouch

The deep perineal pouch (space) will not be dissected. The deep perineal pouch lies superior (deep) to the perineal membrane (FIG. 5.28). Note the contents of the deep perineal pouch in the female (FIG. 5.31):

- Urethra
- Part of the vagina
- External urethral sphincter muscle
- Branches of the internal pudendal artery and vein (most notably, the dorsal artery of the clitoris)

FIGURE 5.31 Contents of the deep perineal pouch in the female.

perineal pouch until a small triangular opening is created (FIG. 5.29). The perineal membrane is the deep boundary of the superficial perineal pouch, and the bulb of the vestibule and crura are attached to it.

8. On the left side of the cadaver, use blunt dissection to remove the bulbospongiosus muscle and identify the bulb of the vestibule (FIG. 5.30). The bulb of the vestibule is an elongated mass of erectile tissue that lies lateral to the vaginal orifice. Note that the greater vestibular gland is found in the superficial perineal pouch immediately posterior to the bulb of the vestibule.

9. Anteriorly, the bulbs of the two sides are joined at the commissure of the bulbs and the commissure is continuous with the glans of the clitoris. Do not attempt to find the commissure of the bulbs.

10. On the left side of the cadaver, use blunt dissection to remove the ischiocavernous muscle from the crus of the clitoris (L. crus, a leg-like part; pl. crura) (FIG. 5.30). The crus of the clitoris attaches the corpus cavernosum clitoris to the ischiopubic ramus and perineal membrane.

11. Use an atlas illustration to study the erectile bodies of the clitoris. [276; L 284; N 358; R 362] Note the following:
   - Two corpora cavernosa form the body of the clitoris.
   - The glans clitoris caps the two corpora cavernosa.
• **Branches of the pudendal nerve** (most notably, the dorsal nerve of the clitoris)

1. Use an atlas illustration to study the following: [G 258; L 285; N 358; R 366; C 345]

• **Urethra** – extends from the internal urethral orifice in the urinary bladder to the external urethral orifice in the vestibule of the vagina (about 4 cm).

• **External urethral sphincter (sphincter urethrae) muscle** – a voluntary muscle that surrounds the urethra. When the external urethral sphincter muscle contracts, it compresses the urethra and stops the flow of urine.

• **Deep transverse perineal muscle** (paired) – has a lateral attachment to the ischial tuberosity and the ischiopubic ramus and a medial attachment to the perineal body. Its fiber direction and function are identical to those of the superficial transverse perineal muscle (which is a content of the superficial perineal pouch).

2. Other contents of the deep perineal pouch include **branches of the internal pudendal artery** and **branches of the pudendal nerve** that supply the external urethral sphincter muscle, the deep transverse perineal muscle, and the clitoris (FIG. 5.30).

3. Collectively, the muscles within the deep perineal pouch plus the perineal membrane are known as the **urogenital diaphragm**. This older anatomical nomenclature is still in clinical use.

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**DISSECTION FOLLOW-UP**

1. Replace the muscles of the urogenital triangle in their correct anatomical positions.
2. Review the contents of the female superficial perineal pouch. Visit a dissection table with a male cadaver and view the contents of the superficial perineal pouch.
3. Use an atlas illustration to review the course of the internal pudendal artery from its origin in the pelvis.
4. Use an atlas illustration to review the course and branches of the pudendal nerve.
5. Review an atlas illustration that shows the female urethra and note its course from the urinary bladder to the perineum.

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**FEMALE PELVIC CAVITY**

**Dissection Overview**

The female pelvic cavity contains the urinary bladder anteriorly, the female internal genitalia, and the rectum posteriorly (FIG. 5.32). The term **adnexa** (L. adnexa, adjacent parts) refers to the ovaries, uterine tubes, and ligaments of the uterus. Removal of the uterus (hysterectomy), with or without the ovaries, is a common surgical procedure. If the uterus has been surgically removed from your cadaver, examine it in other cadavers.

The order of dissection will be as follows: The peritoneum will be studied in the female pelvic cavity. The pelvis will be sectioned in the midline and the cut surface of the sectioned pelvis will be studied. The uterus and vagina will be studied. The uterine tube will be traced from the uterus to the ovary. The ovary will be studied.

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**CLINICAL CORRELATION**

**OBSTETRIC CONSIDERATIONS**

To alleviate the pain of childbirth, a **pudendal nerve block** is performed by injecting a local anesthetic around the pudendal nerve near the ischial spine. To perform the injection, the ischial spine is palpated through the vagina, and the needle is directed through the skin toward the ischial spine.

As the head of the baby passes through the vagina during childbirth, the anus and the levator ani muscle are forced posteriorly toward the sacrum and coccyx. The urethra is forced anteriorly toward the pubic symphysis. Perineal lacerations during childbirth are common, and it may be necessary to surgically widen the vaginal orifice (episiotomy). If the perineal body is lacerated, it must be repaired to prevent weakness of the pelvic floor, which could result in prolapse of the urinary bladder, uterus, or rectum.

**FIGURE 5.32** Peritoneum in the female pelvis. The numbered features of the peritoneum are explained in the text.
Dissection Instructions

**Peritoneum** [G 236, 237; L 265; N 342; R 354; C 342]

1. Using **FIGURE 5.32** as a reference, examine the peritoneum in the female pelvis. Note that the peritoneum:

   1. Passes from the anterior abdominal wall superior to the pubis
   2. Covers the superior surface of the urinary bladder
   3. Passes from the superior surface of the urinary bladder to the uterus where it forms the **vesicouterine pouch**
   4. Covers the fundus and body of the uterus and contacts the wall of the posterior part of the vaginal fornix
   5. Forms the **rectouterine pouch** between the uterus and the rectum
   6. Covers the anterior surface and sides of the rectum
   7. Forms the sigmoid mesocolon beginning at the level of the third sacral vertebra

2. The **paravesical fossa** (paired) is a shallow depression in the peritoneal cavity on the lateral side of the urinary bladder.

3. The **pararectal fossa** (paired) is a shallow depression in the peritoneal cavity on the lateral side of the rectum.

**Clinical Correlation**

**PELVIC PERITONEUM**

As the urinary bladder fills, the peritoneal reflection from the anterior abdominal wall to the bladder (**FIG. 5.32**, item 2) is elevated above the level of the pubis. A filled urinary bladder can be penetrated by a needle inserted superior to the pubis without entering the peritoneal cavity.

4. Identify the **broad ligament of the uterus**. The broad ligament of the uterus is formed by two layers of peritoneum that extend from the lateral side of the uterus to the lateral pelvic wall. The **uterine tube** is contained within the superior margin of the broad ligament. The broad ligament has three parts (**FIG. 5.33**): [G 240; L 269; N 352; R 357; C 334]

   - **Mesosalpinx** (Gr. salpinx, tube) – supports the uterine tube.
   - **Mesovarium** – attaches the ovary to the posterior aspect of the broad ligament.
   - **Mesometrium** – the part of the broad ligament that is below the attachment of the mesovarium.

**FIGURE 5.33** Parts of the broad ligament of the uterus. Peritoneum has been removed from the inner surface of the abdominal wall on the right side of the illustration.
5. The tissue enclosed between the two layers of the broad ligament is called parametrium (Gr. para, beside; metra, womb, uterus).

6. Identify the round ligament of the uterus, which is visible through the anterior layer of the broad ligament (FIG. 5.33). Observe that the round ligament of the uterus passes over the pelvic brim and exits the abdominal cavity by passing through the deep inguinal ring, lateral to the inferior epigastric vessels. The round ligament of the uterus passes through the inguinal canal and ends in the labium majus.

7. Identify the ovarian ligament, which is a fibrous cord within the broad ligament that connects the ovary to the uterus.

8. Identify the suspensory ligament of the ovary, which is a peritoneal fold that covers the ovarian vessels. The suspensory ligament of the ovary extends into the greater pelvis from the superior aspect of the ovary.

9. The endopelvic fascia (extraperitoneal fascia) contains condensations of connective tissue that passively support the uterus. Study an atlas illustration and note the following: [G 255; L 270; N 345; C 355]

- Uterosacral (sacrogenital) ligament – extends from the cervix to the sacrum. The uterosacral ligament underlies the uterosacral fold.
- Transverse cervical ligament (cardinal ligament) – extends from the cervix to the lateral wall of the pelvis.
- Pubocervical (pubovesical) ligament – extends from the pubis to the cervix.

Section of the Pelvis

The pelvis will be divided in the midline. First, the pelvic viscera and the soft tissues of the perineum will be cut in the midline with a scalpel. Use a scalpel to divide the uterus in its median plane. Extend the cut through the cervix and into the fornix of the vagina.

1. Begin this dissection with a new scalpel blade.
2. Use your hand to position the uterus in the midline. Use a scalpel to divide the uterus in its median plane. Extend the cut through the cervix and into the fornix of the vagina.
3. Beginning posterior to the pubic symphysis, make a midline cut through the superior surface of the urinary bladder. Open the bladder and sponge the interior, if necessary.

4. Identify the internal urethral orifice in the bladder and insert a probe into it. Using the probe as a guide, cut through the inferior part of the bladder, dividing the urethra.

5. Extend the midline cut in the posterior direction. Cut through the anterior and posterior walls of the rectum and the distal part of sigmoid colon. Sponge them clean.

6. In the perineum, insert the tip of a probe into the external urethral orifice. Use the probe as a guide to make a midline cut through the clitoris, dividing it into right and left sides. Extend this cut posteriorly, dividing the urethra and vagina into right and left sides.

7. In the midline, cut through the perineal membrane, perineal body, and anal canal. Extend the cut to the tip of the coccyx.

8. Use a saw to make two cuts in the midline:

- Pubic symphysis – With the cadaver in the supine position, cut through the pubic symphysis from anterior to posterior. Do not allow the saw to pass into the scalpel incision.
- Sacrum – Turn the cadaver to the prone position. Cut through the sacrum from posterior to anterior. Do not allow the saw to pass between the soft tissue structures that were cut with the scalpel. Spread the opening and extend the midline cut as far superiorly as the body of the third lumbar vertebra.

9. Return the cadaver to the supine position. To mobilize the right lower limb, use a scalpel to cut the right common iliac vein, right common iliac artery, and right ovarian vessels. Cut the right ureter and the branches of the right lumbar plexus.

10. In the transverse plane, use the scalpel to cut the psoas major muscle and quadratus lumborum muscles at vertebral level L3. Use the saw to cut horizontally through the right half of the intervertebral disc between L3 and L4. Now, the right lower limb can be removed.

11. Clean the rectum and anal canal.

Female Internal Genitalia [G 236; L 268, 269; N 342, 348; R 354; C 342]

1. Study the cut surface of the sectioned specimen (FIG. 5.34).
2. Trace the sectioned urethra anteroinferiorly from the urinary bladder to the external urethral orifice. Attempt to identify the external urethral sphincter muscle that surrounds the urethra. The external urethral sphincter muscle may be difficult to see.
3. In the sectioned specimen, observe the vagina (FIG. 5.34). Observe that the anterior vaginal wall is
CHAPTER 5: THE PELVIS AND PERINEUM

shorter than the posterior vaginal wall. Identify the **vaginal fornix** and explore its four parts (FIGS. 5.34 and 5.35):

- **Anterior part**
- **Lateral part** (paired: right and left)
- **Posterior part**

4. Observe that the posterior wall of the vagina (near the posterior part of the vaginal fornix) is in contact with the peritoneum that lines the rectouterine pouch.

5. Study the **uterus** (FIGS. 5.34 and 5.35). Observe that the uterus is tilted approximately 90° anterior to the axis of the vagina (anteverted). The position of
the uterus changes as the bladder fills, and during pregnancy. [G 241, 287; L 270; N 355; R 356, 357; C 332, 334]

6. Identify the following features of the uterus (FIG. 5.35):

- **Fundus** – the rounded part of the body that lies superior to the attachments of the uterine tubes.
- **Body** – the part of the uterus between the fundus and the cervix. The **vesical surface** of the body of the uterus faces the vesicouterine pouch and the **intestinal surface** faces the rectouterine pouch. Note that the broad ligament is attached to the lateral surface of the body of the uterus.
- **Isthmus** – the narrowed portion of the body that is superior to the cervix.
- **Cervix** – the thick-walled portion of the uterus that protrudes into the vaginal canal.

7. Identify the **uterine cavity**. In a coronal section, it is triangular (FIG. 5.35). In a sagittal section, it is a slit (FIG. 5.34).

8. Note that the uterine mucosa is called **endometrium**. The thick muscular wall of the uterus is called myometrium. The peritoneal covering on the surface of the uterus is called perimetrium (Gr. peri, around). The tissues within the broad ligament are called parametrium (Gr. para, beyond).

9. Identify the **uterine tube** (FIG. 5.35). Use your fingers to follow the uterine tube as it passes laterally within the mesosalpinx. Observe:

- **Isthmus** – the narrow, medial one-third of the uterine tube.
- **Ampulla** – the widest and longest part of the uterine tube.
- **Infundibulum** – the funnel-like end of the uterine tube.
- **Fimbriae** – multiple processes that surround the distal margin of the infundibulum.

10. Observe the **ovary**. The ovary is ovoid, with a **tubal (distal) extremity** and a **uterine (proximal) extremity**. The ovarian vessels enter the tubal extremity of the ovary, and the ligament of the ovary is attached to the uterine extremity.

11. The ovary sits in the **ovarian fossa**. The ovarian fossa is a shallow depression in the lateral pelvic wall bounded by the ureter, external iliac vein, and uterine tube.

12. Review the abdominal origin and course of the ovarian vessels. Note that they pass through the **suspensory ligament of the ovary** (FIG. 5.35).

**Dissection Follow-up**

1. Review the position of the female pelvic viscera within the pelvic cavity. Visit a dissection table with a male cadaver and observe the position of the male pelvic viscera.

2. Review the peritoneum in the female pelvic cavity. Visit a dissection table with a male cadaver and compare differences in the female and male peritoneum (FIGS. 5.17 and 5.34).

3. Trace the round ligament of the uterus from the superficial inguinal ring to the uterus.

4. Visit a table with a male cadaver and trace the ductus deferens from the epididymis to the ejaculatory duct, noting its relationships to vessels, nerves, the ureter, and the seminal vesicle.

5. Compare the pelvic course of the ductus deferens with the pelvic course of the round ligament of the uterus.

6. Review the parts of the broad ligament and review the function of the endopelvic fascia in passive support of the uterus.

**URINARY BLADDER, RECTUM, AND ANAL CANAL**

**Dissection Overview**

The urinary bladder is a reservoir for urine. When empty, it is located within the pelvic cavity. When filled, it extends into the abdominal cavity. The urinary bladder is a retroperitoneal organ that is surrounded by **endopelvic fascia**. Between the pubic symphysis and the urinary bladder, there is a potential space called the **retropubic space** (prevesical space) (FIG. 5.32). The retropubic space is filled with fat and loose connective tissue that accommodates the expansion of the urinary bladder. The **pubovesical ligament** is a condensation of fascia that ties the neck of the urinary bladder to the pubis across the retropubic space. The pubovesical ligament defines the inferior limit of the retropubic space (FIG. 5.32). The lower one-third of the rectum is surrounded by endopelvic fascia. The middle and upper thirds of the rectum are partially covered by peritoneum (FIG. 5.32).

The order of dissection will be as follows: The parts of the urinary bladder will be studied. The interior of the urinary bladder will be studied. The interior of the rectum and anal canal will be studied.

**Dissection Instructions**

**Urinary Bladder** [L 266, 267; N 350]

1. Identify the **parts of the urinary bladder** (FIG. 5.36):

   - **Apex** – the pointed part directed toward the anterior abdominal wall. The apex of the urinary
2. Identify the four surfaces of the urinary bladder (FIG. 5.36):
   - **Superior** – covered by peritoneum.
   - **Posterior** – covered by peritoneum on its superior part and by the endopelvic fascia on its inferior part.
   - **Inferolateral** (paired) – covered by endopelvic fascia.

3. Examine the wall of the urinary bladder and note its thickness. The wall of the urinary bladder consists of bundles of smooth muscle called the **detrusor muscle** (L. detruere, to thrust out).

4. Identify the **trigone** on the inner surface of the fundus (FIG. 5.37). The angles of the trigone are the internal urethral orifice and the two orifices of the ureters. The internal urethral orifice is located at the most inferior point in the urinary bladder. The interureteric crest is a ridge that extends across the trigone between the orifices of the ureters. **[L 267; N 350; R 338]**

5. Observe that the mucous membrane over the trigone is smooth. The mucous membrane lining the other parts of the urinary bladder lies in folds when the bladder is empty but will accommodate expansion.

6. Insert the tip of a probe into the orifice of the ureter and observe that the ureter passes through the wall of the urinary bladder in an oblique direction.
7. Find the ureter where it crosses the external iliac artery or the bifurcation of the common iliac artery. Use a probe to follow the ureter to the fundus of the urinary bladder. Observe that the ureter crosses inferior to the uterine artery and superior to the vaginal artery. [G 238; L 268; N 380; R 330]

Rectum and Anal Canal [G 215, 236; L 272; N 342, 373; R 354; C 342, 359]

1. Recall that the rectum begins at the level of the third sacral vertebra. Observe the sectioned pelvis and note that the rectum follows the curvature of the sacrum (FIG. 5.34).

2. Identify the ampulla of the rectum (FIGS. 5.34 and 5.38). At the ampulla, the rectum bends approximately 80° posteriorly (anorectal flexure) and is continuous with the anal canal.

3. Examine the inner surface of the rectum. Note that the mucous membrane is smooth except for the presence of transverse rectal folds (FIG. 5.34). There is usually one transverse rectal fold on the right side and two on the left side. The transverse rectal folds may be difficult to identify in some cadavers.

4. Observe that the anal canal is only 2.5 to 3.5 cm in length (FIG. 5.38). The anal canal passes out of the pelvic cavity and enters the anal triangle of the perineum.

5. Examine the inner surface of the anal canal (FIG. 5.38). Note that the mucosal features of the anal canal may be difficult to identify in older individuals, but attempt to identify the following:

   - **Anal columns** — 5 to 10 longitudinal ridges of mucosa in the proximal part of the anal canal. The anal columns contain branches of the superior rectal artery and vein.
   - **Anal valves** — semilunar folds of mucosa that unite the distal ends of the anal columns. External to each anal valve is a small pocket called an anal sinus.
   - **Pectinate line** — the irregular line formed by all of the anal valves.

**KLINICAL CORRELATION**

**KIDNEY STONES**

Kidney stones pass through the ureter to the urinary bladder and they may become lodged in the ureter. The point where the ureter passes through the wall of the urinary bladder is a relatively narrow passage. If a kidney stone becomes lodged, severe colicky pain results. The pain stops suddenly once the stone passes into the bladder.

6. The anal sphincter muscles surround the anal canal. Identify the external anal sphincter muscle and the internal anal sphincter muscle in the sectioned specimen (FIGS. 5.34 and 5.38). The longitudinal muscle of the anal canal separates the two sphincter muscles. If you have difficulty identifying them, use a new scalpel blade to cut another section through the wall of the anal canal to improve the clarity of the dissection.

**HEMORRHOIDS**

In the anal columns, the superior rectal veins of the hepatic portal system anastomose with middle and inferior rectal veins of the inferior ven a caval system. An abnormal increase in blood pressure in the hepatic portal system causes engorgement of the veins contained in the anal columns, resulting in internal hemorrhoids. Internal hemorrhoids are covered by mucous membrane, which is innervated by autonomic nerve fibers. They may not experience pain or the pain may be poorly localized. **External hemorrhoids** are enlargements of the tributaries of the inferior rectal veins. External hemorrhoids are covered by skin which is innervated by somatic nerves (inferior rectal nerves). External hemmorrhoids experience highly specific, somatic pain.
CHAPTER 5: THE PELVIS AND PERINEUM

The internal iliac artery commonly divides into an anterior division and a posterior division. Branches arising from the anterior division are mainly visceral (branches to the urinary bladder, internal genitalia, external genitalia, rectum, and gluteal region). Parietal branches arise from the posterior division (branches to the pelvic walls and gluteal region).

The order of dissection will be as follows: The branches of the anterior division of the internal iliac artery will be identified. The branches of the posterior division of the internal iliac artery will be identified. The nerves of the sacral plexus will be dissected. Finally, the pelvic portion of the sympathetic trunk will be dissected.

**Dissection Follow-up**

1. Use the dissected specimen to review the features of the urinary bladder, rectum, and anal canal.
2. Review the relationships of the uterus, vagina, and ureters to the rectum and fundus of the urinary bladder.
3. Visit a dissection table with a male cadaver and review the relationships of the seminal vesicles, ampulla of the ductus deferens, and ureters to the rectum and fundus of the urinary bladder.
4. Review the kidney, the abdominal course of the ureter, the pelvic course of the ureter, and the function of the urinary bladder as a storage organ.
5. Review all parts of the large intestine and recall its function in absorption of water and in compaction and elimination of fecal material.
6. Recall that the external anal sphincter muscle is composed of skeletal muscle and is under voluntary control, whereas the internal anal sphincter muscle is composed of smooth muscle and is involuntary.

**INTERNAL IliAC ARTERY AND SACRAL PLEXUS**

**Dissection Overview**

Anterior to the sacroiliac articulation, the common iliac artery divides to form the external and internal iliac arteries (FIG. 5.39). The external iliac artery distributes to the lower limb and the internal iliac artery distributes to the pelvis. The internal iliac artery has the most variable branching pattern of any artery, and it is worth noting at the outset of this dissection that you must use the distribution of the branches to identify them, not their pattern of branching.

**Dissection Instructions**

**Blood Vessels** [G 246; L 274; N 380, 382]

1. The internal iliac vein is typically plexiform. To clear the dissection field, remove all tributaries to the internal iliac vein.
2. Identify the common iliac artery and follow it distally until it bifurcates.
3. Identify the internal iliac artery. Use blunt dissection to follow the internal iliac artery into the pelvis.
4. Identify the branches of the anterior division of the internal iliac artery (FIG. 5.39):

   - Umbilical artery – in the medial umbilical fold, find the medial umbilical ligament (the remnant of the umbilical artery) and use blunt dissection to trace it posteriorly to the umbilical artery. Note that several superior vesical arteries arise from the inferior surface of the umbilical artery and descend to the superolateral aspect of the urinary bladder.

**FIGURE 5.39** Branches of the internal iliac artery in the female.
160

GRANT’S DISSECTOR

- **Obturator artery** — passes into the obturator canal. Find the obturator artery where it enters the obturator canal in the lateral wall of the pelvis, and follow the artery posteriorly to its origin. In about 20% of cases, an aberrant obturator artery (a branch of the external iliac artery) crosses the pelvic brim and is at risk of injury during surgical repair of a femoral hernia.

- **Uterine artery** — courses along the inferior attachment of the broad ligament. Use blunt dissection to trace it to the lateral aspect of the uterus and note that it passes superior to the ureter. The uterine artery divides into a large superior branch to the body and fundus of the uterus and a smaller branch to the cervix and vagina. Observe the close relationship of the lateral part of the vaginal fornix to the uterine artery. In a living person, the pulsations of the uterine artery may be felt through the lateral part of the vaginal fornix.

**CLINICAL CORRELATION**

**UTERINE ARTERY**

The close proximity of the ureter and the uterine artery near the lateral fornix of the vagina is of clinical importance. During hysterectomy, the uterine artery is tied off and cut. The ureter may be unintentionally clamped, tied off, and cut where it crosses the uterine artery. This would have serious consequences for the corresponding kidney. To recall this relationship, use the mnemonic device “water under the bridge.” The “water” is urine; the “bridge” is the uterine artery.

- **Vaginal artery** — passes across the floor of the pelvis, inferior to the ureter. The vaginal artery supplies the vagina and the urinary bladder. Note that the ureter passes between the vaginal artery and the uterine artery.

- **Middle rectal artery** — courses medially toward the rectum. To confirm the identity of the middle rectal artery, follow it to the rectum.

- **Internal pudendal artery** — exits the pelvic cavity by passing through the greater sciatic foramen inferior to the piriformis muscle. The internal pudendal artery often arises from a common trunk with the inferior gluteal artery.

- **Inferior gluteal artery** — usually passes out of the pelvic cavity between ventral rami S2 and S3 but it may pass between ventral rami S1 and S2. The inferior gluteal artery exits the pelvis by passing through the greater sciatic foramen inferior to the piriformis muscle. The inferior gluteal artery may share a common trunk with the internal pudendal artery, or less commonly, with the superior gluteal artery.

5. Identify the branches of the posterior division of the internal iliac artery (FIG. 5.39):

- **Iliolumbar artery** — passes posteriorly, then ascends between the lumbosacral trunk and the obturator nerve. It may arise from a common trunk with the lateral sacral artery.

- **Lateral sacral artery** — gives rise to a superior branch and an inferior branch. Observe that the inferior branch passes anterior to the sacral ven-tral rami.

- **Superior gluteal artery** — usually exits the pelvic cavity by passing between the lumbo-sacral trunk and the ventral ramus of spinal nerve S1.

6. Use an atlas illustration to study the vesical venous plexus, uterine venous plexus, vaginal venous plexus, and rectal venous plexus. All of these plexuses drain into the internal iliac vein.

**Nerves** [G 211, 246; L 275; N 392, 487; R 471; C 362]

The somatic plexuses of the pelvic cavity are the sacral plexus and coccygeal plexus. These plexuses are located between the pelvic viscera and the lateral pelvic wall, within the endopelvic fascia. These somatic nerve plexuses are formed by contributions from anterior rami of spinal nerves L4 to S4.

The primary visceral nerve plexus of the pelvic cavity is the inferior hypogastric plexus (also called pelvic plexus). It is formed by contributions from the hypogastric nerves, sacral splanchnic nerves (sympathetic), and pelvic splanchnic nerves (parasympathetic).

1. Use your fingers to dissect the rectum from the anterior surface of the sacrum and coccyx.

2. Retract the rectum medially and identify the sacral plexus of nerves. The sacral plexus is closely related to the anterior surface of the piriformis muscle. Verify the following (FIG. 5.40):

- The lumbosacral trunk (anterior rami of L4 and L5) joins the sacral plexus.

- The anterior rami of S2 and S3 emerge between the proximal attachments of the piriformis muscle.

- The sciatic nerve is formed by the anterior rami of spinal nerves L4 through S3. The sci-
**CHAPTER 5: THE PELVIS AND PERINEUM**

1. **Gray rami communicantes** – connect the sympathetic ganglia to the sacral anterior rami. Each gray ramus communicans carries postsynaptic sympathetic fibers to an anterior ramus for distribution to the lower extremity and the perineum.

2. **Sacral splanchnic nerves** – arise from two or three of the sacral sympathetic ganglia and pass directly to the **inferior hypogastric plexus**. Sacral splanchnic nerves carry sympathetic fibers that distribute to the pelvic viscera.

3. **Identify the pelvic splanchnic nerves (nervi erigentes).** Pelvic splanchnic nerves are branches of the anterior rami of spinal nerves S2, S3, and S4 (FIG. 5.40). Pelvic splanchnic nerves carry presynaptic parasympathetic axons for the innervation of pelvic organs and the distal gastrointestinal tract (from the left colic flexure through the anal canal). [G 251; L 275, 276; N 392; C 362]

4. The **sacral portion of the sympathetic trunk** is located on the anterior surface of the sacrum, medial to the anterior sacral foramina. Identify the following:

   - **Sympathetic trunk** – continues from the abdominal region into the pelvis. The sympathetic trunks of the two sides join in the midline near the level of the coccyx to form the **ganglion impar**.
FIGURE 5.41 Pelvic diaphragm in the female. A. Left lateral view. B. Inferior view.
Dissection Instructions

1. Perform the dissection of the pelvic diaphragm on one side of the cadaver. Save the side with the best dissection of arteries and nerves for review. [G 206, 209; L 278, 279; N 337–339; C 343]
2. Retract the urinary bladder, uterus, and rectum toward the midline.
3. Use blunt dissection to remove any remaining fat and connective tissue from the superior surface of the pelvic diaphragm.
4. To find the tendinous arch of the levator ani muscle (FIG. 5.41A), palpate the medial surface of the ischial spine and then locate the obturator canal. The tendinous arch lies just inferior to a line connecting these two structures. Note that the tendinous arch is the superior edge of the levator ani muscle.
5. Identify the three muscles that form the levator ani muscle. The muscles are identified by their anterior attachments. Learn, but do not dissect, their posterior attachments. Identify the following:
   - Puborectalis muscle – its anterior attachment is the body of the pubis. Its posterior attachment is the puborectalis muscle of the opposite side (in a midline raphe). The puborectalis muscle forms the margin of the urogenital hiatus (FIG. 5.41B). The two puborectalis muscles form a “puborectal sling,” which causes the anorectal flexure at the ampulla of the rectum (FIG. 5.38). During defecation, the puborectalis muscles relax, the anorectal flexure straightens, and the elimination of fecal matter is facilitated.
   - Pubococcygeus muscle – its anterior attachment is the body of the pubis. Its posterior attachment is the coccyx and the anococcygeal raphe.
   - Iliococcygeus muscle – its anterior attachment is the tendinous arch. Its posterior attachment is the coccyx and the anococcygeal raphe.
6. The levator ani muscle supports the pelvic viscera and resists increases in intra-abdominal pressure.
7. Identify the coccygeus muscle. The coccygeus muscle completes the pelvic diaphragm posteriorly. The anterior attachment of the coccygeus muscle is the ischial spine and its posterior attachment is the lateral border of the coccyx and the lowest part of the sacrum (FIG. 5.41A).
8. Place the fingers of one hand in the ischioanal fossa and the fingers of the other hand on the superior surface of the pelvic diaphragm. Palpate the pelvic diaphragm and appreciate its thinness.
9. Observe that the obturator internus muscle forms the lateral wall of the ischioanal fossa. The medial attachment of the obturator internus muscle is the margin of the obturator foramen and inner surface of the obturator membrane. The lateral attachment of the obturator internus muscle will be studied when the gluteal region is dissected. Superior to the tendinous arch of the levator ani muscle, the obturator internus muscle forms the lateral wall of the pelvic cavity. Inferior to the tendinous arch, the obturator internus muscle forms the lateral wall of the perineum.
10. Use your textbook to learn the general pattern of lymphatic drainage of the pelvis and the location of each of the following groups of lymph nodes: [G 217, 248, 249; L 290; N 386; R 360]
   - Internal iliac nodes
   - External iliac nodes
   - Common iliac nodes
   - Sacral nodes
   - Lumbar nodes

Dissection Follow-up

1. Use the dissected specimen to review the proximal attachment and action of each muscle of the pelvic diaphragm.
2. Review the relationship of the branches of the internal iliac artery to the pelvic diaphragm.
3. Review the relationship of the sacral plexus to the pelvic diaphragm.
4. Use an atlas illustration to review the role played by the pelvic diaphragm in forming the boundary between the pelvic cavity and the perineum. Review the function of the pelvic diaphragm and perineal body in supporting the pelvic and abdominal viscera.
5. Use an atlas illustration to review the lymphatic drainage from the pelvis and perineum. Realize that structures in the perineum (including the labia majora and the lower part of the anal canal) drain into superficial inguinal lymph nodes. The lymphatic drainage of the ovary follows the ovarian vessels to the lumbar chain of nodes, bypassing the pelvic drainage systems.
6. Review the formation of the thoracic duct to complete your understanding of the lymph drainage from this region.
7. Visit a dissection table with a male cadaver and perform a complete review of the dissected male pelvis.
The Lower Limb

The functional requirements of the lower limb are weight bearing, locomotion, and maintenance of equilibrium. As such, it is constructed for strength at the cost of mobility. The lower limb is divided into four parts: hip, thigh, leg, and foot (FIG. 6.1). It is worth noting that the term leg refers only to the portion of the lower limb between the knee and ankle, not to the entire lower limb.

SURFACE ANATOMY

[G 373; L 87; N 469; R 476, 477; C 410]

The surface anatomy of the lower limb can be studied on a living subject or on the cadaver. Place the cadaver in the supine position and palpate the following structures (FIG. 6.1):

- Iliac crest
- Anterior superior iliac spine
- Pubic tubercle
- Patella
- Medial femoral epicondyle
- Lateral femoral epicondyle
- Medial malleolus
- Lateral malleolus

SUPERFICIAL VEINS AND CUTANEOUS NERVES

Dissection Overview

The order of dissection will be as follows: The entire lower limb will be skinned. The superficial veins and cutaneous nerves will be dissected. The subcutaneous connective tissue and fat will be removed, leaving selected superficial veins and cutaneous nerves intact. The deep fascia of the thigh will be studied.

Dissection Instructions

Skin Incisions
1. The objective is to remove the skin from the lower limb, leaving the superficial fascia, superficial veins, and cutaneous nerves undisturbed.

ATLAS REFERENCES:

G = Grant’s Atlas, 13th ed., page number
L = LWW Atlas of Anatomy, 1st ed., page number
N = Netter’s Atlas, 5th ed., plate number
R = Color Atlas of Anatomy, 7th ed., page number
C = Clemente’s Atlas, 6th ed., plate number
2. Refer to FIGURE 6.2A. Make a cut from the anterior superior iliac spine (D) along the inguinal ligament to the pubic tubercle. Extend this cut around the medial side of the thigh to the posterior surface of the thigh (E). If the abdomen and perineum have been dissected, this cut has been made previously.

3. Make a vertical cut from the midpoint of the inguinal ligament (F) passing over the patella to the dorsum of the foot (G).

4. Make a cut across the dorsum of the foot at the webs of the toes (H to H). The skin is very thin on the dorsum of the foot. Do not cut too deeply.

5. Make one cut along the dorsal midline of each toe to the proximal end of the nail (H to P).

6. Remove the skin from the thigh, leg, and dorsum of the foot as far laterally and medially as possible. Make as many transverse skin incisions as are needed to speed up the skinning process.

7. Turn the cadaver into the prone position and refer to FIGURE 6.2B.

8. If not already done during the dissection of the pelvis, remove the skin from the gluteal region. Make a midline incision and work from medial to lateral. Detach the skin along line J to K and the lateral side of the hip and place it in the tissue container.

9. Make a cut along the midline of the thigh and leg from the gluteal fold to the heel (E to I).

10. Extend the previous transverse skin incisions around the limb to join incision E to I. Begin at line E to I and work both medially and laterally. Remove the skin completely from the lower limb and place it in the tissue container.

11. Remove the skin from the sole of the foot using the cuts indicated in FIGURE 6.2C. The skin is thick over the heel and over the heads of the metatarsal bones, but it is thinner on the toes and the instep.

Superficial Fascia of the Posterior Lower Limb

1. With the cadaver still in the prone position, examine the structures contained in the superficial fascia of the posterior aspect of the lower limb (FIG. 6.3B).

2. Find the small saphenous vein where it passes posterior to the lateral malleolus at the ankle (FIG. 6.3B). Use blunt dissection to follow it superiorly. Note the following:

   • The small saphenous vein arises from the lateral end of the dorsal venous arch.
   • It pierces the deep fascia in the popliteal fossa.
   • It drains into the popliteal vein.

3. Identify the sural nerve (L. sura, calf of the leg). The sural nerve pierces the deep fascia halfway down the posterior aspect of the leg and courses parallel to the small saphenous vein. The sural nerve innervates the skin of the lateral aspect of the ankle and foot.

4. Use an illustration (FIG. 6.3B) to study the cutaneous innervation of the posterior surface of the lower limb and note the following:

   • Cluneal nerves innervate the skin of the gluteal region (L. clunos, buttock):
     - Superior cluneal nerves – branches of the posterior rami of L1 to L3 innervate the upper buttock.
     - Middle cluneal nerves – branches of the posterior rami of S1 to S3 innervate the middle part of the buttock.
     - Inferior cluneal nerves – branches of the posterior cutaneous nerve of the thigh wrap around the inferior border of the gluteus maximus muscle and innervate the skin over the lower part of the buttock.

   • Posterior cutaneous nerve of the thigh – lies deep to the deep fascia (FIG. 6.3B, ghosted). Branches of this nerve pierce the deep fascia to supply the skin on the posterior surface of the thigh and popliteal fossa.
FIGURE 6.3 Cutaneous nerves and superficial veins of the lower limb. A. Anterior view. B. Posterior view.
Sural nerve – pierces the deep fascia on the posterior side of the leg. It innervates the skin of the posterior side of the leg and lateral side of the foot.

5. Remove all remnants of superficial fascia from the posterior aspect of the gluteal region, thigh, and leg. Preserve the deep fascia, cutaneous nerves, and superficial veins that you have dissected.

Superficial Fascia of the Anterior Lower Limb

1. Turn the cadaver to the supine position and refer to FIGURE 6.3A.
2. Find the great saphenous vein (Gr. saphenous, manifest; obvious) where it arises from the medial end of the dorsal venous arch of the foot (FIG. 6.3A). Use blunt dissection to follow it proximally. Note the following:
   - At the ankle, the great saphenous vein passes anterior to the medial malleolus.
   - At the knee, it passes over the posterior border of the medial epicondyle of the femur.
   - Beginning at the level of the knee, the great saphenous vein courses anterolaterally to eventually lie on the anterior surface of the proximal thigh.
   - Perforating veins connect the great saphenous vein to the deep venous system.
   - Many superficial veins join the great saphenous vein. Most of these are not named.
   - Accessory saphenous vein, a named tributary that drains the superficial fascia and skin of the medial side of the thigh (FIG. 6.3A).
   - Three small superficial veins (superficial external pudendal, superficial epigastric, and superficial circumflex iliac) join the great saphenous vein near its proximal end (FIG. 6.3A).

3. About 4 cm inferior to the inguinal ligament, the great saphenous vein passes deeply through the saphenous opening (saphenous hiatus) and drains into the femoral vein. The saphenous opening is an opening in the deep fascia that will be dissected later.

4. Use an illustration (FIG. 6.3A) to study the cutaneous innervation of the anterior surface of the lower limb and note the following:
   - Lateral femoral cutaneous nerve – passes deep to the lateral end of the inguinal ligament and innervates the skin of the lateral thigh.
   - Anterior cutaneous branches of the femoral nerve – innervate the skin of the anterior thigh. These branches enter the superficial fascia lateral to the great saphenous vein.

CLINICAL CORRELATION

GREAT SAPHENOUS VEIN

Superficial veins and perforating veins have valves that prevent the backflow of blood. If these valves become incompetent, then the veins become distended—a condition known as varicose veins.

Portions of the great saphenous vein may be removed and used as graft vessels in coronary bypass surgery. The distal end of the vein is attached to the aorta so that the valves do not impede the flow of blood.
CHAPTER 6: THE LOWER LIMB

1. Examine the deep fascia of the lower limb. It is named regionally:
   - Fascia lata (L. latus, broad) – in the thigh. The lateral portion of the fascia lata is particularly strong and is called the iliotibial tract.
   - Crural fascia – in the leg.
   - Pedal fascia – in the foot.

Dissection Follow-up

1. Trace the course of the superficial veins from distal to proximal and note where perforating veins drain deeply.
2. Review the location and pattern of distribution of each cutaneous nerve that you have dissected in the lower limb.
3. Review the extent and bony attachments of the deep fascia and name its parts.
4. Use an illustration to review the lymphatic drainage of the lower limb.

ANTERIOR COMPARTMENT OF THE THIGH

Dissection Overview

The fascia lata is connected to the femur by intermuscular septa (FIG. 6.5) to form the three fascial compartments of the thigh: anterior (extensor), medial (adductor), and posterior (flexor). The anterior compartment of the thigh contains five muscles: sartorius, rectus femoris, vastus lateralis, vastus intermedius, and vastus medialis. Four of these muscles (rectus femoris, vastus lateralis, vastus intermedius, and vastus medialis) collectively are called the quadriceps femoris muscle. The shared action of the anterior thigh muscles is extension of the leg. The major blood supply to the lower limb (femoral artery and deep femoral artery) passes through the anterior compartment of the thigh. [G 376, 377; L 101; N 483; R 455]

The order of dissection will be as follows: The fascia lata of the thigh will be reviewed and its saphenous opening will be studied. The anterior surface of the superior part of the fascia lata will be opened to expose the femoral triangle. The femoral triangle will be dissected and its vascular contents will be followed distally. The sartorius muscle will be identified and the adductor canal will be dissected. The anterior surface of the inferior part of the fascia lata will be opened and the remaining anterior thigh muscles will be studied.

Skeleton of the Thigh

Refer to a skeleton and FIGURE 6.6.

On the pelvis, identify: [G 390; L 92; N 474; R 436; C 324]
   - Anterior superior iliac spine
   - Anterior inferior iliac spine
   - Pecten pubis
   - Pubic tubercle
   - Ischiopubic ramus

On the femur, identify: [G 390; L 92; N 477; R 439; C 478, 479]
   - Greater trochanter
   - Lesser trochanter
   - Lateral condyle and lateral epicondyle
   - Medial condyle and medial epicondyle
   - Medial supracondylar line
   - Adductor tubercle
   - Linea aspera
   - Pectineal line
On the tibia, identify: [G 390; L 94; N 501; R 440; C 496]

- Tuberosity

On the patella, identify:

- Anterior surface
- Articular (posterior) surface

**Dissection Instructions**

**Saphenous Opening** [G 378, 379; L 88; N 471; R 478; C 416]

1. Remove any remnants of superficial fascia that remain on the anterior surface of the fascia lata. The superficial inguinal lymph nodes must be removed during this step of the dissection. Preserve the great saphenous vein.

2. Follow the great saphenous vein superiorly and observe that it turns posteriorly approximately 4 cm inferior to the inguinal ligament and disappears. Use a probe to dissect the connective tissue around the great saphenous vein where it passes deeply and define the margin of the saphenous opening (FIG. 6.7). The saphenous opening is a natural opening in the fascia lata that is filled with a relatively weak layer of fascia. Trace the great saphenous vein through the saphenous opening and observe that it drains into the anterior surface of the femoral vein.

3. Insert your finger into the saphenous opening inferior to the great saphenous vein. Push your finger inferiorly deep to the fascia lata until your fingertip reaches the level of the sartorius muscle. Use scissors to cut through the fascia lata from the saphenous opening to the sartorius muscle (FIG. 6.7, cut 1).

4. Use scissors to make a second cut through the fascia lata that extends laterally from the superior margin of the saphenous opening, parallel to the

**FIGURE 6.6** Bones of the thigh. A. Anterior view. B. Posterior view.
Femoral Triangle (Fig. 6.7, cut 2). This cut should extend laterally to a point that is directly inferior to the anterior superior iliac spine.

5. Use scissors to make a third cut through the fascia lata that extends medially from the superior margin of the saphenous opening, parallel to the inguinal ligament (Fig. 6.7, cut 3). This cut should extend medially to a point that is directly inferior to the pubic tubercle.

6. Use blunt dissection to separate the fascia lata from deeper structures. Reflect the flaps of fascia lata medially and laterally. You have opened the superficial boundary (roof) of the femoral triangle.

**Femoral Triangle** [G 380, 381; L 103, 104; N 488; R 479–481; C 423]

1. Identify the **boundaries of the femoral triangle** (Fig. 6.8):
   - Superior – inguinal ligament
   - Lateral – sartorius muscle
   - Medial – adductor longus muscle
   - Floor – iliopsoas and pectineus muscles

   The base of the femoral triangle is the inguinal ligament and its apex is located inferiorly.

2. The **contents of the femoral triangle** are (Fig. 6.8):
   - Femoral nerve and its branches
   - Femoral artery and some of its branches
   - Femoral vein and some of its tributaries (notably, the great saphenous vein)
   - Femoral sheath

**Clinical Correlation**

**Femoral Triangle**

The pulse of the femoral artery can be palpated about 3 cm inferior to the midpoint of the inguinal ligament. Within the femoral triangle, the femoral vessels are accessed for diagnostic purposes. A catheter introduced into the femoral artery can be advanced superiorly to the aorta and its branches. A catheter introduced into the femoral vein can be advanced superiorly to the inferior vena cava and into the right atrium of the heart.

3. Identify the **femoral sheath** (Fig. 6.8). The femoral sheath is an extension of transversalis fascia into the thigh. The femoral sheath is divided by connective tissue into three compartments (Fig. 6.8):
   - Lateral – containing the femoral artery
   - Intermediate – containing the femoral vein
   - Medial – containing lymphatics

4. Note that the lateral-to-medial arrangement of structures that pass under the inguinal ligament (including the contents of the femoral sheath) can be arranged by use of the mnemonic device NAVL (pronounced navel): femoral Nerve, femoral Artery, femoral Vein, Lymphatics.

5. The medial compartment of the femoral sheath is also called the **femoral canal**, and its proximal opening into the abdominal cavity is called the **femoral ring**. The femoral canal and femoral ring are seen from the abdominal side of the inguinal ligament.
6. Use blunt dissection to clean the femoral artery and femoral vein within the femoral triangle. Inferior to the apex of the femoral triangle, note that the femoral artery courses inferiorly between the sartorius muscle and the adductor longus muscle (FIG. 6.9A).

7. Note that three small arteries arise from the femoral artery just distal to the inguinal ligament (FIG. 6.9B):
   - Superficial external pudendal artery
   - Superficial epigastric artery
   - Superficial circumflex iliac artery

8. Retract the femoral artery medially and identify the deep artery of the thigh. The deep artery of the thigh courses parallel to the femoral artery but posterior to the adductor longus muscle (FIG. 6.9B). The deep artery of the thigh supplies the medial and posterior compartments of the thigh.

9. Identify the lateral circumflex femoral artery (FIG. 6.9B). The lateral circumflex femoral artery usually arises from the deep artery of the thigh very close to the femoral artery but it may arise directly from the femoral artery. The lateral circumflex femoral artery passes laterally, deep to the superior end of the rectus femoris muscle, and supplies the muscles and soft tissues of the lateral part of the thigh. It has three branches, each of which participates in an anastomosis:
   - Ascending branch – passes superiorly deep to the tensor fascia lata muscle and anastomoses with the superior gluteal artery.
   - Transverse branch – passes deep to the rectus femoris muscle and anastomoses with the medial circumflex femoral artery.
   - Descending branch – also passes deep to the rectus femoris muscle, then courses inferiorly
on the anterior surface of the vastus intermedius muscle. It anastomoses with the genicular arteries at the knee.

10. Identify the **medial circumflex femoral artery** (FIG. 6.9B, C). The medial circumflex femoral artery typically arises from the deep artery of the thigh close to the femoral artery but it may arise directly from the femoral artery. The medial circumflex femoral artery passes posteriorly between the pectineus and iliopsoas muscles. In addition to supplying the soft tissues of the region, the medial circumflex femoral artery is an important blood supply to the head and neck of the femur.

11. Identify the iliopsoas muscle and the pectineus muscles that lie posterior to the vessels.

12. The iliacus and psoas major muscles collectively are named the **iliopsoas muscle**. Although the attachments cannot be seen at this time, note that the superior attachment of the iliacus muscle is the iliac fossa, and the superior attachments of the psoas major muscle are the transverse processes and bodies of vertebrae T12 to L5. The inferior attachment of the iliopsoas tendon is on the lesser trochanter of the femur. The iliopsoas muscle is a strong flexor of the thigh.

13. The superior attachment of the **pectineus muscle** is the pecten pubis and the superior ramus of the pubis, and its inferior attachment is the pectinal line of the femur. The pectineus muscle adducts and flexes the thigh.

14. Identify the **femoral nerve**, which lies on the floor of the femoral triangle lateral to the femoral artery (FIG. 6.8). Follow the femoral nerve inferiorly and observe that it divides into numerous branches. The femoral nerve innervates the anterior thigh muscles and the skin of the anterior thigh.

15. Verify that the **anterior cutaneous branches of the femoral nerve** enter the superficial fascia by penetrating the fascia lata along the anterior surface of the sartorius muscle (FIG. 6.3A). Its motor branches will be identified later.

**Adductor Canal and Sartorius Muscle** [G 388; L 102, 103; N 488; R 480; C 423]

1. The **adductor canal** is a fascial compartment located deep to the sartorius muscle. It contains the femoral artery and vein, and two branches of the femoral nerve. The adductor canal begins at the **apex of the femoral triangle** and ends at the **adductor hiatus**, which is located just above the knee (FIG. 6.9A, C). The femoral vessels pass through the adductor hiatus to reach the popliteal fossa.

2. Use scissors to cut the fascia lata along the superficial surface of the sartorius muscle. The cut should extend from the anterior superior iliac spine to the medial epicondyle of the femur.

3. Use a probe and your fingers to separate the sartorius muscle from the deep fascia that is both anterior and posterior to it. Retract the sartorius muscle laterally so that its superior and inferior attachments can be defined and its blood and nerve supplies can be identified. The superior attachment of the sartorius muscle is the anterior superior iliac spine, and its inferior attachment is the medial surface of the proximal tibia. Observe that the sartorius muscle crosses both the hip joint and the knee joint. It flexes and laterally rotates the thigh and flexes the leg.

4. Transect the sartorius muscle near the apex of the femoral triangle. Reflect the distal part of the sartorius muscle inferiorly. Posterior to the sartorius muscle, observe a sheath of connective tissue that encloses the femoral vessels. This connective tissue sheath is the adductor canal.

5. Use scissors to open the adductor canal and examine the femoral vessels. Observe that the **femoral vein** lies posterior to the **femoral artery**. Use blunt dissection to follow the femoral artery distally through the adductor hiatus, where its name changes to **popliteal artery** (FIG. 6.9C).

6. The **nerve to vastus medialis** and the **saphenous nerve** accompany the femoral vessels in the adductor canal. The nerve to vastus medialis is the motor nerve to the vastus medialis muscle, and the saphenous nerve is a cutaneous nerve that innervates the skin on the medial side of the leg, ankle, and foot.

**Quadriceps Femoris Muscle** [G 385, 388; L 103; N 489; R 481; C 421]

1. Use scissors to make a vertical cut through the fascia lata beginning at the apex of the femoral triangle and ending at the superior border of the patella. Make a transverse incision in the fascia lata above the patella. This incision should extend from the medial femoral epicondyle to the lateral femoral epicondyle.

2. Use blunt dissection to open the fascia lata widely. Follow the inner surface of the fascia lata laterally with your fingers and observe that it is attached to the **lateral intermuscular septum** (FIG. 6.10). The lateral intermuscular septum is attached to the linea aspera on the posterior aspect of the femur.

3. The **quadriceps femoris muscle** occupies most of the anterior compartment of the thigh (FIG. 6.10). The four parts of the quadriceps femoris muscle are the rectus femoris, vastus lateralis, vastus intermedius, and vastus medialis. The tendons of all four muscles unite to form the **quadriceps femoris tendon**. The quadriceps femoris tendon is attached to the patella. The **patellar ligament** attaches the patella to the tibial tuberosity, so the inferior attachment of the quadriceps femoris muscle is ultimately on the tibial tuberosity (FIG. 6.11).
7. Identify the vastus medialis muscle on the medial side of the anterior thigh (FIG. 6.11). The superior attachments of the vastus medialis muscle are the medial lip of the linea aspera of the femur and the intertrochanteric line. The inferior attachment of the vastus medialis muscle is the tibial tuberosity and it extends the leg.

8. Identify the vastus intermedius muscle, which lies between the vastus lateralis and vastus medialis muscles (FIG. 6.11). The superior attachments of the vastus intermedius muscle are the anterior and lateral surfaces of the femur. The inferior attachment of the vastus intermedius muscle is the tibial tuberosity and it extends the leg.

9. Observe the descending branch of the lateral circumflex femoral artery, which can be seen on the anterior surface of the vastus intermedius muscle, deep to the rectus femoris muscle.

10. Identify the motor branches of the femoral nerve to the anterior thigh muscles (FIG. 6.11). The motor branches of the femoral nerve are located between the rectus femoris muscle and the three vastus muscles. Note that the femoral nerve innervates the sartorius muscle and the pectineus muscle in addition to innervating the quadriceps femoris muscle.
Dissection Follow-up
1. Replace the anterior thigh muscles in their correct anatomical positions.
2. Use the dissected specimen to review the boundaries and contents of the femoral triangle.
3. Review the origin and course of the femoral artery and its branches in the thigh.
4. Use the dissected specimen to review the attachments and actions of the muscles of the anterior compartment of the thigh.
5. Recall the rule of innervation of the anterior compartment of the thigh: [L 149]
   • All muscles in the anterior compartment of the thigh are innervated by the femoral nerve.

MEDIAL COMPARTMENT OF THE THIGH
[G 386; L 105–107; N 489; R 481; C 425]

Dissection Overview
The medial compartment of the thigh contains six muscles: gracilis, adductor longus, adductor brevis, pectineus, adductor magnus, and obturator externus. The shared function of this group of muscles is to adduct the thigh. Therefore, they are also known as the adductor group of thigh muscles.

The order of dissection will be as follows: The fascia lata will be removed from the medial thigh. The gracilis muscle will be studied. The adductor muscles will be separated from each other by following the medial circumflex femoral artery, the deep artery of the thigh, and the branches of the obturator nerve. Note: The anterior and posterior branches of the obturator nerve pass anterior and posterior, respectively, to the adductor brevis muscle. The branches of the deep artery of the thigh and the obturator nerve are excellent aids to help you define the planes of separation between the muscles of the medial compartment of the thigh.

Dissection Instructions
1. On the medial aspect of the thigh, use your hands to separate the fascia lata from the muscles of the medial compartment. Begin at the medial border of the femoral triangle and work medially. Be careful not to remove the gracilis muscle. Use scissors to cut the fascia lata from its attachments to the pelvis superiorly and medial intermuscular septum. Remove this fragment of the fascia lata and place it in the tissue container.
2. Identify the gracilis muscle. The superior attachment of the gracilis muscle is the pubic bone and its inferior attachment is on the medial condyle of the tibia. Use your fingers to define the borders of the gracilis muscle. The gracilis muscle crosses both the hip and knee joints. It adducts the thigh and assists in flexion of the leg.

3. Use an illustration (FIG. 6.12) to observe the superior attachments of the gracilis muscle, pectineus muscle, and adductor longus muscle on the pubic bone. [G 390; L 98; N 478; R 453; C 478]
4. The pectineus and adductor longus muscle fan out to their inferior attachments on the pectineal line or the linea aspera of the femur. Both muscles are adductors of the thigh.
5. Observe that the deep artery of the thigh passes between the pectineus and adductor longus muscles. Follow the deep artery of the thigh inferiorly between the pectineus and adductor longus muscles and use blunt dissection to define the borders of these muscles.
6. Continue to follow the deep artery of the thigh posterior to the adductor longus muscle and observe that it courses inferiorly between the adductor longus muscle and the adductor brevis muscle. Follow the artery to separate the adductor longus muscle from the adductor brevis muscle. Transect the adductor longus muscle 5 cm inferior to its superior attachment and reflect it as shown in FIGURE 6.12.

FIGURE 6.12 Branches of the obturator nerve. The anterior and posterior branches of the obturator nerve are used to define the borders of the adductor brevis muscle.
7. The adductor brevis muscle is now exposed. The superior attachments of the adductor brevis muscle are the body and inferior ramus of the pubis and its inferior attachments are the pectineal line and linea aspera of the femur. The adductor brevis muscle adducts the thigh.

8. Clean the deep artery of the thigh and identify one or two perforating arteries. Perforating arteries penetrate the adductor brevis and adductor magnus muscles, encircle the femur, and supply the muscles of the posterior compartment of the thigh.

9. Refer to Figure 6.12 and note that the anterior branch of the obturator nerve crosses the anterior surface of the adductor brevis muscle and that the posterior branch of the obturator nerve crosses its posterior surface.

10. Superiorly, the anterior branch of the obturator nerve passes deep to the pectineus muscle but is superficial to the adductor brevis muscle (FIG. 6.12). Follow the anterior branch of the obturator nerve superiorly to separate the pectineus muscle from the adductor brevis muscle. Note that the superior border of the adductor brevis muscle is deep to the pectineus muscle. Use blunt dissection to clean the adductor brevis. Do not damage the anterior branches of the obturator nerve.

11. The posterior branch of the obturator nerve lies between the adductor brevis muscle and the adductor magnus muscle. Use blunt dissection to follow the posterior branch of the obturator nerve superiorly to separate the adductor brevis muscle from the adductor magnus muscle.

12. Raise the adductor brevis muscle and observe the adductor magnus muscle. The superior attachments of the adductor magnus muscle are the ischiopubic ramus and the ischial tuberosity, and its inferior attachments are the glutal tuberosity, linea aspera, medial supracondylar line, and adductor tubercle of the femur. The most medial part of the adductor magnus muscle (the part that attaches to the adductor tubercle) is called the ischiocondylar portion and it is innervated by the tibial division of the sciatic nerve rather than by the obturator nerve. The adductor magnus muscle adducts and extends the thigh.

13. Trace the tendon of the ischiocondylar portion of the adductor magnus muscle inferiorly to its attachment on the adductor tubercle. On the lateral side of this tendon, observe the adductor hiatus, which is an opening in the adductor magnus muscle (FIG. 6.12). Note that the femoral artery and vein pass from the anterior compartment of the thigh into the posterior compartment of the thigh by passing through the adductor hiatus.

14. Study an illustration of the obturator externus muscle. Do not attempt to dissect this muscle, as it lies deep to the pectineus muscle and iliopectineus tendon. The medial attachment of the obturator externus muscle is the superior pubic ramus, the ischiopubic ramus, and the external surface of the obturator membrane. Its lateral attachment is into the trochanteric fossa on the medial side of the greater trochanter of the femur. The obturator externus muscle is a lateral rotator of the thigh.

Dissection Follow-up

1. Replace the medial thigh muscles in their correct anatomical positions.
2. Use the dissected specimen to review the attachments and action of each muscle dissected.
3. Trace the deep artery of the thigh from its origin to its termination as the fourth perforating artery.
4. Trace the medial circumflex femoral artery from its origin to where it passes between the iliopsoas and pectineus muscles.
5. Trace the course of the anterior and posterior branches of the obturator nerve superiorly as far as the superior border of the adductor brevis muscle.
6. Recall the rule for innervation of the medial thigh muscles: [L 150]
   - The obturator nerve innervates the muscles of the medial compartment of the thigh with the following exceptions:
     • The pectineus muscle receives motor innervation from both the femoral nerve and the obturator nerve.
     • The ischiocondylar portion of the adductor magnus muscle is innervated by the tibial division of the sciatic nerve.

GLUTEAL REGION

Dissection Overview

The gluteal region (Gr. gloutos, buttock) lies on the posterior aspect of the pelvis. It is the most superior part of the lower limb. It contains muscles that abduct and laterally rotate the thigh.

The order of dissection will be as follows: The fat and superficial fascia will be removed from the gluteal region. The borders of the gluteus maximus muscle will be defined and it will be reflected laterally to expose the muscles that lie deep to it. Muscles that lie deep to the gluteus maximus muscle will be studied. Arteries and nerves in the region will be studied. Note that the piriformis muscle will be a key landmark in understanding the relationships of this region.
Dissection Instructions

1. Place the cadaver in the prone position.
2. If not done previously, remove the superficial fascia from the surface of the fascia lata in the gluteal region. You should see the gluteal aponeurosis (FIG. 6.14) before you proceed to step 3.
3. Identify the gluteus maximus muscle (FIG. 6.14). The medial attachment of the gluteus maximus muscle is the part of the ilium that lies posterior to the posterior gluteal line, the posterior surface of the sacrum and coccyx, and the sacrotuberous ligament. The lateral attachment of the gluteus maximus muscle is the iliotibial tract, and through it, the lateral condyle of the tibia. The deeper part of the inferior half of the gluteus maximus muscle attaches to the gluteal tuberosity of the femur. The gluteus maximus muscle is a powerful extensor of the thigh. [G 392; L 112; N 483; R 455; C 431]
4. Clean the inferior border of the gluteus maximus muscle. You may find the inferior cluneal nerves while cleaning. If not, do not make a special effort to find them. The inferior border of the gluteus

Skeleton of the Gluteal Region

Refer to a skeleton and an illustration of an articulated pelvis with intact ligaments. On the pelvis, identify (FIG. 6.13): [G 391; L 93; N 474; R 437; C 432]

- Gluteal lines (posterior, anterior, inferior)
- Greater sciatic foramen
- Greater sciatic notch
- Ischial spine
- Lesser sciatic notch
- Lesser sciatic foramen
- Ischial tuberosity
- Sacrotuberous ligament
- Sacropinous ligament

On the femur, identify (FIG. 6.13): [G 391; L 93; N 477; R 439; C 479]

- Greater trochanter
- Intertrochanteric crest
- Trochanteric fossa
- Quadrate tubercle
- Gluteal tuberosity

FIGURE 6.13  Skeleton of the gluteal region.
maximus muscle should be visible from its medial attachment on the sacrum and coccyx to its lateral attachment on the iliotibial tract before proceeding to step 5 (FIG. 6.14).

5. Remove the fascia lata from the surface of the gluteus maximus muscle and use your fingers or a probe to define the superior border of the muscle. The superior border of the muscle should be visible from its medial attachment on the iliac crest to its lateral attachment on the iliotibial tract before proceeding to step 6 (FIG. 6.14).

6. The fascia lata is relatively thin over the surface of the gluteus maximus muscle, but superior to the muscle it becomes thicker and forms the gluteal aponeurosis. The gluteal aponeurosis spans from the superior border of the gluteus maximus muscle up to the iliac crest.

7. Insert your fingers between the gluteus maximus muscle and the gluteal aponeurosis (FIG. 6.14, arrow) and separate the gluteus maximus muscle from the aponeurosis.

8. Use scissors to detach the gluteus maximus from its medial attachment. Start at the superior border of the muscle and cut the gluteus maximus muscle close to the ilium, sacrum, and sacrotuberous ligament (FIG. 6.14, dashed line).

9. As you push your fingers deep to the gluteus maximus muscle, palpate the inferior gluteal artery, vein, and nerve, which are located near the center of the muscle. The inferior gluteal nerve is the only nerve supply to the gluteus maximus muscle but the muscle receives blood from both the superior gluteal artery and the inferior gluteal artery.

10. Use scissors to cut the inferior gluteal vessels and nerve. Use your fingers to loosen the gluteus maximus muscle from deeper structures and reflect it laterally. The gluteus maximus muscle should remain attached only along its lateral attachment, leaving the deeper structures of the gluteal region exposed (FIG. 6.15). [G 394, 397; L 112; N 483; R 454, 483; C 432]

11. To expose the gluteus medius muscle, use a scalpel to cut the gluteal aponeurosis along the iliac crest and use skinning motions to remove the gluteal aponeurosis. Note that the aponeurosis is firmly attached to the gluteus medius muscle and that it serves as an attachment for that muscle.

12. Identify the gluteus medius muscle. To define its inferior border, insert your finger or a probe lateral to the superior gluteal vessels (FIG. 6.15) and open the interval between the gluteus medius muscle and the piriformis muscle.

13. The superior attachment of the gluteus medius muscle is the deep surface of the gluteal aponeurosis and the lateral surface of the ilium between the posterior gluteal line and the anterior gluteal line. The inferior attachment of the gluteus medius muscle is the greater trochanter of the femur. It abducts the thigh.

14. The piriformis muscle is located inferior to the gluteus medius muscle. Note that its superior border lies adjacent to the inferior border of the gluteus medius muscle. To define its inferior border, insert your finger or a probe lateral to the inferior gluteal vessels and open the interval between the piriformis muscle and the superior gemellus muscle.

15. The medial attachment of the piriformis muscle is the anterior surface of the sacrum and its lateral attachment is on the greater trochanter of the femur. The piriformis muscle is a lateral rotator of the thigh. Verify that the piriformis muscle passes through the greater sciatic foramen and nearly fills it.

16. Use blunt dissection to clean the superior border of the piriformis muscle. Observe the following structures that exit the pelvic cavity and enter the gluteal region by passing above the superior border of the piriformis muscle:

- Superior gluteal artery and vein
- Superior gluteal nerve

17. Use blunt dissection to clean the inferior border of the piriformis muscle. Observe the following structures that exit the pelvic cavity and enter the
19. To follow the sciatic nerve inferiorly, make a vertical cut through the fascia lata posterior to the nerve. Follow the sciatic nerve for 6 or 7 cm into the thigh.

20. On the medial side of the sciatic nerve, identify the **posterior cutaneous nerve of the thigh** (FIG. 6.15).

21. Return to the inferior border of the piriformis muscle and identify the cut ends of the **inferior gluteal vessels** and **nerve**, which lie on the medial side of the posterior cutaneous nerve of the thigh (FIG. 6.15).

22. Identify the **nerve to obturator internus**, **internal pudendal artery and vein**, and **pudendal nerve** near the medial end of the inferior border of the piriformis muscle (FIG. 6.15). The pudendal nerve and internal pudendal vessels exit the pelvis by passing through the greater sciatic foramen. They pass between the piriformis and superior gluteal region by passing below the inferior border of the piriformis muscle (FIG. 6.15):

- **Sciatic nerve**
- **Posterior cutaneous nerve of the thigh**
- **Inferior gluteal artery and vein**
- **Inferior gluteal nerve**
- **Nerve to obturator internus**
- **Internal pudendal artery and vein**
- **Pudendal nerve**

18. Examine the **sciatic nerve** (FIG. 6.15). The sciatic nerve is the largest nerve in the body. It has a **tibial division** and a **common fibular division**. In about 12% of specimens, the divisions may emerge from the pelvis separately. When this happens, the common fibular division passes over the superior border of the piriformis muscle or through the center of the piriformis muscle.
24. Identify the obturator internus muscle (FIG. 6.15). The medial attachment of the obturator internus muscle is on the inner surface of the margin of the obturator foramen and the inner surface of the obturator membrane. The obturator internus muscle exits the lesser pelvis by passing through the lesser sciatic foramen, which nearly fills. The lateral attachment of the obturator internus muscle is on the medial side of the greater trochanter of the femur, superior to the trochanteric fossa. The obturator internus muscle is a lateral rotator of the thigh.

25. Identify the gemellus muscles (L. gemellus, twin) (FIG. 6.15). The medial attachment of the superior gemellus muscle is the ischial spine superior to the obturator internus muscle. The medial attachment of the inferior gemellus muscle is the ischial tuberosity inferior to the obturator internus muscle. Both gemellus muscles attach, along with the obturator internus tendon, on the greater trochanter of the femur and both are lateral rotators of the thigh. Note: The two gemellus muscles may be broad enough to hide the obturator internus tendon.

26. You must reflect the distal part of the gluteus medius muscle to identify the gluteus minimus muscle (FIG. 6.15). First locate the branches of the superior gluteal vessels superior to the piriformis muscle (FIG. 6.15). Insert your finger along the course of the superior gluteal vessels and deep to the gluteus medius muscle. Push your finger superiorly along the course of these vessels to open the plane of separation between the gluteus medius muscle and the gluteus minimus muscle. Use scissors to transect the gluteus medius muscle, following the course of the superior gluteal vessels. Gently reflect the superior portion of the muscle superiorly and observe the superior gluteal nerve and the gluteus minimus muscle.

27. The superior attachment of the gluteus minimus muscle is the lateral surface of the ilium between the anterior gluteal line and the inferior gluteal line. The interior attachment of the gluteus minimus muscle is on the greater trochanter of the femur and it abducts the thigh.

28. Identify the tensor of the fascia lata (tensor fasciae latae muscle). It is enclosed within the fascia lata inferior to the anterior superior iliac spine (FIG. 6.15). The superior attachment of the tensor of the fascia lata is the anterior superior iliac spine and its inferior attachment is the iliobibial tract. The tensor of the fascia lata is an abductor and medial rotator of the thigh.

CLINICAL CORRELATION

INTRAGLUTEAL INJECTIONS

The gluteal region is commonly used for intramuscular injections. These injections are made in the superior lateral quadrant of the gluteal region. Injections into the two inferior quadrants of the gluteal region would endanger the sciatic nerve, or the nerves and vessels that pass inferior to the piriformis muscle. Injections into the superior medial quadrant could injure the superior gluteal nerve and vessels. Intragluteal injections into the superior lateral quadrant are relatively safe because the superior gluteal nerve and vessels are well branched in this region.

Dissection Follow-up

1. Replace the muscles of the gluteal region in their correct anatomical positions.
2. Review the attachments, action, and innervation of each muscle.
3. Study the functions of muscles in the gluteal region:
   - Extend your thigh. This movement is accomplished by the gluteus maximus muscle.
   - Abduct your thigh. This movement is accomplished by the gluteus medius muscle, gluteus minimus muscle, and tensor of the fascia lata.
   - Laterally rotate your thigh. This motion is accomplished by the piriformis muscle, obturator internus muscle, superior gemellus muscle, inferior gemellus muscle, and quadratus femoris muscle.
4. Review the anatomy of the safe intragluteal injection site.
5. If you have completed the dissection of the pelvis and perineum prior to dissection of the lower limb, study the continuity of muscles, vessels, and nerves observed in the gluteal and pelvic regions:
   - Within the pelvis, identify the obturator internus muscle and follow the muscle posteriorly into the gluteal region.
Dissection Instructions

Posterior Thigh  [G 393, 395; L 115; N 483; R 484, 485; C 430, 436–439]

1. Place the cadaver in the prone position. Use scissors to make a vertical cut through the fascia lata from the level of the gluteus maximus muscle to the knee. Open the fascia lata widely and observe:

- Posterior cutaneous nerve of the thigh – courses deep to the fascial lata and sends cutaneous branches through the fascia lata to the posterior surface of the thigh.
- Sciatic nerve – courses as far as the knee where it branches into the tibial and common fibular nerves. It passes deep (anterior) to the long head of the biceps femoris muscle (FIG. 6.16).

2. Identify the long head of the biceps femoris muscle. The superior attachment of the long head of the biceps femoris muscle is the ischial tuberosity and its inferior attachment is on the head of the fibula.

3. Retract the long head of the biceps femoris muscle laterally to observe the short head of the biceps femoris muscle (FIG. 6.16). The superior attachment of the short head of the biceps femoris muscle is the lateral lip of the linea aspera of the femur. The tendon of the short head of the biceps femoris muscle joins the tendon of the long head and it attaches on the head of the fibula. The biceps femoris muscle extends the thigh and flexes the leg.

4. Note that the biceps femoris muscle has two nerves:

- Long head – innervated by the tibial division of the sciatic nerve
- Short head – innervated by the common fibular division of the sciatic nerve

5. On the medial side of the thigh, identify the semitendinosus muscle (FIG. 6.16). The semitendinosus (“half tendon”) muscle is named for the long, cord-like tendon at its inferior end. The superior attachment of the semitendinosus muscle is the ischial tuberosity and its inferior attachment is on the medial surface of the superior part of the tibia. The semitendinosus muscle extends the thigh and flexes the leg. The semitendinosus muscle is innervated by the tibial division of the sciatic nerve.

6. Use your fingers to separate the semitendinosus muscle from the semimembranosus muscle.
8. Follow the sciatic nerve through the posterior compartment of the thigh to the area behind the knee (FIG. 6.16). Note that the sciatic nerve supplies unnamed muscular branches to the posterior thigh muscles and that its named branches (tibial and common fibular nerves) arise just above the knee. The sciatic nerve typically divides at the level of the knee but this division may occur more superiorly, either in the thigh or in the gluteal region.

7. Verify that the hamstring part of the adductor magnus muscle arises from the ischial tuberosity deep to the superior attachments of the posterior thigh muscles. Recall that the adductor magnus muscle is in the medial compartment of the thigh. It forms the anterior boundary of the posterior compartment of the thigh (FIG. 6.16).

The semimembranosus (“half membrane”) muscle is named for the broad, membrane-like tendon at its superior end. The superior attachment of the semimembranosus muscle is the ischial tuberosity and its inferior attachment is on the posterior part of the medial condyle of the tibia. The semimembranosus muscle extends the thigh and flexes the leg. The semimembranosus muscle is innervated by the tibial division of the sciatic nerve.

5. Follow the sciatic nerve through the posterior compartment of the thigh to the area behind the knee (FIG. 6.16). Note that the sciatic nerve supplies unnamed muscular branches to the posterior thigh muscles and that its named branches (tibial and common fibular nerves) arise just above the knee. The sciatic nerve typically divides at the level of the knee but this division may occur more superiorly, either in the thigh or in the gluteal region.

The semimembranosus (“half membrane”) muscle is named for the broad, membrane-like tendon at its superior end. The superior attachment of the semimembranosus muscle is the ischial tuberosity and its inferior attachment is on the posterior part of the medial condyle of the tibia. The semimembranosus muscle extends the thigh and flexes the leg. The semimembranosus muscle is innervated by the tibial division of the sciatic nerve.
Inferomedial – medial head of the gastrocnemius muscle
Posterior – skin and deep (popliteal) fascia
Anterior – popliteal surface of the femur, the posterior surface of the capsule of the knee joint, and the popliteus muscle

2. At the superior border of the popliteal fossa, the sciatic nerve divides into the tibial and common fibular nerves (FIG. 6.17).

3. Use blunt dissection to follow the common fibular nerve laterally along the superolateral border of the popliteal fossa. Note that the common fibular nerve parallels the biceps femoris tendon and passes superficial to the lateral head of the gastrocnemius muscle and the plantaris muscle.

4. Remove the remnants of the deep fascia (popliteal fascia) to expose the medial and lateral heads of the gastrocnemius muscle. Use your fingers to separate the tibial nerve from the loose connective tissue that surrounds it and follow the nerve inferiorly. The tibial nerve passes deep to the plantaris and gastrocnemius muscles at the inferior border of the popliteal fossa (FIG. 6.16).

5. At the inferior border of the popliteal fossa, insert your index fingers between the two bellies of the
5. Review the course of the deep artery of the thigh through the medial compartment of the thigh, and then review the course of its perforating vessels, which pass through the adductor magnus and brevis muscles to reach the posterior compartment of the thigh.

6. Review the genicular anastomosis around the knee, naming the branches of the popliteal artery and lateral circumflex femoral artery that participate.

7. Review the principal muscle groups of the thigh, the group functions, and the innervation of each muscle group (FIG. 6.18):

- The anterior thigh muscles are innervated by the femoral nerve.
- The medial thigh muscles are innervated by the obturator nerve.
- The posterior thigh muscles are innervated by the tibial and common fibular divisions of the sciatic nerve. [L 152]

8. Recall the exceptions to the rules of innervation stated previously:

- The pectineus muscle receives motor innervation from both the femoral nerve and the obturator nerve.
- The ischiocondylar portion of the adductor magnus muscle is innervated by the tibial division of the sciatic nerve.

LEG AND DORSUM OF THE FOOT

The two bones of the leg are unequal in size. The larger tibia is the weight-bearing bone of the leg. The fibula is surrounded by muscles except at its proximal and distal
CHAPTER 6: THE LOWER LIMB

185

• Navicular
• Cuboid
• Three cuneiform bones, first (medial), second (intermediate, middle), and third (lateral)

On the calcaneus, identify (FIG. 6.21):

• Calcaneal tuberosity
• Sustentaculum tali

Identify the five metatarsal bones and the tuberosity of the fifth metatarsal bone.
Identify 14 phalanges. Note that the first toe has only two phalanges, whereas the other toes each have three phalanges.

POSTERIOR COMPARTMENT OF THE LEG

Dissection Overview
The posterior compartment of the leg lies posterior to the interosseous membrane, tibia, and fibula (FIG. 6.19). A
**Dissection Instructions**

1. Use scissors to make a vertical cut through the crural fascia from the popliteal fossa to the calcaneal tuberosity. Open the posterior compartment.

2. Identify the gastrocnemius muscle (FIG. 6.22). The gastrocnemius muscle is the most superficial muscle in the posterior compartment of the leg. The superior attachments of the two heads of the gastrocnemius muscle are on the femur.
just superior to the lateral and medial femoral condyles. The inferior attachment of the gastrocnemius muscle is on the calcaneal tuberosity by way of the calcaneal tendon (Achilles tendon). The gastrocnemius muscle plantar flexes the foot and flexes the leg.  

3. Use scissors to transect the two heads of the gastrocnemius muscle at the point where they join (FIG. 6.22). Reflect the superior and inferior portions of the muscle.

4. Identify the soleus muscle, which is located deep to the gastrocnemius muscle. The superior attachments of the soleus muscle are the soleal line of the tibia and the head of the fibula. The inferior attachment of the soleus muscle is the calcaneal tendon. The soleus muscle plantar flexes the foot.  

[FIG. 6.22] Contents of the superficial posterior compartment of the leg.
5. Identify the tendon of the **plantaris muscle** *(FIG. 6.22)*. The plantaris muscle and tendon may be absent in a small percentage of cases. The belly of the plantaris muscle lies in the popliteal fossa and its superior attachment is the lateral supracondylar line of the femur. In the superior part of the leg, the plantaris tendon courses between the gastrocnemius and soleus muscles. In the inferior part of the leg, the plantaris tendon may be seen on the medial side of the tendon of the gastrocnemius muscle. The plantaris tendon joins the calcaneal tendon and ultimately attaches to the calcaneal tuberosity. The plantaris muscle is a plantar flexor of the foot and a weak flexor of the leg.

6. The **tibial nerve** and **posterior tibial vessels** exit the popliteal fossa by passing deep to the tendinous arch of the soleus muscle *(FIG. 6.22)*. They course distally within the **transverse intermuscular septum** that separates the superficial posterior muscle group from the deep posterior muscle group *(FIG. 6.19)*.

7. To see the deep muscle layer, the soleus muscle must be reflected. Use scissors to transect the calcaneal tendon about 5 cm superior to the tuberosity of the calcaneus *(FIG. 6.22)*, dashed line. Use your fingers to separate the calcaneal tendon from the muscles that lie deep to it.

8. Use scissors to cut the soleus muscle beginning at its tibial (medial) attachment and extending across the leg to its fibular attachment *(FIG. 6.22)*, dashed line, but leave the muscle attached to the fibula. This cut should pass 2 cm inferior to the tendinous arch of the soleus muscle *(FIG. 6.23)*. Retract the soleus muscle and the distal part of the gastrocnemius muscle laterally to expose the transverse intermuscular septum.

9. Identify the **posterior tibial artery and vein** and the **tibial nerve** within the transverse intermuscular septum *(FIG. 6.23)*. The posterior tibial artery is usually accompanied by two veins. Remove the veins to clear the dissection field. *(G 444; L 121; N 506; R 490; C 465)*

10. Use blunt dissection to follow the posterior tibial artery and the tibial nerve proximally. Observe that the popliteal artery bifurcates at the inferior border of the popliteus muscle to form the **posterior tibial artery** and the **anterior tibial artery**.

11. Retract the contents of the popliteal fossa laterally and examine the **popliteus muscle** *(FIG. 6.23)*. The superior attachment of the popliteus muscle is the lateral condyle of the femur and its inferior attachment is the posterior surface of the proximal tibia. The popliteus muscle rotates the femur on the tibia to unlock the extended knee. It is also a weak flexor of the leg. *(G 445; L 121; N 506; R 457; C 466)*

12. Identify the **tibialis posterior muscle**. The superior attachments of the tibialis posterior muscle are the tibia, fibula, and interosseous membrane. The inferior attachments of the tibialis posterior muscle are the plantar surfaces of several tarsal bones. The tibialis posterior muscle is an inverter and plantar flexor of the foot.

13. The superior attachment of the **flexor digitorum longus muscle** is the tibia. Inferiorly, its tendons attach to the bases of the distal phalanges of the lateral four toes. The flexor digitorum longus muscle flexes toes 2 to 5 and plantar flexes the foot.

14. The superior attachment of the **flexor hallucis longus muscle** *(L. hallucis, great toe; genitive, hallucis*) is the inferior two-thirds of the fibula and interosseous membrane, and its inferior attachment is the base of the distal phalanx of the great toe. The flexor hallucis longus muscle flexes the great toe and plantar flexes the foot.

15. Posterior to the medial malleolus and deep to the flexor retinaculum, observe that the **posterior tibial artery** and the **tibial nerve** lie between the tendons of the flexor digitorum longus and flexor hallucis longus muscles *(FIG. 6.23)*. Posterior to the medial malleolus, the following mnemonic device may be used to identify the tendons and vessels in anterior to posterior order: **Tom, Dick and Harry** *(Tibialis posterior, flexor Digitorum longus, posterior tibial Artery, tibial Nerve, flexor Hallucis longus)*. *(G 446; L 120, 121; N 504; R 490; C 464)*

16. Once again, observe the vascular distribution in the posterior compartment of the leg *(FIG. 6.23)*. Identify the **fibular artery**. The fibular artery arises from the posterior tibial artery about 2 or 3 cm distal to the inferior border of the popliteus muscle. The fibular artery courses distally between the tibialis posterior muscle and the flexor hallucis longus muscle. It also supplies blood to the muscles of the lateral compartment of the leg and lateral side of the posterior compartment of the leg by means of several small branches.

17. The **perforating branch of the fibular artery** usually arises just above the ankle joint *(FIG 6.23)*. It perforates the interosseous membrane and anastomoses with a branch of the anterior tibial artery. Occasionally, the perforating branch of the fibular artery will give rise to the dorsalis pedis artery.
Dissection Follow-up

1. Replace the muscles of the posterior compartment of the leg into their correct anatomical positions.
2. Use the dissected specimen to review the attachments and action of each muscle dissected.
3. Follow the popliteal artery into the posterior compartment of the leg and identify its branches. Follow the posterior tibial artery distally and identify the origin of the fibular artery. Review the distribution of the arteries of the posterior compartment of the leg.
4. Follow the tibial nerve through the popliteal fossa and posterior compartment of the leg, observing that it gives off numerous muscular branches.
5. Review the relationships of the nerve, tendons, and vessels posterior to the medial malleolus and use this pattern to organize the contents of the deep posterior compartment of the leg.
6. Recall the rule of innervation of the posterior compartment of the leg:
   - All muscles in the posterior compartment of the leg are innervated by the tibial nerve.
LATERAL COMPARTMENT OF THE LEG

Dissection Overview

The lateral compartment of the leg contains two muscles: fibularis brevis and fibularis longus. The nerve of the lateral compartment is the superficial fibular nerve. The group action of the muscles in the lateral compartment of the leg is to evert and plantar flex the foot.

Dissection Instructions

1. Examine the crural fascia on the lateral side of the leg. Identify the superior fibular retinaculum, a thickening of the crural fascia (FIG. 6.24). It is found on the lateral side of the ankle posterior to the lateral malleolus.

2. About 2/3 of the way down the leg, identify the superficial fibular nerve where it penetrates the crural fascia (FIG. 6.3A). Follow the superficial fibular nerve distally. It is the primary cutaneous nerve to the dorsum of the foot and gives rise to several dorsal digital branches. The superficial fibular nerve is a branch of the common fibular nerve.

3. Use scissors to cut the crural fascia overlying the lateral compartment of the leg. Extend the cut as far inferiorly as the superior fibular retinaculum. Open the crural fascia and observe that the fibularis longus muscle is attached to its inner surface.

4. Follow the tendons of the fibularis brevis and fibularis longus muscles distally and observe that their tendons pass posterior to the lateral malleolus deep to the superior and inferior fibular retinacula (FIG. 6.24). Note that the tendon of the fibularis brevis is anterior to the tendon of the fibularis longus where they pass posterior to the lateral malleolus.

5. Follow the tendon of the fibularis brevis muscle inferiorly to its distal attachment on the tuberosity of the fifth metatarsal bone (FIG. 6.24).

6. Follow the tendon of the fibularis longus muscle inferiorly and observe that it turns around the lateral side of the cuboid bone and enters the sole of the foot. The tendon of the fibularis longus muscle attaches to the plantar surface of the medial cuneiform and first metatarsal bones and it will be dissected with the sole of the foot.

Dissection Follow-up

1. Use the dissected specimen to review the attachments and actions of the muscles in the lateral compartment of the leg.

2. Understand that the fibular artery supplies the muscles of the lateral compartment of the leg by contributing several small branches that penetrate the posterior intermuscular septum.

3. Recall the rule of innervation for the lateral compartment of the leg: [L 151]

   - The two muscles in the lateral compartment of the leg are innervated by the superficial fibular nerve.

ANTERIOR COMPARTMENT OF THE LEG AND DORSUM OF THE FOOT

Dissection Overview

The anterior compartment of the leg contains four muscles: tibialis anterior, extensor hallucis longus, extensor
digitorum longus, and fibularis tertius. The deep fibular nerve innervates the muscles of the anterior compartment. The group actions of the muscles in the anterior compartment are dorsiflexion of the foot, inversion of the foot, and extension of the toes.

The order of dissection will be as follows: The distribution of cutaneous nerves over the lower anterior surface of the leg and dorsal surface of the foot will be reviewed. The anterior aspect of the deep fascia of the leg and foot will be examined and the extensor retinacula will be identified. The anterior compartment of the leg will be opened and the relationships of tendons, vessels, and nerves will be examined on the anterior surface of the ankle. The tendon of each muscle of the anterior compartment will be followed into the foot. The intrinsic muscles of the dorsum of the foot will be identified. The deep vessels and deep nerve of the leg and dorsum of the foot will be dissected.

**Dissection Instructions**

1. Place the cadaver in the supine position.
2. Recall that the superficial fibular nerve provides most of the cutaneous innervation to the anterior surface of the ankle and dorsum of the foot (FIG. 6.3A).
3. Remove the remnants of superficial fascia on the anterior surface of the leg and dorsum of the foot so that the crural fascia and deep fascia of the foot are clearly exposed. Preserve the branches of the superficial fibular nerve.
4. Observe the crural fascia and note that it is firmly attached to the anterior border of the tibia.
5. Identify the superior and inferior extensor retinacula on the anterior surface of the ankle (FIGS. 6.24 and 6.25). The retinacula are transverse thickenings of the crural fascia that hold tendons in place. The superior extensor retinaculum extends across the tendons superior to the ankle joint. The inferior extensor retinaculum is at the level of the ankle joint and it is Y-shaped. The stem of the “Y” is directed laterally and is attached to the calcaneus (FIG. 6.24).
6. Use a scalpel to make a vertical cut through the crural fascia just below the lateral condyle of the tibia. Use forceps to lift the edges of the crural fascia and observe that the muscles of the anterior compartment are attached to its deep surface. Extend the cut through the crural fascia in the distal direction as far as the inferior extensor retinaculum.
7. The superior attachments of the anterior muscles of the leg are on the proximal tibia, fibula, and interosseous membrane. Do not attempt to dissect the superior attachments.
8. Observe the vessels and nerves, and the tendons of the anterior muscles of the leg where they pass deep to the inferior extensor retinaculum. From medial to lateral, identify (FIG. 6.25):

   - Tibialis anterior tendon
   - Extensor hallucis longus tendon
   - Anterior tibial vessels
   - Deep fibular nerve
   - Extensor digitorum longus tendon
   - Fibularis tertius muscle

9. Follow the tendon of the tibialis anterior muscle into the foot. Observe that the inferior attachment of the tibialis anterior tendon is the first cuneiform bone and the base of the first metatarsal bone. The tibialis anterior muscle dorsiflexes and inverts the foot.
10. Follow the tendon of the extensor hallucis longus muscle into the foot. Observe that the inferior attachment of the extensor hallucis longus tendon is the base of the distal phalanx of the great toe. The extensor hallucis longus muscle extends the great toe and dorsiflexes the foot.
11. Observe that the tendons of the extensor digitorum longus muscle attach to the middle and distal phalanges of the lateral four toes. The extensor digitorum longus muscle extends the toes and dorsiflexes the foot. Note that each of these tendons forms an extensor expansion (FIG. 6.25).
12. Follow the tendon of the fibularis tertius muscle to its inferior attachment on the dorsal surface of the shaft of the fifth metatarsal bone (FIG. 6.25). The fibularis tertius muscle dorsiflexes the foot and assists in eversion of the foot. The fibularis tertius muscle is absent in about 5% of specimens.
13. At the level of the superior extensor retinaculum, identify the anterior tibial artery (FIG. 6.25). Follow the anterior tibial artery proximally. Use your fingers to forcibly separate the extensor digitorum longus muscle and the tibialis anterior muscle. Follow the anterior tibial artery proximally between these two muscle bellies. [G 432; L 132; N 507; R 494; C 447]
14. Use blunt dissection to clean the anterior tibial artery. Note that it passes posteriorly over the superior border of the interosseous membrane (FIG. 6.25).
15. Observe that the deep fibular nerve joins the anterior tibial artery just below the knee (FIG. 6.25). The deep fibular nerve is the motor nerve of the anterior compartment of the leg and the muscles in the dorsum of the foot. Trace the deep fibular nerve proximally and confirm that it is a branch of the common fibular nerve.
**CLINICAL CORRELATION**

**COMMON FIBULAR NERVE**

The common fibular nerve is the most frequently injured nerve in the body because of its superficial position and relationship to the head and neck of the fibula. When the common fibular nerve is injured, there is impairment of eversion, dorsiflexion of the foot, and extension of the toes. The result is a condition called “foot drop,” resulting in steppage gait (the advancing foot hangs with the toes pointed toward the ground, the knee being lifted high so that the toes may clear the ground). There will also be sensory loss on the dorsum of the foot and toes.

16. Use scissors to cut the superior and inferior extensor retinacula between the extensor digitorum longus and extensor hallucis longus tendons (FIG. 6.25, dashed lines). Retract the tendons of the extensor digitorum longus muscle in the lateral direction.

17. On the dorsum of the foot deep to the tendons of the extensor digitorum longus muscle, identify the extensor digitorum brevis muscle and the extensor hallucis brevis muscle (FIG. 6.25). The extensor digitorum brevis and extensor hallucis brevis muscles share a common muscle belly that attaches to the calcaneus. Four tendons arise from this muscle belly and attach to the extensor expansions of toes 1 to 4. The portion of this muscle that attaches
on the great toe is called the extensor hallucis brevis muscle. These muscles extend the toes and they are innervated by the deep fibular nerve.

18. Return to the ankle region and trace the anterior tibial artery deep to the inferior extensor retinaculum. As the anterior tibial artery crosses the ankle joint, its name changes to dorsalis pedis artery (L. pes, pedis, foot). [G 434; L 133; N 508; R 499; C 450]

19. Follow the dorsalis pedis artery onto the dorsum of the foot. The dorsalis pedis artery lies on the lateral side of the extensor hallucis longus tendon at the ankle. In the living person, the pulse of the dorsalis pedis artery can be palpated between the tendons of the extensor hallucis longus muscle and the extensor digitorum longus muscle.

20. Identify the arcuate artery. The arcuate artery is a branch of the dorsalis pedis artery that crosses the proximal ends of the metatarsal bones. The lateral three dorsal metatarsal arteries are branches of the arcuate artery. [G 435; L 133; N 508; R 499; C 459]

21. Identify the lateral tarsal artery. The lateral tarsal artery arises from the dorsalis pedis artery near the ankle joint and passes deep to the extensor digitorum brevis and extensor hallucis brevis muscles. The lateral tarsal artery joins the lateral end of the arcuate artery to complete an arterial arch.

22. Identify the deep plantar artery. The deep plantar artery arises from the dorsalis pedis artery near the origin of the arcuate artery. The deep plantar artery passes between the first and second metatarsal bones to enter the sole of the foot. In the sole of the foot, the deep plantar artery anastomoses with the plantar arch.

23. At the level of the ankle, identify the deep fibular nerve between the tendons of the extensor hallucis longus and extensor digitorum longus muscles (FIG. 6.25). Use blunt dissection to follow the deep fibular nerve onto the dorsum of the foot. Note that the deep fibular nerve innervates the extensor digitorum brevis muscle and the extensor hallucis brevis muscle. The deep fibular nerve then continues toward the great toe to give rise to two dorsal digital branches.

24. Use an illustration and your cadaver specimen to trace the cutaneous branch of the deep fibular nerve to the region of skin between the great toe and the second toe (FIG. 6.25). Understand that the skin between the great toe and the second toe is the only skin on the dorsum of the foot that is innervated by the deep fibular nerve.

Dissection Follow-up

1. Use the dissected specimen to review the attachments and actions of the muscles in the anterior compartment of the leg.
The order of dissection will be as follows: The plantar aponeurosis will be cleaned of superficial fascia and studied. It will then be reflected to expose the first layer of the sole. The dissection will proceed from superficial (inferior) to deep (superior) and each of the four layers of the sole will be dissected. Note that abduction and adduction movements of the toes are described around an axis of reference that passes through the second digit (second toe). This convention differs from the hand, in which the axis of reference passes through the third digit.

Dissection Instructions

Plantar Aponeurosis and Cutaneous Nerves [G 451; L 134; N 520; R 463; C 470]

1. Place the cadaver in the prone position.
2. If the skin has not been removed from the sole of the foot, refer to FIGURE 6.2C and complete the skin removal.

3. Note that the plantar fascia over the medial and lateral sides of the sole is thin. In the middle of the sole, it is thickened to form the plantar aponeurosis (FIG. 6.27A).
4. Use a scalpel blade to scrape the superficial fascia off the plantar aponeurosis. The plantar aponeurosis is attached to the calcaneus posteriorly and it divides distally into five bands, one to each toe. Note that the five bands are joined by the superficial transverse metatarsal ligaments.
5. Use a scalpel to cut the plantar aponeurosis longitudinally (FIG. 6.27B, dashed line). The plantar aponeurosis is approximately 4-mm thick. Do not cut too deeply.
6. Make two transverse cuts through the plantar aponeurosis: one cut at the proximal end close to the calcaneus and one cut in the anterior one-third of the foot (FIG. 6.27B, dashed lines).
7. Tough bands of connective tissue attach the plantar aponeurosis to the metatarsal bones. Use a
First Layer of the Sole  [G 452; L 135; N 521; R 463; C 471]
1. Identify the flexor digitorum brevis muscle, which lies immediately deep to the plantar aponeurosis (FIG. 6.28). The proximal attachments of the flexor digitorum brevis muscle are the calcaneal tuberosity and the plantar aponeurosis. The distal attachments of the flexor digitorum brevis muscle are the middle phalanges of the lateral four toes. The flexor digitorum brevis muscle flexes the lateral four toes. Trace the flexor digitorum brevis tendons to their distal attachments. Remove remnants of the plantar aponeurosis as necessary.

2. Identify the abductor hallucis muscle (FIG. 6.28). The abductor hallucis muscle is located on the medial side of the flexor digitorum brevis muscle. The proximal attachments of the abductor hallucis muscle are the medial side of the calcaneal tuberosity and the plantar aponeurosis. The distal attachment of the abductor hallucis muscle is on the medial side of the base of the proximal phalanx of the great toe and it abducts the great toe. Use blunt dissection to follow the tendon to its distal attachment.

3. Identify the abductor digiti minimi muscle (FIG. 6.28). The proximal attachments of the abductor digiti minimi muscle are the lateral side of the calcaneal tuberosity and the plantar aponeurosis and its distal attachment is on the lateral side of the base of the proximal phalanx of the fifth (small) toe. The abductor digiti minimi muscle abducts the fifth toe. Follow the tendon to its distal attachment.

4. In the distal one-third of the sole of the foot, look for common and proper plantar digital nerves, which are branches of the medial and lateral plantar nerves (FIG. 6.28). The common and proper digital nerves lie between the tendons just identified.

Second Layer of the Sole  [G 453; L 136; N 522; R 464; C 472]
1. Use scissors to transect the flexor digitorum brevis muscle close to the calcaneus (FIG. 6.28, dashed line). Reflect the muscle distally.

2. Scalpel to cut these bands and release the plantar aponeurosis from the underlying structures. Reflect the flaps medially or laterally, respectively, and remove them.
2. Push a probe deep to the abductor hallucis muscle from superior to inferior along the course of the posterior tibial artery and tibial nerve. Cut the abductor muscle over the probe (FIG. 6.28, dashed line).
3. Use blunt dissection to follow the posterior tibial artery and tibial nerve into the sole. Identify the medial and lateral plantar nerves and arteries (FIG. 6.29).
4. Identify the quadratus plantae muscle, which is deep to the flexor digitorum brevis muscle (FIG. 6.29). The proximal attachment of the quadratus plantae muscle is the calcaneus and its distal attachment is the tendon of the flexor digitorum longus muscle. The quadratus plantae muscle assists the flexor digitorum longus muscle in flexing the lateral four toes.
5. Use a probe to dissect the flexor digitorum longus tendons in the sole of the foot. Observe that its four tendons pass through the tendons of the flexor digitorum brevis muscle in the toes (FIG. 6.29).
6. Observe that four lumbrical muscles arise from the tendons of the flexor digitorum longus muscle. The distal attachments of the lumbrical muscles are the extensor expansions of the lateral four toes.

Third Layer of the Sole [G 454; L 137; N 523; R 465; C 475]
1. Use scissors to transect the flexor digitorum longus tendon where it is joined by the quadratus plantae muscle (FIG. 6.29, dashed line). Reflect the tendons distally, along with the lumbrical muscles.
2. Identify the flexor hallucis brevis muscle (FIG. 6.30). The flexor hallucis brevis muscle has a medial head and a lateral head, and each head has its own tendon. A sesamoid bone is found in each of the tendons. The proximal attachments of the flexor hallucis brevis muscle are the first metatarsal bone, the cuboid bone, and the third cuneiform bone. The distal attachment of the flexor hallucis brevis muscle is the base of the proximal phalanx of the great toe and it flexes the great toe.
3. Observe that the tendon of the flexor hallucis longus muscle passes between the sesamoid bones that are located in the two flexor hallucis brevis tendons. Verify that the tendon of the flexor hallucis longus is attached to the base of the distal phalanx of the great toe (FIG. 6.30).
4. Identify the adductor hallucis muscle. The adductor hallucis muscle has a transverse head and
FIGURE 6.30 Sole of the foot. Third layer of muscles.

an oblique head (FIG. 6.30). Both heads attach to the lateral side of the base of the proximal phalanx of the great toe. The adductor hallucis muscle ad-ducts the great toe (i.e., moves it toward the second toe).

5. Identify the flexor digiti minimi brevis muscle. The proximal attachment of the flexor digiti minimi brevis muscle is the base of the fifth metatarsal bone and its distal attachment is the base of the proximal phalanx of the fifth toe. The flexor digiti minimi brevis muscle flexes the fifth toe.

Fourth Layer of the Sole  [G 455; L 138; N 524; R 465; C 476]

1. Use blunt dissection to trace the lateral plantar artery distally. At the level of the base of the metatarsal bones, the lateral plantar artery turns deeply to form the plantar arch (FIG. 6.30). Follow the plan- tar arch medially until it passes deep to the oblique head of the adductor hallucis muscle.

2. The medial end of the plantar arch is formed by the deep plantar artery, a branch of the dorsalis pedis artery (FIG. 6.25). Use an illustration to study the pattern of distribution of the plantar metatarsal arteries that arise from the plantar arch.  [G 454; L 138; N 524; R 502; C 476]

3. The interosseous muscles are located superior (deep) to the plantar arch. Use an illustration to study the interosseous muscles (FIG. 6.31).  [G 455; L 138; N 525; R 465, 502; C 476] The four Dorsal interosseous muscles are ABductors (DAB), and the three Plantar interosseous muscles are ADductors (PAD) of the toes. Recall that the reference axis for abduction and adduction passes through the second toe.

4. Locate the fibularis longus tendon posterior to the lateral malleolus (FIG. 6.30). Insert a probe along its superficial surface, deep to the flexor digiti minimi brevis and abductor digiti minimi muscles. Use scissors to transect the muscles over the probe and reflect them. Follow the fibularis longus tendon into the sole of the foot and note that it turns deeply around the lateral surface of the cuboid bone.
5. In the sole, insert the probe along the superficial surface of the fibularis longus tendon (into its tendon sheath) and gently push the probe medially across the sole as far as it will go. The tip of the probe will stop near the distal attachment of the fibularis longus tendon. Wiggle the probe so that you can see where the tip is and note that the fibularis longus tendon crosses the sole of the foot at its deepest plane. The distal attachment of the fibularis longus tendon is onto the base of the first metatarsal bone and the first cuneiform bone.

6. Follow the tibialis posterior tendon distally and verify that it has a broad distal attachment on the navicular bone, all three cuneiform bones, and the bases of the second, third, and fourth metatarsal bones (FIG. 6.30).

7. Once again, identify the flexor hallucis longus muscle in the posterior compartment of the leg. Follow its tendon distally until it disappears into an osseofibrous tunnel at the medial side of the ankle. Push a probe into the tunnel, and then open the tunnel by cutting down to the probe with a scalpel. Lift the tendon of the flexor hallucis longus muscle with a probe and verify that it crosses the inferior surface of the sustentaculum tali. The sustentaculum tali acts as a pulley to change the direction of force of the flexor hallucis longus muscle.

Dissection Follow-up

1. Replace the structures of the four layers of the sole of the foot into their correct anatomical positions.

2. Using the dissected specimen, review the attachments and action of each muscle. Organize the muscles from superficial (inferior) to deep (superior).

3. Follow the posterior tibial artery from its origin in the leg to its bifurcation in the sole of the foot. Use an illustration and the dissected specimen to review the distribution of the medial and lateral plantar arteries. Review the connection between the deep plantar arch and the deep plantar branch of the dorsalis pedis artery.

4. Trace the course of the tibial nerve from the popliteal fossa to the medial side of the ankle. Follow its two branches in the sole of the foot (medial and lateral plantar nerves). Use a textbook description to help you relate the motor and sensory function of the lateral and medial plantar nerves to your dissected specimen: [L 153]

- The medial plantar nerve innervates the abductor hallucis muscle, flexor digitorum brevis muscle, flexor hallucis brevis muscle, and medial lumbrical muscle. The medial plantar nerve will provide cutaneous innervation to the plantar surfaces of the medial 3½ toes. The motor and cutaneous distribution of the medial plantar nerve is comparable to the distribution of the median nerve in the hand.

- The lateral plantar nerve innervates all other muscles in the sole of the foot and provides cutaneous innervation to the plantar surfaces of the lateral 1½ toes. The motor and cutaneous distribution of the lateral plantar nerve is comparable to the distribution of the ulnar nerve in the hand.

- The proper plantar digital nerves innervate the dorsal surface of the toes as far proximally as the distal interphalangeal joint. The nail bed is included in the area innervated by the proper plantar digital nerves. This pattern of innervation has significance for proper application of local anesthesia prior to removal of damaged toe nails.

JOINTS OF THE LOWER LIMB

Dissection Overview

Dissect the joints of one lower limb. Keep the soft tissue structures of the other limb intact for review purposes.

The order of dissection will be as follows: The hip will be dissected, then the knee joint. The ankle joint will be dissected. The intermetatarsal joints, which are responsible for inversion and eversion, will be studied. During this dissection, the muscles of one limb will be removed. Take advantage of this opportunity to review the attachments, innervation, and action of each muscle as it is removed.

Dissection Instructions

Hip Joint

1. Review the bony features of the hip joint. Three bones form the acetabulum: ilium, ischium, and

...
CHAPTER 6: THE LOWER LIMB

199

1. Review the proximal end of the femur and identify the following: head, fovea for the ligament of the head, neck, and intertrochanteric line.

2. Remove the sartorius muscle, rectus femoris muscle, and pectineus muscle.

3. Identify the iliopsoas muscle. Trace its tendon to the lesser trochanter. Sever the tendon of the iliopsoas muscle close to the lesser trochanter and reflect the muscle superiorly.

4. Use an illustration to identify the ligaments that contribute to the formation of the fibrous joint capsule: iliofemoral ligament, ischiofemoral ligament, and pubofemoral ligament (FIGS. 6.32 and 6.33). [G 402, 403; L 140; N 475; R 444, 445; C 480]

5. Examine the iliofemoral ligament. Verify that the distal end of the iliofemoral ligament is attached to the intertrochanteric line of the femur. The proximal end is attached to the anterior inferior iliac spine and the margin of the acetabulum.

6. Flex and extend the femur. Observe that the iliofemoral ligament becomes lax in flexion and taut in extension. The iliopsoas ligament prevents over-extension of the hip joint.

7. Use a scalpel to open the anterior aspect of the joint capsule as illustrated in FIGURE 6.32.

8. Inside the joint capsule, observe the cartilage on the articular surface of the head of the femur.

9. Abduct and laterally rotate the femur. Identify the ligament of the head of the femur (FIG. 6.32).

10. Identify the obturator externus muscle. Note that the obturator externus muscle passes inferior to the neck of the femur.

11. Remove the obturator externus muscle to expose the pubofemoral ligament.

12. Turn the specimen to the prone position.

13. Remove the piriformis, superior gemellus, obturator internus, inferior gemellus, quadratus femoris, gluteus medius, and gluteus minimus muscles.

14. Use a scalpel and scraping motions to clean the posterior surface of the joint capsule (FIGURES 6.32 and 6.33).

15. Identify the ischiofemoral ligament, which runs from the acetabular margin to the neck of the femur. Note that the ischiofemoral ligament does not attach to the intertrochanteric crest but leaves an area where the synovial membrane of the hip joint is exposed.

16. Extend the femur. Observe that the ischiofemoral ligament becomes taut and limits extension of the hip joint.

17. Open the posterior wall of the joint cavity by incising the capsule as shown in FIGURE 6.33. Observe the thickness of the joint capsule.
18. The next objective is to disarticulate the hip joint. Return the specimen to the supine position. Insert a probe under the ligament of the head of the femur (FIG. 6.32) and cut the ligament with a scalpel. Rotate the femur laterally and the head of the femur will come out of the acetabulum.

19. Examine the head and neck of the femur (FIG. 6.34). Identify the articular surface of the head of the femur. Observe the cut end of the ligament of the head of the femur and identify the artery of the ligament of the head of the femur in the center of the ligament. Use an illustration to review the blood supply to the head and neck of the femur.

20. Identify the lunate surface in the acetabulum (FIG. 6.34). Note that the ligament of the femur lies in the acetabular notch. [G 404; L 141; N 475; R 445; C 481]

21. Identify the transverse acetabular ligament that bridges the acetabular notch and the acetabular labrum that surrounds the rim of the acetabulum.

**Clinical Correlation**

**Neck of the Femur**

A fracture of the neck of the femur disrupts the blood supply to the head of the femur. If the blood supply (via the artery of the ligament of the head) is insufficient, the head will become necrotic. Necrosis of the femoral head is a common complication in femoral neck fractures in the elderly.

**Knee Joint**

1. Review the skeleton of the knee. On the distal end of the femur, identify the **medial condyle, lateral condyle, and intercondylar fossa**. On the proximal end of the tibia, identify the **superior articular surface, medial condyle, lateral condyle, and intercondylar eminence**. On the patella, identify the **articular surface and anterior surface**.

2. On the medial side of the knee, use a scalpel to detach the tendons of the sartorius, gracilis, and semitendinosus muscles from their distal attachments (pes anserinus). [G 420; L 142, 143; N 494; R 447; C 485]

3. Reflect the muscles and identify the **tibial collateral ligament** of the knee (FIG. 6.35). Note that the tibial collateral ligament is attached to the medial meniscus through the joint capsule.

4. On the lateral side of the knee, cut the tendon of the biceps femoris muscle close to its distal attachment on the head of the fibula.

5. Reflect the biceps femoris muscle and identify the **fibular collateral ligament** of the knee. Note that the fibular collateral ligament is not attached to the external surface of the joint capsule (FIG. 6.35). Observe that the popliteus tendon passes between the fibular collateral ligament and the joint capsule. [G 420; L 145; N 494; R 447; C 487]

6. On the posterior surface of the knee, remove the popliteal vessels, the tibial nerve, and the common fibular nerve.

7. Detach the semimembranosus and semitendinosus tendons near their distal attachments and reflect the muscles. Note the oblique popliteal ligament that sweeps superiorly and laterally from the tendon of the semimembranosus muscle. The oblique popliteal ligament reinforces the posterior surface of the knee joint capsule.

8. Free the plantaris muscle and both heads of the gastrocnemius muscle from the joint capsule. Detach the superior attachments of these muscles close to the femur.

9. Remove the popliteus muscle. As you do so, note the presence of the arcuate popliteal ligament that spans across the superficial surface of the popliteus tendon. During removal of the popliteus muscle, the posterior wall of the joint capsule will be opened. Clear away the remnants of the posterior wall of the joint capsule to expose the joint cavity.

10. From the posterior view, identify the **posterior cruciate ligament** (FIG. 6.35A). Verify that the cruciate ligaments are located outside of the synovial cavity but are inside the joint capsule. [G 418; L 145; N 497; R 447; C 492]

11. On the anterior surface of the knee, identify the tendon of the quadriceps femoris muscle. Observe that the tendon has **patellar retinacula** that help...
The anterior cruciate ligament prevents the tibia from being pulled anteriorly.

17. Flex the leg and pull the tibia anteriorly. Note the tightness of the joint. Cut the anterior cruciate ligament. Now flex the leg and pull the tibia anteriorly. Feel the forward movement of the tibia. This forward movement indicates a ruptured anterior cruciate ligament and is an important clinical sign (anterior drawer sign).

18. Observe the menisci (FIG. 6.35C). Note that the medial meniscus is firmly attached to the tibial collateral ligament. In contrast, the lateral meniscus is not attached to the fibular collateral ligament.

**Clinical Correlation**

**Knee Injuries**

The medial meniscus is injured six to seven times more often than the lateral meniscus because the medial meniscus is firmly attached to the tibial collateral ligament.

Forced abduction and lateral rotation of the leg may result in the simultaneous injury of three structures: tibial collateral ligament, medial meniscus, and anterior cruciate ligament. The injury has been named the "unhappy triad." This injury is caused by a blow to the lateral side of the knee and is a common injury in contact sports.
Ankle Joint  [G 462; L 146; N 515; R 451; C 502, 503]
1. Review the bony landmarks related to the ankle joint. On the distal end of the fibula, identify the lateral malleolus. On the distal end of the tibia, identify the medial malleolus. On the talus, identify the trochlea. Review the tarsal bones.
2. Cut and reflect the tendons, vessels, and nerves that cross the anterior aspect of the ankle joint. Leave a 7.5-cm long portion of the tibialis anterior tendon attached to the medial cuneiform and first metatarsal bone.
3. On the medial aspect of the ankle joint, cut and reflect the flexor digitorum longus muscle. Retract the tendon of the tibialis posterior muscle anteriorly. Do not cut it.
4. Clean and define the medial (deltoid) ligament of the ankle (FIG. 6.36A). Identify its four parts:
   • Posterior tibiotalar ligament
   • Tibiocalcaneal ligament
   • Tibionavicular ligament
   • Anterior tibiotalar ligament
5. On the lateral side of the ankle, identify the tendons of the fibularis longus and fibularis brevis muscles. Open the superior and inferior fibular retinacula.

FIGURE 6.36 Right ankle joint. A. Medial view. B. Lateral view.
wired laboratory skeletons can be damaged). With one hand, immobilize the ankle joint by holding the talus stationary between the tibia and fibula. With the other hand, invert and evert the foot. Observe:

- The talus remains fixed in the ankle joint.
- The foot rotates about the inferior surface of the talus (subtalar joint) and anterior surface of the talus (talonavicular and talocuboid joints).

2. In the cadaver specimen, produce eversion by pulling on the tendons of the fibularis longus and fibularis brevis muscles. Produce inversion by simultaneously pulling on the tendons of the tibialis anterior and tibialis posterior muscles.

3. Observe that these movements occur in the transverse tarsal joint (calcaneocuboid and talonavicular joints) and the subtalar joint.

4. The longitudinal arch of the foot is supported by ligaments that span the tarsal bones. In the sole of the foot, remove the flexor digitorum brevis and quadratus plantae muscles. Observe the long plantar ligament and the short plantar ligament (FIG. 6.37). [G 472; L 147; N 516; R 450; C 506]

5. Remove the tendon of the tibialis posterior muscle where it crosses inferior to the talus. Identify the plantar calcaneonavicular (spring) ligament (FIG. 6.37). This ligament and the tibialis posterior tendon support the head of the talus and the longitudinal arch.

Retract the tendons of the fibularis longus and fibularis brevis muscles anteriorly.

6. Clean and define the lateral ligament of the ankle (FIG. 6.36B). Identify its three parts:

- Posterior talofibular ligament
- Calcaneofibular ligament
- Anterior talofibular ligament

7. Dorsiflex and plantar flex the ankle joint. Observe that these are the only actions of the ankle joint.
The Head and Neck

The study of head and neck anatomy provides a considerable intellectual challenge because the region is packed with small, important structures. These structures are associated with the proximal ends of the respiratory and gastrointestinal systems, the cranial nerves, and the organs of special sense. Dissection of the head and neck provides a special problem in that peripheral structures must be dissected long before their parent structure can be identified and a full understanding of the region cannot be gained until the final dissection is completed.

NECK

The neck is a region of transition between the head and the thorax. The major vessels that supply the head pass through the neck. The nerves that innervate the organs within the thorax and abdomen pass through the neck. Portions of several systems are located in the neck: gastrointestinal system (pharynx and esophagus), respiratory system (larynx and trachea), cardiovascular system (major vessels to the head and upper limbs), central nervous system (spinal cord), and endocrine system (thyroid and parathyroid glands). Finally, nerves and vessels to the upper limbs pass through the inferior part of the neck.

The superficial aspects of the neck (superficial fascia, superficial veins, and cutaneous nerves) will be dissected first. Then the neck will be divided into regions defined as triangles. The boundaries of the triangles will be described and the anatomy discussed within these boundaries. It is important to note that the triangles are merely organizational aids and that their boundaries must not be allowed to interfere with understanding the neck as an integrated whole. The vascular structures that go to the head as well as the endocrine glands in the neck will be dissected. The pharynx and larynx will be dissected after the head because they cannot be mobilized until after the head is dissected.

Skeleton of the Neck

The bones of the neck were first studied in Chapter 1, The Back. Use an articulated skeleton and your atlas to recall several characteristics of the cervical vertebrae. Cervical vertebrae have:

- Small bodies
- Relatively large vertebral foramina
- Bifid spinous processes
- Transverse processes that contain a transverse foramen (foramen transversarium)

Observe the following features of individual cervical vertebrae: [G 298; L 7, 8; N 19, 22; R 200; C 388]

- Atlas (C1)
  - Anterior arch and tubercle
  - Transverse process with transverse foramen
  - Groove for vertebral artery
  - Posterior arch and tubercle
  - Superior articular surface for occipital condyle
  - Note that the atlas does not have a body.

- Axis (C2)
  - Dens
  - Body
  - Transverse process with transverse foramen
  - Lamina
  - Spinous process
  - Superior articular facet for atlas

- Vertebrae C3 to C7
  - Body
  - Transverse process with transverse foramen
  - Groove for spinal nerve
  - Lamina
  - Spinous process
  - Note that C7 has the longest cervical spinous process (vertebra prominens).
The external jugular vein will be identified. Several cutaneous branches of the cervical plexus (great auricular nerve, lesser occipital nerve, transverse cervical nerve, and supraclavicular nerves) will be dissected. The accessory nerve (cranial nerve XI) will be identified and followed from the sternocleidomastoid muscle to the trapezius muscle.

Dissection Instructions
Skin Removal
1. The skin is thin on the neck. Be careful when removing it.
2. Refer to FIGURE 7.2 and make an anterior midline skin incision from the jugular notch of the sternum (E) to the chin (F).
3. Make a second skin incision 1 cm superior to the base of the mandible from point F to a point just anterior to the ear lobe (G).
4. Make a skin incision in the transverse plane from point G to the external occipital protuberance (H). If the back has been dissected, part of this incision has been made previously.
5. If the back has not been dissected, make a skin incision along the superior border of the trapezius muscle from point H to the acromion (I).
6. If the thorax has not been dissected, make an incision along the anterior surface of the clavicle from point I to the jugular notch of the sternum (E).

Dissection Overview
The order of dissection will be as follows: The skin will be removed from the anterior and lateral surfaces of the neck. The platysma muscle will be studied and reflected.

The visceral part of the neck has the following boundaries:

- **Posterior** – the cervical vertebrae
- **Posterolateral** – the scalene muscles
- **Lateral** – the sternocleidomastoid muscle
- **Anterior** – the infrahyoid muscles

Large vessels and nerves lie lateral to the cervical viscera (Fig. 7.1). The carotid artery (internal carotid artery at more superior levels), internal jugular vein, and vagus nerve are contained within the carotid sheath.

### FIGURE 7.1
Transverse section through the neck.
CHAPTER 7: THE HEAD AND NECK

7. Beginning at the anterior midline, reflect the skin in the lateral direction as far as the anterior border of the trapezius muscle. Detach the skin and place it in the tissue container.

**Posterior Triangle of the Neck** [G 758; L 297; N 25, 26; R 178; C 529]

For descriptive purposes, the neck is divided into an anterior triangle and a posterior triangle (FIG. 7.3). The boundaries of the posterior triangle of the neck are:

- **Anterior** – the posterior border of the sternocleidomastoid muscle
- **Posterior** – the superior border of the trapezius muscle
- **Inferior** – the middle one-third of the clavicle
- **Superficial (roof)** – investing layer of the deep cervical fascia
- **Deep (floor)** – muscles of the neck covered by prevertebral fascia

The cutaneous nerves for the shoulder and anterior neck pass to the surface through the posterior triangle of the neck. Therefore, these structures are dissected with the posterior cervical triangle even though they may distribute over the shoulder or anterior triangle. Note that the structures identified in dissection steps 1 through 5 lie within the superficial fascia of the neck. The accessory nerve identified in step 6 lies deep to the investing layer of the deep cervical fascia.

1. Examine the **platysma muscle** in the superficial fascia (FIG. 7.4). The platysma muscle covers the lower part of the posterior triangle. At its inferior end, the platysma muscle passes superficial to the clavicle and attaches to the superficial fascia of the deltoid and pectoral regions. Superiorly, the platysma muscle is attached to the mandible, skin of the cheek, angle of the mouth, and orbicularis oris muscle. It is innervated by the **cervical branch of the facial nerve** (VII).

2. Note that some of the structures to be dissected in steps 4 and 5 are in contact with the deep surface of the platysma muscle (supraclavicular nerves,
transverse cervical nerve, external jugular vein). Preserve them while performing dissection step 3.

3. Near the clavicle, use a probe to raise the medial inferior border of the platysma muscle (FIG. 7.4, arrow). Carefully use sharp dissection to free the platysma muscle from the vessels and nerves on its deep surface and reflect the muscle superiorly as far as the mandible. Leave the platysma muscle attached along the base of the mandible.

4. Identify the external jugular vein (FIG. 7.5). The external jugular vein is in the superficial fascia deep to the platysma muscle. The external jugular vein begins posterior to the angle of the mandible and crosses the superficial surface of the sternocleidomastoid muscle. About 3 cm superior to the clavicle, the external jugular vein pierces the investing layer of the deep cervical fascia (roof of the posterior triangle) to drain into the subclavian vein. [G 760; L 306; N 30; R 178; C 530]

5. The skin of the neck and part of the posterior head is innervated by cutaneous nerves that are branches of the cervical plexus. The cutaneous nerves enter the superficial fascia near the midpoint of the posterior border of the sternocleidomastoid muscle (FIG. 7.5). Identify:

- **Lesser occipital nerve** – parallels the posterior border of the sternocleidomastoid muscle as it passes superiorly. The lesser occipital nerve supplies the part of the scalp that is immediately behind the ear.

- **Great auricular nerve** – crosses the superficial surface of the sternocleidomastoid muscle parallel to the external jugular vein. The great auricular nerve supplies the skin of the lower part of the ear, the skin over the parotid gland, and an area of skin extending from the angle of the mandible to the mastoid process.

- **Transverse cervical nerve** – passes transversely across the sternocleidomastoid muscle and neck. It supplies the skin of the anterior triangle of the neck. If you have trouble finding the transverse cervical nerve, it may have been removed with the platysma muscle.

- **Supraclavicular nerves** – pass inferiorly to innervate the skin of the shoulder. Observe medial, intermediate, and lateral branches.

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**CLINICAL CORRELATIONS**

**DIAPHRAGMATIC PAIN REFERRED TO THE SHOULDER**

The supraclavicular nerves and the phrenic nerve share a common origin from spinal cord segments C3 and C4. Irritation of the parietal pleura or parietal peritoneum covering the diaphragm produces pain that is carried by the phrenic nerve and referred to the area supplied by the supraclavicular nerves (shoulder region).

6. The **accessory nerve (XI)** crosses the posterior cervical triangle deep to the investing layer of deep cervical fascia. It courses from slightly superior to the midpoint of the posterior border of the sternocleidomastoid muscle to the superior border

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**FIGURE 7.5** Posterior triangle of the neck. The accessory nerve lies deep to the investing layer of deep cervical fascia.
CHAPTER 7: THE HEAD AND NECK

5. Review the course of the occipital artery at the apex of the posterior triangle.

ANTERIOR TRIANGLE OF THE NECK

Dissection Overview

The boundaries of the anterior triangle of the neck are (FIG. 7.3):

- **Medial** – the median plane of the neck
- **Lateral** – the anterior border of the sternocleidomastoid muscle
- **Superior** – the inferior border of the mandible
- **Superficial (roof)** – investing layer of the deep cervical fascia
- **Deep (floor)** – larynx and pharynx

For descriptive purposes, the anterior triangle is divided by the digastric and omohyoid muscles into smaller triangles: muscular, carotid, submandibular, and submental (FIG. 7.3).

Bones and Cartilages

Use an illustration to identify the bony and cartilaginous landmarks that will be used as reference structures (FIG. 7.6): [G 767; L 307; N 28; R 175; C 519]

- **Hyoid bone** – (Gr. hyoideus, U-shaped) at the angle between the floor of the mouth and the superior end of the neck

Dissection Follow-up

1. Review FIGURE 7.1 and note that the platysma muscle, external jugular vein, and cutaneous nerves of the neck are all located in the superficial fascia. Of the structures just dissected, only the accessory nerve is located deep to the investing layer of deep cervical fascia.

2. Use an atlas illustration to review the relationship of the platysma muscle to the cutaneous branches of the cervical plexus. Note that the transverse cervical nerve crosses the neck deep to the platysma muscle but that its branches pass through the muscle to reach the skin of the anterior neck.

3. Review the area of distribution of all cutaneous branches of the cervical plexus.

4. Review the course of the accessory nerve. Note that the accessory nerve is superficial in the neck where it is vulnerable to injury by laceration or blunt trauma.

7. The inferior portion of the posterior triangle will be dissected with the root of the neck.

of the trapezius muscle (FIG. 7.5). Use blunt dissection to free the accessory nerve from the surrounding connective tissue. Note that branches of spinal nerves C3 and C4 join the accessory nerve in the posterior cervical triangle and these branches provide proprioceptive sensory innervation. The accessory nerve innervates the sternocleidomastoid muscle and the trapezius muscle. If the back has been dissected, confirm that the accessory nerve may be found on the deep surface of the trapezius muscle.

Platysma m. (cut)
Anterior belly of digastric m.
Mylohyoid m.
Submandibular gland
Stylohyoid m.
Posterior belly of digastric m.
Hypoglossal n.
Carotid sheath
Nerve to thyrohyoid m.
Thyrohyoid m.
Superior belly of omohyoid m.
Great auricular & transverse cervical nn.
Sternothyroid m.
Supravcavicular nn.
Inferior belly of omohyoid m.
External jugular v.
Subclavian v.
Sternocleidomastoid m.
Sternothyroid m.

FIGURE 7.6 Anterior triangle of the neck.
The contents of each subdivision of the anterior triangle will be dissected in the following order: muscular triangle, submandibular triangle, submental triangle, and carotid triangle.

Dissection Instructions

**Superficial Fascia**  
1. The platysma muscle has been removed, revealing the external jugular vein. Follow the external jugular vein superiorly and observe that it is formed by the joining of the posterior division of the retromandibular vein and the posterior auricular vein (Fig. 7.5).
2. Identify the anterior jugular vein in the superficial fascia near the anterior midline (Fig. 7.5). It begins near the hyoid bone and courses inferiorly near the midline to the suprasternal region where it penetrates the investing layer of the deep cervical fascia. The anterior jugular vein passes laterally deep to the sternocleidomastoid muscle to join the external jugular vein in the root of the neck.
3. A communicating vein is frequently seen along the anterior border of the sternocleidomastoid muscle. This vein connects the common facial vein with the anterior jugular vein. It can be very large.

**Muscular Triangle**  
1. The contents of the muscular triangle of the neck are the infrahyoid muscles, the thyroid gland, and the parathyroid glands. The boundaries of the muscular triangle are (Fig. 7.3):
   - **Superolateral** – superior belly of the omohyoid muscle
   - **Inferolateral** – anterior border of the sternocleidomastoid muscle
   - **Medial** – median plane of the neck
2. Near the midline of the neck, use a probe to break through the investing layer of the deep cervical fascia. Identify the sternohyoid muscle (Fig. 7.6). The inferior attachment of the sternohyoid muscle is the sternum and its superior attachment is the body of the hyoid bone. The sternohyoid muscle depresses the hyoid bone.
3. Lateral to the sternohyoid muscle, identify the superior belly of the omohyoid muscle. The superior belly is attached to the inferior border of the hyoid bone. The inferior belly of the omohyoid muscle attaches to the superior border of the scapula near the suprascapular notch. The omohyoid muscle depresses the hyoid bone.
4. Use blunt dissection to loosen the medial border of the sternohyoid muscle from the structures that lie deep to it. Use scissors to transect the sternohyoid muscle close to the hyoid bone and reflect the muscle inferiorly. If the thorax has been dissected previously, the sternohyoid muscle has been detached from the sternum. It should remain attached by deep fascia to other muscles. Conserve this deep fascial attachment so that the muscle is not removed.
5. Use a probe to raise the medial border of the superior belly of the omohyoid muscle and loosen it from deeper structures. Use scissors to transect the superior belly of the omohyoid muscle close to the hyoid bone and reflect it inferiorly.
6. Identify the sternothyroid muscle (Fig. 7.6). The inferior attachment of the sternothyroid muscle is the sternum and its superior attachment is the oblique line of the thyroid cartilage. The sternothyroid muscle depresses the larynx.
7. Identify the thyrohyoid muscle. The inferior attachment of the thyrohyoid muscle is the oblique line of the thyroid cartilage and its superior attachment is the hyoid bone. The thyrohyoid muscle elevates the larynx.
8. The ansa cervicalis innervates three of the four infrahyoid muscles (omohyoid, sternohyoid, and sternothyroid). It will be identified later. The nerve to the thyrohyoid muscle innervates the thyrohyoid muscle.
9. Gently retract the right and left sternothyroid muscles to widen the gap in the midline. Identify (Fig. 7.6):  
   - **Laryngeal prominence**
   - **Cricothyroid ligament**
   - **Cricoid cartilage**
   - **First tracheal ring**
   - **Isthmus of the thyroid gland**

**Clinical Correlations**

**Tracheotomy**

Tracheotomy (tracheostomy) is the creation of an opening into the trachea. As an emergency operation, it must be rapidly performed in cases with sudden obstruction of the airway (e.g., aspiration of a foreign body, edema of the larynx, or paralysis of the vocal folds). The opening is made in the midline between the infrahyoid muscles of the neck.
CHAPTE R 7: THE HEAD AND NECK

211

the facial vein passes superficial to the submandibular gland and the facial artery courses deep to the gland.

6. Preserve the facial vessels and use scissors to remove the superficial part of the submandibular gland. Do not disturb the deep part of the gland.

7. Use blunt dissection to clean the superficial surface of the anterior and posterior bellies of the digastric muscle (FIG. 7.7). The anterior attachment of the anterior belly is the digastric fossa of the mandible. The anterior belly of the digastric muscle is innervated by the mylohyoid nerve, a branch of the mandibular division of the trigeminal nerve (V3). The posterior attachment of the posterior belly is the mastoid process of the temporal bone and it is innervated by the facial nerve (VII). The two bellies attach to each other by an intermediate tendon. The intermediate tendon is attached to the body and the greater horn of the hyoid bone by a fibrous sling. The digastric muscle elevates the hyoid bone and depresses the mandible.

8. Identify the tendon of the stylohyoid muscle, which attaches to the body of the hyoid bone by straddling the intermediate tendon of the digastric muscle (FIG. 7.7). The stylohyoid muscle is innervated by the facial nerve and it elevates the hyoid bone.

9. Use a probe to follow the hypoglossal nerve (XII) through the submandibular triangle. Observe that the hypoglossal nerve enters the submandibular triangle by passing deep to the posterior belly of the digastric muscle. It passes deep to the mylohyoid muscle within the submandibular triangle (FIG. 7.7).
Submental Triangle  [G 764; L 307; N 30; R 174; C 545]
1. The contents of the submental triangle are the submental lymph nodes. The submental triangle is an unpaired triangle that crosses the midline. The boundaries of the submental triangle are (FIG. 7.3):
   - Right and left – anterior bellies of the right and left digastric muscles
   - Inferior – hyoid bone
   - Superficial (roof) – investing layer of the deep cervical fascia
   - Deep (floor) – mylohyoid muscle

2. Use a probe to clean the superficial fascia from the surface of the right and left mylohyoid muscles. Each mylohyoid muscle has a lateral attachment on the mylohyoid line of the mandible and medial attachments on the hyoid bone and the mylohyoid raphe (FIG. 7.7). The mylohyoid muscle supports the floor of the oral cavity.

Carotid Triangle  [G 769; L 312, 313; N 31; R 182; C 531]
1. The contents of the carotid triangle are the carotid arteries (common, internal, and external), the branches of the external carotid artery, part of the hypoglossal nerve (XII), and branches of the vagus nerve (X). The boundaries of the carotid triangle are (FIG. 7.3):
   - Inferomedial – superior belly of the omohyoid muscle
   - Inferolateral – anterior border of the sternocleidomastoid muscle
   - Superior – posterior belly of the digastric muscle

2. Review the course of the great auricular nerve across the lateral surface of the sternocleidomastoid muscle (FIG. 7.5). Cut the nerve near the angle of the mandible and reflect it inferiorly.

3. Clean the anterior border of the sternocleidomastoid muscle from its inferior end to its superior attachment on the mastoid process. At its superior end the sternocleidomastoid muscle is in contact with the parotid gland (FIG. 7.5) and this connection must be broken by using sharp dissection.

4. If the thorax has been dissected, the sternocleidomastoid muscle has already been detached from its inferior attachments. If the thorax has not been dissected, transect the sternocleidomastoid muscle about 5 cm superior to its attachments to the sternum and clavicle.

5. Reflect the sternocleidomastoid superiorly by bluntly dissecting it from the investing fascia that lies posterior to it. Attempt to conserve the cutaneous branches of the cervical plexus that radiate from the posterior border of the sternocleidomastoid muscle and leave them attached to the cervical vertebral column. Use your fingers to free the sternocleidomastoid muscle from the investing fascia as far superiorly as the mastoid process. You must free the sternocleidomastoid all the way to its attachment on the mastoid process to facilitate the future dissection of the parotid region.

6. Find the accessory nerve (XI) where it crosses the deep surface of the sternocleidomastoid muscle near the base of the skull. Trace the accessory nerve superiorly as far as possible. Note that the accessory nerve passes through the jugular foramen to exit the skull but this relationship is too far superior to be seen at this time.

7. To allow better access to deeper structures, cut the common facial vein where it empties into the internal jugular vein (FIG. 7.7). Transect the digastric muscle at its intermediate tendon and reflect the posterior belly.

8. Palpate the tip of the greater horn of the hyoid bone (FIG. 7.7). Find the hypoglossal nerve (XII) superior to the tip of the greater horn of the hyoid bone. Observe that a muscular branch of the occipital artery crosses superior to the hypoglossal nerve. In addition to its cranial nerve axons, the hypoglossal nerve also carries axons of spinal nerve C1. Some of these C1 axons branch off as the nerve to the thyrohyoid muscle. [G 769; L 313; N 31; R 182; C 532]

9. Use blunt dissection to trace the hypoglossal nerve anteriorly. Verify that the hypoglossal nerve passes medial to the posterior belly of the digastric muscle, medial to the stylohyoid muscle, and deep to the mylohyoid muscle (FIG. 7.7).

10. The superior root of the ansa cervicalis travels with the hypoglossal nerve (FIG. 7.7). The superior root of the ansa cervicalis is mainly composed of fibers from the anterior ramus of the C1 spinal nerve. The inferior root of the ansa cervicalis (anterior rami of C2, C3) passes around the lateral side of the carotid sheath to join the superior root (FIG. 7.8). Thus, a loop (L. ansa, handle) is formed.

11. Clean the ansa cervicalis and trace its delicate branches to the lateral borders of the infrathyroid muscles (FIG. 7.8).

12. Use a probe to raise the posterior border of the thyrohyoid muscle and identify the thyrohyoid membrane that extends between the thyroid cartilage and the hyoid bone (FIG. 7.7). Find the internal branch of the superior laryngeal nerve where it passes through the thyrohyoid membrane. The internal branch of the superior laryngeal nerve supplies sensory fibers to the mucosa of the larynx.
13. Follow the internal branch of the superior laryngeal nerve superiorly. It joins the external branch of the superior laryngeal nerve to form the superior laryngeal nerve (FIG. 7.9). The superior laryngeal nerve may be too far superior to be seen at this stage of the dissection.

14. Trace the external branch of the superior laryngeal nerve inferiorly and observe that it innervates the cricothyroid muscle. It also innervates part of the inferior pharyngeal constrictor muscle.

15. While preserving the ansa cervicalis, use scissors to open the carotid sheath. The carotid sheath contains the common carotid artery, internal carotid artery, internal jugular vein, and vagus nerve (X).

16. Observe that the internal jugular vein is located lateral to the common carotid or internal carotid artery in the carotid sheath (FIG. 7.10). Use an illustration (FIG. 7.8) to study its largest tributaries: common facial vein, superior thyroid vein, and middle thyroid vein. Use blunt dissection to separate the internal jugular vein from the common and internal carotid arteries.

17. To clear the dissection field, you may remove the three tributaries of the internal jugular vein described above.
18. Near the level of the superior border of the thyroid cartilage, find the origin of the external carotid artery (FIG. 7.9). Use blunt dissection to follow the external carotid artery superiority until it passes on the medial side of (deep to) the posterior belly of the digastric muscle (FIG. 7.7). Temporarily replace the posterior belly of the digastric muscle in its correct anatomical position to confirm this relationship. [G 772; L 314; N 33; R 183; C 532]

19. The external carotid artery has six branches in the carotid triangle (FIG. 7.9). Each branch has a companion vein that may be removed to clear the dissection field. At this time, identify five branches:

- **Superior thyroid artery** – arises from the anterior surface of the external carotid artery near the level of the superior horn of the thyroid cartilage. The superior thyroid artery descends to the superior pole of the lobe of the thyroid gland. The superior laryngeal artery is a branch of the superior thyroid artery, which pierces the thyrohyoid membrane together with the internal branch of the superior laryngeal nerve.

- **Lingual artery** – arises from the anterior surface of the external carotid artery near the level of the greater horn of the hyoid bone (FIG. 7.9). It passes deeply into the muscles of the tongue. Do not follow it at this time.

- **Facial artery** – arises from the anterior surface of the external carotid artery immediately superior to the lingual artery (FIG. 7.9). It passes medial to the posterior belly of the digastric muscle and deep to the superficial part of the submandibular gland. The facial artery crosses the inferior border of the mandible to enter the face. Do not follow it into the face at this time. In 20% of cases, the lingual and facial arteries arise from a common trunk.

- **Occipital artery** – arises from the posterior surface of the external carotid artery and supplies part of the scalp (FIG. 7.9).

- **Posterior auricular artery** – arises from the posterior surface of the external carotid artery and passes posterior to the ear to supply part of the scalp. This branch may not be visible if the sternocleidomastoid muscle was not reflected completely in step 5.

20. Use blunt dissection to clean the bifurcation of the common carotid artery. Identify the carotid sinus, which is a dilation of the internal carotid artery near its origin. The wall of the carotid sinus contains pressoreceptors that monitor blood pressure. The carotid sinus is innervated by the glossopharyngeal nerve (IX) and the vagus nerve (X).

21. The carotid body is a small mass of tissue located on the medial aspect of the carotid bifurcation. The carotid body monitors changes in oxygen and carbon dioxide concentration of the blood. The carotid body is innervated by the glossopharyngeal nerve (IX) and the vagus nerve (X).

22. The ascending pharyngeal artery is the sixth branch of the external carotid artery. It arises from the medial surface of the external carotid artery close to the bifurcation of the common carotid artery. Use your fingers to retract the external carotid artery and look for the origin of the ascending pharyngeal artery.

23. Identify the vagus nerve (X) within the carotid sheath where it lies between and posterior to the vessels (FIG. 7.10). To see the vagus nerve, retract the internal jugular vein laterally and the common carotid artery medially.

**Dissection Follow-up**

1. Replace the sternocleidomastoid muscle and the infrahyoid muscles in their correct anatomical positions. Review the attachments and actions of the infrahyoid muscles.

2. Review the cutaneous branches of the cervical plexus. Review the ansa cervicalis.

3. Use the dissected specimen to review the positions of the common carotid and internal carotid arteries, internal jugular vein, and vagus nerve within the carotid sheath.
4. Follow each branch of the external carotid artery through the regions dissected, noting their relationships to muscles, nerves, and glands.
5. Trace the branches of the superior laryngeal nerve inferiorly and note their distribution.
6. Review the course of the hypoglossal nerve.
7. Review the ansa cervicalis and its relationship to the hypoglossal nerve and carotid sheath.
8. Note that the superior laryngeal nerve passes medial to the internal and external carotid arteries and the hypoglossal nerve passes lateral to the internal and external carotid arteries.

THYROID AND PARATHYROID GLANDS

**Dissection Overview**

The cervical viscera are the pharynx, esophagus, larynx, trachea, thyroid gland, and parathyroid glands. The thyroid gland and parathyroid glands lie between the infrahyoid muscles and the larynx and trachea, and these glands will be dissected now. The pharynx, esophagus, larynx, and trachea will be dissected after head disarticulation has been performed.

**Dissection Instructions**

1. Once again, reflect the sternocleidomastoid and sternohyoid muscles.
2. Observe the thyroid gland. The thyroid gland is located at vertebral levels C5 to T1. Laterally, the thyroid gland is in contact with the carotid sheath (FIG. 7.10).
3. Identify the right lobe and left lobe of the thyroid gland. The two lobes are connected by the isthmus, which crosses the anterior surface of tracheal rings 2 and 3 (FIG. 7.10).
4. Frequently, the thyroid gland has a pyramidal lobe that extends superiorly from the isthmus. The pyramidal lobe is a remnant of embryonic development that shows the route of descent of the thyroid gland.
5. Identify the superior thyroid artery where it enters the superior end of the lobe of the thyroid gland (FIG. 7.10). Recall that the superior thyroid artery is a branch of the external carotid artery. The inferior thyroid artery will be dissected later.
6. The superior and middle thyroid veins are tributaries of the internal jugular vein (FIG. 7.10). The right and left inferior thyroid veins descend into the thorax on the anterior surface of the trachea. The right and left inferior thyroid veins drain into the right and left brachiocephalic veins, respectively.

7. Look for the thyroid ima artery (L. ima, lowest). The thyroid ima artery is a relatively rare (published reports place the incidence at 2% to 12% of the population) but clinically significant variant. When present, the thyroid ima artery enters the thyroid gland from inferiorly, near the midline.
8. Use scissors to cut the isthmus of the thyroid gland. Use blunt dissection to detach the isthmus from the tracheal rings. Spread the lobes widely apart.
9. On both sides of the cadaver, use blunt dissection to display the recurrent laryngeal nerve that passes immediately posterior to the lobe of the thyroid gland in the groove between the trachea and esophagus. Note the close relationship of the recurrent laryngeal nerve to the thyroid gland.

**Clinical Correlation**

**Recurrent Laryngeal Nerve**

If a recurrent laryngeal nerve is injured by a thyroid tumor or during thyroidectomy (removal of the thyroid gland), paralysis of the laryngeal muscles will occur on the affected side. The result is hoarseness of the voice.

**Parathyroid Glands**

The parathyroid glands play an important role in the regulation of calcium metabolism. During thyroidectomy, these small endocrine glands are in danger of being damaged or removed. To maintain proper serum calcium levels, at least one parathyroid gland must be retained during surgery.
Dissection Follow-up
1. Review the relationship of the thyroid gland to the infrahyoid muscles, carotid sheaths, larynx, and trachea.
2. Use an illustration and the dissected specimen to review the blood supply and venous drainage of the thyroid gland. Note that there are only two thyroid arteries on each side (superior and inferior) but there are three thyroid veins (superior, middle, and inferior).
3. Review the relationship of the parathyroid glands to the thyroid gland. Use an embryology textbook to review the origin and migration of the thyroid and parathyroid glands during development.

ROOT OF THE NECK

Dissection Overview
The root (base) of the neck is the junction between the thorax and the neck. The root of the neck is an important area because it lies superior to the superior thoracic aperture. All structures that pass between the head and thorax or the upper limb and thorax must pass through the root of the neck.

The order of dissection will be as follows: The branches of the subclavian artery will be dissected. The course of the vagus and phrenic nerves will be studied. The muscles that form the floor of the posterior cervical triangle will be studied. Some of these structures will be followed superiorly or inferiorly beyond the root of the neck.

Dissection Instructions
1. The clavicle has been cut at its mid length and the thoracic wall was removed during dissection of the thorax. Remove the anterior thoracic wall and set it aside.
2. Reflect superiorly the sternocleidomastoid muscle, sternohyoid muscle, and sternothyroid muscle.
3. Use blunt dissection to clean the inferior belly of the omohyoid muscle (FIG. 7.8). Note that its inferior belly and superior belly are joined by an intermediate tendon. A fascial sling binds the intermediate tendon to the clavicle. Review the attachment and action of the omohyoid muscle.
4. Use scissors to cut the fascial sling that binds the intermediate tendon of the omohyoid muscle to the clavicle.
5. Follow the external jugular vein inferiorly from the upper part of the neck until it passes through the investing layer of deep cervical fascia near the clavicle. Note that the external jugular vein is the only tributary of the subclavian vein (FIG. 7.11).
6. To expose the blood vessels in the root of the neck, remove the investing layer of deep cervical fascia that forms the roof of the lower part of the posterior cervical triangle. Preserve the external jugular vein while removing the investing fascia.

7. Identify the **subclavian vein** (FIG. 7.11). Use blunt dissection to loosen the subclavian vein from structures that lie deep to it.

8. Follow the subclavian vein medially to the point where it is joined by the **internal jugular vein** to form the **brachiocephalic vein**. Note that the **vertebral vein** joins the posterior surface of the brachiocephalic vein in the root of the neck but it cannot be seen at this time.

9. Identify the **subclavian artery**. Observe that the right subclavian artery is a branch of the brachiocephalic trunk, and the left subclavian artery is a branch of the aortic arch. [G 780; L 309, 310; N 32; R 170, 184; C 544]

10. The subclavian artery has three parts that are defined by its relationship to the anterior scalene muscle (FIG. 7.12):
   - **First part** – from its origin to the medial border of the anterior scalene muscle
   - **Second part** – posterior to the anterior scalene muscle
   - **Third part** – between the lateral border of the anterior scalene muscle and the lateral border of the first rib

11. The **first part of the subclavian artery** has three branches:
   - **Vertebral artery** – courses superiorly between the anterior scalene muscle and the longus colli muscle (FIG. 7.12). Trace the vertebral artery superiority until it passes into the transverse foramen of vertebra C6.
   - **Internal thoracic artery** – arises from the anteroinferior surface of the subclavian artery and passes inferiorly to supply the anterior thoracic wall (FIG. 7.12).
   - **Thyrocervical trunk** – arises from the anterosuperior surface of the subclavian artery (FIG. 7.12). The thyrocervical trunk has three branches:
     - **Transverse cervical artery** – crosses the root of the neck about 2 to 3 cm superior to the clavicle and deep to the omohyoid muscle (FIG. 7.11). It supplies the trapezius muscle.
     - **Suprascapular artery** – passes laterally and posteriorly to the region of the suprascapular notch (FIG. 7.11). In the shoulder it passes superior to the transverse scapular ligament and supplies the supraspinatus and infraspinatus muscles.
     - **Inferior thyroid artery** – passes medially toward the thyroid gland. Trace the inferior thyroid artery toward the thyroid gland. Usually, the inferior thyroid artery passes posterior to the cervical sympathetic trunk. The **ascending cervical artery** is a branch of the inferior thyroid artery.

12. The **second part of the subclavian artery** has one branch, the **costocervical trunk** (FIG. 7.12). The costocervical trunk arises from the posterior surface of the second part of the subclavian artery. Use your fingers to elevate the subclavian artery from the surface of the first rib and use blunt dissection to look for the costocervical trunk passing posteriorly above the cupula of the pleura. The costocervical trunk divides into the **deep cervical artery** and the **suprascapular artery**. The supreme intercostal artery gives rise to posterior intercostal arteries 1 and 2.

13. The **third part of the subclavian artery** has one branch, the **dorsal scapular artery**. The dorsal scapular artery passes between the superior and middle trunks of the brachial plexus to supply the muscles of the scapular region (FIG. 7.11). In about 30% of cases, the dorsal scapular artery arises from the transverse cervical artery instead of from the subclavian artery.

14. On the left side, find the **thoracic duct**, which ascends from the thorax into the neck. The thoracic duct is posterior to the esophagus at the level of the superior thoracic aperture, and then it arches anteriorly and to the left to join the venous system near the junction of the **left subclavian vein** and the **left internal jugular vein** (FIG. 7.11). The thoracic duct is usually a single structure, which has the diameter of a small vein but it may be represented by several smaller ducts. [G 779; L 309; N 200; R 182; C 210]
15. On the right side of the neck, several small lymphatic vessels join with lymph vessels from the right upper limb and right side of the thorax to form the **right lymphatic duct**. The right lymphatic duct drains into the junction of the right subclavian vein and right internal jugular vein.

16. On both sides of the neck, find the **vagus nerve** in the carotid sheath and follow it into the thorax. Note that the vagus nerve passes posterior to the root of the lung. [G 778; L 309; N 31; R 184; C 534]

17. The right vagus nerve passes anterior to the subclavian artery, where it gives off the **right recurrent laryngeal nerve** (FIG. 7.11). The left vagus nerve passes on the left side of the aortic arch, where it gives off the **left recurrent laryngeal nerve**.

18. Follow the right and left recurrent laryngeal nerves superiorly along the lateral surface of the trachea and esophagus. Trace them as far as the first tracheal ring. Do not follow them into the larynx at this time.

19. Verify that the **phrenic nerve** crosses the anterior surface of the anterior scalene muscle (FIG. 7.11). Follow the phrenic nerve into the thorax and confirm that it passes anterior to the root of the lung and inervates the diaphragm.

20. Identify the cervical portion of the **sympathetic trunk**. Note that the inferior cervical sympathetic ganglion is located low in the neck, near the superior thoracic aperture. Verify that the cervical sympathetic trunk is continuous with the thoracic sympathetic trunk.

21. Examine the muscles that form the floor of the posterior cervical triangle. Identify the **spleunus capitis**, the **levator scapulae**, and the **anterior**, **middle**, and **posterior scalene muscles**. [G 779; L 310; N 32; R 185; C 533]

22. Use blunt dissection to define the borders of the **anterior scalene** and **middle scalene muscles**. Inferiorly, the anterior and middle scalene muscles attach to the first rib. The first rib and the adjacent borders of the anterior and middle scalene muscles form the boundaries of the **interscalene triangle**. Observe (FIG. 7.11):

- The **subclavian artery** and the **roots of the brachial plexus** pass between the middle scalene muscle and the anterior scalene muscle (through the interscalene triangle).
- The **subclavian vein**, **transverse cervical artery**, and **suprascapular artery** cross the anterior surface of the anterior scalene muscle.
- The **phrenic nerve** descends vertically across the anterior surface of the anterior scalene muscle.

23. Use blunt dissection to clean the **roots of the brachial plexus** at the level of the interscalene triangle.

24. If the upper limb has been dissected previously, follow the suprascapular nerve as far laterally as the suprascapular notch of the scapula where it is joined by the suprascapular artery.

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**CLINICAL CORRELATION**

**INTERSCALENE TRIANGLE**

The **interscalene triangle** becomes clinically important when anatomical variations (additional muscular slips, an accessory cervical rib, or exostosis on the first rib) narrow the interval. As a result, the subclavian artery and/or roots of the brachial plexus may be compressed, resulting in ischemia or nerve dysfunction in the upper limb.

**Dissection Follow-up**

1. Replace the anterior thoracic wall in its correct anatomical position. Replace the infrahyoid muscles and sternocleidomastoid muscle in their correct anatomical positions. Review the boundaries of the posterior cervical triangle. Review the attachments of the infrahyoid muscles. Review the distribution of the cutaneous branches of the cervical plexus.

2. Remove the anterior thoracic wall. Review the origin and course of the brachiocephalic artery, left common carotid artery, and left subclavian artery in the superior mediastinum.

3. Review the three parts and the branches of the subclavian artery.

4. Review the distribution of the transverse cervical, suprascapular, and dorsal scapular arteries to the superficial muscles of the back and scapulohumeral muscles.

5. Use an illustration to review the course of the vertebral artery from its origin on the first part of the subclavian artery to the cranial cavity.

**HEAD**

The dissection of the head is foremost a dissection of the course and distribution of the cranial nerves and the branches of the external carotid artery. All of the cranial nerves and many blood vessels pass through openings in the skull. Therefore, the skull is an important tool with which to organize the study of the soft tissues of the head and neck. Parts of the skull will be studied as needed and details will be added as the dissection proceeds.
CHAPTER 7: THE HEAD AND NECK

219

Mental foramen
Mental protuberance

Parts of several bones combine to form the following features (FIG. 7.13):

• Nasion – the junction between the frontal and nasal bones
• Orbital margin – formed by three bones (frontal, maxillary, and zygomatic)
• Anterior nasal aperture – bounded by the nasal bones and maxillae

Lateral View of the Skull [G 616; L 299; N 6; R 21; C 568]
Examine the skull from a lateral view and identify (FIG. 7.14):

• Parietal bone
  Superior temporal line
  Inferior temporal line
• Frontal bone
• Sphenoid bone
  Greater wing
• Zygomatic bone
  Frontal process
  Temporal process

Skull

All parts of the skull are fragile, but the bones of the orbit are exceptionally delicate. The medial wall of the orbit is very easily broken. Never hold a skull by placing your fingers into the orbits.

Anterior View of the Skull [G 614; L 298; N 4; R 22; C 567]
Examine the skull from an anterior view and identify (FIG. 7.13):

• Frontal bone
  Glabella
  Superciliary arch
  Supraorbital notch (foramen)
• Nasal bone
• Zygomatic bone
• Maxilla
  Frontal process
  Infraorbital foramen
  Anterior nasal spine
  Alveolar process
• Nasal septum
• Mandible
  Alveolar process
  Mental foramen
  Mental protuberance

FIGURE 7.13 The skull. Anterior view.
The calvaria is the skull cap that is formed by parts of the frontal, parietal, and occipital bones. Examine the external surface of the calvaria and identify (FIG. 7.16):
CHAPTER 7: THE HEAD AND NECK

Dissection Overview

Sensory innervation for the skin of the face is provided by three divisions (branches) of the trigeminal nerve (V). Branches of cervical spinal nerves innervate the skin of the posterior part of the head (FIG. 7.18).

- **Ophthalmic division** (V\(_1\)) – innervates the skin of the forehead, upper eyelids, and nose
- **Maxillary division** (V\(_2\)) – innervates the skin of the lower eyelid, cheek, and upper lip
- **Mandibular division** (V\(_3\)) – innervates the skin of the lower face and part of the side of the head

**Surface Anatomy**

Palpate the following structures on the head of the cadaver (FIG. 7.17):

- Vertex
- Supraorbital margin
- Nasal bones
- Alveolar process of the maxilla
- Mental protuberance of the mandible
- Zygomatic arch

**FACE**

- Frontal (metopic) suture – between the ossification centers of the frontal bone, usually not seen in the adult
- Coronal suture – between the frontal bone and the two parietal bones
- Sagittal suture – between the two parietal bones
- Bregma – the point where the sagittal and coronal sutures meet
- Lambdoid suture – between the occipital bone and the two parietal bones
- Lambda – the point where the sagittal and lambdoid sutures meet
• Branches of cervical spinal nerves 2 and 3:
  
  • Greater occipital nerve – innervates the skin of the
    back of the head as far superiorly as the vertex
  • Lesser occipital nerve – innervates the skin behind
    the ear
  • Great auricular nerve – innervates the skin of the
    lower part of the ear and skin over the angle of the
    mandible and lower part of parotid gland

The motor innervation to all muscles of facial expression is provided by the facial nerve (VII). [G 637; L 324, 325; N 24; R 78; C 552]

The order of dissection will be as follows: The skin of the face will be removed to expose the superficial fascia. The parotid duct and gland will be identified. Branches of the facial nerve will be identified as they emerge from the anterior border of the parotid gland. Several facial muscles will be identified. Two important sphincter muscles will receive particular attention: the orbicularis oris (mouth) and the orbicularis oculi (eye). The terminal branches of the three divisions of the trigeminal nerve will be exposed where they emerge from openings in the skull.

Dissection Instructions

Skin Incisions

The skin of the face is very thin. It is firmly attached to the cartilage of the nose and ears but it is mobile over other parts of the face. This mobility permits the muscles of facial expression to move the skin. The muscles of facial expression are attached to the skin superficially and the bones of the skull deeply. They act as sphincters and dilators for the openings of the eyes, mouth, and nostrils.

1. Place the cadaver in the supine position and refer to FIGURE 7.19.
2. In the midline, make a shallow (2 mm) skin incision that begins on the forehead at about the level of the hairline (A) passes through the nasion (B) and continues to the mental protuberance (C). Encircle the mouth at the margin of the lips.
3. An incision was made from the mental protuberance (C) along the inferior border of the mandible to point D when the neck was dissected.
4. On the lateral surface of the head, make a skin incision from point A to the upper part of the ear, then passing anterior to the ear down to the level of the ear lobe. This incision should end at the incision that was made when dissecting the neck (D).
5. Starting at the nasion (B), make an incision that encircles the orbital margin. Extend the incision from the lateral angle of the eye to the incision near the ear.
6. Beginning at the midline, remove the skin of the forehead. Note that the skin adheres to tough subcutaneous connective tissue. Leave this connective tissue intact and do not remove the frontalis muscle with the skin.
7. Remove the skin of the lower face, beginning at the midline and proceeding laterally. The superficial fascia of the face is thick and contains the muscles of facial expression.
8. Detach the skin along the incision line from the forehead to the angle of the mandible (A to D) and place it in the tissue container.

Superficial Fascia and Facial Nerve [G 632; L 324, 325; N 3; R 76; C 547]

The superficial fascia of the face contains the parotid gland, muscles of facial expression, branches of the facial nerve (VII), branches of the trigeminal nerve (V), and the facial artery and vein. The muscles of facial expression are attached to the skin, and these attachments have been severed during skin removal. The goal of this stage of the dissection is to identify some of the muscles of facial expression and follow branches of the facial nerve posteriorly into the parotid gland.

1. A small part of the platysma muscle extends into the face along the inferior border of the mandible (FIG. 7.4). Recall that the inferior attachment of the platysma muscle is the superficial fascia of the upper thorax and that it forms a sheet of muscle that covers the anterior neck. Use blunt dissection to define the superior attachment of the muscle on the inferior border of the mandible, skin of the cheek, and angle of the mouth.
2. Identify the parotid duct (FIG. 7.20). The parotid duct is approximately the diameter of a probe handle and it crosses the lateral surface of the masseter muscle about 2 cm inferior to the zygomatic arch. Use blunt dissection to follow the parotid duct anteriorly as far as the anterior border of the masseter muscle.
6. Note that the buccal branches course parallel to the parotid duct. Use blunt dissection to locate one of the buccal branches superior or inferior to the parotid duct and follow it into the parotid gland, removing parotid tissue piece by piece. Within the parotid gland, the nerve will join other facial nerve branches to form the **parotid plexus**. Once the parotid plexus is found, follow the other branches peripherally (toward the facial muscles) to complete the dissection.

7. Follow the parotid plexus branches posteriorly and deeply (below the ear lobe) until they combine to form a single nerve. It emerges from the stylomastoid foramen in the temporal bone. You will not be able to follow the facial nerve all the way to the stylomastoid foramen.

8. Use a probe to define the anterior border of the **masseter muscle**. Anterior to the masseter muscle is the **buccal fat pad**. Remove the buccal fat pad and expose the **buccinator muscle**. Verify that the **parotid duct** pierces the buccinator muscle.

9. Observe two nerves associated with the buccinator muscle (**FIG. 7.20**):

- **Buccal branch of the facial nerve** – crosses superficial to the masseter muscle and provides motor innervation to the buccinator muscle.
- **Buccal nerve** – a branch of the mandibular division of the trigeminal nerve (V₃), emerges from
deep to the masseter muscle. The buccal nerve is a sensory nerve and it does not supply motor innervation to the buccinator muscle. It pierces the buccinator muscle to provide sensory innervation to the mucosa of the cheek. The buccal nerve also provides sensory innervation to the skin of the cheek.

**Facial Artery and Vein**  [G 632; L 326; N 3; R 79; C 554]

The facial artery and vein follow a winding course across the face and they may pass either superficial or deep to the muscles of facial expression.

1. Find the **facial artery** where it crosses the inferior border of the mandible at the anterior border of the masseter muscle (FIG. 7.20). The facial vein should be located posterior to the facial artery. At this location, the facial artery and vein are covered only by skin and the platysma muscle.

2. Preserve the facial vessels. Cut the platysma muscle along the inferior border of the mandible and detach it from the angle of the mouth. Place the platysma muscle in the tissue container.

3. Follow the facial artery inferiorly and recall that it passes deep to the submandibular gland in the neck, then it becomes superficial where it crosses the inferior border of the mandible. The facial vein passes superficial to the submandibular gland and may have been cut when the gland was removed earlier.

4. Use blunt dissection to trace the facial artery superiorly toward the angle of the mouth. Observe that the facial artery has several loops or bends in this part of its course. Near the angle of the mouth, the facial artery gives off the **inferior labial and superior labial arteries**.

5. Continue to trace the facial artery as far as the lateral side of the nose, where its name changes to the **angular artery**.

6. The **facial vein** receives tributaries that correspond to the branches of the facial artery (FIG. 7.20). The angular vein has a clinically important anastomotic connection with the ophthalmic veins in the orbit, which will be described when the orbit is dissected.

**Muscles Around the Orbital Opening**  [G 632, 636; L 324, 325; N 25; R 58; C 548]

1. Several muscles alter the shape of the mouth and lips. Use blunt dissection to define the borders of the following muscles (FIG. 7.21):

   - **Levator labii superioris muscle** – has a superior attachment to the maxilla just below the orbital margin and an inferior attachment to the upper lip. It elevates the upper lip.
   - **Zygomaticus major muscle** – has a lateral attachment to the zygomatic bone and a medial attachment to the angle of the mouth. It draws the angle of the mouth superiorly and posteriorly.
   - **Orbicularis oris muscle** – passes both superior and inferior to the oral opening. It has medial attachments to the maxilla, mandible, and skin in the median plane and a lateral attachment to the angle of the mouth. The orbicularis oris muscle is the sphincter of the mouth.

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**FIGURE 7.21** Muscles of facial expression.
CHAPTER 7: THE HEAD AND NECK

CLINICAL CORRELATION

DENTAL ANESTHESIA

Study the infraorbital foramen and infraorbital canal in the skull. For purposes of dental anesthesia, the infraorbital nerve may be infiltrated with anesthetic where it emerges from the infraorbital foramen. The needle is inserted through the oral mucosa deep to the upper lip and then directed superiorly.

4. Mental nerve – a branch of the mandibular division of the trigeminal nerve (V₃). It emerges from the mental foramen (L. mentum, chin) of the mandible to supply sensory innervation to the lower lip and chin. The mental nerve is covered by the depressor anguli oris muscle. To expose the nerve, first define the borders of the depressor anguli oris muscle using blunt dissection, then transect the muscle near the angle of the mouth. Reflect the depressor anguli oris muscle inferiorly and find the mental nerve where it exits the mental foramen. Observe that the mental artery and vein also emerge from the mental foramen.

Sensory Nerves of the Face  [G 636; L 324; N 2; R 69; C 554]

1. Three branches of the trigeminal nerve supply sensory innervation to the face (FIG. 7.22).

2. Supraorbital nerve – a branch of the ophthalmic division of the trigeminal nerve (V₁). The supraorbital nerve passes through the supraorbital notch (foramen) of the frontal bone to reach the skin above the eye. It will be seen when the scalp is studied.

3. Infraorbital nerve – a branch of the maxillary division of the trigeminal nerve (V₂). It passes through the infraorbital foramen of the maxilla to supply sensory innervation to the inferior eyelid, side of the nose, and upper lip. It is covered by the levator labii superioris muscle. On the right side of the face, use blunt dissection to define the borders of the levator labii superioris muscle. Transect the muscle close to the infraorbital margin and reflect it inferiorly to expose the infraorbital nerve. Observe that the infraorbital artery and vein also emerge from the infraorbital foramen.

• Buccinator muscle – has posterior attachments to the pterygomandibular raphe and the lateral surfaces of the alveolar processes of the maxilla and mandible. The anterior attachment of the buccinator muscle is the angle of the mouth. It compresses the cheek against the molar teeth, keeping food on the occlusal surfaces during chewing.

• Depressor anguli oris muscle – has an inferior attachment to the mandible and a superior attachment to the angle (corner) of the mouth. It depresses the angle of the mouth.

2. The muscles described previously are innervated by the zygomatic, buccal, and mandibular branches of the facial nerve.

CLINICAL CORRELATION

FACIAL NERVE

Bell’s palsy is a sudden loss of control of the muscles of facial expression on one side of the face caused by injury to the facial nerve. The patient presents with drooping of the mouth and inability to close the eyelid on the affected side.
Several smaller branches of the trigeminal nerve (lacrimal, infratrochlear, zygomaticofacial, zygomaticotemporal, etc.) also innervate the facial region. Do not dissect these small branches. The auriculotemporal nerve (a branch of \( V_3 \)) will be dissected later.

**Dissection Follow-up**

1. Use the dissected specimen to trace the branches of the facial nerve from the parotid plexus to the muscles of facial expression.
2. Review the attachments, action, and innervation of each muscle that was identified in this dissection.
3. Use a skull and the dissected specimen to review the branches of the trigeminal nerve that were dissected and the openings in the bones that they pass through.
4. Use an illustration and the dissected specimen to review the origin and course of the facial artery and vein.

**PAROTID REGION**

**Dissection Overview**

The parotid region is the area on the side of the face that lies anterior to the ear and inferior to the zygomatic arch. The parotid bed is the area occupied by the parotid gland. The parotid gland develops as an evagination of the oral mucosa and it surrounds the posterior edge of the ramus of the mandible. Therefore, the parotid gland is in close contact with nerves, vessels, muscles, bones, and ligaments in the region. The superficial portion of the parotid gland was removed to expose the branches of the facial nerve. The goal of this dissection is to remove the remainder of the parotid gland piece by piece, preserving the nerves and vessels that pass through it.

The order of dissection will be as follows: The branches of the facial nerve will be reviewed and followed posteriorly toward the stylomastoid foramen. The motor root of the facial nerve will be transected near the lobe of the ear and the parotid plexus and its branches will be reflected anteriorly. The retromandibular vein will then be followed superiorly through the parotid gland as the parotid tissue that lies superficial to it is removed. The external carotid artery will then be followed superiorly as additional parotid tissue is removed. Remnants of the parotid gland that adhere to the posterior belly of the digastric muscle and anterior border of the sternocleidomastoid muscle will be removed in a final cleanup step.

**Skeleton of the Parotid Region**

Refer to a skull and identify (FIG. 7.23):

- **Temporal bone**  
  [G 670; L 327; N 6; R 21; C 568]
  Mandibular fossa
  External acoustic meatus
  Styloid process
  Stylohyoid bone

- **Mandible**  
  [G 660; L 327; N 17; R 52; C 634]
  Head
  Neck
  Angle
  Ramus

- **Greater wing of sphenoid bone**
- **Zygomatic bone**
- **Maxilla**
- **Zygomaticofacial**
- **Zygomaticotemporal**
- **Infratrochlear**
- **Lacrimal**

Use the skull and an illustration to define the boundaries of the parotid bed (FIG. 7.24):  
[G 668; L 326; N 33; R 77; C 552]

- **Posterior** — mastoid process and posterior belly of the digastric muscle
- **Anterior** — medial pterygoid muscle, ramus of the mandible, and masseter muscle
- **Medial** — styloid process and associated muscles (stylopharyngeus, styloglossus, and stylohyoid)
- **Posterosuperior** — floor of the external acoustic meatus

**Dissection Instructions**

1. Identify the great auricular nerve where it crosses the sternocleidomastoid muscle and note that it ends over the angle of the mandible. Detach the great auricular nerve at its superior end and reflect it inferiorly off the surface of the sternocleidomastoid muscle. Leave it attached to the cervical plexus.
2. Review the branches of the facial nerve: temporal, zygomatic, buccal, mandibular, and cervical (FIG. 7.20).  
   [G 668; L 326; N 24; R 77; C 554]
3. Trace the facial nerve branches posteriorly toward the lobe of the ear and again identify the main branch before it divides.
4. Cut the facial nerve as far posteriorly as possible, leaving a stump emerging from the stylo mastoid foramen. Reflect the parotid plexus and all of its branches anteriorly.
5. Review the course of the parotid duct. Cut the parotid duct where it exits the parotid gland and reflect the duct anteriorly. Do not disturb its passage through the buccinator muscle.
6. Identify the auriculotemporal nerve, a branch of the mandibular division of the trigeminal nerve (V). The auriculotemporal nerve passes between the head of the mandible and the external acoustic meatus. It crosses the zygomatic process of the temporal bone and innervates the skin of the anterior side of the ear and temporal region. As the auriculotemporal nerve passes through the parotid gland, it delivers postsynaptic parasympathetic nerve fibers from the otic ganglion.
7. In the neck, find the external jugular vein (FIG. 7.24). Use blunt dissection to follow the external jugular vein superiorly to the point where it is formed by the joining of the posterior auricular vein and the retromandibular vein.
8. Use blunt dissection to follow the retromandibular vein superiorly into the parotid gland. Remove parotid tissue as you follow the retromandibular vein.
9. Trace the retromandibular vein to the point where it is formed by the joining of the maxillary vein and the superficial temporal vein. Do not follow the maxillary vein, as it will be dissected later.
10. Follow the superficial temporal vein superiorly until it crosses the superficial surface of the zygomatic arch, removing the parotid gland as you proceed. The intent is to completely remove the parotid tissue from the veins and adjacent structures (mandible and masseter muscle).
11. Return to the neck and find the external carotid artery (FIG. 7.24). Use blunt dissection to follow the external carotid artery superiorly as far as the angle of the mandible, removing the lower part of the parotid gland. It will not be possible to follow the external carotid artery deep to the posterior border of the mandible because the retromandibular vein lies superficial to it. The external carotid artery passes superiorly along the posterior edge of the ramus of the mandible (FIG. 7.24) and near the neck of the mandible it divides into its two terminal branches, the maxillary artery and the superficial temporal artery.
12. The superficial temporal artery crosses the zygomatic process of the temporal bone just anterior to the external acoustic meatus (FIG. 7.24). At this location, the superficial temporal artery is anterior to the auriculotemporal nerve. Find the artery and clean any remaining parotid tissue away from the zygomatic arch and lateral surface of the masseter muscle. The superficial temporal artery supplies the lateral part of the scalp.
13. Once again find the posterior belly of the digastric muscle and the stylohyoid muscle (FIG. 7.24). Clean away any parotid tissue that remains on their anterior borders or lateral surfaces. Expose the digastric muscle all the way to its attachment on the mastoid process.
The connective tissue layer of the scalp contains collagen fibers that attach to the external surface of the blood vessels. When a blood vessel of the scalp is cut, the connective tissue holds the lumen open, resulting in profuse bleeding. If an infection occurs in the scalp, it can spread within the loose connective tissue layer. Therefore, the loose connective tissue layer is often called the “dangerous area.” From the “dangerous area,” the infection may pass into the cranial cavity through emissary veins.

Dissection Instructions
1. These cuts should be made through the entire thickness of the scalp and the scalpel should contact the bones of the calvaria.
2. Refer to FIGURE 7.25 and make a midline cut from the nasion (C) through the vertex (A) to the external occipital protuberance (G).
3. Make a cut in the coronal plane from the vertex (A) to a point 13 mm anterior to the ear (D). Duplicate this cut on the opposite side of the head.

The order of dissection will be as follows: The five layers of the scalp will be reflected as one. The muscles of the scalp will be examined on the cut surface of the scalp.

**DISSECTION FOLLOW-UP**
1. Replace the facial nerve in its correct anatomical position and approximate the cut ends.
2. Replace the parotid duct in its correct anatomical position.
3. Use an illustration, a skull, and the dissected specimen to review the course of the facial nerve from the internal acoustic meatus to the scalp.
4. Review the superficial venous drainage of the lateral side of the head and neck, beginning with the superficial temporal veins and ending with the subclavian vein in the root of the neck.
5. Review the origin, course, and branches of the external carotid artery.
6. Review the boundaries of the parotid bed.

**SCALP**

The scalp consists of five layers that are firmly bound together:

- **Skin**
- **Connective tissue** – dense subcutaneous tissue containing the vessels and nerves of the scalp
- **Aponeurosis** (epicranial aponeurosis) – connecting the frontalis muscle to the occipitalis muscle
- **Loose connective tissue** – permits the scalp to move over the calvaria
- **Pericranium** – the periosteum of the cranial bones

As an aid to memory, note that the first letters of the names of the five layers spell the word scalp.
4. Beginning at the vertex, use forceps to grasp one corner of the cut scalp and insert a chisel between the scalp and the calvaria. Use the chisel to loosen the scalp from the calvaria.

5. Once the flap of scalp is raised, grasp the flap with both hands and pull it inferiorly.

6. Reflect (do not remove) all four flaps of scalp down to the level that a hatband would occupy (FIG. 7.26). Do not detach the flaps.

7. Examine the cut edge of the scalp and identify the **occipitofrontalis muscle** (FIG. 7.27). The inferior attachment of the occipital belly is the occipital bone and its superior attachment is the **epicranial aponeurosis**. The superior attachment of the frontal belly is the epicranial aponeurosis and its inferior attachment is the skin of the forehead and eyebrows. Both muscles are innervated by the facial nerve (VII). [G 635, 640; L 325; N 2, 3, 25; R 59, 63; C 551, 553]

8. Pull the anterior scalp flap inferiorly to expose the supraorbital margin. Identify the **supraorbital nerve and vessels** where they exit the supraorbital notch and enter the deep surface of the scalp (FIG. 7.26).

9. Use an illustration to observe that nerves and vessels are contained within the flaps of the scalp (FIG. 7.28). Note that the nerves and vessels enter the scalp from more inferior regions.

10. On the lateral surface of the calvaria, note that the scalp has separated from the fascia that covers the **temporalis muscle** (temporal muscle) (FIG. 7.26).

**Dissection Follow-up**

1. Replace the flaps of scalp in their correct anatomical positions.

2. Use an illustration to review the course of nerves and vessels that supply the scalp.

3. Use a skull and the dissected specimen to review the course of the supraorbital nerve through the supraorbital notch.

4. Use an illustration to study the course of the greater occipital nerve from the cervical region to the posterior surface of the head.

5. Recall the attachments of the occipitofrontalis muscle and review its two bellies in the sagittal scalp cut.
TEMPORAL REGION

Dissection Overview
The temporal region consists of two fossae: temporal and infratemporal. The temporal fossa is located superior to the zygomatic arch and it contains the temporalis muscle. The infratemporal fossa is inferior to the zygomatic arch and deep to the ramus of the mandible. The infratemporal fossa contains the medial and lateral pterygoid muscles, branches of the mandibular division of the trigeminal nerve (V₃), and the maxillary vessels and their branches. The infratemporal and temporal fossae are in open communication with each other through the area between the zygomatic arch and the lateral surface of the skull.

The dissection will proceed as follows: The masseter muscle will be studied. The zygomatic arch will be detached and the masseter muscle will be reflected with the arch attached to it. The temporalis muscle will be studied. The coronoid process will be detached from the mandible and the temporalis muscle will be reflected with the coronoid process attached to it. The superior part of the ramus of the mandible will then be removed, and the maxillary artery will be traced across the infratemporal fossa. The branches of the mandibular division of the trigeminal nerve will be dissected. The medial and lateral pterygoid muscles will be studied and the temporomandibular joint will be dissected.

Skeleton of the Temporal Region
Refer to a lateral view of the skull and identify the following (FIGS. 7.14 and 7.23): [G 670; L 327; N 6; R 21; C 568]

- Superior and inferior temporal lines – on the parietal bone.

- Temporal fossa – formed by parts of four cranial bones: parietal, frontal, squamous part of temporal, and greater wing of sphenoid. Review the location of the pterion.
- Zygomatic arch – formed by the zygomatic process of the temporal bone and the temporal process of the zygomatic bone.
- Mandibular fossa and articular tubercle – on the temporal bone (FIG. 7.23).

From a lateral view of the mandible, identify (FIG. 7.29A):
[G 670; L 327; N 17; R 52; C 634]

- Head (condyle)
- Neck
- Mandibular notch
- Coronoid process
- Ramus
- Angle

On the internal surface of the mandible, identify (FIG. 7.29B):

- Lingula – for the attachment of the sphenomandibular ligament
- Mandibular foramen – for the inferior alveolar nerves and vessels
- Mylohyoid groove – for the nerve to mylohyoid and mylohyoid vessels

Remove the mandible from the skull and view the bones of the infratemporal fossa from the lateral perspective. Identify (FIG. 7.30): [G 671; L 327; N 6; C 596]

- Pterygomaxillary fissure – between the lateral plate of the pterygoid process and the maxilla
4. Cut the temporal fascia along the superior temporal line and use a scalpel to peel it inferiorly. Observe that the temporalis muscle is attached to the deep surface of the temporal fascia. Cut the temporal fascia along the superior border of the zygomatic arch and remove the fascia.

5. Near the anterior end of the zygomatic arch, insert a probe deep to the zygomatic arch as close to the orbit as possible (FIG. 7.31, arrow 1). Use a saw to cut through the zygomatic bone to the probe.

6. Insert the probe deep to the zygomatic arch near the anterior border of the head of the mandible (FIG. 7.31, arrow 2). Use a saw to cut through the zygomatic arch to the probe.

**Dissection Instructions**

**Masseter Muscle and Removal of the Zygomatic Arch**

1. Reflect the facial nerve branches and the parotid duct anteriorly.
2. Clean the lateral surface of the masseter muscle and define its borders. The superior attachment of the masseter muscle is the inferior border of the zygomatic arch and its inferior attachment is the lateral surface of the ramus of the mandible. The masseter muscle elevates the mandible (closes the jaw) and protrudes the mandible. It is innervated by the masseteric branch of the mandibular division of the trigeminal nerve (V₃). [G 672; L 328; N 54; R 56; C 552]
3. Review the course of the superficial temporal vessels and auriculotemporal nerve across the zygomatic arch. Detach the anterior scalp flap from the region of the zygomatic arch, taking care to preserve the vessels and nerves where they cross the arch.
must be removed on both sides of the head to permit the head to be bisected in a later dissection step.

4. The first step is to remove the coronoid process and reflect the temporalis muscle with the coronoid process attached. Insert a probe through the mandibular notch posterior to the temporalis tendon and push the probe anteroinferiorly toward the third mandibular molar tooth (FIG. 7.32, arrow 1). Keep the probe in close contact with the deep surface of the mandible. Use a saw to cut halfway through the coronoid process toward the probe, then use bone cutters to break the bone along the scored line.

5. Reflect the coronoid process together with the temporalis muscle in the superior direction. Use blunt dissection to release the temporalis muscle from the skull and note that the deep temporal nerves (branches of the mandibular division of the trigeminal nerve) enter the muscle from its deep surface. The deep temporal nerves provide motor innervation to the temporalis muscle and they are accompanied by deep temporal arteries.

6. Insert a probe medial to the neck of the mandible (FIG. 7.32, arrow 2). Use a saw to cut halfway through the neck of the mandible, then use bone cutters to break the bone along the scored line.

7. Use bone cutters to carefully nibble away the superior part of the mandible, beginning at the mandibular notch and proceeding inferiorly. Stop at the level of the lingula (FIG. 7.32, dashed line 3). Make small cuts and stay on the lateral side of muscles, nerves, and vessels.

8. Deep to the mandible, identify the inferior alveolar nerve and vessels (FIG. 7.33). Clean the inferior

Temporal Region  [G 672; L 328; N 54; C 552]
1. The superficial boundary of the temporal region is the temporal fascia, which was reflected previously.
2. On a skull, identify the bony boundaries of the temporal fossa (FIG. 7.14):
   - Superior and posterior – superior temporal line
   - Anterior – frontal and zygomatic bones
   - Inferior – zygomatic arch superficially and infratemporal crest of the sphenoid bone deeply
   - Deep – parts of the frontal, parietal, temporal, and sphenoid bones
3. Identify the temporalis (temporal) muscle. Observe:
   - The superior attachment of the temporalis muscle is the temporal fascia (removed earlier) and the surface of the temporal fossa.
   - The inferior attachment of the temporalis muscle is the coronoid process of the mandible.
   - Fibers of the anterior portion of the temporalis muscle have a vertical direction (elevation of the mandible).
   - Fibers of the posterior portion of the temporalis muscle have a more horizontal direction (retraction of the mandible).

Infratemporal Fossa  [G 674; L 329; N 39; R 80; C 565]
1. On a skull, identify the boundaries of the infratemporal fossa:
   - Superior:
     - Zygomatic arch superficially
     - Infratemporal crest of the sphenoid bone deeply
   - Anterior – infratemporal surface of maxilla
   - Lateral – ramus of mandible
   - Medial – lateral plate of the pterygoid process
2. Wear eye protection for all steps that require the use of bone cutters.
3. The ramus of the mandible must be removed to view the contents of the infratemporal fossa and it
Identify the maxillary artery where it arises from the bifurcation of the external carotid artery (FIG. 7.33). The maxillary artery crosses either the superficial surface (two-thirds of cases) or the deep surface (one-third of cases) of the lateral pterygoid muscle. If the maxillary artery in your specimen passes deep to the lateral pterygoid muscle, perform step 15 first and then return to step 12.

Use blunt dissection to trace the maxillary artery through the infratemporal fossa. The maxillary artery has 15 branches. At this time, identify only the following five branches (FIG. 7.33):

- **Middle meningeal artery** – arises medial to the neck of the mandible and courses superiorly, passing deep to the lateral pterygoid muscle. Just below the base of the skull, it passes through a split in the auriculotemporal nerve. The middle meningeal artery passes through the foramen spinosum to enter the middle cranial fossa. It supplies the dura mater.
- **Deep temporal arteries (anterior and posterior)** – pass superiorly and laterally across the roof of the infratemporal fossa at bone level and enter the deep surface of the temporalis muscle.
- **Masseteric artery** (cut in a previous dissection step) – courses laterally and passes through the mandibular notch to enter the deep surface of the masseter muscle.
- **Inferior alveolar artery** – enters the mandibular foramen with the inferior alveolar nerve.
- **Buccal artery** – passes anteriorly onto the buccinator muscle to supply the cheek.

**CLINICAL CORRELATION**

**DENTAL ANESTHESIA**

A mandibular nerve block is produced by injecting an anesthetic agent into the infratemporal fossa. Understand from your dissection that the mandibular nerve block will anesthetize not only the inferior alveolar nerve but also the lingual nerve, resulting in anesthesia of the mandibular teeth, lower lip, chin, and the tongue.
13. Identify the lateral pterygoid muscle (FIG. 7.33). The lateral pterygoid muscle has two heads. The anterior attachment of the superior head is the infratemporal surface of the greater wing of the sphenoid bone. The anterior attachment of the inferior head is the lateral surface of the lateral plate of the pterygoid process. The posterior attachments of the lateral pterygoid muscle are the articular disc within the capsule of the temporomandibular joint and the neck of the mandible. The lateral pterygoid muscle depresses the mandible (opens the jaw). [G 678; L 329; N 55; C 565]

14. Inferior to the lateral pterygoid muscle, identify the medial pterygoid muscle (FIG. 7.33). The lingual nerve and inferior alveolar nerve pass between the inferior border of the lateral pterygoid muscle and the medial pterygoid muscle, and can be used as guides to separate the two muscles. The superior attachments of the medial pterygoid muscle are the maxilla and the medial surface of the lateral plate of the pterygoid process. The inferior attachment of the medial pterygoid muscle is the inner surface of the ramus of the mandible. The medial pterygoid muscle elevates the mandible (closes the jaw).

15. Remove the lateral pterygoid muscle to see the deeper part of the infratemporal fossa (FIG. 7.34). Define the inferior border of the lateral pterygoid muscle by inserting a probe between it and the medial pterygoid muscle. Use scissors to cut the lateral pterygoid muscle close to its posterior attachments to the neck of the mandible and the articular disc. Remove the muscle in a piecemeal fashion to preserve superficially positioned nerves and vessels.

16. Use blunt dissection to follow the inferior alveolar nerve and the lingual nerve superiorly toward the foramen ovale in the roof of the infratemporal fossa.

17. Identify the chorda tympani, a thin nerve that joins the posterior side of the lingual nerve high in the infratemporal fossa (FIG. 7.34).

18. Follow the maxillary artery toward the pterygopalatine fossa. Before entering the pterygopalatine fossa, the maxillary artery divides into four branches: posterior superior alveolar artery, infraorbital artery, descending palatine artery, and sphenopalatine artery. At this time, identify only the posterior superior alveolar artery, which enters the infratemporal surface of the maxilla (FIG. 7.34). The other branches will be dissected later.

**Temporomandibular Joint** [G 681; L 328; N 18; R 54; C 558]

1. Identify the capsule of the temporomandibular joint. The joint capsule is loose and its lateral surface is reinforced by the lateral ligament (FIG. 7.34).

2. Preserve the superficial temporal vessels and auriculotemporal nerve. Use a scalpel to trim away the lateral side of the joint capsule and the lateral ligament.

3. Within the joint, observe the articular disc and identify the superior and inferior synovial cavities (FIG. 7.35).

4. Note that the tendon of the lateral pterygoid muscle is attached to both the neck of the mandible and the articular disc (FIG. 7.35).

5. Examine the articular disc and note that it is thin near its center and thicker near its edges.
CHAPTER 7: THE HEAD AND NECK

INTERIOR OF THE SKULL

Dissection Overview

Many schools remove the brain before the cadaver is placed on the dissection table. If the brain has been removed in your specimen, skip ahead to the section entitled “Cranial Meninges.” If you must remove the brain yourself, proceed with the following instructions.

The bones of the calvaria provide a protective covering for the cerebral hemispheres. To view the internal features of the cranial cavity, the calvaria must be removed.

The order of dissection will be as follows: The scalp and temporalis muscle will be reflected inferiorly. The calvaria will be cut with a saw and removed. The dura mater will be examined and then opened to reveal the arachnoid mater and pia mater.

Dissection Instructions

Removal of the Calvaria

1. The cadaver should be in the supine position. Reflect the scalp inferiorly.

2. Use a scalpel to detach the temporalis muscle from the calvaria and reflect the temporalis muscle inferiorly. Fold it down over the reflected scalp (FIG. 7.36).

3. Observe the pericranium that covers the calvaria. Use a scalpel or chisel to scrape the bones of the calvaria clean of periosteum and muscle fibers.

4. Place a rubber band around the circumference of the skull (FIG. 7.36, dashed line). Anteriorly, the rubber band should be about 2 cm superior to the supraorbital margin. Posteriorly, the rubber band should be about 2 cm superior to the external occipital protuberance.

5. Two types of movements occur in the temporomandibular joint. In the superior synovial cavity, gliding movements occur between the articular disc and the mandibular fossa (protrusion and retraction). In the inferior synovial cavity, hinge movements occur between the head of the mandible and the articular disc.

6. Place your fifth digit in the cartilaginous portion of your external acoustic meatus. Palpate the head of the mandible as you elevate, depress, protrude, and retract your mandible.

Dissection Follow-up

1. Review the attachments and actions of the four muscles of mastication (masseter, temporalis, medial pterygoid, and lateral pterygoid).

2. Use an atlas illustration to study the origin of the mandibular division of the trigeminal nerve (V) at the trigeminal ganglion and trace it to the foramen ovale. Follow the mandibular division of the trigeminal nerve through the foramen ovale into the infratemporal fossa. Review the sensory and motor branches of the mandibular division.

3. Follow the external carotid artery from its origin near the hyoid bone to the infratemporal fossa.

4. Review the course of the superficial temporal artery and the maxillary artery. Follow the branches of the maxillary artery that were identified in dissection to their regions of supply.

5. Note the relationship of the middle meningeal artery to the auriculotemporal nerve.

6. Use an illustration and the dissected specimen to preview the terminal branches of the maxillary artery.
Its caliber increases from anterior to posterior (direction of venous blood flow).
- It has lateral expansions called lateral venous lacunae.
- Arachnoid granulations may be seen in the lateral venous lacunae (FIGS. 7.37 and 7.38). The arachnoid granulations return cerebrospinal fluid (CSF) to the venous system.

5. Refer to a skull. Remove the calvaria and note that the bones of the calvaria have three layers:

- **Outer lamina** – compact bone
- **Diploë** – spongy bone between the outer and inner laminae
- **Inner lamina** – compact bone

6. Use a saw to cut along the marked line. The saw cut should pass through the outer lamina of the calvaria but not completely through the bone. If you saw through the inner lamina, you may damage the underlying dura mater or the brain. Moist red bone on the saw blade indicates that the saw is within the diploë. Be particularly careful when cutting the squamous part of the temporal bone, which is very thin.

7. While sawing, turn the body alternately from supine to prone and back to supine as you work your way around the skull. After making a complete circumferential cut, break the inner lamina of the calvaria by repeatedly inserting a chisel into the saw cut and striking the chisel gently with a mallet. Continue with this procedure until the calvaria can be pried loose.

8. Remove the calvaria by prying it from the dura mater with the handle of a forceps or a chisel blade. Work from anterior to posterior and do not use more force than is necessary. Violent pulling may result in tearing of the dura and damage to the brain.

**Cranial Meninges**  
[**G 642; L 344; N 100, 101; C 573, 574**]

1. The brain is covered with three membranes called meninges (Gr. *meninx*, membrane). From outside to inside they are (FIG. 7.37):

- **Dura mater** – the outer tough membrane
- **Arachnoid mater** – the intermediate membrane
- **Pia mater** – a delicate membrane that is closely applied to the surface of the brain

2. The **dura mater** (L. *dura mater*, hard mother) consists of two layers, an external **periosteal layer** and an internal **meningeal layer** (FIG. 7.37). The two dural layers are indistinguishable except where they separate to enclose the dural venous sinuses.

3. Identify the **superior sagittal sinus**. (FIGS. 7.37 and 7.38).  
[**G 643; L 342, 343; N 100–103; R 87; C 575**]

4. Use scissors to make a longitudinal incision in the superior sagittal sinus (FIG. 7.38) and verify that:

- Its inner surface is smooth because it is lined by endothelium.
5. Examine the surface of the dura mater that covers the cerebral hemispheres and observe the branches of the middle meningeal artery (FIGS. 7.38 and 7.39). The middle meningeal artery supplies the dura mater and adjacent calvaria. Note that the anterior branch of the middle meningeal artery crosses the inner surface of the pterion, where it may tunnel through the bone. Fractures through the pterion may result in tearing of the middle meningeal artery.

6. Examine the inner surface of the removed calvaria. Identify the following features: [L 300; N 9; C 570]

- Groove for the superior sagittal sinus
- Granular foveolae – shallow depressions caused by the arachnoid granulations
- Grooves for the branches of the middle meningeal artery

7. Use a scalpel to cut through the dura mater along the same line that the calvaria was cut (FIG. 7.39, red dashed line). Stop the cuts posteriorly about 3.5 cm lateral to the midline. The objective is to permit the dura mater to be pulled free from the surface of the brain but to leave it attached posteriorly in the area of the superior sagittal sinus.

8. Using your fingers, gently retract the anterior pole of the dura and insert scissors between the cerebral hemispheres and cut the cerebral falx where it attaches to the crista galli.

9. Grasp the anterior pole of the dura mater and gently pull it posteriorly, gradually working the cerebral falx free from between the cerebral hemispheres.

10. Observe bridging veins that pass from the surface of the brain into the superior sagittal sinus along its lateral sides. These bridging veins connect the superior cerebral veins to the superior sagittal sinus. Cut these bridging veins to permit the cerebral falx to be completely retracted from between the cerebral hemispheres. Continue this procedure until the dura mater is attached to the skull only near its posterior pole, and the arachnoid mater covering the surface of the brain is completely exposed.

11. Observe the arachnoid mater (Gr. arachnoeides, like a cobweb—in reference to the spider web-like connective tissue strands in the subarachnoid space). The arachnoid mater loosely covers the brain and spans across the fissures and sulci. In the living person, the arachnoid mater is closely applied to the internal meningeal layer of the dura mater with no space between (FIG. 7.37). [G 643; L 344; N 101; R 85]

12. Observe the cerebral veins that are visible through the arachnoid mater. The cerebral veins empty into the superior sagittal sinus via bridging veins. At the point where the bridging veins enter the superior sagittal sinus, they may be torn in cases of head trauma.

13. Use scissors to make a small cut (2.5 cm) through the arachnoid mater over the lateral surface of the brain (FIG. 7.38). Use a probe to elevate the arachnoid mater and observe the subarachnoid space. In the living person, the subarachnoid space is a real space that contains cerebrospinal fluid.
Dissection Follow-up

1. Review the bones that form the calvaria.
2. Review the external features of the cranial dura mater and note that the external periosteal layer is attached to the skull.
3. Review the features of the spinal dura mater and compare it to the cranial dura mater.
4. Review the extradural (epidural) space in the vertebral canal and recall that it contains fat and the internal vertebral venous plexus. Under normal conditions, there is no extradural space in the cranial cavity.
5. Compare and contrast the features of an epidural hematoma and a subdural hematoma.

REMOVAL OF THE BRAIN

Dissection Overview

The internal meningeal layer of the dura mater forms inwardly projecting folds (dural infoldings) that serve as incomplete partitions of the cranial cavity. Three of these folds (cerebral falx, cerebellar tentorium, and cerebellar falx) extend inward between parts of the brain. These infoldings must first be cut before the brain can be removed.

The order of dissection will be as follows: Bony features of the cranial cavity will be studied on a skull. The brain will be removed intact, along with the arachnoid mater and pia mater. The dura mater will be left in the cranial cavity, where the dural infoldings will be studied.

Dissection Instructions

1. Use a skull to identify the following features (FIG. 7.40): [G 623; L 302; N 11; R 30; C 586]
   - Crista galli
   - Cribriform plate
   - Anterior clinoid process
   - Posterior clinoid process
   - Superior border of the petrous part of the temporal bone
   - Internal acoustic meatus
   - Jugular foramen
   - Hypoglossal canal
   - Foramen magnum
   - Groove for the sigmoid sinus
   - Groove for the transverse sinus

2. If the brain has been removed from your cadaver, skip ahead to the section entitled “Dural Infoldings and Dural Venous Sinuses.”
3. Use an atlas figure to help you identify the structures to be cut. [G 646; L 346; N 103; R 75; C 588]
4. Use your fingers to gently elevate the frontal lobes. Use a probe to lift the olfactory bulb from the cribriform plate on each side of the crista galli.
5. Use a scalpel to cut the following structures bilaterally: optic nerve, internal carotid artery, and oculomotor nerve. Cut the stalk of the pituitary gland in the midline.
6. On the right side, gently lift the temporal lobe (lateral part of brain) and observe the cerebellar tentorium. Use a scalpel to cut the cerebellar tentorium as close to the superior border of the petrous part of the temporal bone as possible. The cut should begin anteriorly near the posterior clinoid process and extend posterolaterally to the end of the superior border of the petrous part of the temporal bone, near the groove for the sigmoid sinus (FIG. 7.40). Repeat the cut on the left side of the cadaver. The following structures will be cut bilaterally during this step: trochlear nerve, trigeminal nerve, and abducens nerve.
7. With the cerebellar tentorium cut, the brain may be gently moved to gain access to structures that lie inferior to the tentorium. Elevate the cerebrum and...
brainstem slightly, and cut the following structures bilaterally: facial and vestibulocochlear nerves near the internal acoustic meatus; glossopharyngeal, vagus, and accessory nerves near the jugular foramen; and hypoglossal nerve near the hypoglossal canal.

8. Use a scalpel to sever the two vertebral arteries where they enter the skull through the foramen magnum and the cervical spinal cord as low in the foramen magnum (or cervical vertebral canal) as you can reach.

9. Support the cerebral hemispheres from behind with the palm of one hand. Insert the other hand (palm facing superiorly) between the frontal lobes and the skull with your middle finger extending down the ventral surface of the brainstem. Insert the tip of your middle finger into the cut that was made across the cervical spinal cord to support the brainstem and cerebellum. Using upward pressure on the cut end of the cervical spinal cord, roll the brain, brainstem, and cerebellum posteriorly and out of the cranial cavity in one piece.

10. The brain should be stored in a bath of preservative fluid.

DURAL INFOLDINGS AND DURAL VENOUS SINUSES

Dissection Overview

The two layers of the dura mater separate from each other in several locations to form dural venous sinuses. The dural venous sinuses collect venous drainage from the brain and conduct it out of the cranial cavity.

The order of dissection will be as follows: The dura mater will be repositioned to recreate its three-dimensional morphology during life. The infoldings of the dura mater and the associated dural venous sinuses will be identified.

Dissection Instructions

Dural Infoldings  [G 644; L 342, 343; N 102; R 87; C 577]

1. Return the dura mater to its correct anatomical position. This study can be made easier by removing the right side of the dura mater to expose the lateral side of the cerebral falx and the cranial cavity as illustrated in FIGURE 7.41.

2. Identify the cerebral falx (falc cerebri) (FIG. 7.41). In the living person, the cerebral falx lies between the cerebral hemispheres. The cerebral falx is attached to the crista galli at its anterior end, to the calvaria on both sides of the groove for the superior sagittal sinus, and to the cerebellar tentorium posteriorly.

3. Identify the cerebellar tentorium (tentorium cerebelli; L. tentorium, tent) (FIG. 7.41). The cerebellar tentorium is attached to the clinoid processes of the sphenoid bone, the superior border of the petrous bone extending (right and left). The infoldings of the dura mater will be repositioned to recreate its three-dimensional morphology during life. The infoldings of the dura mater and the associated dural venous sinuses will be identified.

4. Identify the cerebellar falx (falc cerebelli), which is a low ridge of dura mater located inferior to the cerebellar tentorium in the midline. Note that the cerebellar falx is attached to the inner surface of the occipital bone and that it is located between the cerebellar hemispheres.

Dural Venous Sinuses  [G 645; L 342, 343; N 103; R 87; C 577]

1. Review the position of the superior sagittal sinus (FIG. 7.41). Note that the superior sagittal sinus begins near the crista galli and ends near the cerebellar tentorium by draining into the confluence of sinuses.

2. Identify the inferior sagittal sinus, which is in the inferior margin of the cerebral falx (FIG. 7.41). The inferior sagittal sinus begins anteriorly and ends near the cerebellar tentorium by draining into the anterior end of the straight sinus. Note that the inferior sagittal sinus is much smaller in diameter than the superior sagittal sinus.

3. The straight sinus is located in the line of junction of the cerebral falx and the cerebellar tentorium. At its anterior end, the straight sinus receives the inferior sagittal sinus and the great cerebral vein (the great cerebral vein was torn when the brain was removed). The straight sinus drains into the confluence of sinuses.

4. Identify the transverse sinuses (right and left). Each transverse sinus carries venous blood from portion of the temporal bone, and the occipital bone on both sides of the groove for the transverse sinus. The opening in the cerebellar tentorium is called the tentorial notch (tentorial incisure). The brainstem passes through the tentorial notch. In the living person, the cerebellar tentorium is between the cerebral hemispheres and the cerebellum.
the confluence of sinuses to the sigmoid sinus. Use a scalpel to open the lumen of the transverse sinus and note that it is lined with smooth endothelium.

5. Identify the sigmoid sinuses (FIG. 7.41, right and left). Each sigmoid sinus begins at the lateral end of the transverse sinus and ends at the jugular foramen. Use a scalpel to open the lumen of the sigmoid sinus and trace it to the jugular foramen. The internal jugular vein is formed at the external surface of the jugular foramen.

6. Observe the floor of the cranial cavity. Note that the dura mater covers all of the bones and provides openings through which the cranial nerves pass. There are small dural venous sinuses located between the layers of the dura mater in the floor of the cranial cavity. Because these small dural venous sinuses are difficult to demonstrate, use an atlas illustration to study the following: [G 645; L 342; N 103; R 87; C 588]

- Sphenoparietal sinus
- Cavernous sinus
- Superior petrosal sinus
- Inferior petrosal sinus
- Basilar plexus

Dissection Follow-up
1. Review the infoldings of the dura mater and obtain a three-dimensional understanding of their arrangement.
2. Naming all venous structures encountered along the way, trace the route of a drop of blood from:
   - A superior cerebral vein to the internal jugular vein
   - The sphenoparietal sinus to the sigmoid sinus
   - The great cerebral vein to the internal jugular vein

GROSS ANATOMY OF THE BRAIN

Dissection Overview
The study of brain anatomy is highly specialized and is usually reserved for a neuroscience course. The description that is provided here is intended to relate the major features of the external surface of the brain to the parts of the skull that will be studied in subsequent dissections. An additional goal of this study is to establish a mental picture of the continuity of the arteries and nerves of the brain with those same structures that are left behind in the cranial fossae after brain removal.

Dissection Instructions
1. Examine the lateral surface of the brain and identify (FIG. 7.42): [G 728; L 348; N 104; R 92]
   - Frontal lobe
   - Central sulcus

2. Identify the cerebellum and the brainstem.
3. Refer to a skull and identify the three cranial fossae: anterior, middle, and posterior (FIG. 7.42). Use the cadaver specimen and the brain to verify the following: [N 11; C 586]
   - The frontal lobe is located in the anterior cranial fossa.
   - The temporal lobe is located in the middle cranial fossa.
   - The cerebellum is located in the posterior cranial fossa.
   - The occipital lobe is located superior to the cerebellar tentorium.
   - The brainstem becomes continuous with the cervical spinal cord at the foramen magnum.

4. Examine the inferior surface of the brain and note that it is covered by arachnoid mater. Use a probe to peel back the arachnoid mater and expose the arteries. Observe the arteries and note the following (FIG. 7.43): [G 652; L 347, 351; N 137; R 93; C 581, 582]
• Two vertebral arteries and two internal carotid arteries supply the brain.
• Each vertebral artery gives rise to one posterior inferior cerebellar artery (PICA).
• The two vertebral arteries combine to form the basilar artery.
• The basilar artery gives off the anterior inferior cerebellar artery, the superior cerebellar artery, and several pontine branches.
• The basilar artery terminates by branching into two posterior cerebral arteries.
• Each posterior cerebral artery gives off a posterior communicating artery that anastomoses with the internal carotid artery.
• After giving off the ophthalmic artery, each internal carotid artery terminates by dividing into a middle cerebral artery and an anterior cerebral artery.
• The anterior cerebral arteries are joined across the midline by the anterior communicating artery.

• The cerebral arterial circle is formed by the posterior cerebral, posterior communicating, internal carotid, anterior cerebral, and anterior communicating arteries.

5. On the inferior surface of the brain, identify the 12 cranial nerves by name and by number (FIG. 7.43):
• Olfactory bulb and tract (I)
• Optic (II)
• Oculomotor (III)
• Trochlear (IV)
• Trigeminal (V)
• Abducent (VI)
• Facial (VII)
• Vestibulocochlear (VIII)
• Glossopharyngeal (IX)
• Vagus (X)
• Accessory (XI)
• Hypoglossal (XII)

![FIGURE 7.43 Blood vessels and cranial nerves at the base of the brain.](image-url)
Dissection Follow-up
1. Review the parts of the brain and the cranial fossae in which they are found.
2. Review the infoldings of the dura mater and their relationship to the cerebral hemispheres and cerebellum.
3. Review the formation of the cerebral arterial circle.
4. Recall the origins of the internal carotid and vertebral arteries and the route that each takes to enter the cranial cavity.

CRANIAL FOSSAE
Dissection Overview
The order of dissection will be as follows: The bones of the floor of the cranial cavity will be studied and the boundaries of the cranial fossae will be identified. The vessels and the nerves of each cranial fossa will be studied. Because the floor of the cranial cavity is covered by dura mater, the dissection is much easier if a skull is held beside the cadaver specimen during dissection to permit direct observation of the foramina.

Skeleton of the Cranial Base
Use a skull to identify (FIG. 7.44): [G 622, 623; L 302; N 11; R 30; C 586]

- Ethmoid bone
  - Crista galli
  - Cribriform plate
- Frontal bone
  - Orbital part
- Sphenoid bone
  - Lesser wing
  - Sphenoidal crest
  - Superior orbital fissure
  - Anterior clinoid process
  - Sphenoidal limbus
  - Optic canal
  - Hypophyseal fossa
  - Posterior clinoid process
  - Greater wing
  - Foramen rotundum
  - Foramen ovale
  - Foramen spinosum
- Temporal bone
  - Squamous part
  - Petrous part
  - Superior border (petrous ridge)
  - Groove for the sigmoid sinus
  - Internal acoustic meatus
- Occipital bone
  - Clivus

FIGURE 7.44 Features of the three cranial fossae.
Identify the **foramen lacerum**, which is formed by portions of the greater wing of the sphenoid bone and the temporal bone.

The **anterior cranial fossa** is separated from the **middle cranial fossa** by the right and left sphenoidal crests and the sphenoidal limbus. The middle cranial fossa is separated from the **posterior cranial fossa** by the superior border of the petrous part of the temporal bone. The cerebellar tentorium is attached to the superior border of the petrous part of the temporal bone and it forms the roof of the posterior cranial fossa.

**Dissection Instructions**

**Anterior Cranial Fossa**  [G 646; L 346; N 103; R 75; C 588]

1. On the right side of the cadaver only, use a probe to loosen the dura mater along the cut edge of the frontal bone. Grasp the dura mater with your fingers and pull it posteriorly as far as the lesser wing of the sphenoid bone. Use scissors to detach the dura mater along the sphenoidal crest and along the midline and place it in the tissue container.

2. Note that the sphenoparietal venous sinus is located along the sphenoidal crest and that its lumen may now be visible where you detached the dura mater.

3. Identify the three bones that participate in the formation of the **anterior cranial fossa**: sphenoid bone, ethmoid bone, and orbital part of the frontal bone (FIG. 7.44). Note that the orbital part of the frontal bone forms the roof of the orbit.

4. Before the brain was removed, the cerebral falx was attached to the crista galli and the frontal lobe of the brain rested on the orbital part of the frontal bone. The olfactory bulb rested on the cribiform plate and the fibers of the **olfactory nerve** (I) passed through the openings of the cribiform plate to enter the nasal cavity (FIG. 7.45).

**Middle Cranial Fossa**  [G 646, 650; L 346, 355; N 103; R 73; C 588]

1. Recall that the **middle cranial fossa** contains the temporal lobe of the brain.

2. Observe the dura mater that covers the floor of the middle cranial fossa. The dura mater hides all of the openings in the skull and the nerves and vessels that pass through them (FIG. 7.45, left side).

3. Identify the **middle meningeal artery** that can be seen through the dura mater (FIG. 7.45). It appears as a dark line extending laterally from the deepest point of the middle cranial fossa. The middle meningeal artery enters the middle cranial fossa by passing through the **foramen spinosum**.

4. Grasp the dura mater along the sphenoidal crest and peel it posteriorly as far as the superior border of the petrous part of the temporal bone. Note that the middle meningeal artery adheres to the external surface of the dura mater. Use a probe to tease the proximal part of middle meningeal artery away from the dura mater and leave it in the skull.

5. Use scissors to detach the dura mater along the superior border of the petrous part of the temporal bone and place it in the tissue container. Do not cut the cranial nerves that cross the anterior end of the superior border of the petrous part of the temporal bone (oculomotor, trigeminal, trochlear, and abducent). Note that the lumen of the **superior petrosal sinus** can be seen along the line of the cut (FIG. 7.45).

6. Observe that the floor of the middle cranial fossa is formed by two bones: sphenoid and temporal (FIG. 7.44).

7. Identify the **optic nerve** (II) (FIG. 7.45). The optic nerve passes through the **optic canal** to enter the orbit. The optic nerve is surrounded by a sleeve of dura mater as it exits the middle cranial fossa.

8. Use a probe to identify the **superior orbital fissure** that is located inferior to the lesser wing of the sphenoid bone (FIG. 7.44). Three cranial nerves and part of a fourth exit the middle cranial fossa by passing through the superior orbital fissure:

   - **Oculomotor nerve** (III) – passes over the superior border of the petrous part of the temporal bone and passes anteriorly within the lateral wall of the cavernous sinus.

   - **Trochlear nerve** (IV) – courses anteriorly within the lateral wall of the cavernous sinus immediately inferior to the oculomotor nerve (FIG. 7.45). The trochlear nerve is a very small nerve that enters the dura mater at the anterior end of the tentorial notch. It may have been cut during brain removal but should be intact farther anteriorly.

   - **Ophthalmic division of the trigeminal nerve** (V1) – arises from the trigeminal ganglion and passes anteriorly within the lateral wall of the cavernous sinus inferior to the trochlear nerve (FIG. 7.45).

   - **Abducent nerve** (VI) – enters the dura mater over the clivus of the occipital bone (FIG. 7.45). The abducent nerve passes anteriorly within the cavernous sinus in close relationship to the lateral surface of the internal carotid artery.
9. Use a probe to clean the nerves that pass through the superior orbital fissure. Note that three of these nerves are located within the lateral wall of the cavernous sinus (III, IV, V₁) and one is within the cavernous sinus (VI) (FIG. 7.46).

10. Identify the **trigeminal nerve (V)** (FIG. 7.45). It is the largest cranial nerve and is easily found where it crosses the superior border of the petrous part of the temporal bone.

11. Follow the trigeminal nerve anteriorly and identify the **trigeminal ganglion**. Use a probe to define the three divisions (nerves) that arise from the anterior border of the trigeminal ganglion (ophthalmic [V₁], maxillary [V₂], and mandibular [V₃]). Note that these three divisions are named according to their region of distribution and are numbered from superior to inferior as they arise from the trigeminal ganglion.

12. Identify the **maxillary division of the trigeminal nerve (V₂)** and follow it anteriorly to the **foramen rotundum**, where it exits the middle cranial fossa (FIG. 7.45). The maxillary division courses within the lateral wall of the cavernous sinus just inferior...
13. Identify the mandibular division of the trigeminal nerve (V₃) and follow it inferiorly to the foramen ovale, which is where it exits the middle cranial fossa and enters the infratemporal fossa (FIG. 7.45).

14. Return to the area of the cavernous sinus and use a probe to retract the cranial nerves. Identify the internal carotid artery (FIG. 7.45). The internal carotid artery enters the cranial cavity by passing through the carotid canal. It makes an S-shaped bend in the cavernous sinus and emerges near the optic nerve. Cranial nerves III, IV, V₁, V₂, and VI cross the lateral side of the internal carotid artery. Among this group of nerves, the abducens nerve (VI) is most closely related to the internal carotid artery (FIG. 7.46).

15. Identify the region of the hypophyseal fossa. The hypophyseal fossa is covered by the sellar diaphragm (diaphragma sellae), which is a dural infolding (FIG. 7.46). The stalk of the pituitary gland passes through an opening in the sellar diaphragm. The pituitary gland is still contained within the hypophyseal fossa.

16. Anterior and posterior to the stalk of the pituitary gland are two small dural venous sinuses called the anterior and posterior intercavernous sinuses (FIG. 7.45). The intercavernous sinuses connect the right and left cavernous sinuses across the midline. Do not attempt to dissect the intercavernous sinuses.

17. Use an atlas illustration to identify all of the veins and venous sinuses that drain into or out of the cavernous sinus. [G 645; L 342; N 103; R 87; C 588]

**Dissection Follow-up**

1. Review the bones that form the floor of the cranial cavity.

2. Read a description of the dural venous sinuses as you review them in the cadaver.

3. In the cadaver, review the course of each cranial nerve and name the opening through which each passes to exit the cranial cavity. In the skull, review the openings (foramina and fissures) through which the cranial nerves pass.

4. If the brain is still available, hold it beside the cranial and the cadaver.

5. Identify the hypoglossal nerve (XII) where it enters the hypoglossal canal (FIG. 7.45).

6. On the left (undissected) side of the cranial cavity, identify the cranial nerves in order from anterior to posterior (FIG. 7.45).

**CLINICAL CORRELATION**

**Cavernous Sinus**

In fractures of the base of the skull, the internal carotid artery may rupture within the cavernous sinus. The release of arterial blood into the cavernous sinus creates an abnormal reflux of blood from the cavernous sinus into the ophthalmic veins. As a result, the orbit is engorged and the eyeball is protruded and is pulsating in synchrony with the radial pulse (pulsating exophthalmos).

**ORBIT**

**Dissection Overview**

The orbit contains the eyeball and extraocular muscles. The eyeball is about 2.5 cm in diameter and occupies the anterior half of the orbit. The posterior half of the orbit contains fat, extraocular muscles, branches of cranial nerves, and blood vessels. Some vessels and nerves pass through the orbit to reach the scalp and face.

The order of dissection will be as follows: The bones of the orbit will be studied. On the right side only, the floor
of the anterior cranial fossa will be removed and the right orbit will be dissected from a superior approach. Cranial nerves III, IV, V, and VI will be followed through the superior orbital fissure into the orbit and the extraocular muscles will be identified. The left orbit will be dissected from an anterior approach. On the left side only, the anatomy of the eyelid will be studied and then the eyeball will be removed. The attachments of the extraocular muscles will be studied.

**Skeleton of the Orbit**
The bones of the orbit form a four-sided pyramid. The base of the pyramid is the orbital margin and the apex of the pyramid is the optic canal. Viewed from above, the medial walls of the two orbits are parallel to each other and about 2.5 cm apart. The lateral walls of the two orbits form a right angle to each other.

Refer to a skull and identify the bones that participate in the formation of the walls of the orbit (FIG. 7.47): [G 656; L 352; N 4; R 46; C 595]

- Frontal bone
  - Supraorbital notch
  - Orbital surface
  - Lacrimal fossa
- Ethmoid bone
- Lacrimal bone
  - Posterior lacrimal crest
  - Lacrimal groove
- Maxilla
  - Anterior lacrimal crest
  - Infraorbital groove
  - Infraorbital foramen
- Zygomatic bone
- Sphenoid bone
  - Optic canal
  - Lesser wing
  - Superior orbital fissure
  - Greater wing

On the medial wall of the orbit, identify the anterior and posterior ethmoidal foramina.

Identify the *inferior orbital fissure*, which is a gap between the maxilla and the greater wing of the sphenoid bone. Note that the lateral wall of the orbit is stout and strong but the part of the ethmoid bone that forms the medial wall is paper thin and for this reason it is called the *lamina papyracea*. Examine a coronal section through the orbit and note the following relationships (FIG. 7.48):

- **Roof of the orbit** is related to the anterior cranial fossa
- **Floor of the orbit** is related to the maxillary sinus
- **Medial wall of the orbit** is related to the ethmoidal cells

The bones of the orbit are lined with periosteum called *periorbita*. At the optic canal and the superior orbital fissure, the periorbita is continuous with the dura mater of the middle cranial fossa.

**Surface Anatomy of the Eyeball, Eyelids, and Lacrimal Apparatus**
Use a mirror or recruit the assistance of your lab partner to inspect the living eye. Identify: [G 656, 657; L 353; N 81; R 135; C 593]

- **Eyelashes (cilia)**
- **Palpebral fissure (rima)** – the opening between the eyelids
CHAPTER 7: THE HEAD AND NECK

247

- **Medial and lateral palpebral commissures** – where the upper and lower eyelids join
- **Medial and lateral angles (canthi)** – the medial and lateral corners of the eye
- **Sclera** – the whitish posterior five-sixths of the exterior coat of the eyeball
- **Cornea** – the transparent anterior one-sixth of the exterior coat of the eyeball
- **Iris** – the colored diaphragm seen through the cornea
- **Pupil** – the aperture in the center of the iris

In the medial angle of the eye, observe:

- **Lacrimal caruncle** – a pink fleshy bump
- **Lacrimal lake** – the area surrounding the lacrimal caruncle
- **Lacrimal papilla** – a small bump on the medial end of each eyelid
- **Lacrimal puncta** – a small opening at the apex of each lacrimal papilla

Evert the lower lid slightly and observe:

- **Margin of the eyelid** – flat and thick
- **Eyelashes (cilia)** – arranged in two or three irregular rows

Use an illustration to study the following features and relate them to the living eye: [G 661; L 353; N 81; R 132; C 600]

- **Bulbar conjunctiva** – the membrane that lines the surface of the eyeball

**Dissection Instructions**

**Eyelid and Lacrimal Apparatus** [G 657, 661; L 352, 353; N 81, 82; R 142; C 597, 598]

1. Dissect the eyelid and lacrimal gland only in the left eye.
2. Review the attachments of the **orbicularis oculi muscle**. Use a probe to raise the lateral part of the **orbital portion of the orbicularis oculi muscle** and reflect the muscle medially.
3. Raise the thin **palpebral portion of the orbicularis oculi muscle** off the underlying **tarsal plates** and reflect the muscle medially.
4. The **orbital septum** is a sheet of connective tissue that is attached to the periosteum at the margin of the orbit and to the tarsal plates (FIGS. 7.49 and 7.50). The orbital septum separates the superficial fascia of the face from the contents of the orbit.
5. Identify the **tarsal plates**, which give shape to the eyelids (FIG. 7.49). **Tarsal glands** are embedded in

**FIGURE 7.49** Orbital septum and tarsal plates.
the posterior surface of each tarsal plate. Tarsal glands drain by small orifices that are located posterior to the eyelashes. Tarsal glands secrete an oily substance onto the margin of the eyelid that prevents the overflow of lacrimal fluid (tears).

**CLINICAL CORRELATION**

**TARSAL GLANDS**

If the duct of a tarsal gland becomes obstructed, a chalazion (cyst) will develop. A chalazion will be located deep to the tarsal plate, between it and the conjunctiva. In contrast, a hordeolum (stye) is the inflammation of a sebaceous gland associated with the follicle of an eyelash and will be located superficial to the tarsal plate.

6. The **lacrimal gland** occupies the lacrimal fossa in the frontal bone (FIG. 7.49). To find the lacrimal gland, use a scalpel to cut through the orbital septum adjacent to the orbital margin in the superolateral quadrant of the left orbit. Pass a probe through the incision and free the lacrimal gland from the lacrimal fossa. Note that the lacrimal gland drains into the superior conjunctival fornix by 6 to 10 short ducts (FIG. 7.51).

7. Use a skull to identify the **lacrimal groove** at the medial side of the orbital margin. Observe that the anterio lacrimal crest of the maxilla forms the anterior border of the lacrimal groove. The **medial palpebral ligament** is attached to the anterior lacrimal crest and the **lacrimal sac** lies posterior to the medial palpebral ligament in the lacrimal groove (FIG. 7.49).

8. Two **lacrimal canaliculi** drain lacrimal fluid from the medial angle of the eye into the lacrimal sac. The **nasolacrimal duct** extends inferiorly from the lacrimal sac and enters the inferior meatus of the nasal cavity (FIG. 7.51).

9. Lacrimal fluid flows from the lacrimal gland across the eyeball to the medial angle of the eye. During crying, excess lacrimal fluid cannot be emptied through the lacrimal canaliculi and tears overflow the lower eyelids. Increased drainage of tears into the nasal cavity results in sniffing, which is characteristic of crying.

**Right Orbit from the Superior Approach** [G 658; L 356–358; N 86; R 140; C 601]

1. Dissect only the right orbit from the superior approach. **Wear eye protection for all steps that require the use of bone cutters.**

2. In the floor of the anterior cranial fossa, tap the orbital part of the frontal bone with the side of the bone cutters until the bone cracks. Use the bone cutters to pick out the bone fragments and enlarge the opening in the **roof of the orbit**. Remove the roof of the orbit as far anteriorly as the superior orbital margin (FIG. 7.52).
3. The frontal bone contains the **frontal sinus** that may extend into the roof of the orbit. Medially, the **ethmoidal cells** may extend into the roof of the orbit. If either situation occurs in your cadaver, you must remove the mucous membrane that lines the sinus and remove a second layer of thin bone to open the orbit.

4. Identify the membrane just inferior to the roof of the orbit. This is the **periorbita**, which lines the bones of the orbit.

5. Push a probe posteriorly between the roof of the orbit and the periorbita. The probe should pass inferior to the lesser wing of the sphenoid bone, through the superior orbital fissure, and into the middle cranial fossa. Use the probe to break the lesser wing of the sphenoid bone.

6. Use bone cutters to remove the fragments of the lesser wing of the sphenoid bone. Chip away the roof of the optic canal and remove the anterior clinoid process (FIG. 7.52).

7. Examine the periorbita and note that the frontal nerve may be visible through it. Use scissors to incise the periorbita from the apex of the orbit to the midpoint of the superior orbital margin. Use forceps to lift the periorbita off deeper structures and make a transverse incision through the periorbita, close to the superior orbital margin. Use a probe to tease open the flaps of periorbita and use scissors to remove them.

8. The use of a fine probe and fine forceps is recommended from this point onward in the dissection.

9. Three nerves enter the apex of the orbit by passing superior to the extraocular muscles:

   - **Frontal nerve** (a branch of V1) – courses from the apex of the orbit toward the superior orbital margin (FIG. 7.52). Trace the frontal nerve anteriorly and observe that it divides into the **supratrochlear nerve** and the **supraorbital nerve**.
   - **Lacrimal nerve** (a branch of V1) – passes through the superior orbital fissure lateral to the frontal nerve and courses along the lateral wall of the orbit. The lacrimal nerve is much smaller than the frontal nerve (FIG. 7.52). Follow the lacrimal nerve anterolaterally toward the lacrimal gland.
   - **Trochlear nerve** – passes through the superior orbital fissure medial to the frontal nerve (FIG. 7.52). Follow the trochlear nerve to the superior border of the **superior oblique muscle**, which it innervates. The trochlear nerve usually enters the superior border of the superior oblique muscle in its posterior one-third.

10. While preserving the nerves, use forceps to pick out lobules of fat and expose the superior surface of the **levator palpebrae superioris muscle** (FIGS. 7.50 and 7.52). The levator palpebrae superioris muscle attaches to the upper eyelid, which it elevates.

11. Transect the levator palpebrae superioris muscle as far anteriorly as possible and reflect it posteriorly.

12. Identify the **superior rectus muscle** that lies immediately inferior to the levator palpebrae superioris muscle (FIGS. 7.50 and 7.52). Clean the superior rectus muscle and observe that it is attached to the eyeball by a thin, broad tendon.

13. Transect the superior rectus muscle close to the eyeball and reflect it posteriorly (FIG. 7.53). Note that a branch of the superior division of the **oculomotor nerve (III)** reaches the inferior surface of the superior rectus muscle. A branch of the superior division passes around the medial side of the superior rectus muscle to innervate the levator palpebrae superioris muscle. [G 658; L 357; N 86; R 141; C 603]

14. On the medial side of the orbit, identify the **superior oblique muscle** and trace it anteriorly (FIG. 7.53). Observe that the tendon of the superior oblique muscle passes through the trochlea (L. trochlea, pulley), bends at an acute angle, and attaches to the posterolateral portion of the eyeball.
20. Identify the **anterior ethmoidal nerve**, which is a small branch of the nasociliary nerve that passes through the anterior ethmoidal foramen. The anterior ethmoidal nerve supplies part of the mucous membrane in the nasal cavity. Its terminal branch is the **external nasal nerve** that innervates the skin at the tip of the nose.

21. In the middle cranial fossa, identify the **oculomotor nerve** within the lateral wall of the cavernous sinus. Follow the oculomotor nerve through the superior orbital fissure into the orbit where it branches into two divisions:

- **Superior division** – innervates the levator palpebrae superioris and the superior rectus muscles
- **Inferior division** – innervates the medial rectus, inferior rectus, and inferior oblique muscles

22. The **ciliary ganglion** is a parasympathetic ganglion located between the optic nerve and the lateral rectus muscle. It is approximately 2 mm in diameter and is located about 1 cm anterior to the apex of the orbit (FIG. 7.53). Note that short ciliary nerves connect the ciliary ganglion to the posterior surface of the eyeball. Study the autonomic function of the ciliary ganglion.

23. Use an atlas illustration to study the course of the **superior ophthalmic vein** in the orbit. At the medial angle of the eye, the superior ophthalmic vein anastomoses with the angular vein, which is a tributary of the facial vein.

15. On the lateral side of the orbit, identify the **lateral rectus muscle** (FIG. 7.53). The lateral rectus muscle arises by two heads from the **common tendinous ring**. The common tendinous ring surrounds the optic canal and part of the superior orbital fissure, and it is the posterior attachment of the four rectus muscles. The optic nerve (II), nasociliary nerve, oculomotor nerve (III), and abducent nerve (VI) pass through the common tendinous ring.

16. Use scissors to cut the common tendinous ring between the attachments of the superior rectus and lateral rectus muscles. All structures passing through the common tendinous ring are now exposed.

17. Identify the **abducent nerve** (VI). The abducent nerve passes between the two heads of the lateral rectus muscle, turns laterally, and enters the medial surface of the lateral rectus muscle. Find the abducent nerve on the medial surface of the lateral rectus muscle near the apex of the orbit (FIG. 7.53).

18. Identify the **nasociliary nerve**, which is a branch of V (FIG. 7.53). Trace the nasociliary nerve through the orbit and note that it is much smaller than the frontal nerve. The nasociliary nerve crosses superior to the optic nerve and gives off several **long ciliary nerves** to the posterior part of the eyeball.

19. Follow the nasociliary nerve toward the medial wall of the orbit. Use forceps to pick out the fat that fills the intervals between muscles, nerves, and vessels.

24. Identify the **optic nerve** (II) (FIG. 7.53). The optic “nerve” is actually a brain tract and it is surrounded by the three meningeal layers: dura mater, arachnoid mater, and pia mater.
5. Use forceps to grasp the lateral rectus tendon. Pull it anteriorly to adduct the eyeball (turn it medially). Insert scissors into the orbit on the lateral side of the eyeball and cut the optic nerve.
6. Pull the eyeball farther anteriorly and transect the superior and inferior oblique tendons near the surface of the eyeball and remove the eyeball from the orbit.
7. Study the enucleated orbit (FIG. 7.56). Use forceps to pick out lobules of fat from the posterior portion of the orbit. Find the nerve to the inferior oblique muscle and follow it posteriorly to the inferior division of the oculomotor nerve (III).

Left Orbit from the Anterior Approach [G 657; L 354; N 82, 84; R 135; C 605, 608]
1. Use a probe to explore the conjunctival sac. Verify that the bulbar conjunctiva is attached to the sclera.
2. To facilitate the dissection, remove both eyelids and the orbital septum. Examine the orbit from the anterior view and note:
   - The lacrimal gland is located superolaterally.
   - The trochlea is located superomedially.
   - The inferior oblique muscle is attached inferomedially.
3. Review the attachments of the extraocular muscles on the eyeball. The four rectus muscles attach to the sclera near the cornea (FIG. 7.55). The two oblique muscles attach to the sclera on the posterior half of the eyeball.
4. Use a probe to pick up the tendon of each rectus muscle and transect it with scissors (FIG. 7.55).
Use the dissected specimen to review the nerves that course along the lateral wall of the cavernous sinus and pass through the superior orbital fissure to reach the apex of the orbit. Review the orbital course and function of each of these cranial nerves.

2. Review the course of the internal carotid artery through the cavernous sinus and note its relationship to the optic nerve near the optic canal. Note the origin of the ophthalmic artery and its course through the optic canal.

3. Review the course of the optic nerve through the optic canal to the eyeball.

4. Review the attachments of each of the six extraocular muscles. Use the cadaver specimen to find each of the extraocular muscles.

5. Use an illustration to review the movements of the eyeball and relate each movement to the extraocular muscles that are responsible.

6. Review the ciliary ganglion and note the origin of its presynaptic parasympathetic axons and the course of its postsynaptic axons to the eyeball. State the function of the two smooth muscles that are innervated by the ciliary ganglion.

**DISARTICULATION OF THE HEAD**

**Dissection Overview**

The head must be detached from the vertebral column to allow a posterior approach to the cervical viscera. The order of dissection will be as follows: The retropharyngeal space will be opened from the base of the skull to the superior thoracic aperture. A wedge-shaped cut will be made in the occipital bone that will permit the skull to be removed from the vertebral column.

**Skeleton of the Suboccipital Region**

Refer to a skeleton and identify the following:

- **Atlas (C1)** (FIG. 7.57)
  - Anterior arch
  - Superior articular facet
  - Transverse process
  - Posterior arch
  - Anterior tubercle

- **Axis (C2)**
  - Dens

- **Occipital bone** (FIG. 7.58)
  - Occipital condyle
  - Pharyngeal tubercle
  - Foramen magnum

- **Atlanto-occipital joint** – between the occipital condyle and the superior articular facet of the atlas

- **Transverse ligament of the atlas**, holds the dens to the anterior arch of the atlas (FIG. 7.57)

**Dissection Follow-up**

1. Use a skull to review the bones that form the margin of the orbit, the walls of the orbit, and the openings at the apex of the orbit. Examine the middle cranial fossa and review the optic canal and superior orbital fissure.

2. Use the disected specimen to review the nerves that course along the lateral wall of the cavernous sinus and pass through the superior orbital fissure to reach the apex of the orbit. Review the orbital course and function of each of these cranial nerves.

3. Review the course of the internal carotid artery through the cavernous sinus and note its relationship to the optic nerve near the optic canal. Note the origin of the ophthalmic artery and its course through the optic canal.

4. Review the course of the optic nerve through the optic canal to the eyeball.

5. Review the attachments of each of the six extraocular muscles. Use the cadaver specimen to find each of the extraocular muscles.

6. Use an illustration to review the movements of the eyeball and relate each movement to the extraocular muscles that are responsible.

7. Review the ciliary ganglion and note the origin of its presynaptic parasympathetic axons and the course of its postsynaptic axons to the eyeball. State the function of the two smooth muscles that are innervated by the ciliary ganglion.
CHAPTER 7: THE HEAD AND NECK

Dissection Instructions

Retropharyngeal Space

1. Review the structures that pass through the foramen magnum: brainstem, vertebral arteries (left and right), and cervical roots of the accessory nerves (left and right). Review the hypoglossal nerve (XII) where it enters the hypoglossal canal (FIG. 7.45). Review the structures that enter the jugular foramen: glossopharyngeal nerve (IX), vagus nerve (X), accessory nerve (XI), and sigmoid sinus.

2. Detach the peripheral ends of the cutaneous branches of the cervical plexus (transverse cervical, great auricular, lesser occipital) and move them posteriorly so that they remain attached to the vertebral column.

3. Clean the borders (both anterior and posterior) of both sternocleidomastoid muscles all the way up to the mastoid process. Reflect each sternocleidomastoid muscle superiorly all the way up to its insertion on the mastoid process of the temporal bone, taking care to preserve the accessory nerve. Leave the muscles attached to the skull.

4. With the skull facing away from you, insert the fingers of both hands posterior to the sternocleidomastoid muscles and posterior to the carotid sheaths. Push your fingers medially until they touch in the midline to open up the space behind the viscera. Move your fingers superiorly all the way up to the base of the skull and inferiorly to the thorax. You should now have a clear separation between the viscera and the vertebral column called the retropharyngeal (retrovisceral) space (FIG. 7.59, arrow).

Disarticulation of the Head

1. The head will be removed from the vertebral column by making a wedge-shaped cut in the occipital bone. The head will be released from the vertebral column without dissecting the atlanto-occipital joint and a portion of the occipital bone will remain attached to the vertebral column.
2. On the skull, examine the posterior cranial fossa (FIG. 7.44) and identify: [G 623; L 302; N 11; R 30; C 586]
   - Foramen magnum
   - Groove for the sigmoid sinus
   - Groove for the transverse sinus
   - Superior border of the petrous part of the temporal bone
   - Jugular foramen
   - Hypoglossal canal

3. Take care to preserve the accessory nerve and the structures that exit the jugular foramina at the base of the skull as you make the next two cuts.
4. Use a saw to make two cuts through the occipital bone (FIG. 7.60, cuts 1 and 2). These cuts should be parallel to the superior border of the petrous part of the temporal bone and must pass posterior to the opening of the hypoglossal canal and into the anterior part of the foramen magnum. Externally, the saw cuts should pass posterior to the mastoid process of the temporal bone so that the attachment of the sternocleidomastoid muscle remains intact.
5. Use a chisel to cut transversely across the basilar part of the occipital bone to connect the anterior ends of cuts 1 and 2 (FIG. 7.60, cut 3). Angle the chisel toward the pharynx.
6. Force the head anteriorly to release it from the vertebral column (use the chisel to pry it forward). The atlanto-occipital joint will be broken during this step.
7. Some of the deep muscles of the neck (rectus capitis anterior and longus capitis muscles) will adhere to the base of the skull as the skull begins to move away from the vertebral column. Cut these muscles with scissors, taking care not to injure the posterior surface of the pharynx.

8. Identify the sympathetic trunk and the superior cervical sympathetic ganglion on the anterior surface of the cervical vertebral column [G 781; L 310; N 29; C 541]. On the left side, identify the internal carotid nerve, which passes from the superior end of the superior cervical ganglion to the internal carotid artery. On the left side, sever the internal carotid nerve just superior to the superior cervical ganglion and leave the sympathetic trunk attached to the vertebral column. On the right side, leave the internal carotid nerve intact and reflect the sympathetic trunk and the superior cervical ganglion with the head and cervical viscera.

9. Inspect the base of the skull from the posterior perspective and look for remnants of the C1 vertebra (atlas) attached to the atlanto-occipital joint. If remnants of the C1 vertebra are present, use bone cutters to remove them.

**Prevertebral and Lateral Vertebral Regions** [G 780; L 310; N 129; R 184; C 534]

1. On the anterior surface of the cervical vertebral column, examine the prevertebral fascia. The prevertebral fascia covers the prevertebral muscles (longus colli and longus capitis muscles) and the lateral vertebral muscles (anterior, middle, and posterior scalene muscles).
2. On the left side of the cervical vertebral column, study the sympathetic trunk. Identify the superior, middle, and inferior cervical sympathetic ganglia. Observe the gray rami communicantes that connect the sympathetic ganglia with the anterior rami of cervical spinal nerves. Frequently, the inferior cervical ganglion is fused with the first thoracic ganglion to form the cervicothoracic (stellate) ganglion.
3. Identify the longus colli, longus capitis, and anterior scalene muscles (FIG. 7.61). Review the contributions to the brachial plexus made by the anterior rami of spinal nerves C5 to C8.
4. Follow the vertebral artery into the transverse foramen of vertebra C6 and observe where it emerges from the transverse foramen of the atlas (C1). Appreciate that the vertebral artery is well protected within the transverse foramina.

**Dissection Follow-up**

1. Use a skull to review the anatomy of the occipital bone.
2. In the cadaver, review the structures that pass through the foramen magnum, hypoglossal canal, and jugular foramen.
3. Review the course of the sympathetic trunk from the upper thorax to the base of the skull.
CHAPTER 7: THE HEAD AND NECK

Dissection Instructions

Muscles of the Pharyngeal Wall

1. The cadaver should be in the supine position. Push the head anteroinferiorly and let the chin rest on the thorax. Use a probe to clean the buccopharyngeal fascia from the posterior surface of the pharynx.

2. Identify the inferior pharyngeal constrictor muscle. The anterior attachments of the inferior pharyngeal constrictor muscle are the oblique line of the thyroid cartilage and the lateral surface of the cricoid cartilage (FIG. 7.62B). The posterior attachment of the inferior pharyngeal constrictor muscle is the pharyngeal raphe (FIG. 7.62A).

3. Identify the middle pharyngeal constrictor muscle. The anterior attachments of the middle pharyngeal constrictor muscle are the greater horn of the hyoid bone and the inferior portion of the stylohyoid ligament (FIG. 7.62B). The posterior attachment of the middle pharyngeal constrictor muscle is the pharyngeal raphe. Note that the inferior part of the middle pharyngeal constrictor muscle lies deep to the inferior pharyngeal constrictor muscle.

4. Superior to the middle pharyngeal constrictor muscle, identify the superior pharyngeal constrictor muscle. The anterior attachment of the superior pharyngeal constrictor muscle is the pterygomandibular raphe and its posterior attachments are the pharyngeal raphe and pharyngeal tubercle of the occipital bone (FIG. 7.62A). Note that the inferior part of the superior pharyngeal constrictor muscle lies deep to the middle pharyngeal constrictor muscle.

5. To find the stylopharyngeus muscle, first palpate the greater horn of the hyoid bone. One finger’s width above the greater horn of the hyoid bone, use blunt dissection to find the inferior end of the stylopharyngeus muscle where it passes between the superior pharyngeal constrictor muscle and the middle pharyngeal constrictor muscle.

PHARYNX

Dissection Overview

The airway crosses the digestive tract in the pharynx. The pharynx extends from the base of the skull to the inferior border of the cricoid cartilage (vertebral level C6). The pharyngeal wall consists of three layers. From outside inward these layers are:

- **Buccopharyngeal fascia** – the adventitia of the pharynx that is continuous with the connective tissue that covers the buccinator muscle
- **Muscular layer** – composed of an outer circular part and an inner longitudinal part
- **Mucous membrane** – has a thick submucosa that contributes to the pharyngobasilar fascia

The order of dissection will be as follows: The external surface of the pharynx will be dissected from the posterior direction. The pharyngeal plexus of nerves will be identified and the borders of the pharyngeal constrictor muscles will be defined. The stylopharyngeus muscle and glossopharyngeal nerve will be identified. The contents of the carotid sheath will be examined and cranial nerves IX, X, XI, and XII will be followed from the base of the skull to their regions of distribution. The sympathetic trunk will be studied.
8. Use a probe to clean the posterior and lateral surfaces of the stylopharyngeus muscle. Identify the **glossopharyngeal nerve** (IX) that crosses the posterior and lateral surfaces of the stylopharyngeus muscle to enter the pharynx (**FIG. 7.63A**). [G 792; L 316; N 71; R 165; C 644]

9. Examine the inferior part of the inferior constrictor muscle (**FIG. 7.63B**). Note that the most inferior fibers of the inferior constrictor muscle are continuous with the circular fibers of the esophagus.

10. Identify the **pharyngeal plexus of nerves** (**FIG. 7.63A**). The pharyngeal plexus is located on the posterolateral aspect of the pharynx. Note that the pharyngeal plexus receives branches from the:

   - Glossopharyngeal nerve – sensory to the pharyngeal mucosa
   - Vagus nerve – motor to the pharyngeal constrictor muscles
   - Superior cervical sympathetic ganglion – vasomotor

11. Identify the **contents of the carotid sheath** from the posterior view (**FIG. 7.63A**). Follow the internal carotid artery superiorly as far as possible. Note that the internal jugular vein is lateral to the internal carotid artery.

12. Identify the **glossopharyngeal nerve** (IX), **vagus nerve** (X), and **accessory nerve** (XI) where they exit the jugular foramen medial to the internal jugular vein (**FIG. 7.63A**). Follow each nerve inferiorly and observe:

   - **Glossopharyngeal nerve** (IX) – passes between the internal and external carotid arteries as it approaches the stylopharyngeus muscle.
   - **Vagus nerve** – lies posterior to the internal carotid artery and internal jugular vein in the carotid sheath. Trace the vagus nerve from the base of the skull to the thorax. The **superior laryngeal nerve** arises from the vagus nerve about 2.5 cm inferior to the base of the skull. Trace the branches of the superior laryngeal nerve to the larynx (**FIG. 7.63B**). The **pharyngeal branch of the vagus nerve** arises near the base of the skull. Follow the pharyngeal branch to the pharyngeal plexus.
   - **Accessory nerve** (XI) – usually passes between the internal jugular vein and the internal carotid artery to reach the deep surface of the sternocleidomastoid muscle (**FIG. 7.63A**).

13. Identify the **hypoglossal nerve** (XII) in the submandibular triangle and follow it posteriorly and
superiorly as far as the base of the skull (FIG. 7.63B). Note that the hypoglossal nerve passes lateral to the internal and external carotid arteries but medial to the internal jugular vein.

14. On the right side of the cadaver, verify that the **superior cervical sympathetic ganglion** and the **sympathetic trunk** are posterior and medial to the carotid sheath (FIG. 7.63A).

15. On the right side of the specimen, identify the **internal carotid nerve** that passes from the superior end of the superior cervical ganglion to the internal carotid artery.

### Bisection of the Head

1. Use a scalpel to cut the posterior wall of the pharynx in the midline. Start at the superior end of the esophagus and cut through the pharyngeal raphe up to the pharyngeal tubercle. [L 317]
2. Use a scalpel to divide the uvula and the soft palate in the median plane.
3. Turn the specimen and use a scalpel to cut through the upper lip in the midline.
4. A sagittal cut must be made through the skull very close to the median plane. The nasal septum may not be in the median plane, so you must examine each nasal cavity and decide on which side the saw cut should be made in order to avoid the nasal septum.
5. On the chosen side, use a scalpel to cut through the cartilages of the external nose parallel to the nasal septum.
6. Examine a skull and study the bones through which you must cut:
   - **Nasal bone** and **frontal bone**
   - **Cribriform plate of the ethmoid bone**
   - **Body of the sphenoid bone**
   - **Hard palate**
   - **Basilar part of the occipital bone as far as the foramen magnum**

7. Saw through the skull from superior to inferior. Begin lateral to the crista galli (the side of the saw blade should touch the crista galli) and keep the blade close to the nasal septum. Cut through the nasal and frontal bones, ethmoid bone, body of the sphenoid, dorsum sellae, basilar part of the occipital bone, and hard palate. Stop when the saw has passed into the foramen magnum. Do not cut the tongue or mandible at this time.
Enlarged pharyngeal tonsils are called adenoids. Adenoids obstruct the flow of air from the nose through the nasopharynx, making mouth breathing necessary.

6. The oropharynx lies posterior to the oral cavity. It is bounded superiorly by the soft palate and extends inferiorly to the level of the epiglottis (FIG. 7.64).

7. In the oropharynx, identify the palatoglossal fold. The palatoglossal fold forms a dividing line between the oral cavity and the oropharynx. This transitional region between the oral cavity and oropharynx is called the fauces.

8. Identify the palatopharyngeal fold, which is posterior to the palatoglossal fold. The palatopharyngeal fold descends along the lateral wall of the oropharynx. Between the palatoglossal fold and the palatopharyngeal fold is the palatine tonsil. Use a mirror to identify the palatine tonsil on yourself.

9. The laryngopharynx lies posterior to the larynx. This portion of the pharynx extends from the hyoid bone to the lower border of the cricoid cartilage (FIG. 7.64).
10. In the midline of the laryngopharynx, identify the epiglottis and the inlet (adius) of the larynx. Farther inferiorly, identify the piriform recess, which is lateral to the midline. The borders of the piriform recess are:

- **Medial** – larynx
- **Lateral** – thyroid cartilage
- **Posterior** – inferior pharyngeal constrictor muscle

**Dissection Follow-up**

1. Review the attachments, innervation, and action of the pharyngeal constrictor muscles.
2. Use a textbook description and the cadaver to review the pharyngeal plexus.
3. Trace each of the following cranial nerves from the posterior cranial fossa to its area of distribution: glossopharyngeal (IX), vagus (X), accessory (XI), and hypoglossal (XII).
4. Review the relationships of the contents of the carotid sheath.
5. Review the boundaries and contents of each part of the pharynx.

**NOSE AND NASAL CAVITY**

**Dissection Overview**

There are two nasal cavities: right and left. The nostril (naris) is the anterior entrance to the nasal cavity. Posteriorly, each nasal cavity opens into the nasopharynx through a choana. The nasal cavity is lined by mucosa that is attached directly to bones and cartilages. The bones and cartilages give the walls of the nasal cavity their characteristic contours. The superior one-third of the nasal mucosa is olfactory in nature and the remainder is respiratory in nature. The nasal mucosa is highly vascular and capable of engorgement.

The order of dissection will be as follows: The nose and nasal cartilages will be studied. The nasal septum will be examined and removed. The features of the lateral nasal wall will be studied. The openings of the paranasal sinuses will be identified. The maxillary sinus will be opened and examined.

**Skeleton of the Nasal Cavity**

In an anterior view of the skull, identify (FIG. 7.65): [G 615; L 298; N 4; R 22; C 567]

- Nasal bone
- Lacrimal bone
- Maxilla
  - Frontal process
  - Anterior nasal aperture
  - Anterior nasal spine

- Nasal septum – bony part
- Middle nasal concha – part of the ethmoid bone
- Inferior nasal concha

**Ethmoid bone**

- Cribriform plate
- Superior nasal concha
- Middle nasal concha

**Lacrimal bone**

**Inferior nasal concha**

**Maxilla**

- Palatine process
- Incisive canal

**Sphenoid bone**

- Opening of the sphenoidal sinus
- Sphenoidal sinus
- Body
  - Medial plate of the pterygoid process
  - Lateral plate of the pterygoid process

**Palatine bone**

- Perpendicular plate
- Horizontal plate

**Sphenopalatine foramen**
1. The boundaries of the nasal cavity are:
   - **Roof** – a narrow region bounded by the nasal septum and by parts of three other bones: nasal bone, cribriform plate of ethmoid bone, and sphenoid bone
   - **Floor** – palatine process of the maxilla and horizontal plate of the palatine bone
   - **Medial wall** – nasal septum
   - **Lateral wall** (FIG. 7.66) – maxilla, lacrimal bone, ethmoid bone, inferior nasal concha, and perpendicular plate of the palatine bone

2. In the cadaver, observe that the bones and cartilages of the nasal cavity are obscured by the mucosa that covers them. The vessels and nerves of the nasal cavity are contained within this mucosa.

**Nasal Septum** [G 697; L 336, 340; N 38; R 146; C 615]

1. Examine the half of the head that contains the nasal septum. Inferior to the nasal bone palpate the **lateral nasal cartilage** (FIG. 7.67). The lateral nasal cartilage gives shape to the bridge of the nose.
2. The lateral nasal cartilage is an extension of the **septal cartilage**. The septal cartilage separates the right and left nasal cavities and forms the anterior part of the nasal septum.
3. Lateral to the septal cartilage is the **alar cartilage** (FIG. 7.67). The alar cartilage gives shape to the medial side of the nostril.

2. In the cadaver, observe that the bones and cartilages of the nasal cavity are obscured by the mucosa that covers them. The vessels and nerves of the nasal cavity are contained within this mucosa.

**Nasal Septum** [G 697; L 336, 340; N 38; R 146; C 615]

1. Examine the half of the head that contains the nasal septum. Strip the mucosa completely off of the nasal septum and identify the **perpendicular plate of the ethmoid bone, vomer**, and **septal cartilage** (FIG. 7.68).
2. Use a probe and forceps to remove the bony and cartilaginous parts of the nasal septum. Leave intact the mucosa that lines the other side of the nasal septum. In the mucosa of the nasal septum, identify the **nasopalatine nerve** and the **sphenopalatine artery** (FIG. 7.69). Note that the nasopalatine nerve and the sphenopalatine artery pass diagonally down...
Lateral Wall of the Nasal Cavity  [G 700, 701; L 338, 340; N 36; R 144, 145; C 615]

1. Remove the mucosa and remnants of the nasal septum.
2. Inspect the lateral wall of the nasal cavity (FIG. 7.70). Identify:
   - Sphenethmoidal recess – above the superior concha
   - Superior concha
   - Superior meatus – inferior to the superior concha
   - Middle concha
   - Middle meatus – inferior to the middle concha
   - Inferior concha
   - Inferior meatus – inferior to the inferior concha
   - Vestibule – the area superior to the nostril and anterior to the inferior meatus
   - Atrium – the area superior to the vestibule and anterior to the middle meatus

3. Use scissors to remove the inferior concha. Use a probe and forceps to remove the mucosa from the lateral wall of the inferior meatus. Identify the opening of the nasolacrimal duct (FIG. 7.71).
4. Use scissors to remove the middle concha. In the middle meatus, identify a curved slit, the semilunar hiatus (hiatus semilunaris) (FIG. 7.71). Posterior to the curvature of the semilunar hiatus, identify the ethmoidal bulla (bulla ethmoidalis), which bulges into the nasal cavity.
5. Within the semilunar hiatus, identify (FIG. 7.71):
   - Opening of the frontal sinus
   - Opening of the anterior ethmoidal cells
   - Opening of the maxillary sinus

6. On the summit of the ethmoidal bulla, identify the opening of the middle ethmoidal cells.
7. Identify the opening of the posterior ethmoidal cells in the superior meatus.
8. Identify the opening of the sphenoidal sinus in the sphenoethmoidal recess.
9. Examine the sphenoidal sinus (FIG. 7.71). The sphenoidal sinus is a paired structure that is lined by mucosa that is continuous with the mucosa of the nasal cavity. Note that the sphenoidal sinus lies directly inferior to the hypophyseal fossa and pituitary gland. [G 704; L 336; N 48; R 144; C 617]

10. Note that the ethmoidal cells are located between the nasal cavity and the orbit (FIGS. 7.72 and 7.73).
The ethmoidal cells may be observed from the superior perspective by reviewing the dissection of the orbit that was completed previously.

11. The **maxillary sinus** is a three-sided pyramid with an average adult capacity of 15 mL. Observe an illustration of a coronal section through the maxillary sinus and note the following (Fig. 7.73):

- The roof of the maxillary sinus is the floor of the orbit and the infraorbital nerve innervates the mucosa of the sinus.
- The floor of the maxillary sinus is the alveolar process of the maxilla.
- The opening of the maxillary sinus is near its roof.
- The roots of the maxillary teeth may project into the maxillary sinus.

**CLINICAL CORRELATION**

**MAXILLARY SINUS**

When the head is in the upright position, the maxillary sinus cannot drain. If infections of the maxillary sinus persist, an opening may be surgically created through the inferior meatus near the floor of the maxillary sinus to promote drainage.

If the roots of maxillary teeth project into the maxillary sinus, they are covered only by mucosa. During extraction of a maxillary molar or premolar tooth, the mucosa superior to the projecting root may be torn. As a result, a fistula may be formed between the oral cavity and the maxillary sinus.

**Dissection Follow-up**

1. Use an illustration and the dissected specimen to review the features of the lateral wall of the nasal cavity.
2. Review the relationship of the paranasal sinuses to the orbit, anterior cranial fossa, and nasal cavity.
3. Review the drainage point of each paranasal sinus.

**HARD PALATE AND SOFT PALATE**

**Dissection Overview**

The palate forms the floor of the nasal cavity and the roof of the oral cavity. The palate consists of two portions: the **hard palate** forms the anterior two-thirds and the **soft palate** constitutes the posterior one-third. The palate is covered by nasal mucosa on its superior surface and oral mucosa on its inferior surface. Numerous mucous glands (palatine glands) are present on the oral surface of the palate.

The order of dissection will be as follows: The mucosal folds of the inner pharyngeal wall will be reviewed. The mucosa will be stripped from the inner surface of the pharynx and the muscles that constitute the inner longitudinal muscle layer will be examined. Muscles that move the soft palate will then be studied. The nerves and blood vessels of the palate will be identified. The palatine canal and pterygopalatine fossa will be dissected from the medial aspect. The pterygopalatine ganglion will be identified. The nerves and vessels of the nasal cavity and palate will be summarized.

**Skeleton of the Palate**

Refer to a skull. From an inferior view, identify (Fig. 7.74):

- Maxilla
  - Incisive foramen
  - Alveolar process
  - Palatine process
- Palatine bone
  - Horizontal plate
  - Greater palatine foramen
  - Lesser palatine foramina
  - Posterior nasal spine

**Figure 7.74** Skeleton of the palate. Inferior view.
2. Examine the edge of the soft palate where it is cut in the sagittal plane and observe (FIG. 7.76):
   - The thickness of the soft palate is partly due to the presence of palatine glands.
   - The strength of the soft palate is due to the palatine aponeurosis.
   - The mobility of the soft palate is due to muscles that attach to its posterior two-thirds.

3. Use blunt dissection to remove the mucosa from the palatoglossal fold and identify the palatoglossus muscle, which lies within the fold (FIG. 7.77). The superior attachment of the palatoglossus muscle is the palatine aponeurosis and its inferior attachment is the lateral side of the tongue. The palatoglossus muscle elevates the tongue and depresses the soft palate.

4. Remove the mucosa from the palatopharyngeal fold and identify the palatopharyngeus muscle (FIG. 7.77). The superior attachments of the palatopharyngeus muscle are the hard palate and palatine aponeurosis and its inferior attachments are the thyroid cartilage and pharyngeal wall. The palatopharyngeus muscle elevates the larynx during swallowing.

5. Remove the mucosa from the salpingopharyngeal fold and identify the salpingopharyngeus muscle (FIG. 7.77). The superior attachment of the salpingopharyngeus muscle is the cartilage of the pharyngotympanic tube. Its inferior attachments and action are the same as the palatopharyngeus muscle.
10. Remove the mucosa from the posterior border of the **medial plate of the pterygoid process** (FIG. 7.77). Identify the tensor veli palatini muscle, which lies lateral to the medial plate. The superior attachment of the tensor veli palatini muscle is the **scaphoid fossa**. The belly of the tensor veli palatini muscle is located between the medial and lateral plates of the pterygoid process. Its tendon turns medially around the **hamulus of the medial pterygoid plate** and forms the **palatine aponeurosis**. The tensor veli palatini muscle tensions the soft palate. Palpate the hamulus and find the tendon of the tensor veli palatini muscle.

11. Five muscles of the soft palate and pharynx are innervated by the vagus nerve (X) via the pharyngeal plexus: salpingopharyngeus, levator veli palatini, palatoglossus, palatopharyngeus, and musculus uvulae. The tensor veli palatini muscle is innervated by the mandibular division of the trigeminal nerve (V3).

12. To remove the mucosa from the hard palate, use a probe to raise the mucosa on the inferior surface of the hard palate where it was cut during head bisection. Grasp the mucosa with forceps or a hemostat and use blunt dissection to peel it from medial to lateral. Detach the mucosa along the medial side of the alveolar process.

6. Remove the remaining mucosa from the inner surface of the nasopharynx and oropharynx. Identify the **stylopharyngeus muscle**, which enters the pharynx between the superior and middle pharyngeal constrictor muscles (FIG. 7.77). The stylopharyngeus muscle lies anterior and parallel to the palatopharyngeus and salpingopharyngeus muscles, and all three blend near their inferior ends.

7. The gap between the superior border of the superior pharyngeal constrictor muscle and the base of the skull is closed by the **pharyngobasilar fascia**. Passing through this gap are the pharyngotympanic tube and the levator veli palatini muscle (FIG. 7.77).

8. The **pharyngotympanic tube** (auditory tube) connects the nasopharynx to the tympanic cavity. The part of the pharyngotympanic tube that is closest to the pharynx is cartilaginous (approximately two-thirds of its length) and the part that is closest to the middle ear passes through the temporal bone.

9. Remove the mucosa from the torus levatorius and identify the **levator veli palatini muscle** (FIG. 7.77). The superior attachments of the levator veli palatini muscle are the cartilage of the pharyngotympanic tube and the adjacent part of the temporal bone. Its inferior attachment is the palatine aponeurosis. The levator veli palatini muscle elevates the soft palate.

13. Identify the **greater palatine nerve and artery** where they emerge from the **greater palatine foramen** (FIG. 7.78). Use blunt dissection to follow them anteriorly. Note that the **nasopalatine nerve** and the distal end of the **sphenopalatine artery** supply the mucosa over the anterior part of the hard palate (FIG. 7.78).
1. Do not dissect the arterial network of the lateral nasal wall but use an atlas illustration to study the following branches of the sphenopalatine artery:

- Posterior lateral nasal arteries – to the lateral nasal wall
- Posterior septal branch – to the superior part of the nasal septum

2. Remove the mucosa from the posterior part of the lateral nasal wall.

3. Use a probe to locate the sphenopalatine foramen, which is located at the posterior end of the middle nasal concha (FIG. 7.79). Insert the probe into the sphenopalatine foramen and direct it inferiorly toward the greater palatine foramen. Pull the probe medially to break the medial wall of the greater palatine canal.

4. Identify the greater palatine nerve, the lesser palatine nerve, and the descending palatine artery in the greater palatine canal (FIG. 7.80). The descending palatine artery is one of the terminal branches of the maxillary artery.

5. At the inferior end of the greater palatine canal, use a fine probe or needle to separate the nerves and vessels. Note that the descending palatine artery

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**Tonsillar Bed**

1. Identify the palatine tonsil (FIG. 7.76). In older individuals, the palatine tonsil may be inconspicuous or may have been surgically removed. When present, the palatine tonsil is located in the tonsillar bed. The boundaries of the tonsillar bed are:

- Anterior – palatoglossal fold
- Posterior – palatopharyngeal fold
- Lateral – superior pharyngeal constrictor muscle

2. If the cadaver has a palatine tonsil, use blunt dissection to remove it (FIG. 7.76). Section the tonsil and observe the crypts that extend into its surface.

3. The glossopharyngeal nerve (IX) passes between the superior and the middle pharyngeal constrictor muscles to enter the tonsillar bed. Remove the mucosa from the tonsillar bed and observe the glossopharyngeal nerve (FIG. 7.77). The glossopharyngeal nerve innervates the mucosa of the posterior one-third of the tongue and the posterior wall of the pharynx.
divides to give rise to the **greater palatine artery** and the **lesser palatine artery** (FIG. 7.80).

6. Place the fine probe between the greater palatine nerve and the lesser palatine nerve and slide it superiorly until it meets resistance. This is the inferior border of the **pterygopalatine ganglion** (FIG. 7.80).

The pterygopalatine ganglion is the location for synapse of presynaptic axons of the facial nerve (VII) that course first in the greater petrosal nerve and then in the nerve of the pterygoid canal. Postsynaptic axons that arise in the pterygopalatine ganglion distribute with branches of the maxillary division of the trigeminal nerve (V\(_2\)). The pterygopalatine ganglion stimulates secretion from the mucosa of the nasal cavity, paranasal sinuses, nasopharynx, roof of the mouth, and soft palate. The pterygopalatine ganglion also stimulates the lacrimal gland.

7. The **nerve of the pterygoid canal** enters the pterygopalatine fossa from posteriorly. To find it, remove the mucosa from the floor of the sphenoidal sinus. Frequently, a ridge in the floor of the sphenoidal sinus marks the location of the pterygoid canal (FIG. 7.80). Use a probe to break open the pterygoid canal and identify the nerve of the pterygoid canal.

8. Confirm that the nerve of the pterygoid canal ends anteriorly in the pterygopalatine ganglion. The nerve of the pterygoid canal contains presynaptic parasympathetic axons from the greater petrosal nerve and postsynaptic sympathetic axons from the deep petrosal nerve.

9. Turn the specimen and approach it from the lateral aspect. Deep in the **infratemporal fossa**, identify: [G 675; L 330; N 69; R 80; C 565]

- **Maxillary artery** – courses deeply toward the pterygomaxillary fissure. Near the pterygomaxillary fissure, the maxillary artery gives rise to the:
  - **Sphenopalatine artery** – passes through the pterygopalatine fossa and then through the sphenopalatine foramen to enter the nasal cavity
  - **Descending palatine artery** – descends to enter the greater palatine canal where it was dissected from the medial side
  - **Infraorbital artery** – passes through the inferior orbital fissure to enter the infraorbital canal and emerge on the face at the infraorbital foramen
  - **Maxillary division of the trigeminal nerve** (V\(_2\)) – courses from the foramen rotundum to the inferior orbital fissure. The maxillary division passes through the pterygopalatine fossa and gives off pterygopalatine branches that will form the greater and lesser palatine nerves.

**Dissection Follow-up**

1. Use the dissected specimen and an illustration to reconstruct the branching pattern of the maxillary division of the trigeminal nerve. Use a skull and the dissected specimen to follow the maxillary division from the trigeminal ganglion through the foramen rotundum, pterygopalatine fossa, and inferior orbital fissure to the infraorbital groove.

2. Review the distribution of the following branches of the maxillary division of the trigeminal nerve: greater
palatine, lesser palatine, nasopalatine, and infraorbital nerves.

3. Return to the carotid triangle of the neck and follow the external carotid artery superiorly into the infratemporal fossa. Review the origin of the maxillary artery and its course through the infratemporal fossa. Review all branches of the maxillary artery that you dissected previously. Use an illustration to review the terminal branches of the maxillary artery (posterior superior alveolar, infraorbital, descending palatine, and sphenopalatine) and use the dissected specimen to review these branches where you have dissected them.

4. Review the muscles that move the soft palate. State their attachments and actions.

5. Review the pharyngeal wall, placing the pharyngeal constrictor muscles and the muscles of the soft palate into the correct muscle layers (inner longitudinal or outer circular).

6. Review the pharyngeal plexus on the posterior surface of the pharynx and recall its role in innervation of the pharyngeal mucosa and the muscles of the pharynx and soft palate.

7. Use the dissected specimen and an illustration to review the course of the glossopharyngeal nerve from the jugular foramen to the posterior one-third of the tongue.

8. Recall the rule of innervation of the muscles of the soft palate: Five muscles of the soft palate are innervated by the vagus nerve (X) via the pharyngeal plexus: salpingopharyngeus, levator veli palatini, palatoglossus, palatopharyngeus, and musculus uvulae. The tensor veli palatini muscle is innervated by the mandibular division of the trigeminal nerve (V3).

**ORAL REGION**

**Dissection Overview**

The oral region includes the oral cavity and its contents (teeth, gums, and tongue), the palate, and the part of the oropharynx that contains the palatine tonsils. The palate and palatine tonsils have been dissected previously.

The oral cavity consists of:

- **Oral vestibule** – bounded externally by the lips and cheeks and internally by the teeth and gums.

- **Oral cavity proper** – the area between the alveolar arches and teeth. The largest content of the oral cavity proper is the tongue.

The order of dissection will be as follows: The superficial features of the oral region will be examined on a living person. On the cadaver, the tongue will be inspected and the tongue and mandible will be bisected in the midline. The intrinsic muscles of the tongue will be inspected. The sublingual region will be studied and the dissection of the deep part of the submandibular gland will be completed. Finally, the extrinsic muscles of the tongue will be studied.

**Surface Anatomy of the Oral Vestibule**

Use a mirror to examine your mouth and a clean finger to palpate the following structures through the mucosa that lines the oral vestibule:

- **Maxilla**
  - Alveolar process
  - Anterior surface (above the alveolar process)

- **Mandible**
  - Alveolar process
  - Coronoid process and the tendon of the temporalis muscle

- **Masseter muscle** – best palpated when the teeth are clenched

- **Communication between the oral vestibule and the oral cavity proper** – posterior to the third molar tooth

**Surface Anatomy of the Oral Cavity Proper**

Again use a mirror to observe the borders of your oral cavity:

- **Lateral and anterior** – the teeth and gums

- **Superior** – the hard palate

- **Inferior** – the mucosa covering the tongue and sublingual area

- **Posterior** – the palatoglossal folds (right and left)

In your oral cavity, identify:

- **Tongue**
  - Body
  - Apex
  - Median sulcus

- **Sublingual area**
  - Frenulum of the tongue (sublingual frenulum)
  - Sublingual fold (plica sublingualis)
  - Sublingual caruncle
  - Opening of submandibular duct – on the sublingual caruncle

- **Deep lingual veins** – seen on either side of the frenulum of the tongue

**Dissection Instructions**

**Tongue** [G 682; L 334; N 58; R 149; C 628]

1. Inspect the tongue in the cadaver specimen. Identify [FIG. 7.81]:

   - **Root** – the posterior one-third
   - **Body** – the anterior two-thirds
Lingual papillae – four types: vallate, filiform, fungiform, and foliate

2. Note that the body of the tongue lies horizontally in the oral cavity and the root of the tongue lies more vertically. The root of the tongue constitutes the lower part of the anterior boundary of the oropharynx.

3. At the root of the tongue (FIG. 7.81), identify:
   - Median glossoepiglottic fold – a midline fold of mucosa between the dorsum of the tongue and the epiglottis
   - Lateral glossoepiglottic fold – between the dorsum of the tongue and the lateral border of the epiglottis
   - Epiglottic vallecula – a depression between the median and lateral glossoepiglottic folds

Bisection of the Tongue and Mandible

1. Turn the specimen to expose the submental triangle. Use a new scalpel blade for this dissection.

2. Use the scalpel to cut the mylohyoid muscles along their median raphe. Use a probe to separate the mylohyoid muscles from deeper structures.

3. Identify the geniohyoid muscle, which is deep to the mylohyoid muscle (FIG. 7.82). The anterior attachment of the geniohyoid muscle is the inferior mental spine of the mandible, and its posterior attachment is the body of the hyoid bone. The geniohyoid muscle pulls the hyoid bone anteriorly.

4. Use blunt dissection to separate the geniohyoid muscles in the midline. Use a saw to cut through the mandible in the median plane. Do not allow the saw to pass between the genioglossus muscles on the deep side of the mandible.
5. Do not bisect the epiglottis, the hyoid bone, or the larynx at this time. Use a scalpel to bisect the tongue in the median plane, beginning at the apex and proceeding toward the epiglottis. Cut as far inferiorly as the hyoid bone.

6. On the sectioned surface of the tongue, identify the **genioglossus muscle**. The anterior attachment of the genioglossus muscle is the superior mental spine of the mandible and its posterior attachments are the hyoid bone and the tongue. The genioglossus muscle protrudes the tongue. The genioglossus muscle is innervated by the hypoglossal nerve (XII).

**CLINICAL CORRELATION**

**HYPOGLOSSAL NERVE**

The genioglossus muscle protrudes the tongue. If one genioglossus muscle does not function (hypoglossal nerve dysfunction on that side), the tongue cannot be protruded in the midline. The functional side of the tongue protrudes normally and the side with the dysfunctional nerve is protruded less or not at all. Therefore, in testing for hypoglossal nerve lesions, the protruded tongue deviates toward the side of the nerve lesion.

**Sublingual Region** [G 785; L 332; N 51; R 153; C 621]

1. Use the cadaver specimen to review the sublingual features that were identified in your oral cavity:
   - Frenulum of the tongue
   - Sublingual fold
   - Sublingual caruncle
   - Opening of the submandibular duct

2. Carefully use a scalpel to incise the mucous membrane along the medial surface of the mandible. Start the incision at the frenulum of the tongue and stop near the second mandibular molar tooth. Use a probe and forceps to peel the mucosa medially.

3. Identify the **sublingual gland** immediately deep to the mucosa (FIG. 7.82). The sublingual gland rests on the mylohyoid muscle. The sublingual gland has about 12 short ducts that drain along the summit of the sublingual fold.

4. Use a probe to dissect along the medial side of the sublingual gland and find the **submandibular duct** (FIG. 7.82). Follow the submandibular duct anteriorly to its opening on the sublingual caruncle. Use a probe to trace the submandibular duct posteriorly to the deep part of the submandibular gland.

5. Turn the specimen to expose the infratemporal fossa. Find the **lingual nerve** and trace it into the sublingual region. Observe that the lingual nerve passes lateral, inferior, and medial to the submandibular duct (FIG. 7.82). The lingual nerve has several branches that supply the mucosa of the anterior two-thirds of the tongue with general sensation and taste fibers. [G 785; L 332; N 61; R 153; C 626]

6. Near the third mandibular molar tooth, identify the **submandibular ganglion** that is suspended below the lingual nerve. Read a textbook description of the parasympathetic function of the submandibular ganglion.

7. Turn the specimen so that the submandibular triangle is exposed. Define the attachment of the mylohyoid muscle to the hyoid bone. Use scissors to detach the mylohyoid muscle from the hyoid bone and reflect the muscle superiorly.

8. Find the **hypoglossal nerve (XII)** and use a probe to trace it into the sublingual region. Note that the hypoglossal nerve passes between the deep part of the submandibular gland and the hyoglossus muscle (FIG. 7.82). Observe that both the hypoglossal nerve and the lingual nerve pass between the hyoglossus muscle and the mylohyoid muscle to enter the sublingual region. The course of the hypoglossal nerve is inferior to the course of the lingual nerve.

9. Observe the **hyoglossus muscle** (FIG. 7.83). The inferior attachments of the hyoglossus muscle are the body and greater horn of the hyoid bone and its superior attachment is the lateral side of the tongue. The hyoglossus muscle depresses and retracts the tongue.

10. Near the superior end of the hyoglossus muscle, identify the **styloglossus muscle** (FIG. 7.83). The...
superior attachment of the styloglossus muscle is the stylohyoid and its inferior attachment is the lateral side of the tongue. The styloglossus muscle retracts the tongue and draws it superiorly. [G 788; N 59]

11. Use an atlas illustration to study the intrinsic muscles of the tongue and note that they consist of vertical, transverse, superior longitudinal, and inferior longitudinal groups of fibers. [G 685; L 333; N 60; R 149; C 629]

12. Return to the carotid triangle and locate the lingual artery where it arises from the external carotid artery (FIG. 7.83). Follow the lingual artery until it passes medial to the hyoglossus muscle. When the sublingual artery branches off, the lingual artery’s name changes to deep lingual artery. The deep lingual artery is usually located within 5 mm of the inferior surface of the tongue.

13. The intrinsic muscles of the tongue and the three extrinsic muscles of the tongue (styloglossus, genioglossus, and hyoglossus) are innervated by the hypoglossal nerve (XII).

Dissection Follow-up

1. Review the surface features of the tongue.
2. Review the innervation of the lingual mucosa.
3. Follow the submandibular duct from the submandibular triangle to the sublingual caruncle.
4. Trace the lingual nerve from the infratemporal fossa to the tongue. Note the relationship of the lingual nerve to the submandibular duct, hyoglossus muscle, and mylohyoid muscle.
5. Review the chorda tympani and the role that it plays in sensory innervation of the tongue and parasympathetic innervation of the submandibular and sublingual glands.
6. Locate the submandibular ganglion and state its function.
7. Trace the hypoglossal nerve from the base of the skull to the tongue, noting its relationships to arteries and muscles.
8. Organize the muscles of the tongue into extrinsic and intrinsic groups. State the attachments, innervation, and action of each extrinsic muscle.
9. Use an illustration and the dissected specimen to review the origin and course of the facial and lingual arteries.

LARYNX

Dissection Overview

The larynx is contained in the visceral compartment of the neck. The thyroid gland lies anterior to it and the pharynx posterior to it. The larynx is the entrance to the airway and it contains the glottis, a valve that serves the dual function of controlling the airway and producing sound during phonation. The intrinsic muscles of the larynx control the glottis. The extrinsic muscles of the larynx (infrahyoid muscles, suprathyroid muscles, and stylopharyngeus muscle) control the position of the larynx in the neck. In its neutral position, the larynx is located at vertebral levels C3 to C6.

The order of dissection will be as follows: Illustrations and models will be used to study the cartilages of the larynx. Dissection of the larynx involves removal of the mucous membrane and identification of the underlying muscles. First, the mucosa will be removed from the posterior part of the larynx to expose two intrinsic muscles. The left lamina of the thyroid cartilage will then be removed to expose the remaining intrinsic muscles. The larynx will be opened and the mucosal features will be studied. Finally, the nerves to the larynx will be reviewed.

Skeleton of the Larynx [G 804; L 320; N 77; R 158; C 651]

The skeleton of the larynx is responsible for maintaining a patent airway. It consists of a series of articulated cartilages that are united by membranes. Use an illustration and a model of the larynx to study the cartilages and membranes (FIG. 7.84). Identify:

- Epiglottic cartilage – an unpaired cartilage that lies posterior to the tongue and hyoid bone. The stalk of the epiglottic cartilage is attached to the inner surface of the angle formed by the thyroid laminae.
- Thyrohyoid membrane – connects the superior border of the thyroid cartilage to the hyoid bone. When the suprathyroid and infrahyoid muscles move the hyoid bone, the larynx also moves because of this membrane.
- Thyroid cartilage – formed by two laminae that are joined in the anterior midline to form the laryngeal prominence. The superior horn of the thyroid cartilage projects superiorly. The inferior horn of the thyroid cartilage articulates with the cricoid cartilage through the cricothyroid joint.
- Cricoid cartilage – shaped like a ring (Gr. krikos, ring). Its lamina is a broad, flat area that is positioned posteriorly and its arch is located anteriorly.

The arytenoid cartilages are located on the superior border of the lamina of the cricoid cartilage. Each arytenoid cartilage is pyramid-shaped and it articulates with the cricoid cartilage through a synovial joint. Each arytenoid cartilage has a muscular process for attachment of intrinsic laryngeal muscles and a vocal process for attachment of the vocal ligament. The arytenoid cartilages are capable of several movements:

- Tilting anteriorly and posteriorly
- Sliding toward each other (adduction)
- Sliding away from each other (abduction)
- Rotation

Use an illustration to identify the vocal ligaments (FIG. 7.84). The posterior end of each vocal ligament is attached to the vocal process of an arytenoid cartilage. The anterior end of each vocal ligament is attached to the inner surface of the thyroid cartilage at the angle formed by the laminae.
4. Open the posterior wall of the pharynx to expose the posterior surface of the larynx. Palpate the lamina of the cricoid cartilage. Lateral to the lamina, identify the piriform recess.
5. Use blunt dissection to remove the mucosa from the piriform recess. Immediately deep to the mucosa, identify the internal branch of the superior laryngeal nerve and the inferior laryngeal nerve (FIG. 7.85).
6. Use blunt dissection to strip the mucosa from the lamina of the cricoid cartilage and expose the posterior cricoarytenoid muscle (FIG. 7.85). The inferior attachment of the posterior cricoarytenoid muscle is the posterior surface of the lamina of the cricoid cartilage and its superior attachment is the muscular process of the arytenoid cartilage. The posterior cricoarytenoid muscle causes the arytenoid cartilage to rotate, moving the vocal process laterally (abduction of the vocal folds).
7. Superior to the posterior cricoarytenoid muscle, identify the arytenoid muscle (FIG. 7.85). The arytenoid muscle slides the arytenoid cartilages together (adduction of the vocal folds).
8. The cricothyroid joint is a synovial joint that is reinforced by short ligaments. Observe that the recurrent laryngeal nerve enters the larynx by passing posterior to the cricothyroid joint. At this location, the name of the recurrent laryngeal nerve changes to inferior laryngeal nerve.
9. On the left side only, disarticulate the cricothyroid joint. Carefully cut the thyrohyoid membrane. Use scissors to cut the left lamina of the thyroid cartilage.
tidis (L. rima, a cleft or crack). The rima glottidis and the vocal folds collectively are called the **glottis**.

15. Review the function of the intrinsic muscles of the larynx. **The posterior cricoarytenoid muscle is the only muscle that opens the rima glottidis**. The cricothyroid muscle tilts the thyroid cartilage anteriorly and tenses the vocal fold (higher pitch of voice). The thyroarytenoid muscle tilts the thyroid cartilage posteriorly and relaxes the vocal fold (lower pitch of voice).

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**CLINICAL CORRELATION**

**GLOTTIS**

Laryngospasm is a spasmodic closure of the glottis and it is life threatening. Spasm of the intrinsic laryngeal muscles that close the glottis may be produced by irritating chemicals, by severe allergic reactions, and sometimes as a side effect of medications.

The vocal folds can be readily visualized and inspected with the aid of a mirror (indirect laryngoscopy) or with a laryngoscope (direct laryngoscopy). Persistent hoarseness is an indication for laryngoscopy. Persistent hoarseness may be caused by changes of the vocal folds or it may indicate that the recurrent laryngeal nerve is compromised in the thorax or neck.
Interior of the Larynx  [G 807; L 318; N 63; R 161; C 655]

1. In the midline, use scissors to cut the arytenoid muscle, lamina of the cricoid cartilage, and trachea. In addition, cut the arch of the cricoid cartilage in the midline anteriorly.

2. Open the larynx and observe that the laryngeal cavity has three parts (FIG. 7.86):
   - **Vestibule** – superior to the vestibular folds
   - **Ventricle** – the depression between the vestibular fold and the vocal fold
   - **Infraglottic cavity** – inferior to the vocal folds and continuous with the trachea

3. Examine the epiglottis and note that it moves posteriorly during swallowing to close the laryngeal inlet.

4. Inspect the mucosa that lines the interior of the larynx and identify the vestibular fold (false vocal fold) and the vocal fold (true vocal fold). The vocal ligament is located within the vocal fold.

5. Examine the ventricle. The ventricle may extend into a recess called the sacculle.

6. Review the nerve supply to the larynx:
   - **Internal branch of the superior laryngeal nerve** – provides sensory innervation to the mucosa of the vocal fold and to the mucosa superior to the vocal folds
   - **External branch of the superior laryngeal nerve** – innervates the cricothyroid muscle (and also the inferior pharyngeal constrictor muscle)
   - **Inferior laryngeal branch of the recurrent laryngeal nerve** – innervates all of the intrinsic muscles of the larynx except the cricothyroid muscle, and provides sensory innervation to the mucosa inferior to the vocal folds

**Dissection Follow-up**

1. Replace the head and larynx in their correct anatomical positions.

2. Use a cross-sectional drawing of the neck and the dissected specimen to review the relationship of the larynx to the vertebral column, carotid sheaths, and other cervical viscera.

3. Trace the right and left vagus nerves into the thorax and follow the right and left recurrent laryngeal nerves from the thorax to the larynx. Note the differences.

4. Review the branches of the external carotid artery.

5. Follow the superior thyroid artery to the thyroid gland and review the course of the superior laryngeal artery as it passes through the thyrohyoid membrane to enter the larynx. Recall that the superior laryngeal artery courses with the internal branch of the superior laryngeal nerve.

6. Review the course of the superior laryngeal nerve from the vagus nerve to its bifurcation. Follow the external laryngeal branch to the cricothyroid muscle.

7. Use the dissected specimen to review the attachments and action of each intrinsic laryngeal muscle that was identified during dissection.

8. Review the movements of the vocal folds during phonation, quiet breathing, and rapid breathing.

**EAR**

**Dissection Overview**

The ear is composed of three parts: external ear, middle ear, and internal ear. The external ear consists of the auricle and the external acoustic meatus. The middle ear is within the tympanic cavity of the temporal bone. The ossicles (bones of the middle ear) are located in the middle ear. The internal ear (vestibulocochlear organ) is the neurologic part of the ear, which is contained within the petrous portion of the temporal bone.

The order of dissection will be as follows: The parts of the external ear will be examined. The facial nerve will be
CHAPTER 7: THE HEAD AND NECK

• Concha – the deepest part of the auricle
• Tragus
• Antitragus
• Lobule of the auricle

2. Note that the auricular cartilage (FIG. 7.88B) gives the auricle its shape. There is no cartilage in the lobule. Palpate the auricular cartilage on yourself. By palpation, verify that the auricular cartilage is continuous with the cartilage of the external acoustic meatus.

3. The external acoustic meatus begins at the deepest part of the concha and ends at the tympanic membrane (a distance of about 2.5 cm in adults). The wall of the outer one-third of the external acoustic meatus is cartilaginous and the inner two-thirds is bony.

4. Note that the external acoustic meatus is S-shaped, first curving posterosuperiorly and then anteroinferiorly. The external acoustic meatus is straightened for examination by pulling the auricle upward, outward, and backward.

5. Study an illustration of the external surface of the tympanic membrane and relate its surface features to the structures that lie in the middle ear. [G 712; L 361; N 93; R 126; C 659]

Middle Ear (Tympanic Cavity) [G 714; L 360; N 97; R 130; C 667]

1. This dissection approach is intended for use on a decalcified temporal bone. It may also be used on a calcified temporal bone if the appropriate power tool is available. Wear eye protection when cutting bone.

2. The tympanic cavity is an air-filled space within the temporal bone. It is separated from the external acoustic meatus by the tympanic membrane and from the middle cranial fossa by the tegmen tympani (FIG. 7.89). The tympanic cavity will be approached by removing the tegmen tympani portion of the floor of the middle cranial fossa (FIG. 7.90).

Temporal Bone

Refer to a skull. On the intracranial surface of the temporal bone, identify (FIG. 7.87): [G 715; L 362; N 11; R 30; C 586]

- Groove for the greater petrosal nerve
- Tegmen tympani – a portion of the floor of the middle cranial fossa that forms the roof of the tympanic cavity
- Internal acoustic meatus

On the external surface of the temporal bone, review the following: [G 621; L 362; N 10; R 32; C 591]

- External acoustic meatus
- Mastoid process
- Stylo mastoid foramen
- Jugular fossa
- Carotid canal
- Bony portion of the pharyngotympanic tube

Dissection Instructions

External Ear [G 709; L 361; N 93; R 124; C 657]

1. Examine the auricle of the cadaver and identify (FIG. 7.88A):

- Helix – the rim of the auricle
- Antihelix – the curved prominence anterior to the helix

Followed from the posterior cranial fossa into the internal acoustic meatus and the roof of the tympanic cavity will be removed. The auditory ossicles will be identified and one ossicle will be removed. The temporal bone will be cut to reveal the medial and lateral walls of the tympanic cavity. The tympanic membrane will be studied. Features of the medial wall of the tympanic cavity will be examined.

FIGURE 7.87 Temporal bone. Superior view.
3. Obtain a decalcified temporal bone specimen. If the dura mater is still present in the middle cranial fossa of the specimen, peel it off the superior surface of the temporal bone. Start at the superior border of the petrous part of the temporal bone and peel the dura mater in an anterior direction.

4. Look for the greater petrosal nerve in the groove for the greater petrosal nerve (FIGS. 7.87 and 7.90). Note that the greater petrosal nerve lies between the dura mater and the bone.

5. Refer to a schematic illustration of the middle ear and orient yourself to the features of the walls of
the tympanic cavity (FIG. 7.89): [G 712, 716, 717; L 383; N 92; R 122; C 659]

- **Lateral** – the tympanic membrane
- **Posterior** – the *adiitus* (L. *adiitus*, inlet or access), an opening into the mastoid air cells
- **Medial** – the *promontory* and *oval window* (*fenestra vestibuli*) containing the base (footplate) of the *stapes*
- **Anterior** – the opening of the pharyngotympanic tube
- **Superior** – tegmen tympani
- **Inferior** – the floor of the tympanic cavity, which is closely related to the jugular fossa and the jugular bulb

6. Turn to the temporal bone specimen (FIG. 7.90). In the posterior cranial fossa, identify the *facial nerve* (VII) and the *vestibulocochlear nerve* (VIII) as they enter the internal acoustic meatus.

7. Use a scalpel to remove the roof of the internal acoustic meatus and follow the *facial* and *vestibulocochlear nerves* laterally as they pass through the internal acoustic meatus. Remain superior to the nerves when cutting the internal acoustic meatus (FIG. 7.90). [G 716; L 382; N 94; C 667]

8. Follow the facial nerve laterally until it makes a sharp bend in the posterior direction. At this bend, identify the *geniculate ganglion* and the origin of the *greater petrosal nerve* (FIG. 7.90). The geniculate ganglion contains cell bodies of sensory neurons. The greater petrosal nerve carries presynaptic parasympathetic fibers to the pterygopalatine ganglion for innervation of the mucous membranes of the nasal and upper oral cavities, and the lacrimal gland. The presynaptic parasympathetic nerve fibers do not synapse in the geniculate ganglion.

9. The greater petrosal nerve courses anteromedially within the temporal bone and emerges on the floor of the middle cranial fossa at the * hiatus for the greater petrosal nerve*. It then passes inferiorly and medially on the surface of the temporal bone in the *groove for the greater petrosal nerve*. The greater petrosal nerve enters the carotid canal. On the surface of the internal carotid artery, the greater petrosal nerve joins the deep petrosal nerve to form the *nerve of the pterygoid canal*. The nerve of the pterygoid canal carries the presynaptic fibers of the greater petrosal nerve to the pterygopalatine ganglion.

10. Do not attempt to follow the facial nerve through the temporal bone. The facial nerve enters the facial canal at the geniculate ganglion. It travels a short distance in a posterolateral direction, then turns inferiorly and exits the skull at the stylomastoid foramen.

11. The *cochlea* lies anterior to the internal acoustic meatus in the angle formed by the facial nerve, the geniculate ganglion, and the greater petrosal nerve (FIG. 7.90). In the dissected specimen, the modiolus of the cochlea may be seen, depending on the plane of cut.

12. The semicircular canals lie posterior to the internal acoustic meatus. The semicircular canals may be seen as a series of tiny holes in the bone.

13. To open the tympanic cavity, use forceps to remove the *tegmen tympani*. Observe the *auditory ossicles* within the tympanic cavity (FIG. 7.90). Note that the *malleus* is attached to the tympanic membrane, the *incus* occupies an intermediate position, and the *stapes* is the most medial of the auditory ossicles. The malleus and incus are easily seen from the superior view. The stapes is located more inferiorly, making observation more difficult.

14. Use fine forceps to remove the incus. Leave the malleus attached to the tympanic membrane (FIG. 7.91).

15. Looking down from above, identify the *tympanic membrane* on the lateral wall of the tympanic cavity. Attempt to identify the tendon of the tensor tympani muscle, a thin strand of tissue that spans from the medial wall of the tympanic cavity to the handle of the malleus.

16. Insert a scalpel blade into the opening created by removing the incus (FIG. 7.91). Angle the blade parallel to the internal surface of the tympanic membrane. Make a cut that extends down the pharyngotympanic tube and divides the middle ear into medial and lateral walls (see FIG. 7.91 for correct placement of the cut). Make this cut parallel to the superior border of the petrous part of the temporal bone.

17. On the lateral wall of the tympanic cavity, observe the tympanic membrane and identify the *chorda tympani*.
tympani (FIG. 7.92B). The chorda tympani passes between the malleus and the incus. [G 717; L 363; N 94; R 126; C 663]

18. On the medial wall of the tympanic cavity, identify (FIG. 7.92A): [G 716; L 363; N 94; R 126; C 664]

- **Promontory** – a low elevation.
- **Stapes** – still attached to the oval window (fenestra vestibuli). Look for the stapedius tendon, about 1-mm long, passing from the pyramidal eminence to the stapes. The stapedius muscle is innervated by the facial nerve (VII).
- **Round window** (fenestra cochleae) – posteroinferior to the promontory.
- **Tensor tympani muscle** – attaches to the pharyngotympanic tube and sphenoid bone medially, and to the manubrium (handle) of the malleus laterally. Its tendon crosses the tympanic cavity. It is innervated by the mandibular division of the trigeminal nerve (V).)

19. Note that the tympanic cavity and its associated recesses and air cells are covered with mucous membrane. The **glossopharyngeal nerve** (IX) innervates the mucous membrane of the tympanic cavity. It forms the **tympanic plexus** under the mucosa that covers the promontory.

**Internal Ear** [G 720; L 365; N 96; R 129; C 667, 668]

The vestibulocochlear organ is best seen in sectioned histologic material. If you wish to dissect the internal ear, use a decalcified temporal bone. Refer to appropriate atlas illustrations and use a single-edge razor blade to cut thin slices of the temporal bone. This procedure will expose the canals, chambers, and nerve pathways of the internal ear. A dissecting microscope should be used to visualize these structures.

**Dissection Follow-up**

1. Use an illustration to review the external appearance of the tympanic membrane.
2. Relate the tympanic membrane to the handle of the malleus and the chorda tympani.
3. Review the course of the facial nerve from the internal acoustic meatus to the facial muscles.
4. Review the course of the greater petrosal nerve from the geniculate ganglion to the pterygopalatine ganglion. Summarize the distribution of the postsynaptic axons that arise in the pterygopalatine ganglion.
5. Review the course of the special sensory fibers contained in the chorda tympani beginning at the tongue and ending at the internal acoustic meatus. Where are the cell bodies for these sensory axons located?
6. Review the course of the presynaptic parasympathetic axons that synapse in the submandibular ganglion. Review the distribution of the postsynaptic axons that arise from the submandibular ganglion.
7. Review all branches of the glossopharyngeal nerve, including those that give rise to the lesser petrosal nerve.
INDEX

Page numbers in *italics* indicate figures; those followed by "b" indicate boxes.

A

Abdomen
celiac trunk, 102–107, 105
diaphragm, 123, 123–124, 124b
duodenum, 112–114, 113
gallbladder, 102–107, 108
gastrointestinal tract, 114–116
hepatic portal vein, 112–114, 113
inferior mesenteric artery, 110–112, 111
kidneys, 117–118, 119–120
large intestine, 110–112, 111
liver, 102–107, 106, 107b
pancreas, 112–114, 113
peritoneum and peritoneal cavity, 99–102
posterior abdominal viscera, 116–121, 117
posterior wall, 121–123
quadrant system, 89, 89
regions, 89, 90
small intestine, 107–110
spleen, 102–107
stomach, 102–107, 103, 115
superior mesenteric artery, 107–110, 108, 111
suprapancreal glands, 119, 119, 120b
surface anatomy, 89, 89
Abdominal aorta, 108–110, 110, 117, 120
Abdominal viscera, 99–100, 100
Abdominal wall
anterior, 130
muscles, 91–98
deep inguinal ring, 95
external oblique, 92, 92–93, 93
internal oblique, 93–94, 94
deep transversus abdominis, 94–95
posterior, 116–121, 117, 121–123
reflection of, 98–99
skeleton of, 92, 92
superficial fascia, 90, 90–91, 91
superficial veins, 91b
Abducens nerve, 241, 241, 243, 250
Abductor pollicis longus muscle, 54, 55
Accessory nerve, 11, 208, 212, 241, 241, 245
vical root, 245
Acetabular labrum, 200, 200
Acetabular ligament, 200, 200
Acetabular notch, 200, 200
Acetabulum, 125
Acromioclavicular joint, 58, 58
Acromion, 5, 21, 21
Adductor brevis muscle, 173, 176
Adductor canal, 173
Adductor digiti minimi muscle, 176, 195–196
Adductor hallucis muscle, 176, 195
Adductor magnus muscle, 176, 182
Adductor tubercle, 176
Adenoids, 258b
Adnexa, 152, 152
Alveolar artery, 233
Alveolar nerve, inferior, 232, 234
Alveolar vessels, inferior, 232
Anal canal
female, 157, 157
male, 140–142, 142
Anal hiatus, 145, 146, 161, 162
Anal sphincter muscle, 129, 157, 157
Anatomical planes, 3
Anatomical position, dissection and, 2–3
Anatomical snuffbox, 55, 57
Anatomical variation, 3
Anconeus muscle, 39, 39
Ankle
injuries, 203b
joints of, 202, 202–203
Ansa cervicalis, 210, 212, 212
Anterior axillary fold, 21, 213
Anterior axillary fold, 21
Aortic arch, branches, 84
Appendicular artery, 109, 109
Appendix, 112, 112
Arachnoid mater, 17
Arteries, anatomical variations, 104b
Articular processes, 7
Articular tuber, 230
Articulatio capitis, 272
Articulatio temporomandibularis, 272
Articular cartilage, 272
Atlantoaxial joint, 252–253, 253
Atlas, use for dissection, 3
Atlas (C1 vertebra), 14, 14, 15
Auricular artery, 223
Auricular nerve, 208
Auricular nerve, 223
Auricular nerve, 225
Auricularis muscle, 272
Auricularis magnus muscle, 272
Auricularis lateralis muscle, 272
Auricularis posterior muscle, 272
Biceps brachii muscle, 21
Biceps femoris, 181
Blunt dissection, 2
Bony landmarks, for dissection, 3
Brachial artery, 37, 37, 37, 37, 37, 44
high bifurcation of, 44b
Brachial plexus, 32–33, 33, 218
Brachiocephalic vein, 216
Brachioradialis muscle, 44, 53, 54
Brachioradialis tendon, 53, 54
Brain
blood vessels and cranial nerves, 241
cranial cavity floor, 238
cranial fossa, 242–245, 242, 244, 245
dural infoldings, 239, 239–240
dural venous sinuses, 239, 239–240
gross anatomy, 240, 240–241
removal of, 238–239
Brainstem, 240, 240
Breast, 27, 27–30, 278
Bridging veins, 237, 239
Buccal artery, 233
Buccal fat pad, 223
Buccal nerve, 223
Buccinator muscle, 223, 223
 Buccopharyngeal fascia, 255
Buck’s fascia, 134
Bulbospongiosus muscle, 133, 134, 150
Bulbourethral glands, 136

B

Back
muscles
deep, 5, 12, 13
intermediate, 5, 12
superficial, 5, 9–10, 10
skeleton of, 5–7, 6–7
suboccipital region, 14–15, 15
surface anatomy, 5, 5
vertebral canal, 15–16, 16
Basilic vein, 21–24, 23
Biceps brachii muscle, 21, 21
Biceps femoris, 181
Blunt dissection, 2
Bony landmarks, for dissection, 3
Brachial artery, 37, 37, 37, 37, 44
high bifurcation of, 44b
Brachial plexus, 32–33, 33, 218
Brachiocephalic vein, 216
Brachioradialis muscle, 44, 53, 54
Brachioradialis tendon, 53, 54
Brain
blood vessels and cranial nerves, 241
cranial cavity floor, 238
cranial fossa, 242–245, 242, 244, 245
dural infoldings, 239, 239–240
dural venous sinuses, 239, 239–240
gross anatomy, 240, 240–241
removal of, 238–239
Brainstem, 240, 240
Breast, 27, 27–30, 278
Bridging veins, 237, 239
Buccal artery, 233
Buccal fat pad, 223
Buccal nerve, 223
Buccinator muscle, 223, 223
 Buccopharyngeal fascia, 255
Buck’s fascia, 134
Bulbospongiosus muscle, 133, 134, 150
Bulbourethral glands, 136

C

Cadaver, care of, 1
Calcaneal tendon, 186, 187
Calvaria, 235–236
Cardiac veins, 76–77
Carotid artery
common, 213, 213–214
external, 213, 213, 213, 217
internal, 241
Carotid body, 214
Carotid sheath, 213
Carotid sinus, 214
Carpal tunnel syndrome, 50b
Cauda equina, 18, 18
Cavernous sinus, 245b
coronial section, 244
Cecum, 116, 116
Celiac trunk, 102–107, 105
INDEX

L

Labial arteries, 224
Labiium majus, 147
lymphatic drainage, 148b
Laboratory preparation, 3
safety, 3
Lacrimal apparatus, surface anatomy, 247, 248
Lacrimal bone, 246
Lacrimal canaliculi, 248
Lacrimal crest, 248
Lacrimal gland, 248, 251
Lacrimal groove, 248
Lacrimal nerve, 249
Lacrimal sac, 248
Lambda, 220
Lamina papyracea, 246
Large intestine, 110–112, 111
Laryngeal artery, 214
Laryngeal nerve, 213, 213, 272
recurrent, 213b, 217
Laryngopharynx, 258
Larynx, 271–274, 272
interior, 274, 274
intrinsic muscles, 272–273, 273
skeleton, 271
Lateral condyle, 200
Laterality, terms of, 3
Lateral sulcus, 240, 240
Latissimus dorsi, 9, 11
Left atrium, 80–81, 81
Left recurrent laryngeal nerve, 83b
Left ventricle, 81, 82
Levator ani muscle, tendinous arch, 146, 147
Levator labii superioris muscle, 224
Levator palpebrae superioris muscle, 249
Levator scapulae, 9, 11–12, 217
Levator veli palatini muscle, 265, 266
Ligamenta flava, 17
Lingual artery, 214, 271
Lingual nerve, 233, 234, 270
Lingula, 230
Liver, 102–107, 106, 107b
Longissimus capitis muscle, 13
Longissimus muscle, 13
gonas capitis, 254, 255
Longus colli, 254, 255
Lower limb
anterol, 190–193, 192
saphenous veins, 168
superficial fascia, 168
cutaneous nerves, 165–169, 167
foot
dorsal venous arch, 168
portal of, 184–185, 190–193, 192
sole of, 193–198, 195, 196, 197
gluteal region, 176, 176–181, 178, 179
skeleton, 177, 177–178
joints of, 198–203
ankle, 202, 202–203
hip, 198–199, 199, 200
inversion and eversion, 203
knee, 200–201, 201
leg, 184–185, 185
lateral compartment, 190, 190
posterior compartment, 185–189, 187, 189
skeleton, 185, 185
posterior
cuneal nerves, 166
small saphenous vein, 166
superficial fascia, 166
sural nerve, 166
superficial veins, 165–169, 167
surface anatomy, 165, 165
thigh
anterol compartment, 169, 169–173, 172
cutaneous nerve, 166
medial compartment, 175–176
motor nerve territories, 184
posterior compartment, 181–184, 182
skeleton of, 169, 170, 181
transverse section, 174
Lumbar enlargement, 15, 16, 18
Lumbar plexus, 121, 122
Lumbar puncture, 196
Lumbar triangle, 12
Lumbar vertebrae, 7, 7
Lumbosacral trunk, 123, 144, 160
Lumbar muscles, 196
Lungs, 69–71, 69–72
removal, 70
Lymphatic duct, 217
Lymphatics, 104
N

Nasal bone, 218–219, 219
Nasal nerve, external, 250
Nasal septum, 218–219, 219, 260, 261
Nasion, 218–219, 219
Nasociliary nerve, 230
Nasolacrimal duct, 238
Nasopharynx, 258
Navicular fossa, 136
Neck, 205–218
anterol triangle, 209, 209–210
bones and cartilages, 209–210
carotid triangle, 211, 212
muscular triangle, 210
submandibular triangle, 211, 211
submental triangle, 212
superficial fascia, 210
organization of, 205–209
parathyroid gland, 214–215
posterior triangle, 207, 207–209, 208
root of, 215–218, 216
skeleton, 205–206
thyroid gland, 214–215
transverse section, 206
Nose and nasal cavity, 259–263
skeleton, 259–260
O

Oblique muscle, inferior, 251, 251
Obliquus capitis inferior muscle, 14, 15
Obliquus capitis superior muscle, 15, 15
Obturato artery, 143, 143, 160
Obturato canal, 146, 147
Obturato externus muscle, 175, 176, 199
Obturato internus muscle, 146, 147, 161, 162, 180
Obturato nerve, 122, 168, 175, 176
Occipital artery, 8, 8, 15, 214
Occipital bone, 6, 219, 220, 242, 242, 244
252–253, 253
Occipital lobe, 240, 240
Occipital nerve, 208
Occipitofrontalis muscle, 229, 229
Oculomotor nerve, 241, 241, 243, 249, 250,
252–252, 252
Olfactory bulb and tract, 241, 241
Omentum, 102, 102
Omphaloid muscle, 210, 215
Ophthalmoic artery, 241
right orbit, 251
Ophthalmoic veins, 250b
superior, 250
Optic nerve, 241, 241, 243, 250, 252
Oral cavity, 268
Oral region, 268–271
sublingual region, 269, 269–270
Mesovarium, 152, 153
Metacarpophalangeal joints, 61, 61, 62
Metatarsal arteries, 193
Metatarsal bones, 185, 186
Movement, terms of, 3
Mylohyoid groove, 230
Mylohyoid muscle, 269, 270
surface anatomy, 268
tongue, 268–269, 269, 270
Oral vestibule, 268
Orbicularis oculi muscle, 224
Orbit, 245–252, 246–248
left from the anterior approach, 251–252, 252
right from the superior approach, 248–249, 249, 250
skeleton, 246
Orbital margin, 218–219, 219
Orbicularis oculi muscle, 224
Oral vestibule, 268
Pectoralis minor muscle, 29
Pectoralis major muscle, 227
Parotid plexus, 223
Parotid gland, 222, 228
Parotid duct, 222, 223, 227
Parotid muscle, 222, 228
Parotid region, 226–228, 227
skeleton, 226
Parotid sheath, 222
Patellar ligament, 173, 201, 201
Patellar retinaculum, 200
Patellar tendon reflex, 174
Pectoralis muscle, 173
Pectoralis major muscle, 29
Pectoralis minor muscle, 29
Pelvic cavity, muscle, 137–140
Pelvic diaphragm, 125, 161, 162
Pelvic inlet, 125
Pelvic nerve plexuses, 145, 146, 161b
Pelvis, 125, 126
anal triangle, 127–129
coronal section, 125
female
anal canal, 157, 157
anal triangle, 127
external genitalia, 147, 148, 148
iliac artery, 158, 158–159
internal genitalia, 154–155
pelvic cavity, 152–155
pelvic diaphragm, 161, 162
perineum, 147, 149
rectum, 157, 157
sacral plexus, 158, 158–159
sagittal section, 154
urinary bladder, 156, 156–157, 157
urogenital triangle, 127, 148–152
internal iliac artery, 143–145, 143
male
anal canal, 139, 140, 140–142, 142
anal triangle, 127
external genitalia, 129–131
internal genitalia, 138–140, 139, 140
internal iliac artery, 143–145, 143
pelvic cavity, 137–140
pelvic diaphragm, 145–147, 146
rectum, 139, 140, 140–142, 142
urinary bladder, 139–141
urogenital triangle, 127, 132–137
sacral plexus, 143–145
skeleton, 125–127
Penis, 134–135, 135
Perineum, 125, 127
Perineal body, 133, 134, 150
Perineal membrane, 133, 134, 150
Perineal muscle, superficial transverse, 150
Perineal pouch
female
depth, 151, 151
superficial, 149, 149–151
male, 132–134, 132b, 133, 134, 136
depth, 136, 136
Perineum, 125, 127, 132
Periorbita, 249
Peritoneum, 99–102, 99–102
female, 101
male, 151
Pes anserinus, 184
Petrosal sinus, 243
Piriformis muscle, 178
18, 236,
Pia mater, 18,
Poncine branches, 241
Popliteal artery, 173, 184
Popliteal fossa, 181–184, 182, 183
Popliteal muscle, 184
Popliteus muscle, 186, 187, 188
Portal hypertension, 114
Posterior abdominal viscera, 116–121, 117
Posterior axillary fold, 21, 21
Prevertebral fascia, 254
Prevertebral muscles, 254, 255
Probe, 1, 1
Promontory, 278
Prostate, 139, 140
Prostatic urethra, 135–136, 136
Proximal radioulnar joint, 60, 60, 61
Pubic bone, 121
Perineum, 147, 148
Pterygoid canal, 267, 267
Pterygoid muscle
female
superficial, 249
Pterygoid process, 231, 265, 266
Pterygomaxillary fissure, 230
Pterygopalatine fossa, 231, 234, 264
Pubic arch, 126
Pulmonar, 125, 198–199
Pulmonary cavity, 146, 147, 160, 162
Pubofemoral ligament, 199, 199
Puboprostatic ligament, 140
Puborectalis muscle, 146, 147, 160, 162
Pubodental muscle, 137, 143, 144, 160
internal, 143–144
Pudendal canal, 129, 129
Pudendal nerve, 129, 129, 137
block, 151
Pulmonary artery, 68, 68, 71, 72
Pulmonary ligament, 69, 71
Pulmonary pleura, 68
Pulmonary trunk, 74, 74, 75
Pulmonary veins, 68, 68, 71, 72
Pyramidalis muscle, 91, 95, 97
Q
Quadrangular space, 25, 25
Quadratus femoris muscle, 180
Quadratus lumbrorum muscle, 121
Quadratus lumborum muscle, 196
Quadriceps femoris muscle, 173–174
Playsmsa muscle, 28, 207, 207, 222
Pleural cavities, 68, 68–69, 69b
R
Radial groove, 24, 24
Radial nerve, deep branch, 55, 56
Radialulnare joint
distal, 61, 61
intermediate, 61, 61
proximal, 60, 60
Radius, 40, 40
Rectal artery, 143, 143, 160
middle, 143, 143
Rectal examination, 142
Rectouterine pouch, 152
Recto-vesical septum, 139
Rectus, 112
male, 139, 140–142, 142
Rectus capitis posterior major muscle, 14, 15
Rectus femoris muscle, 174
Rectus muscle
lateral
medial and inferior, 251, 251
superior, 249
Reflect, 2
Relationship, terms of, 3
Retina, central artery, 252
Retract, 2
Retromandibular vein, 210
Retroperitoneal space, 116
Retropharyngeal space, 253
Retrubic space, 140, 150
Rhomboïd major, 9, 11
Rhomboïd minor, 9, 11
Rib, 63, 64
Right atrium, 78–79, 79
Right ventricle, 79–80, 80
Rima glottidis, 273
Rotator cuff, 26, 34
Round window, 278

S
Sacral artery, lateral, 143, 144, 159
Sacral plexus, 143–145, 144, 158–160
Sacrococcygeal ligament, 126
Sacrotuberous ligament, 128, 145, 146
Sacrum, 7, 8, 19
Sagittal sinus
inferior, 239
superior, 239
Salpingopharyngeal fold, 258
Salpingopharyngeus muscle, 264
Saphenous hiatus, 168, 169
Saphenous nerve, 173
Saphenous opening, 170–171, 171
Sartorius muscle, 173
Sartorius tendons, 184
Scalene muscles, 217
anterior, 254, 255
Scalp, 228–229, 228h, 229
Scapulæ, 1–2
Scapuλæ fossa, 265, 266
Scapula, 5, 24, 24
Scapular anastomosis, 26
Sciatic foramina, 126
Sciatic nerve, 145, 160, 179, 181, 183b
Sciaticus, 1, 2
technique, 2, 2
Scrotum, 129, 129
Sellar diaphragm, 245
Semimembranosus muscle, 181
Semenal vesicle, 140
Semispinalis capitis muscle, 14, 15
Semispinalis muscle, 181
Semitendinosus tendon, 184
Serratus posterior inferior muscle, 12
Serratus posterior muscle, 12
Sesamoid bone, 196
Sharp dissection, 2
Shoulder, blood and nerve supply, 25
Sigmoid colon, 112
Sigmoid mesocolon, 102, 112
Sigmoid sinuses, 240, 254
Skin
incisions, 8, 8
removal for dissection, 3–4
Small intestine, 107–110, 108
Soleus muscle, 186, 187, 188
Spermatic cord, 130, 130
Sphenoidal sinus, 262b
Sphenoid bone, 219, 220, 242, 244, 244, 246
greater wing, 231
Sphenopalatine foramen, 231
Spinal cord, 16–18, 16–18
Spinalis muscle, 13
Spinal meninges, 17
Spinal nerve, 8, 10, 11, 15
Splanchnic nerves
pelvic, 144, 160
sacral, 145, 160
Spleen, 102–107, 106b
Splenic artery, 105–106, 106
Splenius capitis muscle, 12, 15, 217
Spleniæ cervicis muscle, 12, 15
Spongy urethra, 135–136, 136
Stapes, 278
Sternoclavicular joint, 57–58, 58, 59
Sternoledonostoid muscle, 227
Sternohyoid muscle, 210
Sternohyoid muscle, 210
Stomach, 102–107, 103, 113
Strip a vein, 2
Styloglossus muscle, 270
Stylohyoid muscle, 227
Styloid process, 211
Stylohyoïd muscle, 265, 266
Subarachnoid space, 18, 18, 237
Subclavian artery, 216, 217, 218
Subclavian vein, 216, 217, 218
Subcostal nerve, 122
Subdural hematoma, 237b
Sublingual area, 268
Sublingual artery, 271
Sublingual gland, 270
Sublingual region, 269, 269–270
Submandibular ganglion, 270
Suboccipital region
prevertebral and lateral vertebral regions, 254
retropharyngeal space, 253
Suboccipital triangle, 15, 15
Subscapularis muscle, 24, 25
Subtalar joint, 203
Superior mesenteric artery, 107–110, 108, 110
Superior oblique muscle, 249
Supinator, 74, 55
Superficial nerve, 208
Superficial nerve, 225, 229
Superficial vessels, 229
Superficial vessels
Supraspinatus muscle, 24, 25
Suprascapular artery, 217
Suprascapular nerve, 24, 25
Suprascapular nerve, 217
Supraclavicular nerve, 254
cervical, 217
sacral portion, 145, 161

T
Tarsal arteries, 193
Tarsal glands, 248b
Tarsal joint, 203
Temporal arteries, 233
deep, 232
Temporal bone, 6, 218–219, 219, 220, 226, 242, 242, 244, 275, 275
Temporal fascia, 232
Temporal fossa, 230
Temporalis muscle, 229, 232, 235
Temporal lobe, 240, 249
Temporal nerves, deep, 232
Temporal region, 230–235
infratemporal fossa, 232, 233, 234
masseter muscle and zygomatic arch, 230, 251
skeleton, 230, 231
superficial boundary, 232
temporomandibular joint, 234–235, 235
Temporal vein, superficial, 227
Temporomandibular joint, 234–235, 235
Tensor tympani muscle, 278
Tensor veli palatini muscle, 265, 266
Tentorial notch, 239
Teres major muscle, 24
Teres minor muscle, 24
Testicular varicocele, 117b
Testis, 131, 131
lymphatic drainage, 131b
Thenar muscles, 50–51
Thoracic aperture, 215
Thoracic artery, 216
Thoracic duct, 217
Thoracic nerve, 249
thoracic spinal nerve, 28, 66
Thoracic vertebrae, 6, 6–7
Thoracic wall, anterior, 66–67, 68b
removal, 67
Thoracodorsal artery, 11
Thoracodorsal nerve, 11
injury, 34b
Thoracoacromial fascia, 13
Thorax
heart in, 73, 73–82, 74, 75
intercostal space and muscles, 65, 65–66
lungs, 69–71, 69–72
mediastinum, 72, 72–73
middle, 73–82
posterior, 85–86, 85–87
superior, 82–84, 83
pleural cavities, 68, 68–69
skeleton, 63–64, 64
surface anatomy, 63, 63
Thyroarytenoid muscle, 273
Thyrocerveal trunk, 217
Thyrohyoid membrane, 210, 272
Thyrohyoid muscle, 210, 212
Thyroid artery, 214
injury, 197
Thyroid cartilage, 272
laryngeal prominence, 210
Thyroid gland, 213, 214–215
Tibia, 184–185
Tibial collateral ligament, 200
Tibialis anterior, 190
INDEX

Tibialis artery, 188, 189, 191
Tibialis muscle, 186, 187, 188, 189
Tibialis posterior tendon, 198
Tibial nerve, 183, 188, 193
Tongue, 268–269, 269, 270
Tonsillar bed, 266
Torus tubarius, 258
Trachea, bifurcation of, 84b
Tracheotomy, 210b
Transect, 2
Transverse mesocolon, 101
Transverse sinus, 239, 254
Transversospinal group of muscles, 13, 13
Transversus abdominis muscle, 121
Trapezius muscle, 8–9, 10, 15
Triangle of auscultation, 12
Triangular space, 25, 26
Triceps brachii muscle, 38–39, 39
Trigeminal nerve, 241, 241, 244
ophthalmic division, 243
Trochlea, 202, 251, 251
Trochlear nerve, 241, 241, 243, 249
Tunica albuginea, 131, 136
Tympanic cavity, 275, 276, 277, 278
Tympanic plexus, 278

U

Ulna, 40, 41
Ulnar nerve, 21–24, 23
Umbilical artery, 143, 143, 159
Upper limb
arm, 34–40
anterior compartment, 34–36, 36, 40
cubital fossa, 34, 37, 38
elbow region, 35
posterior compartment, 38–40, 39, 40
axilla, 30, 30–34
axillary artery, 31–32, 32, 33
brachial plexus, 32–33, 33
cutaneous nerves, 21–24, 23
forearm
extensor region, 53–57, 54, 56
flexor region, 40–46
joint, 40
vessels and nerves, 44–46
wrist, 61, 61

V

Vagina, 151, 154
Vaginal artery, 143, 143, 143, 160
Vaginal fornix, 154
Vagus nerve, 213, 213, 214, 217, 241, 241, 245
Vasectomy, 131b
Vastus intermedius muscle, 174
Vastus lateralis muscle, 174
Vastus medialis, nerve to, 173
Vastus medialis muscle, 174
Veins, removal for dissection, 2
Venous plexus, 135, 137, 139, 144, 160
Vertebral artery, 14, 14, 15, 216, 241
Vertebral canal, 15–16, 16, 17, 18
Vertebral column, 6, 6–7
Vertebral vein, 216
Vesical artery, inferior, 143, 143
Vestibulocochlear nerve, 241, 241, 245, 277
Vocalis muscle, 273
Vocal ligaments, 272, 273
W

Wrist joint, 61, 61

X

Xiphisternal junction, 21, 21

Z

Zygomatic arch, 230, 231
Zygomatic bone, 218–219, 219, 220, 246
Zygomaticus major muscle, 224