DEMONSTRATIONS

OF

ANATOMY;

BEING A

GUIDE TO THE KNOWLEDGE OF THE HUMAN BODY

BY

DISSECTION.

BY

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PREFACE.

The plan of this work was designed to teach the Anatomy of the Human Body by dissection in successive stages after the following manner :—

In the dissection of a Part the attention of the Student is directed first to the superficial prominences of bone and muscle, and the hollows that point out the situation of the subjacent vessels. Next the different layers of muscles with their interspersed vessels and nerves, which are interposed between the surface and the bones, are examined in succession, with reference particularly to the natural position of the several objects and their connections with each other, so that they may be observed in much the same order as they would be met with in a Surgical operation.

In the dissection also of the viscera and the organs of the senses, the manner in which the structures of each may be shown, is fully indicated for the guidance of the Student.

The Anatomical description of the Part under examination is arranged in conformity with the dissection in regions, and each muscle, bloodvessel, nerve, or other structure, is described only to such an extent as it may be laid bare.

In this edition I have introduced the actions of muscles, the movements of joints, and the topographical anatomy of the convolutions of the cerebrum; and I have endeavoured to make the work more complete by the correction of inaccuracies; and more efficient, as a guide to dissection, by the introduction of such alterations as greater experience in teaching has shown to be advisable.

The number of illustrations on wood has been increased in this edition. The views of the convolutions of the brain are copied, with the permission of Professor Turner, from the woodcuts in his monograph on the Convolutions of the Human Cerebrum. For the use of the greater number of the others I am indebted to the Publisher of my book.

To the Demonstrators of Anatomy in this College—Mr. Cluff, Mr. Beck, and Mr. Peacock—I tender my thanks for the assistance they have given me in the preparation of the present edition.

G. V. ELLIS.

University College, London,
January, 1869.

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CORRIGENDA.

Page 135, last line. For "it," *read* "palate."
,, 219, line 6. For "interparietal," *read* "intraparietal."
,, 293, line 13. After "musculo-spiral," *add*, "and its accompanying vessels."
,, 341, line 24, Instead of "viz." *insert*, "Between the carpal bones is."
,, 353, line 9 from the bottom. For "branches," *read* "bronchus."

DEMONSTRATIONS OF ANATOMY.

CHAPTER I.

DISSECTION OF THE HEAD AND NECK.

SECTION I.

EXTERNAL PARTS OF THE HEAD.

DIRECTIONS. In the dissection of the head and neck, the student should endeavour to learn the parts described in the first sixty pages before the position of the body is changed; but should want of time necessitate an omission of some part, the examination of the facial nerve (p. 37) can be best deferred till a subsequent stage. In all cases the orbit on one side, and the posterior triangular space on both sides of the neck, as well as the objects on the exterior and in the interior of the head, should be examined whilst the body lies in its first position on the back.

Parts to be learnt before the body is turned.

Position. The student begins with the dissection of the scalp and the muscles of the ear. To obtain the best position, raise the head to a suitable height, and turn the face to the right side. On the left side the muscles are to be seen, and on the opposite half the vessels and nerves are to be displayed.

Position of the body.

EXTRINSIC MUSCLES OF THE EAR. Three muscles attach the outer ear to the side of the head. Two are above it, one elevating, the other drawing it forwards; and the third, a retrahent muscle, is behind the ear. There are other special or intrinsic muscles of the cartilage of the ear, which will be afterwards described.

Muscles of the ear.

Dissection. When the ear has been drawn down by hooks, the position of the upper muscle will be indicated by a slight promi-

Dissection of upper muscle,

nence between the ear and the head; and the muscular fibres may be laid bare by means of the two following incisions, made no deeper than the skin :— One is to be carried upwards on the side of the head for about three inches along the cutaneous ridge before mentioned; and the other, about the same length, is to be directed from before backwards close above the ear, so that the two may join at a right angle. On carefully raising the flaps of skin from below upwards, and removing a little subjacent tissue, a thin fan-shaped muscular layer will come into view—the more anterior fibres constituting the attrahens, and the posterior the attollens aurem muscle.

of posterior muscle.

On drawing forwards the ear a ridge marks, in like manner, the situation of the posterior muscle. To remove the integuments, let the scalpel be drawn down about an inch behind the ear, from the transverse cut above as far as to a level with the lobule of the ear, and then forwards below the lobule. After the piece of skin included by those cuts has been reflected towards the ear, the retrahent muscle must be sought beneath the subcutaneous tissue ; it consists of rounded bundles of fibres, and is stronger and deeper than the others.

Attrahens aurem muscle.

The ATTRAHENS AUREM is a small fan-shaped muscle, and *arises* from the fore part of the aponeurosis of the occipito-frontalis. Its fibres are directed backwards, and are *inserted* into a projection on the front of the rim of the ear. Beneath it are the superficial temporal vessels and nerve.

Attollens aurem muscle.

The ATTOLLENS AUREM (fig. 3, [16]) has the same form as the preceding, though its fibres are longer and better marked. Arising also from the tendon of the occipito-frontalis, the fibres converge to their *insertion* into the inner or cranial surface of the pinna of the ear,—into an eminence corresponding with a fossa (that of the anti-helix) on the opposite aspect.

Retrahens aurem consists of two or three bundles.

The RETRAHENS AUREM (musculi retrahentes, Alb., fig. 3, [18]) consists of two or three roundish but separate bundles of fibres, which are stronger than those of the other muscles. The bundles *arise* from the root of the mastoid process, and pass almost transversely forwards to be *inserted* by aponeurotic fibres into the lower part of the ear (concha) at its cranial aspect. The posterior auricular artery and nerve are in contact with this muscle.

Use of ear muscles.

Action. The three preceding muscles will move the outer ear slightly in the directions indicated by their names : the anterior drawing it upwards and forwards, the middle one upwards, and the posterior backwards.

Occipito-frontalis,

The OCCIPITO-FRONTALIS MUSCLE (fig. 3, [1]) covers the arch of the skull, and consists of an anterior and a posterior fleshy part, with an intervening tendon.

how seen:

Dissection. On the same side of the head (the left) the occipito-frontalis is to be dissected. To bring this muscle into view, a cut may be made along the middle line of the skull, from the root of the nose to a little below the occipital protuberance; and it may be connected in front with the transverse incision on the side of the head. The flap of skin, thus market out, is to be raised from before and thrown backwards; whilst doing this the dissector will meet first with the anterior fleshy part of the muscle, next a white shining thin aponeurosis, and lastly the posterior fleshy belly towards the lateral aspect of the cranium.

take care not to cut it away.

The student should bear in mind that the aponeurosis of the muscle is easily taken away with the granular fat superficial to it; and if the under surface of the flap of integuments presents a white instead of a yellow appearance, he may suppose he is removing that aponeurosis.

Frontal part: Origin. Ending.

The *anterior* or *frontal* part is a thin muscular layer over the os frontis, which is said to take its origin below. Along the line of the eyebrow the fibres are blended with the orbicularis palpebrarum and corrugator supercilii; opposite the nose they join the pyramidalis nasi muscle, and are fixed to the os nasi; whilst externally they are attached to the angular process of the frontal bone (Theile). From those attachments the fibres are directed upwards to the aponeurosis, and end in it rather below the level of the coronal suture.

Occipital part, how attached.

The *posterior* or *occipital* part is stronger than the anterior; it *arises* from the outer half or two-thirds of the upper curved line of the occipital bone, and from the mastoid portion of the temporal bone. The fibres are about one inch and a half in length, and ascend to the aponeurosis.

Aponeurosis. Its attachment.

The *tendon*, or epicranial aponeurosis, extends over the upper part of the cranium, and is continuous across the middle line with the same structure of the opposite half of the head. On the side it gives origin to the auricular muscles, and a thin membrane is here prolonged from it over the fascia covering the temporal muscle, to be fixed to the side of the head. Posteriorly, the aponeurosis is attached to the superior curved ridge of the occipital bone between the fleshy parts of the muscles of opposite sides. The aponeurotic expansion is closely united to the skin; but it is connected to the pericranium only by a loose areolar tissue devoid of fat, so that it moves freely over the skull.

Its connections.

Superficial to the occipito-frontalis are the cutaneous vessels and nerves of the scalp. In front the fleshy fibres of opposite sides are joined above the root of the nose.

Use of anterior and

Action. When the anterior belly takes its fixed point above it elevates the eyebrow, making smooth the skin at the root of the nose and wrinkling transversely that of the forehead. But if the fleshy fibres are fixed along the line of the eyebrow, the scalp will be drawn forwards.

posterior belly. The posterior belly contracting will move back the scalp; and the bellies acting in succession will carry the scalp forwards and backwards.

How to see temporal fascia. *Dissection.* After the removal of the superior auricular muscles and the temporal vessels, together with the epicranial aponeurosis and its lateral prolongation, the attachment of the temporal fascia on the side of the head may be seen.

Temporal fascia. The *temporal fascia* is a white, shining membrane, which is stronger than the epicranial aponeurosis, and gives attachment to the subjacent temporal muscle. Attachments, Superiorly it is inserted into the curved line that limits the temporal fossa on the side of the skull; and inferiorly, where it is narrower and thicker, it is fixed to the zygomatic arch. connections, By its cutaneous surface the fascia is in contact with the muscles already examined, and with the superficial temporal vessels and nerves.

and layers. An incision in the fascia, a little above the zygoma, will show it to consist there of two layers, which are fixed to the edges of the upper border of the zygomatic arch. Between the layers is some fatty tissue, with a small branch of the superficial temporal artery, and a slender twig of the orbital branch of the superior maxillary nerve with its artery.

To see temporal muscle. *Dissection.* The temporal fascia is now to be detached from the skull, and to be thrown down to the zygomatic arch, in order that the origin of the subjacent temporal muscle may be examined. A soft areolar tissue that lies beneath it near the zygoma is to be taken away. The difference in thickness of parts of the fascia will be evident.

Temporal muscle. The TEMPORAL MUSCLE is only in part laid bare. Wide and thin above, it becomes narrower and thicker at the lower part. Origin. The muscle *arises* from the temporal fascia, and from all the surface of the impression on the side of the skull, which is named the temporal fossa. From this origin the fibres descend, Insertion and converging around a tendon, and are *inserted* by its means into the under surface and fore part of the coronoid process of the lower jaw.

connections. On the cutaneous surface is the temporal fascia, with the parts superficial to that membrane; and concealed by the muscle are the deep temporal vessels and nerves which ramify in it. The insertion of the muscle underneath the zygomatic arch will be afterwards followed.

Use. The temporal belongs to the group of masticatory muscles; and its action will be referred to with the description of the pterygoid region.

How to reflect skin *Dissection.* For the dissection of the vessels and nerves, let the face be turned now to the left side, and let an incision be carried along the eyebrow and zygoma to a little behind the ear, so as to allow the skin on the right half of the head to be reflected. The flap of skin is to be raised from before backwards, but the subcutaneous fat should be left till the nerves are found. **on right side.**

Behind the ear the skin should be raised as on the other side, to uncover the posterior auricular vessels and nerves.

Along the eyebrow seek the branches of vessels and nerves that come from the orbit, viz. the supra-orbital and frontal vessels, and the supra-orbital and supra-trochlear nerves: they lie at first beneath the occipito-frontalis, and the student must cut through the muscular fibres to find them. The supra-orbital branches issue opposite the middle, and the supra-trochlear near the inner part of the orbit. **Seek nerves and vessels on the front;**

On the side of the head, in front of the ear, the superficial temporal vessels and nerve are to be traced to the vertex; and above the zygomatic arch the branches of the facial and superior maxillary nerves, whose offsets join, are to be sought. **on the side of the head;**

Behind the ear and below it, the posterior auricular vessels and nerve, and branches from the great auricular nerve to the tip and back of the ear, are to be found; one or more offsets of the last should be followed to their junction with the posterior auricular nerve. **behind ear,**

At the back of the head the ramifications of the occipital vessels, with the large and small occipital nerves, should be denuded; the former nerve lies by the side of the artery, and the latter about midway between this vessel and the ear. **at the back of the head.**

Cutaneous Arteries. The arteries of the scalp are furnished by the internal and external carotid trunks, and anastomose freely over the side of the head. Only two small branches, the supra-orbital and frontal, come from the former; whilst several, viz. the temporal, occipital, and posterior auricular, belong to the latter. **Vessels of the scalp.**

The *supra-orbital artery* leaves the orbit through the notch in the margin of the orbit, and is distributed on the forehead. Some of its branches are superficial to the occipito-frontalis, and ascend towards the top of the head; whilst others remain beneath the muscle, and supply it, the pericranium, and the bone. **Supra-orbital artery.**

The *frontal branch* is close to the inner angle of the orbit, and is much smaller than the preceding. It soon ends in branches for the supply of the muscles, integuments, and pericranium. **Frontal artery.**

The *superficial temporal artery* is one of the terminal branches of the external carotid. After ascending above the zygomatic arch for about two inches, the vessel divides on the temporal fascia into anterior and posterior:— **Superficial temporal has**

The *anterior branch* runs forwards with a serpentine course to the forehead, supplying muscular, cutaneous, and pericranial **anterior and** offsets, and anastomoses with the supra-orbital artery. This is the branch that is opened when blood is taken from the temporal artery.

posterior branch.

The *posterior branch* is larger than the other, and arches backwards above the ear towards the occipital artery, with which it anastomoses. Its offsets are similar to those of the anterior branch, and it communicates moreover with the artery of the opposite side over the top of the head.

Occipital artery.

Occipital artery. The terminal part of this artery, after perforating the trapezius, divides into large and tortuous branches, which spread over the back of the head and the occipito-frontalis muscle. Communications take place with the artery of the opposite side, with the posterior part of the temporal, and with the following artery. Some offsets pass deeply to supply the occipito-frontalis muscle, the pericranium, and the bone.

Posterior auricular.

The *posterior auricular artery* appears in front of the mastoid process, and divides into two branches. One (mastoid) is directed backwards to supply the occipito-frontalis, and anastomose with the occipital artery. The other (auricular) is furnished to the retrahent muscle and the back of the pinna of the ear; and an offset from this pierces the pinna to be distributed on the opposite surface.

Veins of the scalp;

The VEINS of the exterior of the head are so similar to the arteries, that a full notice of each is not required. All the veins corresponding with branches of the internal carotid artery enter the facial vein, whilst the rest open into the jugular veins. These superficial veins communicate both with the sinuses in the interior of the skull by means of small branches named *emissary*, and with the veins occupying the spongy substance (diploë) of the cranial bones.

how they join other veins.

The *frontal vein* is directed towards the inner angle of the orbit, where it receives the *supra-orbital* vein, the two giving rise to the angular vein of the face: near its ending it receives small veins from the eyebrow, and from the upper eyelid and the nose. Both the *superficial temporal* and *posterior auricular* veins open into the external jugular; and the *occipital* joins the internal jugular vein.

Nerves of the scalp are:

CUTANEOUS NERVES. The nerves of the scalp are furnished from cutaneous offsets of both cranial and spinal nerves. The half of the head anterior to the ear receives branches from the three trunks of the fifth cranial nerve, and a few twigs from the facial nerve. All the rest of the head is supplied by spinal nerves (anterior and posterior primary branches), except close behind the ear, where there is an offset of the facial or seventh cranial nerve.

Supra-orbital nerve;

The *supra-orbital nerve* (fig. 7, ^{3}) comes from the first trunk of the fifth nerve, and escapes from the orbit with its companion artery; whilst beneath the occipito-frontalis muscle, the nerve gives offsets to it and the orbicularis palpebrarum, as well as to the pericranium. In the orbicular muscle a communication is established between this and the facial nerve. Finally the nerve ends in two cutaneous branches, which ramify in the teguments:—

One of these (inner) soon pierces the occipito-frontalis, and reaches upwards as high as the parietal bone. The other branch (outer) is of larger size, and perforating the muscle higher up, extends over the arch of the head to the os occipitis. Its two cutaneous branches.

Whilst the nerve is escaping from the supra-orbital notch it furnishes some *palpebral* filaments to the upper eyelid. Palpebral branches.

At the inner angle of the orbit is the small *supra-trochlear branch* of the same nerve. It turns upwards to the forehead close to the bone, and piercing the muscular fibres ends in the integument. Branches are given from it to the orbicularis and corrugator supercilii, and some *palpebral* twigs descend to the eyelid. Supra-trochlear branch. Palpebral branch.

The *superficial temporal nerves* are derived from the second and third trunks of the fifth nerve, and from the facial nerve. Temporal nerves;

The *temporal branch* of the *superior maxillary nerve* (second trunk of the fifth) is usually a slender twig, which perforates the temporal aponeurosis about a finger's breadth above the zygomatic arch. When cutaneous, the nerve is distributed on the temple, and communicates with the facial nerve, also sometimes with the next. from superior maxillary

The *auriculo-temporal branch* of the *inferior maxillary nerve* (third trunk of the fifth) lies near the ear, and accompanies the temporal artery to the top of the head. As soon as the nerve emerges from beneath the parotid gland, it divides into two terminal branches:—The more posterior is the smaller of the two, and supplies the attrahens aurem muscle and the integument above the ear. The other branch ascends vertically in the teguments to the top of the head. The nerve also furnishes an *auricular* branch (upper) to the anterior part of the ear above the auditory meatus. of inferior maxillary; auricular branch;

The *temporal branches* of the *facial nerve* are directed upwards over the zygomatic arch and the temporal aponeurosis to the orbicularis palpebrarum muscle: they will be described with the dissection of the trunk of the facial nerve. and from facial nerve.

The *posterior auricular nerve* lies behind the ear with the artery of the same name. It arises from the facial nerve close to the stylo-mastoid foramen, and ascends in front of the mastoid process. Soon after the nerve becomes superficial it communicates with the great auricular nerve, and divides into an occipital and an auricular branch, which are distributed as their names express:— Posterior auricular nerve has occipital branch,

The *occipital branch* is long and slender, and ends in the posterior belly of the occipito-frontalis muscle. It lies near the occipital bone, enveloped in dense fibrous structure, and furnishes offsets to the integuments.

and auricular.

The *auricular branch* ascends to the back of the ear, supplying the retrahent muscle and the posterior surface of the pinna.

Great auricular nerve.

The *great auricular nerve* of the cervical plexus is seen to some extent at the lower part of the ear, but its anatomy will be afterwards given with the description of the cervical plexus.

Great occipital nerve;

The *great occipital* (fig. 7, [11]) is the largest cutaneous nerve at the back of the head, and is recognised by its proximity to the occipital artery. Springing from the posterior primary branch of the second cervical nerve, it perforates the muscles of the back of the neck, and divides on the occiput into numerous large offsets; these spread over the posterior part of the occipito-frontalis muscle, ending mostly in the integument. As soon as the nerve pierces the trapezius, it is joined by an offset from the third cervical nerve; and on the back of the head it communicates with the small occipital nerve.

junctions.

Small occipital nerve

The *small occipital nerve* of the cervical plexus (fig. 7, [8]) lies midway between the ear and the preceding nerve, and is continued upwards in the integuments higher than the level of the ear. It communicates with the nerve on each side, viz. the posterior auricular and great occipital. Usually this nerve furnishes an *auricular* branch to the upper part of the ear at the cranial aspect, which supplies also the attollens aurem muscle.

has an auricular branch.

Section II.

INTERNAL PARTS OF THE HEAD.

Dissection to open the skull.

Dissection. The skull is now to be opened, but before sawing the bone the dissector should detach on the right side the temporal muscle nearly down to the zygoma, without separating the fascia of the same name from the fleshy fibres; and all the remaining soft parts should be divided by an incision carried around the skull, about one inch above the margin of the orbit at the forehead, and as low as the protuberance of the occiput.

Precautions in cutting through the bone.

The cranium is to be sawn in the same line as the incision through the soft parts, but the saw is to cut only through the outer osseous plate. The inner plate is to be broken through with a chisel, in order that the subjacent membrane of the brain (dura mater) may not be injured. The skull cap is next to be forcibly detached by inserting the fingers between the cut surfaces in front, and the dura mater will then come into view.

Course to be followed.

Directions. It will be more advantageous for the student to proceed at once with the parts described in this SECTION than to examine the brain at this stage. Directions are given (p. 11) for the preservation of the brain, after its removal, till it can be dissected.

Dura mater.

The DURA MATER is the most external of the membranes investing the brain. It is a strong, fibrous structure, which serves as an endosteum to the bones, and supports the cerebral mass.

Appearance of outer surface.

Its outer surface is rough, and presents, now the bone is separated from it, numerous small fibrous and vascular processes; but these are most marked along the line of the sutures, where the attachment of the dura mater to the bone is much the most intimate. Ramifying on the upper part of the membrane are branches of the middle meningeal vessels.

Glands of Pacchioni

Small granular bodies, glands of Pacchioni, are also seen along the middle line. The number of these bodies is very variable; they are found but seldom before the third year, but generally after the seventh, and they increase with age. Occasionally the surface of the skull is indented by these so-called glands.

Cut through the dura mater.

Dissection. For the purpose of seeing the interior of the dura mater, divide this membrane with a scissors close to the margin of the skull, except in the middle line before and behind where the superior longitudinal sinus lies. The cut membrane is then to be raised towards the top of the head; and on the right side the veins connecting it with the brain may be broken through.

Inner surface.

The inner surface of the dura mater is now seen to present a smooth and polished aspect; and this appearance is due to an epithelial layer similar to that lining serous membranes.

Structure,

This external envelope of the brain consists of white fibrous and elastic tissues so disposed as to give rise to two strata, viz. an external or endosteal, and an internal or special. At certain spots those layers are slightly separated, and form thereby the spaces or sinuses for the passage of the venous blood.

and processes.

Moreover, the innermost layer sends processes between different parts of the brain, forming the falx, tentorium, &c.

Falx.

The *falx cerebri* is the process of the dura mater, in shape like a sickle, which dips in the middle line between the hemispheres of the large brain. Its form and extent will be evident if the right half of the brain is gently separated from it.

Form and attachments.

Narrow and pointed in front, where it is attached to the crista galli of the ethmoid bone, it widens posteriorly, and joins a horizontal piece of the dura mater named the tentorium cerebelli.

Borders.

The upper border is convex, and is fixed to the middle line of the skull as far backwards as the occipital protuberance; and the lower, or free border, concave, is turned towards the corpus callosum of the brain, with which it is in contact posteriorly.

Sinuses in it.

In this fold of the dura mater are contained the following sinuses:—the superior longitudinal along the convex border, the inferior longitudinal in the hinder part of the lower edge, and the straight sinus at the line of junction between it and the tentorium.

Superior longitudinal sinus.

The *superior longitudinal sinus* (fig. 1, *b*) extends from the ethmoid bone to the occipital protuberance. Its position in the convex border of the falx will be made manifest by the escape of blood through numerous small veins, when pressure is made from before back with the finger along the middle line of the brain.

Situation and ending; its interior.

When the sinus is opened it is seen to be narrow in front, and to become wider as it proceeds backwards, till it ends in a common point of union of certain sinuses (torcular Herophili) at the centre of the occipital bone. Its cavity is triangular in form, with the apex of the space turned to the falx; and across it are stretched small tendinous cords—chordæ Willisii—near the openings of some of the cerebral veins. Occasionally small glandulæ Pacchioni are present in the sinus.

Veins opening into it.

The sinus receives small veins from the substance and exterior of the skull, and larger ones from the brain; and the blood flows backwards in it. The cerebral veins open chiefly at the posterior part of the brain, and lie for some distance against the wall of the sinus before they perforate the dura mater; their course is directed from behind forwards, so that the current of the blood in them is evidently opposed to that in the sinus: this disposition of the veins may be seen on the left side of the brain, where the parts are undisturbed.

Current of blood in it.

Directions for removal of brain.

Directions. Before the rest of the dura mater can be seen, the brain must be taken from the head. To facilitate its removal, let the head incline backwards, whilst the shoulders are raised on a block, so that the brain may be separated somewhat from the base of the skull. For the division of the nerves of the brain a sharp scalpel will be necessary; and the nerves are to be cut longer on the one side than on the other.

Mode of proceeding, and parts cut in succession.

Removal of the brain. As a first step cut across the anterior part of the falx cerebri, and the different cerebral veins entering the longitudinal sinus; raise and throw backwards the falx, but leave it uncut in the middle line behind. Gently raise with the fingers the frontal lobes and the olfactory bulbs of the large brain. Next cut through the internal carotid artery and the second and third nerves, which then appear; the large second nerve is placed on the inner, and the round third nerve on the outer side of the artery. A small branch of artery to the orbit should likewise be divided at this time. The brain is now to be supported in the left hand, and the pituitary body to be dislodged with the knife from the hollow in the centre of the sphenoid bone.

A strong horizontal process of the dura mater (tentorium cerebelli) comes into view at the back of the cranium. Along its free margin will be seen the small fourth nerve, which is to be cut at this stage of the proceeding. Make an incision through the tentorium on each side, close to its attachment to the temporal bone, without injuring the parts underneath. The following nerves which will be then visible are to be divided in succession. Near the inner margin of the tentorium is the fifth nerve, consisting of a large and small root; whilst towards the middle line of the skull is the long slender sixth nerve. Below the fifth, and somewhat external to it, is the seventh nerve with its facial and auditory parts, the former being anterior and the smaller of the two. Directly below the seventh are the three trunks of the eighth nerve in one line:—of these, the upper small piece is the glosso-pharyngeal; the flat band next below, the pneumo-gastric; and the long round nerve ascending from the spinal canal, the spinal accessory. The remaining nerve nearer the middle line is the ninth, which consists of two small pieces.

Cut through tent, nerves,

After dividing the nerves, cut through the vertebral arteries as they wind round the upper part of the spinal cord. Lastly, cut across the spinal cord as low as possible, as well as the roots of the spinal nerves that are attached on each side. Then on placing the first two fingers of the right hand in the spinal canal, the cord may be raised, and the whole brain may be taken readily from the skull in the left hand.

vessels, and cord.

Its preservation. After removing some of the membranes from the upper part, and making a few apertures through them on the under surface, the brain may be immersed in spirit to harden the texture; and methylated spirit may be used on account of its cheapness. Placing the brain upside down on a piece of calico long enough to wrap over it, set it aside in the spirit.

How to preserve the brain.

Its examination. At the end of two or three days the dissector should examine the other membranes, and the vessels. As soon as the vessels have been learnt, the membranes are to be carefully removed from all the surface of the brain, without detaching the different cranial nerves at the under surface. The brain may remain in the spirit till the dissection of the head and neck has been completed.

Examination of it.

The description of the brain and its vessels will be found after that of the head and neck.

Its description where found.

Directions. After setting aside the brain, the anatomy of the dura mater, and the vessels and nerves in the base of the skull

Directions.

should be proceeded with. For this purpose raise the head to a convenient height, and fasten the tentorium in its natural position with a few stitches. The dissector should be furnished with the base of a skull whilst studying the following parts.

Dura mater in base of skull;

Dura mater. At the base of the cranium the dura mater is much more closely united to the bones than it is at the top of the skull. Here it dips into the different inequalities on the osseous surfaces; and it sends processes through the several foramina, which join for the most part the pericranium and furnish sheaths to the nerves.

its prolongations and connections to bone.

Beginning the examination in front, the student will find the membrane sending a prolongation into the foramen cæcum, as well as a series of tubes through the apertures in the cribriform plate of the ethmoid bone. Through the sphenoidal fissure, a large process enters the orbit; and through the optic foramen a covering is continued on the optic nerve to the eyeball. After lining the sella Turcica, the dura mater adheres closely to the basilar process of the occipital bone; and it may be traced into the spinal canal through the foramen magnum, to the margin of which it is very firmly united.

Tentorium cerebelli;

The *tentorium cerebelli* is the piece of the dura mater that is interposed in a somewhat horizontal position between the cerebellum or small brain, and the posterior part of the cerebrum or large brain.

surfaces,

Its upper surface is raised along the middle, where it is joined by the falx cerebri, and is hollowed laterally for the reception of the back part of the cerebral hemispheres. Its under surface touches the little brain, and is joined by the falx cerebelli.

edges,

The anterior concave margin is free, except at the ends where it is fixed by a narrow slip to each anterior clinoid process. The posterior or convex part is connected to the following bones:—occipital (transverse groove), inferior angle of the parietal, petrous portion of the temporal (upper border), and posterior clinoid process of the sphenoid.

and the sinuses in it.

Along the centre of the tentorium is the straight sinus; and in the attached edge are the lateral and the superior petrosal sinuses on each side.

Falx cerebri.

Falx cerebri. The characters of this fold have been given in page 9.

Falx cerebelli

The *falx cerebelli* has the same position below the tentorium as the falx cerebri above that fold. It is much smaller than the falx of the cerebrum, and will be seen by detaching the tentorium. Triangular in form, this fold is adherent to the middle of the occipital bone below the transverse ridge, and projects between the hemispheres of the cerebellum or small brain. Its base is directed to the tentorium; and the apex ends below at the foramen magnum, to each side of which it gives a small slip. In it is contained the occipital sinus. **contains occipital sinus.**

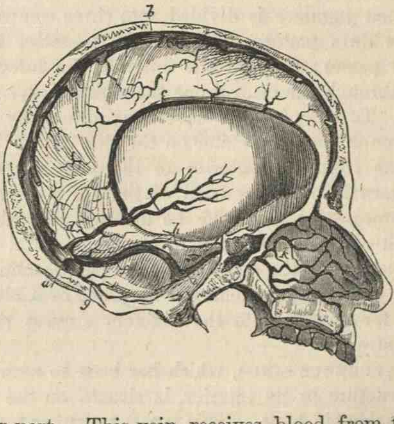
Sinuses of the skull. The SINUSES are venous spaces between the layers of the dura mater, into which the blood is received. All the sinuses open either into a large space named torcular Herophili, opposite the occipital protuberance; or into the two cavernous sinuses on the sides of the body of the sphenoid bone.

Occipital centre receives, A. The TORCULAR HEROPHILI (fig. 1, *a*) is placed in the tentorium, opposite the centre of the occipital bone. It is of an irregular shape, and numerous sinuses open into it, viz. the superior longitudinal above, and the occipital below; the straight in front, and the lateral sinus on each side.

superior and The *superior longitudinal sinus* has been already described (see p. 10).

inferior longitudinal. The *inferior longitudinal sinus* (fig. 1, *c*) resembles a small vein, and is contained in the lower border of the falx cerebri at

Fig. 1.*



the posterior part. This vein receives blood from the falx and the larger brain, and ends in the straight sinus at the edge of the tentorium.

Straight sinus. The *straight sinus* (fig. 1, *d*) lies along the middle of the tentorium, and seems to continue the preceding sinus to the common point of union. Its form is triangular, like the superior longitudinal. Joining it are the inferior longitudinal sinus, the veins

* Some of the sinuses of the skull. *a.* Torcular Herophili. *b.* Superior longitudinal sinus. *c.* Inferior longitudinal. *d.* Straight sinus. *e.* Veins of Galen. *f.* Lateral sinus. *g.* Occipital sinus. *h.* Superior, and *i* inferior petrosal sinus. *k.* Veins of the septum of the nose.

of Galen, *e*, from the interior of the large brain, and some small veins from the upper part of the small brain.

Occipital sinus. The *occipital sinus* (fig. 1, *g*) is a small space in the falx cerebelli, which reaches to the foramen magnum, and collects the blood from the occipital fossæ. This sinus may be double.

Lateral sinus. The *lateral sinus* (fig. 1, *f*) is the channel by which most of the blood passes from the skull. There is one on each side, right and left, which extends from the occipital protuberance to the foramen jugulare, where it ends in the internal jugular vein.

Its position to bone. In this extent the sinus occupies the winding groove in the interior of the skull between the two points of bone before mentioned: and the right is frequently larger than the left.

Sinuses joining it. Besides small veins from the brain, it is joined by the superior petrosal sinus opposite the upper edge of the petrous portion of the temporal bone; and by the inferior petrosal at the foramen jugulare. Oftentimes it communicates with the occipital vein through the mastoid foramen, and sometimes with the veins of the diploë of the skull.

Situation in the foramen jugulare. The foramen jugulare is divided into three compartments by bands of the dura mater. Through the posterior interval the lateral sinus passes; through the anterior the inferior petrosal sinus; and through the central one the eighth nerve.

Dissection. *Dissection.* To examine the cavernous sinus, say on the left side, cut through the dura mater on the side of the body of the sphenoid bone from the anterior to the posterior clinoid process, and internal to the position of the third nerve. Behind the clinoid process, let the knife be directed inwards for about half the width of the basilar part of the occipital bone. By placing the handle of the scalpel in the opening thus made, the extent of the space will be defined. A probe or a blow-pipe will be required for passing into the different sinuses that join the cavernous centre.

Cavernous sinus B. The CAVERNOUS SINUS, which has been so named from the reticulate structure in its interior, is situate on the side of the body of the sphenoid bone. This space, resulting from the separation of the layers of the dura mater, is of an irregular shape, and extends from the sphenoidal fissure to the tip of the petrous portion of the temporal bone.

has nerves in outer wall; The piece of dura mater bounding the sinus externally is of some thickness, and contains in its substance the third and fourth nerves, with the ophthalmic trunk of the fifth nerve, which lie in their numerical order from above down.

The cavity of the sinus is larger behind than before, and in

contains carotid artery and sixth nerve; it are shreds of fibrous tissue with small vessels. Through the space winds the trunk of the internal carotid artery surrounded by the sympathetic, with the sixth nerve on the outer side of the vessel; but all these are shut out from the blood in the space by the thin lining membrane.

and is joined by the following sinuses, viz. The cavernous sinus receives the ophthalmic vein of the orbit, some inferior cerebral veins, and twigs from the pterygoid veins outside the skull. It communicates with its fellow on the opposite side by the circular and transverse sinuses; and its blood is transmitted to the lateral sinus by the superior and inferior petrosal channels.

Circular sinus, The *circular sinus* lies around the pituitary body, and reaches from the one cavernous sinus to the other across the middle line. Besides serving as the means of communcation between those sinuses, it receives small veins from the pituitary body. This sinus is usually destroyed by the removal of the pituitary body.

Transverse sinus, The *transverse* or *basilar sinus* crosses the basilar process of the occipital bone, on a level with the petrous part of the temporal bone, and unites the opposite cavernous sinuses. A second transverse sinus is sometimes found nearer the foramen magnum.

Superior petrosal, The *superior petrosal sinus* (fig. 1, *h*) lies in a groove in the upper margin of the petrous part of the temporal bone, and extends between the cavernous and lateral sinuses. A small vein from the cerebellum, and another from the internal ear, are received into it.

Inferior petrosal. The *inferior petrosal sinus* (fig. 1, *i*) extends between the same sinuses as the preceding, and lies in a groove along the line of junction of the petrous part of the temporal with the basilar process of the occipital bone; it is joined by a small vein from the outside of the skull, through the foramen lacerum at the base of the cranium. This sinus passes through the anterior compartment of the jugular foramen, and ends in the internal jugular vein.

Arteries of dura mater are;— MENINGEAL ARTERIES. These arteries supplying the cranium and the dura mater are found in the three fossæ of the base of the skull; they have been named from their situation, anterior, middle, and posterior meningeal.

Anterior meningeal. The *anterior meningeal* are very small branches of the two ethmoidal arteries (p. 48), which enter the skull by apertures between the frontal and ethmoid bones: they are distributed to the dura mater over and near the ethmoid bone.

Middle meningeal, The *middle meningeal* arteries are three in number: two, named large and small, are derived from the internal maxillary trunk; and the third is an offset of the ascending pharyngeal artery.

from internal maxillary; *a.* The *large meningeal branch* of the internal maxillary artery enters the skull by the foramen spinosum of the sphenoid bone, and ascends towards the anterior inferior angle of the parietal bone. At this spot the vessel enters a deep groove in the cranium, and ends in ramifications that spread over the side of the head, some of them reaching to the top and the occiput, whilst others perforate the bone, and end on the exterior of the head. Two *veins* accompany the artery.

gives branches to dura mater and bone.

Branches. As soon as the artery enters the cranial cavity, it furnishes branches to the dura mater and osseous structure, and to the ganglion of the fifth nerve. One small offset, *petrosal*, enters the hiatus Fallopii, and supplies the surrounding bone (Hyrtl). One or two branches enter the orbit, and anastomose with the ophthalmic artery.

Small meningeal.

b. The *small meningeal* branch is an offset of the large one outside the skull, and is transmitted through the foramen ovale to the membrane lining the middle cranial fossa.

From ascending pharyngeal.

c. Another *meningeal branch* from the ascending pharyngeal artery supplies the middle fossa of the skull, after passing through the foramen lacerum (basis cranii). This is seldom injected, and is then not visible.

Posterior meningeal,

The *posterior meningeal branches* are small, and are furnished by the occipital and vertebral arteries.

from occipital and vertebral.

Those from the occipital, one on each side, enter the skull by the jugular foramen ; and those from the vertebral arise opposite the foramen magnum. Both sets ramify in the posterior fossa of the skull.

Nerves of dura mater.

MENINGEAL NERVES. The source of the nerves of the dura mater is very uncertain. Offsets to it are said to be derived from the fourth, fifth, glosso-pharyngeal, and vagus cranial nerves, and from the sympathetic nerve. To make these nerves apparent, it would be necessary to steep the dura mater in diluted nitric acid.

Cranial nerves in the base of the skull:

CRANIAL NERVES. The cranial nerves pass from the encephalon through apertures in the base of the skull. As each leaves the cranium it is invested by processes of the membranes of the brain, which are thus disposed :—those of the dura mater and pia mater are lost on the nerve ; whilst that of the arachnoid membrane is reflected back, after a short distance, to the interior of the skull. Some of the nerves, those in the middle fossa of the skull for instance, receive sheaths of the dura mater before they approach the foramina of transmission. For the present the nerves will be referred to as nine pairs, but notice will be subsequently taken of a different mode of enumerating them.

only partly seen.

Only part of the course of each nerve will be now seen, the rest must be learnt in the dissection of the base of the brain.

Olfactory nerve,

The FIRST NERVE ends anteriorly in the enlargement of the olfactory bulb. This swelling lies on the cribriform plate of the ethmoid bone, and supplies about twenty branches to

ends in the nose.

the nose through the small foramina in the subjacent bone. These delicate nerves are surrounded by prolongations of the membranes of the brain, and their arrangement will be noticed in the dissection of the nose.

Optic nerve enters the eye.

The SECOND NERVE diverging from its commissure to the eyeball, enters the orbit through the optic foramen; accompanying the nerve is the ophthalmic artery.

Dissection of third and fourth nerves;

Dissection. The third, fourth, and the ophthalmic trunk of the fifth nerve lie in the outer wall of the cavernous sinus; and to see them, it will be necessary to trace them onwards towards the orbit through the dura mater.

of fifth nerve.

Afterwards the student should follow outwards the roots of the fifth nerve into the middle fossa of the skull, taking away the dura mater from them, and the surface of the large Gasserian ganglion which lies on the point of the petrous portion of the temporal bone. From the front of the ganglion arise other two large trunks, viz., superior and inferior maxillary, and these should also be traced to their apertures of exit from the skull. If the dura mater is removed entirely from the bone near the nerves a better dissection will be obtained.

Motor oculi nerve

The THIRD NERVE is destined for the muscles of the orbit. It enters the wall of the cavernous sinus near the anterior clinoid process, and is deprived at that spot of its tube of arachnoid membrane. In the wall of the sinus it is placed above the other nerves; but when it is about to enter the orbit through the sphenoidal fissure, it sinks below the fourth and part of the fifth, and divides into two branches.

passes to orbit.

Near the orbit the nerve is joined by one or two delicate filaments of the cavernous plexus (p. 20).

Trochlear nerve

The FOURTH NERVE courses forwards, like the preceding, to one muscle in the orbit. It is the smallest of the nerves in the wall of the sinus, and is placed below the third; but as it is about to pass through the sphenoidal fissure it rises higher than all the other nerves.

in the wall of sinus.

In the wall of the sinus the fourth nerve is joined by twigs of the sympathetic; and it is sometimes united with the ophthalmic trunk of the fifth.

Trifacial nerve has two roots.

FIFTH NERVE. This nerve is distributed to the face and head, and consists of two parts or roots—a large or sensory, and a small or motory.

The large root of the nerve passes through an aperture in the dura mater into the middle fossa of the base of the skull (fig. 10, [1]). Superficial to the small root it enters immediately the inner side of the Gasserian ganglion.

Gasserian ganglion on large root,

The *ganglion of the root of the fifth nerve* (Gasserian ganglion) (fig. 10 [1]) is placed in a depression on the point of the petrous part of the temporal bone. It is flattened, and is about as wide as the thumb-nail. The upper surface of the ganglion is closely united to the dura mater, and presents a semilunar elevation, whose convexity looks forwards. Some filaments from the plexus of the sympathetic on the carotid artery enters its inner side.

gives three branches.

Branches. From the front of the ganglion proceed the three following trunks :—The ophthalmic nerve (fig. 10, [2]), the first and highest, is destined for the orbit and forehead. Next in order is the superior maxillary nerve, [3], which leaves the skull by the foramen rotundum, and ends in the face below the orbit. And the last, or the inferior maxillary nerve, [4], passes through the foramen ovale to reach the lower jaw, the lower part of the face, and the tongue.

Small root.

The *smaller root*, entering the same tube of dura mater as the large one, passes beneath the ganglion, without communicating with it, and joins only one of the three trunks derived from the ganglion. If the ganglion be raised, this root will be seen to enter the inferior maxillary nerve.

Difference in the use of the roots.

In consequence of the partial blending of the roots, those branches of the ganglion which are unconnected with the smaller or motor root, viz. the ophthalmic and superior maxillary, are solely nerves of sensibility; but the inferior maxillary, which is compounded of both roots, is a nerve of sensibility and motion, like a spinal nerve. The whole of the inferior maxillary nerve has not this double function, for the motor root is mixed almost exclusively with the part of the trunk which supplies the muscles of the lower jaw; and it is, therefore, chiefly that small part of the nerve which possesses a twofold action, and resembles a spinal nerve.

Ophthalmic nerve enters orbit,

The *ophthalmic nerve* is the only one of the three trunks that needs a more special notice in this stage of the dissection. It enters the orbit through the sphenoidal fissure, and is continued through that space to the forehead. In form it is a flat band; and in its course to the orbit the nerve is contained in the wall of the cavernous sinus below the third and fourth nerves. Near the orbit it divides into three branches (p. 43).

supplies dura mater in its course.

In this situation it is joined by filaments of the cavernous plexus of the sympathetic, and gives a small *recurrent* filament to that part of the dura mater which forms the tentorium cerebelli (Arnold).

Abducens nerve is in cavernous sinus;

The SIXTH NERVE enters the orbit through the sphenoidal fissure, and supplies one of the orbital muscles. It pierces the dura mater behind the body of the sphenoid bone, and crosses the space of the cavernous sinus in its course to the orbit, instead of lying in the outer wall of the sinus with the other nerves.

joins sympathetic.

In the sinus the nerve is placed close against the outer side of the carotid artery; and it is joined by one or two large branches of the sympathetic nerve surrounding that vessel.

SEVENTH NERVE according to Willis. This cranial nerve consists of two trunks, facial and auditory, and both enter the meatus auditorius internus. In the bottom of the meatus they separate; the facial nerve courses through the aqueduct of Fallopius to the face, and the auditory nerve is distributed to the internal ear. Seventh nerve has two parts.

EIGHTH NERVE. Three trunks are combined in the eighth cranial nerve of Willis, viz. glosso-pharyngeal, pneumo-gastric, and spinal accessory. All three pass through the central compartment of the foramen jugulare, but all are not contained in one tube of the membranes of the brain. The glosso-pharyngeal nerve is external to the other two, being separated from them by the inferior petrosal sinus, and has distinct sheaths of the dura mater and the arachnoid membrane; but the pneumo-gastric and spinal accessory nerves are inclosed in the same tube of the dura mater, only a piece of the arachnoid intervening between them. Eighth nerve has three parts: their passage through foramen jugulare.

The NINTH NERVE is the motor nerve of the tongue, and consists of two small pieces, which pierce separately the dura mater opposite the anterior condyloid foramen; these unite after passing through that aperture. Ninth nerve.

Dissection. The dissector may now return to the examination of the trunk of the carotid artery as it winds through the cavernous sinus. Dissection of carotid,

On the opposite side of the head, viz. that on which the nerves in the wall of the cavernous sinus are untouched, an attempt may be made to find two small plexuses of the sympathetic on the carotid artery; but in an injected body this dissection is scarcely possible. of sympathetic plexuses:

One of these (cavernous) is near the root of the anterior clinoid process; and to bring it into view it will be necessary to cut off that piece of bone, and to dissect out with care the third, fourth, fifth, and sixth nerves, looking for filaments between them and the plexus. Another plexus (carotid), joining the fifth and sixth nerves, surrounds the artery as this enters the sinus. cavernous, carotid.

The INTERNAL CAROTID ARTERY appears in the base of the skull at the apex of the petrous part of the temporal bone. In its ascent to the brain the vessel lies in the space of the cavernous sinus, along the side of the body of the sphenoid bone, and makes two remarkable bends, so as to look like the letter S reclined. On entering the sinus, the artery ascends at first to the posterior clinoid process; it is then directed forwards to the root of the anterior process of the same name; and lastly it turns upwards internal to this last point of bone, perforates the dura mater bounding the sinus, and divides into cerebral arteries at the base of the brain. In this course the artery is enveloped by nerves derived from the sympathetic in the neck. Internal carotid artery. winds through cavernous sinus.

Branches to dura mater.

The *branches* of the artery are few. In the sinus there are some small arteries (arteriæ receptaculi) for the supply of the dura mater and the bone, the nerves, and the pituitary body; and at the anterior clinoid process the ophthalmic branch arises.

The terminal branches of the carotid will be seen in the dissection of the base of the brain.

Sympathetic forms

Sympathetic Nerve. Around the carotid artery is a prolongation of the sympathetic nerve of the neck, which forms the following plexuses:—

carotid plexus,

The *carotid plexus* is situate on the outer side of the vessel, at its entrance into the cavernous sinus, and communicates with the sixth nerve and the Gasserian ganglion.

cavernous plexus.

The *cavernous plexus* is placed below the bend of the artery which is close to the anterior clinoid process. This small plexus is more immediately connected with that offset of the upper cervical ganglion of the sympathetic, which courses along the inner side of the carotid artery. Filaments are given from the plexus to unite with the third, fourth, and ophthalmic nerves. One filament is also furnished to the lenticular ganglion, either separately from, or in conjunction with the nasal nerve.

Union with cranial nerves.

Distribution.

After forming those plexuses, the nerves surround the trunk of the carotid, and are lost chiefly in the cerebral membrane named pia mater; but some ascend on the cerebral and ophthalmic branches of the carotid, and one offset is said to enter the eyeball with the central artery of the retina.

Three petrosal nerves.

Petrosal nerves. Beneath the Gasserian ganglion is the *large superficial petrosal nerve,* entering the hiatus Fallopii to join the facial nerve. External to this is occasionally seen another small *petrosal* nerve (*external superficial*), which springs from the sympathetic on the middle meningeal artery, and enters the bone to join the facial nerve with the preceding. A third, the *small petrosal* nerve, is contained in the substance of the temporal bone. The source and the destination of those three small nerves will be afterwards learnt. It will suffice now for the student to note the two first, and to see that they are kept moist and fit for examination at a future time.

Two seen in base of skull.

Directions for preserving parts.

Directions. Now the base of the skull has been completed, a preservative fluid or salt should be applied, and the flaps of integuments should be stitched together over all.

SECTION III.

DISSECTION OF THE FACE.

Directions. The left side of the face may be used for the muscles and vessels, and the right side is to be reserved for the nerves. Directions.

Position. The previous position of the body for the examination of the base of the skull will require to be changed. The head is to be lowered, and the side of the face to be dissected is to be placed upwards. Position of body.

Dissection. As a preparatory step, the muscular fibres of the apertures are to be made slightly tense by inserting a small quantity of tow or cotton wool between the eyelids and the eyeball, between the lips and the teeth, and into the opening of the nose. Dissection.

First lay bare the sphincter muscle of the eyelids by a circular incision, only skin deep, over the margin of the orbit, and by raising the skin of the lids towards the aperture of the eye. Much care must be taken in detaching the skin from the thin, and oftentimes pale fibres of the orbicular muscle of the lids, otherwise they will be cut away in consequence of the little areolar tissue that intervenes between the two. How to raise the skin from muscle of eyelid,

Next the integument is to be removed from the side of the face by means of the following incisions :—one is to be made in front of the ear, from above the zygomatic arch to the angle of the jaw; and another is to be continued from the last point along the base of the jaw to the chin. The flap of skin is to be raised from behind forwards, and left adherent along the middle line. On the side of the nose the skin is closely united to the subjacent parts, and must be detached with caution. Around the mouth are many fleshy slips that extend both upwards and downwards from the orbicular muscle, but they are all marked so distinctly as to escape injury, with the exception of the small risorius muscle that comes from the ramus of the lower jaw towards the corner of the mouth. Whilst removing the fat from these muscles, each fleshy slip may be made tense with hooks. from the face, from the side of nose, and around mouth.

The facial vessels and their branches will come into view as the parts are cleaned; but the nerves may be disregarded on this side. Facial vessels

In front of the ear is the parotid gland, whose duct is to be preserved; this is on a level with the meatus auditorius, and pierces the middle of the cheek. and parotid gland.

MUSCLES OF THE FACE. The superficial muscles of the face are gathered around the apertures of the nose, eye, and mouth. In the face the muscles surround the apertures.

An orbicular or sphincter muscle encircles the aperture of the eye and the mouth; and other muscles are blended with each to enlarge the opening in the centre of the fibres. There are three distinct groups of muscles: one of the opening of the eyelids; another of the nostril; and a third of the aperture of the mouth. One of the muscles of mastication, viz. the masseter, is now seen between the jaws.

Muscles of nose.

MUSCLES OF THE NOSE. The muscles of the nose are the following: pyramidalis nasi, compressor naris, levator alæ nasi, dilatator naris, and depressor alæ nasi.

Pyramidalis nasi.

The PYRAMIDALIS NASI (fig. 2, [1]) is a small pyramidal slip that covers the nasal bone, and is continuous above with the occipito-frontalis muscle. Over the cartilaginous part of the nose its fibres end in an aponeurosis, which joins that of the compressor naris. Along its inner border is the muscle of the opposite side.

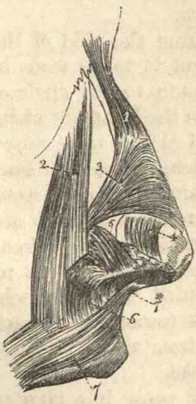
Use.

Action. This muscle makes tight the skin over the nasal cartilages, but renders lax, and sometimes wrinkles transversely the skin towards the root of the nose.

Compressor naris.

COMPRESSOR NARIS. This muscle (fig. 2, [3]) is not well seen till after the examination of the following one. Triangular in shape, it *arises* by its apex from the canine fossa of the upper maxillary bone. The fibres are directed inwards, spreading out at the same time, and end in an aponeurosis, which covers the cartilaginous part of the nose, and joins the tendon of the opposite muscle. This muscle is partly concealed by the next—the common elevator of the ala of the nose and the upper lip.

Fig. 2.*



Use.

Action. It stretches the skin over the cartilaginous part of the nose.

Elevator of wing of nose.

The LEVATOR LABII SUPERIORIS ALÆQUE NASI (fig. 2, [2]) is placed by the side of the nose, and *arises* from the top of the nasal process of the upper maxillary bone, internal to the attachment of the orbicularis. As the fibres descend from the inner part of the orbit, the most internal are attached by a narrow slip to the wing of the nose, whilst the rest are blended inferiorly with the orbicularis oris. Near its origin the muscle is partly concealed by the

* Muscles of the nose and mouth. 1. Pyramidalis nasi. 2. Common elevator of the nose and lip. 3. Compressor naris. 4 and 5. The two slips of the dilatator naris. 6. Depressor alæ nasi. 7* and 7. Orbicularis oris, attached to the septum nasi.

orbicularis palpebrarum, but in the rest of its extent it is subcutaneous. Its outer border joins the elevator of the upper lip.

Action. As the name expresses, it can raise the upper lip, and draw outwards the wing of the nose, dilating the aperture; but it can enlarge the nostril independently of the lip, as when the mouth is shut. **Use.**

Dilatator Naris. In the dense tissue on the outer side of the nostril, are found a few muscular fibres both at the fore and back part of that aperture (fig. 2, [4], and [5]), to which the above name has been given by Theile: they are seldom visible without a lens. The *anterior* slip, [4], passes from the cartilage of the aperture to the integument of the margin of the nostril; and the *posterior*, [5], arises from the upper jawbone and the small sesamoid cartilages, and ends also in the integuments of the nostril. **Dilator of nostril; anterior and posterior parts.**

Action. The fibres enlarge the nasal opening by raising and everting the front and back of the wing of the nose. **Use.**

The DEPRESSOR ALÆ NASI (fig. 2, [6]) will be seen if the upper lip is everted and the mucous membrane is removed from the side of the frænum of that lip. It *arises* below the nose from a depression of the upper jawbone above the roots of the second incisor and canine teeth; and ascends to be *inserted* into the septum nasi and the posterior part of the ala of the nose. **Depressor of wing.**

Action. Drawing down the wing of the nose, and turning in the edge of the dilated nostril, it restores the aperture to the condition of a state of rest. **Use.**

MUSCLES OF THE EYELIDS. The muscles of the eyelids are four in number, viz. orbicularis palpebrarum, corrugator supercilii, levator palpebræ superioris, and tensor tarsi.* The two latter are dissected in the orbit, and will be described with that part. **Four muscles of eyelids.**

The ORBICULARIS PALPEBRARUM (fig. 3, [2]) is the sphincter muscle closing the elliptical opening between the eyelids. It is a flat and thin layer, which extends from the margin of the lids beyond the circumference of the orbit. From a difference in the characters of the fibres, a division has been made of them into two parts—outer and inner. **Orbicularis palpebrarum: two parts.**

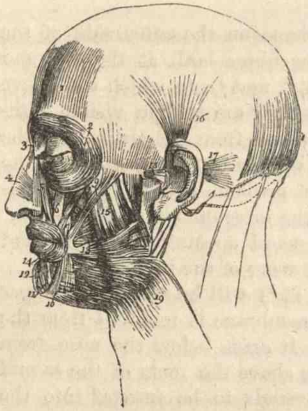
The external fibres (orbital part), the best marked, are fixed only at one point, viz. the inner angle of the orbit. This attachment (origin) is connected with the surface and borders of the small tendo palpebrarum or tarsal ligament; above that tendon with the nasal process of the upper maxillary bone, and the internal angular process of the frontal bone; and below the tendon with the superior maxillary bone, and the inner part of the margin of the orbit. From the origin the fibres are directed **Orbital or external attached internally.**

* The tensor tarsi muscle (p. 51) is sometimes described as a part of the orbicularis.

outwards, giving rise to ovals, which lie side by side, and increase in size towards the outer edge of the muscle, where they project beyond the margin of the orbit.

Internal or palpebral part,

Fig. 3.*



The internal fibres (palpebral part), paler and finer than the outer, occupy the eyelids, and are fixed at both the outer and inner angles of the orbit.

attached at the ends.

Internally (origin) they are united with the tendo palpebrarum, and externally (insertion) with the external tarsal ligament and the malar bone, and some few may blend with the orbital part.

Ciliary bundle.

Close to the cilia or eyelashes the fibres form a small pale bundle, which is sometimes called *ciliary.*

Connection with parts.

The muscle is subcutaneous; and its circumference is free, except above where it is blended with the occipito-frontalis. Beneath the upper half of the orbicularis, as it lies on the margin of the orbit, is the corrugator supercilii muscle with the supraorbital vessels and nerve; and beneath the lower half is part of the elevator of the upper lip. The outer fibres are joined occasionally by slips to the other contiguous muscles below the orbit.

Use of inner and

Action. The inner fibres shut the eye by causing the lids to approach each other; and in forced contraction the outer commissure is drawn inwards. In closure of the eye the lids move unequally—the upper being much depressed, and the lower slightly elevated and moved horizontally inwards.

outer fibres.

When the outer fibres contract, the eyebrow is depressed, and the skin over the edge of the orbit is raised into a roll around the eye, so as to protect the ball. Elevation of the upper lip follows contraction of the outer part of the orbicularis, in consequence of fibres being prolonged to the levator labii superioris.

Corrugator supercilii

The CORRUGATOR SUPERCILII is found beneath the orbicularis, near the inner angle of the orbit. Its fibres *arise* from the inner part of the superciliary ridge of the frontal bone, and are directed

* 1. Occipito-frontalis. 2. Orbicularis palpebrarum. 5. Levator labii superioris et alæ nasi. 6. Levator labii superioris. 7. Levator anguli oris. 8. Zygomaticus minor. 9. Zygomaticus major. 10. Depressor anguli oris. 11. Depressor labii inferioris. 13. points to the buccinator. 14. Orbicularis oris. 15. Masseter. 16, 17, 18. Superior, posterior, and anterior auricular. 19. Platysma myoides.

thence outwards to join the orbicular muscle about the middle of the orbital arch. It is a short muscle, and is distinguished by the closeness of its fibres. **blends with orbicularis.**

Action. It draws inwards and downwards the mid-part of the eyebrow, wrinkling vertically the skin near the nose, and stretching that outside its point of insertion. **Use.**

MUSCLES OF THE MOUTH. The muscles of the aperture of the mouth consist of a sphincter; an elevator of the upper lip, and of the angle of the mouth; depressors of the lower lip and angle of the mouth, with an elevator of the lower lip; together with other small muscles that act on the corner, viz. zygomatici and risorius of Santorini. Lastly, the buccinator muscle may be reckoned in this set, as it acts indirectly on the corner of the mouth. **Muscles of the mouth.**

The ORBICULARIS ORIS MUSCLE (Fig. 3, [14]) surrounds the opening of the mouth, and is united with the several muscles acting on that aperture. It consists of two parts, inner and outer, which differ much in the appearance and arrangement of the fibres. **Sphincter of the mouth consists of two parts,**

The *inner* part (fig. 2, [7]), whose fibres are pale in colour and fine in texture, forms a rounded thick fasciculus, which reaches outwards from the margin of the lip to the arch of the coronary artery. The fibres of this portion of the muscle unattached to bone, blend externally with the buccinators, and some pass from lip to lip round the corner of the mouth. **inner or circular, not fixed to bone.**

The *outer* part is thin, wide, and more irregular in form, and has an attachment to the subjacent bone, besides its union with the adjacent muscles. In the upper lip it is attached, on each side of the middle line, by one slip (naso-labial) to the back of the septum of the nose (fig. 2, [7*]); and by another to the outer surface of the alveolar margin of the upper jaw, opposite the canine tooth, and external to the depressor of the wing of the nose. In the lower lip it is fixed on each side into the inferior jawbone, on the outer aspect, opposite the canine tooth, or external to the levator labii inferioris muscle. To see these attachments the lip must be everted, and the mucous membrane carefully raised. **Outer irregular, fixed to nose and to jaw-bones.**

The inner margin of the muscle is free, and bounds the aperture of the mouth; whilst the outer edge blends with the different muscles that elevate or depress the lips and the angle of the mouth. Beneath the orbicularis in each lip is the coronary artery, with the mucous membrane and the labial glands. **Connections.**

Action. Both parts of the muscle contracting, the lips are pressed together and projected forwards, and the aperture of the mouth is diminished transversely by the approximation of the corners towards each other. **Use of both parts.**

The inner fibres acting alone will turn inwards the red part of the lip, and diminish the width of the buccal opening. **Inner alone.**

Outer alone. The outer fibres press the lips against the dental arches, the free edges being protruded and somewhat everted. At the same time the centre part of the nose is depressed, and the chin raised by means of the fleshy slips connected with those parts.

Elevator of upper lip. The LEVATOR LABII SUPERIORIS (fig. 3, [6]) extends vertically from the lower margin of the orbit to the orbicularis oris. It *arises* from the upper maxillary and malar bones above the infra-orbital foramen, and blends inferiorly with the orbicularis oris. Near the orbit the muscle is overlapped by the orbicularis palpebrarum, but below that spot it is subcutaneous. By its inner side it joins the common elevator of the ala of the nose and upper lip; and to its outer side lie the zygomatic muscles, the small one joining it. Beneath it are the infra-orbital vessels and nerve.

Connections.

Use. *Action.* By the action of this muscle the upper lip is raised, and the skin of the cheek is bulged below the eye.

Depressor of lower lip The DEPRESSOR LABII INFERIORIS (fig. 3, [11]) is opposite the elevator of the upper lip, and has much yellow fat mixed with its fibres. The muscle has a wide *origin* from a depression on the front of the lower jaw, reaching backwards from near the symphysis to a little beyond the hole for the labial vessels and nerve; ascending thence it is united with the orbicularis in the lower lip. Its inner border joins the muscle of the opposite side, and its outer is overlapped by the depressor anguli oris.

is in the middle of chin.

Use. *Action.* If one muscle contracts, the half of the lip of the same side is depressed and everted; but by the use of both muscles, the whole lip is lowered and turned outwards, and rendered tense at the centre.

Elevator of chin. The LEVATOR LABII INFERIORIS (fig. 3, [12]) is a small muscle on the side of the frænum of the lower lip, which is opposite to the depressor of the ala of the nose in the upper lip. When the lip has been everted and the mucous membrane removed, the muscle will be seen to *arise* from a fossa near the symphysis of the lower jaw, and to descend to its *insertion* into the integument of the chin. Its position is internal to the depressor of the lip, and the attachment of the orbicularis.

Use. *Action.* It indents the skin of the chin opposite its insertion, and assists in raising the lower lip.

Elevator of the angle The LEVATOR ANGULI ORIS (fig. 3, [7]) has well-marked fibres, and is partly concealed by the levator labii superioris. Arising from the canine fossa beneath the infra-orbital foramen, its fibres spread out towards the angle of the mouth where they are superficial to the buccinator, and mix with the rest of the muscles, but the greater number are continued into the depressor anguli oris and the lower lip.

joins depressor.

Use. *Action.* This muscle elevates the corner of the mouth, and acts as an antagonist to the depressor.

The DEPRESSOR ANGULI ORIS (fig. 3, [10]) is triangular in shape; it *arises* from the oblique line on the outer surface of the lower jaw, and ascending to the angle of the mouth, its fibres are prolonged into the elevator of the angle. This muscle conceals the labial branch of the inferior dental vessels and nerve. At its origin the depressor is united with the platysma myoides, and near its insertion with the risorius muscle. Depressor of angle.

Action. The angle of the mouth is drawn downwards and backwards, as is exemplified in a sorrowful countenance. Use.

The ZYGOMATIC MUSCLES (fig. 3, [8], [9]) are directed obliquely from the arch of the same name towards the angle of the mouth. One is longer and larger than the other; and they are therefore named major and minor. Zygomatic muscles;

The *zygomaticus major*, [9], arises from the outer part of the malar bone, and is inserted into the angle of the mouth. large and

The *zygomaticus minor*, [8], is attached to the malar bone anterior to the other, and blends with the fibres of the special elevator of the upper lip. small.

Action. The large muscle inclines upwards and backwards the corner of the mouth; and the small one assists the levator labii superioris in raising the upper lip. Use.

The RISORIUS MUSCLE (Santorini) is a thin and narrow bundle of fibres, sometimes divided into two or more parts, which arises externally from the fascia over the masseter muscle, and is connected internally with the apex of the depressor anguli oris. Risorius muscle.

Action. The use of this muscle is indicated by its name, as it retracts the corner of the mouth in laughing. Use.

The BUCCINATOR (fig. 3, [13]) is a flat and thin muscle of the cheek, and occupies the interval between the jaws. The muscle *arises* from the outer surface of the alveolar borders of the upper and lower maxillæ, as far forwards in each as the first molar tooth; and in the interval between the jaws it is attached to a band of fascia—the pterygo-maxillary ligament. From the origin the fibres are directed forwards to the angle of the mouth, where they mix with the other muscles and with both parts of the orbicularis; and as some of the central fibres descend to the lower lip whilst others ascend to the upper lip, a decussation takes place at the corner of the mouth. Buccinator muscle. Origin. Insertion at corners of the mouth.

On the cutaneous surface of the buccinator are the different muscles that converge to the angle of the mouth; and crossing the upper part is the duct of the parotid gland, which perforates the muscle opposite the second upper molar tooth. Internally the muscle is lined by the mucous membrane of the mouth, and externally it is covered by a fascia (bucco-pharyngeal) that is continued to the pharynx. By its intermaxillary origin the buccinator corresponds with the attachment of the superior constrictor of the pharynx. Parts in contact with it.

Use on aperture,

Action. By one muscle the corner of the mouth is retracted and the cheek wrinkled. By both acting the aperture of the mouth is widened transversely.

on cheek,

In mastication the cheek is pressed by the muscular contraction against the dental arches, when the corner of the mouth is fixed by the sphincter.

in expelling air.

In the expulsion of air from the mouth, as in whistling, the muscle is contracted so as to prevent bulging of the cheek; but in the use of a blow-pipe it is distended over the volume of air contained in the mouth, and drives out a continuous stream of air by its action.

Arteries of the face.

The VESSELS OF THE FACE are the facial and transverse facial arteries with their accompanying veins. The arteries are branches of the external carotid; and the facial vein is received into the internal jugular trunk.

Facial artery:

course,

and connections.

The *facial artery* emerges from the neck, and appears on the lower jaw anterior to the masseter muscle. From this point the artery ascends in a tortuous manner, near the angle of the mouth and the side of the nose, to the inner angle of the orbit, where it anastomoses with the ophthalmic artery. The course of the vessel is comparatively superficial, though lying in the mass of fat of the inner part of the cheek. At first the artery is concealed by the platysma whilst crossing the jaw, but this thin muscle does not prevent pulsation being recognised during life; and near the mouth the large zygomatic muscle is superficial to it. The vessel rests successively on the lower jaw, buccinator muscle, elevator of the angle of the mouth, and elevator of the upper lip. Accompanying the artery is the facial vein, which is nearly a straight tube, and lies to the outer side.

Plan of the branches.

Branches. From the outer side of the vessel unnamed branches are furnished to the muscles and integuments, some of which anastomose with the transverse facial artery. From the inner side are given the following branches:—

Inferior labial.

The *inferior labial branch* runs inwards beneath the depressor anguli oris muscle, and is distributed between the lower lip and chin; it communicates with the inferior coronary, and with the labial branch of the inferior dental artery.

Two coronary form an arch in the lips.

Coronary branches. There is one for each lip (superior and inferior), which arise together or separately from the facial, and are directed inwards between the orbicular muscle and the mucous membrane of the lip, till they inosculate with the corresponding branches of the opposite side. From the arterial arches thus formed, offsets are supplied to the lips and labial glands.

Branch to nose.

From the arch in the upper lip a branch is given to each side of the septum of the nose,—*artery of the septum.*

Lateral nasal branch.

The *lateral nasal branch* arises opposite the ala nasi, and passes beneath the levator labii superioris alæque nasi to the side of the nose where it anastomoses with the nasal branch of the ophthalmic artery.

The *angular branch* is the terminal twig of the facial artery at the inner angle of the orbit, and joins with a branch (nasal) of the ophthalmic artery. **Angular branch.**

The *facial vein* commences at the root of the nose by a small vein named angular (p. 6). It then crosses over the elevator of the upper lip, and separating from the artery, courses beneath the large zygomatic muscle to the side of the jaw. Afterwards it has a short course in the neck to join the internal jugular vein. **Facial vein away from artery;**

Branches. At the inner side of the orbit it receives veins from the lower eyelid, *inferior palpebral*, and from the side of the nose. Below the orbit it is joined by the *infra-orbital vein*, also by a large branch that comes from the pterygoid region, *anterior internal maxillary;* and thence to its termination by veins corresponding with the branches of the artery in the face and neck. **joined by branches.**

The *transverse facial artery* is a branch of the temporal, and appears in the face at the anterior border of the parotid gland. It lies by the side of the parotid duct, with branches of the facial nerve, and distributes offsets to the muscles and integuments; some branches anastomose with the facial artery. **Transverse facial artery.**

Dissection. The parotid gland may be next displayed. To see the gland, raise the skin from the surface towards the ear by means of a cut from the base of the jaw to the anterior border of the sterno-mastoid muscle; this cut may be united with that made for the dissection of the posterior muscle of the ear. A strong fascia covers the gland, and is connected above and behind to the zygomatic arch and the cartilage of the ear, but is continued over the face in front; this is to be removed. The great auricular nerve will be seen ascending to the lobe of the ear; and one or two small glands rest on the surface of the parotid. **Lay bare the parotid.**

The PAROTID (fig. 14, [10]) is the largest of the salivary glands. It occupies the space between the ear and the lower jaw, and is named from its position. Its excretory duct enters the mouth through the middle of the cheek. **Parotid gland.**

The shape of the gland is irregular, and is determined somewhat by the bounding parts. Thus inferiorly, where there is not any resisting structure, the parotid projects into the neck, and comes into close proximity with the sub-maxillary gland, though separated from it by a process of the cervical fascia; a line from the angle of the jaw to the sterno-mastoid muscle marks usually the extent of the gland in this direction. Above, the parotid is limited by the zygomatic arch and the temporal bone. Along the posterior part the sterno-mastoid muscle extends; but anteriorly the gland projects somewhat on the face, and in this **Irregular in shape; connections;**

accessory part. direction a small accessory part, *socia parotidis*, is prolonged from it over the masseter.

The duct reaches mouth. Connected with the anterior border is the excretory duct—duct of Stenson (*ductus Stenonis*), which crosses the masseter below the *socia parotidis*, and perforates the cheek obliquely opposite the second molar tooth of the upper jaw. The duct lies between the transverse facial artery and some branches of the facial nerve, the latter being below it. A line drawn from the meatus auditorius to a little below the nostril would mark the level of the duct in the face; and the central point of the line would be opposite the opening into the mouth. Its length and size. The length of the duct is about two inches and a half; and its capacity is large enough to allow a small probe to pass, but the opening into the mouth is much less.

Surface of gland. The cutaneous surface of the parotid is smooth, and one or two lymphatic glands are seated on it; but from the deep part processes are sent into the inequalities of the space between the jaw and the mastoid process.

Dissection to see deep parts. *Dissection.* By removing with caution the parotid gland, the hollows that it fills will come into view: at the same time the dissector will see the vessels and nerves that pass through it. An examination of the processes of the gland, and of the number of important vessels that are in relation with it, will demonstrate the impossibility of completely removing this body, and the dangers attending any operation on it. The duct may now be opened, and a good-sized pin may be passed along it to the mouth to show the diminished size of its aperture.

Deep part sinks behind jaw. Two large processes of the gland extend deeply into the neck. One dips behind the styloid process, and projects beneath the mastoid process and sterno-mastoid muscle, whilst it reaches also the deep vessels and nerves of the neck. The other piece is situate in front of the styloid process; it passes into the glenoid hollow behind the articulation of the lower jaw, and sinks beneath the ramus of that bone along the internal maxillary artery.

Vessels and nerves in the gland. Passing through the middle of the gland is the external carotid artery, which ascends behind the ramus of the jaw, and furnishes the auricular, superficial temporal, and internal maxillary branches. Superficial to the artery is the trunk formed by the junction of the temporal and internal maxillary veins, from which the external jugular vein springs; and this common trunk, receiving some veins from the parotid, is connected with the internal jugular vein by a branch through the gland.* Crossing the gland

* Oftentimes a different arrangement of these veins will be found. In such case the external jugular is continued from the occipital (half or all) and posterior auricular veins; whilst the temporal and internal maxillary veins unite to form a trunk (temporo-maxillary), which receives the facial below the jaw, and opens into the internal jugular vein opposite

from behind forwards is the trunk of the facial nerve, which passes over the artery, and distributes its branches through the parotid. The superficial temporal branch of the inferior maxillary nerve lies above the upper part of the glandular mass; and offsets of the great auricular nerve pierce the gland at the lower part, and join the facial.

Structure of gland.

The *structure* of the parotid resembles that of the other salivary glands. The glandular mass is divided into numerous small lobules by intervening processes of fascia; and each lobule consists of a set of the fine closed saccular extremities of the excretory duct, which are lined by flattened and nucleated epithelium, and surrounded by capillary vessels. These little sacs form by their aggregation the mass of each lobule.

The duct has two coats.

From the lobules issue small ducts, which unite to form larger tubes, and finally all the ducts of the gland are collected into one. An examination of the common duct (duct of Stenson) will show it to be composed of an external fibrous coat, consisting of white and elastic fibres; and of an internal mucous coat which is covered with columnar epithelium.

Vessels and nerves.

The parotid receives its *arteries* from the external carotid; and its *nerves* from the sympathetic, auriculo-temporal of the fifth, facial, and great auricular. Its *lymphatics* join those of the neck.

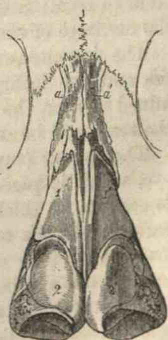
Molar glands.

Two or three small *molar* glands lie along the origin of the buccinator, and open into the mouth near the last molar tooth by separate ducts.

Nasal cartilages.

Cartilages of the Nose. These close the anterior nasal aperture in the skeleton, and form part of the outer nose and the septum. They are five in number, two on each side—lateral cartilage and cartilage of the aperture; together with a central one, or the cartilage of the septum of the nose. Only the lateral cartilages are seen in this stage of the dissection.

Fig 4.*



Take away tissue from surface.

Dissection. The lateral cartilages will be seen when all the muscular and fibrous structure of the left side of the nose, and the skin of the lower part of the nostril of the same side, have been taken away. By turning aside the lateral cartilages that of the septum will appear in the middle line.

The upper

The *upper lateral cartilage* (fig. 4, [1]) is flattened, and is some-

the upper border of the thyroid cartilage. When this condition exists, the temporo-maxillary trunk accompanies the external carotid artery.

* Lateral cartilages of the nose (Arnold). 1. Upper lateral cartilage. 2. Lower lateral, or the cartilage of the aperture.

cartilage touches its fellow. what triangular in form. Posteriorly it is attached to the nasal and superior maxillary bones; and anteriorly it meets the one of the opposite side for a short distance above, but the two are separated below by an interval, in which the cartilage of the septum appears. Inferiorly the lateral cartilage is contiguous to the cartilage of the aperture, and is connected to it by fibrous tissue.

The lower surrounds aperture. The *cartilage of the aperture* (fig. 4, [2]) forms nearly a ring around the opening of the nose. In front it is bent at an acute angle, and from this point a part extends backwards on both the outer and inner sides of the nostril. The cartilage of the aperture has not any attachment directly to bone; but it is united above to the lateral cartilage by fibrous tissue, and is connected below with the dense teguments that form the margin of the aperture of the nostril. At the tip of the nose the cartilages of opposite sides touch.

Not inserted into bone.

One part outside; The *part* of the cartilage, which bounds the opening externally, does not reach downwards to the margin of the nostril, but ceases on a level with the groove on the outer aspect of the wing of the nose; it is narrow and pointed behind, but swells out in front, and forms with its fellow the apex of the nose.

another inside nostril. The *inner part* is narrower, and projects backwards along the septum of the nose nearly to the superior maxillary bone; it assists in the formation of the partition between the nostrils, and extends below the level of the septum nasi.

Accessory cartilages. Behind the outer half of the cartilage of the aperture, in the dense tissue that fixes it to the bone, are two or three small pieces of cartilage—*cartilagines minores* vel *sesamoideæ*, which seem to result from the breaking up of the hinder extremity of the cartilage of the aperture.

Appendages of the eye. The APPENDAGES OF THE EYE include the eyebrow, the eyelid, and the lachrymal apparatus. Some of these can be examined now on the opposite side of the face. The apparatus for the tears will be dissected after the orbit has been completed.

Eyebrow. The *eyebrow* (supercilium) is a curved eminence just above the eye, which is placed over the orbital arch of the frontal bone. It consists of thickened integuments, and its prominence is in part due to the subjacent orbicularis palpebrarum. It is furnished with long coarse hairs, which are directed outwards, and towards one another.

Eyelids. The *eyelids* are two moveable semilunar folds in front of the eye, which can be approached or separated over the eyeball.

Upper largest: The upper lid is the largest and the most moveable, and descends below the middle of the eyeball when the two meet; it is also provided with a special muscle to raise it. The interval between the open lids is named *fissura palpebrarum*. Externally and internally they are united by a commissure or *canthus*.

shape of margin. The free margin is thicker than the rest of the lid, and is semilunar in form for the most part (fig. 11); but towards the inner side, or about a quarter of an inch from the commissure, it becomes straighter. At the spot where the two parts join is a small white eminence, the *papilla lachrymalis;* and in this is the *punctum lachrymale* or the opening of the canal for the tears. Papilla. Punctum.

This margin is provided anteriorly with the eyelashes, and near the posterior edge with a row of small openings of the Meibomian glands: but both the cilia and the glands are absent from the part of the lid which is internal to the opening of the punctum lachrymale. The free margin of each lid is sharp at the anterior edge where it touches its fellow; but is rounded at the posterior, so as to leave an interval between it and the ball for the passage inwards of fluid. Hairs and apertures.

The *eyelashes* (cilia) are two or more rows of curved hairs, which are fixed into the anterior edge of the free border of the lid; they are largest in the upper lid, and diminish in length from the centre towards the sides. The cilia are convex towards one another, and cross when the lids are shut. Eyelashes.

Structure of the Eyelids. Each lid consists fundamentally of a piece of cartilage attached to the bone by ligaments. Superficial to this framework are the integuments with a layer of fibres of the orbicularis palpebrarum, and beneath it a mucous lining of the conjunctiva. The upper lid has also the tendon of the levator palpebræ. Vessels and nerves are contained in the lids. Different parts in eyelids.

Dissection. The student may learn the structure of the lids on the left side, on which the muscles are dissected. Let the bit of tow or wool remain beneath the lids; and let the palpebral part of the orbicularis palpebrarum be thrown inwards by means of an incision around the margin of the orbit. In raising the muscle care must be taken of the thin membranous palpebral ligament, and of the vessels and nerves of the lid. Examine structure of lids.

Orbicularis palpebrarum. The palpebral fibres of this muscle form a pale layer which reaches the free edge of the eyelids (p. 24). A thin stratum of areolar tissue without fat unites the muscle with the skin. Layer of orbicularis.

The *palpebral ligament* is a stratum of fibrous membrane, which is continued from the margin of the orbit to join the ciliary or free edge of each tarsal cartilage. At the inner part of the orbit the ligament is thin and loose, but at the outer part it is somewhat thicker and stronger. A fibrous layer.

The *tarsal cartilages*, one for each eyelid, maintain the form and give strength to the lids, and are formed of yellow or spongy cartilage. Each is fixed internally by the ligament or *tendon* of the eyelids, and externally by a fibrous band—external *tarsal ligament*, to the outer part of the orbit. The margin corresponding with the edge of the lid is free, and thicker than the Cartilage forms part of the lid.

rest of the cartilage. On the inner surface each cartilage is lined by the mucous membrane or conjunctiva.

Difference in the two lids.

The cartilages are not alike in the two lids. In the upper eyelid, where the cartilage is largest, it is crescentic in shape, and is about half an inch wide in the centre; and to its fore part the tendon of the levator palpebræ is attached. In the lower lid the cartilage is a narrow band, about two lines broad, with borders nearly straight.

Ligament of eyelids attaches cartilages.

Ligament or *tendon of the eyelids* (tendo palpebrarum, internal tarsal ligament) is a small fibrous band at the inner part of the orbit, which serves to fix the lids, and is attached to the anterior margin of the lachrymal groove in the upper jaw. It is about a quarter of an inch long, and divides into two processes, which are united one with each tarsal cartilage. This ligament crosses over the lachrymal sac, to which it gives a fibrous expansion, and the fleshy fibres of the orbicularis palpebrarum arise from it.

Sebaceous tubes beneath cartilage,

The *Meibomian glands* or follicles are placed in grooves on the ocular surface of the tarsal cartilages. They extend, parallel to one another, from the thick towards the opposite margin of the cartilage; and their number is about thirty in the upper, and twenty in the lower lid. The apertures of the glands open in a line on the free border of the lid near the posterior edge.

their structure.

Each gland is a small yellowish tube, closed at one end, and having minute lateral cæcal appendages connected with it. Each contains a sebaceous secretion, and is lined by flattened epithelium.

Tendon of levator palpebræ.

If the palpebral ligament be cut through in the upper lid, the *tendon* of the *levator palpebræ* will be seen to be inserted into all the fore part of the tarsal cartilage by a wide aponeurotic expansion.

Mucous lining of lid

The *conjunctiva*, or the mucous membrane, lines the interior of the eyelids, and covers the anterior part of the ball of the eye. Inside the lids it is inseparably united to the tarsal cartilages, and has numerous fine papillæ. At the free margin of the lid this membrane joins the common integuments. Through the lachrymal canals and sac it is continuous with the pituitary membrane of the nose.

forms caruncle

At the inner commissure of the eyelids the conjunctiva forms a prominent and fleshy-looking body—*caruncula lachrymalis*, (fig. 11, [5]) which contains a group of mucous follicles, and has a few minute hairs on its surface. External to the caruncle is a small fold of the mucous membrane—*plica semilunaris* (fig. 8, [4]); this extends to the ball of the eye, and represents the membrana nictitans of birds.

and contiguous fold.

Arteries of lids.

Bloodvessels of the eyelids. The *arteries* of the eyelids are furnished by the ophthalmic artery, and come from the palpebral and lachrymal branches :—

The *palpebral arteries*, one for each eyelid, run outwards from the inner canthus, lying between the tarsal cartilage and the tendon of the special elevator in the upper lid, and between the cartilage and the palpebral ligament in the lower lid ; and they anastomose externally with the lachrymal artery. From the arch that each forms, branches are distributed to the eyelids. Palpebral

The *lachrymal artery* furnishes an offset to each lid to form arches with the palpebral arteries, and then perforates the palpebral ligament at the outer part of the orbit to end in the upper lid. and lachrymal.

The *veins* of the lids open into the frontal and angular veins at the root of the nose. Veins.

The *nerves* of the eyelids are supplied from the ophthalmic and facial nerves. Nerves of lids

The branches of the ophthalmic nerve (of the fifth) which give offsets to the upper lid, are the following: *lachrymal*, near the outer part ; *supra-orbital*, about the middle ; and *supra-trochlear* and *infra-trochlear* at the inner side (pp. 7, 43). In the lower eyelid, about its middle, is a *branch* of the *superior maxillary trunk* of the fifth nerve. from fifth

The *branches* of the *facial nerve* enter both lids at the outer part, and supply the orbicularis muscle ; they communicate with the branches of the fifth nerve. and seventh nerve.

External Ear. The outer ear consists of a trumpet-shaped structure, named pinna or auricle, which collects sounds ; and of a tube—meatus auditorius, which conveys those sounds to the inner ear. The pinna may be examined on the left side of the head ; but the anatomy of the meatus will be described with the rest of the ear. Parts of external ear.

The *pinna*, or *auricle of the ear*, is an uneven piece of yellow cartilage, which is covered with integument, and is fixed to the margin of the meatus auditorius externus. It is of an oval form, with the margin folded, and the larger end placed upwards. Texture and form of pinna.

The surface next the head is generally convex ; but the opposite one is excavated, and presents the undermentioned elevations and depressions. In the centre is a deep hollow named *concha*, which is wide above but narrow below ; it conducts to the meatus auditorius. In front of the narrowed part of the hollow is a projection of a triangular shape—the *tragus*, which has some hairs on the under-surface ; and on the opposite side of the same narrow end, rather below the level of the tragus, is placed another projection,—the *antitragus*. Surfaces marked by fossæ and eminences.

The round, rim-like margin of the ear which extends into the concha is called the *helix ;* and the depression internal to it is the groove, or *fossa of the helix*. Within the helix, between it Margin.

and the concha, is the large eminence of the *antihelix*, which presents at the upper part a well-marked depression, the *fossa of the antihelix.*

Lobule.

Inferiorly the external ear is terminated by a soft, pendulous part, the *lobule.*

Five small muscles of external ear.

The *special muscles of the pinna*, which extend from one part of the cartilage to another, are very thin and pale; and in some bodies all cannot be found. Five small muscles are to be recognised; and these receive their names for the most part from the several eminences of the external ear.

How to find the muscles.

Dissection. In seeking the small auricular muscles, let the integuments be removed only over the spot where each muscle is said to be placed. A sharp knife and a good light are necessary for the display of the muscular fibres. Occasionally the dissector will not find one or more of the set described below.

One muscle on tragus.

The *muscle of the tragus* (fig. 5, 3) is always found on the external aspect of the process from which it takes its name.

Fig. 5.*

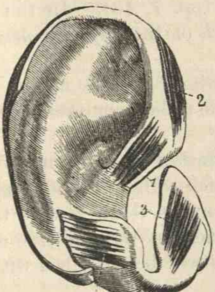
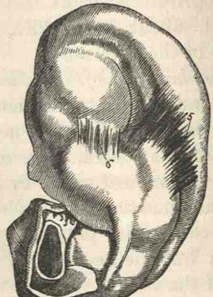


Fig. 6.†



The fibres are short, oblique, or transverse, and extend from the outer to the inner part of the tragus.

One on antitragus.

The *muscle of the antitragus* (fig. 5, 4) is the best marked of all. It *arises* from the outer part of the antitragus, and the fibres are directed upwards to be *inserted* into the pointed extremity of the antihelix.

One on root of helix.

The *small muscle of the helix* (fig. 5, 1) is often indistinct or absent. It is placed on the part of the rim of the ear that extends into the concha.

* Muscles on the front of the ear. 1. Small muscle of the helix. 2. Large muscle of the helix. 3. Muscle of the tragus. 4. Muscle of the antitragus.

† Back of the cartilage of the ear. 5. Transverse muscle. 6. Oblique muscle (Tod) sometimes seen.

The *large muscle of the helix* (fig. 5, [2]) arises above the small muscle of the same part, and is inserted into the front of the helix, where this is about to curve backwards. It is usually present. Another on helix.

The *transverse muscle of the auricle* (fig. 6, [5]) forms a wide layer, which is situate at the back of the ear in the depression between the antihelix and the convexity of the surface. It *arises* from the convexity of the cartilage forming the concha, and is *inserted* into the back of the antihelix. The muscle is mixed with much fibrous tissue, but it is well seen when that tissue is removed. And one at back of concha.

Actions. These muscles are said to alter slightly the condition of the outer ear; the muscles of the helix assisting, and those of the tragus and antitragus retarding the passage of sonorous undulations to the meatus. Use.

Dissection. The pinna may now be detached by cutting it close to the bone. When the integuments are entirely taken off, the cartilage of the pinna will be apparent; but in removing the integuments, the lobule of the ear, which consists only of skin and fat, will disappear. Clean the cartilage.

The *cartilage of the pinna* resembles much the external ear in form, and presents for notice nearly the same parts. The rim of the helix, however, subsides posteriorly in the antihelix about the middle of the pinna; whilst anteriorly a small process projects from it, and there is a fissure near that projection. The antihelix is divided inferiorly into two pieces; one of these is pointed, and is joined by the helix, the other is continued into the antitragus. On the posterior aspect of the concha is a strong vertical process of cartilage. Cartilage forms part of external ear. Deficient inferiorly

Inferiorly the cartilage is fixed to the margin of the external auditory aperture in the temporal bone, and forms the outer part of the meatus auditorius; but it does not give rise to a complete tube, for the upper and posterior part of that canal is closed by fibrous tissue. and at upper part of meatus.

In the piece of cartilage forming the under part of the meatus are two *fissures* (Santorini), one is at the base of the tragus, the other passes from before backwards. Its fissures.

Some *ligaments* connect the pinna with the head, but others pass from one point of the cartilage to another. Ligaments:

The *external* ligaments are condensed bands of fibrous tissue which extend between the same points as the external muscles (p. 2), though commonly only an anterior and a posterior are described. The chief *special* ligament crosses the interval between the tragus and the beginning of the helix, and completes the tube of the meatus. external; special.

The FACIAL NERVE (portio dura, fig. 7, [1]) or the seventh cranial nerve, confers motor power on the muscles of the face. Outline of facial nerve.

Numerous communications take place between it and the fifth nerve; and the chief of these are found above and below the orbit, and over the body of the lower jaw.

Dissection of nerve

Dissection. The facial nerve is to be displayed on the right side of the face if there is time sufficient before the body is turned, otherwise it is to be omitted for the present (see p. 1). Some of the nerve is concealed by the parotid gland, but the greater part is anterior to the glandular mass.

beyond parotid,

To expose the ramifications of the nerve beyond the parotid gland, let the skin be raised from the face in the same manner as on the left side. The different branches are then to be sought as they escape from beneath the anterior border of the gland, and are to be followed forwards to their termination.

on temple,

The highest branches to the temple have been already partly dissected above the zygomatic arch; and their junctions with the temporal branch of the superior maxillary, and with the supra-orbital nerve have been seen. Other still smaller branches are to be traced to the outer part of the orbit, where they enter the eyelids and communicate with the other nerves in the lids; as these cross the malar bone, a junction is to be found with the subcutaneous malar nerve of the fifth.

in eyelids,

in the face,

With the duct of the parotid are two or more large branches, which are to be followed below the orbit to their junction with the infra-orbital, nasal, and infra-trochlear nerves.

on lower jaw.

The remaining branches to the lower part of the face are smaller in size. One joins with the buccal nerve at the lower part of the buccinator muscle; and one or two others are to be traced forwards to the lower lip, and to the labial branch of the inferior dental nerve.

The nerve in the parotid,

To follow backwards the trunk of the nerve through the gland, the integuments should be taken from the surface of the parotid as on the other side, and the gland should be removed piece by piece. In this proceeding the small branches of communication of the great auricular nerve with offsets of the facial, and the branches that dip down from the facial to the auriculo-temporal nerve, are to be sought.

and muscular branches.

Lastly, the first small branches of the facial to the back of the ear, and to the digastric and stylo-hyoid muscles, are to be looked for close to the base of the skull before the nerve enters the parotid.

Branches outside the skull.

THE NERVE OUTSIDE THE SKULL. The nerve issues from the stylo-mastoid foramen, after traversing the aqueduct of Fallopius, and furnishes immediately the three following small branches:—

Posterior auricular branch.

The *posterior auricular branch* (fig. 7, [2]) turns upwards in front of the mastoid process, where it communicates with the great auricular, and is said to be joined by a branch to the ear from the pneumo-gastric (cranial) nerve; it ends in auricular and mastoid offsets (p. 7).

The *branch to the digastric muscle* generally arises in common with the next. It is distributed by many offsets to the posterior belly of the muscle near the skull. Sometimes one of these offsets passes through the fleshy fibres, and joins the glosso-pharyngeal nerve. Branch to digastric.

The *branch to the stylo-hyoideus* is a long slender nerve, which is directed inwards, and enters its muscle about the middle. This branch communicates with the sympathetic nerve on the external carotid artery. Branch to stylo-hyoideus.

As soon as the facial nerve has given off those branches, it is directed forwards through the gland, and divides near the ramus of the jaw into two large trunks—temporo-facial and cervico-facial. Division into two.

The TEMPORO-FACIAL TRUNK furnishes offsets to the side of the head and face, whose ramifications extend as low as the meatus auditorius. As this trunk crosses over the external carotid artery, it sends downwards branches to join the auriculo-temporal portion of the inferior maxillary nerve; and in front of the ear it gives some filaments to the tragus of the pinna. Three sets of terminal branches, temporal, malar, and infra-orbital, are derived from the temporo-facial nerve. The upper part of the trunk has three sets of branches.

The *temporal branches* ascend obliquely over the zygomatic arch to enter the orbicular muscle, the corrugator supercilii, and the anterior belly of the occipito-frontalis; they are united with offsets of the supra-orbital nerve. The attrahens aurem muscle receives a branch from this set; and a junction takes place above the zygoma with the temporal branch of the superior maxillary nerve. Temporal branches to side of head.

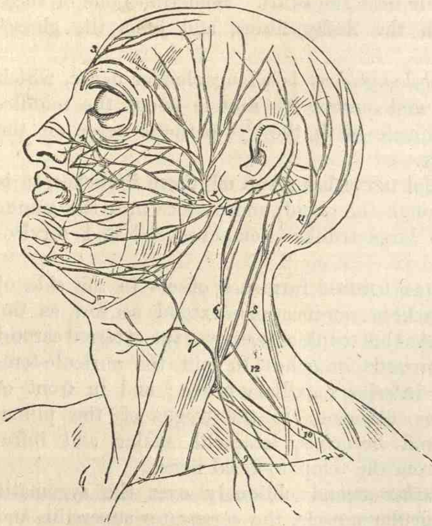
The *malar branches* are directed to the outer angle of the orbit, and are distributed to the orbicularis muscle. In the eye-lids communications take place with the palpebral filaments of the fifth nerve (p. 35); and near the outer part of the orbit, with the small subcutaneous malar branch of the superior maxillary nerve. Malar branches to eyelids.

The *infra-orbital branches* are larger than the rest, and are furnished to the muscles and the integument between the eye and mouth. Close to the orbit, and beneath the elevator of the upper lip, a remarkable communication—*infra-orbital plexus*, is formed between these nerves and the infra-orbital branches of the superior maxillary. After crossing the branches of the fifth nerve, some small offsets of the facial nerve pass inwards to the side of the nose, and others upwards to the inner angle of the orbit, to supply the muscles, and to join the nasal and infra-trochlear branches of the ophthalmic nerve. Branches between eye and mouth.

The CERVICO-FACIAL is smaller than the other trunk, and dis- Lower part of the trunk tributes nerves to the lower part of the face and the upper part of the neck. Its highest branches join the lowest offsets of the temporo-facial nerve, and thus complete the network on the face. This trunk, whilst in the parotid, gives twigs to the gland, and is united with the great auricular nerve. The terminal branches distributed from it are, buccal, supra-maxillary, and infra-maxillary.

three sets of branches.

Fig. 7.*



Buccal to corner of mouth.

The *buccal branches* pass forwards towards the angle of the mouth, giving offsets to the buccinator muscle, and terminate in the orbicularis oris. On the buccinator they join the branch of the inferior maxillary nerve to that muscle.

Supra-maxillary between mouth and chin.

The *supra-maxillary branches* course inwards above the base of the lower jaw to the middle line of the chin, and supply the muscles and the integument between the chin and mouth. Beneath the depressor anguli oris the branches of the facial join offsets of the labial branch of the inferior dental nerve, in the same manner as the junction is made below the orbit; and the branches of the facial cross those of the fifth nerve in their course to the middle line.

Infra-maxillary to neck.

The *infra-maxillary branches* are placed below the jaw, and are distributed to the upper part of the neck. The anatomy of these nerves will be given with the dissection of the anterior triangle of the neck (p. 62).

* Plan of the facial nerve, and the superficial branches of the cervical plexus. 1. Facial nerve. 2. Posterior auricular branch. 3. Supra-orbital nerve. 4. Infra-orbital. 5. Inferior dental, labial branch. 6. Great auricular nerve. 7. Superficial cervical nerve. 8. Small occipital. 9 and 10. Clavicular and supra-acromial branches. 11. Great occipital.

Section IV.

DISSECTION OF THE ORBIT.

Directions. The orbit should be learnt on that side on which the muscles of the face have been seen.

Position. In the examination of the cavity the head is to be placed in the same position as for the dissection of the sinuses of the base of the skull. **Position of the body.**

Dissection. For the display of the contents of the orbit, it will be necessary to take away the cotton wool from beneath the eye-lids, and to remove, as here directed, the bone forming the roof of the space. Two cuts may be made with a saw through the margin of the orbit, one being placed at the outer, the other near the inner angle of the cavity; and these should be continued backwards with a chisel, along the roof of the orbit, so as to meet near the optic foramen. The piece of bone included in the incisions is now to be tilted forwards, but is not to be taken away. **How to open the orbit with saw**

Afterwards all the rest of the roof of the orbit, which is formed by the small wing of the sphenoid bone, is to be cut away with the bone forceps, except a narrow ring around the optic foramen; and any overhanging bone on the outer side, which may interfere with the dissection, may be likewise removed. The dissector should take care that the eye is pulled gently forwards during the examination of the cavity. **and bone forceps.**

The *periosteum* of the orbit, which has been detached from the bone in the dissection, surrounds the contents of the orbital cavity, and is continuous with the dura mater of the brain through the sphenoidal fissure. It incases the contents of the orbit like a sac, and adheres but loosely to the bones. Apertures exist posteriorly in the membrane for the entrance of the different nerves and vessels; and on the sides prolongations of the periosteum accompany the vessels and nerves that leave the cavity. **Periosteum of orbit.** **Apertures in.**

Dissection. The periosteum is next to be divided along the middle of the orbit, and to be taken away. After the removal of a little fat, the following nerves, vessels, and muscles come into view:— **Open periosteum.**

The frontal nerve and the supra-orbital vessels lie in the centre; the lachrymal nerve and vessels close to the outer wall of the cavity; and the small fourth nerve at the back of the orbit: all these nerves enter the orbit above the muscles. The superior oblique muscle is recognised by the fourth nerve entering it: the levator palpebræ and superior rectus lie beneath the **Position of parts in the cavity.**

frontal nerve; and the external rectus is partly seen below the lachrymal nerve. In the outer part of the orbit, near the front, is the lachrymal gland.

Trace superficial nerves.

The frontal and lachrymal nerves should be followed forwards to their exit from the orbit, and backwards with the fourth, through the sphenoidal fissure, to the wall of the cavernous sinus. In tracing them back, it will be expedient to remove the projecting clinoid process, should this still remain; and some care and trouble will be required to follow the lachrymal nerve to its commencement.

Take away some fat.

The muscles and vessels referred to above, are to be cleaned; but it is not requisite to take all the fat from the orbit in this stage of the dissection.

Orbit has seven muscles,

Contents of the orbit. The eyeball and the lachrymal gland, and a great quantity of granular fat, are lodged in the orbit. Connected with the eye are six muscles—four straight and two oblique; and there is also an elevator of the upper eyelid in the cavity.

several cranial nerves;

The nerves in this small space are numerous, viz. the second, third, fourth, ophthalmic of the fifth, and the sixth nerve, together with the small temporo-malar branch of the superior maxillary nerve, and part of the sympathetic; and their general

their distribution;

distribution is as follows:—The second nerve enters the eyeball; the third is furnished to all the muscles of the cavity but two; the fourth enters the superior oblique (one of the two excepted); and the sixth is spent in the external rectus muscle. The fifth nerve supplies some filaments to the eyeball with the sympathetic, but the greater number of its branches pass through

and some vessels.

the orbital cavity to the face. The ophthalmic vessels are also contained in the orbit.

Lachrymal gland at outer part of orbit.

The *lachrymal gland* secretes the tears, and is situate in the hollow on the inner side of the external angular process of the frontal bone. It is of a lengthened form, something like an almond, and lies across the eye and the muscles. From its anterior part a thin accessory piece projects beneath the upper eyelid. The upper surface is convex, and in contact with the periosteum, to which it is connected by fibrous bands that constitute a ligament for the gland; the lower surface rests on the eyeball and the external rectus muscle.

Ducts open on upper eyelid.

In *structure* the lachrymal resembles the salivary glands; and its very fine ducts, from six to eight in number, open by as many apertures in a semicircular line on the inner surface of the upper eyelid, near the outer canthus.

Fourth nerve

The FOURTH NERVE (fig. 8, [4]) is the most internal of the three nerves that enter the orbit above the muscles. After

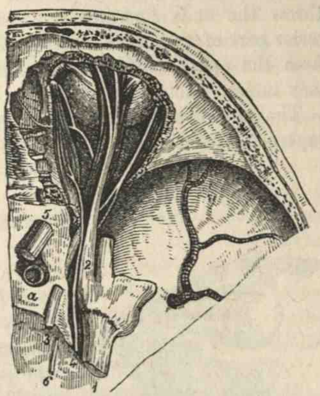
supplies superior oblique.

reaching this space, it is directed inwards to the superior oblique muscle, which it enters at the orbital surface, contrary to the general mode of distribution of the nerves on the ocular surface of the muscles.

Ophthalmic gives three branches.

The OPHTHALMIC NERVE of the fifth (fig. 8, [2], p. 18), as it approaches the sphenoidal fissure, furnishes from its inner side the nasal branch, and then terminates by dividing into the frontal and lachrymal branches; the former enters the orbit between the heads of the external rectus, but the other two lie, as before said, above the muscles.

Fig. 8.*



Frontal branch

The *frontal nerve* (fig. 8) is close to the outer side of the fourth as it enters the orbit, and is much larger than the lachrymal branch. In its course to the forehead the nerve lies along the middle of the orbit, and supplying anteriorly a supra-orbital branch, leaves that cavity by the supra-orbital notch. Taking the name *supra-orbital*, it ascends on the forehead, and supplies the external part of the head (p. 6). supplies following.

Whilst in the notch the nerve gives downwards *palpebral* filaments to the upper lid. Palpebral filaments.

The *supra-trochlear branch* passes inwards above the pulley of the upper oblique muscle, and leaves the orbit to end in the eyelid and forehead (p. 7). Before the nerve turns round the margin of the frontal bone, it sends downwards a branch of communication to the infra-trochlear branch of the nasal nerve. Frequently there are two supra-trochlear branches; in such instances one arises near the back of the orbit. Branch above the pulley sometimes two:

The *lachrymal nerve* (fig. 8) after entering the orbit in a separate tube of the dura mater, is directed forwards in the outer part of the cavity, and beneath the lachrymal gland to the upper eyelid, where it pierces the palpebral ligament, and is distributed to the structures of the lid. Lachrymal nerve ends in eyelid;

The nerve furnishes *branches* to the lachymal gland; and near the gland it sends downwards one or two small filaments to communicate with the temporo-malar or orbital branch of the superior maxillary nerve. Occasionally this nerve has a communicating filament behind with the fourth nerve. offsets join superior maxillary.

* Superficial view of the orbit, with the nerves entering above the muscles. 1. The fifth nerve. 2. Ophthalmic nerve. 3. Third nerve. 4. Fourth nerve. 5. Optic nerve. 6. Sixth nerve. *a*. Internal carotid artery cut across.

Nasal, afterwards.

The *nasal nerve* is not visible at this stage of the dissection: it will be noticed afterwards at p. 46.

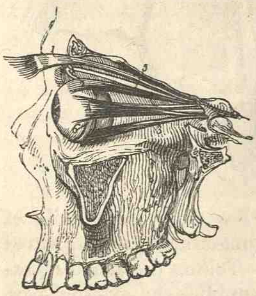
Dissection.

Dissection. Divide the frontal nerve about its middle, and throw the ends forwards and backwards: by raising the posterior part of the nerve, the separate origin of the nasal branch from the ophthalmic trunk will appear. The lachrymal nerve may remain uncut.

Elevator of upper eyelid

The LEVATOR PALPEBRÆ SUPERIORIS (fig. 9, [1]) is the most superficial muscle, and is *attached* posteriorly to the roof of the orbit in front of the optic foramen. The muscle widens as it extends forwards, and bends downwards in front of the eyeball, to be *inserted* by a wide tendon into the fore part of the tarsal cartilage.

Fig 9.*



attached to tarsal cartilage.

Connections.

By one surface the muscle is in contact with the frontal nerve and the periosteum; and by the other, with the superior rectus muscle. If it is cut across about the centre, a small branch of the third nerve will be seen entering the under surface of the posterior half.

Use.

Action. The lid-cartilage is made to glide upwards over the ball by this muscle, so that the upper edge is directed back and the lower forwards, the teguments of the lid being bent inwards at the same time. If the eyeball is directed down, the movement of the lid is less free, because the conjunctiva is put on the stretch.

Upper rectus muscle.

Origin.

Insertion.

The RECTUS SUPERIOR (fig. 9, [2]) is the upper of four muscles that lie around the globe of the eye. It *arises* from the upper part of the optic foramen, and is connected with the other recti muscles around the optic nerve. In front the fleshy fibres end in a tendon, which is *inserted*, like the other recti, into the sclerotic coat of the eyeball about a quarter of an inch behind the union with the cornea.

Position to other parts.

Use.

The under surface of the muscle is in contact with the globe of the eye, and with some vessels and nerves to be afterwards seen; the other surface is covered by the preceding muscle. The action of the muscle will be given with the other recti (p. 50).

Upper oblique muscle.

The SUPERIOR OBLIQUE MUSCLE (fig. 9, [5]) is thin and narrow, and passes through a fibrous loop at the inner angle of the orbit

* The orbit opened on the outer side to show the muscles of the eye. 1. Levator palpebræ. 2, 3, 4. Superior, inferior, and external rectus. 5. Superior oblique, left white. 6. Inferior oblique.

before reaching the eyeball. The muscle *arises* behind from the inner part of the optic foramen, and ends anteriorly in a rounded tendon, which, after passing through the loop before referred to, is reflected backwards and outwards between the superior rectus and the globe of the eye, and is *inserted* into the sclerotic coat behind the middle of the eyeball.

enters a loop.

Insertion.

Connections. The fourth nerve is supplied to the orbital surface of the muscle, and the nasal nerve lies below it. The thin insertion of the muscle lies between the superior and the external rectus, and near the tendon of the inferior oblique.

Pulley of the muscle. The *pulley*, or *trochlea*, is a fibro-cartilaginous ring nearly a quarter of an inch deep, which is attached by fibrous tissue to the depression of the frontal bone at the inner angle of the orbit. A fibrous layer is prolonged from the margins of the pulley on the tendon; and a synovial membrane lines the ring, to facilitate the movement of the tendon through it. To see the synovial membrane and the tendon, this prolongation must be cut away.

Use. For the use of the muscle, see the description of the inferior oblique, p. 50.

Dissection. *Dissection.* The superior rectus muscle is next to be divided about the middle and turned backwards, when a branch of the third nerve to its under surface will be found. At the same time the nasal nerve and the ophthalmic artery and vein will come into view as they cross inwards above the optic nerve: these should be traced forwards to the inner angle, and backwards to the posterior part of the orbit.

To find lenticular ganglion. By taking away some of the fat between the optic nerve and the external rectus, at the back of the orbit, the student will find easily fine nerve-threads (ciliary) with small arteries lying along the side of the optic nerve; and by tracing the ciliary nerves backwards, they will guide to the small lenticular ganglion (the size of a pin's head) and its branches. The dissector should find then two branches from the nasal and third nerves to the ganglion; the nasal branch is slender, and enters the ganglion behind, and that of the third nerve, short and thick, joins the lower part.

Detach nerves. Lastly, he should separate from one another the nasal, third, and sixth nerves, as they enter the orbit between the heads of the external rectus muscle.

Third nerve The THIRD NERVE (fig. 10, [6]) is placed highest in the wall of the cavernous sinus; but at the sphenoidal fissure it descends below the fourth, and two branches (frontal and lachrymal) of the ophthalmic nerve. The nerve enters the orbit between the heads of the outer rectus, having previously divided into two parts.

as it enters orbit.

Its upper branch. The *upper piece*, the smallest in size, ends in the under surface of the levator palpebræ and superior rectus muscles.

Lower branch.

The *lower piece* supplies some of the other muscles, and will be dissected afterwards (p. 49).

Nasal nerve.

The *nasal branch* of the ophthalmic nerve (fig. 10, [5]) enters the orbit between the heads of the rectus, lying between the two parts of the third nerve. In the orbit the nerve is directed obliquely inwards, to reach the anterior of the two foramina in the inner wall. Passing through this aperture with the anterior ethmoidal artery, the nerve appears in the cranium at the outer margin of the cribriform plate of the ethmoid bone. Finally, it enters the nasal cavity by an aperture at the front of the cribriform plate: and after passing behind the nasal bone, it is directed outwards between that bone and the cartilage, to end on the outer side of the nose.

General course to the face.

In the orbit.

In the *orbit* the nasal crosses over the optic nerve, but beneath the superior rectus and levator palpebræ muscles, and lies afterwards below the superior oblique; in this part of its course it furnishes the following *branches*:—

Long root of lenticular ganglion.

The *branch to the lenticular ganglion* is about half an inch long and very slender, and arises as soon as the nerve enters the orbit: this is the long root of the lenticular ganglion.

Long ciliary branches.

Long ciliary branches. As the nasal crosses the optic nerve, it supplies two or more ciliary branches (fig. 10) to the eyeball. These lie on the inner side of the optic, and join the ciliary branches of the lenticular ganglion.

Infra-trochlear branch.

The *infra-trochlear branch* arises as the nasal nerve is about to leave the cavity, and is directed forwards below the pulley of the superior oblique muscle, to end in the upper eyelid, the conjunctiva, and the side of the nose. Before this branch leaves the orbit it receives an offset of communication from the supra-trochlear nerve.

Nasal nerve in the nose,

In the *nose.* Whilst in the nasal cavity the nerve furnishes branches to the lining membrane of the septum narium and the outer wall; these will be subsequently referred to with the nose.

and on the face.

Termination of the nasal nerve. After the nerve becomes cutaneous on the side of the nose, as seen in the dissection of the facial nerve (p. 38), it descends beneath the compressor naris muscle, and ends in the integuments of the wing and tip of the nose.

Lenticular ganglion.

Situation.

The OPHTHALMIC OR LENTICULAR GANGLION of the sympathetic nerve (fig. 10) is a small roundish body, of the size of a pin's head, and of a reddish colour. It is placed at the back of the orbit between the optic nerve and the external rectus, and commonly on the outer side of, and close to the ophthalmic artery.

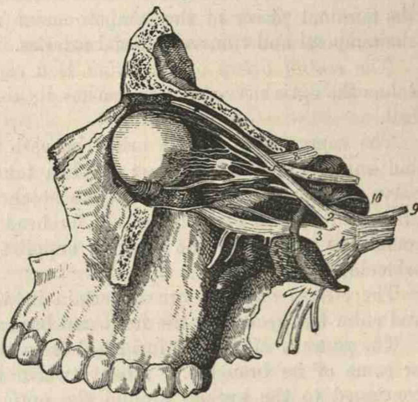
Connections.

By its posterior part the ganglion has branches of communication with other nerves (its roots); and from the anterior part proceed the ciliary nerves to the eyeball. In the ganglion, sensory, motory, and sympathetic filaments are combined.

The *offsets of communication* are three in number. One, the *long root*, is the branch of the nasal nerve before noticed, which joins the superior angle. A second branch of considerable thickness (*short root*) passes from the inferior angle to join the branch of the third nerve that supplies the inferior oblique muscle (fig. 10, 7). And the third *root* is derived from the sympathetic (the cavernous plexus), either in union with the long root, or as a distinct branch to the posterior border of the ganglion.

Three roots: long, short, and sympathetic.

Fig. 10.*



Branches. The short *ciliary nerves* (fig. 10) are ten or twelve in number, and are collected into two bundles, which leave the upper and lower ends (superior and inferior angles) of the ganglion. In the upper bundle are four or five, and in the lower, six or seven nerves. As they extend along the optic nerve to the eyeball they occupy the outer and under parts, and communicate with the long ciliary branches of the nasal neve.

Ciliary branches to eyeball.

The OPHTHALMIC ARTERY is a branch of the internal carotid, and enters the orbit through the optic foramen. At first the vessel is outside the nerve, but it then courses inwards, over or under the nerve, to the inner angle of the orbit, where it ends in a *nasal* branch, which is distributed to the side of the nose, and anastomoses with the angular and nasal branches of the facial.

Ophthalmic artery, in the orbit.

The *branches* of the artery are numerous, though inconsiderable in size, and may be arranged in three sets :—one arising outside the optic nerve, another above it, and a third set on the inner side.

Branches.

The *lachrymal artery* accompanies the nerve of the same name to the upper eyelid, where it ends by supplying that part, and anastomosing with the palpebral arches. It supplies branches,

Lachrymal branch

* Some of the nerves of the orbit, but especially the lenticular ganglion. 1. Ganglion of the fifth. 2. Ophthalmic nerve. 3. Upper maxillary. 4. Lower maxillary. 5. Nasal branch, giving the *long root* to the lenticular ganglion. 6. Third nerve. 7. Inferior oblique branch of the third connected with the ganglion by the *short root*. 8. Optic nerve. 10. Sympathetic on the carotid artery.

to gland: like the nerve, to the lachrymal gland and the conjunctiva; and it anastomoses with the middle meningeal by an offset through the sphenoidal fissure.

offsets. At the front of the orbit it sends a small branch with each of the terminal pieces of the temporo-malar nerve, and these join the temporal and transverse facial arteries.

Branch to retina. The *central artery of the retina* is a very small branch that enters the optic nerve, and so reaches its destination in the eyeball.

Supra-orbital branch. The *supra-orbital branch* arises beneath the levator palpebræ and superior rectus muscles; it then takes the course of the nerve of the same name through the notch in the margin of the orbit, and ends in branches on the forehead (p. 5). As it winds round the margin of the orbit it supplies the eyelid and the orbicularis muscle.

Ciliary arteries are posterior— The *ciliary branches* are uncertain in their place of origin, and enter the eyeball at the front and back:—

The *posterior ciliary* are furnished from the ophthalmic trunk, or some of its branches. About twelve in number, they are continued to the eyeball around the optic nerve, and perforate the sclerotic coat at the posterior part. Two of this set (one on each side of the optic nerve) are named *long* ciliary; they pierce the sclerotic farther out than the others, and lie along the middle of the eyeball.

two named long ciliary;

and anterior. The *anterior ciliary* arteries arise from muscular branches of the ophthalmic, and perforate the sclerotic coat near the cornea: in the eyeball they anastomose with the posterior ciliary. For the ending of these vessels, see the dissection of the eyeball.

Muscular. The *muscular branches* are furnished from the trunk and branches of the artery; and those to the lower muscles often arise together from the trunk.

Ethmoidal branches, The *ethmoidal branches* are two, anterior and posterior, and are directed through the foramina in the inner wall of the orbit:—

posterior The *posterior* is the smaller of the two, and furnishing small meningeal offsets (anterior) to the dura mater of the base of the skull, enters the cavity of the nose through the openings in the cribriform plate of the ethmoid.

and anterior. The *anterior* branch accompanies the nasal nerve to the nasal cavity, and gives likewise meningeal offsets to the dura mater, and the fore part of the falx cerebri.

Branches to eyelids. The *palpebral branches*, one for each eyelid, generally arise together opposite the pulley of the superior oblique muscle, and then separate from one another. The arches they form have been dissected with the eyelids (p. 35).

Frontal branch. The *frontal branch* turns round the margin of the orbit, and is distributed on the forehead (p. 5).

The *ophthalmic vein* corresponds in its course and most of its branches with the artery of the same name. It begins at the inner angle of the orbit, where it joins the facial vein, and receives tributary branches in its progress to the back of the cavity. Posteriorly it leaves the artery, and escapes from the orbit by the sphenoidal fissure between the heads of the external rectus to end in the cavernous sinus.

Ophthalmic vein ends in cavernous sinus.

The OPTIC NERVE in the orbit extends from the optic foramen to the back of the eyeball. As the nerve leaves the foramen it is surrounded by the recti muscles; and beyond that spot the ciliary arteries and nerves entwine around it as far as the eyeball. It terminates in the retinal expansion of the eye.

Optic nerve ends in retina.

Dissection. Take away the ophthalmic artery, and divide the optic nerve about its middle, together with the small ciliary vessels and nerves. Turn forwards the eyeball, and fasten it in that position with hooks. On removing some fat the three recti muscles—inner, outer, and inferior, will appear; and lying on those muscles at the back of the orbit are the offsets of the lower branch of the third nerve.

Dissection.

The *lower branch of the third nerve* supplies three muscles in the orbit. Whilst entering this space between the heads of the external rectus, it lies below the nasal, and rather above the sixth nerve. Almost immediately afterwards the nerve divides into three branches. One enters the internal rectus; another the inferior rectus; and the third, the longest and most external, is continued forwards to the inferior oblique muscle which it enters at the hinder border (fig. 10, [7]).

Lower branch of third nerve supplies muscles,

Soon after its origin the last branch communicates with the lenticular ganglion, forming the short root of that body; and it furnishes two or more filaments to the inferior rectus.

and joins ganglion.

The SIXTH NERVE enters the orbit between the heads of the external rectus, below the other nerves in that interval, and above the ophthalmic vein. In the orbit it is distributed to the external rectus muscle.

Sixth nerve.

RECTI MUSCLES. The *internal*, *inferior*, and *external rectus* muscles (fig. 9) are placed with reference to the eyeball as their names express. They *arise* posteriorly from the circumference of the optic foramen by a common attachment, which partly surrounds the optic nerve. But the external rectus differs from the others in having two heads: The upper joins the superior rectus in the common origin. The lower and larger head blends on the one side with the inferior rectus in the common origin, and is attached in addition to a bony point on the lower border of the sphenoidal fissure, near the inner end; whilst some of its muscular fibres are connected with a tendinous band between the heads. All the muscles are directed forwards, but the upper and lower obliquely, and have a tendinous *insertion* into the ball

Straight muscles of eyeball. Origin. Insertion.

of the eye about a quarter of an inch from the cornea, and in front of the transverse diameter of the ball.

Between heads of outer.

Between the heads of origin of the external rectus, the different nerves before mentioned enter the orbit, viz. the third, the nasal branch of the fifth, and the sixth, together with the ophthalmic vein.

Use of all.

Action. The four recti muscles, attached to the eyeball at opposite sides in front of the transverse diameter, are able to turn the pupil in opposite directions.

Inner and outer.

The inner and outer recti move the ball horizontally around a vertical axis, the former directing the pupil towards the nose and the latter towards the temple.

Upper and lower.

The upper and lower recti elevate and depress the fore part of the ball around a transverse axis; but as their fibres are directed obliquely inwards the upper muscle turns the pupil up and in, and the lower muscle turns it down and in.

Two contiguous.

By the simultaneous action of two contiguous recti, the ball will be moved to a point intermediate to that to which it would be directed by either muscle singly.

Dissect inferior oblique.

Dissection. By opening the optic foramen, the attachment of the recti muscles will be more fully seen. To dissect out the inferior oblique muscle, let the eyeball be replaced in its natural position; then by taking away the conjunctival lining of the lower eyelid near the inner part of the orbit, and removing some fat, the muscle will appear beneath the eyeball, bending from the inner to the outer side; it may be followed outwards to its insertion into the ball.

Lower oblique muscle.

The INFERIOR OBLIQUE MUSCLE (fig. 9, [6]) is situate near the anterior margin of the orbit, and differs from the other muscles in being directed across, instead of parallel to the axis of the orbit.

Origin.

It *arises* from the superior maxillary bone between the margin of the orbit and the groove for the lachrymal sac.

Course.

From this spot the muscle passes outwards beneath the inferior rectus, and between the eyeball and the external rectus,

Insertion.

to be *inserted* into the sclerotic coat between the outer and upper recti.

Connections.

The borders of the muscle look forwards and backwards, and the posterior receives the branch of the third nerve. The tendon of insertion is near that of the superior oblique muscle, but rather closer to the optic nerve.

Use of

Action. The oblique muscles rotate the eyeball around an antero-posterior axis, and are supposed to be used in maintaining the parallelism of the axes of the two eyes.

upper

The upper muscle, when pulled, rotates the ball in such a way as to cause the inner end of the transverse axis to sink, and the pupil to be directed down and out, as in looking to the shoulder.

and lower muscles

The lower muscle, if treated in the same way, produces rotation of the ball in the opposite direction, viz. the inner end of the transverse axis rises, and the pupil is inclined up and out, as in looking to the outer part of the orbit.

During life the rotatory movement is supposed to be chiefly employed in controlling the oblique action of the upper and lower recti. For instance, as the upper rectus turns the pupil upwards and inwards, the inner movement will be counteracted by the rotation out of the inferior oblique. And as the lower rectus inclines the pupil down and in, the motion inwards will be checked by the rotation out of the superior oblique. with recti.

Dissection. To expose the small tensor tarsi muscle, the palpebral ligament uniting the eyelids to the margin of the orbit is to be cut through, where this has not been done; but the lids must be left attached at the inner commissure by means of the tendo palpebrarum. By looking to the posterior aspect of the fibrous band attaching the tarsal cartilages, after the lids have been placed across the nose, the pale fibres of the tensor tarsi will be seen. Seek tensor tarsi.

The TENSOR TARSI MUSCLE *arises* from the ridge on the os unguis, and slightly from the bone behind the ridge. Its fibres are pale, and form a very small flat band, behind the ligamentum palpebrarum, which divides like that structure into a slip for each eyelid. In the lid the slip lies on the lachrymal canal, and blends with the fibres of the orbicularis along the free margin of the tarsal cartilage. Tensor tarsi muscle. Insertion.

Action. By its contraction the muscle draws inwards and backwards the puncta of the lids, so as to favour the reception and passage of the tears. Use.

Dissection. A small nerve, the temporo-malar or orbital branch of the superior maxillary trunk, lies in loose fat along the outer angle of the floor of the orbit, and may be brought into view after the removal of the eyeball and its muscles. This nerve is very soft and easily broken. Two branches, temporal and malar, are to be traced forwards from it: and the junction of a filament of the lachrymal nerve with the former is to be sought. Trace offset of superior maxillary nerve.

The outer wall of the orbit may be cut away, bit by bit, to follow the temporal branch through to the surface of the head.

The *temporo-malar* or *orbital branch* of the superior maxillary nerve arises in the spheno-maxillary fossa, and enters the orbit by the fissure of the same name. At the back of the orbit the nerve divides into malar and temporal branches, which ramify in the face and the side of the head with their companion vessels. Orbital branch of superior maxillary nerve;

The *malar branch* (r. subcutaneus malæ) is directed forwards to the face along the floor of the orbit, and through a foramen in the malar bone. After emerging from its foramen, this its malar branch supplies the orbicularis, and communicates with the facial nerve.

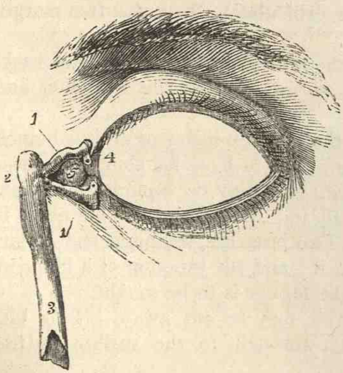
and temporal offsets. The *temporal branch* ascends on the outer wall of the orbit, either beneath the periosteum, or in a groove in the bone; and being joined by a filament from the lachrymal nerve, passes into the temporal fossa through a foramen in the malar bone. The nerve is then directed upwards between the temporal muscle and the skull, and perforates the temporal fascia near the orbit. Its distribution has been seen in the examination of the cutaneous nerves of the head (p. 7).

Apparatus for the tears. LACHRYMAL APPARATUS. The lachrymal glands and ducts, with the puncta, canals, and sac, constitute the apparatus by which the tears are formed, and conveyed to the nose. The gland has been already described (see p. 42).

Dissection. *Dissection.* A bristle should be introduced into each lachrymal canal through the punctum of the eyelid. The lachrymal sac will appear by removing the tensor tarsi and the areolar tissue from its surface, as it lies on the os unguis. The prolongation from the tendo palpebrarum over the sac should be prepared.

Apertures in eyelids. The *puncta lachrymalia* are two small apertures, one for each lid, by which the tears enter the lachrymal canals. Each is situate in the free margin of the lid, about a quarter of an inch from the inner canthus, and in the elevation of the papilla lachrymalis.

Fig. 11.*



Canals for the tears. The *lachrymal canals* (fig. 11, [1]) lead from the puncta, and convey the tears to the lachrymal sac; their situation is marked by the bristles inserted in them. In their course inwards the canals lie along the tendo-palpebrarum, one above and the other below it, and they are somewhat arched with the concavity towards the tendon. Internally they open near together into the lachrymal sac rather above its middle. The canal in the upper eyelid is longer and more arched than that in the lower lid.

Difference in the two lids.

Receptacle of the tears. The *lachrymal sac* and *duct* (fig. 11) extend from the inner

* The eyelids and lachrymal apparatus. 1. Lachrymal canals. 2. Lachrymal sac. 3. Lachrymal duct. 4. Plica semilunaris. 5. Caruncula lachrymalis.

part of the orbit to the nose, and convey the tears into the latter cavity. They form one tube, of which the upper dilated part is the sac, and the lower constricted end the duct.

Situation of the sac, or dilated part.

The *sac*, 2, is situate in the hollow formed by the os unguis and nasal process of the superior maxillary bone. Externally it is crossed by the ligament or tendon of the eyelids, and is covered by an expansion derived from that tendon, which is fixed to the margins of the bony groove. If the aponeurotic covering be removed, the mucous membrane lining the interior will be seen. Into the outer side of the sac the lachrymal canals open.

Canal leading to the nose.

The *duct*, 3 (ductus ad nasum), is the narrowed part of the tube that reaches to the nose, and is about half an inch long. It is entirely incased by bone; and in length, size, and direction, it corresponds with the passage of the same name in the dried skull. In the nasal cavity it opens into the front of the inferior meatus, where its opening is guarded by a fold of the mucous membrane. A bent probe introduced through the nostril may be passed into the duct from the meatus, but with destruction of the valve.

Its opening.

Structure of the duct.

As the duct is continuous with the mucous membrane of the nose it has the same structure, viz. a fibrous external layer with a mucous lining. The epithelium of the sac and duct is ciliated as in the nose, but in the lachrymal canals it is scaly.

Anatomy of eyeball afterwards.

Directions. The examination of the eyeball may be omitted with more advantage to the student till the dissection of the head and neck has been completed. The description of the eye will be found at the end of the book.

SECTION V.

DISSECTION OF THE NECK.

Position of the part.

Position. For the dissection of the right side of the neck let the head be supported on a block at a moderate height, and let the face be turned to the left side and fastened in that position with hooks. To obtain a good view of the region, the right arm may be drawn under the body, with the object of depressing the point of the shoulder, and putting the neck-parts on the stretch. In some bodies, owing to difference in the form of the neck, or in the height on the table, the best position will be obtained by placing the upper limb over the trunk.

Boundaries of the side of the neck.

Surface-marking. The side of the neck presents a somewhat square outline, and is limited in the following way:— Inferiorly is the prominence of the clavicle; and superiorly is the base of the lower jaw with the skull. In front its boundary is marked by a line from the chin to the sternum; and behind, by another line from the occiput to the acromial end of the clavicle.

Division into two triangles by sterno-mastoid.

The part thus included is divided into two triangular spaces (anterior and posterior) by the diagonal direction of the sterno-mastoid muscle. And in consequence of the position of that muscle the base of the anterior space is at the jaw, and the apex at the sternum; whilst the base of the posterior one is at the clavicle, and the apex at the head.

The surface in front of the sterno-mastoid is depressed at the upper part of the neck, near the position of the carotid vessels; and behind the muscle, just above the clavicle, is another slight hollow which points to the situation of the subclavian artery.

Prominences in the middle line of neck,

Along the middle line of the neck the following parts can be recognised through the skin:—About two inches and a half from the base of the jaw is the eminence of the os hyoides, with its cornu extending laterally on each side. Below this may be felt the wide prominence of the thyroid cartilage, called pomum Adami, which is most marked in man; and between the cartilage and the hyoid bone is a slight interval, corresponding with the thyro-hyoid membrane.

Inferior to the thyroid, is the narrow prominent ring of the cricoid cartilage; and between the two the finger may distinguish another interval, which is opposite the crico-thyroid membrane. In some bodies, especially in women, the swelling of the thyroid gland may be recognised by the side of the upper part of the trachea.

and suprasternal depression.

From the cricoid cartilage to the sternum, and between the sterno-mastoid muscles is a depression, whose depth is much increased in emaciated persons, in which the tube of the trachea can be felt.

Direction. As the time will not allow the examination of the whole side of the neck, the student should lay bare in this stage only the parts behind the sterno-mastoid muscle.

Dissection of the platysma.

Dissection. To raise the skin from the posterior triangle of the neck, make an incision along the sterno-mastoid muscle from the one end to the other, and afterwards along the clavicle as far as the acromion. The triangular flap of skin is to be reflected from before back towards the trapezius muscle. The superficial fascia, which will then be brought into view, contains the platysma; and to see that muscle, it will be necessary to take the subcutaneous fat from the surface.

Platysma muscle

The PLATYSMA MYOIDES is a thin subcutaneous muscular layer, which is now seen only in its lower half. The muscle is placed across the side of the neck, and extends from the top of the

arises at shoulder;

shoulder to the face. Its fleshy fibres take *origin* by fibrous bands from the clavicle and the acromion, and below those bones from the fascia covering the pectoral and deltoid muscles; and they ascend over the side of the neck, to be *inserted* into the jaw.

The lower part of the muscle is more closely united to the skin than the upper, and covers the external jugular vein as well as the lower part of the posterior triangle. At first the fibres of the muscle are thin and scattered, but they increase in strength as they ascend. The oblique direction of the fibres should be noted, because in venesection in the external jugular vein the incision is to be so made as to divide them across.

Inserted into jaw; covers triangle.

The use will be found with the description of the remainder of the muscle (p. 61).

Use.

Dissection. The platysma is now to be cut across near the clavicle, and to be reflected upwards as far as the incision over the sterno-mastoid muscle, but it is to be left attached at that spot. In raising the muscle the student must be careful of the deep fascia of the neck; and he should dissect out at the same time the external jugular vein, and the superficial descending branches of the cervical plexus, which are close beneath the platysma.

Dissection.

The *external jugular vein* (fig. 12, [8]) commences in the parotid gland (p. 30), and is directed backwards beneath the platysma to the lower part of the neck, where it pierces the deep cervical fascia to open into the subclavian vein. Its course down the neck will be marked by a line from the angle of the jaw to the middle of the clavicle. Beyond the sterno-mastoid muscle the vein is dilated, and the swollen part (*sinus*) is limited by two pairs of valves,—one being situate below at the mouth of the vein, and the other near the muscle. Small superficial branches join the vein, and an offset connects it with the anterior jugular vein. Its size, and the height at which it crosses the sterno-mastoid muscle, are very uncertain.

External jugular vein crosses side of neck to subclavian.

The *deep cervical fascia* consists, like the aponeuroses in other regions of the body, of a superficial layer which surrounds the neck continuously, and of processes that are prolonged inwards between the muscles. In some bodies this fascia is thin and indistinct.

Cervical fascia.

In its extent round the neck the membrane incases the sterno-mastoideus, and presents a different disposition before and behind that muscle. As now seen passing backwards from the muscle, the fascia continues over the posterior triangular space, and encloses the trapezius in its progress to the spines of the vertebræ. At the lower part of the neck it is attached to the clavicle and is perforated by the external jugular vein, and the cutaneous nerves.

Part behind sterno-mastoid muscle.

After the superficial layer has been removed near the clavicle, a deep process may be observed to surround the small omo-hyoid muscle, and to extend under the clavicle, where it is fixed to the back of that bone, and the inner end of the first rib.

sends a process around omo-hyoid.

POSTERIOR TRIANGULAR SPACE.

Posterior triangular space of the neck.

This space (fig. 12), having the form and position before noted, is about eight inches in length. It contains the cervical and brachial plexuses, together with the portion of the subclavian artery on which a ligature is usually placed, and some offsets of the vessels and nerves.

Dissection of triangular space.

Dissection. By the removal of the cervical fascia and the fat from the space between the sterno-mastoid and trapezius muscles, the posterior triangle of the neck will be displayed. In the execution of this task, the student may obtain some assistance by attention to the following remarks :—

Crossing the space obliquely about an inch above the clavicle, and dividing it into two, is the small omo-hyoid muscle (fig. 12, 3). Close to or under the upper border of the muscle lie the small nerve and vessels to it : the nerve being traceable to the descendens noni, and the artery to the supra-scapular.

Nerves above omo-hyoid ;

Above the omo-hyoid muscle will be found the ramifications of the branches of the cervical plexus, together with the spinal accessory nerve ; the latter will be recognised by its piercing the sterno-mastoid muscle. The greater number of the branches of the cervical plexus descend in the space to the shoulder ; but the small occipital and great auricular nerves ascend to the head, and the superficial cervical branch is directed forwards over the sterno-mastoid muscle.

vessels below, in triangular space.

Below the omo-hyoideus are the subclavian artery and the brachial plexus, which have a deep position. In this part also the following vessels and nerve are to be sought, viz. the supra-scapular vessels behind the clavicle ; the transverse cervical vessels which are higher in the neck, but take an outward direction beneath the omo-hyoid muscle ; and, lastly, the small branch of nerve to the subclavius muscle, which lies about the middle of the space between the clavicle and the omo-hyoideus.

Boundaries.

The space is bounded in front by the sterno-mastoid muscle, 1 ; and behind by the trapezius, 2. Its base corresponds with the middle third of the clavicle, and its apex is at the skull. In its area are several muscles, which are placed in the following order from above down, viz. splenius capitis, levator anguli scapulæ 6 ; and middle scalenus 5 ; and at the lower and outer angle, somewhat beneath the trapezius lies the upper part of the serratus magnus. Covering the space are the structures already examined, viz. the skin and superficial fascia, the platysma over the lower half or two-thirds, and the deep fascia.

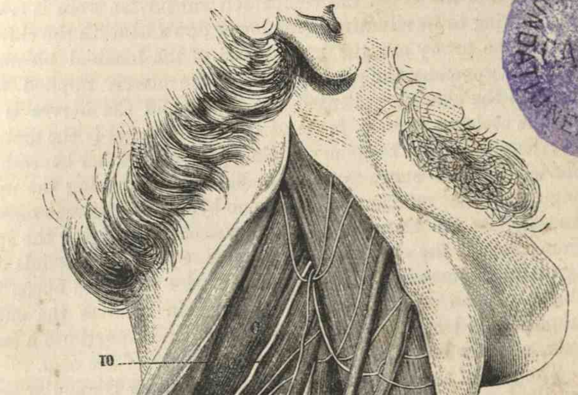
Is divided by omo-hyoideus.

The small omo-hyoid muscle, 3, crosses the lower part of the space, so as to subdivide it into two,—a lower or clavicular, and an upper or occipital.

The *clavicular part* is small in size and close to the clavicle, and contains the subclavian artery. It is triangular in form, with its base directed forwards; and is bounded in front by the sterno-mastoid, 1, above by the omo-hyoid muscle, 3; and below

Part near clavicle.

Fig. 12.*



* The dissection of the posterior triangular space of the neck, but the dissection is not carried high enough to lay bare the splenius muscle. 1. Sterno-mastoideus. 2. Trapezius. 3. Posterior belly of the omo-hyoid muscle. 4. Anterior scalenus, with the phrenic nerve on it. 5. Middle scalenus muscle. 6. Elevator of the angle of the scapula. 7. Third part of the subclavian artery. 8. External jugular vein joining the subclavian below. 9. Nerves of the brachial plexus. 10. Spinal accessory nerve.—The cut, altered slightly, has been copied from a plate in Blandin's Surgical Anatomy.

Extent of the space. by the clavicle. This small space measures commonly about one inch and a half from before backwards, and about half that in front at its base.

Vessels and nerves in this part, Crossing the area of this portion, rather above the level of the clavicle, is the trunk of the subclavian artery, 7 (its third part), which issues from beneath the anterior scalenus muscle, and is directed over the first rib to the axilla. In the ordinary condition of the vessel the companion subclavian vein is seldom seen, owing to its situation being lower down beneath the clavicle. Above the artery are the large cords of the brachial plexus, 9, which accompany the vessel, and become closely applied to it beneath the clavicle. and their relative position. Behind the artery and the nerves is the middle scalenus muscle, 5. And below the vessel is the first rib.

Along the lower boundary of the space, and rather beneath the clavicle lie the supra-scapular vessels ; and crossing the upper angle, at the meeting of the omo-hyoid and sterno-mastoid muscles, are the transverse cervical vessels. Entering the space from above is the external jugular vein, 8, which descends over or under the omo-hyoideus near the anterior part, and opens into the subclavian vein ; in this spot the vein receives the supra-scapular and transverse cervical branches, and sometimes a small vein, over the clavicle, from the cephalic vein of the arm.

Variations in the size of the space ; The size of the clavicular part of the posterior triangular space from before back is influenced by the extent of attachment of the trapezius and sterno-mastoid muscles along the clavicle. In some bodies these muscles occupy nearly the whole length of that bone, leaving but a small interval between them ; and in others they meet, so as to cover the underlying vessels. The space may be further increased or diminished from above down by the position of the omo-hyoideus in the neck ; for this muscle may lie close to the clavicle, being attached thereto, or it may be distant one inch and a half from that bone.

also in the depth, both natural and artificial. In depth the space varies naturally ; and in a short thick neck with a prominent clavicle, the artery is farther from the surface than in the opposite condition of the parts. But the depth may be altered much more by the position of the clavicle, according as the limb may be raised or depressed. And lastly, the artery in its usual position may be concealed entirely by forcing upwards the arm and shoulder, as the collar bone is then raised above the level of the omo-hyoid muscle.

Departure from the ordinary state of the artery. The situation of the trunk of the subclavian artery may vary much, for the vessel may be one inch and a half above the clavicle, or at any point intermediate between this and its usual level just above the prominence of that bone. Further, its position to the anterior scalenus may be changed ; and instead of the vessel being beneath, it may be in front of, or even between the fibres of that muscle.

Commonly there is not any branch connected with the artery in this part of its course; but the posterior scapular branch (fig. 12) may take origin from it at different distances from the scalenus, or there may be more than one branch (Quain). Branches.

The subclavian vein rises upwards not unfrequently as high as the artery, or it may even lie with the artery beneath the anterior scalenus in some rare instances. The position of the external jugular vein with regard to the subclavian artery is very uncertain; and the branches connected with its lower end may form a kind of plexus over the arterial trunk. Position of veins.

The *occipital part* of the posterior triangular space is of larger extent than the other. Its boundaries in front and behind are the sterno-mastoid and the trapezius; and it is separated from the clavicular portion by the omo-hyoid muscle. Occipital part of space

In it are contained chiefly the ramifications of the cervical plexus; and a chain of lymphatic glands lies along the sterno-mastoid muscle. Beneath the spinal nerves is the middle scalenus, and still farther behind are some muscles of the back before seen. The spinal accessory nerve, 10, is directed obliquely across this interval from the sterno-mastoid muscle, which it pierces, to the under surface of the trapezius; and a communication takes place between this cranial nerve and the spinal nerves in the triangular space. contains nerves and lymphatics; also spinal accessory nerve.

Superficial Branches of the Cervical Plexus. Behind the sterno-mastoid muscle appear some of the ramifications of the cervical nerves in the plexus of the same name; and superficial branches are furnished from these both upwards and downwards. Nerves of the cervical plexus

The ascending set (fig. 12) are three in number, viz. small occipital, great auricular, and superficial cervical. that ascend, viz.

The *small occipital branch* (fig. 7, [8]) comes from the second cervical nerve, and is directed upwards to the head along the posterior border of the sterno-mastoid muscle. At first the nerve is beneath the fascia; but near the occiput it becomes cutaneous, and is distributed between the ear and the great occipital nerve (p. 8). Occasionally there is a second cutaneous nerve to the head. Small occipital.

The *great auricular nerve* (fig. 7, [6]) is a branch of that part of the plexus which is formed by the second and third cervical nerves. Perforating the deep fascia at the posterior border of the sterno-mastoid muscle, the nerve is directed upwards beneath the platysma to the lobule of the ear, where it ends in the following branches:— Great auricular,

The *facial branches* are sent forwards to the integuments over the parotid, and a few slender filaments pass through the gland to join the facial nerve. supplies facial,

The *auricular branches* ascend to the external ear, and are chiefly distributed on its cranial aspect; one or more reach the auricular, opposite surface by piercing the pinna. On the ear they communicate with the branches furnished from the facial and pneumogastric nerves.

and mastoid branches.

The *mastoid branch* is directed backwards to the integuments between the ear and the mastoid process; and it joins the posterior auricular branch of the facial nerve (p. 8).

Superficial cervical nerve.

The *superficial cervical nerve* (fig. 7,[7]) springs from the same source as the preceding, and turns forwards round the sterno-mastoid muscle about the middle. Afterwards it pierces the fascia, and ramifies over the anterior triangular space beneath the platysma myoides (see p. 61). There may be more than one branch to represent this nerve.

Nerves that descend are

The DESCENDING SET of branches (fig. 7), (supra-clavicular) are derived from the third and fourth nerves of the plexus, and are directed towards the clavicle over the lower part of the posterior triangular space. Their number is somewhat uncertain, but usually there are about three on the clavicle.

supra clavicular.

The most internal branch (sternal) crosses the clavicle near its inner end; the middle branch lies about the middle of that bone; and the posterior (acromial) turns over the attachment of the trapezius to the acromion. All are distributed in the integuments of the chest and shoulder.

Posterior cutaneous.

Derived from the descending set are two or more *posterior cutaneous nerves*, which ramify in the integument over the lower two thirds of the trapezius.

Lymphatic glands of neck.

The *lymphatic glands* (glandulæ concatenatæ) lie along the sterno-mastoid muscle, and are continuous at the lower part of the neck with the glands in the cavity of the thorax. There is also a superficial chain along the external jugular vein.

Dissection.

Dissection. The dissection of the posterior triangle should be repeated on the left side of the neck, in order that the difference in the vessels may be observed. Afterwards the reflected parts are to be replaced and carefully fastened in their natural position with a few stitches, preservative fluid or salt having been previously applied.

The back to be examined now.

Directions. It is supposed that the body will be now turned on its fore part for the dissection of the back; and during the time allotted for this position the dissector of the head is to learn the posterior part of the neck. (See DISSECTION OF THE BACK.)

After the completion of the dissection of the back, the student should take out the spinal cord, and then return to the examination of the front of the neck.

FRONT OF THE NECK.

Detach the head.

Directions. Supposing the thorax and back finished, the head and neck may be detached from the trunk by dividing the spinal column between the second and third dorsal vertebræ, and cutting through the arch of the aorta beyond its large branches (if this is not done), so as to take that vessel with it. The dissection is to be continued with the remainder of the right side of the neck; but if the facial nerve has been before omitted, it should be first learnt. Examine right side of neck.

Position. After the part has been detached, the face is to be turned from the dissector, and a small narrow block is to be placed beneath the neck. Further, the neck is to be made tense by means of hooks, the chin being well raised at the same time. Position of part.

Dissection. An incision along the base of the jaw on the right side (if it has not been made already) will readily allow the piece of integument in front of the sterno-mastoideus to be raised towards the middle line. Beneath the skin is the superficial fascia, containing very fine offsets of the superficial cervical nerve. Dissection.

To define the platysma muscle, remove the fat which covers it, carrying the knife down and back in the direction of the fleshy fibres.

Platysma Myoides. The anterior part of the platysma, viz. from the sterno-mastoid muscle to the lower jaw, covers the greater portion of the anterior triangular space. At the base of the jaw it is inserted between the symphysis and the masseter muscle; while other and more posterior fibres are continued over the face, joining the depressor anguli oris and risorius, as far as the fascia covering the parotid gland, or even to the cheek bone. Platysma muscle in front of sterno-mastoid. Insertion into jaw.

The fibres have the same appearance in this as in the lower half of the muscle, but they are rather stronger. Below the chin the inner fibres of opposite muscles cross for the distance of about an inch, but those that are superficial do not belong always to the same side. Crossing of the fibres.

Action. The ordinary action of this muscle is confined to the skin of the neck, which it throws into longitudinal wrinkles; but it can depress the corner of the mouth by the slip prolonged to the face. Through its attachment to the jaw it will assist in opening the mouth. Use on skin. Jaw.

Dissection. Raise the platysma to the base of the jaw, and dissect out the branches of the superficial cervical nerve, and the cervical branches of the facial nerve that are beneath it. Clean also the deep fascia of the neck, and the anterior jugular vein which is placed near the middle line. Dissection.

The *superficial cervical nerve* has been traced from its origin in the cervical plexus to its position on the deep fascia of the neck (p. 60); but the nerve may arise from the plexus by two pieces. Beneath the platysma it divides into an ascending and a descending branch, and is distributed on the front of the neck. Superficial cervical nerve,

The *ascending branch* perforates the platysma, supplying it, ascending and ends in the integuments over the anterior triangle, about half way down the neck. Whilst this branch is beneath the platysma it joins the facial nerve.

descending branch.

The *descending branch* likewise passes through the platysma, and is distributed below the preceding, reaching as low as the sternum.

Branches of facial nerve to the neck.

The *infra-maxillary branches of the facial* or *seventh cranial nerve* (rami subcutanei colli) (p. 40) pierce the deep cervical fascia, and pass forwards beneath the platysma, forming arches across the side of the neck (fig. 7), which reach as low as the hyoid bone. Most of the branches end in the platysma, but a few filaments perforate it, and reach the integuments. Beneath that muscle there is a communication established between the branches of the facial and the offsets of the superficial cervical nerve.

Dissection.

Dissection. Cut across the external jugular vein about the middle, and throw the ends up and down. Afterwards the superficial nerves of the neck may be divided in a line with the angle of the jaw, the anterior ends being removed, and the posterior reflected. The great auricular nerve may be cut through and the ends reflected.

Cervical fascia in front of sterno-mastoid

The part of the *deep cervical fascia* in front of the sterno-mastoideus is stronger than that behind the muscle, and has the following arrangement. Near the sternum the fascia forms a white firm membrane, which is attached to that bone; but higher in the neck it becomes thinner, and is fixed above to the lower jaw and the zygoma, covering also the parotid gland. From the ramus of the jaw a piece is prolonged downwards, between the parotid and submaxillary glands, to join the styloid process; this piece is named the *stylo-maxillary ligament;* and from the angle of the jaw a strong piece is continued to the sterno-mastoideus, which fixes forwards the anterior border of that muscle.

forms stylo-maxillary ligament and sheath of vessels.

Intermuscular partitions are sent between the muscles; and the layer beneath the sterno-mastoid is connected with the sheath of the cervical vessels. One of these strata, viz. that beneath the sterno-thyroid muscle, descends in front of the great vessels at the root of the neck to the arch of the aorta and the pericardium.

ANTERIOR TRIANGULAR SPACE.

Triangular space in front of the neck.

This space (fig. 13) contains the carotid vessels and their branches, with many nerves; and it corresponds with the hollow on the surface of the neck in front of the sterno-mastoid muscle.

Dissection of anterior triangle.

Dissection. To define the anterior triangular space and its contents take away the deep fascia of the neck, and the fat, but without injuring or displacing the several parts. First clean the surface of the hyoid muscles that appear along the middle line, leaving untouched the anterior jugular vein.

The trunks into which the large carotid artery bifurcates are to be followed upwards, especially the more superficial one (external carotid), whose numerous branches are to be traced as far as they lie in the space. In removing the sheath from the vessels, as these appear from beneath the muscles at the lower part of the neck, the dissector should be careful of the small descending branch of the hypo-glossal nerve in front of it. In the sheath between the vessels (carotid artery and jugular vein) will be found the pneumo-gastric nerve, and behind the sheath is the sympathetic nerve.

Trace arteries.

Seek longitudinal

Crossing the space, in the direction of a line from the mastoid process to the hyoid bone, are the digastric and stylo-hyoid muscles, with several nerves directed transversely. Thus lying below them is the hypo-glossal nerve, which gives one branch (descendens noni) in front of the sheath, and another to the thyro-hyoid muscle. Above the muscles, and taking a similar direction between the two carotid arteries, are the glosso-pharyngeal nerve and the stylo-pharyngeus muscle. On the inner side of the vessels, between the hyoid bone and the thyroid cartilage, the dissector will find the superior laryngeal nerve; and by the side of the larynx, with the descending part of the superior thyroid artery, the small external laryngeal branch. Directed downwards and backwards from beneath the same muscles to the sterno-mastoideus, is the spinal accessory nerve.

and transverse nerves.

Laryngeal nerves.

Spinal accessory.

Clean then the submaxillary gland close to the base of the jaw; and on partly displacing it from the surface of the mylo-hyoid muscle, the student will expose the small branch of nerve to that muscle with the submental artery.

Clean gland, seek nerve to mylo-hyoid.

The interval between the jaw and the mastoid process is supposed to be already cleaned by the removal of the parotid gland in the dissection of the facial nerve.

Its limits are the following:—Behind is the sterno-mastoid muscle, 1; and in front a line from the chin to the sternum, along the middle of the neck. Above, at the base of the space, would be the lower jaw, the skull, and the ear; and below, at the apex, is the sternum. Over this space are placed the skin and the superficial fascia, the platysma, the deep fascia, and the ramifications of the facial and superficial cervical nerves.

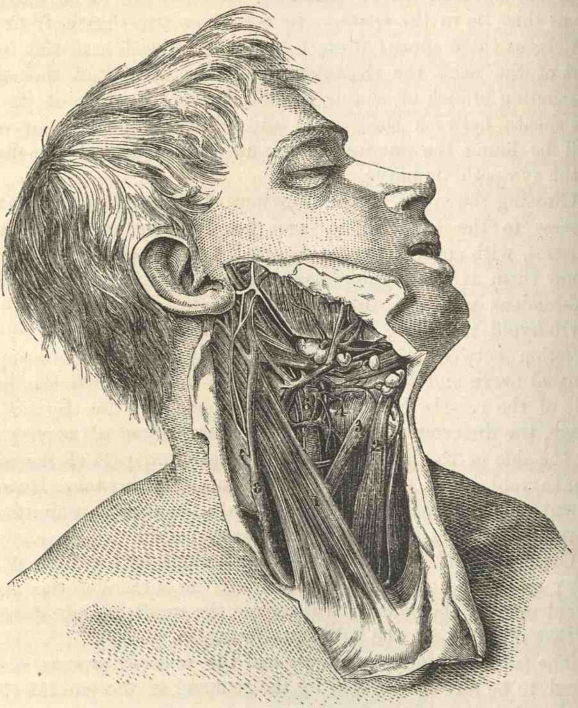
Boundaries.

Muscles in the Space. In the area of the triangular interval, as it is above defined, are seen the larynx, and pharynx in part, and many muscles converging towards the hyoid bone as a centre, some being above and some below it. Below are the depressors of that bone, viz. omo-hyoid, sterno-hyoid, and sterno-thyroid, 2 to 4; and above the os hyoides are the elevator muscles, viz.

Contents of the space.

mylo-hyoid, digastric, and stylo-hyoid. Connected with the back of the hyoid bone and the larynx are some of the constrictor muscles of the gullet.

Fig. 13.*



Carotid artery in space.

Course.

Coverings.

Vessels in the triangular space. The carotid blood-vessels, 6 and 7, occupy the hinder and deeper part of the space along the side of the sterno-mastoid muscle; and their course would be marked on the surface by a line from the sterno-clavicular articulation to a point midway between the angle of the jaw and the mastoid process. As high as the level of the cricoid cartilage they are buried beneath the depressor muscles of the

* View of the anterior triangular space of the neck (from "Quain's Arteries"). 1. Sterno-mastoideus. 2. Sterno-hyoideus. 3. Anterior belly of the omo-hyoideus. 4. Thyro-hyoideus. 6. Common carotid artery dividing. 7. Internal jugular vein. 8. External jugular vein.—In Mr. Quain's drawing the sterno-mastoid is partly cut through.

os hyoides; but beyond that spot they are covered by the superficial layers over the space, and by the sterno-mastoid muscle which, before the parts are displaced, conceals the vessels as far as the parotid gland.

Bifurcation.

For a short distance after its exit from beneath the muscles at the root of the neck, the common carotid artery remains a single trunk, 6; but opposite the upper border of the thyroid cartilage it divides into two large vessels, external and internal carotid. From the place of division these trunks are continued onwards, beneath the digastric and stylo-hyoid muscles, to the interval between the jaw and the mastoid process.

Position of two trunks to one another.

At first the trunks lie side by side, the vessel destined for the internal parts of the head (internal carotid) being the more posterior or external of the two; but above the digastric muscle it becomes deeper than the other.

Branches.

The more superficial artery (external carotid) furnishes many branches to the neck and the outer part of the head, viz. some forwards to the larynx, tongue, and face; others backwards to the occiput and ear; and others upwards to the head.

Changes in the place of division of carotid.

But the common carotid does not always divide, as here said. For the point of branching of the vessel may be moved from the upper border of the thyroid cartilage, either upwards or downwards, so that the trunk may remain undivided till it is beyond the os hyoides, or end in branches opposite the cricoid cartilage. The division beyond the usual place is more frequent than the branching short of that spot. It sometimes ascends as an undivided trunk (though very rarely), furnishing offsets to the neck and head.

Jugular vein.

In close contact with the outer side of both the common and the internal carotid artery, and incased in a sheath of fascia with that trunk, is the large internal jugular vein, which receives branches in the neck corresponding with some of the branches of the superficial artery.

alters position.

In some bodies the vein may cover the artery; and the branches joining it above may form a kind of plexus over the upper part of the common arterial trunk.

Nerves in connection with the arteries.

Nerves in the space. In connection, more or less intimate, with the large vessels, are the following nerves with a longitudinal direction:—In front of the sheath lies the descending branch of the hypo-glossal nerve; within the sheath, between the carotid artery and jugular vein, is the pneumo-gastric nerve; and behind the sheath is the sympathetic nerve. Along the outer part of the vessels the spinal accessory nerve extends for a short distance, till it pierces the sterno-mastoid muscle.

Several nerves are placed across the vessels:—Thus, directed transversely over the two carotids, so as to form an arch below the digastric muscle, is the hypo-glossal nerve, which gives downwards its branch (descendens noni) most commonly in front of the sheath. Appearing on the inner side of the carotid arteries, close to the base of the space, is the glosso-pharyngeal nerve, which courses forwards between them. Inside the internal carotid artery, opposite the hyoid bone, the superior laryngeal nerve comes into sight; whilst a little lower down, with the descending branches of the thyroid artery, is the external laryngeal branch of that nerve.

Glands; submaxillary

Glands in the space. Two glandular bodies, the submaxillary, 11, and thyroid, 12, have their seat in this triangular space of the neck. The submaxillary gland is situated altogether in front of the vessels, and is partly concealed by the jaw; and beneath it on the surface of the mylo-hyoideus is the small nerve to that muscle, with the submental artery. By the side of the thyroid cartilage, between it and the common carotid artery, lies the thyroid body beneath the sterno-thyroid muscle: in the female this body is more largely developed than in the male.

and thyroid body.

Parotid gland.

At the base of the space, if the parts were not disturbed, would be the parotid gland, which is wedged into the hollow between the jaw and the mastoid process, and projects somewhat below the level of the jaw. Its connections have been noticed at p. 29.

Directions. The student has to proceed next with the examination of the individual parts that have been referred to in connection with the triangular spaces.

Anterior jugular vein

Anterior jugular vein. This small vein occupies the middle line of the neck, and its size is dependent upon the degree of development of the external jugular. Beginning in some small branches below the chin, the vein descends to the sternum, and then bends outwards beneath the sterno-mastoid muscle, to open into the subclavian vein, or into the external jugular. In the neck the anterior and external jugular veins communicate. There are two anterior veins, one for each side, though one is usually larger than the other; and at the bottom of the neck they are joined by a transverse branch.

joins subclavian vein.

Sterno mastoid muscle

The STERNO-CLEIDO-MASTOID MUSCLE (fig. 13, [1]) forms the superficial prominence of the side of the neck. It is narrower in the centre than at the ends, and is attached below by two heads of origin, which are separated by an elongated interval. The inner head is fixed by a narrowed tendon to the anterior part of the first piece of the sternum; and the outer head has a wide fleshy attachment to the sternal third of the clavicle. From this origin the heads are directed upwards, the internal passing backwards, and the external almost vertically, and are blended about the middle of the neck in a roundish belly. Near the skull the muscle ends in a tendon, which is *inserted* into the mastoid process at the outer aspect from base to tip,

has its origin at sternum. and clavicle,

and insertion at skull.

and by a thin aponeurosis into a rough surface behind that process, as well as into the outer part of the upper curved line of the occipital bone.

The muscle divides the lateral surface of the neck into two triangular spaces. On its cutaneous aspect the sterno-mastoid is covered by the common integuments and the platysma, by the external jugular vein and superficial branches of the cervical plexus (across the middle), and by the deep fascia. If the muscle be cut through below and raised, it will be seen to lie on the following parts :—The clavicular origin is superficial to the anterior scalenus and omo-hyoid muscles ; and the sternal head conceals the depressors of the hyoid bone, and the common carotid artery with its vein and nerves. After the union of the heads, the muscle is placed over the cervical plexus, the middle scalenus, and the elevator of the angle of the scapula ; and near the skull, on the digastric and splenius muscles, the occipital artery, and part of the parotid gland. The spinal accessory nerve perforates the muscular fibres about the upper third. The extent of the attachment to the clavicle varies, and in some bodies it may reach even to the trapezius. Position to other parts.

Action. Both muscles acting bend the head forwards, and one muscle turns the face to the opposite side. In conjunction with the muscles attached to the mastoid process one sterno-mastoideus will incline the head towards the shoulder of the same side. Use.

In laborious respiration the two muscles will assist in elevating the sternum.

The OMO-HYOID MUSCLE crosses beneath the sterno-mastoideus, and consists of two fleshy bellies united by a small round intermediate tendon (fig. 12, [3]). The *origin* of the muscle from the scapula, and the connections of the posterior part, are to be studied in the dissection of the back. From the intervening tendon the anterior fleshy belly (fig. 13, [3]) is directed forwards along the border of the sterno-hyoid muscle, and is *inserted* into the lower part of the body of the hyoid bone, close to the great cornu. Omo-hyoid muscle begins at the scapula, and ends at hyoid bone.

The anterior belly is in contact with the fascia, after escaping from beneath the sterno-mastoid ; and rests on the sterno-thyroideus. This part of the muscle crosses the common carotid artery and internal jugular vein on a level with the cricoid cartilage. Connections.

Action. The anterior belly depresses the hyoid bone ; and the posterior is said by Theile to make tense the deep fascia of the neck with which it is connected. Use.

The STERNO-HYOID MUSCLE (fig. 13, [2]), is a flat thin band nearer the middle line than the preceding. It *arises* from the posterior surface of the sternum and the cartilage of the first rib, and sometimes from the clavicle. From this spot the fibres Sterno-hyoid muscle.

ascend, and are *inserted* into the lower border of the body of the os hyoides, internal to the preceding muscle.

Parts above and beneath. One surface is in contact with the fascia, and is often marked by a tendinous intersection near the clavicle. When the muscle is divided and turned aside, the deep surface will be found to rest on the sterno-thyroideus and its continuation (thyro-hyoid), and on the superior thyroid vessels. The muscles of opposite sides are separated by an interval which is largest below. The origin of the muscle varies much.

Use. *Action.* It draws the os hyoides downwards after swallowing; and in laborious respiration it will act as an elevator of the sternum.

Sterno-thyroid muscle. The STERNO-THYROID MUSCLE is wider and shorter than the sterno-hyoid, beneath which it lies. Like the other hyoid muscle, it *arises* from the posterior surface of the sternum, from the cartilage of the first rib below the former, and sometimes from the cartilage of the second rib; and is *inserted* into the oblique line on the side of the thyroid cartilage, where it is continuous with the thyro-hyoid muscle.

Parts over and beneath. The inner border touches its fellow for about an inch, and corresponds with the middle line of the neck and the thyroid veins; whilst the outer reaches over the carotid artery. The superficial surface is concealed by the preceding hyoid muscles; and the opposite surface is in contact with the lower part of the carotid artery, the trachea, and the larynx and thyroid body. A transverse tendinous line crosses the muscle near the sternum.

Use. *Action.* Its chief use is to aid the preceding muscle in lowering rapidly the hyoid bone after deglutition; but it can draw down and forwards the thyroid cartilage, and assist in rendering tight the vocal cords.

Like the sterno-hyoid it participates in the movement of the chest in laborious breathing.

Thyro-hyoid muscle. The THYRO-HYOIDEUS (fig. 13, [4]) is a continuation of the last muscle. Beginning on the side of the thyroid cartilage, the fibres ascend to the inner half of the great cornu of the os hyoides, and the outer part of the body of the bone.

On the muscle lie the omo-hyoideus and sterno-hyoideus; and beneath it are the superior laryngeal nerve and vessels. This is sometimes considered one of the special muscles of the larynx.

Use. *Action.* Raising the thyroid cartilage towards the os hyoides, it renders lax the vocal cords, and assists in placing the cartilage preparatory to swallowing.

Directions. The remaining parts included in this SECTION are the scaleni muscles and the subclavian blood-vessels, with the cervical nerves and the carotid blood-vessels. The student may examine them in the order here given.

Dissection *Dissection.* Supposing the sterno-mastoid to be cut, the fat and fascia are to be taken away from the lower part of the neck, so as to prepare the scaleni muscles with the subclavian vessels and their branches. By means of a little dissection the anterior scalenus muscle will be seen ascending from the first rib to the neck, having the phrenic nerve and subclavian vein in front of it, the latter crossing it near the rib.

The part of the subclavian artery on the inner side of the scalenus is then to be cleaned, care being taken not only of its branches, but of the branches of the sympathetic nerve which course over and along it from the neck to the chest. This dissection will be facilitated by the removal of a part or the whole of the clavicle. of the subclavian artery

All the branches of the artery are in general easily found, except the superior intercostal, which is to be sought in the thorax in front of the neck of the first rib. On the branch (inferior thyroid) ascending to the thyroid body, or near it, is the middle cervical ganglion of the sympathetic; and the dissector should follow downwards from it the small nerves to the thorax. Only the origin and first part of the course of the arterial branches can be now seen; their termination is met with in other stages of this dissection, or in the dissection of other parts of the body. and branches;

In this stage the student should seek the small right lymphatic duct that opens into the subclavian vein near its junction with the jugular. A notice of it will be given with the lymphatics of the thorax. of lymphatic duct:

The outer part of the subclavian artery having been already prepared, let the dissector remove more completely the fibrous tissue from the nerves of the cervical and brachial plexuses. From the brachial plexus trace the small branch to the subclavius muscle; and the branches to the rhomboid and serratus muscles, which pierce the middle scalenus. If it is thought necessary, the anterior scalenus may be cut through after the artery has been studied. of brachial plexus;

From the cervical plexus, besides muscular branches, the student should seek small twigs to join the descendens noni; and should define the roots of the phrenic nerve. Lastly, let the surface of the middle scalenus muscle be cleaned, as it lies beneath the cervical nerves. of cervical plexus.

The SCALENI muscles are usually described as three in number, and are named from their relative position, anterior, middle, and posterior; they extend from the first two ribs to the transverse processes of the cervical vertebræ. Number of scaleni muscles.

The SCALENUS ANTICUS (fig. 14, [1]) extends from the first rib to the lower cervical vertebræ, and is somewhat conical in shape. Scalenus anticus.
It is attached by its apex to the inner border and the upper surface of the first rib, so as to surround the rough surface or projection on this aspect of the bone; and by its base it is *in-* Origin;

insertion; *serted* into the anterior transverse processes of four of the cervical vertebræ, viz. sixth, fifth, fourth, and third.

connections, vessels, and nerves. More deeply seated below than above, the muscle is concealed by the clavicle and the subjacent muscle (subclavius), and by the clavicular part of the sterno-mastoid: the phrenic nerve lies along the cutaneous surface of the muscle, and the subclavian vein crosses over it near the rib. Along the inner border is the internal jugular vein. Beneath the scalenus are the pleura, the subclavian artery, and the nerves of the brachial plexus. The insertion into the vertebræ corresponds with the origin of the rectus capitis anticus major muscle.

Use. *Action.* The anterior of these muscles raises strongly the first rib, in consequence of its forward attachment. If the rib is fixed, it bends forwards the lower part of the neck, partly if one muscle acts, completely if both are used.

Scalenus medius. Origin; The SCALENUS MEDIUS MUSCLE (fig. 14, ²) is larger than the anterior, and extends farthest of all on the vertebræ. Inferiorly it is attached to the inner border of the first rib; and to a groove on the upper surface of the rib, which extends obliquely backwards for one inch and a half from the inner border to the tubercle. The muscle ascends behind the spinal nerves, and is insertion. *inserted* into the tips of the posterior transverse processes of all the cervical vertebræ.

Parts in contact with it. In contact with the anterior surface are the subclavian artery and the spinal nerves, together with the sterno-mastoid muscle; whilst the posterior surface touches the posterior scalenus, and the deep lateral muscles of the back of the neck. The outer border is perforated by the nerves of the rhomboid and serratus muscles.

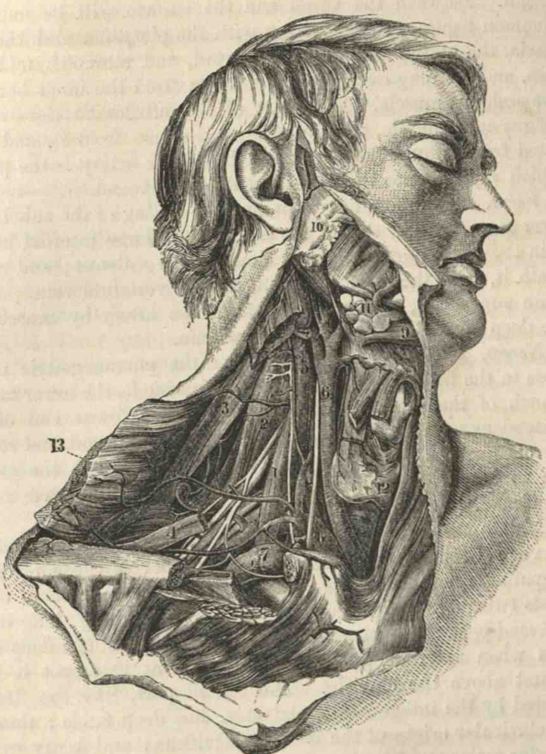
Use. *Action.* Usually it elevates the first rib. With the rib fixed, the cervical part of the spine will be inclined laterally by one muscle.

Scalenus posticus. Attachments. The SCALENUS POSTICUS is inconsiderable in size, and appears to be but part of the preceding. It is attached below by a slip, about half an inch wide, to the upper border of the second rib, in front of the elevator of that bone; and it is inserted above with the scalenus medius into two or three of the lower cervical transverse processes.

Use, *Action.* It acts as an elevator of the second rib; and its fibres having the same direction as those of the medius, it will incline the neck in the same way.

Subclavian artery; extends to upper limb, The SUBCLAVIAN ARTERY (fig. 14) is the first part of the large vessel supplying the upper limb with blood, which is thus designated from its position beneath the clavicle. This vessel, 8, is derived from the branching of the innominate artery behind the sterno-clavicular articulation, and the part of it named subclavian extends as far as the lower border of the first rib. To reach the limb the artery crosses the lower part of the neck, taking an arched course over the bag of the pleura and the first

Fig. 14.*



rib, and between the scaleni muscles. For the purpose of describing the numerous connections of the subclavian artery the vessel may be divided into three parts: the first extending from the sterno-clavicular articulation to the inner border of the anterior scalenus; the second, beneath the scalenus; and the third, and is divided into three parts.

* A view of the common carotid and subclavian arteries (from Quain's "Arteries"). 1. Anterior scalenus, with the phrenic nerve on it. 2. Middle scalenus. 3. Levator anguli scapulæ. 4. Omohyoideus. 5. Rectus capitis anticus major. 6. Common carotid artery. 7. Subclavian vein. 8. Subclavian artery. 9. Digastric muscle. 10. Parotid gland. 11. Submaxillary gland. 12. Thyroid body. 13. Trapezius muscle reflected.

from the outer border of that muscle to the lower edge of the first rib.

First part internal to scalenus is deep.

First part. Internal to the anterior scalenus the artery lies deeply in the neck, and ascends slightly from the level of its origin. Between the vessel and the surface will be found the common tegumentary coverings with the platysma and the deep fascia, the sterno-mastoid, sterno-hyoid, and sterno-thyroid muscles, and a strong deep process of fascia from the inner border of the scalenus muscle. This part of the subclavian lies over the longus colli muscle, though at some distance from it, and separated from it by fat and nerves. Below the artery is the pleura, which ascends into the arch formed by the vessel.

In front, behind, below.

Veins with the artery.

Veins. The innominate vein, and the ending of the subclavian, form an arch below that of the artery. The large internal jugular vein crosses the arterial trunk close to the scalenus; and underneath it, with the same direction, lies the vertebral vein. Much more superficial, and separated from the artery by muscles, is the deep part of the anterior jugular vein.

Position of nerves before,

Nerves. In front of the artery lies the pneumogastric nerve, close to the internal jugular vein; and inside it, the lower cardiac branch of the same trunk. Sometimes the lower end of the descendens noni nerve, which enters the sterno-hyoid and sterno-thyroid muscles, is large enough to reach as far as the artery, and to cross it superficial and internal to the two nerves before mentioned.

and behind.

Behind the subclavian trunk winds the recurrent branch of the vagus or pneumogastric; and still deeper is the cord of the sympathetic nerve with its cardiac branches, one or more of its offsets twining round the artery, and others creeping along it.

Second part beneath scalenus.

Second part. Beneath the scalenus the vessel is less deep than it is when internal to that muscle, and at this spot it rises highest above the clavicle. The second part, like the first, is covered by the integuments, platysma, and deep fascia; then by the clavicular origin of the sterno-mastoideus; and lastly by the anterior scalenus with the phrenic nerve. Behind the vessel is the middle scalenus. Below the level of the artery is the bag of the pleura, which ascends between the scaleni.

In front, behind, below.

Position of veins;

Veins. Below the level of the artery, and separated from it by the anterior scalenus muscle, lies the arch of the subclavian vein.

of nerves to the artery.

Nerves. In front of the scalenus descends the phrenic nerve; and above the vessel, in the interval between the scaleni, are placed the large trunks of the cervical nerves; but the trunk formed by the last cervical and first dorsal is interposed between the artery and the middle scalenus.

Third part

Third part. Beyond the scalenus the subclavian artery is contained in the clavicular part of the posterior triangular space

(p. 58), and is nearer the surface than in the rest of its course. This part of the vessel is enclosed in a tube of the deep cervical fascia, which it receives as it passes from between the scaleni. It is comparatively superficial whilst in the space before mentioned, for it is covered only by the integuments, the platysma, and deep fascia; but near its termination the vessel gets under cover of the suprascapular artery and vein, and the clavicle and subclavius muscle. In the third part of its course the artery rests on the surface of the first rib, which is interposed between it and the pleura.

is superficial.

Parts covering it;

above and beneath,

Veins. The arch of the subclavian vein is close to the artery, not being separated by muscle, but lies at a lower level commonly than that vessel. The external jugular vein crosses in front near the scalenus muscle, and the suprascapular and transverse cervical branches which enter the jugular, form sometimes a plexus over the third part of the artery.

Position of veins;

Nerves. The large cords of the brachial plexus are placed above and close to the vessel; and the small nerve of the subclavius crosses it about the middle. Superficial to the cervical fascia have been seen the descending cutaneous branches of the cervical plexus.

of nerves to artery.

Peculiarities. There are some peculiarities affecting the origin, the course, and the level in the neck of the subclavian artery.

Peculiarities of origin of the trunk,

The height at which it springs from the innominate trunk may vary; so that in one case it will be above the sterno-clavicular articulation, in another, below that joint.

Or the artery may spring as a separate trunk from the arch of the aorta; and in such a deviation the vessel takes a deeper place than usual to reach the scaleni muscles.

It has been before said (p. 58), that the artery may be in front of the scalenus or in its fibres; and that it may be placed one inch and a half above the level of the clavicle.

course and level.

Branches of the subclavian. Usually there are four chief branches to the subclavian artery. Three branches arise from the first part of the arterial trunk;—one (vertebral) ascends to the head; another (internal mammary) descends to the chest; and the remaining one (thyroid axis) is a short thick trunk, which furnishes branches inwards and outwards, viz. to the thyroid body and the shoulder. These arise commonly near the scalenus muscle, so as to leave an interval at the origin free from offsets. This interval varies in length from half an inch to an inch in the greater number of cases; and its extremes range from somewhat less than half an inch to an inch and three quarters. But in some instances the branches are scattered over the whole extent of this part of the artery (Quain).*

Branches of subclavian.

From first,

* The student is referred for fuller information respecting the pecu-

second,

The fourth branch (superior intercostal) arises from the second part of the artery, viz. that beneath the anterior scalenus, and gives off the deep cervical branch. A small spinal artery comes sometimes from this part of the trunk.

and third part.

If there is a branch present on the third part of the artery, it is commonly the posterior scapular: if more than one, the preceding branch with the internal mammary; and if more than two, an offset belonging to the thyroid axis will be added.

Vertebral artery in the neck.

The *vertebral artery* is generally the first and largest branch of the subclavian, and arises from the upper and posterior part of the vessel. Ascending between the contiguous borders of the scalenus and longus colli muscles, this branch enters the aperture in the lateral part of the sixth cervical vertebra, and is continued upwards to the skull through the foramina in the other cervical vertebræ. Before the artery enters its aperture it is partly concealed by the internal jugular vein, and passes beneath the thyroid artery; it is accompanied by branches of the sympathetic nerve, and supplies small muscular offsets. Its course and distribution will be given afterwards.

Small branches.

On left side.

On the left side the commencement of the vertebral artery is crossed by the thoracic duct.

Difference in place of origin.

The origin of the vertebral may vary in its position along the first part of the trunk of the subclavian. It may be transferred to the arch of the aorta, especially on the left side; or to the right common carotid artery (though rarely), when the subclavian of the right side arises from the aorta.

The course of the artery is not constant through the hole in the sixth vertebra; it may enter any other as high as the second.

Vertebral vein, and branches.

The *vertebral vein* issues with its accompanying artery, to which it is superficial in the neck, and is directed over the subclavian artery to join the subclavian vein; it receives the *deep cervical vein*, and the *branch* that accompanies the ascending cervical artery.

Internal mammary artery in the neck.

The *internal mammary branch* leaves the lower part of the subclavian artery, and coursing downwards beneath the clavicle and subjacent muscle and the beginning of the right innominate vein, enters the thorax between the first rib and the bag of the pleura. As the artery is about to enter the chest, it is crossed (superficially) by the phrenic nerve. The vessel is distributed to the walls of the chest and abdomen; and its anatomy will be given with the dissection of those parts.

Thyroid axis

Thyroid axis. This is a short thick trunk (fig. 13) which arises from the front of the artery near the anterior scalenus muscle, and soon divides into three branches,—one to the thyroid

divides into three.

liarities of the vessels, and the practical applications to be deduced from them, to the original and valuable work on the Anatomy of the Arteries of the Human Body, by Richard Quain, F.R.S.

body, and two to the scapula. On the left side of the body the thoracic duct lies in front of the thyroid axis.

Supra-scapular branch.

The *suprascapular branch* courses outwards across the lower part of the posterior triangular space of the neck, behind the clavicle and subclavius muscle, to the superior costa of the scapula, and entering the supraspinal fossa is distributed on the dorsum of that bone. The connections of this artery are more fully seen in the dissection of the back.

Transverse cervical branch.

The *transverse cervical branch*, usually larger than the preceding, takes a similar direction, though higher in the neck, and ends beneath the border of the trapezius muscle in the superficial cervical and posterior scapular arteries. (See "DISSECTION OF THE BACK.") In its course outwards through the space containing the third part of the subclavian artery, this branch crosses the anterior scalenus, the phrenic nerve, and the brachial plexus. Some small offsets are supplied by it to the posterior triangular space of the neck.

Offsets.

Size and ending vary.

Though the transverse cervical artery supplies ordinarily the posterior scapular branch, there are many bodies in which it is too small to give origin to so large an offset. In such instances the diminished artery ends in the trapezius muscle; whilst the posterior scapular branch arises separately from the third, or even the second part of the subclavian artery (fig. 12).

Inferior thyroid branch

The *inferior thyroid branch* is the largest offset of the thyroid axis. Directed inwards with a flexuous course to the thyroid body, the branch passes beneath the common carotid artery and the accompanying vein and nerves, and in front of the longus colli muscle and the recurrent nerve. At the lower part of the thyroid body it divides into branches which enter the under surface; these communicate with the superior thyroid, and with the corresponding artery of the opposite side, forming a very free anastomosis between those vessels.

gives laryngeal offset,

Near the larynx a *laryngeal branch* is distributed to that tube, and other offsets are furnished to the trachea.

and ascending cervical branch.

The *ascending cervical artery* is a branch of the thyroid near the commencement; it is directed upwards between the scalenus and rectus capitis anticus major, and ends in branches to those muscles and the posterior triangle of the neck. Some small spinal offsets are conveyed along the spinal nerves to the cord and its membranes.

Veins corresponding to arteries.

The *veins* corresponding with the branches of the thyroid axis have the following destination:—those with the suprascapular and transverse cervical arteries open into the external jugular vein. But the inferior thyroid vein begins in a plexus connected with the thyroid body, and descends in front of the trachea, beneath the muscles covering this tube, to end in the innominate vein.

Superior

The *superior intercostal artery* arises from the posterior part intercostal artery. of the subclavian, and bends downwards over the neck of the first rib to the thorax. Its distribution to the first two intercostal spaces will be seen in the thorax.

Deep cervical artery. Arising in common with this branch is the *deep cervical artery* (art. profunda cervicis). Analogous to the dorsal branch of an intercostal artery (Quain), it passes backwards between the transverse process of the last cervical vertebra and the first rib, and ends beneath the complexus muscle at the posterior part of the neck.

Spinal branch. A *spinal branch* (Quain) is frequently given from the second part of the artery, and sends offsets into the spinal canal through the intervertebral foramina.

Subclavian vein. The SUBCLAVIAN VEIN has not the same limits as the companion artery, reaching only from the lower edge of the first rib to the inner border of the anterior scalenus muscle. It is a continuation upwards of the axillary vein, and ends by joining the internal jugular in the innominate trunk. Its course is arched below the level of the artery, from which it is separated by the anterior scalenus muscle.

Its branches; opening of lymphatic ducts. The anterior and external jugular join the subclavian vein outside the scalenus, and the vertebral vein enters it inside that muscle. Into the angle of union of the subclavian and jugular veins the right lymphatic duct opens; and at the same spot, on the left side, enters the large lymphatic or thoracic duct. A pair of valves exists in the vein at about an inch from its ending, and outside the opening of the external jugular.*

Position may vary. It should be borne in mind that not unfrequently the vein is as high in the neck as the third part of its companion artery; and that the vein has been seen twice with the artery beneath the anterior scalenus.

Cervical nerves. Position and number. The ANTERIOR PRIMARY BRANCHES OF THE CERVICAL NERVES spring from the common trunks in the intervertebral foramina, and appear on the side of the neck between the intertransverse muscles. These spinal nerves are eight in number, and are equally divided between the cervical and the brachial plexus; the highest four being combined in the former, and the remaining nerves in the latter plexus. The nerves receive offsets of communication from the sympathetic at their beginning, and intermix by means of numerous branches near the spine.

First two differ from rest. To this general statement respecting the nerves, some addition is needed for the first two nerves; and the peculiarities concerning them will be noticed in SECTION 18.

Brachial plexus. BRACHIAL PLEXUS. The first dorsal and four lower cervical nerves are blended in this plexus; and a fasciculus is added to

* See a Paper on the Valves in the Veins of the Neck in the Edin. Med. Journal, of Nov. 1856, by Dr. Struthers.

them from the lowest nerve entering the cervical plexus. Thus formed, the plexus reaches from the neck to the axilla, where it ends in nerves for the upper limb. Only the part of it above the clavicle can be now seen. In the neck the nerves have but little of a plexiform disposition: they lie at first between the scaleni muscles, opposite the four lower cervical vertebræ, and have the following arrangement:— formed by five nerves.

The fifth and sixth nerves unite near the vertebræ; the seventh remains distinct as far as the outer border of the middle scalenus; and the last cervical and first dorsal are blended in one trunk beneath the anterior scalenus; so that they make at first three cords. Near the attachment of the middle scalenus to the rib, the seventh nerve throws itself into the trunk of the united fifth and sixth, and then there result two cords to the plexus:— the one (upper) formed by the fifth, sixth, and seventh cervical nerves; and the other (lower) by the eighth cervical and the first dorsal nerve. These two trunks accompany the subclavian artery, lying to its acromial side, and are continued to the axilla where they are more intimately blended. Disposition of nerves in the plexus.

Branches. The branches of the plexus may be classed into those above the clavicle, and those below that bone. The highest set end mostly in the muscles of the lower part of the neck and the scapula; whilst the other set consist of the terminal branches, and are furnished to the upper limb, with which they will be referred to. Branches in the neck are

Branches above the Clavicle. The *branch of the subclavius muscle* is a slender twig, which arises from the trunk formed by the fifth and sixth nerves, and is directed downwards over the subclavian artery to the under surface of the muscle; it is often united with the phrenic nerve at the lower part of the neck. Nerve of subclavius,

The *branch for the rhomboid muscle* springs from the fifth nerve in the substance of the middle scalenus, and perforates the fibres of that muscle; it is directed backwards beneath the levator anguli scapulæ to its destination. Branches are given usually from this nerve to the levator anguli scapulæ. Nerve of rhomboideus,

The *nerve of the serratus* (posterior thoracic nerve) is contained in the scalenus, like the preceding, and arises from the fifth and sixth nerves, near the intervertebral foramina. Piercing the fibres of the scalenus lower than the preceding branch, the nerve is continued behind the brachial plexus, and enters the serratus magnus muscle on the axillary surface. Nerve of serratus,

Branches for the scaleni and longus colli muscles. These are small twigs that are seen when the anterior scalenus is divided; they arise from the trunks of the nerves as soon as these leave the spinal canal. Nerves of scaleni and longus colli,

The *suprascapular nerve* is larger than either of the others. It arises near the subclavian branch from the same cord of the Suprascapular nerve.

plexus, viz., that formed by the fifth and sixth nerves. Its destination is to the muscles on the dorsum of the scapula, and it will be dissected with the arm.

Offset to the phrenic.

Occasionally an offset comes from the fifth cervical trunk, and joins the phrenic nerve on the anterior scalenus muscle.

Cervical plexus

The CERVICAL PLEXUS is formed by the anterior primary branches of the first four cervical nerves. Situate at the upper part of the neck, it lies beneath the sterno-mastoid muscle, and on the middle scalenus and the levator anguli scapulæ. It differs much from the brachial plexus, for it resembles a network more than a bundle of large cords. The following is the general arrangement of the nerves in the plexus :—Each nerve, except the first, divides into an ascending and a descending branch, and these unite with similar parts of the contiguous nerves, so as to give rise to a series of arches. From these loops or arches the different branches arise.

forms a network,

Arrangement of the nerves.

Its offsets are superficial,

Branches. The branches of the plexus are superficial and deep. The superficial set has been described with the triangular space of the neck, as consisting of ascending and descending (p. 59). In this stage of the dissection the ascending branches may be seen to spring from the union of the second and third nerves; and the descending to take origin from the loop between the third and fourth nerves. The deep set of branches remains to be examined.

and deep.

Deep branches are :

The DEEP BRANCHES OF THE PLEXUS are muscular and communicating, and may be arranged into an internal and an external series.

Phrenic nerve,

INTERNAL SERIES. The *phrenic* or muscular *nerve* of the diaphragm (fig. 14) is derived from the fourth, or third and fourth nerves of the plexus; and it may be joined by a fasciculus from the fifth cervical nerve. Descending obliquely on the surface of the anterior scalenus from the outer to the inner edge, it enters the chest in front of the internal mammary artery, but behind the subclavian vein, and traverses that cavity to reach the diaphragm. At the lower part of the neck the phrenic nerve is joined by a filament of the sympathetic, and sometimes by an offset of the nerve of the subclavius muscle.

On the left side the nerve crosses over the first part of the subclavian artery.

Nerves to join descendens noni,

The *branches communicating with the descendens noni* are two in number. One of them arises from the second, and the other from the third cervical nerve; they are directed inwards over the internal jugular vein, and communicate in front of the carotid sheath with the descending muscular branch (descendens noni) of the hypoglossal nerve. Sometimes these branches pass under the jugular vein.

Branches to recti,

Muscular branches are furnished to the recti muscles; they arise from the loop between the first two nerves, and from the trunks of the other nerves close to the intervertebral foramina.

Some *connecting branches* pass from the loop between the first two nerves, and unite with the sympathetic and some cranial nerves near the base of the skull: these will be afterwards described. **Branches to other nerves,**

External or Posterior Series. *Muscular branches* are given from the second nerve to the sterno-mastoideus; from the third nerve to the levator anguli scapulæ; and from the third and fourth nerves to the trapezius. Further, some small branches supply the substance of the middle scalenus. **Branches to muscles,**

Connecting branches with the spinal accessory nerve. The communications are numerous between this cranial and the spinal nerves. First, in the sterno-mastoid muscle; next, in the posterior triangular space; and lastly, beneath the trapezius. The union with the branches distributed to the trapezius has the appearance of a plexus. **Branches joining spinal accessory.**

The common carotid artery is the leading vessel for the supply of blood to the neck and head (fig. 14, [6]). The origin of the vessel differs on opposite sides of the body, beginning at the lower part of the neck on the right, and in the thorax on the left side. **Common carotid artery.**

The right vessel commences opposite the sterno-clavicular articulation in the bifurcation of the innominate artery, and ends at the upper border of the thyroid cartilage by dividing into the two trunks before seen, viz. external and internal carotid. The course of the artery is along the side of the trachea and larynx, gradually diverging from the vessel on the opposite side in consequence of the increasing size of the larynx; and its position will be marked by a line from the sterno-clavicular articulation to a point midway between the angle of the jaw and the mastoid process. **Origin.** **Course.** **Situation.**

Contained in a sheath of cervical fascia with the internal jugular vein and the pneumo-gastric nerve, the carotid artery has the following connections with the surrounding parts:—As high as the cricoid cartilage the vessel is deeply placed, and is concealed by the common coverings of the skin, platysma, and fasciæ, and by the muscles at the lower part of the neck, viz., sterno-mastoid (sternal origin), sterno-hyoid, sterno-thyroid, and omohyoid. But above the cricoid cartilage to its termination the artery is less deep, being covered only by the sterno-mastoid with the common investments of the part. The vessel rests mostly on the longus colli muscle, but close to its ending on the rectus capitis anticus major. To the inner side of the carotid lie the trachea and larynx, with the œsophagus and pharynx, and the thyroid body, the last overhanging the vessel by the side of the larynx. Along the outer side of the carotid sheath is a chain of lymphatic glands. **Parts covering it,** **beneath it,** **and on its sides.**

Position of veins;

Veins. The large internal jugular is contained in the sheath of the carotid, lying on the outer side and close to it at the upper end, but separated from it below by an interval of about half an inch: on the left side the vein is over the artery below, as will be afterwards seen. One or two upper thyroid veins and their branches cross the upper part of the arterial trunk; and opposite the thyroid body another small vein (middle thyroid) is directed back over the vessel. Near the clavicle the anterior jugular passes out under the sterno-mastoid: it is superficial to the artery, and separated from it by the sterno-hyoid and thyroid muscles.

of arteries;

Arteries. Offsets of the upper thyroid artery descend over the top of the sheath; and the inferior thyroid crosses under it below the level of the cricoid cartilage.

of nerves to carotid.

Nerves. The descendens noni nerve lies in front of the sheath, crossing from the outer to the inner side, and is joined there by the cervical nerves. The pneumogastric nerve lies within the sheath, behind and between the artery and the vein. The sympathetic cord and branches rest on the spine behind the sheath. All the nerves above mentioned have a longitudinal direction; but the remaining one, inferior-laryngeal or recurrent, crosses obliquely inwards behind the sheath towards the lower end of the artery.

Branches of carotid. As a rule, the common carotid artery does not furnish any collateral branch, though it is very common to have the superior thyroid springing from its upper end. At the terminal bifurcation of the artery into the two carotids it is slightly bulged.

Internal jugular vein

INTERNAL JUGULAR VEIN. This vein extends upwards to the base of the skull by the side of the carotid blood-vessels, but only the part of it that accompanies the common carotid artery is now seen. Placed behind or external to its artery, the vein ends below by uniting with the subclavian in the innominate vein.

lies close to side of artery,

except below.

Its proximity to the carotid is not equally close throughout, for at the lower part of the neck the vein inclines backwards, leaving a space between it and the artery, in which the vagus nerve is seen about midway between the two. Sometimes the vein is superficial to the artery as on the left side.

The lower part of the vein is marked by a dilatation or sinus. Near its ending it becomes contracted, and is provided with a pair of valves (Struthers).

Branches.

In this part of its course the vein receives the superior and middle thyroid branches.

Differences in origin;

Peculiarities.—Some of the following peculiarities of the common carotid may be met with. Its origin on the right side may be above or below the point here stated; or it may be transferred to the arch of the aorta, or to the left carotid in the thorax. Mention has been made of the difference in the place of bifurcation, and of the fact that, occasionally, the common carotid artery is not divided into two. (See page 65.)

Instead of one, there may be two trunks issuing from beneath the hyoid muscles, for the common carotid has been found divided in one case after an extent of one inch and a half. As an extremely rare occurrence its usual terminal branches, the external and internal carotids, may arise as distinct arteries from the arch of the aorta. In number.

Usually without branch, it may give origin to the superior thyroid, the inferior thyroid, or the vertebral artery. Its branches.

Dissection. The dissector may next trace out completely the trunk of the external carotid, and follow its branches until they disappear beneath different parts. Afterwards he may separate from one another the digastric and stylo-hyoid muscles, which cross the carotid; and may define their origin and insertion. Dissection.

The DIGASTRIC MUSCLE (fig. 14,[9]) consists of two fleshy bellies, united by an intervening tendon, whence its name. The posterior belly, the larger of the two, *arises* from the groove beneath the mastoid process; whilst the anterior belly takes origin on the side of the symphysis of the lower jaw. From these places of origin the fibres are directed to the intervening tendon:—those of the posterior belly, the longest, are inclined obliquely forwards; and those of the anterior belly pass more vertically downwards. The tendon of the muscle, surrounded by fibres of the stylo-hyoideus, is united to its fellow and the os hyoides by means of an aponeurotic expansion, which keeps in position the arch of the muscle, and is attached to the body and part of the great cornu of the hyoid bone. Digastric muscle has two bellies, which are joined by a tendon.

The arch formed by the digastric is superficial, except at the outer end, where it is beneath the sterno and trachelo-mastoid muscles. The posterior belly covers the carotid vessels and the accompanying veins and nerves; and is placed across the anterior triangular space of the neck in the position of a line from the mastoid process to a little above the hyoid bone: along its lower border lie the occipital artery and the hypoglossal nerve; the former passing backwards, the latter forwards. The anterior belly rests on the mylo-hyoid muscle. Position to other parts.

The digastric muscle forms the lower boundary of a space which reaches upwards to the jaw, the base of the skull in front of the ear, and the mastoid process. This space is subdivided into two by the stylo-maxillary ligament. In the posterior portion are contained the parotid gland, 10, and the vessels and nerves in connection with it (p. 30); in the anterior are the submaxillary gland, 11, and the facial and submental vessels, and deeper still the muscles between the chin and the hyoid bone. The muscle bounds a space containing glands.

Action. The lower jaw being moveable, the muscle depresses that bone and opens the mouth. If the jaw is fixed the two bellies acting will elevate the hyoid bone. Use.

It is supposed that the posterior belly may assist in moving back the head when the jaw is fixed.

Stylo-hyoideus. Origin. Insertion.

The STYLO-HYOID MUSCLE is thin and slender, and has the same position as the posterior belly of the digastric. It *arises* from the outer surface of the styloid process, near the base or about the middle, and is *inserted* into the body of the os hyoides.

Surrounds digastric tendon.

The muscle has the same connections as the posterior belly of the digastric; and its fleshy fibres are usually perforated by the tendon of that muscle. In some bodies the stylo-hyoideus is absent.

Use.

Action. This muscle elevates the os hyoides preparatory to swallowing, and checks, with the posterior belly of the digastric, the too forward placing of the bone by the other elevators.

Ninth nerve in the anterior triangle.

The HYPOGLOSSAL NERVE (ninth cranial) may be now examined in the anterior triangle of the neck. Appearing at the lower edge of the digastric muscle, the nerve hooks round the occipital artery; it is then directed forwards to the tongue below the digastric, and disappears in front beneath the mylo-hyoid muscle. In this course the nerve passes over the two carotid vessels; and near the cornu of the os hyoides it crosses also the lingual artery, so as to become higher than the vessel.

Branches:

Branches. In this part of its course the nerve gives the descendens noni branch, and a small muscular offset to the thyro-hyoideus.

to hyoid muscles

The *descending branch* (ram. descend. noni) arises from the trunk of the hypoglossal on the outer side of the carotid artery, and descends on the front of (sometimes in) the sheath of the vessel to about the middle of the neck, where it is joined by the communicating branches of the cervical nerves. After the union of the spinal nerves, offsets are supplied to the depressor muscles of the os hyoides, viz., omo-hyoid (both bellies), sterno-hyoid, and sterno-thyroid. Sometimes another offset is continued to the thorax, where it joins the phrenic and cardiac nerves.

is joined with cervical nerves

by intercommunicating fibrils.

The connection between the descendens noni and the spinal nerves is formed by two or more cross filaments, so as to construct an arch with the concavity upwards; and an interchange of fibrils between the two nerves is supposed to take place.

External carotid vessel.

The EXTERNAL CAROTID ARTERY (fig. 14) springs from the bifurcation of the common carotid at the upper border of the thyroid cartilage, and furnishes branches to the face, the neck, and the outer parts of the head.

Extent.

From the place of origin the vessel ascends to the interval between the jaw and the mastoid process, and ends near the condyle of the jaw in the internal maxillary and temporal branches. In its course the artery lies at first to the inner side of the internal carotid, but it afterwards becomes superficial to that vessel; and its direction is somewhat arched forwards,

Course and direction,

though the position would be marked sufficiently by a line from the front of the meatus of the ear to the cricoid cartilage.

At first the external carotid is comparatively superficial, and easily reached from the surface, being overlaid by the sterno-mastoideus, and by the common coverings of the anterior triangular space, viz. the skin, the superficial and deep fasciæ with the platysma. But above the level of a line extended from the mastoid process to the hyoid bone, the artery is crossed by the digastric and stylo-hyoid muscles; and still higher it enters the substance of the parotid gland. At its beginning the artery is unsupported beneath by muscles, though it rests against the pharynx; but above the angle of the jaw it is placed over the styloid process and stylo-pharyngeus muscle, which separate it from the internal carotid. To the inner side of the vessel at first is the pharynx, and still higher come the ramus of the jaw and the stylo-maxillary ligament.

Parts superficial to it, beneath it, and on inner side.

Veins. There is not any companion vein with the external carotid as with most arteries; but sometimes a vein, formed by the union of the temporal and internal maxillary branches, will accompany it. Near the beginning it is crossed by the facial and lingual branches joining the internal jugular vein; and near the ending the external jugular vein lies over it.

Veins in contact with the artery

Nerves are directed from behind forwards over and under the artery. At the lower border of the digastric the hypoglossal lies over the vessel, and near the ending the ramifications of the facial nerve are superficial to it. Three nerves lie beneath it:—beginning below, the small external laryngeal; a little higher, the superior laryngeal; and near the base of the jaw, the glosso-pharyngeal.

and nerves.

The *branches* of the external carotid are numerous, and are classed into an anterior, posterior, and ascending set. The anterior set comprise branches to the thyroid body, the tongue, and the face, viz. superior thyroid, lingual, and facial arteries. In the posterior set are the occipital and posterior auricular branches. And the ascending set include the ascending pharyngeal, temporal, and internal maxillary arteries. Besides these, the carotid gives other branches to the sterno-mastoid muscle and the parotid gland.

Its branches are anterior, posterior, and ascending:

The place of origin of the branches of the carotid (as this will be described) may be departed from by their closer aggregation on the trunk. The usual number may be diminished by two or more taking origin in common; or the number may be increased by some of the secondary offsets being transferred to the parent trunk.

change in origin and in number.

Directions. All the branches, except the ascending pharyngeal, lingual, and internal maxillary, may be now examined; but those three will be described afterwards with the regions they occupy.

Branches now seen are

Superior thyroid, The *superior thyroid artery* arises near the cornu of the os hyoides, and runs downwards on the inner side of the common carotid trunk, passing beneath the omo-hyoid, sterno-hyoid, and sterno-thyroid muscles to the thyroid body, to which it is distributed on the anterior aspect. has offsets to This artery is superficial in the anterior triangle, and furnishes offsets to the lowest constrictor and the muscles beneath which it lies, in addition to the following named branches :—

the hyoid branch, The *hyoid branch* is very inconsiderable in size, and runs inwards below the hyoid bone : it supplies the muscles attached to that bone, and anastomoses with the vessel of the opposite side.

to sterno-mastoid muscle, A branch for the *sterno-mastoid muscle* lies in front of the sheath of the common carotid artery, and is distributed chiefly to the muscle from which it takes its name.

to larynx, The *laryngeal branch* pierces the membrane between the hyoid bone and the thyroid cartilage, with the superior laryngeal nerve, and ends in the interior of the larynx.

to crico-thyroid membrane. A small *crico-thyroid branch* is placed on the membrane between the cricoid and the thyroid cartilage, and communicates with the corresponding artery of the opposite side, forming an arch.

Accompanying vein. The *superior thyroid vein* commences in the larynx and the thyroid body, and crosses the end of the common carotid artery to open into the internal jugular vein.

Facial artery The *facial artery* arises above the lingual, and is directed upwards over the lower jaw to the face. In the neck the artery passes beneath the digastric and stylo-hyoid muscles, and is afterwards lodged on the submaxillary gland, on which it makes a remarkable sigmoid turn. Its disposition in the face has been examined (p. 28). supplies neck branches From the cervical part branches are given to the pharynx, and to the structures below the jaw, viz. :—

to the palate, The *inferior palatine branch* ascends to the pharynx beneath the jaw, passing between the stylo-glossus and stylo-pharyngeus muscles, and is distributed to the soft palate, after furnishing a branch to the tonsil. This branch frequently arises from the ascending pharyngeal artery.

tonsil, The *tonsillar branch* is smaller than the preceding, and ascends between the internal pterygoid and stylo-glossus muscles. Opposite the tonsil it perforates the constrictor muscle, and ends in offsets to that body.

sub-maxillary gland, *Glandular branches* are supplied to the submaxillary gland from the part of the artery in contact with it.

and mylo-hyoid muscle. The *submental branch* arises near the inferior maxilla, and passes forwards on the mylo-hyoideus to the anterior belly of the digastric muscle, where it ends in offsets : some of these turn over the jaw to the chin and lower lip ; and the rest supply the muscles between the jaw and the hyoid bone, one or two perforating the mylo-hyoideus and anastomosing with the sublingual artery.

The *facial vein* (p. 29) joins the internal jugular vein. In the cervical part of its course it receives branches corresponding with the offsets of the artery. It often throws itself into the temporo-maxillary trunk. **Facial vein.**

The *occipital artery* is of considerable size, and is destined for the back of the head. It arises from the carotid opposite the facial branch, and near the lower border of the digastric muscle. From this spot the artery ascends to the inner part of the mastoid process of the temporal bone; next it turns horizontally backwards on the occipital bone, passing above the transverse process of the atlas; and finally becomes cutaneous near the middle line (p. 6). In the neck this artery passes beneath the digastric muscle and a part of the parotid gland; and crosses over the internal carotid artery, the jugular vein, and the spinal accessory and hypoglossal nerves. **Occipital artery** **ends on occiput;**

The only offset from the artery in the front of the neck is a small *posterior meningeal branch* to the dura mater in the posterior fossa of the base of the skull. This ascends along the internal jugular vein, and enters the skull by the foramen jugulare (p. 16). The branches at the back of the neck will be afterwards seen. **offset to dura mater.**

The *occipital vein* begins at the back of the head (p. 6), and has the same course as the artery; it communicates with the lateral sinus through the mastoid foramen, also with the diploic veins, and coalesces with the internal (sometimes the external) jugular vein. **Occipital vein.**

The *posterior auricular artery* is smaller than the preceding branch, and takes origin above the digastric muscle. Ascending in the same direction as the occipital artery, viz. to the interval between the ear and the mastoid process, it divides finally into two branches for the ear and occiput (p. 6). **Posterior auricular**

A small branch, *stylo-mastoid*, enters the foramen of the same name, and supplies the internal ear. **a branch to the ear.**

The *vein* with the artery receives a stylo-mastoid branch, and terminates in the trunk formed by the temporal and internal maxillary veins. **Vein with artery.**

The *temporal artery* is in direction the continuation of the external carotid trunk, and is one of the terminal branches of that artery. Ascending under the parotid gland, in the interval between the ear and the articulation of the jaw, the vessel divides on the temporal fascia into anterior and posterior branches about two inches above the zygoma; these are distributed to the front and side of the head (p. 5). The trunk of the artery gives offsets to the surrounding parts, viz.:— **Temporal artery, terminal branches,** to parotid, to articulation, and ear.

Parotid branches are furnished to the gland which conceals the artery. *Articular* twigs are supplied to the articulation of the lower jaw; and other *muscular* branches enter the masseter. Some *anterior auricular* branches are distributed to the pinna and meatus of the external ear.

Branch to face.

The *transverse facial branch* quits the temporal artery opposite the condyle of the jaw, and is directed forwards over the masseter muscle (p. 29); on the side of the face it supplies the muscles and integuments, and anastomoses with the facial artery.

Branch to temporal muscle

The *middle temporal branch* arises just above the zygoma, and pierces the temporal aponeurosis to enter the substance of the temporal muscle. In the muscle it anastomoses with branches of the internal maxillary artery.

and temple.

A small branch of the temporal artery is likewise found between the layers of the temporal fascia; this anastomoses with an offset of the lachrymal, and becomes cutaneous near the orbicularis muscle.

Corresponding vein.

The *temporal vein* commences on the side of the head (p. 6), and is contiguous to its companion artery. Near the zygoma it is joined by the middle temporal vein; next it receives branches which are companions of the offsets of the artery; and finally it ends by uniting with the internal maxillary vein.

Directions. The lower part of the neck will not be returned to again for some days, so that the dissector may stitch together the flaps of skin, when he has applied salt to preserve it.

Section VI.

PTERYGO-MAXILLARY REGION.

Contents of the region.

In this region are included the muscles superficial to and beneath the ramus of the lower jaw, together with the articulation of that bone. In contact with the muscles (pterygoid) beneath the ramus of the jaw, are the internal maxillary blood-vessels, and the inferior maxillary trunk of the fifth nerve.

Dissection.

Dissection. The masseter muscle, which is superficial to the jaw, has been partly laid bare in the dissection of the facial nerve. To see it more fully the branches of the facial nerve, and the transverse facial artery should be cut through, and turned backwards off the face. A little cleaning will suffice to define the origin and insertion of the muscle.

Should there be in the mouth any of the material that made tense the fibres of the orbicularis, let it be removed.

The MASSETER (fig. 3, [15]) conceals the ramus of the lower jaw, and is partly aponeurotic at the upper attachment. Masseter.

The muscle *arises* from all the lower border of the zygomatic arch, extending forwards to the upper jaw; and from the inner surface of the arch by fine fleshy fibres. From this origin most of the fibres are inclined down and somewhat back, and are *inserted* into the outer surface of the coronoid process, ramus, and angle of the lower jaw; and by a pointed piece into the contiguous part of the body of the bone as far as the second molar tooth. Some of the deeper fibres are inclined down across the others. Origin. Insertion.

The lower part of the masseter is subcutaneous, but the upper is partly concealed by the parotid gland (socia parotidis), and is crossed by Stenson's duct, and by the transverse facial vessels and the facial nerve. The anterior border projects over the buccinator muscle, and a quantity of fat resembling that in the orbit is found beneath it. The muscle covers the ramus of the jaw, and the masseteric branches of nerve and artery entering it at the under surface. Muscle nearly subcutaneous; lies on the jaw.

Action. It raises the lower jaw in the mastication of the food. Use.

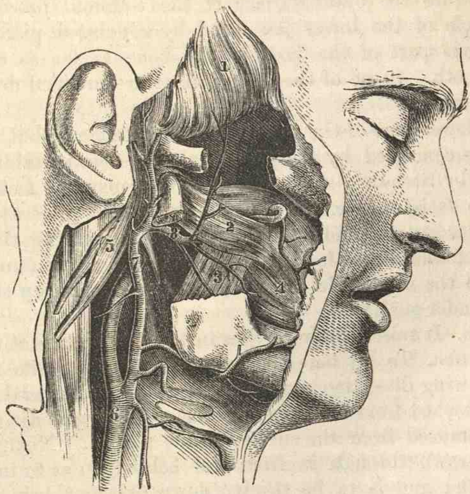
Dissection. To lay bare the temporal muscle to its insertion, the following dissection may be made:—The temporal fascia is to be detached from the upper border of the zygomatic arch, and to be removed from the surface of the muscle. Next, the arch is to be sawn through in front and behind, so as to include all its length; and is to be thrown down (without being cut off) with the masseter muscle still attached to it, by separating the fibres of that muscle from the upper part of the ramus of the jaw. In detaching the masseter muscle, the nerve and artery to it, which pass through the sigmoid notch, will be found. To see surface of temporal muscle.

The surface of the temporal muscle may be then cleaned: and to expose its insertion and extent of origin, let the coronoid process be sawn off by a cut passing from the centre of the sigmoid notch nearly to the last molar tooth, so as to include the whole of the insertion of the muscle. In sawing the bone let the student be careful of the buccal vessels and nerve issuing from beneath it; or better still, let him find and separate previously the two from the muscle. Lastly, the coronoid process should be raised and the fat removed in order that the extent of the lower fibres of the temporal muscle, and their contiguity to the external pterygoid close below them, may be observed. To see the insertion.

The *temporal muscle* has been before seen to take its *origin* from the whole of the temporal fossa (p. 4), reaching up to the semicircular line on the side of the skull, and downwards to the crest on the outer aspect of the great wing of the sphenoid bone. From this extensive attachment, as well as from the fascia over it, the fibres converge to a superficial tendon, which is *inserted* Origin of temporal muscle. Insertion.

into the inner surface of the coronoid process, as well as into a groove on the same process which reaches from the apex to near the last molar tooth.

Fig. 15.*



Behind the posterior border of the tendon are the masseteric vessels and nerve, and in front of it the buccal vessels and nerve: the last nerve perforates occasionally some of the fibres of the muscle.

Use. *Action.* All the fibres contracting the muscle will raise the mandible and press it forcibly against the upper jaw; but the hinder fibres can retract the bone after this has been moved forwards by the external pterygoid in mastication.

To dissect pterygoid muscles, *Dissection.* For the display of the pterygoid muscles, it will be necessary to remove a piece of the ramus of the jaw. But the greater part of the temporal muscle is to be first detached from the subjacent bone with the handle of the scalpel, and the deep temporal vessels and nerves are to be sought in its fibres.

saw through A piece of the ramus of the jaw is next to be removed, but

* Dissection of the pterygoid region (from Quain's Arteries). 1. Temporal muscle. 2. External pterygoid. 3. Internal pterygoid. 4. Buccinator. 5. Digastric and stylo-hyoid muscles cut and thrown back. 6. Common carotid dividing into external and internal trunks. 8. Internal maxillary artery (beneath the pterygoid) and its branches.—The nerves are omitted in this wood-cut.

without injuring the vessels and nerves in contact with its inner surface, by sawing across the bone close to the condyle, and again close above the dental foramen; and to make the dental vessels and nerve secure from injury, the handle of the scalpel may be inserted between them and the bone, and carried downwards to their entrance into the foramen. The masseteric artery and nerve are liable to be cut in sawing the bone; should these be divided, turn them upwards for the present, and afterwards tie together the ends. ramus of jaw;

After the loose piece of bone has been removed, and the subjacent parts freed from much fat, the pterygoid muscles will appear,—the external being directed outwards to the condyle of the jaw, and the internal, which is parallel in direction to the masseter, being inclined to the angle of the jaw. In removing the fatty tissue, the student must be careful not to take away the thin internal lateral ligament, which is on the internal pterygoid muscle beneath the ramus. take it away and the fat.

Position of vessels and nerves. Many vessels and nerves will be found in this region, with the following position to other parts. Crossing inwards over the external pterygoid muscle, is the internal maxillary artery, which distributes offsets upwards and downwards: sometimes the artery will be placed beneath the muscle. Position of the artery.

Most of the branches of the inferior maxillary nerve appear in this stage of the dissection. Thus, issuing from beneath the lower border of the same muscle are the large dental and gustatory nerves, the latter being the more internal of the two; and coming out behind the joint of the jaw is the auriculo-temporal nerve. Appearing between the upper border of the muscle and the cranium, are the small masseteric and deep temporal nerves. The buccal branch of the nerve perforates the fibres of the external pterygoid near the inner attachment. Branches of the above-mentioned artery accompany the nerves. Nerves.

At the front of the space now dissected, coursing along the posterior part of the upper jaw, is the small posterior dental nerve with an artery. Posterior dental.

Between the jaws is the whitish narrow band of the pterygo-maxillary ligament, to which the buccinator and superior constrictor muscles are connected. Intermaxillary band.

The EXTERNAL PTERYGOID MUSCLE (fig. 15, [2]) extends almost horizontally from the zygomatic fossa to the condyle of the lower jaw. Its *origin* is from the outer surface of the great wing of the sphenoid bone below the crest, and from the outer surface of the external pterygoid plate. The fibres are directed outwards and somewhat backwards, those attached to the upper margin of the spheno-maxillary fissure forming at first a separate bundle, and are *inserted* into the hollow in front of the neck of the lower jaw bone, and into the interarticular fibro-cartilage of the joint. External pterygoid. Attachments. Insertion.

Contiguous parts.

Externally the pterygoid is concealed by the temporal muscle and the lower jaw, and the internal maxillary artery lies on it. By the deep surface it is in contact with the inferior maxillary nerve, with a plexus of veins, and with the internal lateral ligament of the joint of the jaw. The parts in contact with the borders of the muscle have been enumerated above.

A second head.

Sometimes the slip of the muscle, which is attached to the margin of the spheno-maxillary fissure and the root of the external pterygoid plate, is described as a separate head with an insertion mostly into the interarticular cartilage.

Use of both muscles,

Action. If both muscles act the jaw is moved forwards, so that the lower dental arch is placed in front of the upper, and the grinding teeth are rubbed together in an antero-posterior direction. In order that the front teeth may be able to pass one another the jaw is depressed.

of one muscle.

One muscle contracting (say the right), the condyle of the same side is drawn inwards and forwards, and the grinding teeth of the lower jaw are moved horizontally to the left across those of the upper. By the alternate action of the two muscles the trituration of the food is effected.

Internal pterygoid is beneath the ramus of the jaw.

The INTERNAL PTERYGOID MUSCLE (fig. 15, ³), is nearly parallel to the ramus of the jaw, and its fibres are longer than those of the preceding muscle. *Arising* in the pterygoid fossa, and chiefly from the inner surface of the external pterygoid plate, the muscle is further attached below outside the fossa to the outer surface of the tuberosity of the palate bone, and to the tuberosity of the upper jaw bone. The fibres descend to be *inserted* into the angle and inner surface of the ramus of the jaw, as high as the inferior dental foramen.

Attachments.

Vessels and nerves around.

On the muscle are placed the dental and gustatory nerves, the dental artery, and the internal lateral ligament of the jaw. The deep surface is in relation below with the superior constrictor, and at its origin with the tensor palati muscle.

Use.

Action. From the direction and attachment of the fibres the muscle will unite with the masseter in elevating the jaw.

Directions. Before proceeding further in the dissection, the student may learn the anatomy of the articulation of the lower jaw.

Joint of lower jaw.

TEMPORO-MAXILLARY ARTICULATION. In this articulation are the condyle of the jaw and the anterior part of the hollow of the glenoid fossa of the temporal bone; but the osseous surfaces are not in contact, for a piece of fibro-cartilage and two synovial sacs are interposed between them. The bones are retained in apposition mostly by the strong muscles of the lower jaw; but the following ligaments serve to unite them.

Capsule of the joint.

Capsule. This is a thin fibrous tube enclosing the joint, and is wider above than below. By the upper end it is fixed around the articular surface of the temporal bone in front of the Glaserian fissure; and it is inserted below around the condyle of the lower jaw. The space in the interior is divided into two, upper and lower, by a piece of fibro-cartilage, which is united to the capsule by its circumference.

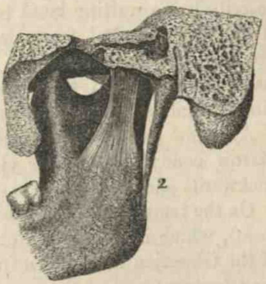
External lateral and

The *external lateral* is a short ligamentous band, being but a part of the capsule, which is attached above to the tubercle at the root of the zygoma, and below to the outer side of the neck of the inferior maxilla.

internal lateral ligament.

The *internal lateral ligament* (fig. 16, [1]), is a long, thin, membranous band, which is not in contact with the joint. Superiorly it is connected by a pointed piece to the spinous process of the sphenoid, and the vaginal process of the temporal bone; and inferiorly it is inserted into the orifice of the dental canal in the lower jaw. The ligament lies beneath the ramus of the jaw, between it and the internal pterygoid; and its origin is concealed by the external pterygoid muscle. Between the ligament and the jaw is the internal maxillary artery.

Fig. 16.*



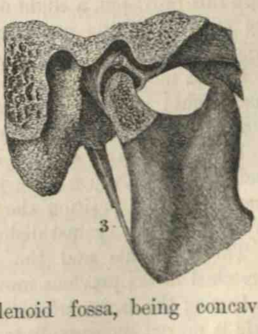
second internal.

An offset of this band, which better deserves the name of internal lateral ligament of the joint, is attached by a pointed end to the neck of the lower jaw behind the insertion of the external pterygoid muscle.

Dissection.

Dissection. After the external lateral ligament and the capsule of the joint have been examined, an interarticular fibro-cartilage, with a synovial membrane above and below it, will be exposed by taking away the capsule on the outer side.

Fig. 17.†



Fibro-cartilage;

The *interarticular fibro-cartilage* (fig. 17, [4]) is adapted to the surfaces of the bones. It is elongated transversely, is thinner in the centre than at the margins, and an aperture is sometimes present in the middle. The upper surface fits into the glenoid fossa, being concavo-

* Ligaments of the jaw—an inner view (Bourgery and Jacob). 1. Internal lateral ligament. 2. Stylo-maxillary.

† A view of the interior of the compound temporo-maxillary joint (Bourgery and Jacob). 3. Stylo-maxillary ligament. 4. Interarticular

and attachments. convex from before backwards, and the lower is moulded to the convexity of the condyle of the jaw. By the circumference it is connected with the capsule and the external lateral ligament; and in front the external pterygoid muscle is attached to it.

The interarticular cartilage allows greater freedom of movement in the joint without dislocation; diminishes the effect of pressure; and deadens the sound of the jaw striking the skull.

Two synovial membranes. Two *synovial membranes* are present in the articulation—one above, and one below the fibro-cartilage. The lower one is the smaller of the two.

Stylo-maxillary ligament. Another structure—the *stylo-maxillary ligament* (fig. 17, [3]) is described as a uniting band to this articulation. It is a process of the deep cervical fascia, which extends from the styloid process to the hinder part of the ramus of the jaw. The piece of fascia here referred to gives attachment to the stylo-glossus muscle, and separates the parotid and submaxillary glands.

Surface of jaw *Articular surfaces of the bones.* The lower jaw possesses a thin narrow condyle, which is elongated transversely, and inclined backwards and inwards.

and temporal bone. On the temporal bone is a narrow deep articular hollow (glenoid fossa), which is elongated from without in, and is placed in front of the Glaserian fissure. In front of this is a prominence of bone, the transverse root of the zygomatic process, which is convex from before back and rather hollowed from side to side.

Kinds of movement. *Movements of the joint.* This condyloid articulation is provided with an up and down, a to and fro, and a lateral movement.

In opening the mouth, how jaw moves. In *depressing the jaw*, as in opening the mouth, the articular condyle moves forwards till it is placed under the convexity at the fore part of the articular hollow, so that the interposition of a fibro-cartilage is needed to give security to the joint. Dislocation. Even with this provision, a slight degree more of sudden motion throws the condyle off the prominence of the temporal bone into the zygomatic fossa, and gives rise to dislocation.

State of ligaments. In this movement the fore and lateral parts of the capsule are made tight; and the fibro-cartilage is drawn forwards with the condyle by the external pterygoid muscle.

Shutting mouth; condyle moves. When the *jaw* is *elevated* and the mouth closed, the condyle and the fibro-cartilage glide back into the hollow of the glenoid fossa. In this position the condyle is placed in the state of greatest security against dislocation.

State of ligaments. The ligaments and the surrounding muscles which were stretched in the previous movement are set at rest.

Forward and backward movement, During the *horizontal motion forwards* and *backwards* the condyle is moved successively to the front and back of the temporal

fibro-cartilage—the dark intervals above and below are the hollows lined by the synovial membranes.

articular surface; and the lower jaw is slightly depressed, in order that the fore teeth in the upper dental arch should not impede those of the lower. condyle moves.

By turns the front and back of the capsule will be stretched, and the fibro-cartilage always follows the condyle of the jaw, even in dislocation. State of ligaments.

Dislocation forwards will be prevented by the coronoid process of the jaw striking against the zygomatic arch; and that backwards, by the meeting of the condyle and the auditory process of the os temporis.

Lateral horizontal movement puts the jaw first to one side and then to the other. When the jaw is forced to the left side, the right condyle sinks into its articular hollow, whilst the left is projected; and the grinding teeth of the lower dental arch are moved to the left across those of the upper. By the alternate action to opposite sides the food is triturated. Lateral movement, condyle moves.

The inner part of the capsule on the right, and the outer part on the left side, will be put on the stretch when the jaw is carried to the left of the middle line; and the opposite. State of ligaments.

With old edentulous jaws the capsule is much enlarged, and permits the condyle to wander backwards behind the Glaserian fissure. Without this provision the altered lower jaw would not meet the upper to crush the food. Joint in old people.

Dissection. The condyle of the jaw is next to be disarticulated, still keeping the external pterygoid muscle uncut; and it with the attached muscle is to be drawn forwards so as to allow the fifth nerve to be seen. Whilst cutting through the articular capsule, the dissector must be careful of the auriculo-temporal nerve close beneath. Dissection of fifth nerve,

On drawing forwards the pterygoid muscle, and removing some fat, the dissector will find the trunk of the inferior maxillary nerve. All the small muscular branches of the nerve before noted should be traced to the trunk in the foramen ovale of the sphenoid bone. The auriculo-temporal branch should be followed backwards with care behind the articulation, and the dental and gustatory nerves beneath the muscle should be cleaned. The small chorda tympani is then to be found joining the posterior part of the gustatory nerve near the skull.

The middle meningeal artery is to be sought beneath the external pterygoid. Sometimes the trunk of the internal maxillary artery lies beneath that muscle, and in such case, it and its branches are to be traced out. and arteries.

The INTERNAL MAXILLARY ARTERY (fig. 15, [8]) is one of the terminal branches of the external carotid, and takes a winding course beneath the lower jaw and the temporal muscle to the spheno-maxillary fossa, where it ends in branches for the face, the interior of the nose, and the palate and pharynx. Internal maxillary artery.

Course and connections. At first the artery is directed inwards beneath the jaw, between that bone and the internal lateral ligament of the joint, and crosses the dental nerve. Next, the vessel winds over the external pterygoid muscle, being placed between it and the temporal muscle. And lastly, the artery enters the spheno-maxillary fossa between the processes of origin of the external pterygoid muscle.

Varies in its position. The course of the artery is sometimes beneath, instead of over the external pterygoid muscle: in such a state the artery gains the spheno-maxillary fossa by coming upwards through the origin of the muscle covering it, as in the wood-cut.

Branches are three sets. The *branches* of this artery are very numerous, and are classed into three sets: thus one set arises beneath the jaw; another between the muscles; and another in the spheno-maxillary fossa.

Those beneath jaw, Two branches, viz. the inferior dental and middle meningeal, leave the internal maxillary artery whilst it is in contact with the ramus of the jaw.

inferior dental; The *inferior dental branch* descends between the internal lateral ligament and the jaw, and enters the foramen on the inner surface of the ramus, along with the dental nerve, to supply the teeth, and end in the lower part of the face.

has a branch to mylo-hyoid muscle. As this artery is about to enter the foramen it furnishes a small twig, *mylo-hyoid branch*, to the muscle of that name; this is conducted by a groove on the inner surface of the bone, in company with a branch from the dental nerve, to the superficial surface of the mylo-hyoid muscle, where it anastomoses with the submental artery.

Middle meningeal artery, The *middle* or *great meningeal artery* is the largest branch, and arises opposite the preceding one. It ascends beneath the external pterygoid muscle, and between the roots (oftentimes) of the auriculo-temporal nerve; crossing the internal lateral ligament, it enters the skull through the foramen spinosum of the sphenoid bone.

ends in skull, When in the skull the artery ascends to the vertex of the head, and supplies the bone and the dura mater (p. 15).

but gives Before the meningeal artery enters the skull, it furnishes the following small branches:—

branch to tympanum, The *tympanic branch* (inferior) passes into the tympanum through the Glaserian fissure, and is distributed to the membrana tympani and that cavity.

A *deep auricular branch* arises with the former or separately, enters the meatus through the cartilage, or between this and the bone, and ramifies in the meatus and on the membrana tympani.

to dura mater. The *small meningeal branch* begins near the skull, and courses through the foramen ovale with the inferior maxillary nerve; it ramifies in the dura mater in the middle fossa of the skull.

Another small branch springs from the dental artery or the internal maxillary trunk, and accompanying the gustatory nerve, ends in the cheek and the mucous membrane of the mouth. Branch with gustatory.

The branches from the second part of the artery, viz. whilst it is between the temporal and external pterygoid, are distributed to the temporal, masseteric, buccal, and pterygoid muscles. Branches of second part are

The *deep temporal arteries* are two in number (anterior and posterior); and each occupies the part of the temporal fossa indicated by its name. They ascend beneath the temporal muscle, and anastomose with the superficial temporal artery: the anterior also communicates, through the malar bone, with branches of the lachrymal artery. to the temporal muscle;

When the parent trunk has the unusual position beneath the pterygoid, the anterior branch lies under that muscle, instead of over it.

The *masseteric artery* is directed outwards with the nerve of the same name behind the tendon of the temporal muscle; and passing through the sigmoid notch, enters the under surface of the masseter muscle. Its branches anastomose with the other branches to the muscle from the external carotid trunk. to the masseter;

The *buccal branch* quits the artery near the upper jaw, and in the unusual position of the artery it may perforate the fibres of the pterygoid; it descends beneath the coronoid process with its companion nerve, and is distributed to the buccinator muscle, the cheek, and the side of the face, joining the branches of the facial artery. to the buccinator;

The *pterygoid branches* are uncertain in their position; whether derived from the trunk or some of the branches of the internal maxillary, they enter the pterygoid muscles. to pterygoid muscles.

Of the branches that arise from the artery when it is about to enter, or has entered the spheno-maxillary fossa, only one, the superior dental, will be now described. The remainder will be examined with the superior maxillary nerve and Meckel's ganglion; they are infraorbital (p. 108); superior palatine, naso-palatine, vidian, and pterygo-palatine (SECTION 14). Branches of third part only one now seen.

The *superior* or *posterior* dental branch takes origin near the top of the upper maxilla, and descends with a tortuous course on the outer surface of that bone, along with a small branch of the superior maxillary nerve. It enters the foramina in the bone, and supplies the upper molar and bicuspid teeth; but some external offsets are furnished to the gums. A few branches reach the lining membrane of the antrum. Superior dental.

The INTERNAL MAXILLARY VEIN receives the veins accompanying the branches of the artery in the first two parts of its course: these veins form a plexus—*pterygoid*, between the two pterygoid muscles, and in part between the temporal and external pterygoid muscles. The plexus communicates with the alveolar plexus; Internal maxillary vein begins in plexus, with the facial vein by a large branch (anterior internal maxillary); and with the cavernous sinus in the interior of the skull, by branches that pass through the base of the cranium.

and ends in external jugular.

Escaping from the plexus, the vein accompanies the artery to the parotid gland, and there joins the superficial temporal vein,—the union of the two giving rise to the external jugular vein. Sometimes this common vessel enters the internal jugular vein (p. 30).

Inferior maxillary nerve

consists of a motor and sensory part.

The INFERIOR MAXILLARY NERVE is the largest of the three trunks arising from the Gasserian ganglion (p. 17); and resembles a spinal nerve in possessing fibrils that confer both motory and sensory properties on the parts to which it is distributed. The nerve leaves the skull by the foramen ovale in the sphenoid bone, and divides beneath the external pterygoid muscle into two chief pieces, viz. an anterior, small, moto-sensory part; and a large, posterior, sensory portion.

Directions. Should the internal maxillary artery obstruct the view of the nerve, it may be cut through or taken away.

Muscular piece

The SMALLER PART, formed mainly by its contribution from the trunk of the nerve, receives nearly all the fibrils of the motor root, and ends in branches for the muscles of the jaw, viz. temporal, masseter, and one pterygoid: and for the muscle of the cheek, the buccinator.

supplies two temporal;

The *deep temporal branches* are furnished to the under surface of the temporal muscle. Like the arteries, they are two in number, anterior and posterior. From their origin these nerves course upwards along the outer surface of the skull, and pass beneath the external pterygoid muscle.

posterior and

The *posterior branch* is the smallest, and is often derived from the masseteric nerve; it is placed near the back of the temporal fossa.

anterior.

The *anterior branch* supplies the greater part of the muscle, and communicates sometimes with the buccal nerve.

Masseteric.

The *masseteric branch* takes at first a backward course above the external pterygoid muscle, and then a horizontal one, behind the temporal muscle and through the sigmoid notch, to the under surface of the masseter muscle. In the masseter the nerve can be followed to near the anterior border.

Articulation.

As this branch passes by the articulation of the jaw it gives one or more twigs to that joint.

Branches to pterygoid muscles.

The *pterygoid branches* are supplied to the muscles of that name, and come from both parts of the inferior maxillary nerve.

External.

The branch or branches to the *external pterygoid* spring from the small part, or from the buccal nerve, and enter the under surface.

Internal.

The nerve to the *internal pterygoid* arises from the large part of the maxillary trunk close to the skull, and may be traced with care beneath the upper border of the muscle, to the deep surface of which it is distributed; it will be learnt in the dissection of the otic ganglion (SECTION 14).

The *buccal branch* is longer and larger than the others, and perforates the inner attachment of the external pterygoid; afterwards it is directed inwards, beneath the coronoid process and the temporal muscle, to the surface of the buccinator, where it ends in terminal branches. As the nerve perforates the pterygoid muscle filaments are given to the fleshy substance; and after it has passed through the fibres it furnishes a branch to the temporal muscle, which frequently joins the anterior deep temporal nerve. Some offsets are distributed likewise to the upper part of the buccinator muscle and the lining mucous membrane. **Buccinator nerve, supplies muscles**

The continuation of the nerve is inclined towards the angle of the mouth, supplying the integument, the buccinator muscle, and the lining mucous membrane. This part is united freely with the facial nerve, the two forming a plexus. **and mucous membrane.**

The LARGER PART of the inferior maxillary nerve divides into three trunks—auriculo-temporal, dental, and gustatory. A few of the fibrils of the small (motor) root of the fifth are applied to this part, and are conveyed by it to certain muscles, viz., tensor tympani, circumflexus palati, pterygoideus internus, mylohyoideus, and digastricus. **Sensory part of inferior maxillary conveys motor fibrils.**

The AURICULO-TEMPORAL NERVE separates from the others near the base of the skull, and has commonly two roots. Its course to the surface of the head is first backwards beneath the external pterygoid muscle, as far as the inner part of the articulation of the jaw; and lastly, upwards with the temporal artery in front of the ear, and beneath the parotid gland. The nerve furnishes branches to the surrounding parts, viz., the joint, the ear, and the parotid gland; and it communicates also with the facial nerve. Its ramifications on the head are described at page 7. In the part now dissected its branches are the following:— **Auriculo-temporal lies beneath jaw, and supplies branches**

Branches of the meatus auditorius. Two offsets are directed to the interior of the auditory meatus from the point of union of the branches of the facial with the auriculo-temporal nerve, and enter it between the cartilage and bone. **to the meatus**

Articular branch. The branch to the articulation of the jaw is supplied from the trunk of the auriculo-temporal near the same spot, or from the branches to the meatus. **and joint of jaw;**

The *inferior auricular branch* supplies the external ear below the meatus auditorius: this branch sends offsets along the internal maxillary artery, which communicate with the sympathetic nerve. **the ear, and**

Parotid branches. These are small filaments that enter the substance of the gland. **parotid,**

Branches communicating with the facial and *sympathetic nerves.* **to join facial** and sympathetic

Two or more branches around the external carotid artery communicate with the facial and sympathetic nerves.

and otic ganglion.

Filaments to the *otic ganglion* arise near the beginning of the trunk.

Inferior dental

is between pterygoid muscles,

then in the jaw,

and supplies

The INFERIOR DENTAL is the largest of the three trunks into which the inferior maxillary nerve divides. Directed to the canal in the lower jaw, the nerve lies at first beneath the external pterygoid muscle, where it is external in position to the gustatory; and it is afterwards placed on the internal pterygoid, and on the internal lateral ligament near the dental foramen. After the nerve enters the bone, it is continued forwards beneath the teeth to the foramen in the side of the jaw, and ends at that spot by dividing into an incisor and a labial branch. Only one muscular offset (mylo-hyoid) is supplied by the dental nerve before it enters the bone. Its branches are :—

branch to mylo-hyoideus.

The *mylo-hyoid branch* arises from the trunk of the nerve as this is about to enter the foramen, and is continued along a groove on the inner aspect of the ramus of the jaw to the cutaneous surface of the mylo-hyoideus, and to the anterior belly of the digastric muscle.

Dental branches to grinding

The *dental branches* arise in the bone, and supply the molar and bicuspid teeth. If the bone is soft, the canal containing the nerve and artery may be laid open so as to expose these branches.

and cutting teeth.

The *incisor branch* continues the trunk of the nerve onwards to the middle line, and furnishes offsets to the canine and incisor teeth, beneath which it lies.

Branch to lower lip.

The *labial branch* (mental ?) issues on the face beneath the depressor of the angle of the mouth. At first it communicates with the facial nerve, and gives branches to the muscles below the aperture of the mouth; but the greater part of the nerve is directed upwards beneath the depressor labii inferioris, and is distributed on the inner and outer surfaces of the lower lip.

Dental artery

has an

The *inferior dental artery*, after entering the lower jaw with the nerve, has a similar course and distribution. Thus it supplies offsets to the bone, dental branches to the molar and bicuspid teeth, and ends anteriorly in an incisor and a labial branch.

incisor and

The *incisor branch* is continued to the symphysis of the jaw, where it ends in the bone: it lies beneath the canine and incisor teeth, to which it furnishes branches.

labial branch.

The *labial branch*, after it has left the bone, ramifies in the structures covering the lower jaw, and communicates with the branches of the facial artery.

Gustatory nerve

courses to

The GUSTATORY OR LINGUAL NERVE is the remaining trunk of the inferior maxillary, and is concealed at first, like the others, by the external pterygoid muscle. It is then inclined inwards with a small artery over the internal pterygoid muscle, and under cover of the side of the jaw to the tongue. The remainder of the nerve will be seen in the dissection of the submaxillary region. the tongue;

In this course under the jaw the nerve does not distribute any branch to the parts around, but the following communicating branch is received by it. no branch here.

The *chorda tympani* is a branch of the facial nerve, and is distributed to the tongue. The origin of the nerve, and its course across the tympanum to its position beneath the external pterygoid, are described in SECTION 14. Chorda tympani.

After issuing from the tympanum by the Glaserian fissure, this small branch is applied to the gustatory nerve at an acute angle. At the point of junction some fibrils communicate with the gustatory, but the greater part of the chorda tympani is conducted along that nerve to the tongue. Joins gustatory, ends in tongue.

SECTION VII.

SUBMAXILLARY REGION.

The submaxillary region is situate between the lower jaw and the hyoid bone. In it are found muscles of the os hyoides and tongue, the vessels and nerves of the tongue, and the sublingual and submaxillary glands. Extent. Parts in it.

Position. In this dissection the position of the neck is the same as in the examination of the anterior triangle. Position of the part.

Dissection. Directions for the cleaning of this region were given in the dissection of the anterior triangular space; but if any fatty tissue has been left on the submaxillary gland, or on the mylo-hyoid muscle, let it be taken away. Dissection.

The *submaxillary gland* (fig. 14, [11]) lies below the jaw in the anterior part of the space limited by that bone and the digastric muscle. Its shape is irregular, and the facial artery winds over the surface. The gland rests on the mylo-hyoideus, and sends a process round the posterior or free border of that muscle. In front of it is the anterior belly of the digastric; and behind it is the stylo-maxillary ligament separating it from the parotid. Occupying a position somewhat beneath the side of the jaw, the gland is very near the surface, being covered only by the integuments and platysma, and the deep fascia. Situation and connections of submaxillary gland.

In structure the submaxillary resembles the parotid gland (p. 31); and its duct—duct of Wharton—issuing from the deep part, extends beneath the mylo-hyoid muscle to the mouth. Structure.

Dissection.

Dissection. To see the mylo-hyoid muscle, detach the anterior belly of the digastric from the jaw, and dislodge without injury the submaxillary gland from the maxilla.

Mylo-hyoideus

arises from jaw;

inserted into hyoid bone.

The MYLO-HYOID MUSCLE is triangular in shape, with the base at the jaw and the apex at the hyoid bone, and unites along the middle line with its fellow of the opposite side. It *arises* from the mylo-hyoid ridge on the inner surface of the lower jaw as far back as the last molar tooth; and is *inserted* into the middle of the body of the os hyoides, as well as into a central tendinous band between that bone and the jaw.

Parts around it.

On the cutaneous surface are the digastric muscle, the submaxillary gland, the facial artery with the submental offset, and its own branch of nerve and artery. Its fibres are frequently deficient near the jaw, and allow the next muscle to be seen. Only the posterior border is unattached, and round it a piece of the submaxillary gland winds. The parts in contact with the deep surface of the muscle will be perceived after the following dissection has been made.

Use: on os hyoides,

Action. The lower jaw being fixed the muscle approaches the os hyoides to the jaw, enlarging the pharynx preparatory to swallowing.

on jaw.

With the hyoid bone fixed it can help in depressing the jaw, and opening the mouth.

Dissection, to detach mylo-hyoid.

Dissection. To bring into view the muscles beneath the mylo-hyoid, and to trace the vessels and nerves to the substance of the tongue, the student should first divide the facial vessels on the jaw, and remove them with the superficial part of the submaxillary gland; but he should be careful to leave the deep part of the gland that turns beneath the mylo-hyoideus, because the small submaxillary ganglion is in contact with it. Next he should cut through the small branches of vessels and nerve on the surface of the mylo-hyoideus; and detaching that muscle from the jaw and its fellow, should throw it down to the os hyoides, but without injuring the genio-hyoid muscle beneath it.

To see deep muscles saw the jaw,

Afterwards the soft parts covering the lower jaw are to be cut, and the bone is to be sawn through rather on the right side of the symphysis. The side of the jaw, which will then be loose (for the ramus of the bone has been previously sawn), is to be raised to see the parts beneath, and it may be fastened up out of the way with a stitch; but it should not be detached from the mucous membrane of the mouth.

fasten tongue,

The apex of the tongue is to be now drawn well out of the mouth over the upper teeth, and fastened with a stitch to the septum of the nose, whilst the left half of the jaw is drawn down forcibly with hooks. The scalpel should be then passed from below upwards between the sawn surfaces of the jaw, for

and cut

the purpose of dividing a strong band of the mucous membrane of the mouth; and it should be carried onwards along the middle line of the tongue to the tip. mucous membrane.

By means of a stitch the os hyoides may be fastened down, and the muscular fibres made tense. All the fat and areolar tissue are to be removed, and in doing this the student is to take care of the Whartonian duct, and the hypoglossal nerve and its branches, which lie on the hyo-glossus muscle; also of the gustatory nerve, nearer the jaw. Between the gustatory nerve and the deep part of the submaxillary gland the student should seek the small submaxillary ganglion (the size of a small pin's head), with its offsets; and should endeavour to separate from the trunk of the gustatory the small chorda tympani nerve, and to define the offset from it to the submaxillary ganglion. Define nerves,

At the hinder border of the hyo-glossus clean the lingual vessels, the stylo-hyoid ligament, and the glosso-pharyngeal nerve, all passing beneath the muscle; and at the anterior border find the issuing ranine vessels which, with the gustatory and hypoglossal nerves, are to be traced on the under surface of the tongue to the tip. and vessels.

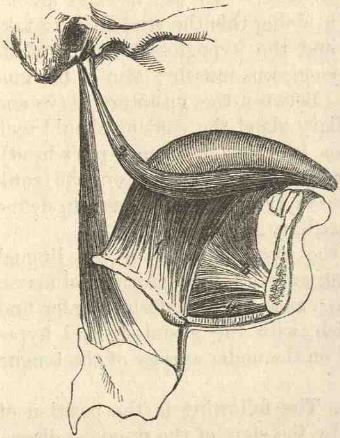
Parts beneath mylo-hyoideus. The following is the position of the objects brought into view by the steps of the previous dissection. Extending from the cornu of the hyoid bone to the side of the tongue is the hyo-glossus muscle, whose fibres are crossed superiorly by those of the stylo-glossus. On the hyo-glossus are placed, from below upwards, the hypoglossal nerve, the Whartonian duct, and the gustatory nerve, the latter crossing the duct; and near the inner border of the muscle the two nerves are united by branches. Beneath the same muscle lie, from below upwards, the lingual artery with its vein, the stylo-hyoid ligament, and the glosso-pharyngeal nerve. Above the hyo-glossus is the mucous membrane of the mouth, with the sublingual gland attached to it in front, and some fibres of the superior constrictor muscle covering it behind near the jaw. Parts beneath mylo-hyoid on side of neck.

Between the chin and the os hyoides, along the middle line, is situate the genio-hyoid muscle; and larger and deeper than it is a fan-shaped muscle, the genio-hyo-glossus. Along the outer side of the last muscle lie the ranine vessels; and a sublingual branch for the gland of the same name springs from the lingual artery at the inner border of the hyo-glossus. On the under surface of the tongue, near the margin, lies the gustatory nerve; and in the fibres of the genio-hyo-glossus runs the hypoglossal nerve. and along middle line.

The HYO-GLOSSUS MUSCLE (fig. 18, [1]) is thin and somewhat square in shape. The muscle *arises* from the lateral part of the body of the os hyoides (basio-glossus), from all the great cornu of the same bone (cerato-glossus), and separately from the small cornu (chondro-glossus). The two first pieces form a thin sheet, Hyo-glossus, named from attachment;

and enter the back part and side of the tongue; they will be seen afterwards to mingle with fibres of the palato- and stylo-glossus.†

Fig. 18.*



in contact with many parts.

The parts in contact with the surfaces of the hyo-glossus have been already enumerated; and beneath the muscle also are portions of the genio-hyo-glossus and middle constrictor. Along the anterior border is the genio-hyo-glossus muscle; and beneath the posterior pass the lingual artery, the stylo-hyoid ligament, and the glosso-pharyngeal nerve, as before said.

Use: tongue free;

Action. When the tongue is at rest the muscle can press that organ to the floor of the mouth, drawing down the sides and giving a rounded form to the dorsum; but if the tongue is protruded from the mouth, the fibres will retract it into that cavity.

tongue fixed.

If the tongue is fixed against the roof of the mouth, even though the lower jaw is depressed, this muscle with the genio-hyo-glossus will elevate the os hyoides and allow swallowing to take place.

Stylo-glossus

The STYLO-GLOSSUS (fig. 18, [2]) is a slender muscle, whose attachments are expressed by its name. *Arising* from the styloid process near the apex, and from the stylo-maxillary ligament, the muscle is continued forwards to the side of the tongue.

comes to side of tongue.

Here it gives fibres to the dorsum, and crossing the preceding turns to the under surface, and extends to the tip of the tongue. Beneath the jaw this muscle is crossed by the gustatory nerve.

Use of both;

Action. Both muscles will raise the back of the tongue against the roof of the mouth, but if the tongue is protruded they will restore it to the cavity.

of one.

One muscle can direct the point of the tongue towards its own side of the mouth.

* Muscles of the tongue. 1. Hyo-glossus. 2. Stylo-glossus. 3. Genio-hyo-glossus. 4. Genio-hyoideus. 5. Stylo-pharyngeus.

† The third part (chondro-glossus) is distinct from the others, and is not dissected; it ends on the upper surface of the tongue near the root. For further details respecting the anatomy of this and the other lingual muscles, reference is to be made to the dissection of the tongue, SECTION 15.

The GENIO-HYOID MUSCLE (fig. 18, [4]) *arises* from the lower of the two lateral tubercles on the inner aspect of the symphysis of the jaw, and is *inserted* into the middle of the hyoid bone. Genio-hyoideus.

Covered by the mylo-hyoideus, this muscle rests on the genio-hyo-glossus. The inner border touches the muscle of the opposite side, and the two are often united. Connections.

Action. As long as the mouth is shut it raises the hyoid; but acting from the os hyoides, and the closers of the mouth being relaxed, it can depress the jaw and open the mouth. Use.

The GENIO-HYO-GLOSSUS (fig. 18, [3]) is the largest muscle of this region; it has a triangular form, the apex being at the jaw, and the base at the middle line of the tongue. It takes *origin* from the upper tubercle behind the symphysis of the jaw. From this spot the fibres radiate, the posterior passing downwards to their *insertion* into the body of the hyoid bone, the anterior forwards to the tip of the tongue, and the intermediate to the whole length of the tongue from root to point. Genio-hyo-glossus. Origin. Insertion.

Lying along the middle of the tongue, it is in contact with its fellow. The lower border of this muscle corresponds with the genio-hyoideus, and the upper with the frænum linguæ. On its outer side are the ranine vessels, and the hyo-glossus muscle; and the hypoglossal nerve perforates the posterior fibres. Contiguous parts.

Action. By the simultaneous action of all the fibres the tongue is depressed in the floor of the mouth, and hollowed along the middle. But different parts of the muscle are thought to have different uses when they act from the jaw:—Thus the fibres attached to the os hyoides advance and fix that bone before swallowing; the hinder tongue fibres raise the root of the tongue and protrude the tip; and the anterior lingual fibres retract the protruded tip of the tongue. Use: the tongue free;

When the mouth is open swallowing can be performed if the tongue is fixed against the teeth and roof of the mouth, because this muscle and the hyo-glossus can then raise the hyoid bone. tongue fixed.

The *lingual artery* is one of the anterior branches of the external carotid, and arises between the superior thyroid and facial branches. At first it is directed inwards above the os hyoides, but is afterwards inclined slightly upwards beneath the hyo-glossus to the under part of the tongue, and ends at the anterior border of that muscle in the sublingual and ranine branches. Before reaching the hyo-glossus the artery is comparatively superficial, but it is crossed near that muscle by the ninth nerve, and by the digastric and stylo-hyoid muscles. Beneath the hyo-glossus, the vessel rests on the middle constrictor and genio-hyo-glossus muscles, and is below the level of the glosso-pharyngeal nerve. Its *branches* are these:— Lingual artery ascends to the tongue beneath hyo-glossus.

Its branches are—

A small *hyoid branch* is distributed on the upper border of the os hyoides, supplying the muscles; it anastomoses with the one to hyoid bone;

of the opposite side, and with the hyoid branch of the superior thyroid artery.

to back of the tongue; A *branch to the dorsum of the tongue* arises beneath the hyo-glossus muscle, and ascends to supply the substance of the tongue and the tonsil. The fibres of the hyo-glossus must be divided to see it.

to the sub-lingual gland; The *sublingual branch* springs from the final division of the artery at the edge of the hyo-glossus, and is directed outwards to the gland from which it takes its name. Some offsets supply the gums and the contiguous muscles, and one continues behind the incisor teeth to join a similar artery from the other side.

to the substance of tongue. The *ranine branch* is the terminal part of the lingual artery, and extends forwards along the outer side of the genio-hyo-glossus to the tip of the tongue where it ends. Muscular offsets are furnished to the substance of the tongue; but the ramifications of each artery are confined to its own side (Hyrtl). This artery

Ranine is along frænum. lies along the frænum linguæ near the tip of the tongue, but is embedded in the muscular fibres.

Lingual vein. The *lingual vein* commences on both the upper and under surfaces of the tongue. It lies with its companion artery, and ends in the internal jugular vein.

Lingual nerve The GUSTATORY or LINGUAL NERVE has been followed in the examination of the pterygo-maxillary region to its passage between the ramus of the lower jaw and the internal pterygoid

along side of tongue muscle. In this dissection the nerve is seen to be inclined forwards to the side of the tongue, over the mucous membrane of the mouth and the origin of the superior constrictor muscle, and above the deep part of the submaxillary gland. Lastly, the nerve is directed across the Whartonian duct, and along the side of the tongue to the apex. In this region the gustatory nerve is separated from the cavity of the mouth by the mucous membrane.

gives branches *Branches* are furnished to the surrounding parts, thus:—

to the ganglion, Two or more branches connect it with the submaxillary ganglion, near the gland of that name.

to ninth nerve, Farther forwards branches descend on the hyo-glossus to unite in a kind of plexus with twigs of the hypoglossal nerve.

to mucous membrane, Other filaments are supplied to the mucous membrane of the mouth, the gums, and the sublingual gland.

to the papillæ. Lastly, the *branches for the tongue* ascend through the muscular substance, and are distributed to the conical and fungiform papillæ.

Submaxillary ganglion; *Submaxillary ganglion.* This ganglion resembles the other ganglia connected with the three trunks of the fifth nerve, and communicates with sensory, motory, and sympathetic nerves.

nature; It is small, sometimes reddish, of less size than the lenticular ganglion, and is placed above the deep process of the submaxillary gland. Offsets proceed upwards to connect it with other nerves; and from the lower part arise the branches that are distributed to the adjacent structures.

Connection with nerves—roots. Two or three branches, in the form of loops, pass from the ganglion to the gustatory nerve. At the posterior part the ganglion is further joined by an offset from the chorda tympani (of the facial nerve) which lies in contact with the gustatory. And its sympathetic branch comes from the nerves around the facial artery. joins gustatory, facial, and sympathetic nerves.

Branches. From the lower part of the ganglion five or six branches descend to the substance of the submaxillary gland; and from the anterior part other filaments are furnished to the mucous membrane of the mouth and the Whartonian duct. Branches.

Chorda tympani. Joining the gustatory above by fibrils (p. 99), it is applied to the back of that nerve till near the side of the tongue, and can be easily separated from it; but beyond that point it enters amongst the fibres of the gustatory nerve to be conveyed to the superficial lingualis. Near the submaxillary gland an offset is sent to the submaxillary ganglion. Chorda tympani; course.

The HYPO-GLOSSAL or NINTH NERVE, after crossing the side of the neck and the anterior triangle (p. 82), enters between the small muscles of the submaxillary region. Here the nerve lies on the hyo-glossus muscle, being concealed by the mylo-hyoideus: but at the inner border of the hyo-glossus it enters the fibres of the genio-hyo-glossus, and is continued along the middle line of the tongue to the apex. Ninth nerve, between the chin and hyoid bone.

Branches. On the hyo-glossus the ninth nerve furnishes branches to the muscles of the submaxillary region, except the mylo-hyoid and the digastric, viz., to the hyo-glossus, stylo-glossus, genio-hyoideus, and genio-hyo-glossus. Further, some offsets ascend on the hyo-glossus to communicate with the gustatory nerve. Its branches supply muscles

Along the middle of the tongue the nerve sends upwards long filaments with the branches of the ranine artery, which supply the muscular structure, and communicate with the gustatory nerve. and the tongue.

The *glosso-pharyngeal* cranial nerve, issuing between the two carotid arteries, courses over the stylo-pharyngeus and the middle constrictor of the pharynx, and ends under the hyo-glossus in branches for the tongue. See DISSECTION OF THE TONGUE. Glosso-pharyngeal.

The *duct of the submaxillary gland*, Wharton's duct, issues from the deep part of the glandular mass that turns round the border of the mylo-hyoid muscle. It is about two inches in length, and is directed upwards on the hyo-glossus muscle, and beneath the gustatory nerve, to open on the side of the frænum linguæ in the centre of an eminence: its opening in the mouth will be seen if a bristle be passed along it. The duct has a thin wall, and consists externally of a fibrous layer with much elastic tissue, and internally of a mucous lining with cylindrical epithelium. Wharton's duct opens by frænum linguæ. Structure.

The deep part of the submaxillary gland extends along the side of the duct, reaching, in some instances, the sublingual gland.

Sublingual gland is beneath tongue.

The *sublingual gland* is somewhat of the shape of an almond, and the longest measurement, which is about one inch and a half, is directed backwards. It is situate beneath the anterior part of the tongue, in contact with the inner surface of the lower jaw, and close to the symphysis. Separated from the cavity of the mouth by the mucous membrane, the gland is prolonged across the upper border of the genio-hyo-glossus muscle, so as to touch the one of the opposite side.

Structure.

Ducts open in mouth.

The sublingual is an aggregation of small glandular masses, each being provided with a separate duct (Henle). The ducts (ductus Riviniani) are from eight to twelve in number. Some of them open beneath the tongue along a crescentic-shaped fold of the mucous membrane, and others join the Whartonian duct; one or more form a larger tube, which either joins that duct or opens near it.

Section VIII.

SUPERIOR MAXILLARY NERVE AND VESSELS.

Superior maxillary nerve.

Directions. The student may examine next the remaining trunk of the fifth nerve, viz. the superior maxillary, as this can be seen most conveniently after the dissection of the pterygo-maxillary and submaxillary regions has been made.

Dissection.

Dissection. The superior maxillary division of the fifth nerve, in its course to the face, occupies successively the skull, the spheno-maxillary fossa, and the infraorbital canal; and to lay bare the nerve, the cranium and the orbit must be opened. If the orbit has not been dissected, refer to the necessary steps (p. 41).

The beginning of the nerve in the cranium has been already demonstrated, if the preceding instructions have been followed.

In spheno-maxillary fossa.

To trace the nerve in the spheno-maxillary fossa, the student may make the following dissection:—The middle fossa of the base of the skull is to be cut through from the inside with a chisel, the cut being made from the sphenoidal fissure in front to the foramen spinosum behind, and outside the line of the foramen rotundum and foramen ovale. The side of the skull is then to be sawn vertically in front of the petrous part of the temporal bone, so that the incision shall end at the posterior extremity of the cut made in the base with the chisel. Afterwards the outer wall of the orbit is to be sawn horizontally about its middle into the spheno-maxillary fissure. The piece of bone forming part of cranium and orbit is now loose, and is to be removed with the temporal muscle.

By the removal of the fat the nerve can be partly seen as it crosses the spheno-maxillary fossa: but to bring it more completely into view, some of the sphenoid bone bounding the fossa is to be taken away, so as to leave only an osseous ring round the nerve at its exit from the skull. In the fossa the student seeks the following offsets,—the orbital branch entering the cavity of the orbit; branches to Meckel's ganglion which descend in the fossa; and a dental branch along the back of the upper jaw. Its offsets here.

To follow onwards the nerve in the floor of the orbit, the contents of the cavity having been taken away, the bony canal in which it lies must be opened to the face. Near the front of the orbit the anterior dental branch is to be traced downwards for some distance in the bone. The infraorbital vessels are to be prepared with the nerve. In floor of the orbit.

The SUPERIOR MAXILLARY NERVE commences in the Gasserian ganglion (p. 18), and leaves the cranium by the foramen rotundum. The course of the nerve is then almost straight to the face, across the spheno-maxillary fossa, and along the orbital plate of the superior maxilla and the infraorbital canal. Issuing from the canal by the infraorbital foramen, the nerve is concealed by the elevator of the upper lip, and ends in branches to the eyelid, nose, and upper lip:— Upper maxillary nerve passes to face, through infraorbital canal.

The *orbital branch* arises in the spheno-maxillary fossa, and enters the orbit through the fissure of the same name; it divides into a malar and a temporal branch (see p. 51). Its branches are to orbit;

The *spheno-palatine branches* descend from the nerve in the fossa, and supply the nose and the palate; they are connected with Meckel's ganglion, and will be dissected with it (SECTION 14). to the nose and palate;

A *posterior dental branch* leaves the trunk of the nerve near the upper jaw. It enters a canal in the maxilla, and supplies branches to the molar teeth and the lining membrane of the antrum; it joins the anterior dental branch near the teeth. Before entering the canal it furnishes one or more offsets to the gums and the buccinator muscle. to the teeth and buccinator;

The *anterior dental branch* quits the trunk of the nerve in the floor of the orbit, and descends to the anterior teeth in a special canal in front of the antrum. It is distributed by two branches. One (the inner) gives nerves to the incisor and canine teeth, and furnishes, moreover, one or two filaments to the lower meatus of the nose; the other (outer) ends by supplying the bicuspid teeth. to anterior teeth.

Before the trunk ends in the facial branches, it supplies a small *palpebral branch* to the lower eyelid; this is directed upwards to the lid in a groove in the margin of the orbit. Branch of eyelid.

Infraorbital or facial branches. These are larger than the other Infraorbital branches, offsets of the nerve, and form its terminal ramifications. Some incline inwards to the side of the nose, and the rest descend to the upper lip. Near the orbit they are crossed by branches of the facial nerve, with which they communicate, the whole forming the *infraorbital plexus* (p. 39).

join facial nerve, and supply the

nose

The *branches for the side of the nose* supply the muscular and tegumentary structures.

and upper lip.

The *branches for the upper lip* are three or four in number, which divide as they descend, and are distributed chiefly to the surfaces of the lip, though they supply as well the labial glands and the muscles.

Infraorbital artery

The *infraorbital artery* is one of the terminal branches of the internal maxillary trunk in the spheno-maxillary fossa, and accompanies the superior maxillary nerve. Taking the course of the nerve through the infraorbital canal, the vessel appears in the face beneath the elevator muscle of the upper lip; and it ends in branches, which are distributed, like those of the nerve, to the parts between the eye and mouth. In the face its branches anastomose with the facial and buccal arteries.

ends in face;

branches to orbit,

In the canal in the maxilla this artery furnishes branches to the orbit.

and one to anterior teeth.

Another branch, *anterior dental*, runs with the nerve of the same name, and supplies the incisor and canine teeth. This gives offsets to the antrum of the maxilla, and near the teeth it anastomoses with the posterior dental artery.

Infraorbital vein.

The *vein*, accompanying the artery, communicates in front with the facial vein; and terminates behind in a plexus of veins (alveolar) corresponding with the offsets of the internal maxillary artery in the spheno-maxillary fossa.

SECTION IX.

DEEP VESSELS AND NERVES OF THE NECK.

Parts in this section.

In this section are included the deepest styloid muscle, the internal carotid and ascending pharyngeal arteries, and some cranial and sympathetic nerves.

Position.

Position. The position of the part is to remain as before, viz. the neck is to be fixed over a small block.

Dissection of the stylo-pharyngeus,

Dissection. To see the remaining styloid muscle, the posterior belly of the digastric, and the stylo-hyoid muscle should be detached from their origin and thrown down. The trunk of the external carotid artery is to be removed by cutting it through where the hypoglossal nerve crosses it, and by dividing those branches that have been already examined, as well as the veins accompanying the arteries. In cleaning the surface of the stylo-pharyngeus muscle, the glosso-pharyngeal nerve and its branches, and the stylo-hyoid ligament may be prepared. The side of the jaw is to be well drawn upwards and forwards on the face. glosso-pharyngeal nerve.

The STYLO-PHARYNGEUS MUSCLE (levator pharyngeus externus) resembles the other styloid muscles in its elongated form. The fibres *arise* from the root of the styloid process on the inner surface, and descend between the superior and middle constrictors to be *inserted* partly into the pharynx, and partly into the upper border (hinder border, Merkel*) of the thyroid cartilage. Stylo-pharyngeus. Origin. Insertion.

The muscle lies below the stylo-glossus, and between the carotid arteries; and the glosso-pharyngeal nerve turns over the lower part of its fleshy belly. Is between carotid arteries.

Action. It elevates and draws outwards the part of the pharynx above the hyoid bone, making this ready for the reception of the morsel to be swallowed. From its attachment to the thyroid cartilage it will raise the larynx. Use.

The *stylo-hyoid ligament* is a fibrous band, which extends from the tip of the styloid process to the small cornu of the os hyoides. Its position is between the stylo-glossus and stylo-pharyngeus muscles, and over the internal carotid artery; whilst the lower end is placed beneath the hyo-glossus muscle. To the posterior border the middle constrictor muscle is attached below. It is frequently cartilaginous or osseous in part of, or in all its extent. Occasionally a slip of fleshy fibres is continued along it. Stylo-hyoid ligament lies by side of preceding.

The INTERNAL CAROTID ARTERY supplies parts within the head, viz., the brain, the eye and orbit, and the nose; and takes a circuitous course through and along the base of the skull before it terminates in the brain. Internal carotid artery.

The arterial trunk in the cranium, and its offset to the orbit, have been already examined; but the vessel in the neck and the temporal bone remain to be dissected. The branches of the carotid to the brain are described with the encephalon. Some parts already seen.

Dissection. For the display of the cervical part of the artery there is now but little dissection required. By detaching the styloid process at the root, and throwing it with its attached muscles to the middle line, the internal carotid artery and the jugular vein may be followed upwards to the skull. Only a dense fascia conceals them, but this is to be taken away carefully, so that the branches of the nerves in contact with the vessels near the base of the skull may not be injured. Dissection of carotid in the neck;

In the fascia, and directed inwards over the artery, seek the small pharyngeal branch of the vagus near the skull, and the and cranial nerves;

* Anatomie und Physiologie des Menschlichen Stimm und Sprach Organs. Leipzig, 1857. Von Dr. Merkel.

glosso-pharyngeal nerve and its branches lower down; still lower, the superior laryngeal branch of the vagus, with its external laryngeal offset, crossing beneath the carotid. Between the vein and artery, close to the skull, will be found the vagus, hypoglossal, and sympathetic nerves; and crossing backwards, over or under the vein, the spinal accessory nerve. External to the position of the vessels a loop of the first and second cervical nerves over the transverse process of the atlas is to be defined; and from it branches of communication are to be traced to the large ganglion of the sympathetic beneath the artery, and to the vagus and hypoglossal nerves. Ascending to the cranium, on the inner side of the carotid, the ascending pharyngeal artery will be met with.

in the temporal bone.

To open the carotid canal in the temporal bone, and to follow the contained artery into the cranium, make a cut along the side of the skull in the following manner:—the saw being placed behind the mastoid process, cut forwards obliquely to the foramen spinosum in the wing of the sphenoid bone (to which spot the side of the skull has been already taken away), and let the instrument be directed through the stylo-mastoid foramen and the root of the styloid process, but rather external to the jugular foramen and the carotid canal. When the piece of bone has been detached, the carotid canal may be opened with the bone forceps.

Nerves on it.

In cleaning the artery in the canal, large and rather red branches of the superior cervical ganglion of the sympathetic will be found on it; and in a fresh part two small filaments may be recognised with care,—one from Jacobson's nerve, joining the sympathetic at the posterior part of the canal; the other from the vidian nerve, at the front of the canal.

Piece of tympanum obtained.

On the piece of bone that has been cut off, the dissector may prepare very readily the tympanum with its membrane and chain of bones, and the chorda tympani nerve.

Internal carotid

The *internal carotid artery* springs from the bifurcation of the common carotid trunk. It extends from the upper border of the thyroid cartilage to the base of the skull; then through the petrous portion of the temporal bone; and lastly along the base of the skull to the anterior clinoid process, where it ends in branches for the brain. This winding course of the artery may be divided into three parts:—one part in the neck, another in the temporal bone, and a third in the cranium.

enters the skull.

Its course is first

through the neck

Cervical part. In the neck the artery ascends almost vertically from its origin to the carotid canal, and is in contact with the pharynx on the inner side. The line of the common carotid artery would mark its position in the neck. Its depth from the surface varies like that of the external carotid; and the digastric muscle may be taken as the index of this difference. Thus, below that muscle, the internal carotid is contained in the anterior triangular space, being overlapped by the sterno-mastoid, and covered by the common teguments, fascia, and the platysma, and is on the same level as the external carotid, though farther back. But, above that muscle, the vessel is placed deeply beneath the external carotid artery and the parotid gland, and is crossed by the styloid process and the stylo-pharyngeus muscle. Whilst in the neck the internal carotid lies on the rectus capitis anticus major muscle, which separates it from the vertebræ.

where it is superficial below,

but deep above;

resting on longus colli.

Vein. The internal jugular vein accompanies the artery, being contained in a sheath with it, and placed on the outer side.

Position of vein,

Small vessels. Below the digastric the occipital vessels (artery and vein) are directed back over the carotid, and offsets from them belonging to the sterno-mastoideus may run down on it. Above the digastric the posterior auricular vessels cross the artery.

of vessels,

Nerves. The pneumogastric is contained in the sheath between the artery and vein, being parallel to them; and the sympathetic, also running longitudinally, lies behind the sheath of the vessels. Crossing the artery superficially, from below up, are the hypoglossal, which sends the descendens noni along the carotid; next the glosso-pharyngeal; and lastly the small pharyngeal branch of the vagus. Directed inwards beneath the carotid is the superior laryngeal nerve, furnishing the external laryngeal branch; together with pharyngeal offsets of the upper ganglion of the sympathetic. Close to the skull the cranial nerves of the neck are interposed between the artery and the vein. Around the artery entwine branches of the sympathetic, and offsets of the glosso-pharyngeal nerve.

of nerves.

The cervical part of the artery remains much the same in size to the end, and usually does not furnish any branch.

Part in the temporal bone. In the carotid canal the tortuous course of the vessel commences. Following the winding of its canal, the artery first ascends in front of the inner ear (cochlea and tympanum); next it is directed forwards almost horizontally; and lastly it turns upwards into the cranium opposite the foramen lacerum (basis cranii). Branches of the sympathetic nerve surround the carotid in the temporal bone.

Second part in temporal bone.

Whilst in the temporal bone the artery supplies a small branch to the cavity of the tympanum.

Offset to the tympanum.

The *cranial part* of the artery is described with the base of the skull (see p. 19).

Third part.

Peculiarities in the carotid. The length of the internal carotid vessel varies in a given number of bodies from differences in the point of division of the common carotid trunk, and in the length of the neck. The course of the vessel may be very tortuous, instead of being straight.

Peculiarities in length, and direction.

Absence.

Further, this vessel may be absent from the neck: in such case the common carotid may take its place, and give the usual offsets of the external carotid. In one instance (Quain) where the artery was deficient in the neck, two branches of the internal maxillary entered the skull, and formed by their union a substitute for it in the cranium.

Internal jugular vein joins inferiorly subclavian.

The INTERNAL JUGULAR VEIN is continuous with the lateral sinus of the skull, and extends from the foramen jugulare to the sterno-clavicular articulation. At the lower part of the neck it has been seen to join the subclavian, to form the innominate vein (p. 80).

Is on outside of carotids.

As far as the thyroid cartilage the vein accompanies the internal carotid, but below that point it is the companion to the common carotid artery; and it lies on the outer side of each. Its contiguity to the artery is not equally close in all its extent, for near the skull there is a small interval between them, containing the cranial nerves; and at the lower part of the neck there is a still larger intervening space, in which the pneumogastric nerve with its cardiac branch is found.

Size.

It is joined by branches below os hyoides.

The size of the upper part of the vein remains much the same till near the os hyoides, where it is suddenly increased by the addition of those branches of the head and neck, corresponding with branches of the external carotid artery, which do not join the external jugular vein.* Its lower dilatation and its valves have been before referred to (p. 80).

The following *branches* open into the internal jugular, viz. the facial, lingual, thyroid (superior), occipital, and pharyngeal; and at the lower part of the neck it receives the middle thyroid vein.

Ascending pharyngeal artery.

The *ascending pharyngeal artery* is a long slender branch of the external carotid, which arises near the commencement of that vessel. Directed upwards on the spinal column between the internal carotid and the pharynx, the artery becomes tortuous near the skull, and enters the pharynx above the upper constrictor to end in the soft palate. In the neck the artery gives some small offsets to the surrounding parts, viz. the muscles on the vertebræ, the nerves, and the lymphatic glands.

gives near skull

a branch to meninges,

A *meningeal branch* enters the cranium through the foramen lacerum (basis cranii), and is distributed on the dura mater of the middle fossa of the skull: this is seldom seen in the cranium because it is but rarely injected.

and ends in palate.

The *palatine branch*, which is larger than the preceding, turns inwards to the pharynx, and divides into two main pieces, which are directed across the fore part of the palate beneath the mucous membrane, to anastomose and form arches with like branches of the opposite side: one of these is near the upper, and

* Sometimes the term *internal cephalic* is applied to the vein between the skull and the hyoid bone; and the name *internal jugular*, to the part below that bone and the junction of its large branches.

the other near the lower edge of the soft palate.* The size of the *palatine* artery depends upon that of the inferior palatine branch of the facial artery.

Pharyngeal branches. Other small arteries ramify in the upper constrictor, the Eustachian tube, the back of the soft palate, and the tonsil. and to pharynx.

The *vein* accompanying the pharyngeal artery receives branches from the cranium, the palate, and the pharynx, and ends in the internal jugular vein. Its vein.

Dissection of the cranial nerves in the neck. By the time the student has arrived at this stage of the dissection, the condition of the parts will not permit him to trace the very minute filaments of the three cranial nerves in the foramen jugulare of the skull; and he is recommended therefore to omit, for the present, all the paragraphs marked with an asterisk. Afterwards, if a fresh piece of the skull can be obtained, in which the nerves have been hardened by spirit and the bone softened by acid, he may return to the examination of the branches that are now passed over. Directions concerning eighth nerve.

* *In the foramen lacerum.* Supposing the dissection of the internal carotid to be made as it is described at page 110, let the student cut across with care the jugular vein near the skull. Let him then remove bit by bit with the bone forceps, or with a scalpel if the part has been softened, the ring of bone that bounds externally the jugular foramen, proceeding as far forwards as the osseous crest between that foramen and the carotid canal. Between the bone as it is cut away and the coat of the jugular vein, the small auricular branch of the pneumo-gastric nerve is to be found; it is directed backwards to an aperture near the styloid process. Dissection to open jugular foramen.

* Trace then the spinal accessory and pneumo-gastric nerves through the canal, by opening the fibrous sheath that surrounds them. Two parts, large and small, of the spinal accessory nerve should be defined; the latter is to be shown joining a ganglion on the vagus, and then applying itself to the trunk of that nerve. A communication between the two parts of the spinal accessory is also to be found. On the pneumo-gastric is a small well-marked ganglion, from which the auricular branch before referred to takes origin; and from which filaments are to be sought passing to the smaller portion of the spinal accessory nerve, and to the ascending branch of the upper cervical ganglion of the sympathetic. Follow spinal accessory and pneumo-gastric;

* Next follow the glosso-pharyngeal nerve through the fore part of the foramen, and take away any bone that overhangs it. This nerve presents two ganglia as it passes from the skull: afterwards glosso-pharyngeal

* The Anatomy of the Arteries. By R. Quain, F.R.S., p. 110.

one (jugular), which is scarcely to be perceived, near the upper part of the tube of membrane that contains it; the other, much larger (petrous), is situated at the lower border of the petrous portion of the temporal bone. From the lower one, seek the small nerve of Jacobson, which enters an aperture in, or on the side of the crest of bone between the jugular foramen and the carotid canal; and another filament of communication with the ganglion of the sympathetic. Sometimes the dissector will be able to find a filament from the lower ganglion to join the auricular branch of the pneumo-gastric; and another to end in the upper ganglion of the pneumo-gastric nerve.

and its branches.

Dissection of the nerves in the neck:

Below the foramen of exit from the skull, the cranial nerves have been greatly denuded by the dissection of the internal carotid; but the intercommunications of the vagus, hypo-glossal, sympathetic, and first two spinal nerves are to be traced out more completely near the skull.

of spinal accessory:

The larger part of the spinal accessory has been sufficiently laid bare already; but its small piece is to be traced to the vagus, close to the skull, and onwards by the side of that trunk.

of glosso-pharyngeal;

The chief part of the glosso-pharyngeal has been also dissected, but the offsets on the carotid, and others to join the pharyngeal branch of the vagus and the pharyngeal plexus, are to be displayed.

of vagus;

Taking the pneumo-gastric trunk as completed, the student will define an enlargement on it close to the skull (ganglion of the trunk) to which the hypo-glossal nerve is intimately united.

of pharyngeal plexus;

From the ganglion proceed two branches (pharyngeal and laryngeal), which are to be traced to the parts indicated by their names, especially the first which enters the pharyngeal plexus. The task of disentangling the ramifications of the branch of the vagus, and those of the glosso-pharyngeal and sympathetic in the plexus, is by no means easy, in consequence of the dense tissue in which they are contained.

of cardiac offsets;

Two or more cardiac offsets of the vagus, one at the upper and another at the lower part of the neck, may be recognised readily.

of recurrent;

Lastly the dissector may prepare more fully the recurrent branch coursing up and in beneath the lower part of the common carotid: by removing the fat around it, its offsets should be seen entering the chest and the windpipe.

of hypo-glossal;

Only the first, or the deep part of the hypo-glossal nerve remains to be made ready for learning: its communications with the vagus, sympathetic, and the spinal nerves are to be demonstrated.

of sympathetic in part.

A dissection for the sympathetic will be given farther on (p. 120); but its large ganglion near the skull (upper cervical) should be defined, and the small branches from it to the pharyngeal plexus should be pursued beneath the carotid artery.

Eighth nerve consists of the three following trunks:

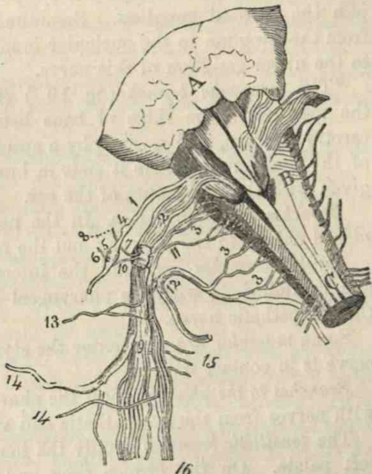
The *three cranial nerves*, glosso-pharyngeal, pneumo-gastric, and spinal accessory, which constitute the eighth nerve of Willis, leave the cranium by the foramen jugulare (p. 19). Outside the skull the nerves take different directions according to their destination; thus the glosso-pharyngeal is inclined inwards to the tongue and pharynx; the spinal accessory backwards to the sterno-mastoid and trapezius muscles; and the pneumo-gastric nerve descends to the viscera of the thorax and abdomen.

Glosso-pharyngeal nerve:

The GLOSSO-PHARYNGEAL NERVE (fig. 19, [1]) is the smallest of the three trunks. In the jugular foramen it is placed somewhat in front of the other two, and lies in a groove in the lower border of the petrous part of the temporal bone. In the aperture of exit the nerve is marked by two ganglionic swellings, the upper one being the jugular, and the lower the petrous ganglion.

has two ganglia in foramen lacerum.

Fig. 19.*



Its upper

Ganglia. The *jugular ganglion*, 4, (ganglion superius) is very small, and is situate at the upper part of the osseous groove that contains the nerve. It is placed on the outer surface of the glosso-pharyngeal trunk, and includes only some fibrils of the nerve. The *petrosal ganglion*, 5, (gang. inferius), is much larger than the preceding, and encloses all the fibrils of the nerve. Ovalish in form, it is placed in a hollow in the lower border of the temporal bone; and from it spring the branches that unite the glosso-pharyngeal with other nerves.

and lower ganglion.

In the neck

After the nerve has quitted the foramen it comes forwards between the jugular vein and the carotid artery, and crossing

* Diagram (Bendz) of the eighth nerve. 1. Glosso-pharyngeal trunk. 2. Vagus. 3. Spinal accessory. 4. Jugular ganglion. 5. Petrosal ganglion. 6. Jacobson's nerve. 7. Root ganglion of vagus. 8. Its auricular branch. 9. Trunk ganglion of vagus. 10. Branch joining the petrosal and upper ganglion of the vagus. 11. Small part of spinal accessory. 12. Chief part of spinal accessory. 13. Pharyngeal branch of vagus. 14. Superior laryngeal branch of vagus.

inwards over the artery, reaches the lower border of the stylo-pharyngeus muscle. At this spot the nerve becomes almost transverse in direction in its course to the pharynx ; it passes over the stylo-pharyngeus, and forms an arch across the side of the neck (p. 105), above the superior laryngeal nerve. Finally the nerve enters beneath the hyo-glossus muscle, and ends in branches to the pharynx, the tonsil, and the tongue.

courses to the tongue and pharynx.

Branches to join

The *branches* of the glosso-pharyngeal may be classed into those connecting it with other nerves at the base of the skull, and those distributed in the neck.

with others, viz.

Connecting branches arise chiefly from the petrosal ganglion ; and in this set is the tympanic nerve.

sympathetic and vagus,

*A *filament* ascends from the *sympathetic nerve* in the neck to join the petrosal ganglion. Sometimes there is an offset given from the ganglion to the auricular branch of the vagus, as well as to the upper ganglion of this nerve.

facial and sympathetic.

*The *tympanic branch* (fig. 19 [6]) (nerve of Jacobson) enters the aperture in the ridge of bone between the jugular and the carotid foramen, and ascends by a special canal to the inner wall of the tympanum, where it ends in branches : its distribution is given with the tympanum of the ear.

Distributed to

Branches for Distribution. In the neck the branches are furnished chiefly to the pharynx and the tongue.

carotid artery,

Carotid branches surround the internal artery of that name, and communicate with the pharyngeal branch of the vagus, and the sympathetic nerve.

stylo-pharyngeus,

Some *muscular branches* enter the stylo-pharyngeus, whilst the nerve is in contact with it.

and pharyngeal plexus,

Branches to the pharynx form the pharyngeal plexus by uniting with nerves from the sympathetic and vagus.

the tonsil,

The *tonsillitic branches* supply the tonsil and the arches of the soft palate. On the former they end in a kind of plexus—circulus tonsillaris.

and the tongue.

Lingual branches. The terminal branches of the nerve supply the root and posterior part of the tongue, as well as the lateral surface. The distribution of these is described with the tongue (SECTION 15).

Vagus nerve

The PNEUMO-GASTRIC NERVE (fig. 19, [2]) (vagus nerve) is the largest of the cranial nerves in the neck, and passes through the jugular foramen in the same sheath of dura mater as the spinal accessory. In the aperture of exit it has a distinct ganglion (gang. of the root), to which the smaller part of the spinal accessory nerve is connected.

in foramen jugulare,

and in the neck,

When the nerve has escaped from the foramen, it receives the small part of the spinal accessory, and swells into a large ganglion (gang. of the trunk). Here the nerve lies between the internal carotid artery and jugular vein, and communicates with several nerves at this part. To reach the thorax, the vagus descends almost vertically between the internal jugular vein and the internal and common carotid arteries; and enters that cavity, on the right side, by crossing over the subclavian artery, but beneath the innominate vein. courses to the thorax.

Ganglia. The *ganglion of the root* (gang. superius), 7, is of a greyish colour, and in texture is like the ganglion on the large root of the fifth nerve. The small branches of the vagus in the foramen jugulare come from this ganglion. The *ganglion of the trunk* (gang. inferius), 9, is cylindrical in form, is reddish in colour, and is nearly an inch in length. It communicates with the hypoglossal, spinal, and sympathetic nerves. All the intrinsic fibres of the trunk of the nerve are surrounded by the ganglionic substance, but those derived from the spinal accessory nerve, 16, pass over the ganglion without being inclosed in it. One ganglion in foramen, another below.

The *branches* of the pneumo-gastric nerve may be arranged into those uniting it with other nerves, and those distributed to parts around. Branches

Connecting Branches. Branches of communication arise from the ganglion of the root and the ganglion of the trunk of the vagus. to unite with others;

**From the ganglion of the root.* Its chief branch is the following:—The *auricular branch*, 8, arises from the ganglion, and crosses the jugular fossa to enter an aperture near the root of the styloid process; it traverses the substance of the temporal bone, and reaches the outer ear, on which it is distributed. Its farther course will be described with the anatomy of the ear. auricular branch;

*One or two short filaments unite this ganglion with the spinal accessory nerve; and a branch of the sympathetic nerve in the neck enters the ganglion. Occasionally there is an offset, 10, to join the lower (petrosal) ganglion of the glosso-pharyngeal nerve. with spinal accessory, sympathetic,

From the ganglion of the trunk. This ganglion is connected with the hypo-glossal nerve by communicating filaments. Other branches pass between it and the upper ganglion of the sympathetic, 15; and between it and the loop of the first two cervical nerves. with ninth, sympathetic, spinal nerves.

Branches for Distribution. These cervical branches arise from the inner side of the nerve, and are directed inwards, to supply the pharynx, the larynx, and the heart. Branches to supply

The *pharyngeal branch*, 13, is an offset from the upper part of the ganglion of the trunk of the pneumo-gastric, and terminates, as the name expresses, in the pharynx. The nerve is directed inwards over the internal carotid artery, and joins the branches of the glosso-pharyngeal nerve on that vessel. Finally it courses to the side of the middle constrictor muscle, and communicates with branches of the glosso-pharyngeal, superior laryngeal, and sympathetic nerves, to form the *pharyngeal plexus*. From the plexus branches are furnished to the constrictors and palato- pharynx and join glosso-pharyngeal and pharyngeal plexus.

glossus and pharyngeus, and to the pharyngeal mucous membrane between the tongue and the hyoid bone.

To enter larynx,

The *superior laryngeal nerve*, 14, is much larger than the preceding branch, and comes from the middle of the ganglion of the trunk of the vagus. From this point the nerve inclines obliquely inwards beneath the internal carotid artery, and reaches the larynx opposite the interval between the hyoid bone and the thyroid cartilage. The nerve then perforates the thyro-hyoid membrane, and is distributed to the mucous lining of the larynx. (See "LARYNX.") In the neck it furnishes branches to the thyroid body, and the following offset to one laryngeal muscle and the pharynx.

and supply it and

a branch outside larynx

The *external laryngeal branch* arises in the neck beneath the internal carotid artery. Taking a course similar to but below that of the superior laryngeal nerve, this branch reaches the side of the larynx, and gives offsets to the pharyngeal plexus. Finally, the nerve is continued beneath the sterno-thyroideus, to supply the crico-thyroid muscle and the inferior constrictor. Near its origin this branch communicates with the superficial cardiac branch of the sympathetic nerve..

to crico-thyroid and pharynx.

Branches to the heart, upper and lower.

Cardiac branches. Some small cardiac nerves spring from the pneumo-gastric at the upper part of the neck, and join cardiac branches of the sympathetic. At the lower part of the neck, on each side, there is a single cardiac nerve :—that of the right side enters the chest, and joins one of the deep nerves to the heart from the sympathetic ; and on the left side the corresponding nerve terminates in the superficial cardiac plexus of the thorax.

Branch to larynx,

The *inferior laryngeal* or recurrent nerve of the right side leaves the pneumo-gastric trunk opposite the subclavian artery, and winding round that vessel, takes an upward course in the neck to the larynx. To reach its destination, the nerve ascends beneath the common carotid and inferior thyroid arteries, and then between the trachea and the œsophagus. At the larynx it enters beneath the ala of the thyroid cartilage, where it will be afterwards traced. The following branches arise from it :—

ends in muscles in interior :

branches to heart,

Some *cardiac branches* leave the nerve as it turns round the subclavian artery ; these enter the thorax, and join the cardiac nerves of the sympathetic.

to trachea, œsophagus, and pharynx.

Muscular branches spring from the recurrent nerve whilst it lies between the trachea and the œsophagus, and are distributed to both those tubes. Near the larynx some filaments are furnished to the inferior constrictor muscle.

Left recurrent nerve.

On the left side of the body the recurrent nerve arises in the thorax, opposite the arch of the aorta, around which it bends. In the neck its position is between the trachea and œsophagus, as on the right side.

Spinal accessory

The SPINAL ACCESSORY NERVE (fig. 19, [12]) courses through the foramen jugulare with the pneumo-gastric, but is not marked by any ganglion while in the foramen. The nerve is constructed of two parts, viz. accessory to the vagus, and spinal, which have a different origin and distribution. (Origin of the cranial nerves.) has two parts

The part *accessory to the vagus*, 11, is the smaller of the two, and finally blends with the pneumo-gastric beyond the skull. In the foramen of exit from the skull, it lies close to the vagus; and there it joins the upper ganglion of that nerve by one or two filaments. accessory to vagus in foramen.

Having passed through the foramen, this part is applied to the vagus; it is then continued over the lower ganglion of that nerve, and blends with the trunk beyond the ganglion, 16. It gives offsets to join the pharyngeal and upper laryngeal branches of the pneumo-gastric; and according to Bendz, offsets from it may be traced into many other branches of the same nerve. Below foramen: how ends.

The *spinal* part (fig. 19, [12]) is much larger, is round and cord-like, and is connected with the smaller piece whilst it is passing through the foramen jugulare. Spinal part in foramen.

Beyond the foramen the nerve takes a backward course through the sterno-mastoid muscle, and across the side of the neck to end in the trapezius muscle. At first it is concealed by the jugular vein, but it then passes either over or under that vessel, to take the course above indicated. The connections of the nerve beyond the sterno-mastoideus have been already examined (p. 59). In the neck, crosses to trapezius.

This nerve furnishes muscular offsets to the sterno-mastoideus and the trapezius. Supplies muscles.

The HYPOGLOSSAL NERVE (ninth of Willis), after passing from the cranium by the anterior condyloid foramen, lies deeply between the internal carotid artery and the jugular vein. It next comes forwards between the vein and artery, turning round the outer side of the vagus to which it is united. The nerve now descends in the neck, and becomes superficial below the digastric muscle in the anterior triangular space; from this spot it is directed inwards to the tongue and its muscles. Ninth nerve crosses inwards to tongue.

The *branches* of the nerve are motor to muscles, and communicating to other nerves. Branches join it with

Connecting branches. Near the skull the hypoglossal is connected by branches with the vagus nerve, the two being almost inseparably united. the vagus,

Rather lower down the nerve is joined by offsets with the sympathetic, and the loop of the first two spinal nerves. sympathetic, and spinal;

The *branches for distribution* have been met with in the foregoing dissections. Thus in the neck it supplies, in union with the spinal nerves, the depressors of the hyoid bone. In the submaxillary region it furnishes branches to one elevator (genio-hyoid) of the os hyoides; to the extrinsic muscles of the tongue except and supplies muscles.

the palato and pharyngeo-glossus; and to all the intrinsic of the tongue, with the exception of the superficial lingualis.

Dissection of rectus lateralis. *Dissection.*—The small rectus capitis lateralis muscle, between the transverse process of the atlas and the base of the skull, is now to be cleaned and learnt. At its inner border the anterior branch of the first cervical nerve, which forms part of the loop on the atlas, is to be found.

Rectus lateralis is first inter-transverse muscle. The RECTUS CAPITIS LATERALIS (fig. 32, [5]) is small and thin, and represents an intertransverse muscle. It *arises* from the anterior transverse process, and the tip of the united transverse processes of the atlas; and is *inserted* into the jugular eminence of the occipital bone.

Parts around. On the anterior surface rests the jugular vein; and in contact with the posterior is the vertebral artery. To the inner side lies the anterior primary branch of the first cervical nerve.

Use. *Action.* It assists the muscles attached to the mastoid process in inclining the head laterally.

Dissection of first nerve. *Dissection.* For the purpose of tracing backwards the anterior branch of the first cervical nerve divide the rectus lateralis muscle, observing the offset to it; then cut off the end of the lateral mass of the atlas, and remove the vertebral artery, so as to bring into view the nerve as it lies on the first vertebra.

Sub-occipital nerve The *anterior* primary *branch* of the *first* or *sub-occipital nerve* is slender in size, and arises from the common trunk on the neural

lies on atlas, arch of the atlas. From that origin it is directed forwards on the arch, beneath the vertebral artery, to the inner side of the rectus lateralis. Here the nerve bends down in front of the

forms a loop with second. lateral mass of the bone, and forms a loop by uniting with the second cervical nerve. Branches connect this loop with the vagus,

Branches. hypoglossal, and sympathetic nerves. As the nerve passes forwards it supplies the rectus lateralis muscle, and sends a filament along the side of the vertebral artery.

Sympathetic nerve in neck has three ganglia: SYMPATHETIC NERVE. In the neck the sympathetic nerve consists, on each side, of a gangliated cord, which lies close to the vertebral column, and is continued into the thorax. On this part of the nerve are three ganglia:—One near the skull, another on the neck of the first rib, and a third somewhere between the two; these are named respectively superior, inferior, and middle ganglion. From the ganglia proceed connecting branches with the spinal and most of the cervical cranial nerves; and branches for distribution to viscera and blood-vessels.

other ganglia on fifth nerve. Besides the ganglia above mentioned, there are other ganglia in the head and neck, in connection with the three trunks of the fifth nerve.

Dissection of upper ganglion. *Dissection.* To display the branches of the sympathetic nerve requires greater care than is necessary in dissecting the white-fibred nerves, for they are softer, more easily torn, and generally of smaller size. In the neck the ganglia and their branches have been already partly prepared, and will require only the following additional dissection to bring them into view:—The jugular vein having been already cut through, the upper ganglion will be seen by raising the carotid artery, and the trunks of the vagus and hypoglossal nerves, and by cutting through the branches that unite these two to the loop of the atlas. The several branches of the ganglion should be traced upwards on the carotid artery, inwards to the pharynx, down along the neck, and outwards to other nerves.

Middle The dissector has already seen the middle ganglion on or near the inferior thyroid artery, and has to trace out now its branches to spinal nerves, and along the neck.

and inferior ganglion. To obtain a view of the inferior ganglion the greater part of the first rib is to be taken away, and the subclavian artery is to be cut through and drawn aside, without however destroying the fine nerves that pass over it. The clavicle is supposed not to be in position, otherwise it must be removed. The ganglion is placed on the neck of the first rib; its branches are large, and are easily followed outwards to the vertebral artery and the spinal nerves, and downwards to the thorax.

Superior ganglion is near skull, beneath carotid. The SUPERIOR CERVICAL GANGLION is the largest of the three, and is of a reddish grey colour. Of a fusiform shape, it is as long as the second and third cervical vertebræ, and is placed on the rectus capitis anticus major muscle, beneath the carotid artery and the contiguous cranial nerves. Branches connect the ganglion with other nerves; and some are distributed to the blood-vessels, the pharynx, and the heart.

Branches *Connecting branches* unite the sympathetic with both the spinal and the cranial nerves.

with spinal nerves, *With the spinal nerves.* The four highest spinal nerves have branches of communication with the upper ganglion of the sympathetic; but the offset to the fourth nerve may come from the cord connecting the upper to the next ganglion.

with cranial outside skull, *With the cranial nerves.* Near the skull the trunks of the vagus (its lower ganglion) and hypoglossal nerves are joined by branches of the sympathetic. In the foramen jugulare also, both the petrosal ganglion of the glosso-pharyngeal and the ganglion of the root of the vagus receive small filaments, one to each, from an ascending offset of the ganglion.

and with some in the skull. Communications are formed with several other cranial nerves by means of the offset continued upwards from the ganglion into the carotid canal (p. 20).

Branches *Branches for Distribution.* This set of branches is more numerous than the preceding, and the nerves are larger in size.

to external carotid, *Branches for blood-vessels* (nervi molles). These nerves surround the external carotid artery, and ramify on its branches so as to form plexuses on the arteries with the same name as the vessels they surround. Some small ganglia are occasionally found on these ramifying nerves. By means of the plexus on the facial artery the submaxillary ganglion communicates with the sympathetic; and through the plexus on the internal maxillary artery the otic ganglion obtains a similar communication.

forming plexuses and ganglia;

to internal carotid,

Another offset of the ganglion accompanies the internal carotid artery and its branches. This offset ascends from the upper part of the ganglion, of which it appears to be the continuation. Near the skull it divides into two pieces, which enter the canal for the carotid artery, one on each side of that vessel: and are continued, forming secondary plexuses on the ophthalmic and cerebral arteries, to the eyeball and the pia mater of the brain. In the carotid canal communications are formed with the tympanic nerve (p. 116) and with the spheno-palatine ganglion (p. 150); the former being placed near the lower, and the latter near the upper opening of the canal. The communications and plexuses which these nerves form in their course to the base of the brain are described at p. 20.

which join cranial nerves;

to pharyngeal plexus,

The *pharyngeal nerves* pass inwards to the side of the pharynx, where they join in the pharyngeal plexus with the other branches of the cranial nerves (p. 117).

to cardiac plexuses.

Cardiac nerves. The cardiac nerves enter the thorax to join in the plexuses of the heart. There are three cardiac nerves on each side, viz. superior, middle, and inferior, each taking its name from the ganglion of which it is an offset.

One nerve to deep plexus

The *superior cardiac nerve* (superficial) of the right side courses behind the sheath of the carotid vessels, and enters the thorax beneath, or in front of the subclavian artery. In the neck the nerve is connected with the cardiac branch of the vagus, the external laryngeal, and the recurrent nerve. In some bodies it ends by joining one of the other cardiac nerves.

joins others in neck.

Middle ganglion.

Situation.

The MIDDLE CERVICAL GANGLION (gang. thyroideum) is of small size, and is situate opposite the fifth cervical vertebra, usually on or near the inferior thyroid artery. It has a roundish shape, and lies beneath the great vessels. Its *branches* are the following:—

Is joined to spinal nerves;

Connecting branches with the spinal nerves sink between the borders of the longus colli and anterior scalenus to join the fifth and sixth cervical nerves.

offsets,

Branches for Distribution. These consist of nerves to the thyroid body, together with the middle cardiac nerve.

thyroid branches

The *thyroid branches* ramify around the inferior thyroid artery, and end in the thyroid body; they join the external and recurrent laryngeal nerves.

and a cardiac nerve.

The *middle* or great *cardiac nerve* descends to the thorax across the subclavian artery; its termination in the cardiac plexus will be learnt in the chest. In the neck it communicates with the upper cardiac and recurrent laryngeal nerves.

The INFERIOR CERVICAL GANGLION is irregular in shape, and occupies the interval between the first rib and the lateral mass of the last cervical vertebra, its position being internal to the superior intercostal artery. Oftentimes it extends in front of the neck of the rib, and joins the first swelling of the knotted cord in the thorax. Its *branches* are similar to those of the other two ganglia.

Inferior ganglion on neck of first rib.

One or two branches surround the trunk of the subclavian artery, and supply filaments to that blood-vessel.

Branches to blood-vessels,

Connecting branches join the last two cervical nerves. Other nerves accompany the vertebral artery in its canal, forming a plexus—*vertebral*, around it, and communicate with the spinal nerves as high as the fourth.

and spinal nerves,

Only one branch for distribution, the *inferior cardiac nerve*, issues from the lower ganglion. It lies beneath the subclavian artery, joining in that position the recurrent laryngeal nerve, and enters the thorax to terminate in the deep cardiac plexus behind the arch of the aorta.

and one cardiac.

Directions. The remains of the right half of the head and neck should be carefully preserved during the time occupied in the examination of the left half.

SECTION X.

DISSECTION OF THE LEFT SIDE OF THE NECK.

Directions. In repeating the dissection of the left half of the neck, the differences observable between it and the right side are specially to be studied. When the description of the right side will suffice, reference will be made to it.

After the neck has been made tense over a narrow block, the anterior part of it is to be prepared as on the opposite side. The description of the right side (p. 63) is to be used for the anterior triangular space, the sterno-mastoideus, and the depressor muscles of the hyoid bone.

Dissection of anterior triangle of neck,

Next the scaleni muscles and the subclavian vessels are to be learnt. The dissection and description of those parts on the right side (p. 69), will serve for these on the left, except that the student will meet on the left side with the thoracic duct.

of scaleni and subclavian artery:

The thoracic duct is contiguous to the part of the subclavian artery inside the scalenus muscle. If it is uninjected it looks like a vein rather smaller than a crow-quill; and it will be found between the carotid artery and jugular vein about half an inch

to thoracic duct.

above the clavicle, as it courses from beneath the artery to end in the subclavian vein.

On this side the clavicle may remain articulated, in order that the joint may be learnt.

Subclavian artery

The LEFT SUBCLAVIAN ARTERY arises from the arch of the aorta, instead of from an innominate trunk, and ascends thence over the first rib in its course to the upper limb. With this difference on the two sides in the origin of the subclavian,—the one vessel beginning opposite the sterno-clavicular articulation, the other in the thorax,—it is evident that the length and connections of the part of the artery on the inner side of the scalenus must vary much on opposite sides.

differs much from right subclavian

in the first part of its extent.

First part. The part of the artery internal to the anterior scalenus is much longer on the left than the right side, and is almost vertical in direction, instead of being horizontal like its fellow. Moreover, after it leaves the chest it is deeply placed in the neck, near the spine and the œsophagus; and does not rise usually so high above the first rib as the right subclavian.

Connections with surrounding parts.

Between the artery and the surface are the same parts as are superficial to the right vessel, viz. the common teguments with the platysma and deep fascia, and the sterno-mastoid, hyoid, and thyroid muscles. Behind the vessel is the longus colli muscle. To the inner side are the œsophagus and the thoracic duct; and the pleura is in contact with the outer and anterior parts. Its connections lower in the chest are described in the dissection of the thorax.

Veins.

Veins. The internal jugular and left innominate veins are superficial to the artery.

Position of nerves.

Nerves. The pneumo-gastric nerve lies parallel to the vessel instead of across it as on the right side; and the phrenic nerve crosses over it close to the scalenus. Accompanying the subclavian artery are the cardiac branches of the sympathetic, which course along the inner side of the vessel to the chest; and beneath it is the inferior cervical ganglion.

Rest of artery.

The *second* and *third* parts of the artery, viz. beneath and beyond the scalenus, are nearly the same as on the right side; but the student must note for himself the variations that may exist in the connections.

Branches resemble those of right vessel.

The *branches* of this artery resemble so closely those of the right trunk, that one description will serve for both. It may be remarked, that the superior intercostal of the left side is usually internal to, instead of beneath the scalenus as on the right side; in other words, this branch arises sooner (see p. 73).

Thoracic duct comes from the thorax

The *thoracic duct* conveys the chyle and lymph of the greater part of the body into the venous circulation. Escaping from the thorax between the subclavian artery and the œsophagus, the duct ascends in the neck as high as the seventh or sixth cervical vertebra. At the spot mentioned the duct, issuing from beneath the carotid trunk, arches outwards above the subclavian artery, and in front of the scalenus muscle and the phrenic nerve, to open into the subclavian close to the union with the internal jugular vein. Double valves, like those of the veins, are present in the interior of the tube; and two guard the opening into the posterior part of the vein, to prevent the passage of the blood into it. and joins subclavian vein.

Frequently the upper part of the duct is divided; and there may be separate openings into the large vein, corresponding with those divisions.

Structure. This tube is formed of three coats like the blood-vessels, viz. inner, middle, and outer. The inner is an elastic reticulate layer of longitudinal fibres covered by epithelium; the middle is muscular and elastic with transverse fibres; and the outer is constructed chiefly of fibrous tissues arranged longitudinally and obliquely. Structure.

Examine next the brachial and cervical plexuses, using the description of the right side (p. 76). Spinal nerves.

Common carotids. On opposite sides these vessels have differences like those between the right and left subclavian arteries; for on the left side the vessel arises from the arch of the aorta, and is therefore deep in the chest, and longer than the right. The part of the artery between its origin and the upper piece of the sternum will be included in the dissection of the thorax. Difference in origin of right and left carotids.

Beyond the sterno-clavicular articulation the vessels, on both sides, so nearly resemble one another that the same description may serve for the two (p. 79). On the left side, however, the jugular vein and the pneumo-gastric nerve are much nearer to the carotid than on the right side, and are placed over the artery in the lower third of the neck.* In the neck difference in vein and nerve.

The thyroid body is a soft reddish mass, which is situate opposite the upper part of the trachea. It consists of two lobes, one on each side, which are united by a narrow piece across the front of the windpipe. The connecting piece, about half an inch in depth, is named the *isthmus*, and is placed opposite the second and third rings of the air tube. Thyroid body consists of two lobes and a cross piece.

Each lobe is somewhat conical in shape, with the smaller end upwards, and is about two inches in length. It is interposed between the windpipe and the sheath of the common carotid artery, and is covered by the sterno-thyroid, sterno-hyoid, and omo-hyoid muscles. The extent of the lobe depends upon variations in its size; but usually the lateral piece reaches as high as the ala of the thyroid cartilage, and as low as the sixth ring of the trachea. Connections and extent of lobes.

* Occasionally these differences will be reversed—the vein and nerve being over the artery on the right side, and away from it on the left.

Accessory piece or pyramid.

From the upper part of the thyroid body, and most commonly from the left lobe, a conical piece—*pyramid*, ascends towards the hyoid bone, to which it is connected by a fibrous band. Sometimes this part is attached to the hyoid bone by a slip of muscle, the *levator glandulæ thyroideæ* of Sœmmerring.

Weight and size.

This body is of a brownish red or purple hue, is granular in texture, and weighs from one to two ounces. Its size is larger in the woman than in the man. On cutting into the gland a viscid yellowish fluid escapes. It has not any excretory tube or duct.

No distinct capsule.

Structure. The thyroid body is not provided with a distinct capsule; but it is surrounded by areolar and fine elastic tissues, which project into the substance and divide it into masses.

Consists of vesicles, with a yellow fluid, and special membrane.

The substance of the gland consists of spherical or elongated vesicles, which vary in size, some being as large as the head of a small pin, and others only $\frac{1}{850}$th of an inch. These vesicles are simple sacs, distinct from one another, and contain a yellowish fluid with corpuscles. The wall of the vesicles consists of a thin proper membrane with a nucleated epithelial lining. Fine vessels and areolar tissue unite together the vesicles into small irregular masses or lobules of the size of the little finger nail.

Blood-vessels. Superior, Inferior,

The *arteries* of the thyroid body are two on each side—superior and inferior thyroid. The branches of the external carotids (superior thyroid) ramify chiefly on the anterior aspect; while those from the subclavians (inferior thyroid) pierce the under surface of the thyroid body. A very free communication is established between all the vessels; and in the substance of the thyroid body the arteries form a capillary network around the vesicles.

and lowest thyroid.

Occasionally there is a third thyroid branch (*art. thyroid. ima*) which arises from the innominate artery in the thorax, and ascending in front of the trachea assists in supplying the thyroid body.

Veins.

Inferior form a plexus on trachea.

The *veins* are large and numerous; they are superior, middle, and inferior thyroid on each side. The first two enter the internal jugular vein (p. 81). The *inferior thyroid vein* issues from the lower part of the thyroid body, and descends on the trachea, the two forming a plexus on that tube beneath the sterno-thyroid muscles; it enters finally the innominate vein of its own side.

Trachea lies in neck and thorax.

Form.

The TRACHEA, or air tube, is continued from the larynx to the thorax, and ends by dividing into two tubes (bronchi), one for each lung. It occupies the middle line of the body, and extends commonly from the fifth cervical to the third dorsal vertebra, measuring about four inches and a half in length, and nearly one in breadth. The front of the trachea is rounded in consequence of the existence of firm cartilaginous bands in the anterior wall, but at the posterior aspect the cartilages are absent, and the tube is flat and muscular.

The cervical part of the trachea is very moveable, and has the following relative position to the surrounding parts. Covering it in front are the small muscles reaching from the sternum to the hyoid bone, with the deep cervical fascia: beneath those muscles is the inferior thyroid plexus of veins; and near the larynx is the isthmus of the thyroid body. Behind the tube is the œsophagus, with the recurrent nerves. On each side are the common carotid artery and the thyroid body. Cervical part is amongst muscles and vessels.

The structure of the trachea is described in Section XVII.

The ŒSOPHAGUS, or gullet, reaches from the pharynx to the stomach. It commences, like the trachea, opposite the fifth cervical vertebra, and ends opposite the tenth dorsal vertebra. The tube reaches through part of the neck, and through the whole of the thorax; and occupies the middle line of the body. In length it measures about nine inches. Œsophagus occupies neck and thorax.

In the neck its position is behind the trachea till near the thorax, where it projects to the left side beyond the air tube, and touches the thyroid body and the thoracic duct. Behind the œsophagus is the longus colli muscle. On each side is the common carotid artery, the proximity of the left being greatest because of the projection of the œsophagus towards the same side. Position in neck and connections.

The structure of the œsophagus will be examined in the dissection of the thorax.

Directions. The dissector may learn next the digastric and stylo-hyoid muscles, with the hypoglossal nerve. Afterwards he is to take the trunk of the external carotid, with the following branches,—superior thyroid, facial, occipital, posterior auricular, and superficial temporal. The description of the right side (p. 82) may be used for those parts. Muscles and vessels in anterior triangle.

The dissector is not to examine at this stage the pterygo-maxillary or submaxillary regions on the left side of the neck, because such a proceeding would interfere with the subsequent dissections. Before learning the pharynx he should lay bare, on this side, the middle and inferior ganglia of the sympathetic with their branches. Regions to be omitted.

Dissection. For the display of the two lower ganglia of the sympathetic and their branches, it will be necessary to take away the great blood-vessels by cutting these across at the lower part of the neck, and near the digastric muscle. In removing the vessels care must be taken of the sympathetic beneath them. Dissection of sympathetic,

The middle ganglion must be sought in the fat and areolar tissue near the inferior thyroid artery; and the inferior one will be seen on the neck of the first rib, after the subclavian artery has been divided. The upper cardiac nerve will be found descending beneath the carotid sheath. viz. middle and lower ganglia.

Reserve sternal joint.

The upper end of the sternum with its attached clavicle is to be taken away next, by cutting through the middle of the first rib; and the piece of bone thus obtained is to be put aside for the subsequent examination of the sterno-clavicular articulation.

Ganglia of sympathetic nerve.

The *middle* and *inferior cervical ganglia* of the sympathetic nerve are so similar to the corresponding ganglia of the right side, that the same description will suffice (p. 122).

Cardiac nerves.

The *cardiac nerves* are three in number on the left as on the right side, viz. superior, middle, and inferior, but they present some differences.

Upper.

The *superior cardiac nerve* has a similar course in the neck on both sides; but the left in entering the chest lies between the carotid and subclavian arteries, and parallel to them.

Middle.

The *middle cardiac nerve* unites frequently with the next nerve, and passes beneath the subclavian artery to the deep cardiac plexus.

Lower.

The *inferior cardiac nerve* is generally a small branch, which enters the thorax conjoined with the preceding, and ends in the cardiac plexus.

SECTION XI.

DISSECTION OF THE PHARYNX.

Directions.

The pharynx, or the commencement of the alimentary passage, can be examined only when it has been separated from the rest of the head; and it will therefore be necessary to cut through the base of the skull in the manner mentioned below, so as to have the anterior half, with the pharynx connected to it, detached from the posterior half.

To detach pharynx

Dissection. Preparatory to sawing the skull certain other steps are needed. In the first place, the block being removed from beneath the neck, the head is to be placed downwards, so that it may stand on the cut surface of the skull. Next the trachea and œsophagus, together with the vagus and sympathetic nerves, are to be cut near the first rib (should these be still uncut), and all are to be separated from the spine as high as the basilar process of the occipital bone; and without injuring, on the left side, the vessels and nerves near the skull.

partly divide base of skull externally,

For the division of the skull, let the student chisel through the basilar process of the occipital bone between the attachments of the pharynx and the muscles of the spinal column, the instrument being directed backwards. Turning upwards next the inner surface of the base of the skull the dissector will make the following incisions in the posterior fossa. On the right side a cut with the chisel is to be carried along the line of union of the petrous part of the temporal with the occipital bone, as far as the incision across the basilar process. On the left side, another cut with the chisel is to be made in the same direction, but through the occipital bone internal to the foramen jugulare and the inferior petrosal sinus: this is to begin rather behind the foramen, and to end opposite the one on the other side.

and cut remainder from inside.

Lastly, the side of the skull is to be sawn through vertically on the left side close behind the mastoid part of the temporal bone, so that the incision shall meet the outer end of the cut made with the chisel. The base of the skull is now divided into two parts (one having the pharynx attached to it, the other articulating with the spine), which can be readily separated with a scalpel.

Saw the side of skull,

then cut soft parts.

The spinal column with the piece of the occipital bone connected with it should be set aside and kept for after examination.

Preserve piece of spine.

Dissection of the pharynx. Let the student take the anterior part of the divided skull, and, after moderately filling the pharynx with tow, fasten it with hooks on a block, so that the œsophagus may be pendent and towards him.

Fasten pharynx.

On the left side of the pharynx a view may be obtained of the cranial and sympathetic nerves near the skull, when some loose areolar tissue, and the styloid process with its muscles, have been removed.

Dissect nerves on left side,

Afterwards the dissector may proceed to remove the fascia from the constrictor muscles in the direction of the fibres, these radiating from the side to the middle line. The margins of the two lower constrictor muscles (middle and inferior) are to be defined. Beneath the lower one near the larynx, will be found the recurrent nerve; whilst intervening between the middle and superior, are the stylo-pharyngeus muscle and the glosso-pharyngeal nerve.

then muscles.

Lower and middle constrictor.

To see the attachment of the superior constrictor to the lower jaw and the pterygo-maxillary ligament, it will be necessary to cut through the internal pterygoid muscle of the right side. Above the upper fibres of this constrictor, and near the base of the skull (petrous part of the temporal bone), will be found two small muscles of the palate which enter the pharynx:—one,—tensor palati, lies between the internal pterygoid plate and the pterygoid muscle; and the other,—levator palati, is rather farther back, and larger.

Upper constrictor.

The PHARYNX is situate behind the nose, mouth, and larynx. Through the part of the passage above the mouth the air moves in respiration; whilst through that below the mouth both air and food are transmitted—the air passing to the aperture of the windpipe, and the food to the œsophagus. Its extent is from the base of the skull to the cricoid cartilage of the larynx, where it ends

Pharynx is behind mouth and nose.

Extent,

form, in the œsophagus. In form it is somewhat conical, with the dilated part upwards, and the apex or narrower part downwards. length. In length it measures from five to six inches.

Is an incomplete bag. The tube of the pharynx is incomplete in front, where it communicates with the cavities above mentioned, but is quite closed behind. Connections. On each side of it are placed the trunks of the carotid arteries, with the internal jugular vein and the accompanying cranial and sympathetic nerves. Behind it is the spinal column, covered by the deep muscles, viz. longus colli and rectus capitis anticus major.

Attachments. In front the pharynx is attached to the larynx, the hyoid bone and the tongue, and to the bony framework of the nasal cavity; but behind it is unattached, and is formed of thin, fleshy and membranous strata. Construction. In the posterior wall are contained elevator and constrictor muscles; and at the upper part the bag is further completed by an aponeurotic expansion which fixes it to the base of the skull. The whole is lined by mucous membrane.

Aponeurosis of pharynx. The *aponeurosis* of attachment is seen at the upper part of the pharynx, where the muscular fibres are absent, to connect the tube to the base of the skull, and to complete the posterior boundary. Superiorly it is fixed to the basilar process of the occipital, and the petrous part of the temporal bone, as well as to the cartilage between the two; but inferiorly it becomes thin, and extends between the muscular and mucous strata. On this membrane some of the fibres of the constrictor muscles terminate.

Constrictors. The CONSTRICTORS are three thin muscles, which are arranged like scales, the lower partly overlaying the middle, and the middle the upper.

Fig 20*.

Lower muscle arises from larynx. The *inferior constrictor* (fig. 20,[10]), the most superficial and lowest, *arises* from the side of the cricoid cartilage, from the oblique line and upper and lower borders of the thyroid cartilage, and from the part of the latter which is behind the oblique line. and ends in the middle line. The origin is small when compared with the insertion, for the fibres are directed backwards, radiating, and are *inserted* into a *raphé* along the middle line, where it meets the corresponding muscle of the opposite side.

Parts in The outer surface of the muscle is in contact with the sheath

* External view of the pharynx. 1. Buccinator muscle. 2. Points to the pterygo-maxillary ligament. 3. Orbicularis oris. 6. Mylo-hyoid. 8. Thyro-hyoid. 9. Crico-thyroid. 10. Inferior; 11. middle; and, 12. superior constrictor.

of the carotid artery, and with the muscles covering the spinal column. The lower border is straight, and is continuous with the fibres of the œsophagus; whilst the upper border overlaps the fibres of the middle constrictor. The recurrent nerve enters beneath the lower border.

contact with it.

Middle constrictor: origin from hyoid bone.

The *middle constrictor* has nearly the same shape as the preceding, that is to say, it is narrowed in front and expanded behind. Its fibres *arise* from the great cornu of the os hyoides, from the small cornu of the same bone, and from the stylo-hyoid ligament. From this origin the fibres radiate, and are blended along the middle line with the other muscles.

Connections.

The surfaces have connections similar to those of the preceding constrictor. The upper border is separated from the superior constrictor by the stylo-pharyngeus muscle and the glosso-pharyngeal nerve, and ends on the aponeurosis of the pharynx, about an inch from the base of the skull. The lower border descends beneath the inferior constrictor; and opposite the interval between the two is the superior laryngeal nerve.

Upper constrictor.

The *superior constrictor* (fig. 20, [12]) is the least strong of the three muscles, and wants the same regular or conical form. Its *origin* is extensive, and is connected successively, from above down, with the inner surface of the internal pterygoid plate (the lower third or less), with the pterygo-maxillary ligament ([2]), with the posterior part of the mylo-hyoid ridge of the lower jaw, and with the mucous membrane of the mouth and the side of the tongue. The fleshy fibres pass backwards, and are *inserted* on the aponeurosis of the pharynx, as well as into the *raphé* along the middle line.

Origin in front.

Insertion behind as the others.

Contiguous parts.

The parts in contact externally with this muscle are, all the deep vessels and nerves of the neck; and internally it is lined by the aponeurosis and the mucous membrane. The upper border consists of arched fibres which are directed backwards from the pterygoid plate; and above it the levator palati muscle is seen. The lower border is overlaid by the middle constrictor muscle. The attachment to the pterygo-maxillary ligament corresponds with the origin of the buccinator muscle.

Use of constrictors,

Action of constrictors. The muscles of both sides contracting will diminish the size of the pharynx; and as the anterior attachments of the lower muscles are nearer together than those of the upper, the tube will be contracted more behind the larynx than near the head.

in swallowing.

In swallowing the morsel is seized first by the middle constrictor, and is delivered over to the inferior, by which it is conveyed to the œsophagus. Both muscles act involuntarily. By the contraction of the upper muscle the space above the mouth will be narrowed, so that the soft palate being raised, the upper portion of the pharyngeal space can be shut off from the lower.

Dissection.

Dissection. Open the pharynx by an incision along its middle, and, after removing the tow from the interior, keep it open with hooks. A better view of the cavity will be obtained by partly dividing the occipital attachment on each side. The mucous membrane is to be carefully removed below the dilated extremity of the Eustachian tube on the right side, for the purpose of finding some pale muscular fibres, salpingo-pharyngeus, which descend from it.

The ELEVATORS of the pharynx are two in number on each side, an external (stylo-pharyngeus), and an internal (salpingo-pharyngeus).

Stylo-pharyngeus.

The *stylo-pharyngeus* (external elevator) may be read again with the pharynx. Its description is given in p. 109.

Salpingo-pharyngeus. Attachments.

Salpingo-pharyngeus (internal elevator). This little band is fixed by tendon to the lower border of the cartilage of the Eustachian tube near the orifice. The fleshy fibres that succeed end below by joining those of the palato-pharyngeus. If the part is not fresh the muscle may not be discovered.

Use.

Action. This thin muscle takes but a small share in raising the pharynx preparatory to swallowing; it elevates the upper and lateral part above the spot where the large external elevator enters the wall.

Interior of pharynx.

The *interior of the pharynx* is wider from side to side than from before back, and its greatest width is opposite the hyoid bone; from that spot it diminishes both upwards and downwards, but much more rapidly in the latter than in the former direction.

Objects to be noted.

In it the following objects are to be noticed.

At the top are situate the posterior apertures of the nasal cavity, which are separated by the septum nasi; and below them hangs the soft palate, partly closing the cavity of the mouth. By the side of each nasal aperture is the trumpet-shaped end of the Eustachian tube.

Below the soft palate, the opening into the mouth—isthmus faucium, is to be recognised; and on each side of this is the tonsil, which is placed in a hollow between two prominences named pillars of the soft palate,—the one proceeding from the soft palate to the side of the tongue, and the other from the same part to the side of the pharynx.

Next in order, below the mouth, comes the aperture of the larynx; and close in front of it is the epiglottis, or the valve which assists to close that opening during deglutition. Lowest of all is the opening from the pharynx into the œsophagus.

Seven apertures, viz.

The *apertures* into the pharynx are seven in number, and have the following position and boundaries:—

Posterior nares.

The posterior *openings* of the *nasal fossæ* are oval in form, and measure about an inch from above down, but only half an inch across. Each is constructed in the dried skull by the sphenoid and palate bones above and below; by the vomer inside, and internal pterygoid plate outside; and it is lined by mucous membrane.

The *Eustachian tube* is a canal, partly osseous, partly cartilaginous, by which the tympanic cavity of the ear communicates with the external air. Only the cartilaginous part that is external to the bone can be now seen. Eustachian tube;

If the mucous membrane be removed from the tube on one side, the cartilaginous part appears to be nearly an inch long. It is narrow superiorly, where it is fixed to the margins of a groove between the petrous part of the temporal and the sphenoid bone; but it increases in width as it is directed downwards to the pharynx, and ends by a wide aperture inside the internal pterygoid plate, and on a level with the inferior meatus. Its opening in the pharynx is oval in form; and the inner side, which is larger than the outer, projects forwards, giving rise to a trumpet-shaped mouth. cartilaginous part is an inch long. has a wide opening;

This part of the tube is constructed by a triangular piece of cartilage, whose margins are bent downwards so as to enclose a narrow space; but at the under aspect the cartilage is deficient, and the wall is formed by fibrous membrane. Closely united to the pterygoid plate, the tube is covered by the mucous membrane; and through it the mucous lining of the cavity of the tympanum is continuous with that of the pharynx. is a bent piece of cartilage. Mucous membrane covers and lines it.

The *isthmus faucium* is the narrowed channel between the mouth and the fauces, whose size is altered by the elevated or pendent position of the soft palate. The space is bounded below by the root of the tongue; above by the soft palate; and on each side by the projecting anterior arches of the soft palate, which are named *pillars* of the *fauces*. Opening of the fauces.

The *aperture of the larynx* is wide in front, where it is bounded by the epiglottis, and pointed behind between the arytænoid cartilages. The sides are sloped from before back, and are formed by folds of the mucous membrane extending between the arytænoid cartilages and the epiglottis. Posteriorly it is limited by the cornicula laryngis, and by the arytænoid muscle covered by mucous membrane. During respiration this aperture is unobstructed, but in the act of deglutition it is closed by the epiglottis. Upper opening of larynx.

The *opening into the œsophagus* is the narrowest part of the pharynx, and is opposite the cricoid cartilage and the fifth cervical vertebra. Internally the mucous membrane in the œsophagus is paler than that in the pharynx; and externally the point at which the pharynx ends is marked by a slight contraction, and by a change in the direction of the muscular fibres. Beginning of œsophagus.

The SOFT PALATE (velum pendulum palati) is a moveable structure between the mouth and the pharynx, which can either close the isthmus of the fauces, or cut off the passage to the nose, Soft palate at back of mouth;

according as it is depressed or elevated. In the usual position of the soft palate (the state of relaxation) the anterior surface is somewhat curved, and is continuous with the roof of the mouth, whilst the opposite surface is convex and turned to the pharynx. The upper border is fixed to the posterior margin of the hard palate; and each lateral part joins the pharynx. The lower border is free, and presents in the centre a conical pendulous part—the *uvula.* Along the middle line is a slight ridge, indicative of the original separation into two halves.

surfaces,

borders;

from it hangs uvula.

Springing from the lower part of the soft palate, near the uvula, are two folds on each side, containing muscular fibres, which are directed downwards on the sides of the isthmus faucium. These are named *arches* or *pillars* of the *palate,* and are distinguished from one another by their relative position. The *anterior* reaches from the fore part to the side of the tongue near the root; and the *posterior,* longer than the other, is continued from the lower border to the side of the pharynx. As they diverge from their origin to their termination, they limit a triangular space in which the tonsil lies.

Arches or pillars;

anterior,

posterior.

The velum consists of an aponeurosis, with muscles, vessels, nerves, and mucous glands; and the whole is enveloped by the mucous membrane.

Constituents of velum.

Dissection. Some of the muscles of the palate are readily displayed, but others require care in their dissection.

Dissection.

On the right side the two principal muscles of the soft palate —the elevator and tensor, are very plain. These have been partly dissected on the outside of the pharynx; but to follow them to their termination, let the upper attachment of the pharynx on the same side, the salpingo-pharyngeus, and the part of the superior constrictor which arises from the internal pterygoid plate, be cut through. The levator will be fully laid bare by the removal of the mucous membrane, and the muscular fibres covering its lower part. The tendon of the tensor palati should then be followed round the hamular process of the pterygoid plate; and its situation in the palate beneath the levator should be made evident. The position of the Eustachian tube with respect to those muscles should be ascertained.

Levator and tensor on right half.

On the left side, the mucous membrane is to be raised with care from the posterior surface of the palate, to obtain a view of the superficial muscular fibres. Immediately beneath the mucous covering are some fine transverse fibres of the palato-pharyngeus muscle; and beneath them, in the middle line, the longitudinal fibres of the azygos uvulæ. A deeper set of fibres of the palato-pharyngeus is to be followed beneath the levator and azygos muscles.

On left palato-pharyngeus,

azygos uvulæ,

The student should remove next the mucous membrane from the muscular fibres contained in the arches of the palate, and should follow these upwards and downwards. In order to see them in the anterior fold, it will be necessary to take the membrane from the anterior surface of the palate. If the part is not tolerably fresh, some of the paler fibres may not be visible. *and palato-glossus.*

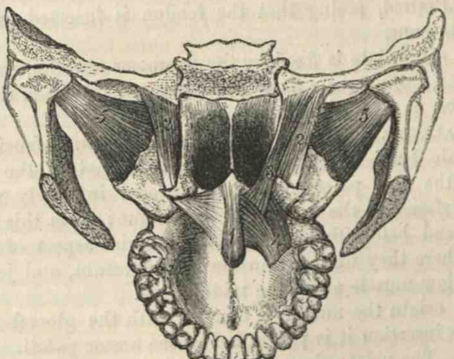
Aponeurosis of the soft palate. Giving strength to the velum is a thin but firm aponeurosis, which is attached to the hard palate. This membrane becomes thinner as it descends in the velum; and it is joined by the tendon of the tensor palati muscle. *Aponeurosis of palate.*

The MUSCLES of the soft palate are four on each side,—an elevator and tensor; together with the palato-glossus and palato-pharyngeus, which act as depressors in swallowing. In addition there is a small median azygos muscle. *Nine muscles.*

The LEVATOR PALATI (fig. 21 [3]) is a thick, roundish muscle, which is partly situate outside the pharynx. It *arises* from the under surface of the apex of the petrous portion of the temporal bone, and from the inner and hinder part of the cartilage of the Eustachian tube. The fibres descending enter the pharynx above the superior constrictor, and then spread out in the soft palate, where they join along the middle line with those of the muscle of the opposite side. *Elevator muscle arises outside pharynx, and is lost in velum.*

Outside the pharynx this muscle rests against the Eustachian *Connections.*

Fig. 21.*



tube. In the palate it forms a stratum that reaches the whole depth of that structure, and is embraced by two planes of fibres of the palato-pharyngeus ([4]).

Action. It tilts backwards the free edge of the soft palate towards the pharynx so as to enlarge the isthmus faucium, and to shut off with the contracted pharynx the nose openings. In swallowing it is raised and is arched ever the bolus passing from *Use on palate,*

* 1. Azygos uvulæ. 2. Tensor palati. 3. Levator palati. 4. Palato-pharyngeus origin. 5. External pterygoid.

on tube. the mouth to the pharynx. For its action on the Eustachian tube, see Tensor palati.

Tensor muscle arises outside pharynx, The TENSOR vel CIRCUMFLEXUS PALATI (fig. 21, [2]) arises like the preceding outside the pharynx, and is a thin riband-like band, situate between the internal pterygoid plate and muscle. About one inch and a half wide at its origin, it is attached to the slight depression (scaphoid fossa) at the root of the internal pterygoid plate, to the outer and fore part of the Eustachian tube, and still farther out to the spinous process of the sphenoid, and to the vaginal (tympanic) process of the temporal bone. Inferiorly the fleshy fibres end in a tendon, which, entering the pharynx between the attachments of the buccinator muscle, is reflected round the hamular process, and is *inserted* into about half an inch of the posterior border of the palate, viz. from the central spine to a projecting point; and inferiorly into the aponeurosis of the velum.

turns around hamular process;

As the tendon winds round the bone, it is thrown into folds; and between the two is a bursa. In the soft palate it lies beneath the levator muscle. The Eustachian tube is directed inwards between this muscle and the preceding.

is deeper than the other.

Use in palate, *Action.* Acting from the skull the muscle will fix and make tense the lateral part of the soft palate; but its movements will be very limited, seeing that the tendon is inserted partly into the palate bone.

on tube. If the soft palate is fixed by the depressor muscles, the levator and tensor, taking their fixed points below, can open the Eustachian tube, as in swallowing.

Palato-glossus. The PALATO-GLOSSUS MUSCLE (constrictor isthmi faucium) is a small, pale band of fibres, which is contained in the anterior arch of the soft palate. It is connected inferiorly with the lateral surface and the dorsum of the tongue; from this spot the fibres ascend before the tonsil to the anterior aspect of the soft palate, where they form a thin muscular stratum, and join those of the fellow muscle along the middle line.

Attachments.

At its origin the muscle is blended with the glossal muscles, and at its insertion it is placed before the tensor palati.

Use: *Action.* The palato-glossus narrows the fauces, the muscles of opposite sides moving inwards towards each other, and separates from the mouth the morsel to be swallowed.

tongue fixed. If the tongue is fixed the muscle will draw down and render tense the soft palate.

Palato-pharyngeus, in pillar of soft palate. The PALATO-PHARYNGEUS is much larger in size than the preceding muscle, and gives rise to the eminence of the posterior pillar of the soft palate. The muscle is attached below to the posterior border of the thyroid cartilage, some fibres blending with the contiguous portion of the pharynx; and it decussates across the middle line with corresponding fibres of the muscle of the opposite side (Merkel).* Ascending thence behind the tonsil, the fibres enter the side of the palate, and separate into two fleshy strata (fig. 21, [4]). The posterior of the two, thin and in contact with the mucous membrane, joins at the middle line a like offset of its fellow. The deeper or anterior stratum, much the strongest, enters the substance of the palate between the levator and tensor, and joins at the middle line the corresponding part of the opposite muscle, whilst some of the upper fibres end on the aponeurosis of the palate. Attachments.

In the palate the muscle encloses the levator palati and azygos uvulæ between its two strata.

Action. Taking its fixed point at the thyroid cartilage the muscle depresses and makes tense the soft palate. Use: on palate,

During the act of swallowing both muscles move back the lower edge of the soft palate towards the pharynx; and approaching each other, form an oblique plane for the downward direction of the food: in that state the uvula lies in the interval between the two. in swallowing.

The AZYGOS UVULÆ (fig. 21, [1]) is situate along the middle line of the velum near the posterior surface. The muscle consists of two narrow slips of pale fibres, which *arise* from the spine at the posterior border of the hard palate, or from the contiguous aponeurosis, and end inferiorly in the tip of the uvula. Behind this muscle, separating it from the mucous membrane, is the thin stratum of the palato-pharyngeus. Azygos muscle is single along middle; attachments.

Action. Its fibres elevate the uvula, shortening the mid part of the soft palate, and turn that process backwards. Use.

The *tonsil* is a collection of follicular capsules resembling those on the dorsum linguæ, which is placed close above the base of the tongue, and between the arches of the soft palate. Each is a roundish in shape, but variable in size, and apertures are apparent on its surface. Externally the tonsil is situate opposite the superior constrictor muscle and the angle of the lower jaw; and when enlarged it may press against the internal carotid blood-vessel. Tonsil is between pillars of palate.

The apertures on the surface lead to rounded terminal recesses or hollows which are lined by mucous membrane. External to each recess is a layer of small closed capsules which are seated in the tissue beneath the mucous membrane, and are filled with a grayish substance containing cells and nuclear-looking bodies. No openings from the capsules are to be recognised in the recesses. Formed of closed capsules.

Its *arteries* are numerous and are derived from the facial, Vessels.

* Dr. Merkel, in the elaborate work before referred to, states that this muscle has no firm fixed attachment below, and that it ends altogether in the wall of the pharynx, decussating with the muscle of the opposite side. This assertion does not accord with my experience.

lingual, ascending pharyngeal, and internal maxillary branches of the external carotid. Its *veins* have a plexiform arrangement on the outer side. *Nerves* are furnished to it from the fifth and glosso-pharyngeal cranial nerves.

Nerves.

Mucous membrane of pharynx

The *mucous membrane of the pharynx* is continuous anteriorly with the lining of the mouth, nose, and larynx. Covering the soft palate and its numerous small glands (palatine), the membrane is continued to the tonsils on each side, and is prolonged by the Eustachian tube to the tympanum. In front of each arytænoid cartilage it encloses a mass of muciparous glands (arytænoid). Inferiorly, it is continued by the œsophagus to the stomach.

superiorly has columnar, inferiorly scaly epithelium.

The mucous membrane is better provided with glands in the upper, than in the lower part of the pharynx; and its character, near the different apertures, resembles that of the membrane lining the cavities communicating with the pharynx. Its epithelium is scaly below the nares (Henle); but is columnar and ciliated above that spot, where only the air is transmitted.

Beginning of œsophagus.

Beginning of the œsophagus. In addition to what has been said of the commencement of the œsophagus, and its connections in the neck, it may be added that this tube is much smaller than the pharynx, and that the walls are flaccid.

Formed of two layers of fibres;

On dissection the gullet will be found to consist of two layers of muscular fibres, with a lining of mucous membrane.

outer or longitudinal,

The *external layer* is formed of longitudinal fibres, which begin opposite the cricoid cartilage by three bundles, anterior and two lateral;—the former is attached to the ridge at the back of the cartilage, and the others join the inferior constrictor.

and inner or circular.

The *internal layer*, on the other hand, is formed of circular fibres, which are continuous with those of the constrictor. The structure of the œsophagus is described more fully in the dissection of the thorax.

Section XII.

CAVITY OF THE MOUTH.

The cheeks, the lips, and the teeth, are to be examined with the mouth, as all may be considered accessory parts.

Mouth.

THE MOUTH. The cavity of the mouth is situate below that of the nose, and extends from the lips in front to the isthmus of

Situation,

the fauces behind. Its boundaries are partly osseous and partly muscular, and its size depends upon the position of the lower

form,

jaw bone. When the lower is moderately removed from the upper jaw, the mouth is an oval cavity with the following boundaries. The *roof* is concave, is constituted by the hard and soft palate, and is limited anteriorly by the arch of the teeth. In the *floor* is the tongue, bounded by the arch of the lower teeth; and beneath the tip of that body is the frænum linguæ, with the sublingual gland on each side. Each *lateral boundary* consists of the cheek and the ramus of the lower jaw; and in it, near the second molar tooth in the upper jaw, is the opening of the parotid duct. The anterior opening of the mouth is bounded by the lips, and the posterior corresponds with the anterior pillars of the soft palate. and boundaries.

The *mucous membrane* is much thicker on the hard than the soft parts bounding the mouth; it lines the interior of the cavity, and is reflected over the tongue. Anteriorly it is continuous with the tegument, and posteriorly with the lining of the pharynx. Lining of the mouth

On tracing its arrangement the membrane is seen to form a small fold—frænulum, between each lip and the front of the corresponding jaw. differs in parts,

On the bony part of the roof it is thick and thrown into folds, and covers vessels, nerves, and glands; but on the soft palate it is smooth and thinner. Along the middle of the palate is a ridge, which ends in front in a small papilla. on roof,

In the floor of the mouth the membrane forms the frænum linguæ beneath the tip of the tongue, and sends tubes into the openings of the Whartonian and sublingual ducts; whilst on each side of the frænum it is raised into a ridge by the subjacent sublingual gland. floor,

On the interior of the cheek and lips the mucous lining is smooth, and is separated from the muscles by small buccal and labial glands in addition to the ordinary submucous tissue. cheek, and lips.

Over the whole oral cavity, but especially on the lips, are papillæ for the purpose of touch. The epithelium covering the membrane is of the scaly nucleated variety. Epithelium.

The CHEEK extends from the commissure of the lips to the ramus of the lower jaw, and is attached above and below to the alveolar process of both jaws on the outer aspect. The chief constituent of the cheek is the fleshy part of the buccinator muscle. On the inner surface of this is the mucous membrane; and on the outer the integuments, with some muscles, vessels, and nerves. The parotid duct perforates the cheek near the second molar tooth of the upper jaw. Cheek: extent and structure.

The LIPS surround the opening of the mouth; they consist of the fleshy part of the orbicularis oris muscle, covered externally by integument, and internally by mucous membrane. The lower lip is the larger and more moveable of the two. Between the muscular structure and the mucous covering lie the labial glands; and in the substance of each lip, nearer the inner than the outer Lips, formed by orbicularis:

contains artery.

surface, and at the line of junction of the two parts of the orbicularis, is placed the arch of the coronary artery.

Teeth, number and arrangement in jaw;

TEETH. In the adult there are sixteen teeth in each jaw, which are set in the alveolar borders in the form of an arch, and are surrounded by the gums. Each dental arch has its convexity turned forwards; and, commonly, the arch in the maxilla overhangs that in the mandible when the jaws are in contact. The teeth are similar in the half of each jaw, and have received the following names:—the most anterior two are incisors, and the one next behind is the canine tooth; two, still farther back, are the bicuspids; and the last three are molar teeth. Moreover, the last molar tooth has been called also "dens sapientiæ," from the late period of its appearance. The names applied to the teeth indicate very nearly the part they perform in mastication; thus the incisor and canine teeth act as dividers of the food, whilst the bicuspid and molar teeth serve to grind the aliment.

different kinds.

Use in mastication.

Fuller notice elsewhere.

The several parts of the teeth, viz. the crown, fang, and neck; the general and special characters of those parts in the different groups of teeth; and the structure of the different components of a tooth, must be referred to in some general treatise on anatomy.

SECTION XIII.

DISSECTION OF THE NOSE.

Directions.

To obtain a view of the interior of the nose, it will be necessary to make a longitudinal section through the base of the skull. Whilst the student is examining the boundaries of the nose he will derive advantage from being provided with a vertical section of a dried nasal cavity.

Dissection.

Dissection. Before making the necessary sawing of the bone, the loose part of the lower jaw on the right side should be taken away; further, the tongue, hyoid bone, and larynx, all united, may be detached from the opposite half of the lower jaw, and laid aside till the dissector is ready to use them.

Cut through the bone with saw.

On the right side of the middle line saw through the frontal and nasal bones, the cribriform plate of the ethmoid, and part of the body of the sphenoid bone, without letting the saw descend into the nasal cavity.

Next the roof of the mouth is to be turned upwards, and the soft parts are to be divided on the right of the median line, opposite the cut in the roof of the nose. The saw is then to be carried through the hard palate on the right side of the septum nasi, and through the body of the sphenoid bone in such a direction as to make the cut join the incision above.

The piece of the skull is now easily separated into two parts, right and left; and by proceeding as above directed, the delicate bones of the nose are less injured than they would be by sawing continuously in one direction. The right half will serve for the examination of the meatuses, and the left will show the septum nasi, after the mucous membrane has been removed.

The CAVITY OF THE NOSE is placed in the centre of the bones of the face, being situate above the mouth, below the cranium, and between the orbits, and the sinuses of the superior maxillary bones. This space is divided into two parts—nasal fossæ, —by a vertical partition. **Situation of nose.** **Division into two.**

Each fossa is larger below than above; and is flattened in form, so that the measurement from before back or above down exceeds much that from within out. It communicates with both the face and the pharynx by apertures named nares, and has also apertures of communication with the sinuses in the surrounding bones, viz. frontal, ethmoid, sphenoid, and superior maxillary. In each fossa are to be examined a roof and floor, an inner and outer wall, and an anterior and posterior opening. **Form.** **Openings.**

The *roof* is somewhat arched, and is formed by the cribriform plate of the ethmoid bone in the centre; by the frontal and nasal bones and the cartilages in front; and by the body of the sphenoid, the sphenoidal spongy bone, and the os palati, at the posterior part. In the dried skull many apertures exist in the ethmoid bone for the branches of the olfactory nerve; and in the front of the body of the sphenoid is the opening of its sinus. **Roof.**

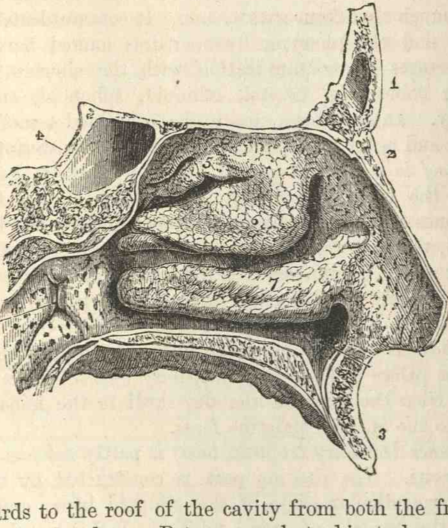
The *floor* is slightly hollowed from side to side, and in it are found the palate and superior maxillary bones—their palate processes. Near the front in the dry skull is the incisor foramen leading to the anterior palatine fossa. **Floor.**

The *inner boundary* (septum nasi) is partly osseous and partly cartilaginous. The osseous part is constructed by the vomer, by the perpendicular plate of the ethmoid bone, and by those parts of the frontal and nasal with which this last bone articulates. The irregular space in front in the prepared skull is filled by the *triangular cartilage of the septum*, which forms part of the partition between the nostrils, and supports the cartilages of the anterior aperture. Fixed between the vomer, the ethmoid plate, and the nasal bones, the cartilage rests anteriorly on the median ridge between the superior maxillæ, and projects even between the cartilages of each nostril. The septum nasi is commonly bent to one side. **Inner boundary** **partly osseous,** **partly cartilaginous.**

The *outer boundary* has the greatest extent and the most irregular surface. Six bones enter into its formation, and they come in the following order from before backwards:—the nasal **Outer boundary,** formed of many bones, and superior maxillary; the small os unguis with the lateral mass of the ethmoid bone; and posteriorly the ascending part of the palate bone, with the internal pterygoid plate of the sphenoid bone: of these, the nasal, ungual, and ethmoidal reach only about half way from roof to floor, whilst the others extend the whole depth. Altogether in front of the bones, the lateral cartilages may be said to construct part of this boundary.

is irregular on surface; extent of spongy bones; On this wall are three convoluted osseous pieces, named *spongy* or *turbinate bones* (fig. 22), which project into the cavity:—the two upper, ^{5} and ^{6}, are processes of the ethmoid, but the lower one, ^{7}, is a separate bone—the inferior spongy. The spongy bones are confined to a certain portion of the outer wall, and their extent would be limited by a line continued nearly verti-

Fig. 22.*



presents hollows. cally upwards to the roof of the cavity from both the front and back of the hard palate. Between each turbinate bone and the wall of the nose is a longitudinal hollow or meatus; and into these hollows the nasal duct and the sinuses of the surrounding bones open.

Meatuses. The *meatuses* are the spaces arched over by the spongy bones; and as the bones are limited to a certain part of the outer wall, so are the spaces beneath them.

* Spongy bones and meatuses of the nasal cavity. 5. Upper spongy bone. 6. Middle spongy bone. 7. Inferior spongy bone. The three meatuses are the spaces beneath the spongy bones. Above the upper spongy bone is the fourth or rudimentary meatus. 8. Opening of the Eustachian tube. The woodcut shows also the glands of the nose.

The *upper* one (fig. 22) is the smallest and straightest of the three meatuses, and equals in length about the posterior half of the space included by the vertical lines before mentioned. Into it the posterior ethmoidal sinuses open at the front; and at its posterior part, in the dried bone, is the spheno-palatine foramen by which nerves and vessels enter the nose. Upper meatus.

The *middle meatus* (fig. 22) is longer than the preceding; it is curved upwards in front, and reaches all across the space referred to on the outer wall. Anteriorly it communicates by a funnel-shaped passage (infundibulum) with the frontal sinus and the anterior ethmoidal cells; and near its middle is a small aperture, which leads into the cavity of the upper jaw. Middle meatus.

The *inferior meatus* (fig. 22) is straighter than the middle one, and rather exceeds the width of the included space on the outer wall; and when the bone is clothed by the mucous membrane the space extends still farther forwards. In its front is the opening of the ductus ad nasum. Lower meatus.

Occasionally there is a small fourth or rudimentary meatus above the rest, which communicates with a posterior ethmoidal cell. Fourth meatus.

The *nares*. In the recent condition of the nose each fossa has a distinct anterior opening in the face, and another in the pharynx; but in the skeleton there is only one common opening in front for both sides. These apertures, and the parts bounding them, have been before described (pp. 32 and 132). Nares.

The *mucous membrane* lining the nasal fossa is called the pituitary or Schneiderian membrane; and from its blending with the periosteum it acquires much strength. It is continuous with the integument at the nostril, and with the membrane lining the pharynx through the posterior opening: moreover, it is also continuous with the mucous membrane of the eyeball, and with that of the different sinuses, viz. frontal, ethmoidal, sphenoidal, and maxillary. Mucous lining of the nose.

The foramina in the dry bones, which transmit nerves and vessels, are entirely closed by the membrane, viz. incisor, spheno-palatine, and the holes in the cribriform plate; but the apertures that lead to the sinuses and the orbit are only somewhat diminished by the lining they receive: the membrane is stretched over the opening of the ductus ad nasum, forming a flap or valve to close the aperture. Some foramina closed, others diminished by it.

The characters of the membrane in the lower part of the nose differ greatly from those of the same layer near the roof.

In the lower region of the nose, through which the air passes to the lungs, the membrane is thick, and closely united to the subjacent periosteum and perichondrium; and on the margins of the two inferior spongy bones it is projected somewhat by the large submucous vessels, so as to increase the extent of surface. Differs on spongy bones and in sinuses.

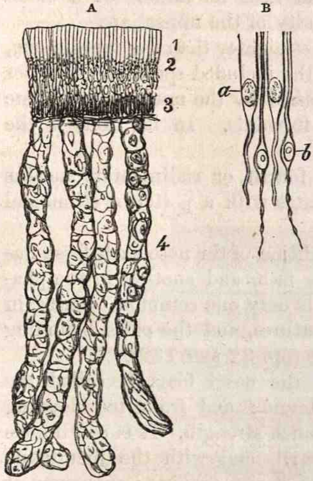
In the canals and sinuses it is very thin. Near the nostril it is furnished with papillæ, and small hairs (vibrissæ).

Apertures of glands; The surface is covered by the apertures of branched mucous glands, which are in greatest abundance, and of largest size, about the middle and posterior parts of the nasal fossa (fig. 22).

and epithelium. In the lower part of the nose, and in the sinuses, the epithelium is of the columnar ciliated kind; but it becomes laminated or scaly in the dilatation (vestibule) inside the nostril.

Olfactory region. *Olfactory region* (fig. 23).—This is the part of the nose in which the olfactory nerve is distributed; and it is therefore the seat of the sense of smell.

Fig. 23.*



Extent. This region is situate at the top of the nasal cavity, and is confined to the surface of the roof formed by the cribriform plate of the ethmoid; to a portion of the outer wall constructed by the lateral mass of the ethmoid bone: and to a corresponding extent of the septum, viz. about one third.

Mucous membrane. The mucous membrane in the olfactory region differs much from that in the lower portion of the nose. It is less strong and vascular, and is of a yellowish brown colour, owing to pigment in the epithelium and the glands.

Epithelium. The epithelium (fig. 23 A) is thicker but softer here than lower in the cavity, and it is columnar on the surface, but not ciliated. Beneath the surface layer are strata of granules and ovalish cells ([2]), amongst which sink the pointed or attached ends of the processes of the epithelium.

Olfactorial cells. Around the pieces of the columnar epithelium stand numerous bodies named *olfactorial cells* by Schultze (fig. 23 B, *b*). They consist of small spindle-shaped nucleated cells, with a rounded filament prolonged from each end towards the attached and free surfaces of the mucous membrane: that to the free

* Magnified vertical section of the mucous membrane of the nose (altered from Henle).

A. 1. Columnar epithelium at the free surface. 2. Granular or middle layer of the same. 3. Deepest layer of elongated cells placed vertically. 4. Secreting tubular glands.

B. *a*. Pieces of the columnar epithelium greatly enlarged. *b*. Olfactorial cells amongst the epithelium particles.

surface, the larger, ends on a level with the pieces of the columnar epithelium ; but the connections of the deeper threads or processes are unknown ; they have been supposed to unite with the olfactory nerve.

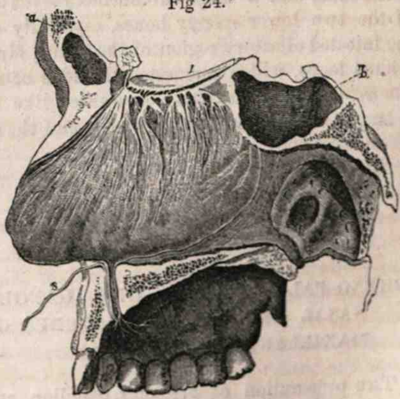
The glands in the olfactory region are simple lengthened tubes (fig. 23 A, [4]) like those in the stomach, but are slightly wavy, and end in the submucous tissue by closed extremities. A flattened epithelium, with coloured granular contents, lines the tubes.—(Henle.) **Glands.**

Dissection. By the time the student has arrived at this stage of the dissection, little will be seen of the fine distribution of the olfactory nerve. If the septum nasi be removed, so as to leave entire the membrane covering it on the opposite side (the left), the filaments of the nerve will appear on the surface, near the cribriform plate. In the membrane too, near the front of the septum, is an offset of the nasal nerve. **Dissection of nerves and vessels.**

The naso-palatine nerve and artery are to be sought lower down, as they are directed from behind forwards, towards the anterior palatine fossa : the artery is readily seen, especially if it is injected, but the fine nerve, which is about as large as a coarse hair, is embedded in the membrane and will be found by scraping with the point of the scalpel.

By cutting through the fore and upper part of the membrane that has been detached from the septum nasi, other branches of the olfactory nerve may be traced on the outer wall of the nasal fossa.

Fig 24.*



The OLFACTORY NERVE forms a bulb on the cribriform plate of the ethmoid bone, and sends branches to the olfactory region of the nose through the apertures in the roof. These branches are about twenty in number, and are divisible into three sets. An inner set, the largest, descend in the grooves on the septum **Olfactory nerve** **is distri-**

* Nerves of the septum of the nose. 1. Olfactory bulb and its ramifications on the septum. 8. Naso-palatine nerve from Meckel's ganglion.

buted to olfactory region.

nasi (fig. 24), and then branching, extend over the upper third. A middle set is confined to the roof of the nose. And an external set is distributed on the upper spongy bone, on the anterior square surface of the os ethmoides, and on the fore part of the middle spongy bone.

Ending.

As the branches of the olfactory nerve leave the skull, they receive tubes from the dura mater and pia mater, which are lost in the tissue to which the nerves are distributed. The nerves ramify in the pituitary membrane in tufts of filaments which communicate freely with the contiguous twigs, forming a network, but their mode of termination in the tissue is unknown. It has been suggested by Schulze that they join the deep processes or ends of the so-called olfactorial cells; but this ending has not been seen.

Structure.

The olfactory nerve differs in structure from the other cranial nerves; for its branches are deficient in the white substance of Schwann, are not divisible into fibrillæ, and are nucleated and granular in texture. They resemble the gelatinous fibres, and seem to consist of an extension of the nervous matter of the olfactory bulb. (Todd and Bowman.)

The other branches of the nerves in the nose will be described in the following section.

Blood-vessels of nose: arteries,

Blood-vessels. For a statement of the different vessels of the nose, see p. 151. The *arteries* form a network in the pituitary membrane, and a large submucous plexus on the edge of each of the two lower spongy bones, especially on the inferior. In the injected olfactory region of the fœtus, Mr. Bowman recognised dilated loops, which suggested the idea of rudimentary papillæ.

veins.

The *veins* have a plexiform disposition like the arteries, and this is largest on the lower spongy bone and the septum nasi.

Section XIV.

SPHENO-PALATINE AND OTIC GANGLIA, FACIAL AND NASAL NERVES, AND BRANCHES OF THE INTERNAL MAXILLARY ARTERY.

Branches of Meckel's ganglion;

The preparation of Meckel's ganglion and branches, and of the terminal branches of the internal maxillary artery, is a somewhat difficult task in consequence of the nerves and vessels being contained in osseous canals, which require to be opened. As is the case with other dissections, the student seeks first the branches, and traces these to the ganglion and trunk.

Dissection

Dissection. The left half of the head is to be used for the display of the ganglion and its branches, but the student may previously acquire some skill by attempting the dissection on the remains of the right side.

To lay bare the branches of the palate, detach the soft parts in the roof of the mouth from the bone until the nerves and vessels escaping from the posterior palatine foramina are arrived at. Cut off with a bone forceps the posterior part of the hard palate to a level with the vessels and nerves ; and cleaning these, trace offsets behind into the soft palate, and follow the main pieces forwards to the front of the mouth. Take away without injury to the naso-palatine nerve and vessels, the hinder part of the loose piece of mucous membrane before detached from the septum nasi, and separate the mucous membrane from the outer wall of the nasal fossa, behind the spongy bones, as high as the spheno-palatine foramen. In reflecting forwards the membrane many branches of vessels and nerves will be seen entering it through the foramen ; but these may be left for the present, as directions for their dissection will be subsequently given. If the lining membrane of the nose has been removed as directed above, palatine nerves and vessels will be seen through the thin translucent palate bone, and will be readily reached by breaking carefully through it with a chisel. Afterwards the tube of membrane containing the vessels and nerves being opened, these are to be followed down to the soft palate and roof of the mouth, and upwards to the ganglion which is close to the body of the sphenoid bone. **of palatine branches;**

To bring the ganglion fully into view, it will be necessary to saw through the overhanging part of the sphenoid bone, to cut away pieces of the bones surrounding the hollow in which it lies, and to remove with care the enveloping fat and the periosteum. The ganglion then appears as a flattened reddish-looking body, from which the vidian and pharyngeal nerves pass backwards. Besides the branches referred to, the student should seek two large nerves from the upper part of the ganglion to join the upper maxillary, and smaller offsets to the floor of the orbit. **body of ganglion;**

To trace backwards the vidian branch to the carotid plexus and the facial nerve, the student must lay open the canal which contains it and its artery in the root of the pterygoid process ; and in doing this he must define the small pharyngeal branches of nerve and artery that are superficial to the vidian, and lie in the pterygo-palatine canal. At the back of the pterygoid canal, a small branch from the vidian to the plexus on the internal carotid artery is to be looked for. Lastly, the vidian nerve is to be followed into the skull by cutting away the point of the petrous portion of the temporal bone, and dividing the internal carotid artery ; and it is to be pursued on the surface of the temporal bone, beneath the ganglion of the fifth nerve, to the hiatus **vidian nerve.**

Fallopii. Its junction with the facial nerve will be seen with the dissection of that nerve. It is rather a troublesome undertaking to separate the vidian from the cartilage in the foramen lacerum (basis cranii).

Seek branches to the nose.

The branches of the ganglion to the nose will be found entering the outer surface of the detached mucous membrane opposite the spheno-palatine foramen, with corresponding arteries. One of these nerves (naso-palatine), before referred to as lying in the membrane of the septum, is to be isolated, and to be followed forwards to where it enters the floor of the nose. The branches of the internal maxillary artery with the nerves are to be dissected at the same time.

Ganglion of Meckel.

The SPHENO-PALATINE GANGLION (fig. 25,[4]) (ganglion of Meckel) occupies the spheno-maxillary fossa, close to the spheno-palatine foramen, and is connected with the branches of the superior maxillary nerve to the palate. The ganglionic mass is somewhat triangular in form, and of a reddish-grey colour. It is situate, for the most part, behind the branches (spheno-palatine) of the superior maxillary nerve to the palate, so as to surround only part of their fibres; and it is prolonged posteriorly into the vidian nerve. Meckel's ganglion resembles the other ganglia in connection with the fifth nerve in having sensory, motor, and sympathetic offsets or roots connected with it.

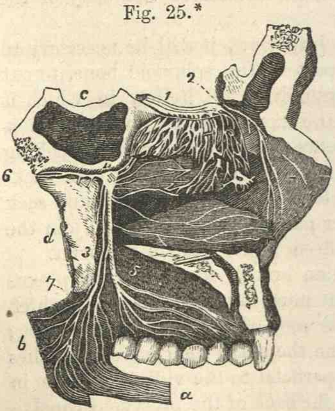
Situation and connection with fifth nerve.

Composition.

Branches given.

The *Branches* of the ganglion are distributed for the most part to the nose and palate, but small offsets are given to the pharynx and the orbit. Other offsets connect it with surrounding nerves.

Fig. 25.*



Nasal branches are

Branches of the nose. The nasal branches, from three to five in number, are for the most part very small and soft, and pass inwards through the spheno-palatine foramen. One of these is the naso-palatine nerve. Their distribution is mentioned below.

Superior nasal,

The *superior nasal branches* are distributed in the mucous membrane on the two upper spongy bones, and a few filaments reach the back part of the septum nasi.

* Nerves of the nose and palate. *a* and *b*. Soft palate. 1. Olfactory nerve. 2. Nasal nerve of the ophthalmic trunk. 3. Smaller palatine nerve. 4. Meckel's ganglion. 5. Larger palatine nerve. 6. Vidian nerve. 7. External palatine nerve.

The *naso-palatine nerve* (nerve of Cotunnius) (fig, 24,[8]) crosses the roof of the nasal fossa to reach the septum nasi, and descends on that partition to near the front. The nerve now enters a special canal by the side of the septum, that of the left side of the body being anterior to the other, and is conveyed to the roof of the mouth, where it lies in the centre of the anterior palatine fossa. Finally, the nerves of opposite sides are united in the mouth, and are distributed in the mucous membrane behind the incisor teeth ; at their distribution they are connected with the great palatine nerves. On the septum nasi filaments are supplied by the naso-palatine nerve to the mucous membrane. To follow the nerve to its termination, the canal in the roof of the mouth must be opened. Naso-palatine.

Branches of the palate. The nerves of the palate, though connected in part with the ganglionic mass, are the continuation of the spheno-palatine branches of the superior maxillary nerve (p. 107). Below the ganglion they are divided into three palatine nerves (large, small, and external), which are distributed to the roof of the mouth, the soft palate and tonsil, and the lining membrane of the nose. To the palate, are three.

The *large palatine nerve* (anterior) (fig. 25,[5]) reaches the roof of the mouth through the largest palatine canal, and extends forwards nearly to the incisor teeth, where it joins the naso-palatine nerve. Whilst in the canal, the nerve furnishes two or more filaments (*inferior nasal*) to the membrane on the middle and lower spongy bones; and, in the roof of the mouth, it supplies the mucous membrane and glands, and gives an offset to the soft palate. Large nerve has branches to nose,

The *small palatine nerve* (posterior), 3, lies in the smaller canal, and ends inferiorly in the soft palate, and the levator palati and azygos uvulæ muscles; it supplies the uvula and tonsil. small, and

The *external palatine nerve*, 7, is smaller than the other two, and descends in the canal of the same name. Leaving the canal, the nerve is distributed to the velum palati and the tonsil. external palatine.

The *pharyngeal branch* is very small, and is directed through the pterygo-palatine canal to the mucous membrane of the pharynx near the Eustachian tube, in which it ends. Pharyngeal branch.

Branches to the orbit. Two or three in number, these ascend through the spheno-maxillary fissure, and end apparently in the periosteum, though possibly in the layer called *musculus orbitalis* by H. Müller. It will be necessary to cut through the sphenoid bone to follow these nerves to their termination. To the orbit.

Connecting branches. The ganglion is united as before said with the spheno-palatine branches of the fifth nerve, receiving sensory nerve fibres from them; and through the medium of the Uniting branches, to fifth, vidian, which is described below, it communicates with a motor nerve (facial), and with the sympathetic nerve.

and to facial and sympathetic through the vidian.

The *vidian nerve*, 6, passes backwards through the vidian canal, and sends some small filaments through the bone, to the membrane of the back part of the roof of the nose (*upper posterior nasal branches*). At its exit from the canal, the nerve furnishes a soft reddish offset (*carotid branch*) to join the sympathetic on the outer side of the carotid artery. The continuation of the nerve enters the cranium through the cartilaginous substance closing the foramen lacerum (basis cranii), and is directed backwards in a groove on the surface of the petrous part of the temporal bone, where it takes the name of *large superficial petrosal nerve* (fig. 26, [2]). Lastly it is continued through the hiatus Fallopii, to join the gangliform enlargement on the facial nerve. Whilst in the temporal bone, the vidian receives a twig from the tympanic nerve.

Vidian a compound nerve.

The vidian nerve is supposed to consist of motor and sympathetic fibres in the same sheath, these being combined in the same manner as in the connecting branches between the sympathetic and spinal nerves.

Directions. The student may now give his attention to the remaining nerves and vessels in the nasal cavity.

Seek other nerves and

Dissection. The nasal nerve is to be sought in the nose behind the nasal bone, by gently detaching the lining membrane, after having cut off the projecting bone. A branch is given from the nerve to the septum nasi, but probably this and the trunk of the nerve will be seen but imperfectly in the present condition of the part, unless it has been well preserved.

vessels of nose.

The terminal branches of the internal maxillary artery in the spheno-maxillary fossa have been laid bare in the dissection of Meckel's ganglion, but they may be now completely traced out.

Nasal nerve

The *nasal nerve* (of the ophthalmic) (fig. 10, [2]) has been already seen in the orbit and skull, and at its termination in the face (p. 46); and the part that connects the two through the nose is now to be learned. Entering the nasal fossa by an aperture at the front of the ethmoid bone, the nerve gives a branch to the membrane of the septum, and is then continued in a groove behind the os nasi to the lower margin of this bone, where it escapes to the surface of the nose in the face.

lies beneath nasal bone; gives

branch to septum

Branches. The *branch to the septum* divides into filaments that ramify on the anterior part of that partition, and reach nearly to the lower border.

and to outer wall.

One or *two filaments* are likewise furnished by the nerve to the mucous membrane of the fore part of the outer wall of the nasal fossa; these extend as low as the inferior spongy bone.

Branches of internal

TERMINAL BRANCHES OF THE INTERNAL MAXILLARY ARTERY. The branches of the artery in the spheno-maxillary fossa, which have not been examined, are the superior palatine, naso-palatine, pterygo-palatine, and vidian. **maxillary artery are**

The *superior* or *descending palatine* is the largest branch, and accompanies the large palatine nerve through the canal. Arrived at the palate, the vessel is directed forwards in the roof of the mouth, and anastomoses behind the incisor teeth with the artery of the opposite side, and with a branch that descends from the nose through the incisor foramen. In its course the artery supplies branches to the other palatine canals, which pass with the contained nerves to the soft palate and tonsil; and some offsets are furnished to the lining membrane of the nose. In the roof of the mouth the mucous membrane, glands, and gums, receive their vessels from this artery. **palatine branch,**

The *nasal* or *spheno-palatine artery* enters the nose through the spheno-palatine foramen, and divides into branches:—Some of these are distributed on the spongy bones and the outer wall of the nasal fossa, and supply offsets to the membrane lining the posterior ethmoidal cells. One long branch, artery of the septum (*art. naso-palatina*), runs on the partition between the nasal fossæ to the incisor foramen, through which it anastomoses with the superior palatine in the roof of the mouth. This branch accompanies the naso-palatine nerve, and covers the septum with numerous ramifications. **nasal branches,** **one to septum nasi,**

The *pterygo-palatine* is a very small branch which, passing backwards through the canal of the same name, is distributed to the lining membrane of the pharynx. **pterygo-palatine branch,**

The *vidian* or *pterygoid branch* is contained in the vidian canal with the nerve of the same name, and ends on the mucous membrane of the Eustachian tube and the upper part of the pharynx. **vidian branch.**

Some small *nasal arteries* are furnished to the roof of the nasal fossa by the anterior and posterior ethmoidal branches of the ophthalmic (p. 48); and others from the facial artery supply the part near the nostril. **Other nasal arteries.**

Veins. The veins accompanying the terminal branches of the internal maxillary artery unite in the spheno-maxillary fossa in the *alveolar* plexus. Into this plexus offsets are received from the pterygoid plexus and the infraorbital vein; and from the plexus in this position a large trunk (anterior internal maxillary) is directed forwards below the malar bone to join the facial vein (p. 29). Beneath the mucous membrane of the nose the veins have a plexiform arrangement as before said. **Veins;** **alveolar plexus.**

FACIAL NERVE IN THE TEMPORAL BONE. This nerve winds through the petrous part of the temporal bone; and it is followed with difficulty in consequence of the extreme density of the bone, and the absence of marks on the surface to indicate its position. To render this dissection easier, the student should be provided **Facial nerve.**

with a temporal bone, in which the course of the facial nerve and the cavity of the tympanum are displayed.

Dissection of nerve in the bone,

Dissection. The examination of the nerve is to be begun at the stylo-mastoid foramen, and to be carried inwards from that point. With this view, the side of the skull should be sawn through vertically between the meatus externus and the anterior border of the mastoid process, so as to open the posterior part of the aqueduct of Fallopius. The nerve will be then seen entering deeply into the substance of the temporal bone; and it will be readily followed if the dissector cuts away with the bone forceps all the bone projecting above it. In this last step the cavity of the tympanum will be more or less opened, and the chain of bones in it laid bare.

The nerve is now to be traced onwards along the inner side of the tympanum, till it becomes enlarged, and bends suddenly inwards to the meatus auditorius internus. The surrounding bone is to be removed from the enlargement on the nerve, so as to allow of the petrosal nerves being traced to it; and then the meatus auditorius is to be laid open, to see the facial and auditory nerves in that hollow.

of chorda tympani,

The course of the chorda tympani nerve (branch of the facial) across the tympanum will be brought into sight by the removal of the central ear bone, the incus. The nerve may be also followed through the wall of the cavity behind, as well as out of the cavity in front.

and other branches.

The remaining branches of the facial nerve in the bone are very minute, and are not to be seen except on a fresh piece of the skull which has been softened in acid. The student may therefore omit the paragraphs marked with an asterisk, till he is able to obtain a part on which a careful examination can be made.

Facial nerve winds through temporal bone, is marked by swelling which receives many twigs.

The *facial nerve* is received into the internal auditory meatus, and entering the aqueduct of Fallopius at the bottom of that hollow, is conducted through the temporal bone to the stylo-mastoid foramen and the face (p. 38). In its serpentine course through the bone, the nerve is first directed outwards to the inner wall of the tympanum: at that spot it suddenly bends backwards, and is marked by a gangliform swelling (intumescentia gangliformis) fig. 26, to which several small nerves are united. From this swelling the nerve is continued through the arched aqueduct, passing along the inner wall of the tympanum, and then behind that cavity to the aperture of exit from the bone.

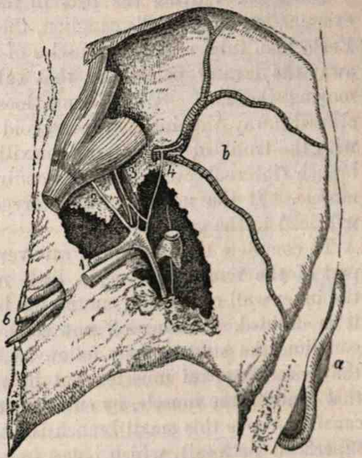
The *branches* of the nerve in the bone serve for the most part to connect it with other nerves; but one supplies the tongue, and another the stapedius muscle.

Branches

Connecting branches. These branches communicate with the auditory and glosso-pharyngeal nerves; and with two trunks (superior and inferior maxillary) of the fifth nerve. joining nerve

* *Union with the auditory nerve.* In the bottom of the meatus the facial and auditory nerves are connected by one or two minute filaments. to auditory nerve,

Fig. 26.*



* *Connecting branches of the gangliform enlargement.* The swelling of the facial nerve receives three small twigs. One in front is the *large superficial petrosal* nerve (vidian) (fig. 26, [2]); another is the *small superficial petrosal* of the tympanic nerve, [3]; and the third is the *external superficial petrosal*, [4], which is derived from the sympathetic on the middle meningeal artery. to superior maxillary tympanic, and sympathetic,

* The *branch* of the *stapedius muscle* arises at the back of the tympanum, and descends to the fleshy fibres.

Chorda tympani. This long but slender branch of the facial nerve crosses the tympanum, and ends in the tongue. Arising about a quarter of an inch from the stylo-mastoid foramen (fig. 26, [5]), it ascends to the tympanum through a canal in the posterior boundary, and enters that cavity below the pyramid. In the cavity the nerve is directed forwards across the handle of the malleus and the membrana tympani to the Glaserian fissure, or to an aperture in the bone on the inner side, through which it leaves the tympanum. As it issues from the cavity it emits a small branch to the laxator tympani muscle. to gustatory by chorda tympani.

Outside the skull the chorda tympani joins the gustatory nerve, and continues along it to the submaxillary ganglion and the tongue (p. 105).

The AUDITORY NERVE will be learnt with the ear. Entering the auditory meatus it divides into two parts, of which one belongs to the cochlea, and the other to the vestibule. Auditory nerve.

OTIC GANGLION. At this stage of the dissection there is little Otic ganglion.

* Nerves joining the enlargement of the facial nerve. 1. Facial nerve. 2. Large superficial petrosal. 3. Small superficial petrosal. 4. External superficial petrosal. 5. Chorda tympani.

to be seen of the ganglion, but the student should remember that it is one of the things to be examined in a fresh part. Its situation is on the inner aspect of the inferior maxillary nerve, close to the base of the skull, and it must therefore be arrived at from the inner side.

Dissection.

Dissection. Putting the part in the same position as for the examination of Meckel's ganglion, the dissector should define the Eustachian tube and the muscles of the palate, and then take away the levator palati and that tube, using much care in removing the last. When some loose areolar tissue has been cleared away the internal pterygoid muscle comes into view, with the trunk of the inferior maxillary nerve above it; and a branch (internal pterygoid) descending from that nerve to the muscle. If the nerve to the pterygoid be taken as a guide, it will lead to the ganglion.

To define ganglion and its branches.

To complete the dissection, saw vertically through the petrous part of the temporal bone, a little nearer the middle line than the inner wall of the tympanum, the bone being supported whilst it is divided. Taking off now some membrane that covers the ganglion, the student may follow backwards a small branch to the tensor tympani muscle; but he must open the small tube that contains the muscle, by entering it below through the carotid canal. Above this small branch is another minute nerve (small superficial petrosal), which issues from the skull, and joins the back of the ganglion. A small twig is to be sought from the front of the ganglion to the tensor palati muscle; and one, near the same spot, to join the sympathetic nerve on the middle meningeal artery.

Otic ganglion is on inner side of inferior maxillary.

The OTIC GANGLION (gang. auriculare, Arnold) (fig. 27,) is a small reddish body, which is situate on the inner surface of the inferior maxillary nerve close to the skull, and surrounds the origin of the nerve to the internal pterygoid muscle. By its inner surface the ganglion is in contact with the Eustachian tube, and at a little distance behind lies the middle meningeal artery.

Structure.

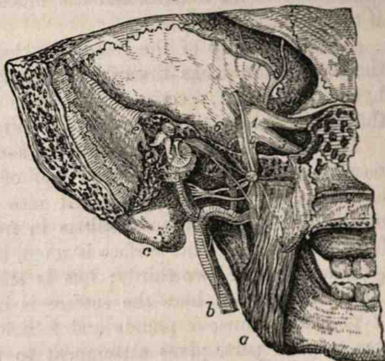
In this ganglion, as in the others connected with the fifth nerve, filaments from motor, sensory, and sympathetic nerves are blended. Some twigs are furnished by it to muscles.

Branches join it with fifth, sympathetic and tympanic nerves.

Connecting branches—roots. The ganglion is joined by a fasciculus from the motor part of the inferior maxillary nerve, and is closely united with the branch of that nerve to the internal pterygoid muscle, thus receiving two of its roots, motor and sensory, from the fifth nerve. Its connection with the sympathetic is established by a twig that is received from the plexus on the middle meningeal artery. Further, the ganglion is connected with the tympanic nerve (of the glosso-pharyngeal) by means of the small superficial petrosal nerve, 6, which joins the posterior part.

Branches to muscles. Two muscles receive their nerves from the otic ganglion, viz. tensor tympani and circumflexus palati. The *nerve* to the *tensor tympani* (fig. 27) is directed backwards, and enters the bony canal containing that muscle. The *branch* for the *circumflexus*, 5, arising from the front of the ganglion, may be supposed to be derived from the internal pterygoid nerve. Other branches enter muscles.

Fig. 27.*



The *nerve of the internal pterygoid muscle* (fig. 27), is a long slender branch, which arises from the inner side of the inferior maxillary nerve near the skull, and is directed downwards to the deep surface of the muscle. This branch is joined by a fasciculus from the motor root of the fifth nerve. Nerve of internal pterygoid.

Directions. The remainder of the pterygo-maxillary region of the left side may be now examined. Directions.

Section XV.

DISSECTION OF THE TONGUE.

Directions. The tongue and larynx are to remain connected with each other whilst the student learns the general form and structure of the tongue. Directions.

Dissection. The ends of the extrinsic lingual muscles that have been detached may be shortened, but enough of each should be left to trace it afterwards into the substance of the tongue. Dissection.

The TONGUE occupies the floor of the mouth, and is rather ovoidal in shape, with the larger end turned backwards. It is Tongue.

* Inner view of the otic ganglion. *a.* Internal pterygoid muscle with its nerve entering it. *b.* External carotid artery with the sympathetic on it. 1. Gasserian ganglion. 2. Ophthalmic trunk. 3. Superior maxillary. 4. Inferior maxillary trunk with the otic ganglion on it. 5. Branch to tensor of the palate; and opposite to it is the small nerve to the tensor muscle of the tympanum. 6. Small superficial petrosal nerve. 7. Chorda tympani.

Situation and form. free over the greater part of the surface; but at the hinder part, and at the posterior two thirds of the under surface, it gives attachment to the muscles and the mucous membrane which fix it to the parts around.

Connections of apex, and base. The apex or tip of the tongue touches the incisor teeth; and the base, which looks towards the pharynx, is attached to the hyoid bone, and is connected likewise with the epiglottis by three folds of mucous membrane—a central and two lateral.

Upper surface. The upper surface or dorsum is somewhat convex, and is received into the hollow of the roof of the mouth; along the anterior two thirds it is divided into two equal parts by a median groove, which ends a little in front of a hollow named foramen cæcum. This surface is rough and covered with papillæ over the anterior two thirds; but is smoother at the posterior third, though even here the surface is irregular in consequence of projecting mucous glands and follicles.

Under surface. The under surface, free only in part, gives attachment to the mucous membrane, and to the different lingual muscles connected with the hyoid bone and the jaw; and in front of those muscles is a fold of the mucous membrane named frænum linguæ.

Borders. The borders of the tongue are thick and round at the base of the organ, where they are marked by vertical ridges and furrows; but gradually become thinner near the apex.

Kinds of papillæ; *Papillæ.* On the dorsum of the tongue are the following kinds of papillæ; the conical and filiform, the fungiform, and the circumvallate.

conical and filiform, The *conical* and *filiform* papillæ are the numerous small projections, like the villi on the mucous membrane of the small intestine, which cover the anterior two thirds of the dorsum of the tongue.

situation on front of tongue; Some of the papillæ (conical) are wider at their attached than at their free ends, and these are most developed over the central part of the tongue. Others become longer (filiform), especially towards the sides of the tongue. These small papillæ are furnished with minuter papillæ, and are provided at the tip with hair-like processes of the epithelium. Towards their limit behind, as well as on the side of the tongue, they have a linear arrangement.

fungiform The *fungiform* papillæ are less numerous but larger than the preceding set, amongst which they are scattered. They are wider at the free end than at the part fixed to the tongue, and

mostly at tip and sides; project beyond the other set; they are situate mostly at the tip and sides of the tongue. They are covered with small simple papillæ.

caliciform, near root of tongue; The *circumvallate* or *caliciform* are fewer in number and larger than the others, and are placed at the junction of the two anterior with the posterior third of the tongue. Their number varies

form; from eight to ten. These papillæ extend across the tongue in a line resembling the letter V with the point turned backwards. Each papilla consists of a central truncated part of a conical form, which is surrounded by a fold of the mucous membrane; its wider part or base projects above the surface, whilst the apex is attached to the tongue. Both the papilla and the surrounding fold are furnished with smaller secondary papillæ.

Minute simple papillæ exist behind the caliciform kind, and on the under surface of the free portion of the tongue; but they are not observed till the epithelium is removed. Other papillæ.

Structure of the Papillæ. The *simple* papillæ are constructed like those of the skin, viz. of a projecting cone of formative membrane, which is covered by epithelium, and filled with a loop of the capillaries, and a nerve. Structure of papillæ. Of simple.

The three other *compound* forms of the papillæ may be said to be formed by outgrowths from the simple kind. Thus smaller papillary eminences spring from the common cone of limiting membrane; and each has its separate investment of epithelium, by which the brush-like appearance on the surface is produced. From the plexus of capillary vessels in the interior of the papilla a looped offset is furnished to each smaller papillary projection. The entering nerve sends offsets to the different subdivisions of the papilla, whose mode of ending in each is unknown, though it has been supposed (Billroth) that they are united with rod-like bodies amongst the pieces of the epithelium, similar to those in the epithelium of the nose. Of compound.

STRUCTURE. The tongue consists of two symmetrical halves separated by a fibrous layer in the middle line. Each half is made up of muscular fibres with interspersed fat; and entering it are the lingual vessels and nerves. The whole tongue is enveloped by the mucous membrane; and a special fibrous membrane attaches it to the hyoid bone. Parts found in tongue.

Dissection. By the time the student has arrived at this stage, the muscular fibres may have faded in colour; but with a fresh part the facts here stated can be easily ascertained. Tongue best seen on fresh part.

To define the septum, and the membrane attaching the tongue to the hyoid bone, the tongue is to be placed on its dorsum; and, the remains of the right mylo- and genio-hyoideus having been removed, the genio-hyo-glossi muscles are to be cleaned, and drawn from one another along the middle line. After separating those muscles, except for an inch in front, and cutting across their intercommunicating fibres, the edge of the septum will appear. By tracing the hinder fibres of the genio-hyo-glossus muscles towards the os hyoides, the hyo-glossal membrane will be arrived at. Define septum; hyo-glossal membrane

At the front of the tongue the genio-hyo-glossus will be afterwards followed out.

Outside this triangular muscle in the middle line, is the longi- and inferior lingualis.

tudinal bundle of the inferior lingualis, which may be cleaned on the left side, though it will be better seen subsequently on the right half.

Fibrous structures of tongue;

Fibrous tissue. Along the middle line of the tongue is placed a thin lamina of this tissue, forming a septum: the root is attached by another fibrous structure, named the hyo-glossal membrane; and covering the organ, for the greater part, is a submucous layer of the same tissue.

its septum.

Septum. This structure forms a vertical partition between the two halves of the tongue, and extends from the base to the apex. It is thicker posteriorly than anteriorly, and is connected behind with the hyo-glossal membrane. To each side the transverse muscle is connected. Its disposition may be better seen subsequently on a vertical section. In some instances a small fibro-cartilage about a quarter of an inch deep and long exists in the septum.

Fibro-cartilage.

Hyo-glossa membrane.

The *hyo-glossal membrane* is a thin but strong fibrous lamina, which attaches the root of the tongue to the upper border of the body of the hyoid bone. On its under or anterior surface some of the hinder fibres of the genio-hyo-glossi are collected, as if this was their aponeurosis to attach them to the os hyoides.

Sub-mucous aponeurosis.

The *submucous fibrous* or aponeurotic *stratum* of the tongue invests the organ, and is continued into the sheaths of the muscles. Over the posterior third of the dorsum its strength is greater than elsewhere; and in front of the epiglottis it forms bands in the folds of the mucous membrane in that situation. Into it are inserted the muscular fibres which end on the surface of the tongue.

Muscles in each half.

Two kinds.

MUSCLES. Each half of the tongue is made up of extrinsic and intrinsic muscles. The former or external are distinguished by having only their termination in the tongue; and the latter or internal, by having both origin and insertion within the organ—that is to say, springing from one part and ending at another.

Extrinsic; number.

The *extrinsic muscles* are the following: palato and stylo-glossus, hyo- and genio-hyo-glossus, and pharyngeo-glossus. Only the lingual endings of these are now to be looked to, for the origin from the bones around has been before made out.

Dissection of palato-, stylo-, and hyo-glossus.

Dissection. After the tongue has been firmly fastened on its left side, the extrinsic muscles may be dissected on the right half. Three of these muscles, viz. palato-, stylo-, and hyo-glossus, come together to the side of the tongue, at the junction of the middle and posterior third; and, to follow their radiating fibres forwards, it will be necessary to remove from the dorsum between the tip and the point at which the muscles come in contact with the border, a thin layer consisting of the mucous membrane and fleshy fibres; but only the mucous membrane from the under surface. On the dorsum of the tongue a thin muscular stratum, the superior lingualis, will be taken away, as before said, with the mucous membrane; and beneath the tip a junction between the stylo-glossus muscles of opposite sides is to be traced.

The part of the constrictor muscle which is attached to the tongue, and the ending of the genio-hyo-glossus, will come into view on the division of the hyo-glossus. **Of constrictor muscle.**

Only the two parts of the hyo-glossus (basio- and cerato-glossus, p. 101), which arise from the body and great wing of the hyoid bone, are referred to above. To lay bare the third part, or the chondro-glossus, which is a small muscular slip, two or three lines in width, and attached to the small cornu of the os hyoides, turn upwards the dorsum of the tongue, and feel the small cornu of the hyoid bone through the mucous membrane. Then remove the mucous membrane in front of the cornu, and the fibres of the muscle radiating forwards will be exposed. **Of hyo-glossus.**

The *palato*, and *stylo-glossus* muscles are partly combined at their attachment to the lateral part of the tongue, and form, together with the following muscle, an expansion that covers the three anterior fourths of the dorsum beneath the superficial lingualis. In this muscular stratum the fibres radiate from the point of contact of the muscles with the tongue—some passing almost horizontally inwards to the middle, and others obliquely forwards to the tip of the organ. **Combined palato- and stylo-glossus; Fibres.**

A great portion of the stylo-glossus is directed along the side of the tongue; and some fibres are inclined to the under surface in front of the hyo-glossus, to join those of the opposite muscle beneath the tip. **Stylo-glossus joins fellow.**

Hyo-glossus. The two superficial parts of the muscle (basio- and cerato-glossus, p. 101) enter the under surface of the tongue, between the stylo-glossus and the lingualis. After entering that surface by separate bundles, they are bent round the margin, and form, with the two preceding muscles, a stratum on the dorsum of the tongue, whose extent has been before stated. **Hyo-glossus; superficial parts;**

The third part of the muscle, or the *chondro-glossus*, is distinct from the rest. About two or three lines wide at its *origin* from the root of the small cornu, and from part of the body of the os hyoides, the muscle is directed upwards and forwards to the tongue; and entering beneath the upper lingualis, it passes obliquely inwards over the posterior third of the dorsum, to blend with the hyo-glossus. **Deeper part, chondro-glossus, origin, ending in the tongue.**

Cortex of the tongue. The muscles above described, together with the superficial lingualis, constitute a cortical layer of oblique and longitudinal fibres, which covers the tongue, except below where some muscles are placed, and resembles "a slipper turned upside down." This stratum is pierced by the deeper fibres. **Muscular cortex of tongue.**

The *genio-hyo-glossus* enters the tongue vertically on the side **Arrange-**

ment in the tongue; of the septum, and perforates the cortical covering to end in the submucous tissue. In the tongue the fibres spread like the rays of a fan from apex to base, and are collected into bundles as they pass through the transversalis. The most posterior fibres end on the hyo-glossal membrane and the hyoid bone; and a slip is prolonged from them, beneath the hyo-glossus, to the upper constrictor of the pharynx. A vertical section at a future stage will show the radiation of its fibres.

its posterior fibres.

Constrictor at the tongue, how ends. The *pharyngeo-glossus* (glosso-pharyngeus), or the part of the upper constrictor attached to the side of the tongue, passes amongst fibres of the hyo-glossus, and is continued with the transverse muscle to the septum.

Intrinsic muscles. The *intrinsic muscles* are three in number in each half of the tongue, viz., transversalis, with a superior and an inferior lingualis.

First show inferior, *Dissection.* To complete the preparation of the inferior lingualis on the right side, the fibres of the stylo-glossus covering it in front, and those of the genio-hyo-glossus over it behind, are to be cut through.

then superior lingualis, The superior lingualis may be shown, on the left side, by taking the thin mucous membrane from the upper surface from tip to base.

then transversalis. The transversalis may be laid bare on the right side, by cutting away on the upper surface the stratum of the extrinsic muscles already seen; and on the lower surface, the inferior lingualis and the genio-hyo-glossus.

Trace the nerves. The nerves for the supply of the tongue are to be dissected on the left half as well as the part will admit; but a recent specimen would be required to follow them satisfactorily.

This is horizontal. Attachments. The *transversalis* muscle forms a horizontal layer in the substance of the tongue from base to apex. The fibres are attached internally to the side of the septum, and are directed thence outwards, the posterior being somewhat curved, to their insertion into the side of the tongue.

Fibres. Its fibres are collected into vertical plates, so as to allow the passage between them of the ascending fibres of the genio-hyo-glossus.

Use. *Action.* By the contraction of the fibres of these muscles the tongue is made narrower and rounder, and is increased in length.

This is superficial. Origin. Fibres. The *superior lingualis* (noto-glossus of Zaglas) is a thin layer of oblique and longitudinal fibres close beneath the submucous tissue on the dorsum of the tongue. Its fibres arise from the frænum epiglottidis, and from the fascia along the middle line; from this attachment they are directed obliquely outwards, the anterior becoming longitudinal, to the margin of the tongue, at which they end like as they began.

Ending.

Use. *Action.* Both muscles tend to shorten the tongue; and they will bend the point back and up.

The *inferior lingualis* is much stronger than the preceding, and is placed under the tongue between the hyo- and genio-hyo-glossus. The muscle arises posteriorly from the fascia at the root of the tongue; and the fibres are collected into a roundish bundle in the position before noted. From its attached surface fasciculi are continued vertically through the transverse fibres upwards to the dorsum; and at the anterior third of the tongue, where the muscle is overlaid by the stylo-glossus, some of the fibres are applied to that muscle and distributed with it. **Position below tongue. Origin. Ending.**

Action. Like the upper lingualis this muscle shortens the tongue, and bends the point down and back. **Use.**

The *mucous membrane* is a continuation of that lining the mouth, and is provided with a laminar epithelium. It partly invests the tongue, and is reflected off at different points in the form of folds (p. 139). At the epiglottis are three small *glosso-epiglottid* folds, connecting this body to the root of the tongue; the central one of these is called the frænum of the epiglottis. Like the membrane of the mouth, it is furnished with numerous muciparous glands, and some follicles. **Mucous membrane; its epithelium. Folds.**

The *follicles* are depressions of the mucous membrane, which are surrounded by closed capsules in the submucous tissue, like the arrangement in the tonsil: they occupy the dorsum of the tongue between the papillæ circumvallatæ and the epiglottis, where they form a continuous stratum, close beneath the mucous membrane. **Follicles,**

The *glands* (lingual) are racemose or compound in structure, similar to those of the lips and cheek, and are placed beneath the mucous membrane and follicles, covering chiefly the posterior third of the dorsum of the tongue. A few are found in front of the circumvallate papillæ, where they project into the muscular substance. Some of their ducts open on the surface; others into the hollows around the large papillæ, or into the foramen cæcum and the depressions of the follicles. **and glands at the base,**

Opposite the papillæ vallatæ, at the margin of the tongue, is a small cluster of submucous glands. Under the tip of the tongue, on each side of the frænum, is another elongated collection of the same kind of glands imbedded in the muscular fibres, from which several ducts issue. **glands at the side, and beneath tip.**

NERVES. There are three nerves on the under part of each half of the tongue, viz., the gustatory, the hypoglossal, and the glosso-pharyngeal. **Nerves from three sources,**

The *gustatory nerve* gives upwards filaments to the muscular substance, and to the two smallest sets of papillæ, conical and fungiform; it joins also the hypo-glossal nerve. **gustatory,**

The *hypo-glossal nerve* is spent in long slender offsets to the muscular substance of the tongue. **hypo-glossal,**

The *glosso-pharyngeal* nerve divides under the hyo-glossus into **and glosso-pharyngeal.**

two branches :—One turns to the dorsum, and ramifies in the mucous membrane behind the foramen cæcum. The other passes beneath the side of the tongue, and ends in branches that enter the muscular substance; it supplies the papillæ circumvallatæ, as well as the mucous membrane covering the lateral part of the tongue.

Arteries and veins.

VESSELS. The arteries are derived chiefly from the lingual of each side; these, together with the veins, have been examined (p. 103). After supplying the muscular substance the vessels enter the papillæ, and end in loops as before said.

SECTION XVI.

DISSECTION OF THE LARYNX.

Outline of larynx.

The LARYNX is the upper dilated part of the air tube, in which the voice is produced. It is constructed of several cartilages united together by ligamentous bands; of muscles for the movement of the cartilages; and of vessels and nerves. The whole is lined by mucous membrane.

Dissection.

Dissection. The tongue may be removed from the larynx by cutting through its root, but this is to be done without injuring the epiglottis.

If the student learns the laryngeal cartilages before he begins the dissection of the larynx, he will obtain more knowledge from the study of this section.

Situation and connections.

Occupying the middle line of the neck, the larynx is placed in front of the pharynx, and between the carotid vessels. It is pyramidal in form. The base is turned upwards, and is attached to the hyoid bone; and the apex, directed downwards, is continuous with the trachea.

Size.

In length it measures about one inch and a half; in width at the top one inch and a quarter, and at the lower end one inch.

Position.

The front is prominent along the middle line of the neck; and the posterior surface is covered by the mucous membrane of the pharynx. The larynx is very moveable, and during deglutition is elevated and depressed by the different extrinsic muscles.

Is very moveable.

Six special muscles of larynx.

MUSCLES. The special muscles of the larynx pass from one cartilage to another, and modify by their action the state of the vocal apparatus. Commonly six muscles are described, but the number is stated differently by anatomists. Three are outside the cartilages, and three are more or less concealed by the thyroid cartilage: they are alike on the two sides of the body, and are in pairs with one exception.

Directions. On one side of the larynx, say the right, the muscles may be dissected, and on the opposite side the nerves and vessels; and those superficial muscles are to be first learnt, which do not require the cartilages to be cut.

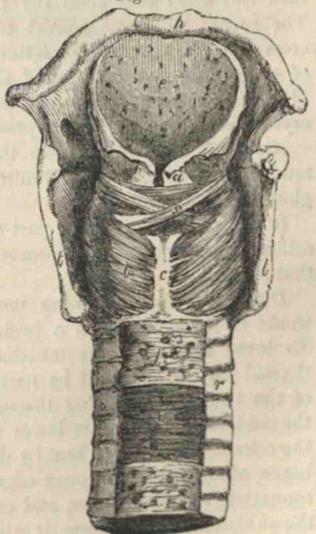
Dissection. The larynx being extended and fastened with pins, **Dissection** the dissector may clear away from the os hyoides and the thyroid cartilage the following extrinsic muscles, viz., constrictor, sterno-hyoid, sterno-thyroid, and thyro-hyoid.

In front, between the thyroid and cricoid cartilages, one of the **of the external set of muscles.** three small external muscles,—crico-thyroid, will be recognised.

The other two external muscles are situate at the posterior aspect of the larynx: to denude them it will be necessary to turn over the larynx, and to remove the mucous membrane covering it. On the back of the cricoid cartilage the dissector will find the crico-arytænoideus posticus muscle; and above it, on the posterior part of the arytænoid cartilages, the arytænoid muscle will appear.

The CRICO-THYROIDEUS MUSCLE (fig. 20, [9]) is triangular in **Crico-thyroideus.** form, and is separated by an interval from the one on the opposite side. It *arises* from the front and the lateral part **Origin.** of the cricoid cartilage; and its fibres ascend, diverging from one another, to be *inserted* into the lower cornu, **Insertion.** and the lower border of the thyroid cartilage as far forwards as a quarter of an inch from the middle line; also, for a short distance (a line), into the inner surface of that cartilage. The muscle rests on the crico-thyroid membrane, and is concealed by the sterno-thyroid muscle.

Fig. 28.*



Action. It approaches the **Use.** thyroid to the cricoid cartilage, making longer the distance between that and the arytænoid cartilages, and tightens indirectly the vocal cords.

The CRICO-ARYTÆNOIDEUS POSTICUS MUSCLE (fig. 28, *b*) lies on **Crico-arytæ-**

* Back of the larynx and wind-pipe. *h*, hyoid bone; *a*, arytænoid cartilage; *e*, epiglottis; *t*, thyroid cartilage; *c*, cricoid cartilage; *r*, trachea; *b*, crico-arytænoideus posticus; *s*, arytænoideus; *n*, muscular layer at the back of the trachea.

noideus posticus is on back of cricoid cartilage. the posterior part of the cricoid cartilage. Its *origin* is from the depression on the side of the vertical ridge at the back of that cartilage. From this origin the fibres are directed outwards, and are *inserted* by fleshy and tendinous fibres into a projection at the outer part of the base of the arytænoid cartilage.

Use. *Action.* It rotates the arytænoid cartilage, turning out the lateral projection at the base, and enlarges the interval between the cartilages. At the same time the upper orifice of the larynx is widened by the separation from each other of its lateral boundaries.

Kerato-cricoideus. *Musculus kerato-cricoideus* (Merkel). This is a small fleshy slip which is occasionally seen below and close to the preceding muscle; it arises from the cricoid cartilage, and is inserted into the back part of the lower cornu of the thyroid cartilage.

Arytænoideus; The ARYTÆNOIDEUS is a single muscle in the middle line (fig. 28, *s*), and is placed on the posterior surface of the arytænoid cartilages. It possesses two sets of fibres, superficial and deep, with different directions. deep or transverse fibres, The deep fibres are transverse, and are inserted into the outer border and the posterior surface of each cartilage; they close the interval between the cartilages. superficial or oblique. The superficial fibres consist of two oblique fasciculi, which cross like the parts of the letter X, each passing from the base of one cartilage to the apex of the other: a few of the oblique fibres are continued beyond the cartilage to join the thyro-arytænoid muscle, and the depressor of the epiglottis.

Use. *Action.* The muscle causes the arytænoid cartilages to glide towards one another, and diminishes much, or closes the rima glottidis.

It acts also as the hinder part of a sphincter to close the upper orifice of the larynx, the depressors of the epiglottis assisting it in that action.

Dissection of internal muscles. *Dissection.* The remaining muscles and the vocal apparatus would be learnt better on a fresh larynx, if this can be obtained. To bring into view the muscles, which are concealed by the thyroid cartilage, it will be necessary to remove the right half of the thyroid, by cutting through it a quarter of an inch from the middle line, after its lower cornu has been detached from Remove half of cartilage. the cricoid cartilage. Then by dividing the crico-thyroid membrane attached to the lower edge, and the thyro-hyoid ligament connected with the upper, and separating the loose piece from the subjacent areolar tissue, it will come away.

Position of muscles. By the removal of some areolar tissue, the dissector will define inferiorly the lateral cryco-arytænoid muscle; above it, the thyro-arytænoideus muscle; and still higher, the thin muscular fibres (depressor of the epiglottis) in the fold of mucous membrane between the epiglottis and the arytænoid cartilage. On cleaning the fibres of the thyro-arytænoideus near the front of the larynx, the top of the sacculus laryngis with its small glands will appear above the fleshy fibres.

The CRICO-ARYTÆNOIDEUS LATERALIS (fig. 29, [3]) is a small lengthened band, which *arises* from the upper border of the cricoid cartilage at the lateral part; its fibres are directed backwards to be *inserted* into a projection on the outer side of the base of the arytænoid cartilage, and into the contiguous part of the outer surface. Lateral crico-arytænoideus

Fig. 29.*

This muscle is concealed by the crico-thyroideus, and its upper border is contiguous to the succeeding muscle. is beneath thyroid cartilage.

Action. Rotating the arytænoid cartilage by moving inwards the projection on the outer part of the base, it replaces the cartilage after this has been everted by the crico-arytænoideus posticus. It can approach the one vocal cord to the other, and so narrow the glottis. Use.

The THYRO-ARYTÆNOIDEUS MUSCLE (fig. 29, [4 8]) extends backwards in the interior of the larynx from the thyroid to the arytænoid cartilage; it is thick below, but thin and expanded above. The muscle *arises* from the thyroid cartilage near the middle line, for about the lower half of the depth, and from the crico-thyroid ligament. The fibres are directed backwards with different inclinations;—The external [4] ascend somewhat, and are *inserted* into the upper part of the outer surface of the arytænoid cartilage, and blend with the depressor of the epiglottis. The internal and lower fibres are transverse, and form a thick bundle,[8] Thyro-arytænoideus. Some fibres ascend to tip, others go to

* View of the internal muscles of the larynx. 1. Crico-thyroideus detached. 2. Crico-arytænoideus posticus. 3. Crico-arytænoideus lateralis. 4. Thyro-arytænoideus, superficial part. 5. Depressor of the epiglottis. 6. Thyro-hoideus, cut. 8. Deep or transverse part of thyro-hyoideus.

base of arytænoid cartilage. which is *inserted* into the fore part of the base of that cartilage, and into the outer surface.

Connections. By its outer surface the muscle is in contact with the thyroid cartilage; and the inner surface rests on the vocal cords, and on the ventricle of the larynx and the pouch.

Use on cord. *Action.* It moves forwards the arytænoid cartilage towards the thyroid, and relaxes the vocal cord. By the thin band of fibres along the upper edge the rima glottidis can be narrowed, and the cord put into the vocalising position.

Depressor of epiglottis; The DEPRESSOR OF THE EPIGLOTTIS (fig. 30) (thyro-arytæno-epiglottideus) is the thin muscular layer, which is contained in the fold of mucous membrane bounding laterally the upper opening of the larynx (fig. 29, [5]). origin. Its fibres *arise* posteriorly from the front of the arytænoid cartilage, some being also continuous below with fibres of the arytænoid and thyro-arytænoid muscles; and anteriorly by a narrow slip from the thyroid cartilage near the middle line. From those attachments the fibres turn upwards with very different directions, and are *inserted* into the Insertion. border of the epiglottis of the same side. The strength of the muscle varies much in different bodies.

Some of the lower fibres of the muscle, which cover the top of the laryngeal pouch, have been described by Mr. Hilton as a separate muscle with the name *arytæno-epiglottideus inferior.*

Use on aperture of larynx, *Action.* By the contraction of the fibres, the tip of the arytænoid cartilage will be moved forwards and inwards, and the epiglottis will be lowered over the orifice of the larynx.

on sacculus. The fibres of the muscle which are spread over the sacculus will compress it, and assist in the expulsion of the contents.

Parts inside larynx. PARTS INSIDE THE LARYNX. The parts more immediately concerned in the production of the voice are, the vocal cords, the glottis, and the ventricle of the larynx and its pouch: these are placed within, and are protected by the laryngeal cartilages.

Dissection to expose them. *Dissection.* For the purpose of displaying the vocal apparatus, let the tube of the larynx be divided along the posterior part; and in cutting through the arytænoid muscle, let the incision be rather to the right of the middle line, so as to avoid the nerves entering it.

On looking into the larynx a hollow (ventricle) will be seen on each side; and bounding the ventricle above and below are the whitish bands of the vocal cords.

If a probe be passed into that hollow, it may be made to enter a small pouch (sacculus laryngis) by an aperture in the anterior and upper part. The dissector should fill the sacculus on the right side by introducing a small piece of cotton wool into it.

Space, extent. The *laryngeal space* reaches from the epiglottis to the lower border of the cricoid cartilage. It opens above into the pharynx, and below into the trachea; and in the intermediate space are lodged the parts producing voice.

The *upper orifice* of the larynx (fig. 28) will be evident on placing in contact the cut surfaces. It is triangular in shape, with the base in front and the apex behind, and its sides are sloped obliquely downwards in the antero-posterior direction. Its boundaries are,—the epiglottis in front, the arytænoid muscle and cartilages behind, and the arytæno-epiglottidean fold of mucous membrane on each side. This aperture is closed by the epiglottis during deglutition. **Upper orifice, shape, and boundaries.**

The *lower opening,* limited by the inferior edge of the cricoid cartilage, is circular in form, and is of the same size as that cartilage. **Lower opening,**

The *laryngeal cavity* is much reduced in size within the thyroid cartilage by the vocal cords, and is dilated above and below them, for the purpose of allowing their free vibration. On a vertical cross section the lower dilatation would be seen to be as large as the ring of the cricoid; and the upper, much smaller, to be formed by the ventricles of the larynx. Above the highest bulge the wall of the larynx slants up to the epiglottis. **cavity of larynx, shape and size.**

The *glottis,* or *rima glottidis,* is the interval between the lower vocal cords; it is placed on a level with the base of the arytænoid cartilages, and is the narrowest part of the laryngeal cavity. In the state of rest it is a narrow fissure which is enlarged a little behind and rounded; but when dilated it is triangular in form, like the upper orifice, though its wider part is turned backwards to the arytænoid muscle. **Glottis, position, form,**

It sides are constructed partly of ligament and partly of cartilage:—thus, for about the two anterior thirds is the elastic vocal cord, whilst at the posterior third is the smooth inner surface of the arytænoid cartilage. Behind it is bounded by the arytænoid muscle, and in front by the thyroid cartilage and the attachments of the vocal cords. **construction,**

The size of the interval differs in the two sexes. In the male it measures from before back nearly an inch (less a line), and across at the base when dilated, about a third of the other measurement. In the female the dimensions will be less by two or three lines. **size differs.**

Alterations in the size and form affect the interval where it is bounded by the cartilages, as well as where it is limited by the ligaments. In the former part, the changes are occasioned by the movements of the arytænoid cartilages; but in the latter they are due to the lengthening or shortening of the bands. **Changes in size, in two ways.**

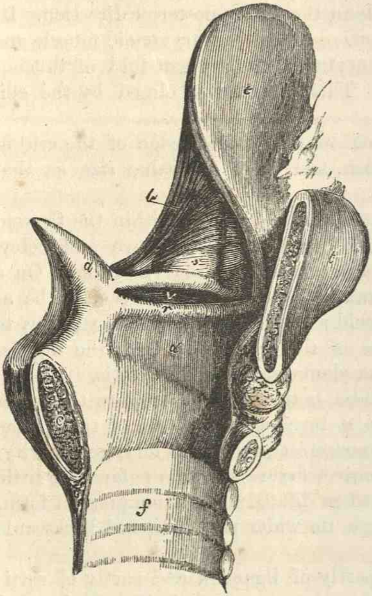
In the living body the fissure is larger in inspiration than in expiration. The muscles too are constantly producing alterations in the fissure, some acting more immediately on the cartilages as dilators or contractors of the base; and others **Action of the muscles,** on sides,

altering the state of the ligaments, by elongating and shortening the sides.

on base.

The base is enlarged, and the interval rendered triangular by the posterior crico-arytænoid; and is diminished by the arytænoid, and the lateral crico-arytænoid. And the ligamentous sides are elongated and made tense by the crico-thyroidei, but are shortened by the thyro-arytænoidei.

Fig. 30.*



Ventricle.

The *ventricle* of the larynx (fig. 30, *v*) will be visible on the left side; it is the oval hollow between the vocal cords.

Situation.

The upper margin of the opening is semilunar, and the lower is straight. On the outer surface are the fibres of the thyro-arytænoid muscle, and in the anterior part is the aperture into the laryngeal pouch.

Parts around.

Pouch of larynx.

The *laryngeal pouch* (sacculus laryngis) (fig. 30, *s*) has been laid bare in part on the right side by the removal of the half of the thyroid cartilage (p. 164), but it will be better seen in a subsequent dissection for the display of the vocal cords.

Form and position.

It is a small membranous sac, half an inch deep and cylindrical in form, which projects upwards between the upper vocal cord and the thyroid slip of the depressor of the epiglottis, and reaches sometimes as high as the upper border of the thyroid cartilage. Its cavity communicates with the front of the ventricle by a somewhat narrow aperture.

Surrounding parts.

On the outer surface are numerous small glands, whose ducts are transmitted through the coats of the sac to the inside. Numerous nerves are distributed over the

* Interior of the larynx with the vocal cords (Hilton). *e*, epiglottis; *a*, arytænoid cartilage; *t*, thyroid, and *c*, crycoid cartilage; *b*, depressor of the epiglottis; *r*, lower or true vocal cord; *v*, ventricle of the larynx, with the false vocal cord above it; *s*, laryngeal pouch.

top. Its upper part is covered by the muscular slip before referred to.

Dissection. The general shape and position of the vocal cords are evident on the left half of the laryngeal tube, but to show more fully the nature of the lower cord, put the cut surfaces in contact, and detach on the right side the crico-arytænoideus lateralis from its cartilages. Remove in like manner the thyro-arytænoideus, raising it from before back. By the removal of the last muscle a fibrous membrane crico-thyroid (fig. 31, [6]) comes into view; and the upper free edge of that membrane can be now perceived to constitute the inferior or true vocal cord. Whilst taking away the thyro-arytænoideus, the ventricle and the sacculus laryngis, which are formed chiefly by mucous membrane, will disappear. Dissection of vocal cord, and crico-thyroid membrane.

The *thyro-arytænoid ligaments*, or the vocal cords (fig. 30), are two bands on each side, which are extended from the angle of the thyroid to the arytænoid cartilage,—one forming the upper, the other the lower margin of the ventricle; they are about seven lines long in man, and two less in the woman. Thyro-arytænoid ligaments.

The *inferior ligament* (chorda vocalis) (fig. 30, *r*), is attached in front to the angle of the thyroid cartilage, about half way down below the notch; the ligament is directed backwards, and is inserted into the anterior prominence at the base of the arytænoid cartilage. Internally this band is covered by thin mucous membrane, and projects towards its fellow into the cavity of the larynx, the interval between it and the opposite one being the glottis. Externally it is connected with the thyro-arytænoid muscle. And inferiorly it is continuous with the crico-thyroid ligament (fig. 31, [1]). The edge that bounds the ventricle is straight and well defined, and vibrates to produce sounds. Inferior or vocal cord has these connections.

The ligament is formed by the upper free edge of the crico-thyroid membrane, and is composed of fine elastic tissue. Nature.

The *upper ligament* (false vocal cord, fig. 30) to be seen on the left side, is semilunar in form, and is much weaker than the other. It is fixed in front to the angle of the thyroid cartilage, near the attachment of the epiglottis; and behind to the outer surface of the arytænoid cartilage. This ligament consists chiefly of white fibrous tissue, which is continuous with that in the arytæno-epiglottidean fold of mucous membrane. Upper ligament is a very slight fibrous band.

The *mucous membrane* of the larynx is derived from that investing the pharynx, and is prolonged to the lungs through the trachea. When entering the larynx it is stretched between the epiglottis and the tip of the arytænoid cartilage, forming the arytæno-epiglottid fold on each side of the laryngeal orifice: at this spot it is very loose, and the submucous tissue abundant. In the larynx the membrane lines closely the cavity, sinks into the ventricle, and is prolonged into the laryngeal pouch. On Mucous membrane. Arrangement.

the thyro-arytænoid ligaments it is very thin and adherent, allowing these to be visible through it.

Epithelium has different nature. A columnar ciliated epithelium covers the surface below the level of the superior vocal cords, but it becomes flattened without cilia on the vocal cords: on the epiglottis it is ciliated in the lower half. In the small part of the larynx above the line mentioned, the epithelium is of the laminar kind and free from cilia.

Glands. Numerous *racemose glands* are connected with the mucous membrane of the larynx; and the orifices will be seen on the surface, especially at the posterior aspect of the epiglottis. In the edge of the arytæno-epiglottidean fold there is a little swelling occasioned by a mass of subjacent glands (arytænoid); and along the upper vocal cord lies another set. None exist over the vocal cords, but close to those bands is the collection of the sacculus laryngis which lubricates the ventricle and the vocal cord.

Dissection of nerves: *Dissection of nerves and vessels.* The termination of the laryngeal nerves may be dissected on the untouched side of the larynx. For this purpose the other half of the thyroid is to be disarticulated from the cricoid cartilage; and care should be taken of the recurrent nerve, which lies near the joint between the two. The trachea and larynx should be fastened down next with pins, and after the thyroid has been drawn away from the cricoid cartilage, the inferior laryngeal nerve can be traced over the side of the latter cartilage to the muscles of the larynx, and to the mucous membrane of the pharynx.

inferior,

superior laryngeal: Afterwards the superior laryngeal is to be found as it pierces the thyro-hyoid membrane, and branches of it are to be traced inwards to the mucous membrane of the larynx, and pharynx. Two communications are to be looked for between the laryngeal nerves; one is beneath the thyroid cartilage, the other in the mucous membrane of the pharynx.

of vessels. An artery accompanies each nerve, and its offsets are to be dissected at the same time as the nerve.

Nerves are from vagus. Nerves. The nerves of the larynx are the superior and inferior laryngeal branches of the pneumo-gastric (p. 118); the former is distributed to the mucous membrane, and the latter to the muscles.

Recurrent nerve supplies special muscles except one. The *inferior laryngeal* nerve (recurrent), when about to enter the larynx, furnishes backwards an offset to the mucous membrane of the pharynx; this joins filaments of the upper laryngeal. The nerve then passes beneath the ala of the thyroid cartilage, and ends in branches for all the special muscles of the larynx, except the crico-thyroideus. Its small muscular branches are superficial, but that to the arytænoid muscle passes beneath the crico-arytænoideus posticus. Beneath the thyroid cartilage the inferior is joined by a long offset of the upper larygeal nerve.

Superior The *superior laryngeal* nerve pierces the thyro-hyoid ligament, and gives offsets to the mucous membrane of the pharynx; it furnishes also a long branch beneath the ala of the thyroid cartilage to communicate with the recurrent nerve. The trunk then terminates in many branches for the supply of the mucous membrane:—Some of these ascend in the arytæno-epiglottid fold to the epiglottis, and the root of the tongue. The others, which are the largest, descend on the inner side of the ventricular pouch, and supply the lining membrane of the larynx as low as the vocal cords. One nerve of this set pierces the arytænoid muscle, and ends in the mucous membrane. laryngeal nerve joins recurrent, and ends in mucous membrane.

VESSELS. The arteries of the larynx are furnished from the superior and inferior thyroid branches (pp. 84, 75). Arteries

The *laryngeal branch* of the *superior thyroid artery* enters the larynx with the superior laryngeal nerve, and divides like it into ascending and descending branches; some of these enter the muscles, but the rest supply the epiglottis, and the mucous membrane from the root of the tongue to the chorda vocalis. Like the nerves, it unites with the following artery both beneath the ala of the thyroid cartilage and in the mucous membrane of the pharynx. from superior thyroid;

The *laryngeal branch* of the *inferior thyroid artery* ascends on the back of the cricoid cartilage and ends in the mucous membrane of the pharynx and the posterior muscles of the larynx. from inferior thyroid:

Some other twigs from the superior thyroid artery perforate the crico-thyroid membrane, and ramify in the mucous lining of the interior of the larynx at the lower part. other source.

Laryngeal veins. The vein accompanying the branch of the superior thyroid artery, joins the internal jugular or the superior thyroid vein; and the vein corresponding with the other artery opens into the plexus of the inferior thyroid veins (pp. 84, 75). Veins end differently.

SECTION XVII.

HYOID BONE, CARTILAGES AND LIGAMENTS OF THE LARYNX, AND STRUCTURE OF THE TRACHEA.

Dissection. All the muscles and the mucous membrane are to be taken away so as to denude the hyoid bone, the cartilages of the larynx, and the epiglottis; but the piece of membrane that joins the hyoid bone to the thyroid cartilage, and the ligaments uniting one cartilage to another on the left side, should not be destroyed. Dissection.

In the arytæno-epiglottidean fold of mucous membrane, a small cartilaginous body (cuneiform) may be recognised; an oblique whitish projection indicates its position.

Hyoid bone. Form.

The *hyoid bone* (os hyoides) is situate between the larynx and the root of the tongue. Resembling the letter U, placed horizontally and with the legs turned backwards, it offers for examination a central part or body, and two lateral pieces or cornua on each side.

Body of the bone.

The body is thin and flattened, and measures most in the transverse direction. Convex in front, where it is marked by a tubercle, it presents an uneven surface for the attachment of muscles; whilst on the opposite aspect it is concave. To the upper border the fibrous membrane (hyo-glossal) fixing the tongue is attached.

Side pieces, large and small.

The cornua are two in number on each side (large and small). The *large* cornu continues the bone backwards, and is joined to the body by an intervening piece of cartilage. The surfaces of this cornu look somewhat upwards and downwards; and the size decreases from before backwards. It ends posteriorly in a tubercle. The *small* cornu, or appendix, is directed upwards from the point of union of the great cornu with the body, and is joined by the stylo-hyoid ligament. It is seldom wholly ossified.

In larynx there are four large and some small cartilages.

Cartilages of the Larynx. There are four large cartilages in the larynx, which are concerned in the production of the voice, viz., the thyroid, the cricoid, and the two arytænoid. In addition there are some cartilaginous structures called yellow cartilage, viz., the epiglottis, a capitulum to each arytænoid cartilage, and on each side a small ovalish piece (cuneiform) in the arytæno-epiglottidean fold of mucous membrane.

Thyroid cartilage is convex in front, concave behind.

The *thyroid cartilage* is the largest of all: it forms the front of the larynx, and protects the vocal apparatus as with a shield. The upper part of the cartilage is considerably wider than the lower, and in consequence of this form the larynx resembles somewhat a funnel. The anterior surface is prominent in the middle line, forming the subcutaneous swelling named *pomum Adami;* but the cartilage is concave behind at the same spot, and gives attachment to the epiglottis and the thyro-arytænoid muscles and ligaments. The upper border is notched in the centre.

Formed of two halves, each having borders and cornua.

The cartilage consists of two square parts or halves, which are united in the middle line. Posteriorly each half of the cartilage has a thick border, which terminates upwards and downwards in a rounded process or cornu. Both cornua are bent slightly inwards: of the two, the upper horn is the longest; but the lower piece is thicker than the other, and articulates with the cricoid cartilage. The inner surface of each half is smooth; but the outer is marked by an oblique line for the attachment of muscles, which extends from a tubercle near the root of the upper cornu, almost to the middle of the lower border.

The *cricoid cartilage* is stronger though smaller than the thyroid, and encircles the cavity of the larynx; it is partly concealed by the shield-like cartilage, below which it is placed. It is very unequal in depth before and behind, the posterior part being three times deeper than the anterior, something like a signet ring. Its size is about as large as the fore finger. **Cricoid cartilage. Form.**

The outer surface is rough, and gives attachment to muscles. At the back of the cartilage there is a flat and rather square portion, which is marked by a median ridge between two contiguous muscular depressions. On each side, immediately in front of the square part, is a shallow articular mark, which receives the lower cornu of the thyroid cartilage. The inner surface is smooth, and is covered by mucous membrane. **Surfaces.**

The lower border is undulating, and is united to the first ring of the trachea by fibrous membrane. The upper border is nearly straight posteriorly, opposite the deep part of the cartilage; and this portion is limited on each side by an articular mark for the arytænoid cartilage. In front of that spot the border is sloped obliquely downwards to the middle line. At the middle line behind there is a slight excavation in each border. **Borders, the upper most uneven.**

The *arytænoid cartilages*, two in number, one on each side of the middle line, are placed at the back of the larynx, on the upper border of the cricoid cartilage. Each cartilage, about half an inch in depth, is pyramidal in shape, and offers for examination a base and apex, and three surfaces. **Arytænoid cartilages. Situation and form.**

The base has a slightly hollowed surface behind for articulation with the cricoid cartilage, and is elongated in front by means of a process which gives attachment to the vocal cord. The apex is directed backwards and somewhat inwards, and is surmounted by the cartilage of Santorini. **Base. Apex.**

The inner surface is narrow, especially above, and flat; but the outer is wide and irregular. On the outer surface there is a small projection at the base, which receives the insertion of some of the muscles. At the posterior aspect the cartilage is concave and smooth. **Three surfaces.**

Cartilages of Santorini. Attached to the apex of each arytænoid cartilage is the small, conical, cartilaginous body of Santorini (corniculum capitulum Santorini), which is bent inwards towards the one of the opposite side. The arytæno-epiglottidean fold is connected with it. **Two cartilages of Santorini.**

Cuneiform cartilages. Two other small cartilaginous bodies, one on each side, which are contained in the arytæno-epiglottid folds, have received this name. Each is somewhat elongated and rounded in form, like a grain of rice; it is situate obliquely in front of the capitulum of the arytænoid cartilage, **Two cartilages of Wrisberg.**

and its place in the fold of the mucous membrane is marked by a slight whitish projection.

Epiglottis. Form and position. The *epiglottis* (fig. 28, *e*) is single, and is the largest of the pieces of yellow cartilage. In form it is cordate; and it resembles a leaf, with the stalk below and the lamina or expanded part above. Its position is behind the tongue, and in front of the orifice of the larynx. During respiration it is placed vertically, but during deglutition it takes a horizontal direction so as to close the opening of the larynx.

Surfaces. Sides. Foot stalk. Glands in it. The anterior surface is bent forwards to the tongue, to which it is connected by three folds of mucous membrane; and the posterior surface, hollowed from side to side, is convex from above down. To its sides the arytæno-epiglottid folds of mucous membrane are united. After the mucous membrane has been removed from the epiglottis its substance will be seen to be perforated by numerous apertures, which lodge mucous glands.

Supposed gland. Between the epiglottis and the hyoid bone is a mass of yellowish fat with some glands; this has been sometimes called the epiglottidean gland.

Ligaments of the larynx, LIGAMENTS OF THE LARYNX. The larynx is connected by extrinsic ligaments with the hyoid bone above and the trachea below. Other connecting ligaments join together the cartilages: and between some of the cartilages synovial membranes exist.

between os hyoides and trachea. *Union of the larynx with the hyoid bone and the trachea.* A thin loose elastic membrane (thyro-hyoid) passes from the thyroid cartilage to the hyoid bone; and a second membrane connects the cricoid cartilage with the trachea.

Thyro-hyoid membrane. The *thyro-hyoid ligament* is attached on the one part to the upper border of the thyroid cartilage; and on the other, to the upper border of the hyoid bone, at the posterior aspect. Of some thickness in the centre, it gradually becomes thinner towards the sides; and it ends laterally in a rounded elastic cord, which intervenes between the extremity of the hyoid bone and the upper cornu of the thyroid cartilage.

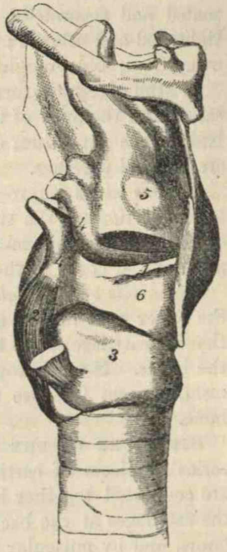
The superior laryngeal nerve and artery perforate the ligament, and a synovial membrane is placed between it and the posterior surface of the hyoid bone. In the elastic lateral part of the ligament will be found occasionally a small ossific nodule (cartilago triticea).

Crico-tracheal membrane. The membrane joining the lower border of the cricoid cartilage to the first ring of the trachea—*crico-tracheal ligament*, resembles the band joining the rings of the trachea to each other.

Between cricoid and thyroid car tilages are *Union of the cricoid and thyroid cartilages.* These cartilages are joined in the middle line in front by ligament; and on the side, by a capsular ligament around the small cornu of the thyroid cartilage.

The *crico-thyroid ligament* or membrane is yellow in colour, and is formed mostly of elastic tissue: only the right half is now visible. At its centre it is thick and strong, but is thinner on each side as it is continued back to the arytænoid cartilage. By the lower border it is fixed to the upper edge of the cricoid as far back on each side as the joint with the arytænoid cartilage. In front it is united to the thyroid cartilage; and behind to the base of the arytænoid. Its upper border, free and rounded, is covered by mucous membrane, and forms the lower vocal cord. an anterior ligament.

Fig. 31.*



Some small apertures exist in this membrane for the passage of fine arteries into the larynx. The ligament is partly concealed by the crico-thyroid muscle.

The strong fore part of the ligament serves the purpose of uniting the two large laryngeal cartilages; and the lateral piece, closing the larynx, ends above in the vocal cord. Use.

A *capsular ligament*, surrounds the articular surfaces between the side of the cricoid and the lower cornu of the thyroid cartilage. Its fibres are strongest behind. A *synovial membrane* lines the capsule. and a lateral joint.

This joint admits forward and backward movements of the thyroid cartilage, by which the condition of the vocal cords is altered. If the cartilage is moved forwards the cords are stretched, and if backwards the cords are relaxed. Use.

Articulation of the cricoid and arytænoid cartilages. This joint allows of most movement. The articular surfaces of the cartilages are retained by a capsule, and possess a synovial sac. Between cricoid and arytænoid

The *capsular ligament* is fixed to each cartilage around its articular surface; and one part—*posterior ligament*, is strongest on the inner and posterior aspects. A loose *synovial membrane* is present in the articulation. is a capsule and synovial sac.

From the flatness of the articular surfaces the arytænoid cartilage glides forwards and backwards, inwards and outwards; and if its horizontal movements are controlled by muscular action it Use.

* View of the vocal cords and crico-thyroid ligaments. 1. True vocal cord. 2. Post crico-arytæn. muscle. 3. Cricoid cartilage. 4. Arytænoid cartilage. 5. Sacculus laryngis. 6. Crico-thyroid membrane.

can be rotated around a vertical axis, the anterior spur being moved inwards and outwards. Obviously the state of the vocal cords will be changed by the movements of the cartilages. When the arytænoids glide in and out the cords will be approximated and separated; when from front to back, they will be tightened and relaxed; and in rotation the cords will be moved away from, and brought towards each other.

Between arytænoid and capitulum.

A kind of *capsule*, formed of thin scattered fibres, with a *synovial sac*, unites the apex of the arytænoid cartilage with the hollowed base of the capitulum of Santorini. Sometimes these cartilages are blended together.

Between thyroid and arytænoid.

Fibrous bands (thyro-arytænoid) join the *thyroid* with the *arytænoid cartilages:* the two inferior are the upper free lateral edges of the crico-thyroid membrane, and have been already examined as the vocal cords in the interior of the larynx (p. 169).

Two ligaments of epiglottis.

Ligaments of the epiglottis. A band, *thyro-epiglottidean*, connects the lower part of the epiglottis to the posterior surface of the thyroid cartilage, close to the excavation in the upper border of the latter. Some fibrous and elastic tissues—*hyo-epiglottid ligament*, connect likewise the front of the epiglottis to the hyoid bone.

Constituents of trachea.

STRUCTURE OF THE TRACHEA. The air tube consists of a series of pieces of cartilage (segments of rings) (fig. 28), which are connected together by fibrous tissue. The interval between the cartilages at the back of the tube is closed by fibrous membrane, and by muscular fibres and mucous glands. The trachea is lined by mucous membrane with subjacent elastic tissue.

Cartilages. Form.

Cartilages. The pieces of cartilage vary in number from sixteen to twenty. Each forms an incomplete ring, which occupies about three-fourths of a circle; and each is convex forwards, forming the front and sides of the air tube.

Peculiarities.

At the extremities of the trachea, both above and below, the cartilaginous pieces are least constant in size and form; for towards the larynx they increase in depth; whilst in the opposite direction they may be slit at their ends or blended together, and the lowest piece of cartilage is shaped like the letter V.

Fibrous tissue.

A fibrous tissue is continued from one to another on both aspects, though in greatest quantity externally, so as to incase and unite them; and it is extended across the posterior part of the air tube.

Dissection.

Dissection. On removing for about two inches the fibrous membrane and the mucous glands from between the cartilages at the back of the trachea, the muscular fibres will appear.

After the muscular fibres have been examined the membranous part of the tube may be slit down, to see the elastic tissue and the mucous membrane.

Muscular

Muscular fibres. Between the ends of the cartilages is a continuous layer of transverse unstriated muscle (fig. 28, *n*), which is attached to the truncated ends and the inner surface of the cartilages. By the one surface the fleshy fibres are in contact with the membrane and glands, and by the other with the elastic tissue. Some longitudinal fibres are superficial to the transverse; they are arranged in scattered bundles, and are attached to the fibrous tissue. **fibres close trachea behind.**

The *elastic tissue* forms a complete lining to the tracheal tube beneath the mucous membrane; and at the posterior part, where the cartilages are deficient, it is gathered into strong longitudinal folds. This layer is closely connected with the mucous membrane covering it. **Elastic tissue lines trachea.**

The *mucous membrane* of the trachea lines the tube, and resembles that of the larynx in being furnished with a columnar ciliated epithelium. **Mucous membrane, epithelium,**

Connected with this membrane are numerous branched *mucous glands* of variable size. The largest are found at the back of the trachea, in the interval between the cartilages, where some are placed beneath the fibrous membrane with the muscular fibres, and others outside that layer. **and glands.**

Other smaller glands occupy the front and sides of the trachea, being situate on and in the fibrous tissue connecting the cartilaginous rings.

Section XVIII.

PREVERTEBRAL MUSCLES AND VERTEBRAL VESSELS.

Directions. On the part of the spinal column that was laid aside after the separation of the pharynx from it, the student is to learn the deep muscles on the front of the vertebræ. **Deep muscles of spine.**

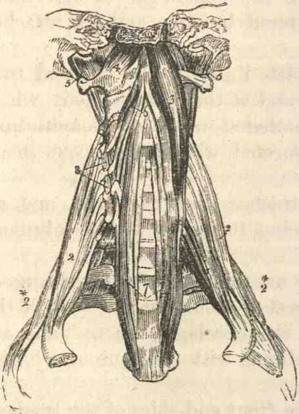
Dissection. The prevertebral muscles will be prepared by removing the fascia and areolar tissue. The muscles are three in number on each side, and are easily distinguished. Nearest the middle line lies the longus colli, which is the longest; the muscle external to this, which reaches to the head, is the rectus capitis anticus major; and the small muscle close to the skull, which is external to the last and partly concealed by it, is the rectus capitis anticus minor. The smaller rectus muscle is often injured in cutting through the basilar process of the occipital bone. **Dissection.**

The LONGUS COLLI MUSCLE (fig. 32, [6] and [7]) is situate on the bodies of the cervical and upper dorsal vertebræ, and is pointed above, but larger below. It consists of two parts—internal and **Longus colli. Origin** external, the former being vertical, and the latter oblique in direction.

by two pieces.

The internal part, 7, *arises* by fleshy and tendinous processes from the bodies of the two upper dorsal, and two lower cervical vertebræ; and the external piece, 6, takes origin from the upper border of the anterior transverse processes of four cervical vertebræ (the sixth, fifth, fourth, and third). Both parts of the muscle are blended above, and the whole is *inserted* by four slips into the lower border of the bodies of the four upper cervical vertebræ. Some of the lowest fibres of the muscle, those which sometimes extend out as far as the head of the first rib, are attached separately by tendon to the anterior transverse process of one or two of the lower cervical vertebræ.

Fig. 32.*



Insertion.

Parts in contact with it.

In contact with the anterior surface of the muscle is the pharynx. The inner border is at some distance inferiorly from the muscle of the opposite side, but superiorly only the pointed anterior common ligament of the vertebræ separates the two. The outer border is contiguous to the scalenus, to the vertebral vessels, and to the rectus capitis anticus major muscle.

Use.

Action. Both muscles bend forwards the neck; and the upper oblique fibres of one will turn the neck and head to the same side.

Rectus capitis major.

Origin.

The RECTUS CAPITIS ANTICUS MAJOR (fig. 32, [3]) is external to the preceding muscle, and is largest at the upper end. Its *origin* is by pointed tendinous slips with the longus colli from the summits of the anterior transverse processes of four cervical vertebræ (sixth, fifth, fourth, and third); and the fibres ascend to be *inserted* into the basilar process of the occipital bone, in front of the foramen magnum.

Insertion.

Connections.

The anterior surface of the muscle is covered by the pharynx, and by the carotid artery and the numerous nerves near the base of the skull. The muscle partly conceals the following one. At

* Prevertebral muscles of the neck and the scaleni muscles—1. Scalenus anticus. 2. Scalenus medius. 2.* Scalenus posticus. 3. Rectus capitis anticus major. 4. Rectus cap. ant. minor. 5. Rectus lateralis. 6 and 7. Longus colli. 8. Intertransverse muscles.

its insertion the rectus is fleshy, and reaches from the middle line to the temporal bone.

Action. Both muscles incline forwards the head; and one will bring the face to the same side by rotating the head. Use.

The RECTUS CAPITIS ANTICUS MINOR (fig. 32, [4]), is a small flat muscle, which *arises* from the anterior transverse process and body of the atlas; and ascending is *inserted* into the basilar process of the occipital bone between the foramen magnum and the preceding muscle, and half an inch from its fellow. Rectus capitis minor is beneath preceding.

The anterior primary branch of the suboccipital nerve lies between the borders of this muscle and the rectus capitis lateralis.

Action. Its power is very slight, but it will help in moving forwards the head. Use.

Dissection. The small intertransversales muscles will come into view when the other muscles have been removed from the front and back of the transverse processes. By tracing towards the spine the anterior primary branches of the cervical nerves the intertransversales will be readily found, for they are placed on the sides of the nerves. Dissection of intertransversales,

After the muscles and nerves have been examined, the tips of the conjoined transverse processes may be cut off to lay bare the vertebral artery.

The INTERTRANSVERSE MUSCLES (fig. 32, [8]) are slender fleshy slips in the intervals between the transverse processes. In the neck there are seven pairs—one for each space. The first pair is between the atlas and axis, whilst the last pair is between the lowest cervical and the first dorsal vertebra. One set is attached to the anterior, and the other to the posterior tubercles on the tips of the conjoined transverse processes. Intertransverse muscles. Number and attachments.

Between the muscles, except in the first two spaces, is the anterior primary branch of a cervical nerve; and beneath the posterior muscle is the other primary branch of the same nerve. In the upper space the posterior muscle is often wanting; and, in the lowest space, the muscle of the anterior set is smaller than the others, or it may be absent. Connections. Peculiarities.

Action. By approximating the transverse processes these muscles bend the spinal column laterally. Use.

Cervical nerves at their exit from the spinal canal. The trunks of the cervical nerves issue from the spinal canal through the intervertebral foramina, with two exceptions, and bifurcate into anterior and posterior branches. Cervical nerves in their foramina give

The *anterior primary branch* passes outwards between the intertransverse muscles, and joins in plexuses (p. 76). anterior

The *posterior primary branch* turns to the back beneath the posterior intertransverse muscle, and the other muscles attached to the posterior transverse processes; in its course it lies close to the bone between the articular processes of the vertebra. and posterior branches.

First two nerves differ

Peculiarities in the first two. The first two nerves leave the spinal canal above the neural arches of the atlas and axis, and divide at the back of the neck into anterior and posterior branches.

in both anterior and

The *anterior primary branch* of the first or suboccipital nerve has been examined (p. 120). The anterior branch of the second nerve, after perforating the membrane between the neural arches of the first and second vertebræ, is directed forwards outside the vertebral artery, and beneath the intertransverse muscle of the first space, to join the cervical plexus.

posterior branches.

The *posterior primary branches* of the first two nerves are described in the dissection of the back.

Vertebral artery in cervical vertebræ.

The *vertebral artery* has been seen at its origin in the neck (p. 74); and its termination will be described with the vessels of the brain. Entering usually the foramen between the transverse processes of the sixth cervical vertebra, the artery ascends vertically through the corresponding foramina of the other vertebræ. After it leaves the aperture in the atlas, the vessel turns backwards on the neural arch of that bone, and passing beneath the ligament joining the first vertebra with the occipital bone, enters the skull through the foramen magnum. In its course through the foramina the artery lies in front of the anterior trunks of the cervical nerves, except those of the first and second,—the former of which crosses on the inner, and the latter on the outer side. The vessel is accompanied by a vein and a plexus of nerves of the same name.

Position to the nerves.

A vein, and nerves are with it.

Branches.

In the neck the artery furnishes small twigs to the surrounding muscles, to the spinal canal, and the spinal cord.

Vertebral vein

The *vertebral vein* begins by small radicles in the occiput, and in the muscles of the back of the neck, and enters the aperture of the atlas, where it receives sometimes a vein from the skull through the posterior condyloid foramen of the occipital bone. Accompanying the artery, the vein traverses the apertures between the transverse processes, and ends in the subclavian vein.

ends in subclavian.

Branches.

In its course it is joined by branches from the internal and external spinal veins; its other branches are described at p. 74.

Plexus of nerves.

The *vertebral plexus of nerves* is derived from the inferior cervical ganglion of the sympathetic (p. 123). It surrounds the artery, and communicates with the spinal nerves as high as the third or fourth.

Section XIX.

LIGAMENTS OF THE VERTEBRÆ AND CLAVICLE.

Directions.

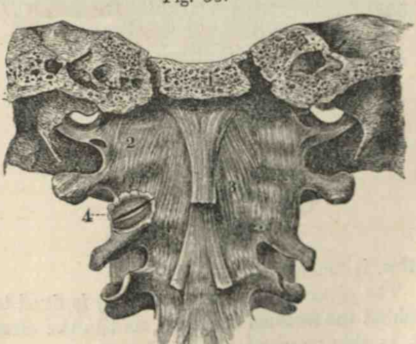
Directions. On the remaining part of the spine, the ligaments connecting the cervical vertebræ to each other and to the occipital bone are to be learnt.

Dissection. *Dissection.* Disarticulate the last cervical from the first dorsal vertebra. Then remove altogether the muscles, vessels, nerves, and areolar tissue and fat from the vertebræ. By sawing through the occipital bone, so as to leave only an osseous ring bounding posteriorly the foramen magnum, the ligaments between the atlas and the occipital bone can be more easily cleaned.

Common ligaments of a vertebra: The COMMON LIGAMENTS attaching together the cervical vertebræ are similar to those uniting the vertebræ in other parts of the spine, viz. an anterior and a posterior common ligament; bands between the laminæ and spines; capsular ligaments and synovial membranes for the articulating processes; and an intervertebral ligament between the bodies of the bones.

these ligaments described elsewhere. *Directions.* The common ligaments will be best learnt on the dorsal or lumbar portion of the spine where they are more fully developed; their preparation and description will be found at the end of the thorax with the dissection of the ligaments of the spine. Should the student examine them in the neck, to see their difference in that region of the spine, he should leave uncut the neural arches of the three highest cervical vertebræ, to which special ligaments are attached.

Fig. 33.*



Special ligaments SPECIAL LIGAMENTS unite the first two cervical vertebræ to each other and to the occipital

* External ligaments in front between the atlas and axis and the occipital bone (Bourgery). 1. Sawn basilar process. 2. Anterior occipito-atloid. 3. Anterior atlo-axoid. 4. Articulation of the articular processes cut open.

bone : some of these are external to, and others within the spinal canal.

between first two vertebræ and occipital bone.

The *ligaments outside the spinal canal* are thin fibrous membranes, which connect the bodies and arches of the first two vertebræ in front and behind; and join the atlas with the occipital bone at the same aspects.

Capsular ligaments surround the articular surfaces of all the bones; but these will be examined more conveniently after the spinal canal has been opened.

Posterior and

Union of the atlas with the axis. The *posterior ligament* (atlo-axoid) (fig. 34, [2]) is a thin loose membrane, which is attached by one margin to the neural arch of the atlas, and by the other to the corresponding arch of the axis. Below the superficial layer are some deeper and stronger fibres. The posterior primary branch of the second nerve pierces it.

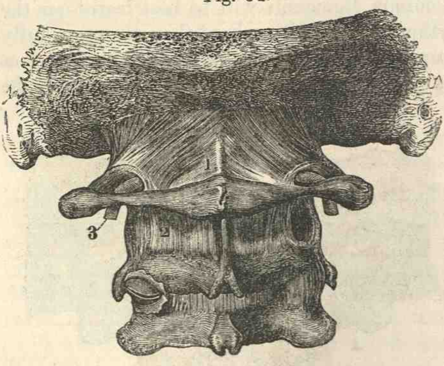
anterior atlo-axoid:

The *anterior ligament* (fig. 33, [3]) unites the bodies of the first two vertebræ in the same manner as the preceding ligament connects their arches. It is thickest in the middle.

and anterior

Union of the atlas with the occipital bone. The *anterior ligament* (occipito atloid) (fig. 33, [2]) is thin and wide, and passes from the basilar process of the occipital bone in front of the foramen magnum to the body of the atlas. The middle part of the ligament, which is fixed to the tubercle on the front of the atlas, is much the thickest.

Fig. 34.*



and posterior occipito-atloid.

The *posterior ligament* (fig. 34, [1]) is fixed to the occipital bone behind the foramen magnum, and to the neural arch of the atlas. It is thin; and at its attachment to the atlas the vertebral artery, and the posterior primary branch of the suboccipital nerve, pass beneath it.

Ligaments internally

The *ligaments inside the spinal canal* are peculiar in form, and

* External ligaments behind between the atlas axis and the occipital bone.—1. Posterior occipito-atloid ligament. 2. Posterior atlo-axoid. 3. Vertebral artery entering beneath the occipito-atloid ligament.

assist in retaining the skull in place during the rotatory and nodding movements of the head. Between the occipital bone and the second vertebra are three strong ligaments—a central, and two lateral or check; and the odontoid process of the axis is fixed against the body of the atlas by a strong transverse band.

between same bones.

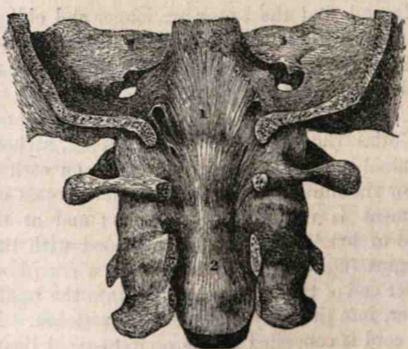
Dissection. Supposing the neural arches of the cervical vertebræ to be removed except from the first three, the arches of these vertebræ are to be sawn through internal to their articular processes. Nextly the ring of the occipital bone bounding posteriorly the foramen magnum is to be taken away. Lastly, the student should detach the tube of dura mater from the interior of the spinal canal; and, on raising from below the upper part of the posterior common ligament of the bodies of the vertebræ, the central ligamentous band between the occipital bone and the axis (occipito-axoid) will come into view.

Dissection of the ligaments.

Union of the occipital bone with the axis. The *central ligament* (occipito-axoidean) (fig. 35, [1]) is a strong, thick band beneath the posterior common ligament of the bodies of the vertebræ, and is rather pyramidal in form with the base uppermost. Above it is attached to the basilar process (on the cranial aspect) near the margin of the foramen magnum, extending as far on each side as the insertion of the check ligaments. From that spot it descends over the odontoid process, and, becoming narrower, is inserted into the body of the axis. Occasionally a bursa is found between the transverse ligament of the atlas and the superficial fibres of the occipito-axoidean ligament which are continued to the second vertebra.

Between skull and axis is a thick central band.

Fig. 35.*



Dissection. After the removal of the occipito-axoidean ligament, by cutting transversely through it above, and reflecting it, the student should define a strong band, the transverse ligament,

Dissection.

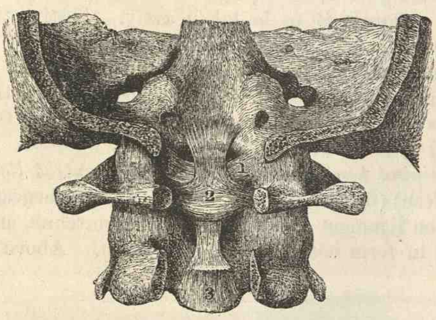
* Internal ligament between occipital bone and axis (Bourgery). 1 and 2. Attachments of the occipito-axoidean ligament.

which crosses the root of the odontoid process, and sends upwards and downwards a slip to the occipital bone and the axis. The upper offset from the transverse ligament may be cut through afterwards for the purpose of seeing the check ligaments which diverge, one on each side, from the odontoid process, and come from beneath the ascending band of the transverse ligament.

And two lateral or check ligaments.

The lateral *odontoid* or *check ligaments* (fig. 36, [1]) are two strong bundles of fibres. Each is attached by one end to the side of the head of the odontoid process, and by the other to a depression on the inner surface of the condyle of the occipital bone. These ligaments are covered by the occipito-axoidean band; their upper fibres are short and almost horizontal, and the lower are longer and oblique.

Fig. 36.*



With a central band.

Between the lateral bands is a central *odontoid ligament*, which connects the tip of the odontoid process to the margin of the basilar process of the occipital bone.

To fix odontoid process there is a transverse ligament, named cruciform,

Union of the atlas with the axis. The *transverse ligament* of the atlas (fig. 36, [2]), is a flat, strong, arched band behind the odontoid process, which is attached on each side to a tubercle below the inner part of the articular process of the atlas. This ligament is widest in the centre; and at this spot it has a band of longitudinal fibres connected with the upper and lower margins (fig. 36), so as to produce a *cruciform* appearance: the upper end of the band is inserted into the basilar process, and the lower, into the body of the second vertebra. Its surface towards the cord is concealed by the occipito-axoid ligament.

This ligament fixes the odontoid process of the second vertebra against the body of the atlas, confining it in a ring (fig. 37).

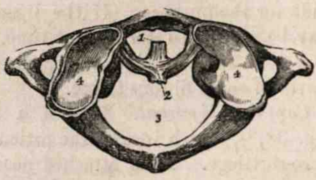
articular surfaces,

When the transverse and check ligaments have been cut through, the tip of the odontoid process will be seen to have two cartilaginous surfaces; one in front where it touches the atlas,

* Internal ligaments between the occipital bone and the atlas and axis (Bourgery). 1. The left check ligament. 2. The transverse ligament, sending offsets upwards and downwards. 3. Cut end of the occipito-axoidean ligament.

the other at the opposite aspect, where it is in contact with the transverse ligament. Two *synovial membranes* facilitate the movements of the odontoid process, one being for the joint between this bony piece and the atlas; and the other for the joint between it and the transverse ligament. and two synovial membranes.

Fig. 37.*



Union of the articular surfaces. The articular surfaces of the occipital bone and atlas are surrounded by a capsular ligament of scattered fibres, which is strongest externally and in front. When the joint is opened, the condyle of the occipital bone will be seen to look somewhat outwards, and the hollowed surface of the atlas inwards. A *synovial membrane* is present on each side. Capsule and synovial sac to articular surfaces.

The articular surfaces of the first two vertebræ are enclosed on each side by a capsule (fig. 34, [4]), which is stronger in front than behind. On opening the joint the surfaces of the bones may be perceived to be almost horizontal. On each side there is a separate loose *synovial membrane*.

Movements of the head. The head can be moved forwards and backwards, from side to side—rotation, and towards the shoulder. Movements, kind of.

Nodding takes place in the joints between the atlas and occipital bone, the condyles gliding forwards and backwards. When the head is bowed more freely flexion of the cervical vertebræ comes into play. To and fro.

Rotation is permitted by the several joints between the atlas and axis. The axis is fixed, and the atlas, bound to it by the transverse ligament, moves to the right and the left, carrying the weight of the head. Too great a movement of the face to the side is checked by the odontoid ligament. Only part of the whole rotatory movement to one side is obtained between the atlas and axis, the rest being made up by the neck. Rotation.

Approximation of the head to the shoulder is effected by the neck movement: perhaps a very slight degree of it may be due to gliding downwards of the occipital condyle of the same side on the articular surface of the atlas. Head laterally.

Sterno-clavicular Articulation. The articular surfaces are somewhat irregular and adapted to each other, with an intermediate fibro-cartilage; and they are retained in contact by a Joint at sternal end of clavicle.

* First vertebra with the odontoid process removed from the socket formed by the bone and the transverse ligament. 1. Socket for the odontoid process. 2. Transverse ligament with its offsets cut. 3. Neural ring of the atlas.

capsular ligament; by a band to the first rib; and by another band between the ends of the clavicles.

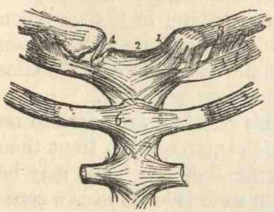
Dissection.

Dissection. For the examination of the ligaments of the sterno-clavicular articulation, take the piece of the sternum that was set aside for the purpose. If the ligaments have become dry, they may be moistened for a short time. The several ligaments will appear in the situation indicated by their names, after the removal of some fibrous tissue.

Capsular ligament.

Capsular ligament. This is a thin membranous expansion (fig. 38, [1]), which incases the articular ends of the bones and the fibro-cartilage. It is attached near the articular surface of each bone, and is thinner before than behind. Sometimes the stronger fibres in front and at the back are described as separate ligaments.

Fig. 38.*



Interclavicular,

The *interclavicular ligament* (fig. 38, [2]) extends above the sternum, between the ends of the clavicles. The fibres do not cross in a straight line, but dip into the hollow between the clavicular bones, and are connected with the upper part of the sternum.

and costo-clavicular ligament.

The *costo-clavicular ligament* (fig. 38, [3]), is a short strong band of oblique fibres between the first rib and the clavicle. Inferiorly it is fixed to the upper surface of the cartilage of the first rib, and superiorly to a tubercle on the under surface of the clavicle near the sternal end. The subclavius muscle is in front of the ligament.

Sometimes the clavicle touches the rib, and is provided with an articular surface and a synovial membrane.

Fibro-cartilage.

The *interarticular fibro-cartilage* (fig. 38, [4]) will come into view by cutting the ligaments before described, and raising the clavicle. It is ovalish in form and flattened, but is thicker at the circumference than the centre. By its upper margin and surface the cartilage is united to the head of the clavicle which is imbedded in it; and by the opposite surface and margin it is inserted into the cartilage of the first rib. At its circumference it unites with the capsule of the joint. Sometimes there is an aperture in the centre of the fibro-cartilage.

Two synovial membranes.

Two *synovial membranes* are present in the articulation, one on each side of the fibro-cartilage. The sac in contact with the sternum is looser than that touching the clavicle.

* Ligaments of the inner end of the clavicle. 1. Capsule. 2. Interclavicular ligament. 3. Costo-clavicular ligament. 4. Interarticular fibro-cartilage. 6. Ligaments of the second rib with the sternum.

Movement. The inner end of the clavicle can be moved up and down, and forwards and backwards, and the direction it takes is the opposite to that of the shoulder: thus when the limb is depressed the sternal end of the clavicle is raised; and so on in the other movements. The extent of each movement is but limited, though those forwards and upwards are the freest; and in spite of the increased security derived from the fibro-cartilage, dislocation may ensue in any direction except downwards from force applied to the limb. **Motion, four ways;**

When the upper limb is swung round there is a restricted movement of circumduction with the head of the clavicle. **in a circle.**

CHAPTER II.

DISSECTION OF THE BRAIN.

Section I.

MEMBRANES AND VESSELS.

Position of the brain.

During the examination of the membranes, the vessels, and the nerves, the brain is to be placed upside down, resting in the coil of a cloth which supports it evenly.

Three meninges.

Membranes of the Brain. The coverings of the brain (meninges) are three in number, viz. dura mater, pia mater, and arachnoid membrane. The dura mater is a firm and fibrous investment, which supports parts of the brain, and serves as an endosteum to the bones. The pia mater is the most internal layer, and is very vascular. And the arachnoid is a thin serous sac, which is situate between the other two.

Dura mater.

Besides enveloping the brain, these membranes are prolonged on the cord into the spinal canal. Only the cranial part of the two last will be now noticed. For the description of the cranial part of the dura mater, see p. 9.

Arachnoid membrane.

The arachnoid is a thin serous membrane, which lines the inner surface of the dura mater, and is reflected over the pia mater and the brain. Around the vessels and nerves that intervene between the skull and the brain, the membrane forms sheaths, which extend a short distance into the several apertures, and then become continuous with the parietal or cranial portion. Like other serous membranes, it forms a sac which contains a lubricating moisture; and it consists of a parietal and a visceral part.

Parietal part.

The *parietal* part is inseparably united to the inner surface of the dura mater, giving this a smooth and polished surface, and is continued in the same manner over the pieces of the fibrous membrane projecting between portions of the brain.

Visceral part is not close to brain,

The *visceral* part covers the encephalon loosely, especially at the under surface of the brain, but is united to the underlying pia mater by fibrous processes; beneath it there is a considerable interval (subarachnoid space).

When traced over the brain, the following is its disposition. On the upper or convex surface of the cerebrum the membrane passes from one convolution to another, without dipping into the intervening sulci; though it lines the great median fissure as low as the extent of the falx. On the lower surface of the cerebrum the arachnoid covers the anterior lobes, and sinks into the median fissure: but farther back there is a large space between it and the brain. Still more posteriorly the serous membrane is closely connected to the pons and the inferior surface of the cerebellum; but between the hemispheres of the little brain there is an interval beneath it, similar to that at the under part of the cerebrum.

hollow beneath varies at spots;

The *subarachnoid space*, or the interval between the arachnoid membrane and the pia mater, is larger in one spot than another; and it contains more or less fluid, which has been named *cerebro-spinal*. The space is largest at the under part of the great brain about its middle, and in the fissure between the hemispheres of both the cerebrum and the cerebellum. If the arachnoid covering is removed from the fissure between the halves of the cerebellum, the aperture of the fourth ventricle will be perceived, by which the cavity in the interior of the brain communicates with the subserous space.

it is the subarachnoid space, which opens into brain.

The PIA MATER closely invests the different parts of the brain, and dips into the fissures, as well as into the sulci between the surface convolutions and laminæ. Besides covering the exterior of the brain, it sends processes into the interior to supply vessels to the walls of the enclosed space: thus, one penetrates into the cerebrum below the corpus callosum, and is named velum interpositum; and two vascular fringes, which project into the fourth ventricle, are known as the choroid plexuses of that cavity.

Pia mater sends pieces into the brain:

This membrane is a net-work of vessels, and is constructed of the minute ramifications of the arteries and veins entering into or issuing from the cerebral substance; whilst the intervals between the vessels are closed by fine areolar tissue, so as to form a continuous thin layer. From the under surface of the membrane proceed numerous fine vessels for the nutrition of the brain.

it is a net-work of blood-vessels,

Vessels and nerves. The arachnoid membrane has but few vessels, whilst the pia mater is composed almost entirely of vessels. The pia mater is largely supplied by offsets of some cranial nerves, and by branches of the sympathetic which accompany the vessels at the base of the brain (p. 122). Bochdalek has described branches to the arachnoid from some cranial nerves.

Vessels and nerves of membranes.

Dissection. To follow out the arteries, let the brain remain upside down, and let the remains of any arachnoid membrane be removed. Having displayed the trunks of the vertebral and carotid arteries, the student should then lay bare on one side the

Dissection of vessels

of large brain; branches to the large brain. Define first the two arteries lying in the median fissure and joining by a short branch; next, an artery that passes outwards transversely between the frontal and temporo-sphenoidal lobes, and pursue it to the outer surface of the hemisphere. Look then for a much smaller vessel (choroid) which enters into the brain substance on the outer side of the crus cerebri. By gently raising the cerebellum of the same side, the last artery of the cerebrum may be traced back along the inner aspect of the hemisphere.

of small brain. Two arteries pass out to the small brain. One on the upper surface may be brought into view on raising the cerebellum; and in dissecting it the student is to be careful of the slender fourth nerve which lies by its side. The other artery turns inwards to the median hollow on the surface of the cerebellum now uppermost, and may be easily pursued.

Subdivisions of the encephalon. Before entering on the description of the arteries, the chief subdivisions of the encephalon will be shortly noticed.

Outline of cranial mass. The cranial or encephalic mass of the nervous system consists of cerebrum or great brain, cerebellum or small brain, pons, and medulla oblongata. Each of these parts has the following situation and subdivisions:—

Upper part of spinal cord. The medulla oblongata, or the upper end of the spinal cord, lies in the groove between the halves of the small brain, and is divided into two symmetrical parts by a median fissure. To it several of the cranial nerves are united.

Pons Varolii and its crura. The pons Varolii is situate in front of the medulla oblongata, and is marked along the middle by a groove, which indicates its separation into halves. Anterior to it are two large processes (crura cerebri) passing to the great brain; on each side it is united to the small brain by a similar white mass (crus cerebelli); and behind it is the enlarged upper part of the cord.

Cerebellum. The cerebellum, or the small brain, is separated into two by a median fissure, and each half will be subsequently seen to consist of lobes.

Cerebrum and its great divisions. The cerebrum, or the large brain, is divided into hemispheres by a longitudinal fissure in the middle line; and each half is further subdivided into two by a transverse sulcus,—the fissure of Sylvius. In the centre of the cerebrum, between the hemispheres and in front of the pons, are several small bodies that will be afterwards enumerated.

Arteries of the brain. ARTERIES OF THE BRAIN. The brain is supplied with blood by the vertebral and internal carotid arteries.

Vertebral ends in basilar, The VERTEBRAL ARTERY is a branch of the subclavian trunk (p. 74), and enters the spinal canal beneath the ligament uniting the atlas and occipital bone. Ascending to the brain, the artery enters the skull through the foramen magnum; and being directed upwards round the medulla oblongata, blends with its fellow in a common trunk (basilar) at the lower border of the pons. As the vessel winds round the upper part of the cord, it lies between the roots of the suboccipital and hypoglossal nerves; but it is afterwards internal to the last. **winds round medulla.**

Branches. Between its entrance into the spinal canal and its termination, each artery furnishes offsets to the spinal cord, the dura mater, and the cerebellum. **Branches**

The *posterior spinal branch* is of inconsiderable size, and arises opposite the posterior part of the medulla: it descends along the side of the cord, behind the nerves, and anastomoses with its fellow, and with branches that enter by the intervertebral foramina. **to spinal cord, anterior and**

The *anterior spinal branch* is small like the preceding, and springs from the artery opposite the front of the spinal cord. It joins the corresponding twig of the opposite side, and the resulting vessel is continued along the middle of the cord on the anterior aspect. **posterior;**

The *posterior meningeal artery* leaves the vertebral trunk opposite the foramen magnum, and ramifies in the dura mater lining the fossæ of the occipital bone. **to dura mater.**

The *inferior cerebellar artery* (posterior) is distributed to the under surface of the cerebellum. Taking origin from the end of the vertebral, or from the basilar artery, this branch winds backwards round the side of the medulla between the pneumo-gastric and spinal accessory nerves, and enters the median fissure of the cerebellum. Directed onwards along the fissure the artery reaches the upper surface of the small brain, and there anastomoses with the superior cerebellar artery. **Branch to the under part of cerebellum.**

An offset of this branch ramifies over the under part of the cerebellum, and ends externally by anastomosing with the artery of the upper surface. As the vessel lies by the side of the aperture of the fourth ventricle it gives a small *choroid* offset to the plexus of that cavity. **Offsets.**

The BASILAR ARTERY, formed by the union of the two vertebrals, reaches from the lower to the upper border of the pons; and it ends at the last spot by dividing into two branches (posterior cerebral) for the cerebrum. The vessel touches the basilar process of the occipital bone, from that circumstance receiving its name, and lies in the median groove of the pons. On each side of, and almost parallel to it is the sixth nerve. **Basilar artery. Extent and situation.**

Branches. Besides the two terminal branches mentioned above, the artery supplies transverse offsets to the pons and the under part of the cerebellum, and a large branch to the upper surface of the cerebellum. **Branches:**

The *transverse arteries* of the pons are four or six small twigs, which are named from their direction, and are distributed to the **transverse to the pons,** substance of the pons. One of them gives an offset to the internal ear along the auditory nerve.

and inferior cerebellar.

Resembling this set of branches is the following artery, the *inferior cerebellar* (anterior): this arises from the basilar trunk, and is directed outwards to the fore part of the under surface of the cerebellum, on which it is distributed.

Superior cerebellar.

The *superior cerebellar artery* is derived from the basilar so near the termination that it is often described as one of the final branches of that vessel. Its destination is to the upper surface of the cerebellum, to which it is directed backwards over the third nerve and the crus cerebri, but parallel with the fourth nerve. On the upper surface of the cerebellum the artery spreads out in branches, and its ramifications anastomose with the vessel of the opposite side, and the inferior cerebellar artery.

Offsets.

Some twigs of this vessel enter the piece of the pia mater (velum interpositum), which projects into the posterior part of the cerebrum.

Posterior cerebral artery;

The *posterior cerebral artery* takes on each side a backward course, similar to that of the preceding artery, but separated from it by the third nerve. The vessel is then inclined to the inner side of the posterior part of the cerebrum, and divides into many branches. Some of these supply the under part, whilst others turn upwards on both the outer and inner surfaces of the back of the hemisphere, and anastomose with the other cerebral arteries.

Branches

Near its origin it is joined by the posterior communicating artery of the carotid; and its branches to the brain are the following:—

to base of brain,

Numerous small long branches leave it close to its origin, and enter the base of the brain between the crura cerebri (posterior perforated spot).

choroid branch.

A small *choroid* artery supplies the fold of pia mater that projects into the cerebrum: this small branch is transmitted between the crus and the hemisphere of the cerebrum to the velum interpositum and the choroid plexus.

Part of brain supplied by vertebral arteries.

From the foregoing examination of the offsets of the vertebral arteries and the basilar trunk, it appears that about half the encephalon—viz. the medulla oblongata, the pons, the cerebellum, and the posterior third of the cerebrum—receives its blood through the branches of the subclavian arteries.

Internal carotid

The INTERNAL CAROTID ARTERY terminates in branches for the remaining part of the cerebrum. Having passed through the space of the cavernous sinus (p. 19), the vessel emerges on the inner side of the anterior clinoid process, and divides at the

ends in cerebral arteries.

inner end of the fissure of Sylvius into cerebral and communicating arteries. At the base of the brain the carotid artery lies between the second and third nerves, but nearest the former.

Branches. In the skull the carotid gives off the ophthalmic offset, before it ceases in the following terminal branches to the cerebrum. Branches.

The *anterior cerebral artery* supplies the inner part of the cerebral hemisphere. The vessel of each side is directed forwards to the median fissure between the halves of the large brain; and as the two are about to enter it, they are united by a short thick artery, the *anterior communicating*. Each artery then passing into the fissure, bends round the anterior part of the corpus callosum, so as to be placed on the upper aspect in the natural position of the brain, and is continued backwards distributing offsets nearly to the posterior extremity of the hemisphere. Anterior cerebral and communicating artery;

The vessel gives off numerous *branches*, and some of them supply the base of the cerebrum, thus:— its offsets

Near the commencement it furnishes small branches to the part of the brain (anterior perforated spot) contiguous to the inner end of the fissure of Sylvius: and it distributes some branches to the under part of the frontal lobe. to base of brain.

The *middle cerebral artery* is the largest offset of the internal carotid, and ramifies over the outer side of the hemisphere. Entering the fissure of Sylvius, the artery divides into many large branches, which issue at the outer end of that groove; and spreading over the external surface of the hemisphere, inosculate with the other two cerebral arteries at the front, the back, and the upper part of the brain. Only a few fine *offsets* require special notice: Middle cerebral artery ends in outer part of hemisphere.

A set of small branches arise at the inner end of the fissure of Sylvius, and enter the cerebral substance through the part called substantia perforata antica. Offsets.

The *posterior communicating artery* is a small twig, which is directed backwards parallel to, and on the inner side of the third nerve, to join the posterior cerebral artery (of the basilar) near the pons. Posterior communicating.

The *choroid artery* (anterior) is small in size, and arises either from the trunk of the carotid, or from the middle cerebral artery. It passes backwards on the outer side of the preceding, and finds its way between the hemisphere and the crus cerebri to the choroid plexus of the lateral ventricle. Choroid artery.

Circle of Willis. The arteries at the under part or base of the brain are united freely both on their own side and across the middle line, and give rise to an arterial anastomosis,—the circle of Willis. On each side this circle is formed by the trunk of the internal carotid giving forwards the anterior cerebral, and backwards the posterior communicating artery. In front it is constructed by the converging anterior cerebral, and the anterior communicating artery. And behind is placed the bifurcation of the basilar trunk into the posterior cerebrals. In the area of the Circle of Willis: vessels that take a share in it, circle lie several parts of the brain corresponding with the floor of the third ventricle.

and the free inosculation between them.

The complete inosculation between the cranial vessels in the circle of Willis allows at all times a free circulation of blood through the brain, even though a large vessel on one side should be obstructed.

Veins of the brain.

The VEINS of the brain enter the sinuses of the dura mater, instead of uniting into trunks as companions to the arteries.

Two sets to cerebrum,

Two sets of veins belong to the *cerebrum*, viz. superficial or external, and deep or internal.

external and

The external veins of the upper surface are collected into the superior longitudinal sinus (p. 10); and those of the lateral and under parts enter the sinuses in the base of the skull, especially the lateral sinus.

internal.

The deep veins of the interior of the cerebrum join the veins of Galen, and reach the straight sinus.

External to cerebellum.

The veins of the *cerebellum* end differently above and below. On the upper surface they are received by the veins of Galen and the straight sinus; and on the lower surface they terminate in the occipital and lateral sinuses.

Dissection.

Dissection. The pia mater and the vessels are now to be stripped from the brain, and the origin of the cranial nerves is to be defined. Over the greater part of the cerebrum, the pons, and the medulla, the pia mater can be detached with tolerable facility by using two pairs of forceps; but on the cerebellum the membrane adheres so closely as to require some care in removing it without tearing the substance of the brain.

Care to be taken in removing pia mater.

In clearing out the fissure between the halves of the cerebellum on the under surface, the membrane bounding on each side the opening of the fourth ventricle will probably be taken away: the student should therefore observe now the position, size, and limits of that opening between the back of the medulla oblongata and the inferior vermiform process.

When the surface has been cleaned, the brain is to be replaced in the spirit till it is hardened.

Section II.

ORIGIN OF THE CRANIAL NERVES.

Origin

The cranial nerves take origin from the encephalon, with one exception (spinal accessory), and pass from it through apertures in the skull.

is apparent and real.

The origin of a nerve is not determined by the place at which it appears on the surface of the brain, for fibres or roots may be traced deeply into the nervous substance. Each nerve has therefore a superficial or apparent, and a deep or real origin in the encephalon.

With respect to the superficial attachment to the brain there cannot be any doubt; but there is much difference of opinion concerning the deep origin, in consequence of the difficulty of tracing the roots. When the roots are followed into the encephalon, they enter masses of gray substance, which are looked upon as ganglia of origin.

Real enters gray matter.

The cranial nerves may be regarded either as nine or twelve pairs, according to the mode of classifying them.*

Classification as nine or twelve pairs.

The several nerves may be designated first, second, third, and so forth: this numerical mode of naming applies to all, and is the one generally used.

Designation from number,

But a second name has been derived for some of the nerves from the parts to which they are supplied; as instances of this nomenclature the terms hypo-glossal, pneumo-gastric, may be taken. And a different appellation is given to others, in consequence of the function conferred on the part to which they are distributed, as the terms auditory and olfactory express. In this way two names may be employed in referring to a nerve:—one being numerical, the other local or functional, as is exemplified below.

name of part, or function.

The FIRST OR OLFACTORY NERVE (olfactory process) (fig. 44, [1]) is soft and pulpy, being destitute of a neurilemma; and it may be considered an advanced part of the brain, for it has both gray substance and white fibres in its composition, like the cerebrum.

Olfactory nerve

The olfactory process is a flat-looking band, wider at each end than in the middle, which is lodged in a sulcus on the under aspect of the frontal lobe of the cerebrum, and is kept in position by the reflection of the arachnoid membrane over it. When the so-called nerve is raised from the sulcus, it is seen to be prismatic in form, the apex of the prism being directed downwards (in this position).

lies on frontal lobe,

Anteriorly the nervous substance swells into the *olfactory bulb*,—a pyriform grayish mass, about half an inch in length, which rests on the ethmoid bone, and distributes nerves to the nose.

forms olfactory bulb,

* Those anatomists, who take the smaller number after the example of Willis, include in one nerve all the trunks contained in the same aperture of the skull: as in the case of the eighth nerve, which consists of three trunks in the foramen jugulare. But those who are disposed with Sömmering to enumerate twelve nerves, consider each of the three trunks of the eighth nerve before mentioned, and in like manner all the other trunks issuing from the encephalon, to constitute a separate cranial nerve, notwithstanding that it may be combined with others in the foramen of exit.

Posteriorly the olfactory process is connected to the cerebrum by three roots of origin, external, internal, and middle.

has external

The *external* or *long root* is a slender white band, which is directed backwards along the outer part of the anterior perforated space, and across the fissure of Sylvius, and sinks into the substance of the cerebrum.

internal and

The *internal* or *short root*, not always visible, is white and delicate, and comes from the inner part of the cerebrum.

middle root.

The *middle* or *gray root* is connected with the gray matter on the surface of the brain by means of a conical elevation at the back of the sulcus which lodges the nerve.

Origin.

Deep origin. The external root is said to be traceable to one of the convolutions of the island of Reil. The inner root joins a band of white fibres connected with a convolution (gyrus fornicatus) to be afterwards examined. And the middle root, continuous with the gray matter of the convolutions, contains white fibres which enter the corpus striatum.

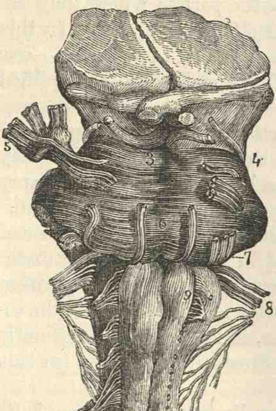
Optic nerve,

The SECOND OR OPTIC (fig. 44, [2]) is the largest of the cranial nerves, except the fifth, and appears as a flat band on the crus cerebri. Anteriorly the nerves of opposite sides are united in a commissure. The part of the nerve posterior to the commissure is named optic *tract;* but the part beyond the commissural union, which is round and firm, is called optic *nerve.* The destination of the nerve is to the eyeball.

part called tract,

part nerve.

Fig. 39.*



Origin from cerebrum.

The *origin* of the nerve will be afterwards seen to come from two of the corpora quadrigemina (nates and testis of one side), and from the optic thalamus and the corpora geniculata.

Tract of the nerve.

The *tract, u,* is the flattened part of the optic winding round the peduncle of the cerebrum. In front it ends in the commissure, and behind it splits into two pieces by which it is fixed to the brain. As the tract reaches forwards it crosses the crus cerebri, to which it is attached

* The superficial attachment of several of the cranial nerves. 1. Spinal nerves. 2. Optic nerve. 3. Third nerve. 4. Fourth nerve. 5. Fifth nerve. 6. Sixth nerve. 7. Seventh nerve. 8. Eighth nerve. 9. Ninth nerve.

by its outer or anterior edge; and in front of the crus it is placed between the substantia perforata antica on the outside, and the tuber cinereum on the inside, but whether it receives filaments from the latter is uncertain.

Its commissure. The *commissure* (chiasma) of the nerves, *c*, measures half an inch across, and lies on the olivary eminence of the sphenoid bone, within the circle of Willis. Situation. It is placed in front of the tuber cinereum; and passing beneath it (in this position of the brain) is the thin lamina cinerea.

Arrangement of fibres. In the commissure each tract is resolved into three sets of fibres with the following arrangement:—The outer fibres, few in number, are continued straight to the eyeball of the same side. The middle, the largest, decussate with the corresponding bundle of the other tract,—those of the right nerve being continued to the left side, so as to enter the opposite eye, and *vice versâ*. And the most internal are continued through the tract of the other side back to the brain without entering the eye. At the front of the commissure are placed some transverse fibres which are prolonged to the eyeballs through the part of each nerve in front of the commissure, but have not any connection with the tracts and the brain.

Trunk of nerve. The part called nerve extends from the commissure to the eyeball. Leaving the skull by the optic foramen, it receives a tube of dura mater, and its course in the orbit has been already seen (p. 49). In the eyeball it ends in the retina.

Origin of third nerve. The THIRD NERVE (fig. 44, [3]), motor nerve of the eyeball, is round and firm, and is attached by a slanting line of separate threads to the inner surface of the cerebral peduncle, near the locus perforatus, and close in front of the pons Varolii.

deep in crus cerebri. *Deep origin.* The deep origin is uncertain. According to Stilling,* the fibres of the nerve pierce the peduncle, passing through the locus niger, and enter a mass of gray substance in the floor of the aqueduct of Sylvius.

Origin of fourth nerve from cerebellum, The FOURTH OR TROCHLEAR NERVE (fig. 44, [4]) cannot be followed backwards at present to its origin. It is the smallest of the cranial nerves, and issues from the valve of Vieussens over the fourth ventricle. The nerve appears between the cerebrum and the cerebellum, on the side of the crus cerebri (fig. 44, [4]); and is then directed forwards to enter an aperture in the free edge of the tentorium cerebelli near the posterior clinoid process.

and Sylvian aqueduct. *Deep origin.* In entering the valve of Vieussens, the nerves of opposite sides cross. Each then divides into two parts: the anterior enters a nucleus of gray matter on the side of the aqueduct of Sylvius; the posterior joins a nucleus (upper trigeminal) near the top of the fourth ventricle (Stilling).

* *Untersuchungen über den Bau des Hirnknotens.*

Fifth nerve has two roots.

The FIFTH OR TRIGEMINAL is the largest of all the cranial nerves, and consists of two parts, large and small. It resembles a spinal nerve in possessing two roots, ganglionic or sensory, and aganglionic or motor, which are partly blended in one trunk beyond the ganglion.

Origin from pons,

The nerve is attached to the side of the pons Varolii, nearer the upper than the lower border (fig. 39, [5]). The small or aganglionic root is highest, and is separated from the other by two or three of the transverse fibres of the pons. Both roots pass outwards through an aperture in the dura mater, above the petrous part of the temporal bone, and are blended in the peculiar manner stated in page 18.

in floor of fourth ventricle;

Both roots penetrate the fibres of the pons, and are connected with nuclei in the floor of the fourth ventricle.

beginning of the large root,

Deep origin. The *large root* divides into two parts near the mass of gray matter called locus cæruleus (p. 244). One piece bends downwards to the restiform body. The other, which is smaller, arises from the locus cæruleus, and from the gray matter near it (upper trigeminal nucleus) with the lower part of the trochlear nerve; from the gray substance in the floor of the fourth ventricle, near the hypoglossal nucleus; and from a deeper nucleus, *lower trigeminal*, opposite the lower border of the pons, within the fasciculus teres (Stilling).

and of small.

The *small root* begins with the fourth nerve in the *upper trigeminal* nucleus near the top of the fourth ventricle (Stilling).

Origin of sixth nerve,

The SIXTH NERVE (fig. 39, [6]), abducent nerve of the eyeball, springs from the pyramidal body close to the pons, and by a second band from the lower part of the pons.

from fourth ventricle.

Deep origin. The fibres of the nerve bend backwards, through the medulla oblongata, to a nucleus in the floor of the fourth ventricle, whose position is on the outer part of the fasciculus teres, and behind the anterior fossa. See Anatomy of the Fourth Ventricle (p. 245).

Seventh nerve has two parts.

The SEVENTH CRANIAL NERVE (Willis) (fig. 39, [7]) appears at the lower border of the pons near the restiform body. It consists of two distinct trunks, facial and auditory; the former being the motor nerve of the face, and the latter the special nerve for the organ of hearing.

Origin of the facial.

The *facial nerve* (portio dura, seventh nerve, Sömmerring) (fig. 44, [7]) is firm and round, and smaller than the auditory, internal to which it is placed. It issues from the lateral tract of the medulla at the upper part, and is connected by a slip with the lower border of the pons.

Small accessory piece.

The facial nerve receives a small accessory band of fibres (intermediate portion of Wrisberg) from the same part of the medulla, and enters the internal meatus with the auditory trunk.

Auditory nerve.

The *auditory nerve* (portio mollis, eighth nerve, Sömmerring) (fig. 44, [7′]) has a surface attachment to the floor of the fourth ventricle and the restiform body. The nerve is very soft, and receives one of its names from that fact.

Deep origin. The *facial nerve* penetrates to the floor of the fourth ventricle, and arises from the same nucleus as the sixth nerve, which it joins (Clarke*). Deep origin of facial;

The fasciculus of the root of the *auditory nerve* which reaches the floor of the fourth ventricle, bends backwards over the restiform body to the auditory nucleus; and some arciform fibres out of the median sulcus are joined with this part of the root. The other fasciculus pierces the restiform body, and takes origin from a network connected with the outer part of the posterior pyramid (Clarke). of auditory.

The EIGHTH CRANIAL NERVE (Willis) (fig. 39, [8]) is placed along the side of the medulla oblongata, and consists of three distinct trunks, glosso-pharyngeal, pneumo-gastric, and spinal accessory: the names of the first two indicate their destination; and the last, besides being accessory to the pneumo-gastric, supplies some muscles. Eighth nerve has three parts.

The *glosso-pharyngeal nerve* (ninth nerve, Sömmerring) (fig. 39, [8]) is the smallest of the three, and is situate highest. Its apparent origin is by three or more fibrils, which penetrate the lateral tract of the medulla close to the facial nerve. Origin of glosso-pharyngeal,

The *pneumo-gastric* or *vagus* (tenth nerve, Sömmerring) (fig. 44, [8']) is connected with the lateral tract of the medulla, below the glosso-pharyngeal nerve, by a series of filaments, which are collected at first into bundles, but are finally gathered into one flat band. vagus,

The *spinal accessory nerve* (eleventh nerve, Sömmerring) (fig. 44, [8'']) consist of two parts—accessory to the vagus, and spinal. spinal accessory has two parts,

The *accessory* part is of small size, and arises by fine filaments in a line with the root of the vagus, as low as the first cervical nerve. Finally this fasciculus throws itself into the pneumo-gastric nerve outside the skull. (See p. 119.) accessory,

The *spinal* part is firm and round, like the third or the sixth nerve, but only a small piece of it can be seen. It arises by a number of fine filaments from the lateral column of the spinal cord, as low as the sixth cervical nerve; the lowest roots are fixed near the lateral fissure and the posterior roots of the nerves, but the highest are attached irregularly and at a distance from the fissure. As the nerve ascends along the side of the cord it lies between the ligamentum denticulatum and the posterior roots of the spinal nerves, with the upper of which it may be sometimes connected; and it finally enters the skull by the foramen magnum. spinal:

All three nerves converge to a spot below the crus cerebelli, where they rest on a small lobe of the cerebellum (flocculus). From that spot they are directed outwards to the foramen jugulare (p. 19). all converge in the skull.

* On the structure of the Medulla Oblongata, by J. Lockhart Clarke, F.R.S., in the Philosophical Transactions for 1858, part i.

The fibrils of the nerves pierce the medulla; and each nerve, except the spinal part of the last, takes origin from a special deposit of gray matter at the back of the medulla oblongata, and near the lower angle of the fourth ventricle. (See p. 245.)

Deep origin of glosso-pharyngeal; *Deep origin.* The *glosso-pharyngeal* penetrates as far as the vagus nucleus, where it ends in fibres: some of these enter that deposit; others join the auditory nucleus; and the rest are directed inwards towards the *raphé*, which they are supposed to join.

of the vagus; The *vagus nerve* arises in a special nucleus; but some fibres are directed inwards through a part of the hypoglossal nucleus, and mingle with fibres of the hypoglossal nerve.

of accessory The *accessory part* of the *spinal accessory nerve* is transmitted to a special nucleus below that of the vagus; but some fibres are directed forwards and inwards in front of the hypoglossal nucleus to decussate across the middle line with their fellows.

and spinal. The roots of the *spinal part* of the nerve, piercing the lateral column of the cord, pass through a collection of cells on the outer border of the gray crescent in the interior (a continuation upwards of the tractus intermedio-lateralis) in their course to the anterior cornu of the crescent (Clarke).

Ninth nerve. The NINTH or HYPOGLOSSAL NERVE of Willis (twelfth nerve, Sömmerring) (fig. 39, [9]) is placed on the front of the medulla oblongata, and arises by a series of filaments from the sulcus between the pyramidal and olivary bodies, in a line with the anterior roots of the spinal nerves.

Origin from medulla. The filaments of origin unite into two bundles, which pierce separately the dura mater, and do not blend together till they are outside the cranial aperture.

Deep origin near fourth ventricle. *Deep origin.* The filaments of the nerve can be traced through the corpus olivare to a nucleus below the level of the fourth ventricle and in front of the canal of the cord; but some join the nucleus of the accessory nerve, and others bend inwards to decussate through the *raphé* with the nerve of the opposite side (Clarke).

Section III.

MEDULLA OBLONGATA AND PONS VAROLII.

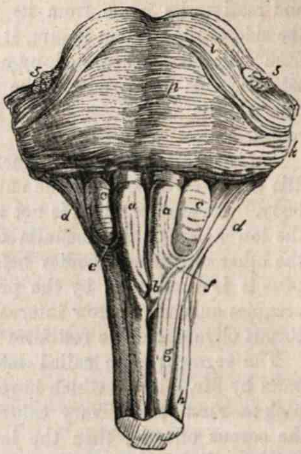
The medulla oblongata and the pons are interposed between the spinal cord and the brain proper. In those bodies the constituents of the cord are increased in volume before they enter the cerebrum and the cerebellum.

Directions. *Directions.* On a single brain the student may ascertain nearly all the anatomy of the parts composing the medulla and the pons; but if he can procure one hardened specimen of the medulla and the pons united, and another of a vertical median section through those bodies, he will comprehend much more readily the following description.

Position of the part. *Position.* The brain is to remain in the position in which it was placed during the examination of the nerves and vessels.

Upper part of spinal cord. The MEDULLA OBLONGATA is the upper dilated part of the spinal cord which is contained in the cranium (fig. 40). Its

Fig. 40.*



Situation limit is the lower border of the pons in one direction, and the upper margin of the atlas in the other. **and form.** This part of the cord is pyramidal in form, and measures about one inch and a quarter in length; half an inch in breadth below, and about an inch at its widest part.

Base. The larger part or the base of the medulla joins the pons, the transverse fibres of the latter marking its limit; **Apex.** and the apex is blended with the spinal cord at the spot before mentioned. **Surfaces.** The anterior surface is irregularly convex, and is in contact with the hollowed basilar process of the occipital bone. The opposite surface is somewhat excavated superiorly, where it forms the floor of the fourth ventricle; and it rests in the fissure between the halves of the cerebellum. On the posterior aspect there are not any cross fibres of the pons, as in front, to mark the extent of the medulla.

Division into halves by fissures. The medulla oblongata is divided into halves by a median fissure in front and behind. The fissures are in a line with those along the cord, and their extent is influenced by the cross fibres before alluded to on the surface; for whilst the anterior one ceases at the pons in a dilated part (foramen cæcum), the posterior is prolonged behind the pons, and into the groove in the floor of the fourth ventricle.

Components of each half. Each half of the medulla is constituted of segments continuous with those of the spinal cord; and indications of these divisions are to be seen on the surface, though the names are changed, and

* Anterior view of the medulla oblongata and pons. *a.* Anterior pyramid. *b.* The decussation. *c.* Olivary body. *d.* Restiform body. *e.* Arciform fibres. *f.* Fibres to the restiform body from anterior pyramid. *g.* Anterior column. *h.* Lateral column. *i* and *p.* Fibres of the pons (superficial).

the fibres differently arranged. Thus at the middle line in front is the anterior pyramid corresponding with the anterior column; at the middle line behind is the restiform body with its pyramidal part, continuous with the posterior and posterior median columns; and between these are the fibres of the lateral tract, with an oval projecting body (corpus olivare) on their exterior, which join the lateral column.

Anterior pyramid is most internal.

The *anterior pyramid* (fig. 40, *a*) is the most internal eminence and receives its name from its position and form. Situate on the side of the median fissure, it is internal to the olivary body, from which it is separated by a slight groove. Enlarging as it ascends, this body enters the pons, but, before disappearing beneath the transverse fibres, it is somewhat constricted and rounded.

Lateral tract varies in size:

Lateral tract. The lateral tract (funiculus lateralis) (fig. 40, *h*) fills the interval between the anterior pyramid and the restiform body. Its surface width is not the same throughout, for opposite the lower part of the medulla oblongata it measures as much as the other constituent bodies before and behind it; but near the pons it is diminished by the projecting olivary body, so that it occupies only the narrow interval between the outer side of the corpus olivare and the restiform body.

Different division of the lateral tract.

The segment here called lateral tract is divided into three parts by Mr. Clarke, which have the following order from before back:—First, the olivary column (fig. 43, *b*), which surrounds the corpus olivare; then the lateral column: and close to the restiform body, the gray cornu or column, *t*, a streak of gray matter.

Olivary body does not reach pons.

The *olivary body* (corpus olivare) (fig. 40, *c*), is the oval projection, about half an inch long, close to the anterior pyramid. A shallow groove separates it from the pyramid, and a deeper and wider one intervenes between it and the restiform body. This eminence is shorter than the pyramid, and does not reach to the pons. Its upper end is most prominent; and arching round the lower end and over the surface are some white fibres (fibræ arciformes).

Some arched fibres.

Restiform body is the largest piece.

Restiform body. The restiform body (restis, a rope) (fig. 40, *d*) forms the largest prominence on the half of the medulla oblongata, and cannot be seen satisfactorily except on a distinct preparation. This body is posterior to the lateral tract, and projects on the side, so as to give the width to the upper part of the medulla oblongata.* Behind, the restiform bodies diverge above from

* Sometimes it is described as consisting of two parts, which are separated by a groove below the level of the olivary body; one of these, the smaller and posterior of the two, is the funiculus gracilis, or the posterior pyramid; and the anterior and larger part has been named funiculus cuneatus (Burdach).

each other, and between them is situate the space of the fourth ventricle.

Posterior pyramid is close to posterior median fissure.

The *posterior pyramid* (funic. gracilis) lies along the side of the posterior median fissure. By drawing forwards the medulla, or by using a separate hardened piece, the pyramid will be seen to be a narrow slip, which is slightly enlarged (clava) at the apex of the fourth ventricle, where the restiform bodies diverge, and then becomes gradually indistinct along the inner part of the corpus restiforme.

Tænia of pyramid.

A little higher than the lower end of the fourth ventricle is a thin lamina of nervous substance on each side (tænia, ligula), which is about a line in width, and forms part of the roof of the fourth venticle; this membranous piece is attached by one edge to the hinder part of the posterior pyramid and the restiform body, but is free by the other, where it is connected with the vascular fold of the ventricle.

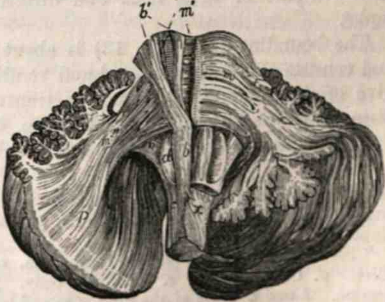
Parts of the medulla.

STRUCTURE. The component parts of the spinal cord, viz. anterior, middle, and posterior columns, are continued into the lower part of the medulla oblongata, where at first they can be recognised; but their contiguous fibres are blended together here as in each half of the cord, and they have a somewhat different arrangement.

Dissection to trace the pyramid.

Dissection. In the pyramid two sets of fibres have to be shown —one from the same, and one from the opposite side of the cord. The fibres from the opposite half of the cord will appear in the median fissure, when the pyramids are gently drawn from one another, where they are named the decussating fibres; and to lay these bare more completely, the small part of the anterior column of the cord on their side, which remains below the cross fibres (for the cord has been cut through near these), may be forcibly turned outwards. The fibres to the pyramid from the same half of the cord will be demonstrated by everting the anterior column below the decussation, as on the other side.

Fig. 41.*



Fibres of anterior pyramid.

The *anterior pyramid* (fig. 41, *b*) receives fibres inferiorly from the anterior column of the cord of its own side, and internally from the opposite half

* Structure of the medulla and pons. *b.* Anterior pyramids. *x.* The decussating fibres from the left half of the cord. *c* and *d.* Fibres of the

Derivation.

of the cord. The inner set of fibres, deep at their origin, become superficial in the median fissure, and are then directed upwards, close to that fissure, joining the fibres continued from the anterior column; and as the inner fibres of each pyramid are derived from the opposite side, they cross each other in the anterior median fissure of the spinal cord—forming thus the decussation of the medulla oblongata.

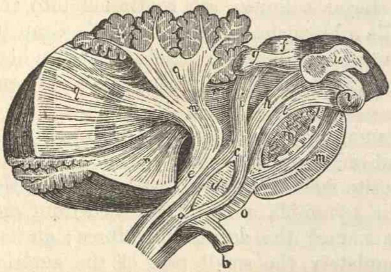
Destination.

The fibres of the pyramid are white and longitudinal, and are collected into a bundle of a prismatic form. Superiorly most of them enter the pons (fig. 41), to reach the cerebrum, but an offset from the outer side, small and superficial, is directed below the corpus olivare to the restiform body.

Olivary body, composition,

The *olivary body*, and its *fillet* (fig. 42, *d*, and *c*). The olivary mass consists of three parts, viz. a gray incasing layer, a central piece or nucleus, and a band prolonged from it—the fillet.

Fig. 42.*



corpus dentatum

The corpus dentatum will be apparent, when the olivary body has been sliced obliquely, as a very thin wavy layer of gray substance surrounding a nucleus of whitish matter.

is an incomplete sac open behind.

It forms a thin capsule or bag, having a zigzag outline in a section, with the dilated part towards the surface, and the narrowed part or neck open and directed backwards near the raphé.

Structure of the gray layer.

The bounding layer (fig. 43) is about $\frac{1}{80}$ of an inch thick, and consists of small nucleated and ramified nerve cells, which give origin to fibres.† Numerous transverse fibres of the arciform system pass by and through it (fig. 43, *h*, Clarke).

Nucleus and

The nucleus is the yellowish white substance filling the cap-

lateral column and the olivary body. *m* and *m′*. Superficial and deep transverse fibres of the pons. *n*. Inferior peduncle of the cerebellum, continuous with the restiform body.

* Structure of the pons and the cerebellum. *c*. Olivary fasciculus or the fillet. *d*. Olivary body. *e*. Restiform body. *f* and *g*. Corpora quadrigemina. *h* and *i*. Parts of the fillet. *m* and *m′*. Transverse fibres of the pons. *n*. Inferior peduncle of the cerebellum. *r*. Superior peduncle of the cerebellum.

† The arrangement of the fibres in the sac is most complicated, and a fuller account may be obtained by consulting Mr. Clarke's Paper in the Philosophical Transactions for 1858.

sule. From it and the capsule issue transverse fibres, which unite the olivary bodies across the middle line, and form the transverse commissure of Clarke (fig. 43, *g*). This commissural band is close below the anterior median fissure, and blends with fibres of the *raphé* of the medulla. transverse commissure.

The fillet is a narrow band of fibres, which ascends from the olivary body to the cerebrum. It is formed in part by longitudinal fibres of the lateral tract which diverge to enclose the corpus olivare, and in part by fibres derived from the sac. The further course of this olivary fasciculus will be visible in the dissection of the pons. Fillet. Composition.

Dissection. For the purpose of seeing the arrangement of the fibres of the lateral tract, the anterior pyramid is to be cut across on the left side, between its decussation and the olivary body, and to be raised towards the pons. Afterwards the remaining part of the pyramid is to be removed by dividing the fibres it receives from the decussation. Dissection of lateral tract.

The *lateral tract* of the medulla is prolonged inferiorly into the portion of the spinal cord between the anterior and posterior roots of the nerves (fig. 40, *h*). Soon after entering the medulla oblongata it gives off an internal set of fibres, which enters the pyramid of the opposite side. The other fibres, the continuation of the column (fig. 42), ascend beneath the olivary body, and leaving the surface of the medulla enter the pons, where they form an eminence (eminentia teres) in the floor of the fourth ventricle. Lateral fibres of medulla pass deeply.

The *decussation of the medulla oblongata* (pyramids) (fig. 40, *b*) occupies the anterior groove of the oblong medulla, at the distance of three quarters of an inch from the pons. It is about a quarter of an inch in length, and is constructed by the crossing of three or four bundles of fibres from each side. Decussation of medulla.

In this intercommunication the fibres are derived mainly from the lateral columns of opposite sides; but according to Mr. Clarke, fibres enter the decussation not only from the lateral column, but from all the constituent parts of the spinal cord except the anterior column. Thus fibres from the lateral column, blended with offsets from the contiguous gray substance, form the chief portion of the decussation; fibres from the posterior column and the adjoining part of the gray crescent enter the upper end; and other fibres from the front of the gray transverse commissure are received at the lower end. Mr. Clarke's view of the decussation formed by lateral column, posterior column, and gray substance.

The *restiform body* (fig. 42, *e*) is continuous inferiorly with the posterior column of the cord; and accessory fibres are received by it in front from the anterior pyramid. Superiorly it bends outwards to the cerebellum without entering the pons. Restiform body enters cerebellum.

The *posterior pyramid* runs below into the posterior median column of the cord, and is directed above along the floor of the

Pyramid passes to cerebrum.

fourth ventricle, joining the fasciculus teres of the same side; it is combined finally with the peduncular fibres of the cerebrum (p. 212).

Commissural fibres.

Arched or *commissural fibres* of the medulla. In each half of the medulla oblongata are fine transverse fibres, both on its exterior and in its substance. And in the middle line the fibres of opposite sides unite and give rise to a commissure between the halves.

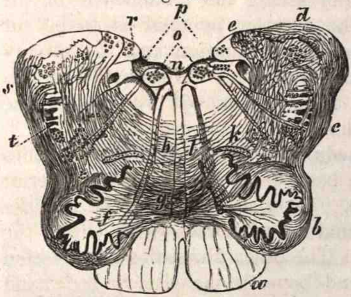
Superficial set; beginning

The *superficial transverse fibres* (fig. 43, *s*, and fig. 40) more or less marked in different bodies, issue from the restiform nucleus (Clarke), and advance over the surface of the olivary and pyramidal bodies to the anterior fissure, where most enter

and ending.

the half of the medulla of the same side; but others cross to the other half of the medulla, joining also the surface band on the pyramid of the opposite side (Clarke). Below the olivary body they form oftentimes a distinct band, the *fibræ arciformes* (fig. 40, *e*).

Fig. 43.*



Fibræ arciformes.

Deep set; beginning,

The *deep transverse fibres* (fig. 43, *h*) begin behind in ganglia contained in the posterior pyramid and the restiform body (Clarke), and penetrate between the longitudinal fibres as they

and ending.

reach forwards to enter the raphé in the middle line. Some surround the corpus olivare, and others traversing it, join with

The two sets join.

its fibres in the commissure of the olivary bodies. This layer communicates often with the superficial one between the longitudinal bundles of fibres.

Raphé.

Situation, and use.

The *raphé* (fig. 43, *h* and *g*) occupies the middle line of the medulla above the decussation of the pyramids, and serves as the commissure between the halves of the medulla and the olivary bodies. As the fibres enter it they diverge, decussating with

* Transverse section of the medulla oblongata above the middle of the olivary body (Clarke). *a*. Anterior pyramid. *b* and *c*. Lateral column. *d*. Restiform body. *e*. Posterior pyramid. *f*. Corpus olivare with roots of the ninth nerve piercing it. *g*. Olivary commissure. *h*. Deep transverse or commissural fibres of the medulla meeting in the raphé (a few more are added in this cut from a second drawing). *k*. Accessory olivary nucleus. *l*. Other gray deposits inside the olivary body. *n*. Floor of the fourth ventricle covered by epithelium. *o*. Nuclei of the ninth nerve. *p*. Nuclei of the vagus and glosso-pharyngeal nerves. *r*. Nucleus of the auditory nerve. *s*. Superficial transverse fibres. *t*. Remains of the gelatinous substance (tuberculo cinereo).

their fellows, and some take an antero-posterior direction along the opposite half of the medulla before they disappear in it. At the upper end of the medulla the antero posterior fibres are most numerous; and they receive behind an accession from the auditory nucleus. Fibres decussate.

Gray matter of the medulla oblongata. In the medulla oblongata there are the remains of the gray matter of the spinal cord, and some special deposits. Cross sections would be required to see them. Gray matter of the medulla.

At the lower part of the medulla the central gray matter resembles that in the spinal cord (see diagram of the spinal cord), but the transverse commissure uniting the crescents is larger, and its canal is closed by granular material; whilst the anterior cornu is thick and club-shaped, and the posterior, long and slender, ends in a tuft of fibres. But it undergoes soon the following changes:*— Changes at lower end of medulla.

From the whole outer border and anterior cornu of each crescent a network of fibres with cells, like the gray substance itself, is prolonged outwards until the outline of the part becomes undistinguishable. In outer part of crescent.

The posterior cornu increases in bulk, and extends towards the side of the cord, where it appears on the surface, in front of the restiform body, as the gray tubercle of Rolando (tuberculo cinereo). Higher in the medulla it becomes the chief nucleus of the sensory root of the fifth nerve. Posterior cornu,

From the back of the gray commissure a network of cells and fibres projects into the posterior pyramid, and forms in it the *post pyramidal ganglion* (fig. 43, *e*). A second larger collection of fibres and cells shoots out external to the preceding into the restiform body, where it gives rise to the restiform nucleus or ganglion (fig. 43, *d*). in gray commissure; forming post pyramidal, and restiform ganglion.

The piece of the gray commissure behind the central canal of the cord joins, higher up, the nucleus of the vagus nerve, and contributes to the auditory nucleus. And the piece in front of the canal is laid bare in the floor of the fourth ventricle by the inclination outwards of the restiform bodies; it disappears above in the fasciculi teretes.

Special deposits of gray matter. Other masses of gray substance are deposited in the medulla, both in front and behind:—those behind are near the floor of the fourth ventricle, and serve as nuclei of origin for certain nerves; whilst those in front are interspersed amongst the fibres continued from the lateral columns of the cord. Special deposits of gray matter.

* The description of the arrangement of the gray matter in the medulla oblongata is a summary of the facts contained in Mr. Clarke's Paper, in the "Transactions of the Royal Society for 1858."

Nucleus of ninth nerve.

Nuclei at the back of the medulla. A *nucleus* for the *hypoglossal nerve* is deposited in front of the central canal, at the level of the point of disappearance of the anterior cornu. It is separated from its fellow by the raphé, and extends upwards into the floor of the fourth ventricle close to the median sulcus (fig. 43, *o*).

Nucleus of spinal accessory.

The *nucleus* of the accessory part of the *spinal accessory nerve* is placed opposite that of the hypoglossal, but behind the central canal. Upwards it joins its fellow over the canal.

Nucleus of vagus,

The *nucleus of the vagus* begins on a level with the fourth ventricle (fig. 43, *p*), and is continuous below with that of the accessory nerve. On the surface it forms a pyriform swelling along the inner side of the posterior pyramid, and limits laterally the calamus scriptorius.

and of glosso-pharyngeal.

Above, each sinks under the auditory nucleus, and joins a *nucleus* for the *glosso-pharyngeal nerve* in a line with it.

Nucleus of auditory.

Above the last two nerves is another collection of cells serving as a *nucleus* for the *auditory nerve.* This projects on the lateral part of the medulla (fig. 43, *r*). Lying over the vagal nucleus, with which it appears to be continuous, it joins below the post pyramidal ganglion.

Gray matter in olivary body, behind it, and at the inner side.

At the front of the medulla. Outside the pyramid is the *gray layer* of the *olivary body* (fig. 43, *f*) already described (p. 204). Behind this is another separate, elongated and flattened yellowish streak, the *accessory olivary nucleus* (fig. 43, *k*); while at the inner part of the olive near the *raphé* is a second *collection* (fig. 43, *l*), which is broken up into pieces. Both of the last deposits Mr. Clarke considers to be but parts of the cut folds of the corpus dentatum.

PONS VAROLII.

Pons: position, form,

The PONS, or ANNULAR PROTUBERANCE (pons Varolii, nodus encephali) (fig. 40), is situate above the medulla oblongata, and between the hemispheres of the cerebellum. In its natural position in the skull it fills the hollow in front of the tentorium cerebelli. It is nearly of a square shape, though it is rather widest from side to side, and measures two inches in the last direction.

surfaces,

The anterior surface is grooved along the middle line (fig. 40), and is received into the basilar hollow in the base of the skull. By the opposite surface the pons enters into the fourth ventricle, forming part of the floor of that space.

and borders.

The upper border is longest and most curved, and arches over the cerebral peduncles; and the lower border overlays the medulla oblongata. On each side is the crus cerebelli, whose fibres radiate over the surface.

It is formed by longi-

Structure. In the pons are alternating strata of transverse and longitudinal fibres :—The tranverse set are continuous with the fibres of the crus cerebelli, much gray matter being interspersed: and the longitudinal are prolonged from the constituent bodies of the medulla oblongata.

tudinal and transverse fibres.

Dissection. The transverse fibres of the pons being divided along the line of the pyramidal body of the left side, may be turned outwards so as to denude the longitudinal fibres of the pyramid.

Dissection to expose the fibres.

In like manner a second mass of transverse fibres, which lie below the longitudinal of the pyramid (first set) may be cut through outside the pyramidal; then the deep longitudinal fibres of the lateral column and posterior pyramid (second set) will appear. Amongst this last set of longitudinal fibres is the fillet of the corpus olivare, which the dissector should trace upwards from that body.

The superficial fibres of the pons can be seen on the side that is untouched.

The *transverse fibres* of the annular protuberance (fig. 42), are collected chiefly into two strata—a superficial and deep, which are united in the middle line: they serve as commissural fibres of the cerebellum, and are derived from the crus or middle peduncle of that body. There are a few other transverse, which will be described with the septum.

The transverse fibres form a

The superficial set (fig. 40, *p*) are mostly horizontal, but some from the upper margin of the pons (*i*), descend obliquely over the others.

superficial

The deep layer (fig. 42, *m*′) is thickest, and contains much gray matter between its fibres.

and a deep layer.

The *longitudinal fibres* consist of two sets, viz. one from the anterior pyramidal body; and another from the lateral tract and the posterior pyramid, to which a slip is added from the corpus olivare. The fibres are not continued simply through the pons, but are increased in number by the addition of others (peduncular), which begin in the upper two thirds of the pons and join them on the outer side.

Two sets of longitudinal fibres.

The fibres of the anterior pyramid (fig. 41) pass through the pons between the two sets of transverse fibres, but not as one mass, for they are divided into a number of small bundles in their progress. Much increased in number, the fibres enter the crus cerebri at the upper border of the pons, and construct that fasciculated surface of the peduncle, which is now uppermost.

From anterior pyramid,

The fibres of the lateral column and posterior pyramid (fig. 42, *t*) are altogether deeper than the transverse fibres of the pons, and are mixed up with gray matter; they are also more numerous than the preceding set. They project close to the middle line, in the floor of the fourth ventricle, and form the eminence of the fasciculus teres; from that spot they are continued upwards to the crus cerebri, where they enter the deeper or cerebral part. In the pons a band from the olivary fasciculus is added to these fibres.

from lateral and posterior pyramid.

from olivary body.

The olivary fasciculus (fillet, p. 204, fig. 42, *c*) divides into two slips in the pons. One (*i*) passes backwards to the upper (in this position deeper) part of the crus cerebri, and ends in and beneath the corpora quadrigemina (p. 235). The other (*h*) is continued to the crus cerebri with the fibres of the lateral column.

Commissure of pons.

Commissure of the pons. In the pons, as in the medulla oblongata, there is a commissure between the halves, but only at the posterior part between the deep longitudinal fibres; for anteriorly the transverse or connecting fibres of opposite sides are continuous. It consists, like that of the medulla oblongata, of antero-posterior and transverse fibres.

Antero-posterior fibres.

The *antero-posterior fibres* are derived partly from the floor of the fourth ventricle and partly from the transverse of the pons, and bend backwards for a certain distance before they cross to the opposite side.

Transverse.

The *transverse fibres*, very slender, would be seen only on cross sections of a hardened pons; they come from the floor of the fourth ventricle, pierce the longitudinal fibres, and are continued across the middle line, as in the medulla oblongata.

Section IV.

DISSECTION OF THE CEREBRUM.

Situation of the cerebrum.

The cerebrum, or the great brain, is the largest of the parts into which the encephalon is subdivided, and weighs from 46 to 53 oz. in the male. It fills the upper part of the cavity of the skull; and its under surface would correspond with an oblique line on the head from the eyebrows to the articulation of the jaw, and from this point to the occipital protuberance.

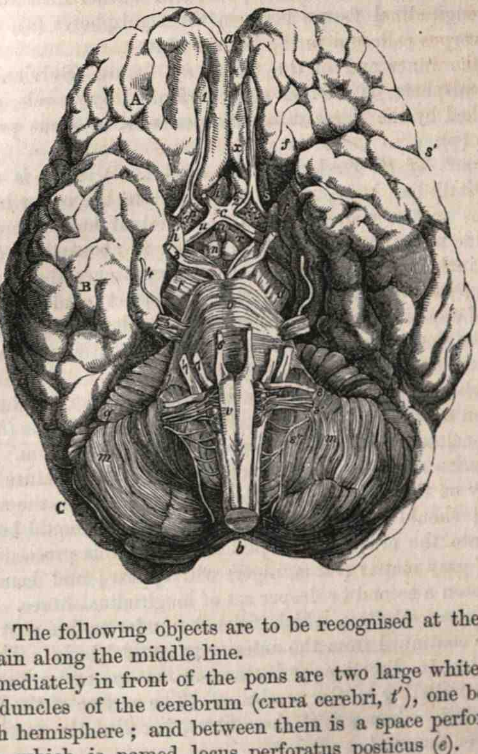
Form: has two hemispheres joined by median parts.

Taking the general form of the cranium, the cerebrum is convex on the upper aspect, and uneven on the lower. It consists of two hemispheres, which are placed side by side, and are partly separated by a median or longitudinal fissure. Across the middle line the halves are united by certain interior parts (commissures), as well as by several connecting structures at the under surface. Superiorly the surface of the hemisphere is without any large cleft; but inferiorly it is divided into two by a transverse fissure—that of Sylvius.

Under surface of cerebrum,

Under Surface or Base of the Cerebrum (fig. 44). At its under part the cerebrum is very irregular, in consequence of its fitting into inequalities in the base of the skull; and on this aspect the separation into hemispheres is not so complete as on the upper, for the median fissure exists only at the front and partly split.

Fig. 44.*



back. The following objects are to be recognised at the base of the brain along the middle line.

Immediately in front of the pons are two large white masses, the peduncles of the cerebrum (crura cerebri, *t′*), one belonging to each hemisphere; and between them is a space perforated by vessels, which is named locus perforatus posticus (*e*). Outside the peduncle is the optic tract (*u*); and between it and the inner part of the hemisphere is a fissure leading into the lateral ventricle. Parts along the middle line.

In front of the peduncles the student will find two white bodies like peas, the corpora albicantia (*n*); and anterior to these a grayish mass, called tuber cinereum (*r′*). From the tuber

* Under surface of the brain. A, frontal; B, temporo-sphenoidal; and C, occipital lobe of the cerebrum. *m.* Cerebellum. *o.* Pons Varolii. *v.* Medulla oblongata. *c.* Commissure of the optic nerves. *d.* and *t.* Crura cerebri. *e.* Locus perforatus. *i.* Infundibulum. *n.* Corpus albicans. *p.* Anterior perforated space. *r.* Tuber cinereum. *s s′.* Sylvian fissure. *u.* Optic tract. Figures 1 to 9 mark the cranial nerves.

cinereum a conical reddish tube, the infundibulum (*i*), descends to the pituitary body in the sella Turcica of the sphenoid bone.

Anterior to the tuber cinereum are the converging optic tracts with their commissure (*c*). Beneath the commissure lies a thin grayish layer (lamina cinerea) ; and still farther forwards is the great longitudinal fissure between the hemispheres (*a*), with the white corpus callosum in the bottom of it.

At the inner end of the transverse fissure (Sylvian) across the hemisphere, is another spot, perforated by vessels, and distinguished by the name substantia perforata, or locus perforatus anticus (*p*).

Crus cerebri is fixed in hemisphere.

Peduncle of the cerebrum (crus cerebri, *d*). This is a large, white, stalk-like body, which reaches from the upper border of the pons to the under part of the cerebral hemisphere of the same side near the inner margin. Each is about three quarters of an inch long, and widens as it approaches the cerebrum. Crossing its outer surface is the optic tract; and between the crura of opposite sides is the interpeduncular space, which contains the locus perforatus, the corpora albicantia, and the tuber cinereum.

Formed of longitudinal fibres.

Structure. The peduncle may be said to be formed by a continuation upwards of the longitudinal fibres of the pons (fig. 42), which enclose here a mass of gray matter between them.

Dissection.

Dissection. For the purpose of showing the structure of the crus, say on the left side, the fibres continuous with the anterior pyramid should be cut across in the pons, and should be raised as far into the crus as the optic tract. In this proceeding the mass of gray matter (locus niger) will appear; and beneath it will be seen a second or deeper set of longitudinal fibres.

Its superficial fibres

The *superficial fibres*, which form the under or free part of the crus, are continued from the anterior pyramidal body. They are longitudinal in direction, and coarse in texture, and are directed upwards radiating to the cerebrum. The surface of the peduncle, which is composed of these fibres, is called the *fasciculated* portion, or the *crust.*

form crust;

deep fibres

The *deeper fibres* are also prolonged to the cerebrum. They are derived chiefly from the lateral tract and posterior pyramid of the medulla oblongata, with a slip from the olivary fasciculus (p. 205). In addition to the longitudinal fibres continued from the medulla oblongata, others come from the cerebellum, and mix with the former : some of these last decussate across the middle line * (see p. 242). The fibres obtained from these sources are situate beneath (as now seen) the gray matter :

* M. Foville describes a median commissure for the medulla oblongata, pons, and cerebral peduncles, which is composed of the interweaving of fibres of opposite sides. See the work of M. Foville entitled : *Traité complet de l'Anatomie, &c., du Système Nerveux cérébro-spinal*, p. 323, 1844.

besides being deeper, they are finer than the superficial set, and enclose much gray substance. The deeper part of the crus, viz., that at the cerebral aspect, is constructed by these fibres, and is named *tegmentum*. **form tegmentum.**

The gray matter (locus niger) of the crus forms a thin septal layer, which reaches nearer the inner than the outer margin of that body, and is convex towards the free surface, but concave in the opposite direction. **Gray matter of crus.**

The *posterior perforated spot* (pons Tarini, *e*) is situate between the peduncles of the cerebrum; grayish matter forms the floor of the space, and into it numerous vessels enter. This structure is opposite the floor of the third ventricle. **Locus perforatus.**

The *corpora albicantia* (corp. mamillaria) are two small, white bodies, about the size of peas, which are formed in greater part, as it will afterwards appear, by the crura of the fornix. If one, say the left, is cut across, it will be found to contain gray matter. In front of them is a mass of gray substance, the tuber cinereum. **Corpora albicantia.**

The median eminence of the *tuber cinereum* (*r*) forms part of the third ventricle, and is continuous with the gray substance in that cavity. In front of it are the optic tracts and commissure, and from its centre projects the following. **Tuber cinereum**

The *infundibulum* (funnel) is a conically-shaped tube (fig. 49, *i*), which reaches from the tuber cinereum to the upper part of the posterior lobe of the pituitary body. In the fetus this tube is open between the third ventricle and the pituitary body, but in the adult it is closed inferiorly. It consists of a layer of gray matter, surrounded by the pia mater; and it is lined by the membrane of the third ventricle as far as it is pervious. **and infundibulum.**

The *pituitary body* will be very imperfectly seen when it has been dislodged from its resting-place: therefore it should be sometimes examined in the base of the skull by removing the surrounding bone. Its use is unknown. **Pituitary body.**

This body (fig. 49, *p*) is situate in the hollow (sella Turcica) in the centre of the sphenoid bone, and consists of two lobes, anterior and posterior. The anterior is the largest, and is hollowed out behind, where it receives the round posterior lobe. In the adult this body is solid, and hard in texture; but in the fetus it is hollow, and opens into the third ventricle through the infundibulum. **Situation.**

Structure. It is firm and reddish externally, but softer and yellowish internally. In the *anterior lobe* are vesicular nucleated corpuscles, mixed with a granular semi-fluid substance; and the whole is contained in roundish spaces, which are constructed by a stroma of areolar tissue with blood-vessels (Sharpey). In the *posterior lobe* there are fine nerve tubes and vessels, with a granular material and nuclei. **Structure.**

Dissection. To see the lamina cinerea and the anterior termi- **Dissection.**

nation of the corpus callosum, the fore part of the hemispheres are to be forcibly separated from each other.

Gray lamina.

The *lamina cinerea* is a thin concave layer of gray substance, which gradually tapers forwards from the tuber cinereum to the anterior termination of the corpus callosum. This stratum closes the anterior part of the third ventricle, and is continuous laterally with the anterior perforated spot. In consequence of its great thinness, this structure is often broken through in removing the membranes of the brain.

Corpus callosum

The *corpus callosum*, bent in front (fig. 49, *a*), is continued horizontally backwards in the longitudinal fissure to within a quarter of an inch of the anterior commissure, where it ends in two white narrow processes, the fillets, or peduncles of the corpus callosum. Each band is continued onwards from the line of termination before alluded to, to the anterior perforated spot;

ends inferiorly in two bands,

and between them lies the delicate lamina cinerea. To the anterior bend of the corpus callosum the term knee (genu) is applied, and to the prolonged central part the appellation beak (rostrum)

and extends into hemisphere.

has been given. Laterally the corpus callosum reaches into the frontal lobe, and forms part of the floor of the lateral ventricle.

Substantia perforata antica.

Anterior perforated spot (substantia perforata antica) is a space (*p*) near the inner end of the fissure of Sylvius, which is situate between the frontal and temporo-sphenoidal lobes of the cerebrum, and external to the optic tract. On the inner side it is continuous with the lamina cinerea; and crossing it, from within outwards, is the fillet of the corpus callosum. This space is gray on the surface; it corresponds with the corpus striatum in the interior of the brain, and is perforated by numerous vessels for that body.

Position of brain to examine upper part.

Position of the part. Now the base of the cerebrum has been dissected, the brain should be turned over for the examination of the upper part. Something should then be placed beneath the front, in order that it may be raised to the same level as the back; and a rolled-up cloth should loosely encircle the whole, to support the hemispheres.

Cerebrum is convex above, and divided into two by a

UPPER SURFACE OF THE CEREBRUM. On the upper surface the cerebrum, taken as a whole, is oval in form, with the larger end backwards; and is convex in its outline, in accordance with the shape of the skull.

median fissure.

A *median longitudinal fissure* divides the cerebrum incompletely into two halves. At the front and back the hemispheres are quite separated by it; but at the middle and under parts they are united by connecting pieces, the largest of which is the white corpus callosum. In it the falx cerebri is lodged.

Each half

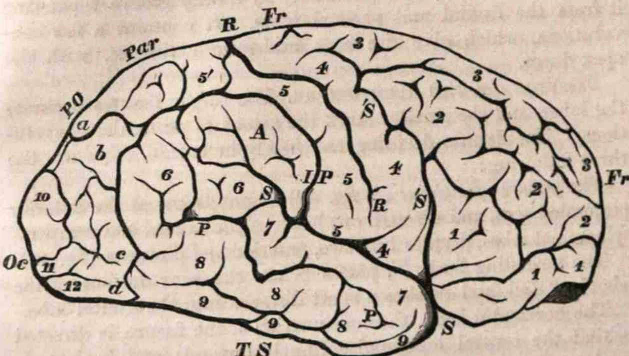
Each hemisphere is smaller in front than behind. Its outer surface is convex; but the inner is flat, and in contact with the opposite half at the fore part. On the upper aspect the surface of the hemisphere is separated by sulci into lobes, and on the under aspect it is cleft into two large pieces by the fissure before seen. The superficies of the hemisphere is marked by tortuous eminences, the projections on it being named convolutions or gyri, and the intervening depressions, sulci or anfractuosities.* is marked by convolutions and sulci.

LOBES OF THE HEMISPHERE. Each hemisphere is divided into five lobes,† according to Gratiolet and others, which have the following names and limits: Number of lobes:

The *frontal lobe* (*Fr*, fig. 45) forms the anterior half of the hemisphere. It is limited below by the fissure of Sylvius, *S*, and behind by the fissure of Rolando,‡ *R* (Turner). Its under part, which rests on the orbital plate, is called the orbital lobule. Frontal lobe and lobule.

The *parietal lobe* (*Par*, fig. 45) is placed behind the preceding, and reaches down to the Sylvian fissure. It is about half as Parietal lobe

Fig. 45.§



long as the frontal. In front it is bounded by the fissure of Rolando, *R*, and behind by a small fissure—the parieto-occipital (*P O*). The upper and hinder part, close to the median fissure, is named the parietal lobule (5'). and lobule.

* In the following description of the surface anatomy of the cerebrum I have followed chiefly the excellent monograph of Professor Turner "ON THE CONVOLUTIONS OF THE HUMAN CEREBRUM;" and to him I am indebted for permission to copy the woodcuts employed in illustration of his publication.

† Formerly only three lobes were described, anterior, middle, and posterior, and all were placed on the under surface. The two first were separated by the fissure of Sylvius, and the posterior was limited by the front of the cerebellum.

‡ By some the anterior limb of the fissure 'S is made the hinder bound of the lobe; but this is not so good an arrangement as that in the text.

§ Lobes of the hemisphere, and convolutions and fissures of the outer surface. — *Fr.* Frontal lobe. *Par.* Parietal lobe. *Oc.* Occipital lobe.

Occipital lobe

The *occipital lobe* (*Oc*, fig. 45) constitutes the pointed end of the hemisphere, and measures about a fifth of the whole. In front it is separated from the parietal lobe by the parieto-occipital fissure (*P O*), but below it blends with the following lobe. It rests on the tentorium. On the inner surface is a triangular piece, the occipital lobule (25, fig. 47).

and lobule.

Temporo-sphenoidal lobe.

The *temporo-sphenoidal lobe* (*T S*, fig. 45) projects into the middle fossa of the base of the skull. It is situate behind the fissure of Sylvius, and below the parietal and occipital lobes. The outer surface is in contact with the cranium, and the opposite is supported on the tentorium.

Central lobe.

The *central lobe*, or the island of Reil (*C*, fig. 46), lies in the Sylvian fissure, and is concealed by the overlapping of the frontal and temporo-sphenoidal lobes. On separating those lobes it will be seen to be bounded in front and behind by the branches of the Sylvian fissure, and externally by a deep groove separating it from the frontal and parietal lobes. It contains a few convolutions, which give rise to a triangular eminence, with the apex down.

Three fissures.

FISSURES OF THE HEMISPHERE. The larger fissures separate the lobes, and the smaller mark the extent of particular convolutions. The fissures dividing the hemisphere into lobes are the three following:

Sylvian,

The *fissure of Sylvius* (*S*, fig. 44) begins below at the anterior perforated spot, and directed out between the frontal and temporo-sphenoidal lobes, divides into two, anterior and posterior (fig. 45).

fore part,

The ascending limb, *'S*, passes before the convolutions of the island of Reil, and reaches a short distance into the frontal lobe.

hinder part.

The horizontal limb, the continuation of the fissure, is directed behind the central lobe, and obliquely upwards and backwards to about the middle of the outer face of the hemisphere. At its extremity it is sometimes divided into smaller sulci.

Fissure of Rolando.

Fissure of Rolando (*R*, fig. 45). Beginning above, in or near the longitudinal fissure of the cerebrum, it is prolonged outwards between the frontal and parietal lobes nearly to the horizontal part of the Sylvian fissure,—about the middle of that cleft.

Outer parieto-occipital fissure.

The *external parieto-occipital* or *perpendicular fissure* (opposite *P O*, fig. 45) separates the parietal and occipital lobes. It is very variable in extent, being sometimes an inch long or more, and

T S. Temporo-sphenoidal lobe. *R.* Fissure of Rolando. *S.* Horizontal. *'S.* Ascending limb of the Sylvian fissure. *P O.* Place of the external parieto-occipital fissure which is not visible in a side view. *I P.* Intra-parietal fissure. *P.* Parallel fissure—1, inferior; 2, middle; and 3, superior frontal gyrus; 4, ascending frontal; and 5, ascending parietal gyrus; 5'. parietal lobule; 6, angular gyrus; 7, superior; 8, middle; and 9, inferior temporo-sphenoidal gyrus; 10, superior; 11, middle; and 12, inferior occipital convolution. A. Supra-marginal lobule—*a*, first; *b*, second; *c*, third; and *d*, fourth, annectant gyrus.

at others only a slight indentation; but it may be always recognised by its continuity with the perpendicular fissure on the inner face of the hemisphere (p. 221).

Convolutions of hemisphere.

CONVOLUTIONS OF THE CEREBRUM. In different brains the convolutions vary slightly in form, and even in the two hemispheres of the same they are not exactly alike; but there is always similarity enough between brains for the recognition of the chief eminences. Each lobe possesses convolutions, but these run into each other by means of smaller gyri, either on the surface of the brain or at the bottom of the sulci; and the student may experience some difficulty at first in defining the limits of each. It is in the smaller gyri that the greatest variability will be found.

Two groups:

The learning of the convolutions will be facilitated by classifying them into one group on the exterior, and another on the inner and tentorial surface of the hemisphere.

on outer surface.

CONVOLUTIONS OF THE OUTER SURFACE. These are more numerous and complicated than the other group. About the middle of the hemisphere are two straight vertical convolutions, one on each side of the fissure of Rolando, *R*, which will serve as a starting point. In front of those two the convolutions are transverse, and behind they take an oblique direction to the back of the brain.

Frontal convolutions.

The *frontal convolutions* (fig. 45) form two sets, one on the outer, and another on the under surface of the frontal lobe: those on the outer aspect are four, viz. one vertical or posterior, and three transverse or anterior, as follows:—

Four outer: one ascending,

The *ascending frontal* * (4) is the vertical, straight convolution before referred to, which bounds in front the Rolando fissure. It reaches down from the median to the Sylvian fissure (posterior limb). Along the anterior border it is joined by the three other frontal convolutions; and below it unites with the most anterior convolution of the parietal lobe round the lower end of the fissure of Rolando, *R*.

and three transverse.

The three *transverse frontal convolutions* are much subdivided and blended, and are separated by two intervening sulci. They are named *superior* (3), *middle* (2), and *inferior* (1): they communicate behind by secondary gyri with the ascending frontal (4), the highest having often two processes, and are directed forwards one above another to the anterior extremity of the hemisphere.

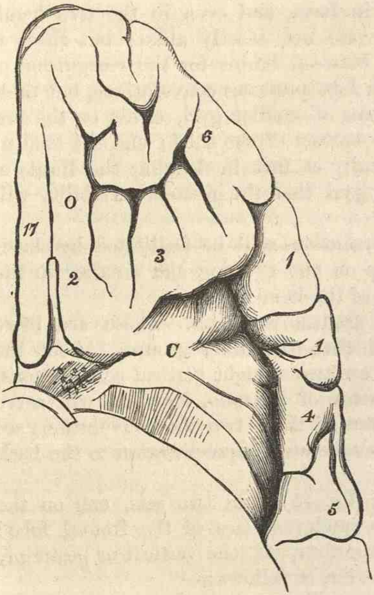
Three inferior,

The under or orbital surface of the frontal lobe, concave, is represented in fig. 46. Near the inner margin is a sulcus, the

* This convolution was formerly considered by Gratiolet to form part of the parietal lobe, and was named by him first ascending parietal. If it is still so arranged, the hinder bound of the frontal lobe, as before said (foot note, p. 215), will be the anterior limb of the fissure of Sylvius.

with marginal. olfactory, lodging the olfactory nerve; and internal to it is the lower end of the marginal convolution (17)[§] External to the sulcus lies a convolution, which is pointed behind, but widened and subdivided in front, and encloses smaller gyri and sulci within its coil: this has been subdivided into three parts, an inner (2), a posterior (3), and an external (6).

Fig. 46.*



Four parietal convolutions: The *parietal convolutions* (fig. 45), like the other frontal, are four in number; an anterior vertical along the fissure of Rolando, and three directed back from it. One named fissure is contained in the lobe.

first, or ascending, The *ascending parietal* (5), narrow and straight, limits behind the fissure of Rolando, and reaches from the middle line to the hinder limb of the Sylvian fissure, *S*. Above, it runs into the parietal lobule, 5′; and below, it joins the ascending frontal round the lower end of the fissure of Rolando. Behind it is separated from the other gyri of the parietal lobe by a special sulcus, *IP*, as follows:—

and its fissure; The *intra-parietal fissure*† (*IP*, fig. 45, Turner) is placed between the ascending parietal and the supra-marginal convolution, *A*. Below, it is commonly separated from the Sylvian fissure by a gyrus which unites the convolution behind it with the ascending parietal; and above, it is directed back near the upper part of the hemisphere between the parietal lobule (5′), and the supra-marginal convolution, *A*.

second or parietal lobule; The *parietal lobule* (5′) appears to be an appendage to the

* View of the orbital lobule and the central lobe.—*C*. Island of Reil or median lobe. *O*. Olfactory sulcus. 2. Internal; 3, posterior; and 6, external orbital convolution. 17. Marginal convolution of the hemisphere.

† According to Professor Turner this fissure is very constant, and he has named it from its position within the parietal lobe.

upper end of the ascending convolution, and is continued back along the upper margin of the hemisphere as far as the parieto-occipital fissure. It consists of two chief parts subdivided on the surface; and it is joined behind to the occipital lobe by the small upper annectant gyrus (*a*). To its outer side lies the upper part of the interparietal fissure; and here it joins usually the angular convolution, *A*.

The *supra-marginal convolution*, *A*, lying outside and below the preceding, is interposed between the interparietal and the upper end of the Sylvian fissure. Variable in shape it joins, below, the ascending parietal convolution (5); it may communicate above with the parietal lobule, and behind with the following. **third, or supra marginal;**

The *angular convolution* (6), very complicated and not well defined, is placed at the extremity of the hinder limb of the Sylvian fissure, and is composed of two or three parts. Above it is the parietal lobule; and below, the temporo-sphenoidal lobe which it joins. In front lies the supra-marginal convolution; and behind, the occipital lobe, with which it blends by the small second annectant gyrus (*b*). **fourth, or angular.**

The *occipital convolutions* (fig. 45) are small and very much divided, so that their outline is uncertain. They are three in number, lying one above another, and separated by sulci, something like the frontal gyri at the opposite end of the hemisphere. **Three occipital convolutions:**

The upper (10), forming part of the margin of the longitudinal fissure, receives the first annectant gyrus from the parietal lobule. **upper,**

The middle (11), crossing outwards the hemisphere, has two annectant gyri to other convolutions; the second annectant (*b*) joining it above to the angular convolution, and the third (*c*) passing to the middle temporo-sphenoidal convolution. **middle,**

The inferior (12) occupies the tip of the hemisphere between the upper and under surfaces. At the inner end it is continuous with the upper gyrus; and at the outer end with the inferior temporo-sphenoidal convolution by the fourth annectant gyrus (*d*). **and lower.**

The *temporo-sphenoidal convolutions* (fig. 45), three in number, run from above down, and are separated from one another by two sulci, of which the anterior or superior is named the parallel fissure. **Three temporo-sphenoidal convolutions:**

The superior (7) bounds posteriorly the horizontal limb of the Sylvian fissure. At the upper end it is connected by a gyrus with the angular convolution. **upper,**

The middle (8) is separated from the first by the parallel fissure (*P*). Above, it blends commonly with the angular convolution, and is connected to the middle occipital convolution by the third annectant gyrus (*c*). **middle,** lower, The inferior (9), less well marked than the other two, forms part also of the inner surface of the temporo-sphenoidal lobe. By the upper end it is united to the third occipital convolution by the fourth annectant gyrus (*d*).

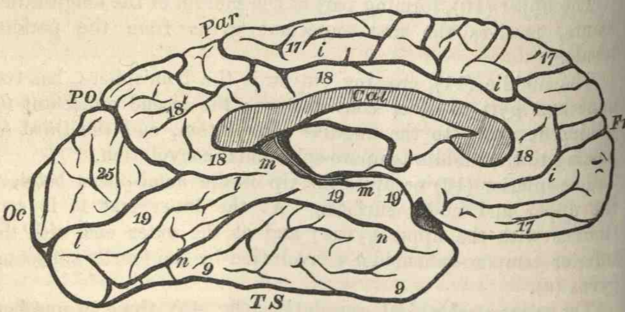
with parallel fissure. The *parallel fissure* (*P*, fig. 45) named from its position to the Sylvian, extends from the lower end of the temporo-sphenoidal lobe to the angular convolution.

Central lobe convolutions. The *convolutions of the central lobe* (*C*, fig. 46), about six in number, are straight for the most part, and are separated by shallow sulci: they are directed upwards from apex to base of the lobe. The posterior gyri are the longest and broadest; and the anterior joins the convolutions of the under surface of the orbital lobe.

Convolutions on inner surface of hemisphere. The CONVOLUTIONS ON THE INNER SURFACE of the hemisphere (fig. 47) are generally well defined; but some being so long as to reach beyond the extent of a lobe, the arrangement of them in lobes cannot be followed here, as on the exterior.

How to see them. *Dissection.* Without the use of a separate hardened hemisphere, the parts to be now described will not be seen satisfactorily. If the student possesses only one brain, he may bring into view much of the inner surface by cutting off the left hemisphere as low as the white corpus callosum in the median fissure.

Fig. 47.*



Convolution of corpus callosum. *Convolution of the corpus callosum*, gyrus fornicatus (18), is long and simple, and arches round the body from which it takes its

* Convolutions and fissures on the inner face of the hemisphere.—*P O.* Internal parieto-occipital fissure. *Cal.* Corpus callosum, cut. *i*, calloso-marginal fissure; *l*, calcarine fissure; *m*, dentate fissure; *n*, collateral fissure; 17, marginal gyrus; 18, convolution of corpus callosum; 18′, quadrilateral lobule; 19, uncinate gyrus; 19′, crochet or hook of the uncinate gyrus; 25, occipital lobule; 9, inferior temporo-sphenoidal gyrus partly seen.

name. Beginning at the base of the brain in the anterior perforated spot, it bends backwards in contact with the corpus callosum (*Cal*), and below the back of that body blends by a narrowed part with the uncinate convolution (19) of the temporo-sphenoidal lobe.* Anteriorly a fissure separates it from the following convolution; and smaller gyri often connect the two across that sulcus. Under the convolution lies a flat band of longitudinal fibres (the covered band of Reil), which descends to the anterior perforated spot, and will be afterwards seen.

Marginal convolution. The *marginal convolution* (17) is named from its position on the edge of the median fissure. Its extent is rather more than half the length of the hemisphere, for it begins in front at the anterior perforated spot, and terminates near the back of the corpus callosum, just behind the fissure of Rolando. It is much subdivided both internally and externally; and on the under part of the frontal lobe (fig. 46) it lies internal to the olfactory sulcus. Between it and the preceding convolution is situate the calloso-marginal fissure (*i*) which marks its hinder limit.†

and calloso-marginal fissure. The *calloso-marginal fissure* (*i*, Huxley), designated from its situation, begins in front below the corpus callosum, and ends behind, near the back of the same body, by ascending to the edge of the hemisphere. Smaller gyri uniting the two bounding convolutions, frequently interrupt it, and secondary sulci are prolonged from it into the same convolutions.

Quadrilateral lobule. The *quadrilateral lobule* (18) reaches from the marginal convolution in front to the parieto-occipital fissure behind. It is much divided by sulci, and projects above to the edge of the hemisphere; it joins below the gyrus fornicatus.

Occipital lobule. The *occipital lobule* (25) is triangular in shape, with the base up, at the margin of the hemisphere. Measuring about an inch and a half in depth, it lies between the internal parieto-occipital, *P O*, and the calcarine fissure (*l*). Sulci running from apex to base divide it into four or five narrow convolutions.

Inner parieto-occipital fissure. *Internal parieto-occipital* or *perpendicular fissure* (*P O*, fig. 47) separates the two preceding convolutions. Continuous with the external sulcus of the same name, it opens below into the following.

Calcarine fissure. The *calcarine fissure* (*l*, Huxley) is directed across the back of the hemisphere below the level of the corpus callosum, and ends at the gyrus fornicatus, whose hinder limit it marks. It receives above the internal perpendicular fissure; and it sinks into the posterior cornu of the lateral ventricle, forming the eminence of the hippocampus minor.

Three temporo-sphe- *Internal temporo-sphenoidal convolutions* (fig. 47) are three in

* Sometimes it is described as extending along the temporo-sphenoidal lobe; in that case the uncinate gyrus becomes its lower end.

† By Foville this convolution is said to be continued round the posterior end of the hemisphere as far as the temporo-sphenoidal lobe.

noidal convolutions: number, like those of the outer surface of the lobe (p. 219), and are directed in the same way from above down. They occupy the tentorial surface of the hemisphere, lying one below another, and are separated by two fissures.

middle; The most marked of the three above mentioned, the *uncinate* or *hippocampal convolution* (19, middle temp. sphenoid.), is prolonged from the posterior end of the hemisphere nearly to the tip of its lobe. It is somewhat bent and narrowed in the middle where the gyrus fornicatus blends with it; and is enlarged at each end, especially at the outer where it is sub-divided by sulci. Below it is a long curved fissure, the collateral (*n*); and above it are the calcarine (*l*), and the dentate sulcus (*m*). From the anterior extremity a narrow part (19′, uncus) is prolonged back for half an inch on the inner side, like a hook; and with this the tænia hippocampi is united.

inferior; The *inferior convolution* (9) forms the lower edge of the temporo-sphenoidal lobe, appearing both on the inner and the outer face. Much subdivided by sulci it is separated from the middle convolution by the collateral fissure (*n*); and it forms below the tip of the lobe.

with collateral The *collateral fissure* (*n*, Huxley) courses along the lower border of the uncinate convolution, and projects into the inferior cornu of the lateral ventricle, so as to give rise to the prominence of the eminentia collateralis. It is often interrupted by cross gyri, and secondary sulci emanate from it.

and dentate fissure; The *dentate fissure* (*m*, Huxley) is the deep groove at the upper edge of the uncinate convolution, and corresponds with the prominence of the hippocampus major in the descending cornu of the lateral ventricle. Upwards it is limited by the corpus callosum (*Cal*), and downwards it intervenes between the hook and the body of the uncinate convolution. The gray lamina dentata is contained in the fissure.

and superior convolution. The *dentate convolution* (sup. temp. sphenoid.) consists of the slight narrow projecting ridge internal to the notched lamina, which makes the inner edge of the hemisphere. Along the side it is united with the tænia hippocampi, and below it blends with the unciform process.

A convolution has base and summit; *Structure of the convolutions* (fig. 48). From the section now made into the brain each convolution may be perceived to be continuous with the interior of the brain on the one side (base); and to be free on the surface of the brain on the other side, where it presents a summit and lateral parts. Externally it consists of gray cerebral substance as a cortical layer, which is continued from one eminence to another over the surface of the hemisphere; and internally it is composed of white brain substance—its medullary part, which is derived from the fibrous mass in the interior.

is gray outside

and white within.

On a closer examination the cortical layer is found to be composed of three strata:—an outer white stratum, an inner reddish-yellow one, and an intervening gray lamina. The outer white stratum differs in development in different parts of the brain, and is most marked over the internal and lower portions of the uncinate convolution, where it is pierced by minute holes. The inner stratum equals in thickness the other two, and has on its external surface also a thin white lamina, so that white and gray laminæ will alternate with one another in the cortex of the convolutions. **Its structure.**

INTERIOR OF THE CEREBRUM. Each half of the cerebrum consists of a stalk or peduncle, and of a dilated part or hemisphere. In the interior is a large central space, which is subdivided into smaller hollows or ventricles by the before-mentioned connecting pieces. And the whole, except the peduncle, is surrounded by a convoluted crust. **Outline of hemisphere,**

In conducting the dissection of the cerebrum, the student will have to learn the form and situation of the several constituent parts, and afterwards to trace the connections between these by means of fibres.

Dissection. Supposing both hemispheres entire, the left is to be cut off to the level of the convolution of the corpus callosum. When this has been done, the surface displays a white central mass of an oval shape, the centrum ovale minus, which sends processes into the several convolutions. In a fresh brain this surface would be studded with drops of blood escaping from the divided vessels. **Cut down to ovale minus of the hemisphere.**

Next the convolution of the corpus callosum is to be divided about the middle, and the two pieces are to be raised and thrown backwards and forwards. Under it lies a thin narrow band, the covered band of Reil before referred to, which bends down before and behind the corpus callosum. **Reflect gyrus fornicatus.**

The same steps are to be taken on the opposite side; and the tops of the hemispheres being removed to the level of the corpus callosum, the transverse fibres of that body are to be defined as they radiate to the convolutions. **Same on right side.**

Now a much larger white surface comes into view, which has been named larger oval centre—centrum ovale, Vieussens; and the white mass in each hemisphere is seen to be continuous across the middle line through the corpus callosum. **Centrum ovale majus is deeper.**

The *corpus callosum* reaches from the one half of the cerebrum to the other, and forms the roof of a space (lateral ventricle) in each hemisphere. Between the halves of the brain, where it occupies the longitudinal fissure, it is of small extent, being about four inches in length, and somewhat arched from before backwards. It is narrower in front than behind, and extends nearer to the anterior than the posterior part of the cerebrum. **Corpus callosum.** **Situation and form.**

Upper surface, transverse and longitudinal fibres.

On the upper surface the fibres are directed from the hemispheres to the middle line,—the middle being transverse, but those from the anterior and posterior parts oblique. Along the centre is a ridge or raphé, and close to it are two or more longitudinal white lines (nerves of Lancisi). Still further out may be seen other longitudinal lines (covered band, p. 223) beneath the convolution of the corpus callosum, if all of them have not been taken away in the removal of that convolution. The longitudinal fibres in the middle line are continued downwards in front, and joining a prolongation from the covered band or fillet on the side, are continued to the anterior perforated spot.

Anterior part bends down.

In front the corpus callosum is bent to the base of the brain (fig. 49, *a*), as before described (p. 214); and behind it ends in a thick roll (*b*), which is connected with the subjacent fornix (*f*).

Dissection.

Dissection. In order to see the thickness of the corpus callosum, and to bring into view the parts in contact with its under surface, a cut is to be made through that body about half an inch from the central ridge; and is to be extended forwards and backwards on the left side, as far as the limits of the underlying ventricle. Whilst cutting through the corpus callosum, the student may observe that a thin membraniform structure lines its under surface.

Is thickest at each end.

The *corpus callosum* is thicker at each end than at the centre, in consequence of a greater number of fibres being collected from the cerebrum; and the posterior part is the thickest of all.

Under part.

Connected with the under surface is the septum lucidum or partition between the ventricles (fig. 49, *s*), and still posterior to that is the fornix.

Use.

This body is the chief commissural part of the halves of the brain, and reaches laterally even to the convolutions, but its fibres are not distinct far in the hemisphere.

Dissection.

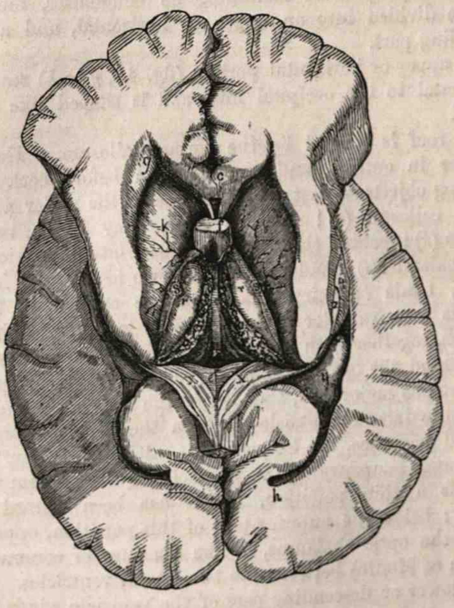
Dissection. The right lateral ventricle is to be now opened in the same way as the left; and to prepare for the examination of the cavity on the left side, as much of the corpus callosum as forms the roof of the space is to be removed. A part of the ventricle extends down in the temporo-sphenoidal lobe towards the base of the brain; and to open it, a cut is to be carried outwards and downwards, through the substance of the left hemisphere, along the course of the hollow. (See fig. 48.)

Five ventricles are in the brain.

VENTRICLES OF THE BRAIN.—The ventricular spaces in the interior of the cerebrum are derived from the subdivision of a large central hollow, and are five in number. One extends into both halves of the brain; but the part in each hemisphere is described as a separate ventricle (the lateral), so that these constitute the first and second. The third occupies the middle line of the brain near the under surface; and the small fifth is included in the partition between the large ventricles of the hemispheres. The fourth ventricle is situate between the cerebellum and the posterior surface of the medulla oblongata and pons.

The *lateral ventricles* (fig. 48) are two in number, one occupying each hemisphere; they are separated incompletely in the middle line by a septum, for they communicate by an aperture below that partition. The interior is lined by a thin stratum of nucleated epithelium (the ependyma ventriculorum), with Lateral ventricle.

Fig. 48.*



cilia at some spots; and at places there is a subjacent stratum of fine areolar tissue.

Each is a narrow interval, which reaches into the anterior, posterior, and middle regions of the corresponding hemisphere. Its central part (body) is almost straight, but the points (cornua) Shape and position;

* View of the lateral ventricles. *c.* Fore part of corpus callosum: the hollow behind it is the fifth ventricle. *e.* Choroid plexus. *f.* Body of the fornix. *g.* Anterior cornu. *h.* Posterior cornu. *k.* Corpus striatum. *l.* Optic thalamus. *n.* Hippocampus minor. *o.* Posterior pillar of the fornix continued into the corpus fimbriatum, *v.* *q.* Hippocampus major. *r.* Convolutions of the exterior. *s.* Tænia semicircularis. *y.* Eminentia collateralis.

by which it reaches into the different lobes are curved. Thus there are three cornua in each, which have the following disposition:—The anterior (fig. 48, *g*) is directed outwards from its fellow in the other hemisphere. The posterior or the digital cavity (*h*) is much smaller in size, and is bent inwards in the occipital lobe towards the one of the opposite side. And the inferior cornu, beginning opposite the posterior fold of the corpus callosum, descends in a curved direction in the temporo-sphenoidal lobe (*q*), with the concavity of the bend turned inwards.

three cornua.

For the purpose of examining its boundaries, the ventricle may be divided into an upper or horizontal, and a lower or descending part.

Consists of two parts.

The upper or horizontal portion (fig. 48, *g* to *h*) reaches from the frontal to the occipital lobe, and is shaped like the Italic letter *f*.

One is horizontal.

The roof is formed by the corpus callosum. The floor is irregular in outline, and presents from before backwards the following objects:—first, a small piece of the under part of the corpus callosum (*c*); next, a large, gray body, the corpus striatum (*k*); behind this, another large white projection, named optic thalamus (*l*); and between the two last bodies is a white line (*s*), tænia semicircularis. On the surface of the optic thalamus is a vascular fold of the pia mater (*e*),—the plexus choroides, together with the thin white half of the fornix (*f*). Close behind the optic thalamus is the beginning of a projection (hippocampus major (*q*)), that lies in the floor of the descending part of the lateral ventricle; and in the posterior cornu is an elongated eminence, the hippocampus minor (*n*).

Its roof; floor, and bodies along it.

The inner boundary of the ventricle, or the septum ventriculorum, is a thin partition, which has been named septum lucidum; below the anterior part of this partition, opposite the front of the optic thalamus, is the aperture of communication (foramen of Monro) between the two lateral ventricles.

Inner boundary. Aperture between two.

The lower or descending part of the ventricle winds beneath the optic thalamus, and forms a curve like the half-bent fore finger. The roof is formed by the optic thalamus and the contiguous part of the hemisphere. In the floor is a large curved, convex eminence, somewhat indented at the end,—the hippocampus major (*q*); and along its concave margin is a thin white band—tænia (*v*), which is prolonged from the fornix. External to the projection of the hippocampus is another white eminence, the eminentia collateralis (*y*), which tapers from above down over the collateral sulcus (fig. 47, [n]). In this part of the ventricle is the vascular fringe of the plexus choroides.

The descending part; roof; floor, and bodies on it.

The *septum lucidum* (fig. 49, *s*), or the thin partition between the lateral ventricles, is translucent, and hangs vertically in the

Septum lucidum; position,

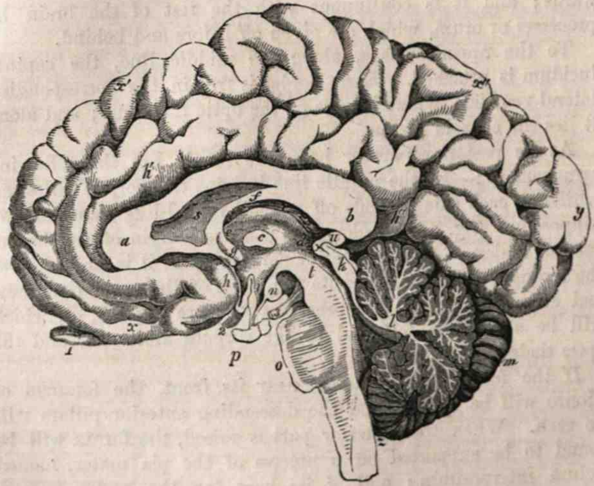
middle line between the corpus callosum and the fornix. It is somewhat triangular in form, with the larger part turned forwards, and the narrow or pointed extremity directed backwards. Its surfaces look to the lateral ventricles. The upper border is attached altogether to the under surface of the corpus callosum; and the lower border is joined in part to the fornix (*f*); but in front of that body it is inserted into the under or prolonged portion (rostrum) of the corpus callosum. The septum consists of two layers, which enclose a space—the fifth ventricle; and each layer is formed of white substance, with an external coating of gray matter.

form, surfaces, borders, structure.

Dissection. The space of the fifth ventricle will come into view by cutting through the part of the corpus callosum that

Dissection.

Fig. 49.*



remains in the middle line, and by detaching and raising forwards the anterior half from the septum lucidum. (See fig. 48).

* Vertical section through the middle of the encephalon. *a* and *b*. Front and back of corpus callosum. *c*. Soft commissure. *d* and *e*. Inner part of optic thalamus, bounding the third ventricle. *f*. Fornix, and *g*, its interior crus. *h* and *h'*. Gyrus fornicatus; and touching the convolution behind at *h*, is the thin lamina cinerea. *i*. Infundibulum. *k*. Corpora quadrigemina, over the passage called aqueduct of Sylvius. *n*. Corpus albicans. *p*. Pituitary body. *r*. Choroid plexus. *s*. Septum lucidum. *t*. Crus cerebri, cut. *u*. Pineal body. *v*. Valve of Vieussens. *x x' x"*. Marginal convolution of the longitudinal fissure. The figures refer to some cranial nerves.

Fifth ventricle.

The *ventricle of the septum*, or the fifth ventricle (fig. 48, *c*), exists in the anterior part of the ventricular partition, where the depth is greatest. Like the septum containing it, its largest part is in front. In the adult it is a closed space; but in the fetus it opens inferiorly into the third ventricle between the pillars of the fornix. Its surface has an epithelial covering like that in the lateral ventricles.

Dissection.

Dissection. The fornix should be next examined. To lay bare this body the posterior part of the corpus callosum should be detached with care from it, and thrown backwards; and the septum lucidum should also be removed from its upper surface.

Fornix: position and form.

The *fornix*, or arch (fig. 49, *f*), is a thin white horizontal stratum beneath the corpus callosum, which, projecting on each side into the lateral ventricle, forms part of the floor of that cavity. It is triangular in shape, with the base turned backwards; and it is continuous with the rest of the brain by processes or crura, which are given off before and behind.

Upper surface and borders.

To the upper surface, along the middle line, the septum lucidum is attached. Each border is free in the corresponding lateral ventricle, where it rests on the optic thalamus; and along it lies the choroid plexus.

Posterior and anterior part.

At its posterior part or base, the fornix has the following arrangement:—In the middle line it joins the corpus callosum, whilst on each side it sends off a small riband-like band—tænia hippocampi (fig. 48, *v*), along the concave margin of the hippocampus major. At the anterior part, or apex, it is arched over the foramen of Monro, opposite the front of the optic thalamus, and ends likewise in two processes or crura (fig. 48, *g*), which will be afterwards followed to the corpora albicantia and the optic thalami (p. 234).

Under surface marked by lines.

If the fornix be cut across near its front, the foramen of Monro will be opened, and the descending anterior pillars will be seen. When the posterior part is raised, the fornix will be found to be supported on a process of the pia mater, named velum interpositum; and at its base (on the under aspect) between the two offsets of the tæniæ hippocampi, is a triangular surface, which is marked by transverse lines: the part which is so defined has been called the lyra.

Fornix formed of two bands.

The fornix may be described as consisting of two bands, right and left, which are united for a certain distance in the central part or body. According to this view each band, commencing in the optic thalamus, passes over the foramen of Monro, and after forming the body of the fornix, is continued as a distinct piece to the surface of the hippocampus major.

This aperture joins lateral ventricles.

The *foramen of Monro* is the interval beneath the anterior part of the fornix, which opens on each side by a slit between the edge of the fornix and the optic thalamus. In it the plexus choroides lies; and through it the lateral ventricles communicate with one another and the third ventricle.

In floor of lateral ventricle is

FLOOR OF THE LATERAL VENTRICLE.—The student may leave untouched, for the present, the membrane on which the fornix rests; and proceed to examine, on the left side, the different bodies that have been enumerated as constituting the floor of the lateral ventricle.

striate body in front.

The *corpus striatum* (superior ganglion of the cerebrum) (fig. 48, *k*), is the large gray body in the anterior part of the lateral ventricle. It is placed opposite the island of Reil in the fissure of Sylvius; and it has received its name from the striated appearance of a vertical section.

Dissection for structure.

Dissection. To see the composition of the corpus striatum, the student should make a cut in it from before backwards, until certain white fibres crossing it obliquely from within outwards are reached. The knife should then be carried through this layer of white fibres until another mass of gray substance, similar to the first, is arrived at.

Its form, and position; is divided into two parts by white fibres.

The *striate body* is a pyriform mass of gray matter of considerable thickness, which is surrounded by the white substance of the hemisphere, except where it projects into the lateral ventricle. Its position is oblique with respect to the middle line of the brain, for the anterior part is near the septum of the ventricles, whilst the posterior is external to the optic thalamus. By means of the incision in the corpus striatum, white fibres can be seen to be directed through it in such a way as to divide the gray matter into two parts, one being situate in the ventricle (intraventricular) above the white fibres, and the other outside the ventricular space (extraventricular), below those fibres.

One part in the ventricle,

The *intraventricular* part (nucleus caudatus) of the striate body is shaped like a kite, and projects into the floor of the ventricle. The end, directed forwards, is large and rounded; whilst the opposite end is thin and pointed, and is continued backwards, outside the optic thalamus, to the roof of the descending cornu of the lateral ventricle. Numerous veins cover this part of the corpus striatum.

the other outside that cavity.

The *extraventricular* part (nucleus lenticularis) will be best seen, afterwards, by sections made from the outer side or from below. It is oval in form, but does not reach so far back as the other, and is bounded inferiorly by a white capsule; through it the anterior commissure of the brain passes very obliquely, as a subsequent dissection will show.

Tænia semicircularis

The *tænia semicircularis* (fig. 48, *s*,) is a thin and narrow white band of longitudinal fibres, which lies between the corpus striatum and the optic thalamus. In front this band becomes broad and joins the pillar of the fornix; and behind it is continued along with the pointed end of the corpus striatum, into ends in inferior cornu. the white substance of the roof of the descending cornu of the lateral ventricle. Superficial to the anterior part of the tænia is a yellowish semi transparent layer (lamina cornea); and beneath this pass some small veins from the corpus striatum in their course to the veins of Galen.

Optic thalamus. The *optic thalamus* is only partly laid bare in this stage of the dissection, and its examination may be omitted till the third ventricle has been learnt.

Hippocampus in posterior cornu: The *hippocampus minor* (calcar avis) resembles a cock's spur (fig. 48, *n*), as it lies in the posterior cornu of the ventricle. It is pointed at its posterior extremity, and is covered on the free surface by a medullary layer continuous with the corpus callosum. how formed. When it is cut across a gray stratum will be found beneath the white; and the eminence itself will be found to be produced by the extension inwards of the calcarine sulcus at the posterior part of the inner surface of the hemisphere (p. 221).

Hippocampus major in lower cornu; The *hippocampus major* (fig. 48, *q*) is the curved projection in the floor of the descending cornu of the lateral ventricle. Convex on the surface that looks to the cavity, this body is curved in the same direction as the cornu, and has its concavity turned inwards. has a large end The anterior extremity is the largest, and presents two or three indentations, which give it the appearance of the foot of a feline animal; hence the designation pes hippocampi.

and notched border. Along the inner or concave margin is the small band or tænia that is prolonged from the fornix; it ends below by joining the small recurved part of the uncinate convolution.

Dissection. *Dissection.* To examine more fully the hippocampus, the parts of the corpus callosum and fornix, which remain in the middle line, should be divided longitudinally, and the posterior part of the left hemisphere should be drawn outwards. When the pia mater has been removed from the inner side of the hippocampus, and this projection has been cut across, its structure will be manifest.

Structure of hippocampus. The *hippocampus* is covered on the ventricular surface by a medullary layer, with which the tænia or the band of the fornix blends. On its opposite surface is the hollow of the dentate sulcus on the exterior of the brain, which is filled with gray substance. Along the free margin of the hippocampus the gray matter projects in the form of a notched ridge, the *lamina dentata:* this is external to the cavity of the ventricle and beneath the tænia.

Great transverse fissure *Transverse fissure of the cerebrum.* By drawing the separated left hemisphere away from the crus cerebri and the optic thalamus, and then replacing it, the dissector will comprehend the position, and the boundaries of the great cleft at the posterior part of the brain.

is beneath fornix and This fissure is placed beneath the fornix, and extends downwards, on each side, from the foramen of Monro in the middle line to the end of the descending cornu; its central part lies beneath the fornix and corpus callosum; and the lateral is placed between the edge of the fornix and the optic thalamus and crus cerebri. Through this great slit the pia mater passes into the brain, and forms the velum interpositum and the plexus choroides. Where the pia mater projects into the lateral ventricle, beneath the edge of the fornix, it is supposed to receive a prolongation from the lining structure of the cavity, by which the interval beneath the fornix is closed. **corpus callosum, and reaches base of brain, Pia mater enters it.**

Parts in the Middle Line of Cerebrum. The student is now to return to the examination of the parts in the centre of the brain, viz. the fold of pia mater and its vessels, with the third ventricle. At the same time the optic thalamus is to be seen. **Parts in the middle of the brain.**

The *velum interpositum* is the central part of the fold of pia mater entering the brain by the great transverse fissure. Triangular in shape, the velum has the same extent as the body of the fornix, and reaches in front to the foramen of Monro. The upper surface is in contact with the fornix, to which it supplies vessels. And the lower surface, looking to the third ventricle, covers the pineal body, and a part of each optic thalamus: attached to it at the middle line are the two choroid plexuses of the third ventricle. Along each side is another vascular and fringed roll of the membrane (choroid plexus). **Velum, or fold of pia mater, is over third ventricle; its lateral part**

The *choroid plexus* of the lateral ventricle (fig. 48, *e*,) is the red, somewhat rounded, and fringed margin of the fold of pia mater in the interior of the brain. Each is described as extending from the foramen of Monro to the extremity of the descending cornu; and the lower end is larger than the upper. On its surface the choroid plexus is villous; and the villi, minutely subdivided, are covered by flattened nucleated epithelium, with fat granules and pigment in the cells.* **is the choroid plexus of the lateral ventricle.**

Vessels of the velum. Small *arteries* have been already traced to the velum and the choroid plexus from the cerebral and cerebellar arteries (p. 192): they are three on each side, and supply the surrounding cerebral substance. The *veins* of the choroid plexus receive branches from the ventricle, and end in the following. **Vessels of the velum. Arteries; veins;**

Veins of Galen. Along the centre of the velum are placed these two large veins; they begin at the foramen of Monro, by the union of branches from the corpus striatum and the choroid plexus. Lying side by side in the membrane they are usually united into one at the posterior part of the velum; and this opens into the straight sinus. **with veins of Galen.**

Dissection. When the velum interpositum has been raised and **Dissection.**

* Particles of brain sand, like that in the pineal body, are sometimes present in the choroid plexus.

thrown backwards, the third ventricle will be visible. In reflecting the piece of pia mater the student must be careful of the pineal body, which would otherwise be detached, as it is surrounded by the membrane. On the under surface of the velum are the choroid plexuses of the third ventricle.

Other choroid plexuses.

The *choroid plexuses* of the *third ventricle* are two short and narrow fringed bodies beneath the velum, which resemble the like parts in the lateral ventricle.

Third ventricle

is near base of brain.

The *third ventricle* is the interval between the optic thalami (fig. 49, *e* to *d*). Its situation is in the middle line of the cerebrum, below the level of the other ventricles with which it communicates; and it reaches to the base of the brain. Its boundaries and communications are the following.

Roof.

Floor.

The roof is formed by the velum interpositum and the fornix. The floor is very oblique from behind forwards, so that the depth of the cavity is about an inch in front and half an inch behind. Corresponding with the floor are the parts at the base of the brain, which lie between the crura cerebri and the median fissure, viz. locus perforatus, corpora albicantia, tuber cinereum, commissure of the optic nerves, and lamina cinerea. On the sides of the cavity are situate the optic thalami. In front of the space are the descending pillars of the fornix, with the anterior commissure of the cerebrum in the interval between them. Behind are the posterior commissure and the pineal body. Crossing the centre of the space, from one optic thalamus to another, is a band of gray matter—the soft commissure (*c*).

Parts on the sides,

in front,

and behind.

Openings into other ventricles.

This space communicates with the other ventricles of the brain in the following way :—In front it joins each lateral ventricle through the foramen of Monro ; and in the fetus opens into the fifth ventricle. Behind is a passage beneath the posterior commissure into the fourth ventricle, which is named aqueduct of Sylvius. At the lower part, in front, there is a depression opposite the infundibulum (iter ad infundibulum).

Lining of cavity.

The lining of the ventricle is continued into the neighbouring cavities through the different apertures of communication, and closes the iter ad infundibulum.

Gray matter of the ventricle.

Gray matter of the ventricle. A stratum of gray matter covers most of the surface of the ventricle. At the lower part of each optic thalamus it envelops the crus of the fornix, and ascends to the septum lucidum ; and in the floor of the cavity it exists in abundance, uniting the structures that form the floor of the third ventricle, and entering into the corpora albicantia. In the middle of the space it reaches from side to side, and forms the *soft commissure.*

Soft commissure.

Anterior commissure:

The *anterior commissure* of the cerebrum is a round bundle of white fibres about as large as a crow-quill, which passes through both corpora striata, and connects the opposite hemispheres. To see it in one half of its extent, the student should make the following dissection :—

Dissection. On the side on which the corpus striatum has been cut into, the commissure is to be followed into the interior of that body, by scraping away the gray matter (intraventricular) with the handle of the scalpel. The commissure may be seen then to perforate below the white fibres of the corpus striatum, and is to be followed through the other mass of gray matter (extraventricular) of the same body. **To see it, cut corpus striatum.**

The *anterior commissure* is free in the middle line for about the eighth of an inch, where it lies before the pillars of the fornix. Laterally it perforates the corpus striatum, passing in succession through the intraventricular gray mass, the white fibres, and the extraventricular gray mass. Lastly, the commissure pierces the white layer bounding externally the corpus striatum, and spreads in the hemisphere over the roof of the inferior cornu of the lateral ventricle. **Position; and course to roof of inferior cornu.**

The *posterior commissure* of the cerebrum is smaller than the anterior, and is placed above the passage into the fourth ventricle. Laterally it enters the substance of the optic thalamus, and piercing it, ends in the hemisphere. **Posterior commissure.**

The *thalamus opticus* (inferior ganglion of the cerebrum) will be best seen on the side on which the inferior cornu of the lateral ventricle has been opened. It has the form of a cube, and bounds the lateral and third ventricles. **Thalamus opticus.**

The upper surface projects in the floor of the lateral ventricle (fig. 48, *l*), and is marked in front by a prominence—anterior tubercle, near the tænia semicircularis. The under surface forms part of the roof of the inferior cornu of the lateral ventricle, and into it the crus cerebri is inserted. **Upper surface. Under part.**

By its inner side it enters into the third ventricle; and along the upper part lies the peduncle of the pineal body. On the outer side are the corpus striatum, and the substance of the hemisphere. **Inner side. Outer side,**

The anterior end looks to the foramen of Monro. And the posterior part, which is free in the inferior cornu of the lateral ventricle, presents inferiorly two small roundish tubercles, which are placed one outside and the other inside the bend (genu) of the optic nerve, and are named from their position to it, *internal* and *external geniculate* bodies. **anterior, and posterior ends. Corpora geniculata.**

The *origin* of the *optic nerve* can now be seen. At the back of the crus cerebri the optic tract receives fibres from the thalamus which it touches, and then divides into two terminal bands:—One of these is connected with the gray matter in the external geniculate body, and is continued onwards to one of the corpora quadrigemina (nates); the other is similarly connected with the internal geniculate body, and is then prolonged to the other quadrigeminal body (testis) of the same side. **Optic nerve. Origin.**

Dissection.

Dissection. The origin of the fornix in the optic thalamus may be followed out next. As a preparatory step the anterior commissure, the anterior part of the corpus callosum, and the commissure of the optic nerves, should be cut along the middle line, so that the left hemisphere can be separated from the other. On the left hemisphere the crus of the fornix is to be traced downwards through the gray matter of the third ventricle to the corpus albicans, and then upwards into the optic thalamus.

Origin of fornix in thalamus;

Anterior pillar of the fornix (fig. 49, *g*). The fornix begins in the thalamus opticus near the tubercle on the upper surface. From this origin it descends in a curved direction to the corpus albicans, where it makes a turn like half of the figure 8, and furnishes a white envelope to the gray matter of that body. The crus then ascends, being bent forwards, through the gray substance on the side of the optic thalamus, and is applied to the like part of the opposite side to form the body of the fornix. It is joined by the bands of fibres from the tænia semicircularis and peduncle of the pineal body.

how forms corpus albicans.

Joined by other fibres.

The *pineal body* and the *corpora quadrigemina*, which are placed behind the third ventricle, may be next examined.

Dissection.

Dissection. All the pia mater should be carefully removed from the surface of the quadrigeminal bodies, especially on the left side, on which they are to be seen. The posterior lobe of the hemisphere of the same side may be taken away.

Pineal gland; position, shape, attachment to thalamus.

The *pineal gland* (conarium) is a small conical body (fig. 49, *u*), which is situate above the posterior commissure, and between the anterior pair of the corpora quadrigemina. In shape like the cone of a fir, it is about a quarter of an inch in length, and has the base or wider part turned forwards. It is connected to the optic thalami by two white bands,—peduncles of the pineal body: these begin at the base of the pineal gland, and extending forwards, one on each side, along the inner part of the optic thalami, end by joining the crura of the fornix. At the base of the gland is a band of transverse white fibres which unites it with the posterior commissure.

Structure.

This body is of a red colour and vascular, and encloses two or more cells containing a thick fluid, with a calcareous material (brain sand) consisting of particles of phosphate and carbonate of lime, and phosphate of magnesia and ammonia.* It contains in its substance large pale nucleated cells without offsets, with a few nerve fibres.

Corpora quadrig.

The *corpora quadrigemina* (fig. 49, *k*) are four small bodies, which are arranged in pairs, right and left, and are separated by

* These particles are referred to by Kölliker, as pathological products; and the concentrically arranged masses amongst them are said to be incrustations of fibrin coagula.

a median groove. Each pair is situate on the cerebral aspect of the peduncle of the cerebrum of the same side.

The anterior eminence (nates) is somewhat larger than the posterior, from which it is separated by a slight depression; it is oblong from before backwards, and sends forwards a white band to join the optic thalamus and the optic tract. **Anterior one (nates).**

The posterior eminence (testis) is rounder in form and whiter in colour than the preceding: it has also a lateral white band, which is directed beneath the corpus geniculatum internum, and blends with the optic tract and the thalamus opticus. **Posterior one (testis).**

These bodies are small masses of gray substance enveloped by white, and are placed on the band of the fillet which forms the roof of the aqueduct of Sylvius. The processes (brachia) to the optic thalamus are accessory parts to the peduncular fibres of the cerebrum. **Structure and their bands.**

Fillet of the olivary body. If the upper margin of the cerebellum be pulled aside, a white band, about a quarter of an inch in width, will be seen to issue from the transverse fibres of the pons, and to be directed upwards over the upper peduncle of the cerebellum to the corpora quadrigemina (fig. 50, *i*). **Fillet of olivary body**

This is the upper or commissural piece of the fillet (p. 210), which passes beneath the corpora quadrigemina, and joins beneath them, over the Sylvian aqueduct, with the similar part of the opposite side. **passes beneath corpora quadrigemina.**

STRUCTURE OF THE CEREBRUM. In each cerebral hemisphere three principal sets of constituent fibres are recognised, viz., diverging, transverse, and longitudinal. The former are in part continuous with those of the spinal cord; while the two latter join distant pieces of the cerebrum, and are considered to be only connecting or commissural in their office. **Three sets of fibres in cerebrum.**

Peduncular or diverging fibres (fig. 50). In the crus cerebri or the root of the cerebral hemisphere, two bundles of longitudinal fibres are collected; these are separated, in part, by gray matter, and are derived from the medulla oblongata (p. 212). **Fibres of crus cerebri to the hemisphere.**

Dissection. A complete systematic view of the diverging fibres cannot be now obtained on the imperfect brain. At this stage the chief purpose is to show the passage of the radiating fibres from the crus through the two cerebral ganglia. **Dissection of them**

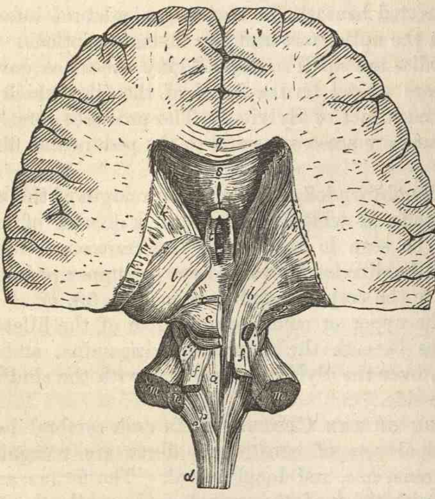
To trace the diverging fibres onwards beyond the crus cerebri, and through the corpus striatum, the nucleus caudatus of this body should be scraped away; and the dissection should be made on the side on which the striate body and the optic thalamus remain uncut. In this proceeding the pecten of Reil comes into view, viz., gray matter passing between the white fibres in the corpus striatum, and giving the appearance of the teeth of a comb. **in the corpus striatum**

On taking away completely the prolonged part of the nucleus caudatus, others of the same set of fibres will be seen issuing from the outer side of the optic thalamus, and then radiating to the posterior and inferior lobes.

and optic thalamus.

After tracing those fibres, the upper part of the optic thalamus may be taken away at the posterior end, to denude the accessory

Fig. 50.*



bundles to the peduncular fibres, from the corpora quadrigemina and the superior peduncle of the cerebellum: the last band lies beneath the corpora quadrigemina.

Fibres of peduncle diverge

Their *arrangement* (fig. 50). The *diverging fibres* radiate from the peduncle of the cerebrum to the surface of the hemisphere, passing in their course through the two cerebral ganglia (optic thalamus and corpus striatum), and they form a conically-shaped bundle, whose apex is below and base above.

in corpus striatum and optic thalamus:

The fibres forming the free or fasciculated part (crust) of the peduncle pass through the striate body to the hemisphere.

* Upper view of the peduncular fibres. *a.* Fasciculus teres. *b.* Fascicular fibres continued into the crus cerebri on the upper aspect (the tegmentum). *c.* Corpora quadrigemina. *f.* Superior peduncles of the cerebellum. *i.* Upper part of the fillet. *k.* Corpus striatum. *l.* Thalamus. *s.* Under portion of corpus callosum in front, decussating laterally at *y*, with the diverging fibres. Other parts are—*p.* Posterior pyramid; *e.* restiform body; *n.* middle peduncles of the cerebellum cut across; *q.* upper surface of corpus callosum.

The fibres on the opposite aspect of the peduncle, which form its tegmentum (fig. 50, *b*), are transmitted to the convolutions through the under part of the optic thalamus, and through the corpus striatum, reaching as far forwards as, but much farther back than, those of the crust.

they decussate here, In the thalamus and the corpus striatum the two sets of fibres decussate, those of the crust being directed up and in through the fibres derived from the tegmentum, which pass down and out. In those two bodies the fibres are greatly increased in number. **their accessory bands.** The upper or sensory set receive also accessory bundles from the superior peduncle of the cerebellum whilst they lie in the crus cerebri (p. 242); and from the pair of the corpora quadrigemina, and the corpora geniculata of the same side, whilst they are passing through the thalamus.

In the hemisphere they extend to convolutions. On escaping from the striate body and the thalamus the fibres decussate with the converging fibres of the corpus callosum, and radiate then into the anterior, middle, and posterior parts of the cerebral hemisphere, forming the *corona radiata*. In the hemisphere the fibres are continued to the convolutions. Their expansion in the hemisphere resembles a fan bent down in front and behind, forming thus a layer which is concave on the under side.

Fibres not reaching throughout. Their *extent*. All the fibres of the peduncle do not reach the surface of the brain, for some end in the corpus striatum and the optic thalamus, especially in the former. Nor are all the fibres at the convolutions derived originally from the peduncle, as some begin in the ganglionic bodies before said, and extend to the surface of the hemisphere.* Thus, in addition to the fibres continued throughout, viz. from the crus to the surface, some unite the peduncle of the cerebrum with the ganglia, and others connect the ganglia with the convolutions on the exterior.

Source from cord. Their *source*. The fibres thus entering inferiorly the cerebrum through its peduncle, and continued thence to the periphery of the hemisphere, are derived from the components of the medulla oblongata except the restiform body (fig. 42), viz., from anterior pyramid, lateral column, and posterior pyramid (p. 209).

Decussation. The *decussation* between the fibres of opposite sides has been before referred to (p. 212).

Commissural transverse fibres. The *transverse or commissural fibres* connect the hemispheres of the cerebrum across the middle line. They give rise to the great commissure or the corpus callosum (fig. 50, *g* and *s*) (p. 224): and to the anterior and posterior commissures (p. 233). Those bodies have been already examined.

* According to Kölliker and others, none of the fibres of the peduncle reach farther than the corpus striatum and the optic thalamus.

Commissural longitudinal fibres.

Longitudinal fibres. Other connecting fibres pass from before backwards, uniting together parts of the same hemisphere.

The chief bands of this system are the following, the fornix, the tænia semicircularis, and the peduncles of the pineal body. Other longitudinal fibres may be enumerated on the upper and under surfaces of the corpus callosum, along the middle line, together with the band of the convolution of the corpus callosum: the fibres in contact with the corpus callosum are connected with the anterior perforated spot of the base of the brain.

Optic thalamus differs above and below.

Structure of the optic thalamus. On making sections of the optic thalamus on the side on which it is entire (the left), this body will be found to consist of layers of gray and white substance at the upper and inner parts; and of the medullary fibres (tegmentum) of the peduncle of the cerebrum, at the lower and outer parts.

Corpora geniculata.

The *corpora geniculata* contain gray substance inside. Into each enter fibres of the optic tract; and from each issues a band to join the fibres of the crus cerebri. They seem to serve as accessory ganglia to the peduncular fibres of the cerebrum.

Section of corpus striatum from outside.

Corpus striatum. By slicing through the corona radiata on the right side, so as to bring into view the extraventricular part (nucleus lenticularis) of the corpus striatum, the extent and form of that mass, and the situation of the anterior commissure in it, will be apparent.

Section of crus cerebri

Crus cerebri. By a vertical section through the right peduncle of the cerebrum, the disposition and the thickness of the two layers of its longitudinal fibres; and the situation and extent of the locus niger between them, may be perceived.

SECTION V.

THE CEREBELLUM.

Prepare cerebellum.

Dissection. The cerebellum is to be separated from the remains of the cerebrum, by carrying the knife through the optic thalamus so that the small brain, the corpora quadrigemina, the crura cerebri, the pons, and the medulla oblongata, may remain united together.

Parts to be separated from one another.

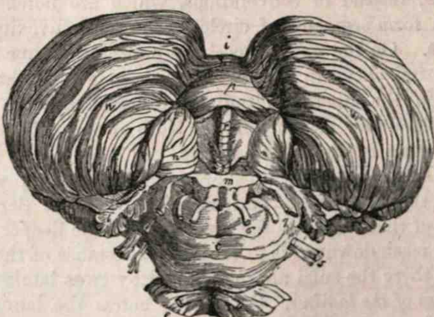
When the cerebellum has been detached as above said, all the pia mater is to be carefully removed from the fissure on its under surface; and the different bodies in that fissure (p. 240) are to be separated from one another. Lastly the handle of the scalpel should be passed along a sulcus at the circumference, which is continued from the crus between the upper and under surfaces.

The *cerebellum*, little brain (fig. 51), is flattened from above down, so as to be widest from side to side, and measures about four inches across. This part of the encephalon is situate in the posterior fossæ of the base of the skull, beneath the tentorium cerebelli. Like the cerebrum, it is incompletely divided into two hemispheres;—the division being marked by a wide groove along the under surface, and by a notch at the posterior part which receives the falx cerebelli. **Form and position of cerebellum. Divisions.**

UPPER SURFACE. On the upper aspect the cerebellum is raised in the centre, but is sloping towards the circumference. There is not any median sulcus on this surface; and the halves are united by a central constricted part or isthmus,—the superior vermiform process. Separating the upper from the under surface, at the circumference, is the horizontal fissure, which is wide in front, and extends backwards from the pons to the middle line of the cerebellum. **No groove on the upper surface; halves joined by median part.**

The UNDER SURFACE is convex, being received into the fossæ of the base of the skull, and is divided into hemispheres (fig. 51, *w*) by a median hollow (vallecula). **A fissure below,**

Fig. 51.*



The *central sulcus*, or the vallecula, receives the medulla oblongata, and is wider at the middle than at either the anterior or the posterior end. In the bottom of the sulcus is a mass named inferior vermiform process (fig. 51, *i* to *s*), which corresponds with the central part connecting the halves of the cere- **which is called valley, and contains vermiform process.**

* Under part of the cerebellum seen from before the medulla oblongata, *m*, being cut away in greater part. *c*. Pons Varolii, with the cerebellum attached to the sides. *l*. Flocculus or subpeduncular lobe. *n*. Amygdaloid lobe. *i* to *s*. Inferior vermiform process, consisting of the following parts:—*p*. Pyramid. *r*. Uvula, and *s*. Nodule. *w*. Biventral lobe. *x*. Posterior medullary velum. The cranial nerves are marked by figures.

bellum on the upper surface: the two parts constitute the general commissure of the halves of the cerebellum.

Constituents of vermiform process.

Constituents of the vermiform process. Entering into the inferior vermiform process are the following eminences, which may be easily separated from one another with the handle of the scalpel:—

Uvula,

Most anteriorly is a narrow body, the *uvula* (fig. 51, *r*), which is named from its resemblance to the same part in the throat; it is longer from before backwards than from side to side, and is divided into laminæ. Its anterior projection into the fourth ventricle is named *nodule*, or laminated tubercle, *s*; and on the side is a band of gray matter with ridges and sulci, the *furrowed band*, which unites it with the almond-like lobe of the hemisphere. Connected with the nodule is a thin white layer,—the *medullary velum*; but this and the furrowed band will be seen in a subsequent dissection (p. 241). Behind the uvula is a tongue-shaped body, named *pyramid*, *p*, which is elongated from side to side, and is marked by transverse laminæ. Still farther back are certain transverse pieces, *i*, extending between the posterior lobes of the hemispheres, of which they were considered by Reil to be the commissures.

nodule, furrowed band, velum, pyramid, and commissures.

Laminæ and their arrangement.

Laminæ. The surface of the cerebellum is covered by plates or laminæ, instead of convolutions, which are notched on the sides, and form segments of circles with their convexity directed backwards. On the upper aspect the anterior laminæ pass from the one hemisphere to the other, with only a slight bending forwards in the superior vermiform process; but the rest and those on the under aspect join the sides of the different bodies or commissures in the median fissure.

Sulci are shallow and deep.

Sulci. Between the laminæ are sulci or fissures, which are lined by the pia mater, and reach to different depths: the shallower of these separate the laminæ; but the deeper limit the lobes, and reach downwards to the white substance of the interior. Here and there the sulci are interrupted by cross laminæ.

A lamina has white inside;

Structure of the laminæ. On cutting across the laminæ of the upper surface on the left side they will be seen to possess a white internal, and a gray external layer (fig. 49). The white part is derived from the central medullary mass; and dividing, like the branching of a tree, it ends in small lateral offsets which enter the subdivisions of the laminæ.

collateral white fibres;

Besides the white stalk of the lamina, derived from the central mass, there are other white fibres which pass from one lamina to another beneath the sulci.

and gray outside.

The stratum of gray matter enveloping the white substance resembles the cortical covering of the convolutions of the cerebrum. It is constructed of two strata, inner and outer, which can be distinguished by a difference in their colour. The superficial stratum is gray, and about equal to the other in thickness; but the deeper one is of a rust-colour, and is generally thickest in the hollows between the laminæ.

Lobes of the Hemisphere. Each hemisphere is subdivided into lobes on both aspects. Seven lobes in each hemisphere.

On the upper surface there are two lobes, anterior and posterior, which are separated by a sulcus, but the interval between them is not well marked. The *anterior* or *square lobe* extends back to a level with the posterior edge of the vermiform process; and the *posterior* reaches thence to the great horizontal fissure at the circumference. Two lobes on upper surface.

On the under surface of the cerebellum, there are five lobes; and three of them are separated by sulci amongst the laminæ of the hemisphere, but they are not more distinct than the lobes on the upper surface. Beginning behind, the student will meet first the *posterior lobe*, which joins the commissural laminæ behind the pyramid in the valley. Next in succession is the *slender lobe*, which is connected with the posterior part of the pyramid, as well as with the other transverse laminæ behind that body. And lastly, attached to the side of the pyramid, is the *biventral lobe*, *w*. Five on under surface, viz., on the hemisphere, posterior, slender, and biventral.

The two other lobes, though smaller are more separate, and appear between the biventral lobe and the medulla oblongata:— One of these is the *amygdaloid lobe* (fig. 51, *n*), which projects into the vallecula opposite the uvula, and touches the medulla oblongata. The other is a small pyramidal slip, which is directed outwards over (the under surface of the cerebellum being uppermost) the crus cerebelli, and is named *flocculus*, or subpeduncular lobe (fig. 51, *l*). Two other lobes in valley; amygdaloid and flocculus.

Dissection. To see the flocculus and the posterior medullary velum, the biventral and slender lobes are to be sliced off on the left side, so that the amygdaloid lobe may be everted from the valley. The flocculus is laid bare by this proceeding, and passing from it to the tip of the uvula is the thin and soft white layer of the posterior velum; beneath the last a bit of paper may be inserted. The furrowed band on the side of the uvula can be fully seen now. Dissection for flocculus.

Flocculus and medullary velum. The position of the flocculus to the crus cerebelli has been before mentioned. This body resembles the other lobes in structure, and may be considered a rudimentary lobe; for it is divided on the surface into laminæ (fig. 51, *l*), and contains a white medullary centre which furnishes offsets to the laminæ. Position and structure of flocculus.

Passing from the flocculus to the tip of the inferior vermiform process (nodule) is the half of a thin white layer (fig. 51, *x*), the *posterior medullary velum*, which serves as a commissure to the flocculi. On each side this band is semilunar in form. Its anterior edge is free; but its posterior border is attached in front of Posteri medullary velum. Form and attachments.

the transverse furrowed band. In front of the nodule the pieces of opposite sides are united.

Cerebellum is solid internally.

INTERIOR OF THE CEREBELLUM. In the cerebellum there is not any cavity or ventricle enclosed as in the cerebrum. In the interior there is a large white centre, corresponding with that of the cerebrum, which furnishes offsets to the laminæ, and to other parts of the encephalon. A space, the fourth ventricle, is situate between the cerebellum and the medulla oblongata.

Dissection of laminæ, of centre, and corpus dentatum.

Dissection. For the purpose of seeing the medullary centre, with its contained corpus dentatum, remove all the laminæ from the upper surface on the right side. This dissection may be accomplished by placing the scalpel in the horizontal fissure at the circumference, and then carrying it inwards as far as the upper vermiform process, so as to detach the cortical stratum. If the corpus dentatum does not at first appear, thin slices may be made in front till it is reached.

White centre of cerebellum.

MEDULLARY CENTRE. In the centre of each cerebellar hemisphere is a large white mass, containing in its substance a dentate body. From its surface offsets are furnished to the different laminæ; and from the anterior part proceeds a large stalk-like process, the crus cerebelli. The crus is further subdivided into three pieces or peduncles, which connect the cerebellum with other parts, viz. an upper offset for the cerebrum, a middle piece for the pons, and a lower one for the medulla oblongata.

Gives offsets, viz.,

superior peduncle is above fourth ventricle.

The *superior peduncle* (processus ad cerebrum) is directed forwards towards the corpora quadrigemina (fig. 50, *f*). It is rather flattened in shape, and forms part of the roof of the fourth ventricle: between the processes of opposite sides the valve of Vieussens is situate. Its fibres, continuous behind with the inferior vermiform process (fig. 49, *r*), receive an offset from the interior of the corpus dentatum; and passing beneath the band of the fillet and the pair of the corpora quadrigemina of the same side, enter the optic thalamus and join with the fibres of the crus cerebri.

Its fibres partly decussate.

Beneath the corpora quadrigemina the internal fibres of the peduncle are directed inwards across the middle line, through the bundle prolonged from the fasciculus teres.* In this way the fibres of each peduncle end partly in the same, and partly in the opposite hemisphere of the cerebrum.

Valve of Vieussens between the two.

Between the superior peduncles is a thin, translucent, white layer,—the *valve of Vieussens* (velum medullare anterius), which

* This intercommunication was known to Reil, and was named "ansa" by him, but the decussation has been noticed more recently by Stilling, *Ueber den Bau des Hirnknotens:* 1846.

enters into the roof of the fourth ventricle (fig. 49, *v*). It is thin and pointed anteriorly, but widens behind, where it is connected with the under part of the vermiform process. Near the corpora quadrigemina the fourth nerve is attached to the upper surface of the valve,—the nerves of opposite sides being united; and close to the cerebellum this surface is marked by some gray transverse ridges.

Middle peduncle

The *middle peduncle* (processus ad pontem), commonly named crus cerebelli (fig. 40), is the largest of the three peduncular processes. Its fibres begin in the lateral part of the cerebellum, and are directed forwards to the pons, of which they form the transverse fibres, and unite with the peduncle of the opposite side. This peduncle is supposed to perform for the cerebellum, the same office as the corpus callosum does for the cerebrum, viz. to serve as a commissural or connecting band between the halves.

is the commissure of cerebellum.

Inferior peduncle to medulla.

The *inferior peduncle* (fig. 42, *n*) (processus ad medullam) passes downwards to the medulla oblongata, and gives rise to the restiform body (*e*). Its fibres begin chiefly in the laminæ of the upper surface of the cerebellum. It will be better seen when the fourth ventricle has been opened.

Fibres of peduncles.

The fibres contained in the peduncles connect one cerebellar hemisphere with the cerebrum, with its fellow, and with the medulla oblongata of the same side, in the manner mentioned above.

Corpus dentatum.

The *dentate body* (corpus dentatum) is contained in the white mass of the cerebellum, and resembles the like part in the corpus olivare of the medulla oblongata. This body measures three fourths of an inch from before back, and is situate near the inner part of the white centre. It consists of a small plicated capsule, which, when cut across, appears as a thin, wavy, grayish-yellow line; this bag is open at the anterior part, and encloses a *nucleus* of whitish substance. Through its aperture issues a band of fibres from the nucleus to join the superior peduncle.

Situation and structure.

Dissection.

Dissection. One other section must be made to show the fourth ventricle and the structure of the vermiform process. The cerebellum still resting on its under surface, let the knife be carried vertically through the centre of the vermiform process; and then the structure of the central uniting part, as well as the boundaries of the fourth ventricle, may be observed on separating the halves of the cerebellum.

Vermiform process is like other parts.

Structure of the vermiform process (fig. 49). The upper and lower vermiform processes of the cerebellum are united in one central part, which connects together the hemispheres. The structure of this connecting piece is the same as that of the rest of the cerebellum, viz. a central white portion and investing laminæ. Here the branching appearance of a tree (arbor vitæ) is best seen, in consequence of the laminæ being more divided, and the white central parts longer and more ramified.

Fourth ventricle. The FOURTH VENTRICLE (fossa rhomboidalis) is a space between the cerebellum and the posterior surface of the medulla oblongata and pons (fig. 49). It has the form of a lozenge, with the points placed upwards and downwards. The upper angle reaches as high as the upper border of the pons; and the lower, to a level with the inferior part of the olivary body. Its greatest breadth is at the spot where the peduncles of the cerebellum are connected with the medulla and pons; and a transverse line in this situation would divide the hollow into two triangular portions—upper and lower. The lower half has been named *calamus scriptorius* from its resemblance to a writing pen.

Form and extent,

breadth,

calamus scriptorius.

Lateral boundary. The *lateral boundaries* are more marked above than below. For about half way down, the cavity is limited on each side by the superior peduncle of the cerebellum, which projecting over it forms part of the roof; and along the lower half on each side lies the eminence of the restiform body.

Roof. The *roof* of the space is somewhat arched, and is formed above by the valve of Vieussens, and the under part of the vermiform process; and below, by the reflection of the pia mater from that process to the spinal cord, as well as by the thin nervous stratum of the ligula (p. 203).

Floor. The *floor* of the ventricle is constituted by the posterior surfaces of the medulla oblongata and pons, and is grayish in colour. Along its centre is a median groove, which ends below, near the point of the calamus, in a minute hole,—the aperture of the canal of the cord. On each side of the groove is a spindle-shaped elevation, the *fasciculus* s. *eminentia teres.* This eminence reaches the whole length of the floor, and is pointed and little marked inferiorly, where it is covered by gray substance; but it becomes whiter and more prominent superiorly, and its widest point is opposite the crus cerebelli.

Parts in it are, median fissure, and central canal. Fasciculus teres.

Foveæ, The outer border of the eminence is limited externally by a slight groove, which (in some bodies well marked) will point out the position of two small fossæ (fovea anterior et posterior). The *posterior*, resembling a fissure, is near the lower end of the groove; and the *anterior* is opposite the crus cerebelli. At the top of the anterior fossa is a deposit of very dark gray substance, *locus cæruleus**, which has a bluish appearance as it is seen through the thin stratum covering it; from it a bluish streak (tænia violacea) is continued upwards, at the outer edge of the

posterior, anterior.

Locus cæruleus.

* The term locus cæruleus seems to be applied to the spot, for the dark vesicular matter in it has been named *substantia ferruginea.*

eminentia teres, to the opening in the top of the fourth ventricle.

White striæ. Crossing the floor on each side, opposite the lower border of the pons, are some white lines, which vary much in their arrangement, and sometimes are not to be recognised: they issue from the central median fissure, and enter the auditory nerve (p. 198); but one may be sometimes seen to sink into the locus cæruleus.

Eminences of nerve nuclei. Besides the objects above mentioned, there are other eminences in the floor of the ventricle indicating the position of the nuclei of origin of certain nerves.

In lower half; nuclei of the lingual, In the lower half of the ventricle are three slight eminences on each side for the lingual, vagus, and auditory nerves:— that for the lingual is close to the middle line below, and corresponds with the lower pointed part of the fasciculus teres.

vagus, glosso-pharyngeal, auditory and accessory. The other two, outside the fasciculus, are placed in a line one above another, but separated by a well-marked groove (fovea posterior); the lower is the nucleus of the vagus and glosso-pharyngeal, and the upper is the nucleus of the auditory nerve. Running into the lower part of the vagus nucleus, is the nucleus of the accessory portion of the spinal accessory nerve. (See p. 200).

In upper half, nucleus of the sixth and facial. In the upper half of the space some other nerves take origin from nuclei, but there is only one projection. This is placed over the common nucleus of the sixth and the facial nerve: it is a globular elevation on the outer part of the eminentia teres, about a line above the white cross striæ on the floor, and close behind the fovea anterior.

Openings of the ventricle. The fourth ventricle communicates at the upper part with the third ventricle through the Sylvian aqueduct; and with the subarachnoid space of the cord and brain, through an aperture in the pia mater intervening between the medulla and the cerebellum: laterally, the ventricular space is extended for a short distance between the cerebellum and the side of the medulla oblongata.

Its lining and epithelium. The lining of the other ventricles is prolonged into this by the aperture of communication with the third. Covering the floor is a columnar epithelium, which is continuous with that in the upper part of the central canal of the spinal cord (fig. 43, *n*). (Clarke.)

Choroid plexus of the cavity. In this ventricle is a vascular fold, or a *choroid plexus*, on each side, similar to the body of the same name in the other ventricles. It is attached to the inner surface of the membrane (pia mater) which closes the ventricle between the medulla and the cerebellum, and it extends upwards on the side of the opening into the sub-arachnoid space. Its vessels are supplied by the inferior cerebellar artery.

Gray matter forms surface stratum.

Gray matter of fourth ventricle. The gray matter forms a surface-covering for the floor of the fourth ventricle. It is continuous below with the gray commissure of the cord, and extends upwards to the aqueduct of Sylvius (p. 207).

Special deposits.

The special nuclei have been referred to already (p. 207).

TABLE OF THE CHIEF ARTERIES OF THE HEAD AND NECK.

Arch of the aorta furnishes to the neck,

- 1. Brachio-cephalic .
  - 1. Common carotid .
    - 1. External carotid .
      - 1. Superior thyroid
        - Hyoid branch
        - laryngeal
        - thyroid.
      - 2. lingual . .
        - Hyoid branch
        - dorsal lingual
        - sublingual
        - ranine.
      - 3. facial . . .
        - Inferior palatine branch
        - tonsillitic
        - glandular
        - submental
        - inferior labial
        - coronary .
          - inferior
          - superior
        - lateral nasal
        - angular.
      - 4. occipital . .
        - Meningeal branch
        - posterior cervical.
      - 5. posterior auricular . . .
        - Stylo-mastoid branch
        - auricular
        - mastoid.
      - 6. ascending pharyngeal . .
        - Pharyngeal branches
        - meningeal.
      - 7. temporal . .
        - Auricular
        - parotid
        - articular
        - transverse facial
        - middle temporal
        - anterior temporal
        - posterior temporal.
      - 8. internal maxillary . . .
        - Inferior dental
        - middle meningeal
        - muscular
        - posterior dental
        - infraorbital
        - spheno-palatine
        - descending palatine
        - vidian
        - pterygo-palatine.
    - 2. internal carotid .
      - 1. Arteriæ receptaculi.
      - 2. ophthalmic . .
        - Lachrymal
        - supraorbital
        - central of the retina
        - ciliary
        - muscular
        - ethmoidal
        - palpebral
        - frontal
        - nasal.
      - 3. anterior cerebral
      - 4. anterior communicating
      - 5. middle cerebral
      - 6. posterior communicating
      - 7. choroid.
  - 2. subclavian . .
    - 1. Vertebral
      - Anterior spinal
      - posterior spinal
      - inferior cerebellar
      - posterior meningeal
      - transverse basilar
      - anterior inferior cerebellar
      - superior cerebellar
      - posterior cerebral.
    - 2. internal mammary
    - 3. thyroid axis. .
      - Inferior thyroid . Ascending cervical.
      - suprascapular . .
        - Supraspinal
        - infraspinal.
      - transverse cervical .
        - Superficial cervical
        - posterior scapular.
    - 4. superior intercostal
      - Deep cervical.
- 2. left common carotid.
- 3. left subclavian.

TABLE OF THE CHIEF VEINS OF THE HEAD AND NECK.

Brachio-cephalic is formed by the union of

- Internal jugular . .
  - 1. Lateral sinus
    - Superior longitudinal sinus
    - inferior longitudinal sinus
    - straight sinus
    - occipital sinuses
    - ophthalmic vein
    - superior petrosal
    - inferior petrosal.
  - 2. ascending pharyngeal.
    - Meningeal branches
    - pharyngeal.
  - 3. lingual . .
    - Superficial dorsal
    - lingual
    - ranine.
  - 4. facial . .
    - Angular . . .
      - Supraorbital
      - frontal
      - palpebral
      - nasal.
    - inferior palpebral
    - dorsal and lateral nasal veins.
    - anterior internal maxillary . . .
      - Alveolar branches
      - infraorbital
      - descending palatine
      - naso-palatine
      - vidian.
    - coronary .
      - superior
      - inferior
    - buccal
    - masseteric
    - labial
    - submental
    - inferior palatine
    - tonsillitic
    - glandular.
  - 5. occipital . .
    - Mastoid vein
    - cervical.
  - 6. superior thyroid . .
    - Thyroid
    - laryngeal.
  - 7. middle thyroid.
- subclavian
  - 1. Vertebral .
    - Spinal
    - deep cervical
    - ascending cervical.
  - 2. external jugular . . .
    - 1. Internal maxillary .
      - Middle meningeal
      - inferior dental
      - deep temporal
      - pterygoid
      - masseteric.
    - 2. temporal . . .
      - Anterior
      - posterior
      - middle temporal
      - parotid
      - anterior auricular
      - transverse facial.
    - 3. posterior auricular .
      - Auricular
      - stylo-mastoid.
    - 4. branch to the internal jugular.
    - 5. suprascapular . .
      - Supraspinal
      - infraspinal.
    - 6. transverse cervical .
      - Superficial cervical
      - posterior scapular.
  - 3. anterior jugular.

TABLE OF THE CRANIAL NERVES.

1. First nerve . . Filaments to the nose.
2. Second nerve . . To retina of the eyeball.
3. Third nerve . To muscles of the orbit.
4. Fourth nerve . To superior oblique muscle.
5. Fifth or tri-facial nerve.
   - Ophthalmic .
     - Meningeal
     - lachrymal . . . — Lachrymal, palpebral.
     - frontal . . . . — Supraorbital, supratrochlear.
     - nasal . . . . — To lenticular ganglion, ciliary nerves, infratrochlear, nasal.
   - ophthalmic or lenticular ganglion. .
     - Connecting branches — To nasal nerve, to the third nerve, to sympathetic.
     - ciliary nerves.
   - superior maxillary . .
     - Orbital branch . . — Malar, temporal.
     - to Meckel's ganglion
     - posterior dental
     - anterior dental
     - infraorbital.
   - Meckel's ganglion . .
     - Internal branches . — Nasal, naso-palatine.
     - ascending . . . To the orbit.
     - descending . . . — Anterior palatine, posterior, external.
     - posterior . . . — Vidian, pharyngeal.
   - inferior maxillary . .
     - Small or muscular part . . . . — Deep temporal, masseteric, buccal, pterygoid.
     - large or sensory part
       - Auriculo-temporal — Articular and to meatus, parotid, auricular, temporal.
       - gustatory . . . . — To submaxillary and sublingual ganglia, to hypoglossal, to the tongue.
       - inferior dental . . — Mylo-hyoid, labial, incisor.
   - otic ganglion .
     - Connecting branches — To Jacobson's nerve, to the fifth and sympathetic.
     - branches for muscles.
   - submaxillary ganglion .
     - Connecting branches — To the gustatory, chorda tympani, and sympathetic.
     - branches to the glands and the mucous membrane of the mouth.

TABLE OF CRANIAL NERVES—*continued.*

- 6. Sixth nerve
  - To external rectus.
- 7. Seventh nerve, or facial
  - Connecting branches
    - To join auditory
    - to Meckel's ganglion
    - tympanic and sympathetic nerves
    - the chorda tympani.
  - Branches for distribution
    - Posterior auricular
    - digastric branch
    - stylo-hyoid branch
    - temporo-facial
      - Temporal
      - malar
      - infraorbital.
    - cervico-facial
      - Buccal
      - supramaxillary
      - inframaxillary.
- 8. Eighth nerve, or auditory
  - To the portio dura
  - nerve to cochlea
  - nerve to vestibule
    - To the common sac
    - to the saccule
    - to the semicircular canals.
- 9. Ninth nerve, or glosso-pharyngeal
  - Connecting branches
    - To vagus
    - to sympathetic
    - Jacobson's nerve
      - Joins otic ganglion,
      - supplies tympanum.
  - Branches for distribution.
    - To carotid artery
    - to the pharynx
    - tonsillitic branches
    - muscular
    - lingual.
- 10. Tenth nerve, or pneumo-gastric
  - Connecting branches
    - To glosso-pharyngeal
    - sympathetic and auricular nerves
    - to the hypoglossal.
  - Branches for distribution
    - Pharyngeal nerve.
    - superior laryngeal
      - External laryngeal
      - ascending
      - descending
        - to the mucous membrane
      - to join the inferior laryngeal.
    - cardiac nerves
    - inferior laryngeal
      - Cardiac
      - œsophageal, tracheal
      - to constrictor and muscles of larynx
      - to join superior laryngeal.
- 11. Eleventh nerve, or spinal accessory
  - Connecting branches
    - To pneumo-gastric
    - to the cervical plexus
  - Branches for distribution
    - To sterno-mastoideus and trapezius.
- 12. Twelfth nerve, lingual or hypo-glossal.
  - Connecting branches
    - To the pneumo-gastric nerve
    - to the sympathetic
    - to loop of atlas
    - to gustatory nerve.
  - Branches for distribution
    - Descendens noni
    - thyro-hyoid nerve.
    - to the lingual muscles and tongue.

TABLE OF THE SPINAL AND SYMPATHETIC NERVES OF THE HEAD AND NECK.

Spinal Nerves.

- The cervical spinal nerves divide into
  - Anterior branches
    - The first four form the CERVICAL PLEXUS, which gives
      - Superficial ascending
        - Small occipital nerve
        - great auricular
        - superficial cervical.
      - superficial descending . .
        - Supraacromial
        - supraclavicular
        - suprasternal.
      - deep internal . .
        - To the pneumo-gastric
        - to the hypoglossal
        - to the sympathetic
        - to join the spinal accessory
        - nerves to descendens noni.
      - deep muscular . .
        - to rectus muscles
        - to diaphragm
        - to the sterno-mastoideus
        - to the trapezius
        - to the levator anguli scapulæ.
    - The last four and first dorsal form the BRACHIAL PLEXUS, which gives . . .
      - Branches above the clavicle .
        - The rhomboid nerve
        - to the phrenic nerve
        - suprascapular nerve
        - subclavian branch
        - posterior thoracic
        - to the scaleni muscles.
      - branches below . .
        - Are dissected with the upper limb.
  - posterior branches
    - Are distributed to the muscles of the back, and give off cutaneous nerves.

Sympathetic Nerve.

- The sympathetic nerve in the neck.
  - 1. Superior cervical ganglion has . .
    - Ascending branches, which unite in plexuses . .
      - Carotid plexus, which gives
        - Branch to tympanic plexus
        - to the vidian
        - to the sixth and fifth cranial nerves.
      - cavernous plexus, which gives branches .
        - To the third cranial nerve
        - to the fourth cranial nerve
        - to the fifth and lenticular ganglion.
        - to the carotid artery and branches.
    - external branches .
      - To join pneumo-gastric and hypoglossal nerves
      - to the spinal nerves.
    - internal branches .
      - Pharyngeal branches
      - superficial cardiac nerve
    - branches to vessels. Nervi molles.
  - 2. Middle cervical ganglion .
    - External branches . To the spinal nerves.
    - internal . . . .
      - Middle cardiac nerve
      - to supply thyroid body and join the external laryngeal.
  - 3. Inferior cervical ganglion .
    - Anterior branches . To the subclavian artery.
    - external . . . .
      - To the spinal nerves forming vertebral plexus.
    - internal. . . . . Inferior cardiac nerve.

CHAPTER III.

DISSECTION OF THE UPPER LIMB.

SECTION I.

THE WALL OF THE THORAX AND THE AXILLA.

Directions for the dissection.

THE parts included in this section, viz., the wall of the chest and the axilla, are to be learnt within a fixed time, in order that the examination of the thorax may be undertaken. Whilst the dissection of the thorax is in progress, the student will have to discontinue his labours on the upper limb; but, on the completion of that cavity, he must be ready to begin the part of the back that belongs to him.

Position of the body.

Position. Whilst the body lies on the back, the thorax is to be raised to a convenient height by a block; and the arm, being slightly rotated outwards, is to be placed at a right angle to the trunk.

Directions. Before the dissection is begun, attention should be given to the chief depressions on the surface, to the prominences of muscles, and to the projections of the bones; because these serve as guides to the position of parts beneath the skin.

Marking of the surface. Arm-pit.

Surface-marking. Between the arm and the chest is the hollow of the arm-pit, in which the large vessels and nerves of the limb are lodged. The extent of this hollow may be seen to vary much with the position of the limb to the trunk; for in proportion as the arm is elevated, the fore and hinder boundaries are carried upwards and rendered tense, and the depth of the space is diminished. In this spot the skin is of a dark colour, and is furnished with hairs and large sweat glands.

Head of bone to be felt.

If the arm is forcibly raised and moved in different directions, whilst the fingers of one hand are placed in the arm-pit, the head of the humerus may be recognised.

Shoulder arch of bone.

On the outer side of the limb is the prominence of the shoulder; and immediately above it is an osseous arch, which is formed internally by the clavicle, and externally by the spine and the acromion process of the scapula. Continued downwards from about the middle of the clavicle, is a slight depression between the pectoral and deltoid muscles, in which the coracoid process can be felt near that bone. A second groove, extending outwards from the sternal end of the clavicle, is sometimes marked: this corresponds with the interval between the clavicular and sternal origin of the great pectoral muscle. Intermuscular depressions.

Along the front of the arm is the prominence of the biceps muscle; and on each side of that eminence is a groove, which subsides inferiorly in a depression in front of the elbow joint. The inner of the two grooves, the deepest, indicates the position of the brachial vessels. Arm: its prominence and grooves.

If the elbow joint be semiflexed, the prominences of the outer and inner condyles of the humerus will be rendered evident, especially the inner. Below the outer condyle, and separated from it by a slight interval, the head of the radius projects; it may be recognised by rotating the bone, the fingers at the same time being placed over it. At the back of the articulation is the prominence of the olecranon. Prominences around the elbow joint.

Dissection. The dissection is to be begun by raising the skin from the side of the chest and the arm-pit, over the great pectoral muscle and the hollow of the axilla. Dissection to raise the integument.

The above-mentioned parts may be denuded by means of the following incisions:—One is to be made along the middle of the sternum. A second, carried along the clavicle for the inner two thirds of that bone, is to be continued down the front of the arm rather beyond the anterior fold of the arm-pit; and lastly it is to be turned across the inner surface of the arm as far as the hinder fold of the axilla. From the xiphoid cartilage a third cut is to be directed outwards over the side of the chest, as far back as to a level with the posterior fold of the arm-pit.

The flap of skin now marked out should be reflected outwards beyond the axilla; but it should be left attached to the body, in order that it may be used afterwards for the preservation of the part. Reflect skin.

The *subcutaneous fascia* of the thorax resembles the same structure in other parts of the body; but in this region its superficial layer does not contain much fat. Fasciæ, superficial,

Beneath the subcutaneous layer is a *deeper* and stronger *special fascia* which closely invests the muscles, and is continuous with the deep fascia of the arm. It is thin on the side of the chest, but becomes much thicker where it is stretched across the axilla. An incision through it, over the arm-pit, will render evident its increased strength in this situation, and its connections with the muscles bounding the axilla which it incases; and if the fore finger be introduced through the opening, some idea will be gained of its capability of confining an abscess in that hollow. and deep: where thickest.

Dissection. The cutaneous nerves of the side of the chest are Dissection of cutaneous nerves of the chest,

to be next sought. At the spots where they are to be sought they are placed beneath the fat, so that the student must cut through it; and those on the clavicle lie also beneath the platysma muscle. Small vessels indicate the position of the nerves.

from cervical,

and intercostal,

Some of them (from the cervical plexus) cross the clavicle at the middle, and at the inner part. Others (anterior cutaneous of the thorax) appear at the side of the sternum,—one from each intercostal space. And the rest (lateral cutaneous of the thorax) should be looked for along the side of the chest, about one inch below the anterior fold of the axilla, there being one from each intercostal space except the first: as the last-mentioned nerves pierce the wall of the thorax, they divide into an anterior and a posterior branch.

and nerve of Wrisberg.

The posterior branches of the highest two nerves are larger than the rest. They are to be followed across the arm-pit, and a junction is to be found there with a branch (nerve of Wrisberg) of the brachial plexus.

Cutaneous nerves of cervical plexus.

Cutaneous nerves of the cervical plexus. These cross the clavicle, and are distributed to the integuments over the pectoral muscle. The most internal branch (sternal) lies near the inner end of the bone, and reaches but a short distance below it. Other branches (clavicular), two or more in number and larger in size, cross the centre of the clavicle, and extend to near the lower border of the pectoralis major; they join one or more of the anterior cutaneous nerves of the thorax.

Cutaneous branches of intercostals;

two rows.

The *cutaneous nerves of the thorax* are derived from the trunks of the intercostal nerves between the ribs. Of these there are two sets:—One set, lateral cutaneous nerves of the thorax, arise from the trunks of the nerves about mid way between the spine and the sternum. The other set, anterior cutaneous nerves of the thorax, are the terminations of the same intercostal trunks at the middle line of the body.

One along middle line.

The *anterior cutaneous* nerves (fig. 52, [1]) piercing the pectoral muscle, are directed outwards in the integuments as slender filaments. The offset of the second nerve joins a cutaneous branch of the cervical plexus; and the others supply the mammary gland and the integuments. Small cutaneous branches of the internal mammary vessels accompany the nerves.

The other on side of the chest:

The *lateral cutaneous* nerves issue with companion vessels between the digitations of the serratus muscle, and divide into an anterior and a posterior branch. There is not usually any lateral cutaneous nerve to the first intercostal trunk.

these have anterior and

The *anterior offsets* (fig. 52, [2]) bend over the pectoral muscle, and end in the mammary gland and the integuments: they increase in size downwards, and the lowest give twigs to the digitations of the external oblique muscle. The cutaneous nerve of the second intercostal trunk wants commonly the anterior offset.

The *posterior offsets* (fig. 52, [3]) end in the integuments over the latissimus dorsi muscle and the back of the scapula, and decrease in size from above down. posterior branches.

Fig 52*.

The branch of the second intercostal nerve is larger than the rest, and perforates the fascia of the axilla; it supplies the integument of the arm (p. 284), and is named *intercosto-humeral*. As it crosses the axilla it is divided into two or more pieces, and is connected to the nerve of Wrisberg by a filament of variable size. One reaches the arm.

The branch of the third intercostal gives filaments likewise to the arm-pit and the inner part of the arm. Third nerve.

The MAMMA is the gland for the secretion of the milk, and is situate on the lateral aspect of the fore part of the chest.† Office of the breast.

Resting on the great pectoral muscle, it is hemispherical in form, but it is rather most prominent at the inner and lower aspects. Its dimensions and weight vary greatly. In a breast that is not enlarged by lactation, the width is commonly about four inches. Longitudinally it extends from the third to the sixth or seventh rib, and transversely from the side of the sternum to the axilla. Its thickness is about one inch and a half. The weight of the mamma ranges from six to eight ounces. Form and position; with its dimensions and weight.

Nearly in the centre of the gland (rather to the inner side) rises the conical or cylindrical projection of the nipple or mamilla. This prominence is about half an inch or rather more in length, Position and form of the nipple,

* Plan of the cutaneous nerves of the chest and abdomen (altered from a plate of M. Bourgery). *b.* Pectoral muscle. *c.* Latissimus dorsi. *d.* External oblique. *e.* Serratus magnus. 1, 1, 1, Anterior cutaneous nerves of the chest and belly. 2, 2, 2. Anterior branches of the lateral cutaneous nerves of the chest and belly. 3, 3, 3. Posterior branches of the same. 4, 4, 4. Cutaneous branches from the posterior divisions of the lumbar nerves. 5. Ilio-hypogastric.

† If the student has a male body, he may disregard the description of the mamma; and if the body is a female, he may set aside the breast for a more convenient examination of its structure.

is slightly turned outwards, and presents in the centre a shallow depression, where it is rather redder. Around the nipple is a coloured ring,—the *areola*, about an inch in width, whose tint is influenced by the complexion of the body, and is altered during the times of menstruation, pregnancy, and lactation. The skin of the nipple and areola is provided with numerous papillæ and lubricating glands; and on the surface are some small tubercles marking the position of the ducts of the glands.

the areola.

Colour is altered.

Skin has glands.

Breast of the male.

In the male the mammary gland resembles that of the female in general form, though it is but slightly prominent; and it possesses a small nipple, which is surrounded by an areola provided with hairs. The glandular or secretory structure is imperfect.

Structure.

Structure. In its texture the mamma resembles those compound glands which are formed by the vesicular endings of branched ducts. It consists of small vesicles, which are united to form lobules and lobes. Connected with each lobe is an excretory or lactiferous duct.

Investing and fibrous tissue.

A layer of areolar tissue, containing fat, surrounds the gland, and penetrates into the interior, subdividing it into lobes; but in the ultimate structure of the gland, the nipple, and the areola, there is not any fatty substance. Some fibrous septa fix the gland to the skin, and support it; these are the *ligamenta suspensoria* of Sir A. Cooper.

Texture and form of the vesicles.

Vesicles. The little vesicles or cells at the ends of the most minute ducts are lenticular or rounded in shape, and when filled with milk or mercury are just visible to the naked eye, being about the size of a small pinhole in paper. (Cooper.) Each is surrounded externally by a close vascular network.

Vesicles form lobules, and lobules lobes.

Lobules and lobes. A collection of the vesicles around their duct forms the smallest division of the gland, viz., lobule or glandule, which varies in size from a pin's head to a small tare. By the union of the lobules the lobes are produced, of which there are about twenty altogether, and each is provided with a distinct duct.

Lactiferous ducts; open on end of nipple.

The *ducts* issuing from the several lobes (about twenty) are named from their office *galactophorous;* they converge to the areola, where they swell into oblong dilatations or reservoirs (sacculi) of one-sixth to one-third of an inch in width. Onwards from that spot the ducts become straight; and, surrounded by areolar tissue and vessels, are continued through the nipple, nearly parallel to one another, and gradually narrowing in size, to open on the summit by apertures varying from the size of a bristle to that of a common pin.

Structure.

Like many other excretory ducts, the milk-tubes consist of an external or fibrous, and an internal or mucous coat; they are sheathed also by a flattened or pavement epithelium.

Beneath the skin of the nipple and areola are branched lubricating glands, which open in the tubercles before mentioned. Small glands of skin.

Bloodvessels, nerves, and lymphatics.—The *arteries* are supplied by the axillary, internal mammary, and intercostal, and enter both surfaces of the gland. The vessels on the cutaneous surface supply branches to the nipple, which pass from base to apex, being nearly parallel. Arteries of the gland

The *veins*, after issuing from the substance of the breast, are thus disposed :—some form a plexus on the anterior aspect with a circle around the areola, and end principally in the axillary and internal mammary trunks; but others enter one or more of the intercostal veins, or ascend over the clavicle to join the veins of the neck. In the nipple the veins have an arrangement like that of the arteries. and veins: in nipple.

The *nerves* are supplied from the anterior and lateral cutaneous branches of the thorax, viz. those of the third, fourth, and fifth intercostal nerves. Nerves.

The *lymphatics* pass from both the inner and the outer part of the gland. At the inner side they accompany the branches of the internal mammary artery, and open into the anterior mediastinal glands : but on the outer side they reach the axilliary glands. Lymphatics.

Dissection. With the arm in the same position with respect to the trunk, the student is first to remove the fascia and the fat from the surface of the great pectoral muscle. In cleaning the muscle the scalpel should be carried in the direction of the fibres, viz., from the arm to the thorax; and the dissection may be begun at either the upper or lower border of the muscle, according as the one or the other may be the most convenient. Dissection of pectoral muscle.

The fascia and the fat are to be taken from the axilla without injury to the numerous vessels, nerves, and glands in the space. The dissection will be best begun at the outer part, by removing the fascia from the large axillary vessels, where these are about to quit the space and enter the arm. Following upwards those bloodvessels, the student will find their branches directed towards the chest, viz., the long thoracic under cover of the anterior boundary; and the circumflex and subscapular vessels and nerves along the posterior boundary of the axilla. Some arterial twigs entering the axillary glands should be traced out. Remove fat of axilla, follow vessels.

In taking away the fascia and fat from the posterior boundary of the space, so as to follow the muscles to their insertion into the humerus, the small internal cutaneous nerve of the musculo-spiral should be looked for near the great vessels. Clean back of space.

The large nerves of the brachial plexus are then to be defined. The smallest of these, which possibly may be destroyed, is the nerve of Wrisberg: it lies close to the hinder edge of the axillary vein, and communicates with the intercosto-humeral nerve, but with moderate caution it cannot be injured. Trace nerves of plexus,

When cleaning the serratus muscle on the ribs the student is to seek on its surface the posterior thoracic nerve; and to define the posterior offsets of the intercostal nerves crossing the axilla. and on inner wall.

THE AXILLA.

Situation and form of the arm-pit.

The axilla is the hollow between the arm and the chest. It is somewhat pyramidal in form, and its apex is directed upwards to the root of the neck. The space is larger near the thorax than at the arm, and its boundaries are as follows :—

Boundaries.

Boundaries. In front and behind the space is limited by folds, which are constructed by the unattached parts of the muscles passing from the trunk to the upper limb. In the anterior fold are the two pectoral muscles, but these take unequal shares in its construction in consequence of the difference in their size and shape :—thus the pectoralis major extends over the whole front of the space, reaching from the clavicle to the lower edge of the anterior fold; whilst the pectoralis minor, which is a narrow muscle, corresponds only with the middle part or third of the space. In the posterior boundary, from above downwards, lie the subscapularis, the teres major, and the latissimus dorsi muscle: this boundary reaches lower than the anterior, especially near the humerus; and its lower margin, which is formed by the latissimus dorsi, projects forwards beyond the level of the subscapularis.

The pectoral muscles in front, and latissimus, teres, and subscapularis behind.

Parts at the inner and outer sides.

On the inner side of the axilla are the first four ribs, with their intervening intercostal muscles, and the part of the serratus magnus taking origin from those bones. On the outer side the space has but small dimensions, and is limited by the humerus and the biceps and coraco-brachialis muscles.

Situation of the apex and base.

The apex of the hollow is situate between the clavicle, the upper margin of the scapula, and the first rib; and the fore-finger may be introduced into the space for the purpose of ascertaining the depth, and the upper boundaries. The base or widest part of the pyramid is turned downwards, and is closed by the thick aponeurosis that reaches from the anterior to the posterior fold.

Contents of the space.

Contents of the space. In the axilla are contained the axillary vessels and the brachial plexus, with their branches; some branches of the intercostal nerves; together with lymphatic glands, and a large quantity of loose areolar tissue and fat. The position of all these, with reference to the boundaries of the space, is to be carefully studied.

Position of vessels and connections

Position of the trunks of the vessels and nerves. The large axillary artery and vein cross the outer portion of the space in passing from the neck to the upper limb. The part of each vessel now seen lies close to the humerus, reaching beyond the line of the anterior fold of the arm-pit, and is covered only by the common superficial layers, viz. the skin, the fatty layer or superficial fascia, and the deep fascia. Behind the vessels are the subscapularis and the tendons of the latissimus and teres muscles. To their outer side is the coraco-brachialis muscle.

On looking into the space from below, the axillary vein will be found on the thoracic side of and concealing the artery. **with vein**

After the vein has been drawn aside, the artery will be seen amongst the large nerves of the upper limb, having the median trunk to the outside, and the ulnar and the small nerve of Wrisberg to the inner side; the internal cutaneous generally superficial to, and the musculo-spiral and circumflex nerves beneath it. This part of the artery gives branches to the side of the chest and the shoulder. The vein receives some branches in this spot. **and nerves, offsets.**

Position of the branches of the vessels and nerves. The several branches of the vessels and nerves have the undermentioned position with respect to the boundaries. **Situation of branches**

Close to the anterior fold, and rather concealed by it, the long thoracic artery runs to the side of the chest; and taking the same direction, though nearer the middle of the hollow, are the small external mammary artery and vein. **in front,**

Extending along the posterior fold, within its lower margin and in contact with the edge of the subscapularis muscle, are the subscapular vessels and nerves; and near the humeral end of the subscapularis the posterior circumflex vessels and nerve bend backwards beneath the large axillary trunks. **behind,**

On the inner boundary, near the upper part, are a few small branches of the superior thoracic artery, which ramify on the serratus muscle; but these are commonly so unimportant, that this part of the axillary space may be considered free from vessels with respect to any surgical operation. Lying on the surface of the serratus magnus, is the nerve to that muscle; and perforating the inner boundary of the space, are the lateral cutaneous nerves of the thorax,—two or more offsets of which are directed across the axilla to the arm, and receive the name intercosto-humeral. **inside.**

The *lymphatic glands* of the axilla are arranged in two sets: one is placed along the inner side of the bloodvessels; and the other occupies the lower and hinder parts of the space, lying near and along the posterior boundary. Commonly they are ten or twelve in number; but in number and size they vary much. Small vascular twigs from the branches of the axillary vessels are furnished to the glands. **Lymphatic glands of the axilla:**

The glands by the side of the bloodvessels receive the lymphatics of the arm; and those along the hinder boundary are joined by the lymphatics of the fore part of the thorax and posterior surface of the back, as well as by some from the mamma. The efferent ducts of all unite to form a trunk, which opens into the lymphatic duct of the same side in the neck, or into the subclavian vein by one or more ducts. **end in the lymphatic duct.**

Pectoralis muscle.

Origin from chest and clavicle.

The PECTORALIS MAJOR is triangular in shape, with the base at the thorax and the apex at the arm. It *arises* internally from the front of the sternum, and the cartilages of the true ribs except the last; superiorly from the sternal half of the clavicle; and inferiorly from the aponeurosis of the external oblique muscle of the abdomen. From this wide origin the fibres take different directions,—those from the clavicle being inclined obliquely downwards, and those from the lower ribs upwards beneath the former; and all end in a tendon, which is *inserted* into the outer edge of the bicipital groove of the humerus for about two inches (fig. 86, [1]).

Insertion into the humerus.

This muscle bounds the axilla anteriorly, and is connected sometimes to its fellow by fibres in front of the sternum. Besides the superficial structures and the mamma, the platysma covers the pectoralis major close below the clavicle. A lengthened interval, which corresponds with a depression on the surface, separates the clavicular from the sternal attachment. One border (outer) is in contact with the deltoid muscle, and with the cephalic vein and a small artery; and the lower border forms the margin of the anterior fold of the axilla. The parts covered by the muscle will be seen subsequently.

Parts covering it,

and along the borders.

Use on the hanging,

Action. If the humerus is hanging, the muscle will rotate it in, and will move forwards the limb until the elbow reaches the front of the trunk.

raised,

When the limb is raised, the pectoralis depresses and adducts it; and acting with other muscles inserted into the opposite side of the humerus, it may dislocate the head of that bone when the lower end is fixed as in a fall on the elbow.

and fixed limbs.

Supposing both limbs fixed as in climbing, the trunk will be raised by both muscles; but if only one is fixed, the body will be moved towards it by the one muscle.

Dissection.

Dissection. The great pectoral muscle is to be cut across now in the following manner :—

Cut clavicular part of the pectoral.

Only the clavicular part is to be first divided, so that branches of the nerve and artery to the muscle may be found. Reflect the cut part of the muscle, and press the limb against the edge of the table, for the purpose of raising the clavicle and rendering tight the fascia attached to the bone; then on carefully removing the fat, and a piece of fascia prolonged from the upper border of the small pectoral muscle, the membranous costo-coracoid sheath will be seen close to the clavicle, covering the axillary vessels and nerves.

At this stage the cephalic vein is to be defined as it crosses inwards to the axillary vein. A branch of nerve (anterior thoracic), and the acromial thoracic artery, which perforate the tube of membrane, are to be followed to the pectoral muscles.

Divide the

The remaining part of the pectoralis major may be cut about its centre, and the pieces may be thrown inwards and outwards. Any fat coming into view is to be removed; and the insertion of the tendon of the pectoralis is to be followed to the humerus. The parts beneath the pectoral muscle are now laid before. rest of the muscle to see its insertion.

Insertion of the pectoralis. The tendon of the pectoralis consists of two parts, anterior and posterior, at its attachment to the bone; the anterior receives the clavicular and upper sternal fibres, and joins the tendon of the deltoid muscle; and the posterior gives attachment to the lower ascending fibres. The tendon is from two inches to two inches and a half wide, and sends upwards one expansion over the bicipital groove to the capsule of the shoulder joint; another backwards into the groove; and a third to the fascia of the arm. Tendon of insertion of pectoralis.

Parts covered by the pectoralis. The great pectoral muscle covers the pectoralis minor, and forms alone, above and below that muscle, the anterior boundary of the axilla. Between the pectoralis minor and the clavicle it conceals the subclavius muscle, the sheath containing the axillary vessels, and the branches that perforate the sheath. Below the small pectoralis it lies on the side of the chest, on the axillary vessels and nerves, and, near the humerus, on the biceps and coraco-brachialis muscles. Parts covered by the muscle.

The PECTORALIS MINOR resembles the preceding muscle in shape, and is extended like it from the thorax to the arm. Its *origin* is connected by slips with the third, fourth, and fifth ribs, external to their cartilages; and between the ribs, with the aponeurosis covering the intercostal muscles. The fibres converge to their *insertion* into the anterior half of the upper surface of the coracoid process of the scapula (fig. 86, [2]). Pectoralis minor arises from chest: inserted into scapula.

This muscle is placed before the axillary space, and assists the pectoralis major in forming the middle of the anterior boundary. In that position it conceals the axillary vessels and the accompanying nerves, and two small anterior thoracic nerves. The upper border lies near the clavicle, but between it and that bone is an interval of a somewhat triangular form. The lower border projects beyond the pectoralis major, close to the chest; and along it the long thoracic artery lies. The tendon of insertion is united with the short head of the biceps and the coraco-brachialis. Connections with parts around.

Action. Acting with the serratus magnus it moves the scapula forwards and somewhat downwards. Use on scapula,

In laborious breathing it becomes an inspiratory muscle, as it takes its fixed point at the scapula. on ribs.

Dissection. Supposing the clavicle raised by the student as before directed, the tube of fascia around the vessels will be demonstrated by making a transverse cut in the costo-coracoid membrane near the clavicle, so that the handle of the scalpel can be passed beneath it. By raising the lower border of the Dissection of costo-coracoid fascia.

subclavius this muscle will be seen to be incased by fascia, which is attached to the bone both before and behind it.

Costo-coracoid membrane

The *costo-coracoid membrane*, or ligament, is a firm membranous band, which receives this name from its insertion on the one side into the rib, and on the other into the coracoid process of the scapula. Between those points of attachment it is inserted into the clavicle, enclosing the subclavius muscle; and is joined by the piece of fascia that incases the small pectoral muscle. From its strength and position it gives protection to the vessels surrounded by their loose sheath.

conceals subclavius,

and joins sheath of vessels.

When traced downwards it is found to descend on the axillary vessels and nerves, joining externally the fascia on the coracobrachialis muscle, and blending below with the sheath of the vessels beneath the small pectoral muscle. Its extent is not so great on the inner as on the outer side, for internally it reaches but a very short distance on the axillary vein.

Sheath of vessels:

The *sheath* of the axillary vessels and nerves is derived from the deep fascia of the neck, being prolonged from that on the scaleni muscles; and resembles, in its form and office, the funnel-shaped tube of membrane that surrounds the femoral vessels in the upper part of the thigh. It is strongest near the subclavius muscle, where the costo-coracoid band is placed; and it receives below an accession from that membrane. The anterior part of the tube is perforated by the cephalic vein, the acromial thoracic artery, and the anterior thoracic nerve.

strongest in front.

Clean the vessels.

Dissection. After the costo-coracoid membrane has been examined, the remains of it are to be taken away; and the subclavius muscle, and the axillary vessels and nerves with their branches, should be carefully cleaned.

Subclavius muscle

The SUBCLAVIUS MUSCLE (fig. 86, [3]) is roundish in form, and is placed between the clavicle and the rib. It *arises* by a tendon from the first rib, at the junction of the osseous and cartilaginous parts, and in front of the costo-clavicular ligament. The fibres ascend obliquely, and are *inserted* into a groove on the under surface of the clavicle, which reaches between the two tubercles (internal and external) for the attachment of the costo and coraco-clavicular ligaments.

is attached to clavicle and first rib.

Connections.

The muscle overhangs the large vessels and nerves of the limb, and is enclosed, as before said, in a sheath of fascia.

Use.

Action. It depresses the clavicle, and indirectly the scapula; but if the shoulder is fixed it elevates the first rib.

Axillary artery;

The AXILLARY ARTERY (fig. 57) continues the subclavian trunk to the upper limb. The part of the vessel to which this name is applied is contained in the axilla, and extends from the lower border of the first rib to the lower edge of the teres major muscle.

extent;

course,

In the axillary space its position will be marked by a line from the middle of the clavicle to the inner edge of the coraco-brachialis. Its direction will vary with the position of the limb to the trunk; for when the arm lies by the side of the body the vessel is curved, its convexity being upwards; and in proportion as the limb is removed to a right angle with the chest the artery becomes straight. In the upper part of the axilla the vessel is deeply placed, but it becomes superficial as it approaches the arm. arched in the axilla. The depth varies.

Its connections with surrounding parts are numerous; and the description of these will be methodised by dividing the artery into three parts—one above, one beneath, and one below the small pectoral muscle. Connections:—

Above the small pectoral muscle the artery is contained in the axillary sheath of membrane. This part is concealed by the clavicular portion of the great pectoral muscle. Behind it are the intercostal muscles of the first space and the first digitation of the serratus magnus muscle. above small pectoral; with muscles,

To the thoracic side is placed the axillary vein. The cephalic vein, and offsets of the acromial thoracic artery and vein, cross over it. vessels,

On the acromial side lie the two cords of the brachial plexus, separated from the vessel by a slight interval. Superficial to it lies an anterior thoracic nerve; and beneath, is the posterior thoracic. and nerves.

Beneath the pectoralis, the pectoralis minor and major are superficial to the axillary vessel. But there is not any muscle immediately in contact behind, for the artery is placed across the top of the axilla, particularly when the limb is in the position required by the dissection. Beneath pectoral; with muscles,

The companion vein lies to the inner side but separated from the arterial trunk by a bundle of nerves. vein,

In this position the cords of the brachial plexus lie around it, one being outside, a second inside, and a third beneath the artery. and nerves.

Beyond the pectoralis minor the artery is concealed in part by the lower border of the great pectoral muscle, but thence to its termination it is covered only by the integuments and the fascia. Beneath it are the subscapularis muscle and the tendons of the latissimus and teres. To the outer side is the coraco-brachialis muscle. And beyond the pectoral; with muscles,

The axillary vein remains as above on the thoracic side of the artery. with vein,

Here the artery lies in the midst of the large trunks of nerves into which the brachial plexus has been resolved:—On the outer side is the median nerve, with the external cutaneous for a short distance; and on the inner side are the ulnar, and the nerve of Wrisberg. Superficial to the artery is the internal cutaneous; and nerves.

and behind are the musculo-spiral and circumflex nerves, the latter extending only as far as the border of the subscapular muscle.

Branches to the thorax

The *branches* of the axillary artery are furnished to the wall of the thorax and the shoulder. The thoracic branches are four in number; two (superior and acromial thoracic) arise from the artery above the pectoralis minor; one (alar thoracic) beneath the muscle; and one (long thoracic) at the lower border. Three branches are supplied to the shoulder, viz., subscapular and two circumflex; the first springs opposite the edge of the muscle of the same name, and the others wind round the neck of the humerus. The last offset is the external mammary.

and the shoulder.

Upper thoracic.

The *superior thoracic* branch is the highest and smallest offset of the artery, and arises opposite the first intercostal space; it ramifies on the side of the chest anastomosing with the intercostal arteries.

Acromial thoracic is large,

The *acromial thoracic* branch (fig. 57) is a short trunk on the front of the artery, which appears at the upper border of the pectoralis minor, and opposite the interval between the large pectoral and deltoid muscles. Its branches are directed inwards, outwards, and upwards.

and supplies thorax and shoulder.

a. The inner or thoracic set supply the thoracic muscles, and give a few offsets to the side of the chest to anastomose with the intercostal and other thoracic arteries.

Inferior acromial offset.

b. The outer or acromial set end mostly in the deltoid; but one small artery accompanies the cephalic vein for a short distance; and another (*inferior acromial*) perforates the deltoid muscle, and anastomoses on the acromion process with a branch of the suprascapular artery of the neck.

Muscular offsets.

c. One or two small twigs ascend to the subclavius and deltoid muscles.

Alar thoracic.

The *alar thoracic* is very inconstant as a separate branch, and its place is mostly taken by offsets of the subscapular or long thoracic arteries; it is distributed to the glands and fat of the axillary space.

Long thoracic.

The *long thoracic* branch is directed along the border of the pectoralis minor (fig. 57, [2]) to about the sixth intercostal space; it supplies the pectoral and serratus muscles, and anastomoses, like the other branches, with the intercostal and thoracic arteries. In the female it gives branches to the mammary gland.

External mammary.

An *external mammary artery* is commonly met with, especially in the female; its position is near the middle of the axilla with a companion vein. It supplies the glands, and ends in the wall of the thorax.

Subscapular has

The *subscapular* branch (fig. 57, [3]) courses with a nerve of the same name along the subscapular muscle, as far as the lower angle of the scapula, where it ends in branches for the serratus magnus, and the latissimus dorsi and teres muscles: it gives many offsets to the glands of the space.

Near its origin the artery sends backwards a considerable *dorsal* branch round the edge of the subscapular muscle: this gives an *infrascapular* offset to the ventral aspect of the scapula, and then turns to the dorsum of that bone, where it will be afterwards dissected. **a dorsal branch, and infra-scapular.**

The subscapular artery is frequently combined at its origin with other branches of the axillary, or with branches of the brachial artery.

The *circumflex* branches (anterior and posterior) arise near the border of the subscapular muscle. One turns in front of, and the other behind the humerus. They will be followed in the examination of the arm. **Two circumflex.**

Small *muscular offsets* enter the coraco-brachialis muscle. **Muscular.**

The AXILLARY VEIN continues upwards the basilic vein of the arm, and has the same extent and connections as the axillary artery. It lies to the thoracic side of its artery, and receives thoracic and subscapular branches. Opposite the subscapular muscle it is joined externally by a large vein, which is formed by the union of the venæ comites of the brachial artery; and near the clavicle the cephalic vein opens into it. **Axillary vein, extent and connections. Branches.**

Dissection. To follow out the branches of the brachial plexus cut through the pectoralis minor near its insertion into the coracoid process, and turn it towards the chest, but without injuring the thoracic nerves in contact with it. The axillary vessels are then to be cut across below the second rib,* and to be drawn down with hooks; and their thoracic branches may be removed at the same time. A dense fascia is to be cleared away from the large nerves of the plexus. **Dissection of brachial plexus.**

The BRACHIAL PLEXUS results from the union of the anterior branches of the first dorsal and the four lower cervical nerves; and a slip is added to it above from the lowest nerve in the cervical plexus. It is placed partly in the neck, and partly in the axilla, and is divided opposite the coracoid process into large trunks for the supply of the limb. The part of the plexus above the clavicle is described in the dissection of the head and neck (p. 76). The part below the clavicle has the same connections with the surrounding muscles as the axillary artery. The nerves interlace in it in the following manner:— **Nerves entering brachial plexus. Its situation and connections.**

At first the plexus consists of two bundles of nerves, which lie on the outer side of the artery, and are thus constituted;—the one nearest the vessel is formed by the last cervical and first dorsal nerves; and the other, by the fifth, sixth, and seventh **The nerves form three cords**

* The student must be careful not to cut the vessels higher than the spot mentioned, otherwise he will injure the dissection of the neck.

cervical nerves. A little lower down a third or posterior cord is produced by the union of two fasciculi, one from each of the other bundles; so that, beneath the small pectoral muscle, the plexus consists of three large bundles or cords, one being on the outer side, another on the inner side, and the third behind the vessel. Occasionally there may be some deviation from the above mentioned arrangement.

around the artery,

and give branches, viz.,

The *branches* of the plexus below the clavicle arise from the several cords in the following way:—

from the outer,

The *outer cord* gives origin to one anterior thoracic branch, the musculo-cutaneous trunk, and the outer head of the median nerve.

inner, and

The *inner cord* produces a second anterior thoracic nerve, the inner head of the median, the internal cutaneous, the nerve of Wrisberg, and the ulnar nerve.

posterior cord.

The *posterior cord* furnishes the subscapular branches, and ends in the circumflex and musculo-spiral trunks.

The following are seen, viz.,

Only the thoracic and subscapular nerves are dissected to their termination at present; the remaining nerves will be seen in the arm.

two anterior thoracic,

The *anterior thoracic* branches, two in number, are named outer and inner, like the cords from which they come.

outer

The *outer* nerve crosses inwards over the axillary artery, to the under surface of the great pectoral muscle in which it ends. On the inner side of the vessel it communicates with the following branch.

and inner.

The *inner thoracic* branch turns upwards between the artery and vein, and after receiving the offset from the other, ends in many branches to the under surface of the pectoralis minor. Some twigs enter the great pectoral muscle, after passing either through the pectoralis minor or above its border.

Three subscapular:

The *subscapular nerves* are three in number, and take their names from the muscles supplied.

upper,

The branch of the subscapularis is the highest and smallest, and enters the upper part of that muscle.

lower, and

The nerve of the teres major gives a small offset to the inferior part of the subscapularis, and ends in its muscle.

long subscapular.

A long nerve of the latissimus dorsi takes the course of the subscapular artery along the posterior wall of the axilla, and enters the fleshy fibres near the outer end.

Posterior thoracic.

Another small nerve, *nerve to the serratus*, (posterior thoracic,) lies on the surface of the serratus muscle. It arises above the clavicle (p. 77), from the fifth and sixth cervical nerves; to reach its destination, it descends behind the axillary artery, and enters that surface of the serratus magnus which is turned towards the axilla.

Latissimus.

The LATISSIMUS DORSI MUSCLE may be examined as far as it enters into the posterior fold of the axilla. Arising from the spine and the back of the trunk, and crossing the lower angle of the scapula, the muscle ascends to be *inserted* by a tendon into the bottom of the bicipital groove. Insertion.

At its attachment to the bone, the tendon is from one inch and a half to two inches in width, and lies in front of the teres; at the lower border aponeurotic fibres connect it with the tendon of the teres, but a bursa intervenes between the two near the insertion. The fibres have a cross arrangement in their course to the tendon; for those from the lower ribs ascend to the upper edge, and those from the spines of the dorsal vertebræ descend to the lower edge. Thus the fibres produce a hollow or groove, which lodges the lower border of the scapula and the teres major muscle. Disposition of its fibres.

Dissection. To lay bare the serratus muscle between the side of the chest and the base of the scapula, the arm is to be drawn from the trunk, so as to separate the scapula from the thorax. The nerves of the brachial plexus may be cut through below the second rib; and the fat and fascia should be cleaned from the muscular fibres. Dissection of the serratus.

The SERRATUS MAGNUS MUSCLE (fig. 86, [4]) extends between the scapula and the thorax. It *arises* by nine pointed processes from the outer surface of the eight upper ribs, about two inches from their cartilages,—the second rib having two pieces; and between the ribs it takes origin from the aponeurosis covering the intercostal muscles. The fibres converge towards the base and angles of the scapula, but from a difference in their direction the muscle appears to consist of three parts. Serratus muscle is attached to the ribs and scapula,

The *upper* part is attached internally to the first two ribs and an aponeurotic arch between them; and externally, to an impression on the ventral surface of the upper angle of the scapula. A *middle* part, which is very thin, extends from the next two ribs (third and fourth) to the base of the shoulder bone. And a *lower* part, which is the strongest, is connected on the one side with four ribs (fifth, sixth, seventh, and eighth), where it digitates with like processes of origin of the external oblique muscle; and, on the other side, it is fixed into the special surface on the costal aspect of the lower angle of the scapula. and its fibres seem to form three parts.

The muscle is applied against the ribs and the intercostal muscles, and is partly concealed by the pectoral muscles and the axillary vessels and nerves: in the ordinary position of the arm the scapula and the subscapularis muscle are in contact with it. Connections of the muscle.

Action. The whole muscle acting, the scapula is carried forwards. But the lower and stronger fibres can move forwards the lower angle, rotating the bone around an axis through the centre, and will raise the acromion. Use on scapula.

on ribs. Supposing the scapula fixed, the muscle elevates the ribs in laboured breathing.

Dissection of the intercostal muscles. *Dissection.* The intercostal muscles will be brought into view by detaching the processes of origin of the serratus from the ribs for a couple of inches, and by taking away the loose tissue on the surface. Towards the front of the chest is a thin aponeurosis, which is continued forwards from each external intercostal muscle to the sternum; this is to be retained. Some of the lateral cutaneous nerves should be preserved.

Intercostal muscles are two layers. The INTERCOSTAL MUSCLES are named from their position between the ribs. There are two layers in each space, but neither occupies the whole length of the space; for the greater number of one layer (the external) cease in front at the costal cartilages; and the other (internal) extend backwards only to the angle of the ribs. The direction of the fibres differs in each stratum; for, whilst the fibres of the external muscle pass very obliquely downwards and forwards, those of the internal layer have an opposite direction between the osseous parts of the ribs, so that they cross.

Outer layer is deficient anteriorly; The *external muscle* is fixed to the outer margin of the ribs of the intercostal space, and consists of fleshy and tendinous fibres. Posteriorly the fibres begin at or near the tubercle of the rib; and anteriorly they end short of the middle line, but after a different manner in the upper and lower spaces. In the intervals

difference above and below. between the true ribs, they cease near the costal cartilages, and a thin aponeurosis is continued onwards from the point of ending to the sternum. In the lower spaces the muscles are continued between the cartilages (Theile); and in the last two they reach the end of the ribs.

Dissection of deeper muscle, *Dissection.* The internal intercostal muscle will be seen by cutting through and removing the external layer and the fascia in one of the widest spaces, say the second; the muscle will be recognised by the difference in the direction of the fibres.

of nerves and vessels. Far back between the two muscles, and close to the rib above, the intercostal nerve and artery will appear. A branch of the nerve to the surface (lateral cutaneous of the thorax) should be followed through the external muscle; and the trunk of the nerve is to be traced forwards in one or more spaces to the sternum and the surface of the thorax.

The hinder part of these muscles will be seen in the dissection of the back and thorax.

Inner layer deficient behind; Each *internal intercostal* muscle, attached to the inner border of the ribs bounding the intercostal space, begins in front at the extremity of the ribs, and ceases behind near their angles. Posteriorly the muscles do not end at the same distance from the spine, for the upper and lower approach nearer than the middle; and, anteriorly, in the two lowest spaces, the muscular fibres are continuous with those of the internal oblique of the abdomen. One surface is covered by the external muscle and in part by the intercostal vessels and nerve; and the opposite surface is in contact with the pleura. joins internal oblique below.

Action. By the alternate action of the intercostal muscles the ribs are moved in respiration. Use of

The *external intercostals* elevate the ribs and evert the lower edges, so as to enlarge the thorax in the antero-posterior and transverse directions: they come into play during inspiration. outer muscles;

The *internal intercostals* act in a different way at the side and fore part of the chest. inner layer,

Between the osseous parts of the ribs they depress and turn in those bones, diminishing in that way the size of the thorax; and they are brought into use in expiration. laterally,

Between the rib-cartilages they raise the ribs, and become muscles of inspiration, like the outer layer. in front.

If both sets of muscles contract simultaneously the motion of the ribs will be arrested; or if two or more bones are broken near the spinal column, the muscles of the space or spaces injured will be unable to move. Both acting.

Dissection. To bring into view the triangularis sterni muscle and the internal mammary vessels, the cartilages of the true ribs, except the first and seventh, are to be taken away with the intervening muscles on the right side of the body;* but the two ribs mentioned are to be left untouched for the benefit of the dissectors of the abdomen and head and neck. Small arteries to each intercostal space and the surface of the thorax, and the intercostal nerves, are to be preserved. The surface of the triangularis sterni will be apparent when the loose tissue and fat are cleaned from it. Dissection of internal mammary vessels.

The TRIANGULARIS STERNI is a thin muscle beneath the costal cartilages. It *arises* internally from the side of the xiphoid cartilage, and the side of the sternum as high as the third costal cartilage; usually also from the lower three true costal cartilages. Its fibres are directed outwards, the upper being most oblique, and are *inserted* by fleshy fasciculi into the true ribs except the last two and the first, at the junction of the bone and cartilage, and into an aponeurosis in the intercostal spaces. Triangularis sterni is in the thorax and attached to the ribs.

The muscle is covered by the ribs and the internal intercostal muscles, and by the internal mammary vessel and the intercostal nerves. It lies on the pleura. Its lower fibres touch those of the transversalis abdominis. Connections.

Action. The muscle assists in depressing the anterior ends of Use.

* On the left side the vessels and the muscle will have been destroyed by the injection of the body.

most of the true ribs; and by diminishing the size of the thorax, it becomes an expiratory muscle.

Internal mammary

The *internal mammary artery* is a branch of the subclavian (p. 74), and enters the thorax beneath the cartilage of the first rib. It is continued through the thorax, lying beneath the costal cartilages and about half an inch from the sternum, as far as the interval between the sixth and seventh ribs; there it gives externally a large muscular branch (musculo-phrenic), and passing beneath the seventh rib, enters the sheath of the rectus muscle in the wall of the abdomen. In the chest the artery lies on the pleura and the triangularis sterni, and is crossed by the intercostal nerves. It is accompanied by two veins, and by a chain of lymphatic glands. The following *branches* take origin in the thorax:—

courses through thorax to abdomen.

Branches

to phrenic nerve,

A small branch (*comes nervi phrenici*) arises as soon as the artery enters the chest, and descends to the diaphragm along the phrenic nerve: this will be met with afterwards.

mediastinal,

A few small *mediastinal* branches are distributed to the remains of the thymus gland, the pericardium, and the triangularis sterni muscle.

intercostal, and

Two *anterior intercostal branches* turn outwards in each space, one being placed on each border of the costal cartilages, and terminate by anastomosing with the aortic intercostal arteries.

perforating branches.

Perforating branches, one or two for each space, pierce the internal intercostal and pectoral muscles, and are distributed on the surface of the thorax with the anterior cutaneous nerves: the lower branches supply the mamma in the female.

Musculo-phrenic branch.

The *musculo-phrenic* branch courses outwards beneath the cartilages of the seventh and eighth ribs, and enters the wall of the abdomen by perforating the diaphragm: it supplies anterior branches to the lower intercostal spaces. Its termination will come in the dissection of the abdominal wall.

Veins.

Two *veins* accompany the artery; these join into one trunk, which opens into the innominate vein.

Intercostal nerves:

The *intercostal nerves*, seen now in the anterior part of their extent, are the anterior primary branches of the dorsal nerves, and supply the wall of the thorax. Placed at first between the layers of the intercostal muscles, each gives off the lateral cutaneous nerve of the thorax, about midway between the spine and the sternum. Diminished in size by the emission of that offset, the trunk is continued onwards, at first in, and afterwards beneath the internal intercostal muscle as far as the side of the sternum, where it ends as the anterior cutaneous nerve of the thorax. *Branches* supply the intercostal muscles, and the triangularis sterni.

course,

termination, and

branches.

Intercostal arteries

The *aortic intercostal arteries* lie with the nerves between the strata of intercostal muscles, and nearer the upper than the lower rib bounding the intercostal space. About the mid point of the space (from before back) the artery bifurcates:—one branch follows the line of the upper rib, and the other descends to the lower rib; both anastomose anteriorly with the intercostal branches of the internal mammary artery. **branch into two.**

A small *cutaneous offset* is distributed with the lateral cutaneous nerve of the thorax; and other branches are furnished to the thoracic wall. **Branches.**

Directions. The dissector of the upper limb waits now the appointed time for the examination of the thorax. But as soon as the body is turned he is to take his share in the dissection of the Back, and to proceed with the parts marked for him in Chapter V. **At this stage the thorax and back are dissected.**

After the back is finished the limb is to be detached from the trunk by sawing the clavicle about the middle, and cutting though the soft parts connected with the scapula.

SECTION II.

SCAPULAR MUSCLES, VESSELS, NERVES, AND LIGAMENTS.

Position. After the limb has been separated from the trunk it is to be placed with the subscapularis uppermost. **Position.**

Dissection. The different muscles that have been traced to the scapula in the dissection of the front of the thorax and the back, are now to be cleaned, and to be followed to their insertion into the bone. A small part of each, about an inch in length, should be left for the purpose of ascertaining more exactly the osseous attachment. **Dissection of muscles**

Between the larger rhomboid and the serratus magnus at the base of the scapula, run the posterior scapular artery and vein, whose ramifications are to be traced.

To the borders and the angles of the scapula the following muscles are connected:— **Muscles inserted**

From the *upper margin* of the scapula arises one muscle, the omohyoid. At its origin that muscle is about half an inch wide, and is attached to the edge of the bone behind the notch, but sometimes to the ligament which converts the notch into a foramen. **into upper margin of the scapula**

The *lower margin*, or costa, gives origin to the long head of the triceps, and to some fibres of the teres major; but these attachments will be ascertained in the progress of the dissection. **into lower margin** into the base; The *base* of the bone has many muscles inserted into it. Between the superior angle and the spine is the levator anguli scapulæ. Opposite the spine the rhomboideus minor is fixed. And between the spine and the inferior angle the rhomboideus major is attached: the upper fibres of this muscle end often in an aponeurotic arch, and are connected indirectly to the bone by means of an expansion from it. Internal to those muscles, and inserted into the base of the scapula, is the serratus magnus muscle.

into the angles of the bone; On the inner surface of the upper and lower *angles* of the scapula the fibres of the serratus magnus are collected. On the outer surface of the inferior angle lies the teres major, which will be subsequently seen.

into coracoid process. The insertion of the small pectoral muscle into the fore part of the upper surface of the *coracoid process* may be ascertained at this stage of the dissection.

Dissection *Dissection.* By the separation of the serratus from the subscapularis a thin fascia comes into view, which belongs to the last muscle, and is fixed to the bone around its margins: after it has been observed, it may be removed.

of subscapularis. The subscapularis muscle is to be followed forwards to its insertion into the humerus. Next, the axillary vessels and nerves, and the offsets of these to the muscles, should be well cleaned.

Subscapularis fills the hollow of scapula; is inserted into humerus. The SUBSCAPULARIS MUSCLE occupies the under surface of the scapula, and is concealed by that bone when the limb is in its natural position. The muscle *arises* from the concave surface on the ventral aspect of the scapula, except at the angles, and this attachment reaches forwards nearly to the neck; it is attached also to the ridges of the bone by tendinous processes. Externally it is *inserted* by a tendon into the small tuberosity of the humerus, and by fleshy fibres into the neck for nearly an inch below that process.

Connections. By one surface the muscle bounds the axilla, and is in contact with the axillary vessels and nerves and the serratus magnus. By the other, it rests against the scapula and the shoulder joint; and between its tendon and the root of the coracoid process is a bursa, which communicates generally with the synovial membrane of the joint. The lower border projects much beyond the bone; it is contiguous to the teres major, the latissimus dorsi, and the long head of the triceps: along this border is the subscapular artery, which here gives backwards its dorsal branch.

Use with arm loose *Action.* It rotates in the hanging limb; and when the humerus is raised it depresses the bone.

and fixed. If the humerus is fixed the subscapularis supports the shoulder joint with the other scapular muscles.

Dissection. *Dissection.* The subscapular muscle is to be separated next from the bone ; and as it is raised its tendinous processes of origin, the connection between its tendon and the capsule of the shoulder joint, and the bursa, are to be observed. A small arterial anastomosis on the ventral surface of the bone is to be dissected out at the same time.

The *infrascapular artery* ramifies on the ventral surface of the scapula, and is an offset of the dorsal branch of the subscapular vessel (p. 265). It enters beneath the subscapularis muscle, and forms an anastomosis with small twigs of the supra and posterior scapular branches. Small infrascapular artery.

Position. The examination of the muscles on the opposite surface of the scapula may be next undertaken. For this purpose the scapula is to be turned over ; and a block, which is deep enough to make the shoulder prominent, is to be placed between that bone and the arm. Position of shoulder.

Dissection. The skin is to be removed from the prominence of the shoulder, by beginning in front at the anterior border of the deltoid muscle. After its removal some small cutaneous nerves are to be found in the fat : the upper of these extend over the acromion; and another comes to the surface about half way down the posterior border of the deltoid muscle. Dissection of the shoulder.

Superficial nerves. Branches of nerves, *super-acromial* (fig. 55, [1]), descend to the surface of the shoulder from the cervical plexus (p. 60). A *cutaneous branch* of the circumflex nerve turns forwards with a small companion artery from beneath the posterior border of the deltoid, and supplies the integuments covering the lower two thirds of the muscle (fig. 55, [2]). Cutaneous nerves.

Dissection. The fat and fascia are now to be taken from the fleshy deltoid, its fibres being made tense at the same time. Beginning at the anterior edge of the muscle, the dissector is to carry the knife upwards and downwards in the direction of the fibres, in order that its coarse muscular fasciculi may be more easily cleaned. As the posterior edge is approached, the cutaneous nerve and artery escaping from beneath are to be dissected out and left. Dissection of deltoid muscle.

At the same time the fascia may be removed from the back of the scapula, so as to denude the teres major and a part of the infraspinatus muscle.

The DELTOID MUSCLE is triangular in form, with the base at the scapula and clavicle, and the apex at the humerus. It *arises* from nearly all the lower edge of the spine of the scapula, from the anterior edge of the acromion, and from the outer half or third of the clavicle. Its fibres converge to a tendon, which is *inserted* into a triangular impression, two to three inches long and about one inch wide at the base, above the middle of the outer surface of the humerus. Deltoid muscle. Origin. Insertion.

The anterior border is contiguous to the pectoralis major Adjacent parts.

muscle and the cephalic vein; and the posterior rests on the infraspinatus and triceps muscles. The origin of the muscle corresponds with the attachment of the trapezius to the bones of the shoulder; the insertion is united with the tendon of the pectoralis major, and a fasciculus of the brachialis anticus is attached on each side of it.

Use on free and

Action. The whole muscle raises the humerus, and abducts it from the trunk. The limb being raised, the anterior fibres will carry it forwards, and the posterior fibres backwards.

fixed limb.

When the humerus is fixed as in climbing, the muscle assists in supporting the weight of the body, and strengthening the joint.

Dissection to detach deltoid.

Dissection. The deltoid is to be divided near its origin, and to be thrown down as much as the circumflex vessels and nerve beneath will permit. As the muscle is raised a large thick bursa between it and the head of the humerus comes into sight. The loose tissue and fat are to be taken away from the circumflex vessels and nerve; and the remains of the bursa are to be removed. The insertion of the muscle should be examined.

Parts covered by the deltoid.

Parts covered by deltoid. The deltoid conceals the head and upper end of the humerus, and those parts of the dorsal scapular muscles which are fixed to the great tuberosity. A large bursa, sometimes divided into sacs, intervenes between the head of the humerus and the under surface of the deltoid muscle and the acromion process. Below the head of the bone are the circumflex vessels and nerve, and the upper part of the biceps muscle. In front of the humerus is the coracoid process with its muscles.

Dissection of posterior circumflex vessels.

Dissection. By following back the posterior circumflex vessels and nerve through a space between the humerus and the long head of the triceps, their connection with the axillary trunks will be arrived at. In clearing the fat from the space a branch of the nerve to the teres minor muscle is to be sought close to the border of the scapula, where it is surrounded by dense fibrous tissue.

Anterior.

Arching outwards in front of the neck of the humerus, is the small anterior circumflex artery: this is to be cleaned.

Two circumflex arteries

The *circumflex arteries* are the last branches of the axillary trunk, and arise near its termination (p. 265). They are two in number, and are named anterior and posterior from their position to the neck of the humerus.

anterior and

The *anterior branch* is a small artery, which courses transversely outwards beneath the coraco-brachialis and biceps muscles, and ascends in the bicipital groove to the articulation and the head of the humerus: it anastomoses in front of the humerus with small offsets of the posterior circumflex.

posterior

The *posterior circumflex* artery is larger in size, and arises opposite the border of the subscapular muscle. It winds backwards through a space between the humerus and the long head of the triceps, and is distributed chiefly to the deltoid muscle, in which it anastomoses with the acromial thoracic artery.

Branches are given from it to the head of the humerus and the shoulder joint, and to anastomose with the anterior circumflex artery. It supplies branches likewise to the teres minor, the long head of the triceps, and the integuments. **Its offsets.**

The *circumflex nerve* leaves the arm-pit with the artery of the same name by turning round the border of the subscapular muscle (fig. 57) (p. 266), and bends forwards round the neck of the humerus, beneath the deltoid muscle in which it ends. Many and large branches enter the deltoid, and terminate in it, with the exception of one or two filaments that pierce the fibres and become cutaneous. **One circumflex nerve; ends in deltoid.**

Branches. In the axilla it gives an *articular* filament to the under part of the shoulder-joint. Behind the humerus it furnishes an *offset* to the *teres minor*, which has a reddish gangliform swelling on it. And at the edge of the deltoid it gives origin to the *cutaneous nerve* before noticed. **Branches: articular, to teres, cutaneous.**

The INFRASPINATUS MUSCLE occupies the infraspinal part of the scapula, and extends to the head of the humerus. The muscle *arises* from the infraspinal fossa, except at three spots, viz. the neck, and the lower angle and inferior border where the teres muscles are attached; it arises also from the lower side of the spinous process, and from the special fascia covering the surface. Its fibres converge to a tendon, which is *inserted* into the middle impression on the great tuberosity of the humerus, and joins the tendons of the supraspinatus and teres minor. **Infraspinatus arises from fossa of that name; Insertion.**

A part of the muscle is subcutaneous, and the fibres arising from the spine of the scapula overlay the tendon: the upper portion is concealed by the deltoid; and the lower end, by the latissimus dorsi. The lower border is parallel to the teres minor, with which it is sometimes united. The muscle lies on the scapula and the humero-scapular articulation, but between it and the joint is a small bursa. The subsequent dissection will show how far the muscle is separated from the bone, at the front of the infraspinal fossa, by vessels and nerve, and the fat. **partly covered by deltoid. Other connections.**

Action. With the humerus hanging it acts as a rotator outwards; and when the bone is raised it will move the same backwards in concert with the hinder part of the deltoid. **Use.**

The TERES MINOR is a narrow fleshy slip, which is often united inseparably with the preceding muscle, along whose lower border it lies. It *arises* on the dorsum of the scapula from a special surface along the upper two thirds of the inferior costa of the bone, and from the investing fascia; and it is *inserted* by a tendon into the lowest of the three marks on the great tuberosity of the humerus, as well as by fleshy fibres into the humerus below that spot—about an inch altogether. **Teres minor is on back of the scapula. Insertion.**

Parts around it. This muscle is partly covered by the deltoid; it rests on the long head of the triceps and the shoulder joint. Underneath it the dorsal branch of the subscapular artery turns.

Use on arm, *Action.* The arm hanging the muscle rotates it out and moves it back; the arm being raised the teres depresses the humerus.

on joint. In climbing it supports the joint like the preceding scapular muscles.

Teres major. The TERES MAJOR muscle is extended from the inferior angle

Origin. of the scapula to the humerus. Its *origin* is from the rough surface on the dorsum of the bone at the inferior angle; from the inferior costa as far forwards as an inch from the long head of the triceps; and from the fascia covering the teres minor. The

Insertion. fibres end in a tendon which is *inserted* partly into, and partly behind the inner edge of the bicipital groove of the humerus.

Adjacent muscles. This muscle assists in forming the posterior fold of the axilla; and is situate beneath the axillary vessels and nerves near the humerus. At its origin it is covered by the latissimus dorsi. The upper border is contiguous to the subscapularis muscle, and the lower is received into a hollow formed by the fibres of the latissimus dorsi. At the humerus the tendon of the muscle is one inch and a half to two inches wide, and is placed behind that

tendon and bursæ. of the latissimus: the two are separated above by a bursa; but they are united below, and an expansion is sent from them to the fascia of the arm. A second bursa lies between the tendon and the bone.

Use on swinging *Action.* If the limb hangs it is rotated inwards by the muscle, and is carried back behind the trunk. The humerus being raised, the muscle depresses and adducts it.

and fixed limb. With the limb fixed by the hand the teres will cause the lower angle of the scapula to move forwards.

Spaces between the teres. Below the scapula (inferior costa), where the teres muscles separate from one another, is a triangular interval, which is bounded in front by the shaft of the humerus, and above and below by the teres muscles. This space is divided into two by

Anterior and the long head of the triceps. Through the anterior part, which is of a quadrilateral shape, the posterior circumflex vessels and

posterior. the circumflex nerve pass: and through the posterior smaller and triangular space, the dorsal branch of the subscapular artery turns.

Dissection *Dissection.* In order that the acromion process may be sawn through to expose the supraspinatus muscle, the ligaments of the scapula and clavicle, which would be injured by such a proceeding, should be next dissected.

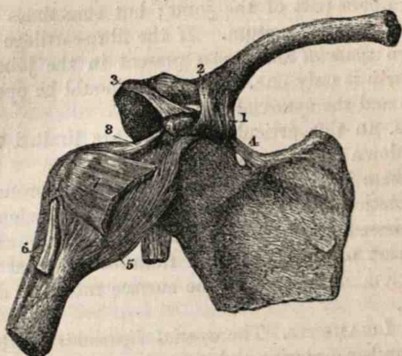
of ligaments of the clavicle One ligament (coraco-clavicular) ascends from the coracoid process to the under part of the clavicle: on removing the areolar tissue it will be seen to consist of two parts, anterior and posterior, differing in size, and in the direction of the fibres.

A capsular ligament, connecting the outer end of the clavicle with the acromion, will be recognised by taking away the fibres of the trapezius and deltoid muscles. capsular;

Another strong band (coraco-acromial) passing transversely between the acromion and the coracoid process; and a small fasciculus (posterior proper ligament), placed over the notch in the superior costa, are then to be defined. and of scapula.

LIGAMENTS OF THE CLAVICLE AND SCAPULA. The clavicle is connected to the scapula by a distinct joint with the acromion, and by a strong ligament (coraco-clavicular) between it and the coracoid process. Union of the clavicle and scapula.

Fig. 53.*



The *coraco-clavicular* ligament consists of two parts, each having a different direction and designation. Coraco-clavicular has

The posterior piece (fig. 53, [1]), called *conoid* from its shape, is fixed by its apex to the posterior and inner part of the coracoid process; and by its base to the tubercle and the contiguous part of the under surface of the clavicle, at the junction of the outer with the middle third of the bone. a conical

The anterior part (fig. 53, [2]), *trapezoid ligament*, is larger than the conoid piece: it is connected inferiorly to the inner border of the coracoid process along the hinder half; and superiorly to the line on the under surface of the clavicle which extends outwards from the tubercle before mentioned. The two pieces and a square piece.

* Ligaments of the clavicle and scapula, and of the shoulder joint (altered from Bourgery and Jacob). 1. Conoid ligament. 2. Trapezoid ligament. 3. Anterior ligament of the scapula. 4. Posterior scapular ligament. 5. Capsule of the shoulder joint. 6. Tendon of the long head of the biceps entering the joint. 7. Tendon of the subscapularis muscle. 8. Coraco-humeral ligament.

of the ligament are united posteriorly, but are separated by an interval in front.

Use of ligament. *Use.* The two parts of the ligament support the scapula in a state of rest; they serve also to restrain the rotatory movements of that bone. When the acromion is rotated down, the motion is checked by the trapezoid band; and when upwards, by the conoid piece.

Joint with acromion. *Acromio-clavicular articulation.* The articular surfaces of the clavicle and acromion process of the scapula are retained in contact by a *capsule* formed of strong fibres. Some of the fibres are thicker above and below, and are considered to constitute a *superior* and an *inferior* ligament.

Capsule,

Fibro-cartilage, An *interarticular fibro-cartilage* is generally found between the bones at the upper part of the joint; but sometimes it forms a complete interarticular septum. If the fibro-cartilage is perfect, there are two *synovial membranes* present in the joint; if it is imperfect, there is only one. The joint should be opened to see the cartilage and the synovial membrane.

and synovial sac.

Movements *Movements.* In this articulation there are limited to and fro, and up and down movements.

in rotation of scapula. Besides, there is a gliding movement of the acromion on the clavicle in rotation of the scapula. For instance, when the acromion is depressed, its articular surface moves from above down at the fore part of the joint, and from below up at the back. When the acromion is elevated the surface moves in exactly the opposite way.

Ligaments of scapula. Scapular Ligaments. The *special ligaments* of the scapula are two in number, anterior and posterior, and extend from one part of the bone to another.

Posterior and The *posterior* ligament (fig. 53, [4]) is a narrow fasciculus of fibres stretching across the notch in the upper costa of the scapula. By one end it is attached to the base of the coracoid process, and by the other to the costa behind the notch. It converts the notch into a foramen, through which the suprascapular nerve passes.

anterior: The *anterior* or *coraco-acromial* ligament (fig. 53, [3]) is triangular in form, and extends transversely between the acromion and the coracoid process. Externally it is inserted by its point or apex into the tip of the acromion; and internally, where it is much wider, it is attached to all the outer border of the coracoid process, reaching backwards to the capsule of the shoulder joint. The ligament consists usually of two thickened bands, anterior and posterior, with a thin intervening part.

this is formed of two pieces.

Use. It forms part of an arch by its position above the shoulder joint, which stops the ascent of the head of the humerus.

Dissection. *Dissection.* To lay bare the supraspinatus muscle, the acromion process is to be sawn through, and to be turned aside with the outer end of the clavicle. A strong fascia covers the surface of the muscle; this is to be taken away after it has been observed.

Supraspinatus; origin The SUPRASPINATUS MUSCLE has the same form as the hollow of the bone that it fills. It *arises* from the surface of the supraspinal fossa of the scapula, except from the cervical part; from the upper side of the spine of the bone; and from the fascia covering the surface. Its fibres end in a tendon, which crosses over the shoulder joint, and is *inserted* into the upper impression on the great tuberosity of the humerus. **is inserted into humerus.**

Connections. The muscle is concealed by the trapezius and the acromion process; and it rests upon the scapula, the shoulder joint, and the suprascapular vessels and nerve. Its tendon joins that of the infraspinatus at the attachment to the humerus.

Use. *Action.* It comes into action with the deltoid in raising the limb, and supporting the joint.

Dissection of suprascapular vessels. *Dissection.* The vessels and nerves on the dorsum of the scapula will be traced by detaching from behind forwards the supra and infraspinatus muscles from the bone. In the supraspinal fossa are the suprascapular vessels and nerve, which are to be followed beneath the acromion to the infraspinal fossa; and entering the infraspinal fossa, beneath the teres minor muscle, is the dorsal branch of the subscapular artery. The anastomosis between those vessels should be carefully cleaned.

Suprascapular artery The *suprascapular artery* is derived from the subclavian trunk, and is one of the branches of the thyroid axis (p. 75). After a short course in the neck it crosses over the ligament at the superior costa, and crossing beneath the supraspinatus muscle, ends in the infraspinal fossa, where it gives offsets to the infraspinatus muscle and the scapula, and anastomoses with the dorsal branch of the subscapular, and the posterior scapular artery of the subclavian. **ends in infraspinatus, and**

gives a supraspinal branch. Beneath the supraspinatus it furnishes a *supraspinal* branch for the supply of the muscle, the bone, and the shoulder joint.

Vein. The companion *vein* of the suprascapular artery joins the external jugular vein.

Suprascapular nerve, The *suprascapular nerve* is a branch of the brachial plexus (p. 77). When it reaches the costa of the scapula, it enters the supraspinal fossa beneath the posterior special ligament. In the fossa it supplies two branches to the supraspinatus; and the nerve is continued finally beneath a fibrous band to the infraspinatus muscle, in which it ends. **branches.**

Articular. The nerve gives some *articular* filaments to the shoulder joint, and other offsets to the scapula.

Posterior scapular. The *posterior scapular artery* runs along the base of the scapula beneath the rhomboid muscles, furnishing offsets to them and the surfaces of that bone. It is more fully noticed with the dissection of the Back.

Dorsal branch of subscapular artery.

The *dorsal branch* of the *subscapular artery* (p. 265) turns backwards below the inferior costa of the scapula, through the posterior of the two spaces between the teres muscles. Entering the infraspinal fossa beneath the teres minor, it supplies that muscle and the infraspinatus, and communicates with the suprascapular artery. This vessel sends a branch along the dorsum of the scapula between the teres muscles, towards the inferior angle of the bone, where it anastomoses with the posterior scapular artery.

Section III.

THE FRONT OF THE ARM.

Position

Position. For the dissection of the superficial vessels and nerves on the front of the arm the limb should lie flat on the table, with the front uppermost.

and incisions in the skin.

Dissection. The skin is to be raised from the fore and hinder parts of the arm and elbow joint. To allow of its reflection, make one incision along the centre of the limb as far as two inches below the elbow; and at the termination, a second cut half round the forearm. Strip now the skin from the limb, as low as the transverse incision, so that the fat or superficial fascia which contains the cutaneous vessels and nerves may be denuded. Between the skin and the prominence of the olecranon a bursa may be seen.

Seek superficial veins.

The cutaneous veins (fig. 54) may be sought first in the fat. These vessels are very numerous below the bend of the elbow, as they issue from beneath the integument. One in the centre of the forearm is the median vein, which bifurcates rather below the elbow. External to this is a small vein (radial); and internal to it are the anterior and posterior ulnar veins, coming from the front and back of the forearm. In the arm these veins are united into two; one (basilic) is to be followed along the inner border of the biceps, and the other (cephalic) along the outer side of the muscle.

Trace cutaneous nerves

The cutaneous nerves may be next traced out. As they appear through the deep fascia they lie beneath the fat; and this layer must be scraped through to find them.

of outer side

On the outer side of the arm (fig. 55), about its middle, two external cutaneous branches of the musculo-spiral are to be sought. In the outer bicipital groove, in front of the elbow or rather below it, the cutaneous part of the musculo-cutaneous nerve will be recognised.

On the inner part of the limb the nerves to the surface are more numerous. Taking the basilic vein as a guide, the internal cutaneous nerve of the forearm will be found by its side, about the middle of the arm; and rather external to this nerve is a small cutaneous offset from it, which pierces the fascia higher up. Scrape through the fat behind the internal cutaneous in the lower third of the arm for the small nerve of Wrisberg; and in the upper third seek the small nerves that have been already met with in the dissection of the axilla, viz., the intercosto-humeral, and the internal cutaneous of the musculo-spiral. and inner side of the limb.

The *superficial fascia* forms a continuous investment for the limb, but it is thicker in front of the elbow than in the other parts of the arm. In that spot it encloses the superficial vessels and lymphatics, and may be divided into two layers. Superficial fat.

CUTANEOUS VEINS. The position and the connections of the superficial veins in front of the elbow are to be attentively noted by the dissector, because the operation of venesection is practised in one of them. The cutaneous veins are

Fig 54.*

The *median vein* of the forearm (fig. 54, [2]) divides into two branches, internal and external, rather below the bend of the elbow; and at its point of division it is joined by an offset from a deep vein. The internal branch (median basilic) crosses to the inner border of the biceps, and unites with the ulnar veins (3) to form the basilic vein of the inner side of the arm. The external branch (median cephalic) is usually longer than the other, and by its junction with the radial vein (7) gives rise to the cephalic vein of the arm. median vein; divides into two branches.

The connections of the two veins into which the median bifurcates, are described below:—

The *median cephalic* vein (fig. 54) is directed obliquely outwards, and lies over the hollow between the biceps and the outer mass of muscles of the forearm. Beneath it is the trunk of the Position and connections of median cephalic,

* Cutaneous veins and nerves at the bend of the elbow. (From Quain's "Arteries.")—1. Median basilic vein. 2. Median vein of the forearm bifurcating. 3. Anterior ulnar veins. 4. Cephalic vein formed by radial from behind and the median cephalic in front. The musculo-cutaneous nerve is by the side of it. 5. Basilic vein; with the large internal cutaneous nerve by its side. 6. Brachial artery, with its companion veins (one cut). 7. Radial vein.

musculo-cutaneous nerve; and over it some small offsets from that nerve are directed. This vein is altogether removed from the brachial artery, and is generally smaller than the median basilic vein. If opened with a lancet, it does not generally yield much blood, in consequence of its position in a hollow between muscles rendering compression of it very uncertain and difficult.

and of the median basilic vein.

The *median basilic* vein (fig. 54, [1]) is usually more horizontal in direction than the preceding, and crosses the brachial artery as it tends to the inner side of the limb. It is larger than the corresponding vein of the outer side of the arm, and is firmly supported by the underlying fascia,—the aponeurosis of the arm, strengthened by fibres from the biceps tendon, intervening between it and the brachial vessels. Branches of the internal cutaneous nerve lie beneath it, and some twigs of the same nerve are placed over it.

Venesection is practised in this branch.

The median basilic is the vein on which the operation of bloodletting is commonly performed. It is selected in consequence of its usually larger size and more superficial position, and the ease with which it may be compressed; but from the close proximity of the vein to the brachial vessels, the spot chosen for the venesection should not be immediately over the trunk of the artery.

Basilic vein on inner side of the arm.

The *basilic vein* (fig. 54, [5]), commencing near the inner condyle of the humerus in the manner before said, ascends near the inner border of the biceps muscle to the middle of the arm, where it passes beneath the deep fascia, and is continuous with the axillary vein. In this course it lies to the inner side of the brachial artery.

Cephalic vein at outer side of the arm.

The *cephalic vein* (fig. 54, [2]) is derived chiefly from the external branch of the median, for the radial vein is oftentimes very small. It is continued to the shoulder along the outer side of the biceps, and sinks between the deltoid and pectoral muscles, near the clavicle, to open into the axillary vein.

Superficial lymphatics.

The *superficial lymphatics* of the arm lie for the most part along the basilic vein, and enter into the glands of the axilla. A few lymphatics accompany the cephalic vein, and passing between the pectoral and deltoid muscles, end as the others in the axillary glands.

Glands.

One or more superficial lymphatic glands are commonly found near the inner condyle of the humerus.

The superficial nerves.

Cutaneous Nerves. The superficial nerves of the arm appear on the inner and outer sides, and spread so as to cover the surface of the limb. With one exception (intercosto-humeral) all are derived from the brachial plexus, either as distinct branches, or as offsets of other nerves. On the outer side of the limb are branches of the musculo-spiral and musculo-cutaneous nerves. On the inner side are two internal cutaneous nerves, large and small, (from the plexus), a third internal cutaneous from the musculo-spiral, and the intercosto-humeral nerve.

Two external cutaneous of musculo-spiral,

EXTERNAL CUTANEOUS NERVES. The *external cutaneous branches of the musculo-spiral nerve* are two in number, and appear at the

Fig. 55.*

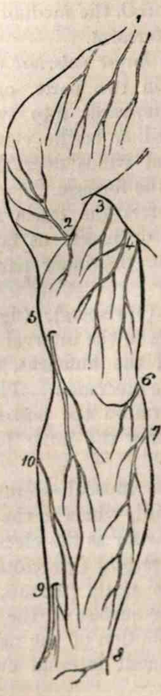
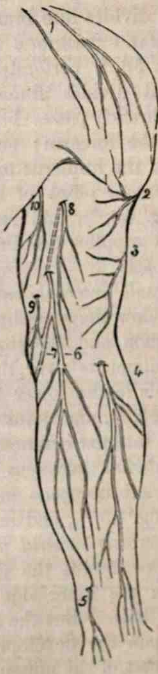


Fig. 56.†



upper,

outer side of the limb in the spot before mentioned. The *upper* small one (fig. 56, [3]) turns forwards with the cephalic vein, and reaches the front of the elbow, supplying the anterior part of the

* Cutaneous nerves of the back of the arm and forearm. 1. Supra acromial nerves of the cervical plexus. 2. Cutaneous branch of the circumflex nerve. 3. Internal cutaneous of the musculo-spiral trunk. 4. Intercosto humeral nerve. 5. Lower external cutaneous of the musculo-spiral. 6. Nerve of Wrisberg. 7. Posterior branch of the internal cutaneous. 8. Dorsal branch of the ulnar nerve. 9. Radial nerve. 10. Posterior branch of the musculo-cutaneous.

† Cutaneous nerves of the front of the arm and forearm. 1. Supra acromial nerves. 2. Cutaneous of the circumflex. 3. Upper external cutaneous of the musculo-spiral. 4. Musculo-cutaneous nerve. 5. Cuta-

and lower, arm. The *lower* and larger (fig. 55, [5]) pierces the fascia somewhat farther down, viz., about the middle of the outer surface of the arm, and after supplying some cutaneous filaments to that part of the limb, is continued to the forearm.

and one of musculo-cutaneous. The cutaneous part of the *musculo-cutaneous nerve* (fig. 56, [4]) pierces the fascia in front of the elbow, at the outer side of the tendon of the biceps muscle. It lies beneath the median cephalic vein, and divides into branches for the forearm.

Two internal cutaneous of brachial plexus. INTERNAL CUTANEOUS NERVES. The *larger internal cutaneous nerve* (fig. 56, [6]) perforates the fascia in two parts, or as one trunk that divides almost directly afterwards into two. Its external branch passes beneath the median basilic vein to the front of the forearm; and the internal winds over the inner condyle of the humerus to the back of the forearm.

Large A *cutaneous* offset of the nerve pierces the fascia near the axilla (fig. 56, [8]), and reaches as far, or nearly as far as the elbow: it supplies the integuments over the inner part of the biceps muscle.

and small. The *small internal cutaneous nerve* (Wrisberg), (fig. 56, [9]), appears below the preceding, and extends to the interval between the olecranon and the inner condyle of the humerus, where it ends in filaments over the back of the olecranon. The nerve gives offsets to the lower third of the arm on the posterior surface (fig. 55, [6]), and joins above the elbow the inner branch of the larger internal cutaneous nerve.

Cutaneous of musculo-spiral. The *internal cutaneous branch* of the musculo-spiral nerve, becoming subcutaneous in the upper third, winds to the back of the arm (fig. 55, [3]), and reaches nearly as far as the olecranon.

Intercosto-humeral. The *intercosto-humeral branch* of the second intercostal nerve (p. 255), perforates the fascia near the axilla (fig. 56, [4]), and ramifies in the inner side and posterior surface of the arm in the upper half. But the size and distribution of the nerve will depend upon the development of the small internal cutaneous and the offset of the musculo-spiral.

Deep fascia of the arm. The *aponeurosis* of the arm is a white shining membrane which surrounds the limb, and sends inwards processes between the muscles. Over the biceps muscle it is thinner than elsewhere. At certain points it receives accessory fibres from the subjacent tendons:—thus in front of the elbow an offset from the tendon of the biceps joins it; and near the axilla the tendons of the pectoralis major, latissimus dorsi, and teres, send prolongations to it.

Disposition above At the upper part of the limb the fascia is continuous with

neous of the ulnar to the forearm. 6 and 7. Internal cutaneous, with an offset 8, to the arm. 9. Wrisberg's nerve. 10. Intercosto-humeral nerve.

that of the axilla, and is prolonged over the deltoid and pectoral muscles to the scapula and the clavicle. Inferiorly it is continued to the forearm, and is connected to the prominences of bone around the elbow joint, especially to the condyloid ridges of the humerus, so as to give rise to the intermuscular septa of the arm.

and below; forms intermuscular septa.

Directions. As the back of the arm will not be dissected now, the skin may be replaced on it until the front has been examined. And to keep in place the vessels and nerves at the upper part of the limb, they should be tied together with string in their natural position, and fastened to the coracoid process.

Directions to be observed.

Position. The limb is still to lie on the back, but the scapula is to be raised by means of a small block; and the bone is to be fixed in such a position as to render tense the muscles. The inner surface of the arm is to be placed towards the dissector.

Position of limb.

Dissection. The aponeurosis is to be reflected from the front of the arm by an incision along the centre, like that through the integuments; and it is to be removed on the outer side as far as the line of the humerus leading to the outer condyle, but on the inner side rather farther back than the corresponding line, so as to lay bare part of the triceps muscle. In raising the fascia the knife must be carried in the direction of the fibres of the biceps muscle; and to prevent the displacement of the brachial artery and its nerves, fasten them here and there with stitches.

Dissection of muscles and vessels,

In front of the elbow is a hollow containing the brachial vessels: the artery should be followed into it, to show its ending in the radial and ulnar trunks.

and elbow hollow.

Muscles on the Front of the Arm. There are only three muscles on the fore part of the arm. The muscle along the centre of the limb is the biceps; and that along its inner side, reaching about half way down, is the coraco-brachialis. The brachialis anticus muscle lies beneath the biceps. Some muscles of the forearm are connected to the inner and outer condyles of the humerus, and to the line above the outer.

Position of the muscles of the arm.

The biceps muscle (fig. 57, [8]) forms the prominence observable on the front of the arm. It is wider at the middle than at either end; and the upper part consists of two tendinous pieces of different lengths, which are attached to the scapula. The short head *arises* from the apex of the coracoid process in common with the coraco-brachialis muscle; and the long head is attached to the upper part of the glenoid cavity of the scapula, within the capsule of the shoulder joint. Muscular fibres spring from each tendinous head, and blend about the middle of the arm in a fleshy belly, which is somewhat flattened from before back. Inferiorly the biceps ends in a tendon, and is *inserted* into the tubercle of the radius.

Biceps has a short and long head. Origin from the scapula. Insertion into radius.

The muscle is superficial except at the extremities. At the

Parts covering

upper part the biceps is concealed by the pectoralis major and deltoid muscles; and at the lower end the tendon dips into the hollow in front of the elbow, having previously given an offset to the fascia of the arm. Beneath the biceps are the brachialis anticus muscle, the musculo-cutaneous nerve, and the upper part of the humerus. Its inner border is the guide to the brachial artery below the middle of the humerus, but above that spot the coraco-brachialis muscle intervenes between them. The connection of the long head of the biceps with the shoulder joint, and the insertion of the muscle into the radius, will be afterwards learnt.

And beneath it.

Inner border is guide to the artery.

Use on radius,

Action. It bends the elbow-joint, and acts powerfully in supinating the radius.

on humerus.

With the radius fixed and the arm hanging, the long head will assist the abductors in removing the limb from the thorax; and after the limb is abducted, the short head will be able to restore it to its pendent position.

Coraco-brachialis.

Origin.

Insertion.

The CORACO-BRACHIALIS is roundish in form, and is named from its attachments. Its *origin* is fleshy from the tip of the coracoid process, and from the tendinous short head of the biceps. Its fibres become tendinous, and are *inserted*, below the level of the deltoid muscle, into the ridge on the inner side of the humerus: from the insertion an aponeurotic slip is continued upwards to the head of the humerus, and is joined by fleshy fibres.

Connections of surrounding parts.

Part of the muscle is beneath the pectoralis major, and forms a prominence in the axilla; but the rest is superficial, except at the insertion where it is covered by the brachial vessels and the median nerve. The coraco-brachialis conceals the subscapular muscle, the anterior circumflex artery, and the tendons of the latissimus and teres. Along the inner border are the large artery and nerves of the limb. Perforating it is the musculo-cutaneous nerve.

Use on limb, hanging

Action. The hanging limb is adducted to the thorax by this muscle; and the action is greater in proportion as the humerus is removed from the trunk.

and fixed.

The humerus being fixed, the muscle will bring down the scapula, and assist in keeping the articular surfaces of the shoulder joint in apposition.

Brachial artery extends to elbow.

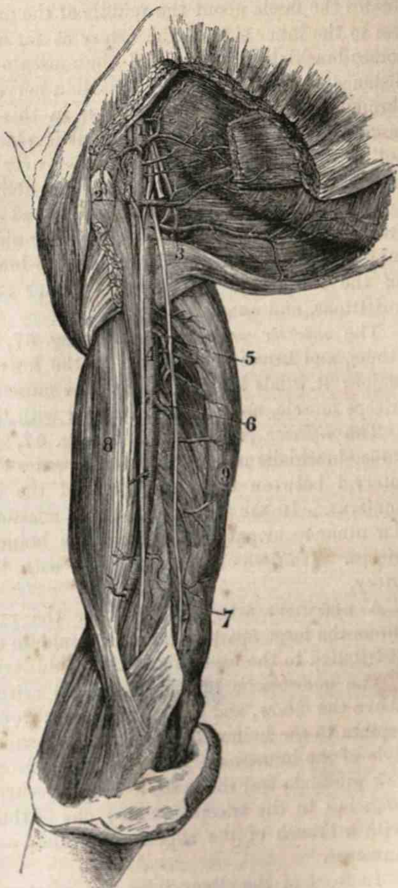
The BRACHIAL ARTERY (fig. 57, [4]) is a continuation of the axillary trunk, and supplies vessels to the upper limb. It begins at the lower border of the teres major muscle, and terminates rather below the bend of the elbow, or "opposite the neck of the radius" (Quain), in two branches—radial and ulnar, for the forearm.

Position to bone, and in the limb.

In the upper part of its course, the vessel is internal to the humerus, but afterwards in front of that bone; and its situation is indicated by the surface depression along the inner border of the biceps and coraco-brachialis muscles.

In all its extent the brachial artery is superficial, being covered by the integuments and the deep fascia; but at the bend of the elbow it becomes deeper, and is crossed by the median basilic vein and the prolongation from the tendon of the biceps. Posteriorly the artery has the following muscular connections: — whilst it is inside the humerus it is placed over the long head of the triceps for two inches, but separated partly by the musculo-spiral nerve and profunda vessels; and over the inner head of the same muscle for about an inch and a half; but when the vessel turns to the front of the bone, it lies on the insertion of the coraco-brachialis and the brachialis anticus. To the outer side are laid the coraco-brachialis and biceps muscles, the latter overlapping it. Connections with muscles and fasciæ,

Fig. 57.*



Veins. Venæ comites lie on the sides of the artery, encircling with vein

* Axillary and brachial arteries and their branches. (From Quain's "Arteries.")—1. Axillary artery and branches: the small branch above the figure is the highest thoracic, and the larger branch close below, the

it with branches, and the median basilic vein crosses over it at the elbow. The basilic vein is near, but inside the artery above, and is superficial to the fascia in the lower half of the arm.

and with nerves.

The *nerves* in relation with the artery are the following:—The internal cutaneous is in contact with the vessel until it perforates the fascia about the middle of the arm. The ulnar nerve lies to the inner side of the artery as far as the insertion of the coraco-brachialis muscle; and the musculo-spiral is behind for a distance of two inches. The median nerve is close to the vessel throughout, but alters its position in this way:—as low as the insertion of the coraco-brachialis it is placed on the outer side, but it then crosses obliquely either over or under the artery, and becomes internal about two inches above the elbow joint.

Its branches are muscular;

Branches spring both externally and internally from the brachial artery. Those on the outer side are *muscular*, and supply the coraco-brachialis, biceps, and brachialis anticus; those on the inner side are named superior and inferior profunda, nutritious, and anastomotic.

superior profunda,

The *superior profunda* branch (fig. 57, [5]) is larger than the others, and leaves the artery near the lower border of the teres major; it winds backwards with the musculo-spiral nerve to the triceps muscle, and will be dissected with the back of the arm.

inferior profunda,

The *inferior profunda* branch (fig. 57, [6]), arises opposite the coraco-brachialis muscle, and accompanies the ulnar nerve to the interval between the olecranon and the inner condyle of the humerus. In the spot mentioned it anastomoses with the posterior ulnar recurrent and anastomotic branches, and supplies the triceps. It arises often in common with the superior profunda artery.

nutrient of the bone,

A *nutritious* artery begins near the preceding branch, and enters the large aperture about the middle of the humerus; it is distributed to the osseous and the medullary substance.

and anastomotic.

The *anastomotic* branch (fig. 57, [7]) arises one to two inches above the elbow, and courses inwards through the intermuscular septum to the hollow between the olecranon and the inner condyle of the humerus. Here the artery inosculates with the inferior profunda and the posterior ulnar recurrent branch, and gives branches to the triceps muscle: one of the offsets forms an arch with a branch of the superior profunda across the back of the humerus.

In front of the elbow joint the anastomotic branch sends an

acromial thoracic. 2. Long thoracic branch. 3. Subscapular branch. 4. Brachial artery and branches. 5. Superior profunda branch. 6. Inferior profunda branch. 7. Anastomotic branch. 8. Biceps muscle. 9. Triceps muscle. The median and ulnar nerves are shown in the arm; the median is close to the brachial artery.

offset to the pronator teres muscle: this joins the anterior ulnar recurrent.

The BRACHIAL VEINS accompany the artery, one on each side, and have branches of communication across that vessel; they receive contributing veins corresponding with the branches of the arteries. Superiorly they unite into one, which joins the axillary vein near the subscapular muscle.

Veins end in the axillary.

Peculiarities in position. The brachial trunk may leave the inner border of the biceps in the lower half of the arm, and course along the inner intermuscular septum, with or without the median nerve,* to the inner condyle of the humerus. At this spot the vessel is directed to its ordinary position in front of the elbow, either through or beneath the fibres of the pronator teres, which has then a wide origin. In this unusual course the artery lies behind a projecting bony point of the humerus.

Deviations in position.

In division. Occasionally, though very rarely, the artery is split for a short distance at its upper part, like the main vessel in the lower limb.

In place of division.

The terminal bifurcation of the vessel may be short of the ordinary spot, or beyond it: the former condition is much the most frequent. In only one instance did Mr. Quain find the vessel carried farther into the limb before it bifurcated, and in that example the point of division was "between two and three inches" beyond the elbow joint.

The origin of the arteries of the forearm. The arteries of the forearm, viz. radial, ulnar, and interosseous, may be carried backwards along the parent trunk to any point between the axilla and the elbow; and this unusual origin from the humeral trunk is most common in the upper third, and least frequent in the middle third. When one of the vessels referred to deviates from the ordinary condition, there would be two large arteries in the arm in the place of one. Commonly the two lie close together; though sometimes one, viz. the trunk that is to supply the front of the forearm and the palm of the hand, will lie close to the intermuscular septum, with the median nerve, like the brachial artery.

In origin of usual arteries of forearm.

In some few cases the brachial artery has been observed to divide into three (radial, ulnar, and interosseous) at some little distance above the elbow, so that three trunks would be present in the lower part of the arm. In one body the three arteries of the forearm sprang from the end of the brachial below the elbow, in the same way as the three arteries of the leg come occasionally from the end of the popliteal trunk.

Unusual branching.

Vasa aberrantia. Occasional long slender vessels connect the brachial or the axillary trunk with the radial artery. The accessory vessel very rarely ends in the ulnar artery.

In aberrant branches.

Muscular covering. In some bodies the humeral artery is covered by an additional slip of origin of the biceps, or of the brachialis anticus muscle. And sometimes a slip of the brachialis may conceal, in cases of high origin of the radial, the remainder of the arterial trunk that continues to the forearm.

In muscular covering.

NERVES OF THE ARM. The nerves on the front of the arm are derived from the terminal cords of the brachial plexus. Few of them furnish offsets above the elbow, but they are continued, for the most part without branching, to the forearm and

Nerves on front of arm.

* Sometimes the nerve takes this unusual position without its large companion artery, and is accompanied by an offset from the superior profunda branch.

the hand. The cutaneous branches of some of them have been referred to (p. 282).

Median nerve with the artery ;

The *median nerve* (fig. 57) arises from the brachial plexus by two roots, one from the outer, and the other from the inner cord (p. 266). Its destination is to the palm of the hand ; and it accompanies the brachial artery to the forearm. Commencing on the outer side of the artery, the nerve crosses over or under the vessel about the middle of the arm, and is placed on the inner side a little above the elbow. It does not give any branch in the arm ; but there may be a fasciculus connecting it with the musculo-cutaneous nerve. Its connections with muscles are the same as those of the artery.

has not any branch.

Ulnar nerve

The *ulnar nerve* (fig. 57) is derived from the inner cord of the brachial plexus, and ends at the inner side of the hand. In the arm the nerve lies at first close to the inner side of the axillary and the brachial artery as far as the insertion of the coraco-brachialis ; then leaving the bloodvessel, it is directed inwards through the inner intermuscular septum to the interval between the olecranon and the inner condyle, being surrounded by the muscular fibres of the triceps. There is not any branch given from the nerve till it reaches the elbow joint, but a branch from the musculo-spiral to the triceps accompanies it in the lower part of its course.

is without branch as far as the elbow.

Internal cutaneous nerve beneath the fascia.

The *internal cutaneous* is a tegumentary nerve of the forearm, to which it is prolonged like the others. Part of the nerve has been before seen (p. 284). Arising from the inner cord of the plexus, it is at first superficial to the humeral artery as far as the middle of the arm, where it divides into two branches that perforate the investing fascia (fig. 56). Near the axilla it furnishes a small cutaneous offset (8) to the integuments of the arm.

Nerve of Wrisberg

The *small internal cutaneous nerve* (nerve of Wrisberg *) arises with the preceding. Concealed at first by the axillary vein, it is directed inwards beneath (but sometimes through) the vein, and joins with the intercosto-humeral nerve. Afterwards it lies along the inner part of the arm as far as the middle, where it perforates the fascia to end in the integument (p. 284).

beneath the fascia.

Musculo-cutaneous nerve in the arm.

The *musculo-cutaneous nerve* (nerv. perforans, Casserii) named from supplying muscles and integuments, ends on the surface of the forearm. It leaves the outer cord of the brachial plexus opposite the lower border of the pectoralis minor, and perforates directly the coraco-brachialis : it is then directed obliquely to the outer side of the limb between the biceps and brachialis anticus muscles. Near the elbow it becomes a cutaneous nerve of the forearm (fig. 56, [4]).

* An account of this nerve is given by Klint. See a Paper in Ludwig's Scriptores Nervologici Minores, tom. iii "De Nervis Brachii."

Branches. The nerve furnishes branches to the muscles in front of the humerus, viz. to the coraco-brachialis as it passes through the fibres, and to the biceps and brachialis anticus where it is placed between them; and sometimes there is a large branch of communication with the median nerve after it has pierced the coraco-brachialis. **Its muscular branches.**

Dissection. The brachialis anticus muscle will be brought into view by cutting through the tendon of the biceps near the elbow, and turning upwards this muscle. The fascia and areolar tissue should be taken from the fleshy fibres; and the lateral extent of the muscle should be well defined on each side, so as to show that it reaches the intermuscular septum largely on the inner side, but only for a short distance above on the outer side. **Dissection.**

Some care is required in detaching the brachialis externally from the muscles of the forearm, to which it is closely applied. As the muscles are separated the musculo-spiral nerve with a small artery comes into sight.

The BRACHIALIS ANTICUS covers the elbow joint, and the lower half of the front of the humerus. It *arises* from the anterior surface of the humerus below the insertion of the deltoid muscle; and from the intermuscular septa on the sides, viz. from all the inner, but only the upper part of the outer. The fleshy fibres converge to a tendon, which is *inserted* into the impression on the ulna below the coronoid process. **Brachialis anticus. Origin. Insertion.**

This muscle is concealed by the biceps. On it lie the brachial artery, with the median, musculo-cutaneous, and musculo-spiral nerves. It covers the humerus and the articulation of the elbow. Its origin embraces by two parts the attachment of the deltoid; and its insertion is placed between two fleshy pieces of the flexor profundus digitorum. The inner border is attached to the intermuscular septum of that side in all its length; but the outer touches the external intermuscular septum only about one inch and a half above, and is separated from it lower down by two muscles of the forearm (supinator longus and extensor carpi radialis longior), which extend upwards on the humerus. The tendon of insertion will be seen in the dissection of the forearm. **Connection of surfaces, of borders.**

Action. The brachialis brings forward the ulna towards the humerus, and bends the elbow-joint. **Use, forearm free.**

If the ulna is fixed, as in climbing with the hands above the head, the muscle bends the joint by raising the humerus. **and fixed.**

BACK OF THE ARM.

Position. During the examination of the back of the arm, the limb being turned over is to be raised into a semiflexed position by means of a block beneath the elbow. The scapula is to be drawn away till it is nearly in a line with the humerus, so as **Position of the part.**

to tighten the muscular fibres; and it is then to be fastened with hooks in that position.

How to lay bare the triceps.

Dissection. On the back of the arm there is one muscle, the triceps, with the musculo-spiral nerve and superior profunda artery. The skin having been reflected already, the muscle will be laid bare readily, for it is covered only by fascia. To take away the fascia, carry an incision along the limb to a little below the elbow; and in reflecting it, the subaponeurotic loose tissue should be removed at the same time.

Separate the middle from the inner and outer heads of the muscle, and trace the musculo-spiral nerve and the vessels beneath it. Define the outer head which reaches down to the spot at which the musculo-spiral nerve appears on the outer side.

Triceps muscle has three heads.

The TRICEPS MUSCLE (fig. 57, [9]) is divided superiorly into three parts or heads of origin, inner, outer, and middle: two of these are attached to the humerus, and one to the scapula.

Origin of middle head.

The *middle* piece, or head, is the longest, and has a tendinous origin, about an inch wide, from the inferior costa of the scapula close to the glenoid cavity, where it is united with the capsule of the shoulder joint. The *outer head* is narrow and *arises* from the back of the humerus above the spiral groove, extending from the root of the large tuberosity to that groove. The *inner head*, fleshy and wide, *arises* from the posterior surface of the humerus below the spiral groove, reaching laterally to the intermuscular septa, and gradually tapering upwards as far as the insertion of the teres major (Theile). From the different heads the fibres are directed with varying degrees of inclination to a common tendon of insertion at the lower part. Inferiorly the muscle is *inserted* into the end of the olecranon process of the ulna, and gives an expansion to the aponeurosis of the forearm. Between the tip of the olecranon and the tendon is a small bursa.

of outer head, and of inner head.

Direction of the fibres. Insertion.

Connections of the muscle.

The triceps is superficial, except at the upper part where it is overlapped by the deltoid muscle. It lies on the humerus, and conceals the musculo-spiral nerve, the superior profunda vessels, and the articulation of the elbow. On the sides the muscle is united to the intermuscular septa; and the lower fibres of the outer head are continuous with the anconeus—a muscle of the forearm.

Use when ulna free,

Action. All the parts of the triceps combining will bring the ulna into a line with the humerus, and extend the elbow-joint. As the long head passes the shoulder it can depress the raised humerus, and adduct the bone to the side.

and fixed.

But if the ulna is fixed in the bent state of the elbow, the heads attached to the humerus can carry back this bone, and the long head will approximate the scapula to the limb.

Two intermuscular septa

The *intermuscular septa* are fibrous processes continuous with the investing aponeurosis of the arm, which are fixed to the ridges leading to the condyles of the humerus: they intervene between the muscles on the front and back of the limb, and give attachment to fleshy fibres. attached to ridges of humerus.

The *internal* is the strongest, and reaches as high as the coraco-brachialis muscle, from which it receives some tendinous fibres. The brachialis anticus is attached to it in front, and the triceps behind; and the ulnar nerve, and the inferior profunda and anastomotic arteries pierce it. An inner and

The *external* septum is thinner, and ceases at the deltoid muscle. Behind it is the triceps; and in front are the brachialis anticus, and the muscles of the forearm (supinator longus and extensor carpi radialis longus) arising above the condyle of the humerus: it is pierced by the musculo-spiral nerve. outer.

Dissection. To follow the superior profunda vessels and the musculo-spiral nerve, the middle head of the triceps should be cut across over them, and the fatty tissue should be removed. The trunks of the vessel and nerve are to be afterwards followed below the outer head of the triceps to the front of the humerus. Dissection of vessels and nerve.

To trace out the branches of the nerve and artery, which descend to the olecranon and the anconeus muscle, the triceps is to be divided along the line of union of the outer with the middle head. Trace branches.

The *superior profunda* branch of the brachial artery (p. 288) supplies the triceps muscle. Accompanying the musculo-spiral nerve, it turns to the back of the humerus in the interval between the inner and outer heads of the triceps. In this position the artery supplies large muscular branches, and is continued onwards in the groove in the bone to the outer part of the arm, where it divides into its terminal offsets:—One of these courses on the nerve to the front of the elbow, anastomosing with the recurrent radial artery: whilst others continue along the intermuscular septum to the elbow, and join the radial and posterior interosseous recurrent arteries. Superior profunda artery lies behind the humerus.

Branches. The *muscular* offsets of the vessel descend to the olecranon, supplying the triceps, and communicate with other branches of the brachial artery, viz. inferior profunda, anastomotic (p. 288), and the recurrent branches of the arteries of the forearm. One slender offset accompanies a branch of the musculo-spiral nerve, and ends in the anconeus muscle below the outer condyle of the humerus. Supplies triceps, and forms a circle around joint.

Two or more *cutaneous* offsets arise on the outer side of the arm, and accompany the superficial nerves. Cutaneous.

The *musculo-spiral nerve* is the largest trunk of the posterior cord of the brachial plexus (p. 266), and is continued along the back and outer part of the limb to the hand. In the arm the nerve winds with the profunda artery beneath the triceps muscle from the inner to the outer part of the limb. At the outer aspect Musculo-spiral nerve winds behind humerus to outer side of the arm.

of the arm it is continued between the brachialis anticus and supinator longus muscles to the external condyle of the humerus, in front of which it divides into the radial and posterior interosseous nerves. In this extent the nerve gives muscular branches, and the following cutaneous offsets to the inner and outer parts of the limb.

Branches.

Internal cutaneous branch.

The *internal cutaneous* branch of the arm (fig. 55, [3]) is of small size, and arises in the axillary space in common with the branch to the inner head of the triceps; it is directed across the posterior boundary of the axilla to the inner side of the arm, where it becomes cutaneous in the upper third, and is distributed as before said (p. 284).

Two external cutaneous.

The *external cutaneous* branches springing at the outer side of the limb are two in number: they are distributed in the integuments of the arm and forearm (p. 283).

Branches to the triceps,

The *muscular* branches of the triceps are numerous, and supply all three heads. One slender offset for the inner head, arises in common with the inner cutaneous branch, and lies close to the ulnar nerve till it enters the muscular fibres at the lower third of the arm. Another long and slender branch behind the humerus, appearing as if it ended in the triceps, can be followed downwards to the anconeus muscle.

and anconeus.

brachialis and muscles of forearm.

On the outer part of the limb the musculo-spiral nerve supplies the brachialis anticus in part, and two muscles of the forearm, viz. supinator longus and extensor carpi radialis longior.

Subanconeal slip.

Attachments.

Subanconeus muscle. This is a thin fleshy stratum beneath the triceps near the elbow. It is described as consisting of two fasciculi, inner and outer, which are attached above the fossa for the olecranon, and end in the synovial sac of the joint. A corresponding muscle is placed beneath the extensor of the knee joint.

Use.

Action. It is said to raise the capsule and synovial membrane in extension of the joint.

Dissection of the shoulder joint.

Dissection. As the dissection of the arm has been completed as far as the elbow, it will be advisable to examine next the shoulder joint. For this purpose the tendons of the surrounding muscles, viz. those of the subscapularis, supra and infraspinatus, and teres minor, must be detached from the capsule: and as these are united some care will be needed not to open the joint.

Shoulder joint; outline of.

SHOULDER JOINT. This joint (fig. 53) is formed between the head of the humerus and the glenoid fossa of the scapula. Inclosing the articular ends of the bones is a fibrous capsule lined by a synovial membrane. A ligamentous band (glenoid ligament) deepens the shallow scapular cavity for the reception of the large head of the humerus.

Looseness.

The bones entering into the joint are but slightly bound together by ligamentous bands, for, on the removal of the muscles, the head of the humerus may be drawn from the scapula for the distance of an inch.

The *capsular ligament* (fig. 53, [5]) surrounds loosely the articular ends of the bones; it is thickened above and below, and receives fibres from the contiguous tendons. Capsular ligament.

At the upper part it is fixed around the neck of the scapula, where it is connected with the long head of the triceps. At the lower part the ligament is attached to the head of the humerus close to the articular surface; but its continuity is interrupted between the tuberosities by the tendon of the biceps muscle, over which it is continued along the groove in the bone. On the inner side there is generally an aperture in the capsule, below the coracoid process, through which the synovial membrane of the joint is continuous with the bursa beneath the tendon of the subscapularis. Attachments. Aperture.

The following muscles surround the articulation;—above are the tendons of the supraspinatus, infraspinatus, and teres minor; below, the capsule is only partly covered by the subscapularis; but internally it is well supported by the last-named muscle. Muscles around.

On the front of the capsule is a rather thick band of fibres,—the *coraco-humeral* or *accessory* ligament (fig. 53, [8]), which springs from the base of the coracoid process of the scapula, and widening over the front of the joint, is attached with the capsule to the margins of the bicipital groove, and the tuberosities. Accessory band.

Dissection. The articulation is to be opened by cutting circularly through the capsule near the scapula. When this has been done the attachment of the capsule to the bones, the glenoid ligament, and the tendon of the biceps will be manifest. Dissection.

The *tendon of the biceps* muscle arches over the head of the humerus, and serves the purpose of a ligament in restraining the upward and outward movements of that bone. It is attached to the upper part of the glenoid fossa of the scapula, and is united on each side with the glenoid ligament. As it is directed outwards it becomes round; and entering the groove between the tuberosities of the humerus, it is surrounded by the synovial membrane. Tendon of the biceps.

The *glenoid ligament* is a firm fibrous band, which surrounds the fossa of the same name, deepening it for the reception of the head of the humerus. It is about two lines in depth, and is connected in part with the sides of the tendon of the biceps; but most of its fibres are fixed separately to the edge of the glenoid fossa. Glenoid ligament.

The *synovial membrane* lines the articular surface of the capsule, and is continued through the aperture on the inner part to join the bursa beneath the subscapular muscle. The membrane is reflected around the tendon of the biceps, and lines the bicipital groove of the humerus. Synovial membrane.

Surface of humerus,

Articular surfaces. The articular head of the humerus is two or three times larger than the hollow in the scapula, and forms about one third of a sphere. The head of the bone is joined to the shaft at an angle as it is in the femur ; and a rotatory movement is possessed by the joint in consequence.

of scapula.

The glenoid surface of the scapula is oval in form with the large end down, is very shallow, and is neither large enough nor deep enough to embrace the head of the humerus.

Kinds of movement.

Movements. In this joint there is the common motion in four directions, with the circular or circumductory ; and in addition a movement of rotation.

Flexion and extension.

In the *swinging* or to-and-fro *movement*, the carrying forwards of the humerus constitutes flexion, and the moving it backwards, extension. During these movements the head of the bone rests in the bottom of the glenoid fossa, turning forwards and backwards around a line representing the axis of the head and neck; and cannot be dislodged by either the rapidity or degree of the motion.

Scapula moves in flexion not in extension.

Flexion is less limited than extension ; and when the joint is most bent the scapula, rotating on its axis, follows the head of the humerus, and assists in retaining the bone in place in the glenoid fossa. In extension the articular surface of the scapula does not move after the humerus.

Muscles.

The muscles have more influence than the loose capsule in controlling the swinging motion.

Abduction and *adduction.* When the limb is raised, it is abducted, and when depressed, adducted ; and in both cases the humerus rolls on the scapula which is fixed.

Abduction. State of bone and capsule.

During abduction of the shaft of the humerus, the head descends to the lower and larger part of the glenoid fossa, and projects beyond it against the capsule ; whilst the great tuberosity rubs against the arch of the acromion. In this condition a little more movement down of the head either by muscles depressing it, or by force elevating the farther end of the humerus, will throw it out of place, giving rise to dislocation.

Adduction. Bone and capsule.

In adduction of the shaft of the bone the head rises into the socket, the limb meets the trunk, and the tense capsule is set at rest. After the reduction of a dislocation the limb is fixed to the side in this position of security against further displacement.

Circumduction.

In *circumduction* the humerus passes in succession through the four different states before mentioned, and describes a cone, whose apex is at the shoulder and base at the digits.

Rotation in,

Rotation. There are two kinds of rotatory movement, viz. in and out, or forwards and backwards ; and in each the motion of the head of the bone and shaft have to be considered.

state of bone ;

In rotation in, the great tuberosity is turned forwards, and the head rolls from before back across the glenoid fossa so as to project behind. The shaft is moved forwards round a line lying on its inner side, which reaches from the point of the head to the inner condyle.

In rotation out, the osseous movements are reversed: thus the tuberosity turns back, the head rolls forward so as to project in front, and the shaft is carried back around the line before said. and out, state of bone,

The upper thickened part of the capsule will be tightened in rotation, but the muscles are the chief agents in checking the movements. and capsule.

Section IV.

THE FRONT OF THE FOREARM.

Position. The limb is to be placed with the palm of the hand uppermost; and the marking of the surface, and the projections of bone, are first to be noted. Position of the limb.

Surface-marking. On the anterior aspect of the forearm are two lateral depressions, corresponding with the position of the main vessels. The external is placed over the radial artery, and inclines towards the middle of the limb as it approaches the elbow. The internal groove is evident only beyond the middle of the forearm, and points out the place of the ulnar artery. Surface of the forearm.

The bones (radius and ulna) are sufficiently near the surface to be traced in their whole length: each ends below in a point,—the styloid process, and that of the radius is the lowest. A transverse line separates the forearm from the hand, and the articulation of the wrist is about an inch above it. Bony projections. Line of the wrist joint.

On each side of the palm of the hand is a lateral projection; the external of these (thenar) is formed by muscles of the thumb, and the internal (hypo-thenar) by muscles of the little finger. Between the projections is the hollow of the palm, which is pointed towards the wrist. Two transverse lines are seen in the palm, but neither reaches completely across it: the anterior one will direct to the line of the articulations between the metacarpus and the phalanges, but is about a quarter of an inch behind the three inner joints when the fingers are extended. Surface of palm of the hand.

The superficial palmar arch of arteries reaches forwards a little way into the hollow of the hand, and its position may be marked by a line across the palm from the root of the thumb, when that digit is placed at a right angle to the hand. Palmar arch.

Transverse lines are seen on both aspects of the joints of the thumb and fingers. The lines on the palmar surface of the Surface of the fingers.

fingers may be used to detect the articulations of the phalanges. Thus the joint between the metacarpal phalanx and the next will be found about a line in front of the chief transverse groove; whilst the articulation between the last two phalanges is situate about a line in front of the single mark.

Lines on the front.

Dissection to remove the skin.

Dissection. With the limb lying flat on the table, an incision is to be carried through the skin along the middle of the front of the forearm, as far as an inch beyond the wrist; and at its termination a transverse one is to cross it. The skin is to be reflected carefully from the front and back of the forearm, without injury to the numerous superficial vessels and nerves beneath; and it should be taken also from the back of the hand, by prolonging the ends of the transverse cut along the margins of the dorsum to a little beyond the knuckles. The fore finger should have the integument removed from it, in order that the nerves may be followed to the end.

Seek the superficial vessels and nerves in front,

The superficial vessels and nerves can be now traced in the fat; most of them have been already dissected above, and have the following position:—Along the inner side in front of the forearm with the ulnar veins is the continuation of the internal cutaneous nerve; and near the wrist there is occasionally a small offset from the ulnar nerve to be found. On the outer side with the radial vein is the superficial part of the musculo-cutaneous nerve.

Close to the hand, in the centre of the forearm, the small palmar branch of the median nerve should be sought beneath the fat, and inside the tendon of the flexor carpi radialis. On the ulnar artery close inside the pisiform bone a small palmar branch of the ulnar nerve is to be looked for.

behind,

At the back of the forearm the largest external cutaneous branch of the musculo-spiral nerve is to be traced onwards; and offsets are to be followed to this surface from the nerves in front.

and on the back of the hand.

On the posterior part of the hand is an arch of superficial veins. Winding back below the ulna is the dorsal branch of the ulnar nerve; and lying along the outer border of the hand is the radial nerve: these should be traced to the fingers.

Subcutaneous veins of the forearm are

CUTANEOUS VEINS. The superficial veins are named median, radial, and ulnar, from their position in the limb. They begin in the hand, chiefly at the dorsal aspect, where they form an arch; and are continued along the forearm to end in the basilic and cephalic veins.

Arch on the hand;

Superficial arch. This arch on the back of the hand is more or less perfect, and receives the posterior or superficial digital veins. At the sides the arch terminates in the radial and ulnar veins.

radial;

The *radial vein* begins in the outer part of the arch above mentioned, and in some small radicles at the back of the thumb.

It is continued along the forearm, at first behind and then on the outer border as far as the elbow, where it gives rise to the cephalic vein by its union with the outer branch of the median vein (fig. 54).

The *ulnar veins* are anterior and posterior, and occupy the front and back of the limb. ulnar: two sets,

The *anterior* arises near the wrist by the junction of small roots from the hand, and runs on the inner part of the forearm to the elbow; here it unites with the inner branch of the median, and forms the basilic vein (fig. 54). anterior

The *posterior* ulnar vein is situate on the back of the limb. It commences by the union of a branch, "vena salvatella," from the back of the little finger, with an offset of the venous arch; it is continued along the back of the forearm nearly to the elbow, and bends forwards to open into the anterior ulnar vein. and posterior;

The *median vein* takes origin near the wrist by small branches which are derived from the palmar surface of the hand; and it is directed along the centre of the forearm nearly to the elbow. Here the vein divides into external and internal branches (median basilic and median cephalic), which unite, as before seen (fig. 54), with radial and ulnar veins. At its point of bifurcation the median receives a communicating branch from a vein (vena comes) beneath the fascia. median.

CUTANEOUS NERVES. The superficial nerves of the forearm are continued from those of the arm. On the inner side from the large internal cutaneous nerve; and on the outer, from the two external cutaneous nerves of the musculo-spiral, and the musculo-cutaneous. On the fore part of the limb there is occasionally a small offset of the ulnar nerve near the wrist. On the back of the hand is the termination of the radial nerve, together with a branch of the ulnar nerve. Superficial nerves of forearm and back of hand are

The *internal cutaneous nerve* divides into two parts. The *anterior* branch (fig. 56, [6]) extends on the front of the forearm as far as the wrist, and supplies the integuments on the inner half of the anterior surface. Near the wrist it communicates sometimes with a cutaneous offset from the ulnar nerve. The *posterior* branch (fig. 55, [7]) continues along the back of the forearm (ulnar side) to rather below the middle. internal cutaneous;

The *cutaneous part* of the musculo-cutaneous nerve (fig. 56, [4]) is prolonged on the radial border of the limb to the ball of the thumb, over which it terminates in cutaneous offsets. Near the wrist the nerve is placed over the radial artery, and some twigs pierce the fascia to ramify on the vessel and supply the carpus. A little above the middle of the forearm the nerve sends backwards a branch to the posterior aspect, which reaches nearly to the wrist, and communicates with the radial, and the following cutaneous nerve. external cutaneous;

external cutaneous of musculo-spiral.

The *external cutaneous branch* of the musculo-spiral nerve (fig. 55, [10]), after passing the elbow, turns to the hinder part of the forearm, and reaches as far as the wrist. Near its termination it joins the preceding cutaneous nerve.

Ending of the radial nerve

The *radial nerve* ramifies in the integument of the back of the hand (fig. 55, [9]), and in that of the thumb and the next two fingers. It becomes cutaneous at the outer border of the forearm in the lower third, and after giving backwards some filaments to the posterior aspect of the limb, divides into two branches :—

by external and

One (external) is joined by the musculo-cutaneous nerve, and is distributed on the radial border and ball of the thumb.

internal branch,

which supply the digits.

The other branch (internal) supplies the remaining side of the thumb, both sides of the next two digits, and half the ring finger; so that the radial nerve distributes the same number of digital branches to the dorsum as the median nerve furnishes to the palm of the hand. This portion of the radial nerve communicates with the musculo-cutaneous and ulnar nerves ; and the offset to the contiguous sides of the ring and middle fingers is joined by a twig from the dorsal branch of the ulnar nerve.

Termination.

On the side of the fingers each of these dorsal digital branches is united with an offset from the digital nerve on the palmar surface.

Branch of ulnar nerve to back of hand and

fingers.

The *dorsal branch* of the *ulnar nerve* (fig. 55, [8]) gives offsets to the rest of the fingers and the back of the hand. Appearing by the styloid process of the ulna, it joins in an arch across the back of the hand with the radial nerve, and is distributed to both sides of the little finger, and to the ulnar side of the ring finger: it communicates with the part of the radial nerve supplying the space between the ring and middle fingers. The ulnar nerve furnishes branches to the same number of digits on the palmar surface.

Deep fascia of the forearm.

The *aponeurosis* of the forearm is continuous with a similar investment of the arm. It is of a pearly white colour, and is formed of fibres that cross obliquely : it furnishes sheaths to the muscles, and is thicker behind than before.

In front.

On the back of the limb.

Near the elbow it is stronger than towards the hand ; and at that part it receives fibres from the tendons of the biceps and brachialis anticus, and gives origin to the muscles attached to the inner condyle of the humerus. On the back of the limb the aponeurosis is connected to the margins of the ulna, so as to leave the upper part of the bone subcutaneous ; and it is joined by fibres from the tendon of the triceps.

Intermuscular pieces.

Horizontal processes are sent downwards from the aponeurosis to separate the superficial and deep layers of muscles, both on the front and back of the forearm ; and longitudinal white bands indicate the position of those intermuscular processes which isolate one muscle from another, and give origin to the muscular fibres.

At the wrist the fascia joins the anterior annular ligament; and near that band the tendon of the palmaris longus pierces it, and receives a sheath from it. Behind the wrist it is thickened by transverse fibres, and gives rise to the posterior annular ligament; but on the back of the hand and fingers the fascia becomes very thin.

At the wrist; annular ligament.

Dissection. The skin is to be replaced on the back of the forearm and hand, as on the back of the arm, in order that the denuded parts may not become dry. Beginning with the dissection of the anterior surface of the limb, let the student divide the aponeurosis as far as the wrist, and take it away with the cutaneous vessels and nerves, except the small palmar cutaneous offsets of the median and ulnar nerves near the wrist. In cleaning the muscles it will be impossible to remove the aponeurosis from them at the upper part of the forearm without detaching the muscular fibres.

Take away fascia, nerves, and veins.

In front of the elbow is the hollow, already partly dissected, between the two masses of muscles arising from the inner and outer sides of the humerus. The space should be carefully cleaned, so as to display the brachial and forearm vessels, the median nerve and branches, the musculo-spiral nerve, and the recurrent radial and ulnar arteries.

Clean out hollow of elbow.

In the lower half of the forearm a large artery, radial, is to be laid bare along the radial border; and at the ulnar side, close to the annular ligament, the trunk of the ulnar artery will be recognised as it becomes superficial. These vessels and their branches should be carefully cleaned.

The anterior annular ligament of the wrist, which arches over the tendons passing to the hand, is next to be defined. This strong band is at some depth from the surface; and whilst the student removes the fibrous tissue superficial to it, he must take care of the small branches of the median and ulnar nerves to the palm of the hand. The ulnar artery and nerve pass over the ligament, and will serve as a guide to its depth.

Define anterior annular ligament.

Hollow in front of the elbow (fig. 58). The hollow in front of the elbow joint corresponds with the popliteal space at the knee, and is situate between the inner and the outer mass of the muscles of the forearm. This interval is somewhat triangular in shape, and the wider part is towards the humerus. It is bounded on the outer side by the supinator longus muscle, and on the inner side by the pronator teres. The aponeurosis of the limb is stretched over the space; and the bones covered by the brachialis anticus and supinator brevis, form the deep boundary.

Hollow in front of the elbow.

Boundaries.

Contents. In this hollow are lodged the termination of the brachial artery with its veins, and the median nerve; the mus-

Contents of the space

culo-spiral nerve; the tendon of the biceps muscle, and small recurrent vessels, with much fat and glands.

and their position to one another. These several parts have the following relative position in the space:—The tendon of the biceps is directed towards the outer boundary to reach the radius, into which it is inserted. On the outer side, concealed by the supinator longus muscle, is the musculo-spiral nerve. Nearly in the centre of the space are the brachial artery and veins and the median nerve, the nerve being internal; but as the artery is inclining to the outer part of the limb, they soon become distant from one another about half an inch. In this hollow the brachial artery divides into two trunks—radial and ulnar; and the recurrent radial and ulnar branches appear in the space, one on the outer and the other on the inner side.

Lymphatic glands. Two or three lymphatic glands lie on the sides of the artery, and one below its point of splitting.

MUSCLES ON THE FRONT OF THE FOREARM (fig. 58). The muscles on the front of the forearm are divided into a superficial and a deep layer.

Superficial layer has five muscles. In the superficial layer there are five muscles, which are fixed to the inner condyle of the humerus, mostly by a common tendon, and lie in the undermentioned order from the middle to the inner side of the limb; viz. pronator radii teres, flexor carpi radialis, palmaris longus, flexor carpi ulnaris; and deeper and larger than any of these is the flexor sublimis digitorum.

The deep layer will be met with in a subsequent dissection (p. 310).

Pronator teres. The PRONATOR RADII TERES (fig. 58, [3]) *arises* from the inner condyle of the humerus by the common tendon; from the ridge

Origin. above the condyle by fleshy fibres; from the inner part of the coronoid process by a second tendinous slip; and from the fascia

Insertion. and the septum between it and the next muscle. It is *inserted* by a flat tendon into an impression, an inch in length, on the middle of the outer surface of the radius.

Connections. The muscle is superficial except at the insertion, where it is covered by the radial artery, and some of the outer set of muscles, viz. supinator longus and radial extensors of the wrist. The pronator forms the inner boundary of the triangular space in front of the elbow: and its inner border touches the flexor carpi radialis. By gently separating the muscle from the rest, it will be found to lie on the brachialis anticus, the flexor sublimis digitorum, and the ulnar artery and the median nerve. The second small head of origin is directed inwards between the artery and the nerve.

Use on radius *Action.* The pronator assists in bringing forwards the radius over the ulna, and pronates the hand. When the radius is fixed

and elbow. the muscle raises that bone towards the humerus, bending the elbow-joint.

The FLEXOR CARPI RADIALIS (fig. 58, [4]) takes its *origin* from the common tendon, from the aponeurosis of the limb, and from the intermuscular septum on each side. The tendon of the muscle, becoming free from fleshy fibres about the middle of the forearm, passes through a groove in the os trapezium, outside the arch of the anterior annular ligament, to be *inserted* into the base of the metacarpal bone of the index finger, and by a slip into that of the middle finger. Radial flexor of the wrist.

Fig. 58.†

This muscle rests chiefly on the flexor sublimis digitorum; but near the origin it is in contact with the ulnar artery and the median nerve, and near the wrist it lies over the flexor longus pollicis,—a muscle of the deep layer. As low as the middle of the forearm the muscle corresponds externally with the pronator teres, and below that with the radial artery to which its tendon is taken as the guide. The ulnar border is at first in contact with the palmaris longus muscle, and for about two inches above the wrist with the median nerve.* The muscle is superficial; is guide to radial artery.

Action. The hand being free the muscle flexes first the wrist joint, inclining the hand somewhat to the radial side; still continuing to contract it bends the elbow. Use.

The PALMARIS LONGUS (fig. 58, [5]) is often absent: or it may present great irregularity in the proportion between the fleshy and tendinous parts. Its *origin* is connected, like that of the preceding muscle, with the common tendon, the fascia, and the intermuscular septa. Its long thin tendon is continued along the centre of the forearm, and piercing the aponeurosis, passes over the annular ligament to end in the palmar fascia, and to join by a tendinous slip the short muscles of the thumb. Long palmar muscle lies over annular ligament and joins the fascia of palm.

* In the body of a woman which was well developed, the muscle was absent on both sides.

† Superficial view of the forearm (from Quain's Arteries). 1. Radial

The palmaris is situate between the flexor radialis and flexor carpi ulnaris, and rests on the flexor sublimis digitorum.

Use. *Action.* Rendering tense the palmar fascia, the palmaris will afterwards bend the wrist and elbow like the other muscles of the superficial layer.

Flexor carpi ulnaris. Origin. The FLEXOR CARPI ULNARIS (fig. 58, [7]) has an aponeurotic *origin* from the inner condyle of the humerus; the inner side of the olecranon; and the ridge of the ulna between the internal and posterior surfaces for three fourths of the length. Most of the fibres are continued vertically downwards, but others obliquely forwards to a tendon on the anterior part of the muscle in the lower half, some joining it as low as the wrist; and the tendon is *inserted* into the pisiform bone and the fascia, an offset being sent to the muscles of the little finger.

Insertion into pisiform bone.

Adjacent parts. One surface of the muscle is in contact with the fascia; and its tendon, which can be felt readily through the skin, may be taken as the guide to the ulnar artery. To its radial side are the palmaris and flexor digitorum sublimis muscles. When the attachment to the inner condyle has been divided, the muscle will be seen to conceal the flexor digitorum sublimis and flexor profundus, the ulnar nerve, and the ulnar vessels; between the attachments to the condyle and the olecranon the ulnar nerve enters the forearm.

Use. *Action.* Firstly the wrist is bent by the contraction of the muscle, and the hand is drawn inwards; secondly, the elbow joint is flexed.

Course and extent of the radial artery. The RADIAL ARTERY (fig. 58, [1]) is one of the vessels derived from the bifurcation of the brachial trunk, and its destination is the palm of the hand. It is placed first along the outer side of the forearm as far as the end of the radius; it winds backwards next below the extremity of that bone: and it enters finally the palm of the hand through the first interosseous space. In consequence of this circuitous course the artery will be found in three different regions, viz. the front of the forearm, the back of the wrist, and the palm of the hand.

Situation in the forearm. *In the front of the forearm.* In this part of the limb the position of the artery will be marked, on the surface, by a line from the centre of the hollow of the elbow to the fore part of the styloid process of the radius. At first it lies on the inner side of the radius, but afterwards over that bone. This vessel is smaller than the ulnar artery, though it appears in direction to be the continuation of the brachial trunk; and it is partly deep and

artery with its nerve outside. 2. Ulnar artery and nerve where they are more superficial. 3. Pronator teres. 4. Flexor carpi radialis. 5. Palmaris longus. 6. Flexor sublimis. 7. Flexor carpi ulnaris. 8. Supinator longus. 9. Biceps. 10. Palmaris brevis. 11. Palmar arch of the ulnar artery.

partly superficial; but where it is more superficial in the lower half it can be felt beating during life as the pulse near the wrist.

In the *upper half* the vessel is placed beneath the supinator longus; and rests successively on the following muscles, the fleshy supinator brevis, the pronator teres, and part of the thin origin of the flexor sublimis. **Connections in upper half with muscles,**

Veins. Venæ comites lie on the sides with cross branches over the artery. **veins,**

Nerve. The radial nerve is parallel to, and outside its companion artery, but separated by a slight interval. **and nerve.**

In the *lower half* the radial artery is superficial, being covered only by the teguments and the deep fascia. Here it is placed in a hollow between the tendons of the supinator longus and flexor carpi radialis. It lies from above down on the origin of the flexor sublimis, on two other muscles of the deep layer, viz. flexor pollicis longus and pronator quadratus, and lastly on the end of the radius. **In lower half with muscles,**

Veins. The usual venæ comites are found on the sides of the artery. **veins,**

Nerves. The radial nerve is still on the outer side of the vessel until it passes backwards beneath the tendon of the supinator longus, and becomes cutaneous. Superficial to the lower end are the ramifications of the musculo-cutaneous nerve, some of which reach the artery by piercing the deep fascia. **nerve.**

Branches. The radial artery furnishes many unnamed muscular and nutrient branches to the surrounding parts; and three named branches, viz. recurrent radial, superficial volar, and anterior carpal. **Branches.**

The *radial recurrent* is the first branch, and supplies the muscles of the outer side of the limb. Its course is almost transverse to the supinator longus muscle, beneath which it terminates in muscular ramifications. One offset ascends beneath the supinator, and anastomoses with the superior profunda branch of the brachial artery. **Radial recurrent.**

The *superficial volar* branch arises usually near the lower end of the radius, but its exact place of origin is uncertain. It is directed towards the palm of the hand, across or through the mass of muscles in the ball of the thumb, and it either ends in those muscles, or joins the superficial palmar arch. **Superficial volar.**

The *anterior carpal* branch is very inconsiderable in size, and will be seen in the examination of the deep layer of muscles. Arising rather above the lower end of the radius, it passes transversely at the lower border of the pronator quadratus, and anastomoses with a similar branch from the ulnar artery: from the arch thus formed, offsets are given to the carpus. **Anterior carpal.**

Peculiarities of the radial artery. The origin of the radial may be carried upwards from the usual place even to the axilla. The vessel arises **Variations in the origin,** from the humeral much more frequently than the other arteries of the forearm, viz. in the proportion in a given number of cases of about three to four. In one instance (Quain), it began between two and three inches below the elbow joint, and in that case a vas aberrans connected it with the axillary artery.

and course of the radial. When the radial has a high origin its course in the arm is close to the brachial artery, along the edge of the biceps muscle ; and in passing the bend of the elbow it may be occasionally subcutaneous, viz. above the deep fascia, and be liable to injury in venesection. In the forearm it may be likewise subcutaneous, and superficial to the supinator longus muscle.

Aberrant arteries. The "vasa aberrantia," or the long slender branches of the axillary or brachial trunk open commonly into the radial artery. In some cases of high origin of the radial, there is a connecting branch at the bend of the elbow between it and the trunk in the place of the brachial artery.

Dissection. *Dissection.* To bring into view the flexor sublimis digitorum, the origin of the flexor carpi radialis and palmaris longus must be cut through near the inner condyle of the humerus, and turned to one side. Small branches of the ulnar artery and median nerve may be seen entering the under surface of those muscles. For the present the pronator teres may be left uncut.

Superficial flexor of fingers. The FLEXOR DIGITORUM SUBLIMIS vel PERFORATUS (fig. 58,[6]) is the largest of the muscles of the superficial layer, and is named from its position to another flexor in the deep layer. It

Origin. *arises* from the inner condyle of the humerus, the internal lateral ligament, and the intermuscular septa in common with the preceding muscles ; and it takes origin in addition from the bones of the forearm, viz. from the inner part of the coronoid process of the ulna ; from the oblique line below the radial tubercle ; and from the anterior margin of the radius as far as, or one or two inches below, the insertion of the pronator teres. Rather below the middle of the forearm the muscle ends in four tendons, which are continued beneath the annular ligament and across the hand

Insertion. to be *inserted* into the middle phalanges of the fingers, after being perforated by the tendons of the deep flexor.

Connections with parts around. The flexor sublimis is concealed by the other muscles of the superficial layer ; and the radial vessels lie on the attachment to the radius. Along the inner border is the flexor carpi ulnaris, with the ulnar vessels and nerve. The tendons of the muscle are arranged in pairs before they pass beneath the annular ligament of the wrist ;—the middle and ring finger tendons being anterior, and those of the index and little finger posterior in position. Dividing the coronoid and condyloid attachments, the muscle will be seen to cover two flexors of the deep layer (flexor digitorum profundus and flexor pollicis), the median nerve, and the upper part of the ulnar artery.

Use on finger, *Action.* This flexor bends primarily the second phalanx of each finger ; and is then able to bring the nearest phalanx towards the palm in consequence of being bound thereto by a sheath. But when the nearest phalanx is fixed by the extensor of the fingers, it remains straight whilst the superficial flexor bends the second phalanx.

After the fingers are bent the muscle will help in flexing the wrist and elbow joints. on elbow and wrist.

The ULNAR ARTERY (fig. 58, [2]), is the larger of the two branches coming from the bifurcation of the brachial trunk ; and is directed along the inner side of the limb to the palm of the hand, where it forms the superficial palmar arch, and joins the radial artery. In the forearm the vessel has an arched direction, and its depth from the surface varies in the first and last parts of its course. Ulnar artery ends in palm of hand.

In the *upper half* the artery is inclined obliquely inwards from the centre of the elbow to the inner part of the limb mid-way between the elbow and wrist. It courses between the superficial and deep layers of muscles, being covered by the pronator teres, flexor carpi radialis, palmaris longus, and flexor sublimis. Beneath it come first the brachialis anticus for a short distance, and afterwards the flexor profundus. Course in upper half. Connections with muscles.

Veins. Two companion veins are situate on the sides of the artery, and join freely together. Position of veins

Nerves. The median nerve lies to the inner side of the vessel for about an inch, but then crosses over it to gain the outer side. About the middle of the forearm the ulnar nerve approaches the artery, and continues thence on the inner side. and nerves.

In the *lower half* it has a straight course to the pisiform bone, and is covered by the teguments and fascia and the flexor carpi ulnaris as far as the wrist. To the outer side are the tendons of the flexor sublimis. Beneath it is the flexor profundus. Lower half with muscles,

Veins. Two companion veins, as in the upper part, accompany the artery, and are united across it at intervals. veins,

Nerves. The ulnar nerve lies close to, and on the inner side of the vessels ; and a small branch of it descends on the artery to the palm of the hand, sending twigs around the vessel. nerves.

On the *annular ligament* of the wrist the artery has pierced the fascia and lies close to the pisiform bone. The ulnar nerve with its palmar branch still accompany the vessel, the large trunk being on the inner side. Position on the annular ligament.

Branches. The greater number of the collateral branches of the artery are distributed to the muscles. But the named branches are the following :— Its branches are

The *anterior ulnar recurrent* branch arises generally in common with the next, and ascending on the brachialis anticus muscle inosculates with the small anastomotic artery beneath the pronator radii teres. It gives offsets to the contiguous muscles. anterior and

The *posterior ulnar recurrent* branch, of larger size than the anterior, is inclined inwards beneath the flexor sublimis muscle to the interval between the inner condyle and the olecranon. posterior recurrent, There it passes with the ulnar nerve between the attachments of the flexor carpi ulnaris, and joins the ramifications of the inferior profunda and anastomotic arteries on the inner side of the elbow joint. Some of its offsets enter the muscles, and others supply the articulation and the ulnar nerve.

interosseous, The *interosseous* branch is a short thick trunk, about an inch long, which is directed backwards towards the interosseous membrane, and divides into anterior and posterior interosseous arteries: these branches will be afterwards followed.

metacarpal, The *metacarpal* branch arises from the artery near the lower end of the ulna, and turns back along the metacarpal bone of the little finger, of which it is the inner dorsal branch.

and carpal. The *carpal* branches (anterior and posterior) ramify on the front and back of the carpus, on which they anastomose with corresponding offsets of the radial artery, and form arches across the wrist.

The origin *Peculiarities of the ulnar artery.* The *origin* of the artery has a tendency to approach the trunk of the body, and it may be transferred to any point of the main vessel in the arm or axilla; but this deviation is less frequent in it than in the radial artery. Once the origin was found between two and three inches below the elbow. (Quain.)

and course of the artery may vary. Its irregular *position* in the forearm varies more than that of the radial under similar circumstances. The artery is generally superficial to the flexor muscles at the bend of the elbow (only one exception, Mr. Quain), but beneath the aponeurosis of the forearm; though sometimes it is subcutaneous with the superficial veins.

Ulnar nerve in the forearm. The ULNAR NERVE enters the forearm between the attachments of the flexor carpi ulnaris to the olecranon and inner condyle of the humerus. Under cover of that muscle the nerve reaches the ulnar artery about the middle (in length) of the forearm, and is continued on the inner side of the vessel to the hand. On the annular ligament the nerve is rather deeper than the artery. It furnishes articular, muscular, and cutaneous branches as below:—

Its branches are

to elbow joint, *Articular nerves.* In the interval between the olecranon and the inner condyle, slender filaments to the joint arise.

to two muscles of forearm, *Muscular branches.* It furnishes offsets near the elbow to two muscles of the forearm; one branch enters the upper part of the flexor carpi ulnaris, and the other supplies the inner half of the flexor profundus digitorum.

cutaneous branch of palm of hand, *Cutaneous nerve of the forearm and hand.* About the middle of the forearm arises a small branch (palmar), which courses on the ulnar artery, sending twigs around that vessel, to end in the integuments of the palm of the hand. Sometimes a cutaneous offset from it perforates the aponeurosis near the wrist, and joins the internal cutaneous nerve.

cutaneous nerve of The *dorsal cutaneous nerve of the hand* arises about two inches above the end of the ulna, and passes obliquely backwards beneath the flexor carpi ulnaris: perforating the aponeurosis it is lost on the back of the hand and fingers (p. 300). back of hand.

The MEDIAN NERVE leaves the hollow of the elbow between the heads of origin of the pronator teres, and takes the middle line of the limb in its course to the hand. It is placed beneath the flexor sublimis as low as two inches from the annular ligament, but it then becomes superficial along the outer border of the tendons of that muscle. Lastly the nerve passes beneath the annular ligament to enter the palm of the hand, where it is distributed. The nerve supplies the muscles on the front of the forearm, and furnishes a cutaneous offset to the hand. Median nerve lies between the two layers of muscles.

Muscular offsets leave the trunk of the nerve near the elbow, and are distributed to all the muscles of the superficial layer except the flexor carpi ulnaris; in addition, the nerve supplies the deep layer through the interosseous branch, except the inner half of the flexor profundus digitorum. Supplies the front muscles, except one and a half.

The *anterior interosseous nerve* accompanies the anterior interosseous artery, and will be dissected with that vessel. By means of this nerve the muscles of the deep layer are supplied, with the exception above specified. Interosseous branch.

The *cutaneous palmar branch* arises in the lower fourth of the forearm; it pierces the fascia near the annular ligament, and crosses that ligament to reach the palm of the hand. A cutaneous branch to palm of hand.

The RADIAL NERVE is the smaller of the two branches into which the musculo-spiral divides in front of the outer condyle of the humerus. This nerve is placed along the outer border of the limb, under cover of the supinator longus, and on the outer side of the radial artery till within three inches of the wrist, where it becomes cutaneous at the posterior border of the tendon of the supinator. On the surface of the limb it divides into two branches, which are distributed on the dorsum of the hand, and on the thumb and the next two fingers (p. 300). No offset is furnished by the part of the nerve beneath the aponeurosis. Radial nerve in the forearm, ends on back of the hand.

Dissection. To examine the deep layer of muscles it will be necessary to draw well over to the radial side of the forearm the pronator teres, to detach the flexor sublimis from the radius, and to remove the fleshy part of the muscle. The areolar tissue is to be taken from the muscular fibres; and the anterior interosseous vessels and nerve, which lie on the interosseous membrane, and are concealed by the muscles, are to be traced out. Dissection of deep layer of muscles.

DEEP LAYER OF MUSCLES. Only three muscles are present in the deep layer on the front of the forearm. One lies on the ulna, and is the deep flexor of the fingers; a second covers the radius, viz. the long flexor of the thumb; and the third is the pronator quadratus, which lies beneath the other two near the lower end of the bones. Three muscles in the deep layer.

Deep flexor of fingers. The FLEXOR DIGITORUM PROFUNDUS vel PERFORANS *arises* from the anterior and inner surfaces of the ulna for three-fourths

Origin. of the length of the bone; from the inner half of the interosseous ligament for the same distance; and from an aponeurosis common to this muscle and the flexor carpi ulnaris. The muscle has a thick fleshy belly, and ends in tendons which, united

Insertion. together, pass beneath the annular ligament, and are *inserted* into the last phalanges of the fingers.

Parts around it. The cutaneous surface of the muscle is in contact with the ulnar nerve and vessels, with the superficial flexor of the fingers, and with the flexor carpi ulnaris. The deep surface rests on the ulna and the pronator quadratus muscle. The outer border touches the flexor pollicis longus and the anterior interosseous vessels and nerve; and the inner is connected by aponeurosis to the posterior margin of the ulna.

Use on fingers and wrist. *Action.* The muscle bends the last phalanges of the fingers and the wrist; but it does not act on the last phalanx till after the second has been bent by the flexor sublimis.

How fingers bend. The fingers are approximated and the joints bent in the following order:—firstly, the articulation between the metacarpal and the middle phalanx, secondly, the last phalangeal joint, and thirdly the metacarpo-phalangeal; but the nearest joint can be held straight by the extensor whilst the farthest two are bent by the superficial and deep flexors.

Long flexor of thumb. The FLEXOR LONGUS POLLICIS *arises* from the hollowed anterior surface of the radius, as low as the pronator quadratus;

Origin. from the outer part of the interosseous membrane; and by a round distinct slip from the coronoid process of the ulna, internal to the attachment of the brachialis anticus. The fleshy fibres descend to a tendon, which is continued beneath the annular

Insertion. ligament, and is *inserted* into the last phalanx of the thumb.

Parts above and beneath it. On the cutaneous surface of the muscle is the flexor sublimis, with the radial vessels for a short distance inferiorly. The muscle lies on the radius and the pronator quadratus. To the inner side is the flexor profundus digitorum.

Use. *Action.* It bends both joints of the thumb, but firstly the distal or ungual. After the phalanges are drawn downwards the muscle flexes the wrist.

Pronator quadratus The PRONATOR QUADRATUS is a flat muscle, and lies on the lower fourth of the bones of the forearm. The muscle *arises* from the anterior and inner surfaces of the ulna, where it is somewhat the widest, and is *inserted* into the fore part of the radius for about two inches.

is deep in position. The anterior surface is covered by the tendons of the flexor muscles of the fingers, and the radial artery; and the posterior surface rests on the radius and ulna with the intervening membrane, and the interosseous vessels and nerve.

Action. The end of the radius is moved forwards over the ulna by this muscle, and the hand is pronated. **Use.**

The *anterior interosseous artery* (p. 308) is continued on the front of the interosseous membrane, between the two deep muscles or in the fibres of the flexor digitorum, till it reaches an aperture beneath the pronator quadratus. At that spot the artery turns from the front to the back of the limb, and descends to the posterior surface of the carpus, where it ends by anastomosing with the posterior interosseous and carpal arteries. **Anterior interosseous artery.**

Branches. Numerous offsets are given to the contiguous muscles. **Muscular branches.**

One long branch, *median*, accompanies the median nerve, supplying it, and either ends in the flexor sublimis, or extends beneath the annular ligament to the palmar arch in the hand. **Median:**

About the middle of the forearm two nutrient vessels of the bones arise from the artery. **nutrient to the bones**

Where it is about to pass backwards through the interosseous membrane it furnishes twigs to the pronator quadratus; and one branch is continued beneath that muscle to anastomose with the anterior carpal arteries. **and the carpus.**

The *anterior interosseous nerve* is derived from the median (p. 309), and accompanies the artery of the same name to the pronator quadratus muscle, on the under surface of which it ends. Some lateral branches are distributed by it to the deep flexor muscles. **Anterior interosseous nerve ends in pronator.**

Dissection. The attachment of the biceps and brachialis anticus to the bones of the forearm may be now cleaned and examined. **Dissection.**

The *insertion of the brachialis anticus* takes place by a broad thick tendon, about an inch in length, which is fixed into the coronoid process of the ulna, and into the contiguous rough part of the bone. **Insertion of brachialis anticus.**

Insertion of the biceps. The tendon of the biceps is inserted into the inner part of the tubercle of the radius, and slightly into the bone behind it. A bursa is found between it and the fore part of the tubercle. Near its attachment the tendon changes the direction of its surfaces; the anterior surface becoming external, and the opposite. The supinator brevis muscle partly surrounds the insertion. **Insertion of the biceps.**

Section V.

THE PALM OF THE HAND.

Dissection. Without any change in the position of the hand, the skin is to be reflected from the palm by means of two incisions. One is to be carried along the centre of the hand from **Dissection.** **Seek the** cutaneous nerves, and muscle. the wrist to the fingers; and the other is to be made from side to side, at the termination of the first. In raising the inner flap, the small palmaris brevis muscle will be seen at the inner margin of the hand, and its insertion into the skin may be left till the muscle has been learnt. In the fat the ramifications of the small branches (palmar) of the median and ulnar nerves are to be traced.

Define the palmar fascia, vessels and nerves, The student should remove the fat from the palmaris muscle, and from the strong palmar fascia in the centre of the hand; and he should take care not to destroy a thin transverse band of tissue (transverse ligament), which lies across the roots of the fingers. When cleaning the fat from the palmar fascia he will recognise near the digits the digital vessels and nerves, and must be especially careful of two,—viz., those of the inner side of the little finger and outer side of the index finger, which appear farther back than the rest, and are most likely to be injured. By the side of the vessels and nerves to each of the four fingers a slender lumbricalis muscle is to be dissected.

and expose digital sheaths. Lastly, the skin and the fat may be reflected from the thumb and fingers by an incision along each, in order that the sheaths of the tendons with the collateral vessels and nerves may be laid bare.

Some unnamed, and named nerves. *Cutaneous palmar nerves.* Some unnamed twigs are furnished to the integument from both the median and ulnar nerves in the hand; and two named cutaneous nerves ramify in the palm.

One of median, One is an offset of the median nerve (p. 309), and crosses the annular ligament: it extends to about the middle of the palm, and is united with the palmar branch of the ulnar. A few filaments are furnished to the ball of the thumb.

other of ulnar nerve. The other palmar branch is derived from the ulnar nerve (p. 308); it has been traced already on the ulnar artery to the hand, and its distribution in the palm may be now observed.

Palmaris brevis is subcutaneous, The PALMARIS BREVIS (fig. 58, [10]) is a small subcutaneous muscle, about two inches wide, whose fibres are collected into separate bundles. It is attached on the outer side to the palmar aponeurosis, and its fibres are directed inwards to join the skin at the inner border of the hand.

and ends in the skin. This muscle lies over the ulnar artery and nerve. After it has been examined it may be thrown inwards with the skin.

Use. *Action.* Drawing inwards the skin of the inner border of the hand towards the centre, it deepens the hollow or cup of the palm.

Palmar fascia. The *palmar fascia* or aponeurosis consists of a central and two lateral parts; but the lateral, which cover the muscles of the thumb and little finger, are so thin as not to require separate notice.

The *central part* is a strong, white, shining layer, which is pointed at the wrist, but is expanded towards the fingers, where it nearly covers the palm of the hand. Posteriorly the fascia receives the tendon of the palmaris longus, and is connected to the annular ligament; and anteriorly it ends in four processes, which are continued forwards, one for each finger, to the sheaths of the tendons. At the point of separation of the processes from one another some transverse fibres are placed, which arch over the lumbricalis muscle, and the digital artery and nerve appearing at this spot. From the pieces of the fascia a few superficial longitudinal fibres are prolonged to the integuments near the cleft of the fingers.

Its central part

ends in a piece for each finger,

and in the skin.

Fig. 59.*

Dissection.

Dissection. To follow one of the digital processes of the fascia to its termination, the superficial fibres being first removed, it must then be divided longitudinally by inserting the knife beneath it opposite the head of the metacarpal bone.

Deep ending of the pieces of fascia.

Ending of the processes. Each process of the fascia sends downwards an offset on both sides of the tendons, which is fixed to the deep ligament connecting together the ends of the metacarpal bones, and to the edges of the metacarpal bone for a short distance.

Ligament of the fingers.

The *superficial transverse ligament of the fingers* is a thin fibrous band, which stretches across the roots of the four fingers, and is contained in the fold of skin forming the rudiment of a web between them. Beneath it the digital nerves and vessels are continued onwards to their terminations.

Sheath of the tendons

Sheath of the flexor tendons (fig. 59). Along each finger the flexor tendons are retained in position against the phalanges by a fibrous sheath. Opposite the middle of each of the two nearest phalanges the sheath is formed by a strong fibrous band (ligamentum vaginale), which is almost tendinous in consistence; but opposite the joints it consists of a thin membrane with scattered and oblique fibres. If the sheath be opened it will be seen to be lined by a synovial membrane, which forms long and slender vascular folds (vincula vasculosa) between the tendons and the bones.

varies in thickness.

Has a synovial sac.

* The flexor and extensor tendons of the finger with accessory muscles. 2. Flexor sublimis tendon. 3. Flexor profundis tendon. 4. Extensor digitorum tendon. 5. Lumbricalis muscle. 6. Interosseous muscle.

Dissection.

Dissection. The palmar fascia, and the thinner parts of the digital sheaths opposite the joints of the fingers, may be taken away. On the removal of the fascia the palmar arch of the ulnar artery, and the median and ulnar nerves become apparent.

Superficial palmar arch.

PALMAR PART OF THE ULNAR ARTERY. In the palm of the hand the ulnar artery is directed outwards towards the muscles of the thumb, where it communicates with two offsets of the radial artery, viz., the superficial volar branch, and the branch to the radial side of the fore finger. The curved part of the artery, which lies across the hand, is named the *superficial palmar arch* (fig. 58, [11]).—Its convexity is turned towards the fingers, and its position in the palm would be nearly marked by a line across the hand from the cleft of the thumb.

Position in the hand and connections.

The arch is comparatively superficial; it is covered in greater part by the integuments and the palmar fascia, but at the inner border of the hand the palmaris brevis muscle lies over it. Beneath it are the flexor tendons and the branches of the ulnar and median nerves. Venæ comites lie on its sides.

Branches are

Branches. From the convexity of the arch proceed the digital arteries, and from the concavity some small offsets to the palm of the hand. A small branch (profunda) arises as soon as the artery enters the hand.

to join the deep arch.

The *profunda* or communicating *branch*, small in size, passes downwards with a branch of the ulnar nerve between the abductor and short flexor muscles of the little finger, to inosculate with the deep palmar arch of the radial artery.

Four digital branches.

The *digital branches* are four in number, and supply both sides of the three inner fingers and one side of the index finger. The branch to the inner side of the hand and little finger is undivided; but the others, corresponding with the three inner interosseous spaces, bifurcate anteriorly to supply the contiguous sides of the above said digits. In the hand these branches are accompanied by the digital nerves, which they sometimes pierce.

In the hand.

They join offsets of the deep arch.

Near the root of the fingers they receive communicating branches from offsets of the deep arch; but the artery for the inner side of the little finger has its communicating branch about the middle of the hand.

Termination on the fingers.

From the point of bifurcation the branches extend along the sides of the fingers, accompanied by the digital nerves; and over the last phalanx the vessels of opposite sides unite in an arch, from whose convexity offsets proceed to supply the ball of the finger.

Branches and arches.

Collateral branches are furnished to the finger and the sheath of the tendons; and small twigs are supplied to the phalangeal articulations from small arterial arches on the bones—an arch being close behind each joint. On the dorsum of the last phalanx is another arch near the nail, from which the nail-pulp is supplied.

PALMAR PART OF THE ULNAR NERVE. The ulnar nerve divides on or near the annular ligament, into a superficial and a deep branch. Ulnar nerve in the hand

The *deep branch* accompanies the profunda artery to the muscles, and will be subsequently dissected with that vessel. has a deep and

The *superficial branch* furnishes an offset to the palmaris brevis muscle, and some filaments to the integument of the inner part of the hand, and ends in two digital nerves for the supply of both sides of the little finger and half the next :— superficial part.

Digital nerves. The more internal nerve is undivided, like the corresponding artery. Digital nerves are two.

The other is directed to the cleft between the ring and little fingers, and bifurcates for the supply of their opposed sides : in the palm of the hand this last branch is connected with an offset from the median nerve.

Along the sides of the fingers the digital branches have the same arrangement as those of the median nerve.

PALMAR PART OF THE MEDIAN NERVE. As soon as the median nerve issues from beneath the annular ligament it becomes enlarged and somewhat flattened, and divides into two nearly equal parts for the supply of digital nerves to the thumb and the remaining two fingers and a half. The more external of the two portions furnishes likewise a small muscular branch to the ball of the thumb. The trunk of the nerve and its branches are covered by the palmar fascia; and beneath them are the tendons of the flexor muscles. Median nerve supplies muscles and fingers.

The *branch to the muscles of the thumb* supplies the outer half of the short flexor, and ends in the abductor and opponens pollicis muscles. Branch to the muscles.

The *digital nerves* are five in number. Three of them, which are distributed to the sides of the thumb and the radial side of the fore finger, are undivided, and come from the external of the two pieces into which the trunk of the median divides. The other two spring from the inner piece of the nerve, and are bifurcated to supply the opposed sides of the middle and fore, and the middle and ring fingers. Five digital nerves.

The *first two* nerves belong to the thumb, one being on each side, and the most external communicates with branches of the radial nerve. First two,

The *third* is directed to the radial side of the index finger, and gives a branch to the most external lumbrical muscle. third,

The *fourth* furnishes a nerve to the second lumbrical muscle, and divides to supply the contiguous sides of the fore and middle fingers. fourth,

The *fifth*, like the fourth, is distributed by two branches to fifth.

the opposed sides of the middle and ring fingers: it is joined by a branch from the ulnar nerve.

On the sides of the fingers. *On the fingers.* On the sides of the fingers the nerves are superficial to the arteries, and reach to the last phalanx, where they end in filaments for the ball at the tip of the finger, and the pulp beneath the nail. In their course forwards the nerves supply chiefly tegumentary branches: one of these is directed backwards by the side of the metacarpal phalanx, and after uniting with the digital nerve on the back of the finger (p. 300), is continued to the dorsum of the last phalanx.

Lateral offsets.

Dissection of the deep tendons. *Dissection.* The tendons of the flexor muscles may be followed next to their termination. To expose them the ulnar artery should be cut through below the origin of the profunda branch; and the small superficial volar branch (of the radial) having been divided, the palmar arch is to be thrown forwards to the fingers. The ulnar and median nerves are then to be cut below the annular ligament, and turned forwards.

Divide ligament. A longitudinal incision is to be made through the centre of the annular ligament, without injuring the small muscles that arise from it, and the pieces of the ligament are to be thrown to the sides.

Open sheaths. Finally the sheaths of the fingers may be opened for the purpose of observing the insertion of the tendons.

Synovial sac surrounds tendons. FLEXOR TENDONS. Beneath the annular ligament the tendons of the deep and superficial flexors are surrounded by a large and loose synovial membrane, which projects upwards into the forearm and downwards into the hand, and sends an offset into the digital sheath of the thumb and the little finger.*

Superficial flexor *Flexor sublimis.* The tendons of the flexor sublimis are superficial to those of the deep flexor beneath the ligament; and all four are nearly on the same level, instead of being arranged in

in the hand. pairs as in the forearm. After crossing the palm of the hand

Insertion. they enter the sheaths of the fingers (fig. 59, [2]), and are *inserted* each by two processes into the margins of the middle phalanx, about the centre. When first entering the digital sheath, the

Slit for the deep flexor. tendon of the flexor sublimis conceals that of the flexor profundus; but near the front of the first phalanx it is slit for the passage of the tendon of the latter muscle.

Dissection. *Dissection.* To see the tendons of the deep flexor and the lumbrical muscles, the flexor sublimis must be cut through above the wrist, and thrown towards the fingers. Afterwards the areolar tissue should be taken away.

Tendons of deep flexor *Flexor profundus.* At the lower border of the annular ligament the tendinous mass of the flexor profundus is divided into four

* Theile refers the notice of this fact to M. Maslieurat-Lagémard, in No. 18 of the "Gazette Médicale," for 1839.

pieces, though in the forearm only the tendon of the fore finger is distinct from the rest. From the ligament the four tendons are directed through the hand to the fingers, and give origin to the small lumbricales muscles. At the root of the fingers each enters the digital sheath with a tendon of the flexor sublimis (fig. 59, [3]), and having passed through that tendon, is *inserted* into the base of the last phalanx.

cross the hand

to their insertion.

Between both flexor tendons and the bones are small membranous folds (ligamenta brevia), one for each. By means of this fold each tendon is connected with the capsule of the joint, and the fore part of the phalanx immediately behind the bone into which it is inserted.*

Short folds to both flexor tendons.

The *lumbricales muscles* (fig. 59, [5]) are four small fleshy slips, which *arise* from the tendons of the deep flexor near the annular ligament; and are directed to the radial side of each finger, to be *inserted* into an aponeurotic expansion on the dorsal aspect of the first or metacarpal phalanx.

Lumbrical muscles attached to deep flexor, and first phalanx.

These muscles are concealed for the most part by the tendons and vessels that have been removed; but they are subcutaneous for a short distance in the hand between the processes of the palmar fascia. The outer two arise from single tendons, but each of the others is connected with two tendons.

Connections.

Different origin.

Action. They draw the nearest phalanges of the fingers towards the palm, and bend the metacarpo-phalangeal joints. And the same joints can be bent by them and the flexors of the digits, when the two last joints of the digits are kept straight by the extensor.

Use.

Tendon of the flexor pollicis longus. Beneath the annular ligament this tendon is external to the flexor profundus; it then turns outwards between the heads of the flexor brevis pollicis, and is *inserted* into the last phalanx of the thumb. The common synovial membrane surrounds it beneath the annular ligament, and sends a prolongation, as before said, into its digital sheath.

Tendon of long flexor of thumb, its insertion.

Dissection. The deep palmar arch of the radial artery, with the deep branch of the ulnar nerve, and the interossei muscles, will come into view if the flexor profundus is cut above the wrist, and thrown with the lumbricales muscles towards the fingers; but in raising the tendons the student should endeavour to preserve two fine nerves entering the two inner lumbrical muscles.

Dissection of muscles of thumb

The dissection of the short muscles of the ball of the thumb

and little finger.

* In the ligament to the long flexor tendon Mr. Marshall finds two thin bands of elastic tissue, which he names the *vincula subflava*. He assigns to those bands the office of drawing down the long tendons after bending of the fingers.—"On certain Elastic Structures connected with the Deep Flexor Tendons of the Fingers and Toes." By John Marshall, F.R.C.S.—Med.-Chir. Review, Jan. 1853.

and little finger is next to be prepared. Some care is necessary to make a satisfactory separation of the different small thumb muscles: but those of the little finger are more easily defined.

Four muscles in the ball of the thumb, viz.

SHORT MUSCLES OF THE THUMB. These are four in number, and are named from their action on the thumb. The most superficial is the abductor pollicis; beneath it is the opponens pollicis, which will be recognised by its attachment to the whole length of the metacarpal bone. To the inner side of the last is the short flexor. And the wide muscle coming from the third metacarpal bone is the adductor of the thumb.

Abductor.

Attachments.

The ABDUCTOR POLLICIS is about an inch wide and thin, and is superficial to the rest. It *arises* from the upper part of the annular ligament at the radial side, and from the ridge of the os trapezium; and is *inserted* into the base of the first phalanx of the thumb.

Is the most superficial.

The muscle is subcutaneous, and rests on the opponens pollicis: it is connected oftentimes at its origin with a slip from the tendon of the extensor ossis metacarpi pollicis.

Use.

Action. It removes the metacarpal bone of the thumb from the other digits; and when it has so acted it may assist the short flexor in bending the metacarpo-phalangeal joint.

Dissection.

Dissection. The opponens pollicis will be seen on cutting through the abductor. To separate the muscle from the short flexor on the inner side, the student should begin near the fore part of the metacarpal bone, where there is usually a slight interval.

Opponens fixed to metacarpal bone,

The OPPONENS POLLICIS *arises* from the annular ligament beneath the preceding, and from the os trapezium and its ridge; it is *inserted* into the front and outer border of the metacarpal bone for the whole length.

beneath former.

This muscle is partly concealed by the preceding, though it projects on the outer side. Along its inner border is the flexor brevis pollicis. An insertion into the external sesamoid bone is described by Theile.

Use.

Action. From its attachment to the metacarpal bone it is able to draw that bone inwards over the palm of the hand, turning it backwards at the same time, so as to allow the ball of the thumb to be applied to the ball of each of the fingers, as in picking up a pin.

Flexor brevis.

Origin:

is inserted by two parts.

The FLEXOR BREVIS POLLICIS is the largest of the short muscles of the thumb: it consists of two pieces (inner and outer) at the insertion, but these are united at the origin. Posteriorly it *arises* from the annular ligament, at the lower part; from the os trapezoides and os magnum; and from the bases of the second and third metacarpal bones. In front it is *inserted* by two heads into the sides of the base of the first phalanx of the thumb,—the inner piece being united with the adductor, and the outer with the abductor pollicis. A sesamoid bone is connected with each lateral piece at its insertion.

The tendon of the long flexor lies on this muscle, and afterwards occupies the interval between the processes of insertion; and the deep palmar arch of the radial artery issues from beneath the inner head. It is deep in the hand.

Action. The muscle bends the metacarpo-phalangeal joint, and assists the opponens in drawing the thumb forwards and inwards over the palm. Use.

The ADDUCTOR POLLICIS is pointed at the thumb, and wide at the opposite end. Its *origin* is fixed to the anterior or lower two thirds of the metacarpal bone of the middle finger, on the palmar aspect; and its *insertion* is attached, with that of the short flexor, to the inner side of the first phalanx of the thumb. Adductor crosses from metacarpal bone, joins short flexor.

The cutaneous surface is in contact with the tendons of the flexor profundus and the lumbrical muscles; and the deep surface lies over (in this position) the first dorsal interosseous muscle, and the second and third metacarpal bones and the intervening muscles.

Action. By its contraction the thumb is applied to the radial border of the hand, and is approximated to the fingers. Use.

SHORT MUSCLES OF THE LITTLE FINGER. There are commonly two muscles in the ball of the little finger,—an abductor and an adductor. Sometimes there is a short flexor between the other two. Two or three muscles to little finger.

The ABDUCTOR MINIMI DIGITI is the most internal of the short muscles. It *arises* from the pisiform bone and the tendon of the flexor carpi ulnaris, and is *inserted* into the ulnar side of the base of the first phalanx of the little finger; an offset from it reaches the extensor tendon on the back of the phalanx. The palmaris brevis partly conceals the muscle. Abductor is the most internal.

Action. Firstly it draws the little finger away from the others; but continuing to act it bends the metacarpo-phalangeal joint. Use.

The FLEXOR BREVIS MINIMI DIGITI appears often to be a part of the abductor. Placed at the radial border of the preceding muscle, it takes *origin* from the tip of the process of the unciform bone, and slightly from the annular ligament; it is *inserted* with the abductor into the first phalanx. Flexor brevis is often absent. Is on the inner side of preceding.

It lies on the adductor; and near its origin it is separated from the abductor muscle by the deep branches of the ulnar artery and nerve.

Action. The first phalanx is moved towards the palm by this muscle, and the metacarpo-phalangeal joint is bent. Use.

The ADDUCTOR vel OPPONENS MINIMI DIGITI resembles the opponens pollicis in being attached to the body of the metacarpal bone. Its *origin* comes from the process of the unciform bone, Opponens pollicis.

is fixed to metacarpal bone.

and the lower part of the annular ligament : its *insertion* is fixed into the ulnar margin of the metacarpal bone of the little finger.

The adductor is partly overlaid by the preceding muscles; and beneath it the deep branches of the ulnar artery and nerve pass.

Use.

Action. It moves the inner metacarpal bone towards the others, and deepens the palm of the hand.

Dissection of deep arch and

Dissection. The radial artery comes into the palm of the hand between the first two metacarpal bones; and to lay bare the vessel, it will be requisite to detach the origin of the flexor brevis pollicis. The deep palmar arch, and the branch of the ulnar nerve accompanying it, together with their offsets, are to be dissected out.

interossei muscles.

A fascia, which covers the interossei muscles, is to be removed, when the dissector has observed its connection with the transverse ligament uniting the heads of the metacarpal bones.

Radial artery in hand

Radial Artery in the Hand. The radial artery enters the palm of the hand at the first interosseous space, between the heads of the first dorsal interosseous muscle : and after furnishing one branch to the thumb, and another to the index finger, turns across the hand towards the ulnar side with its venæ comites, and forms thus the deep arch.

forms deep arch

The *deep palmar arch* extends from the interosseous space to the base of the metacarpal bone of the little finger, where it joins the profunda communicating branch. Its convexity, which is but slight, is directed forwards ; and its position is more posterior, or nearer the carpal bones, than that of the superficial arch. The arch has a deep position in the hand, and lies on the metacarpal bones and the interossei muscles. It is covered by the long flexor tendons, and in part by the flexor brevis pollicis.

which lies near carpal bones,

and beneath all muscles.

Branches:

The *branches* of the deep palmar arch are the following :—

Recurrent.

Recurrent branches pass from the concavity of the arch to the front of the carpus ; these supply the bones, and anastomose with the other carpal arteries.

Perforating.

Three perforating arteries pierce the three inner dorsal interossei muscles, and communicate with the interosseous arteries on the back of the hand.

Inter-osseous.

Usually there are *three palmar interosseous arteries*, which occupy the three inner metacarpal spaces, and terminate by joining the digital branches of the superficial palmar arch at the clefts of the fingers : but the union with the innermost digital takes place about the middle of the palm. These branches supply the interosseous muscles and two or three inner lumbricales, and vary much in their size and distribution.

Digital branches. Artery of the thumb.

Digital branches of the radial. The *large artery of the thumb* (art. princeps pollicis) runs along the first metacarpal bone between the abductor indicis and the flexor brevis pollicis, to reach the interval between the heads of the last muscle, where it divides into the two collateral branches of the thumb: these are distributed like the arteries of the superficial arch.

Artery of the fore-finger.

The *digital branch of the index finger* (art. radialis indicis) is directed over the abductor indicis, and beneath the short flexor and the adductor pollicis, to the radial side of the fore finger. At the free or anterior border of the abductor indicis this branch is usually connected by an offset with the superficial palmar arch; and at the end of the finger it unites with the digital branch furnished to the opposite side by the ulnar artery.

Deep branch of ulnar nerve.

The *deep branch of the ulnar nerve* accompanies the palmar arch of the radial artery as far as the muscles of the thumb, and terminates in branches to the adductor pollicis, the inner head of the short flexor, and the abductor indicis.

Muscular offsets.

Branches. Near its origin the nerve furnishes branches to the muscles of the little finger. In the palm it gives offsets to all the palmar and dorsal interosseous muscles, and the inner two lumbrical muscles, besides the terminal branches before mentioned.

Ligament of heads of metacarpal bones.

The *transverse metacarpal ligament* connects together the heads of the metacarpal bones. Its cutaneous surface is hollowed where the flexor tendons cross it; and beneath it the interossei muscles pass to their insertion. To the posterior border the fascia covering the interossei muscles is united. This ligament should now be taken away to see the interossei muscles.

Seven interossei muscles,

The INTEROSSEI MUSCLES, so named from their position between the metacarpal bones, are seven in number. Two muscles occupy each space, except in the first where there is only one; they arise from the metacarpal bones, and are inserted into the first phalanx of the fingers. They are divided into palmar and dorsal interossei; but all the small muscles are evident in the palm of the hand, though some project more than the others.

divided into palmar and dorsal.

Number and origin of palmar.

The *palmar* muscles (fig. 60), three in number, are smaller than the dorsal set, and are most prominent in the palm of the hand. They *arise* from the palmar surface of the metacarpal bones of the fingers on which they act, viz. those of the fore, ring, and little fingers; and they are inserted into the ulnar side of the fore, and the radial side of the other two digits (supposing the hand supine).

Insertion.

Common insertion of both sets.

Both sets of muscles have a similar termination (fig. 59, [6]):— the fibres end in a tendon, which is *inserted* into the side of the first or metacarpal phalanx, and sends an expansion to join the aponeurotic covering on the dorsum of the bone.

Action.

Action. Their attachments may be kept in mind by considering them adductors of the digits before mentioned to the middle line of the second finger.

Dorsal set.

The *dorsal* interossei (fig. 61) extend farther back than the

Origin. palmar set, and *arise* by two heads from the lateral surfaces of the metacarpal bones between which they lie. The dorsal

Fig. 60.*

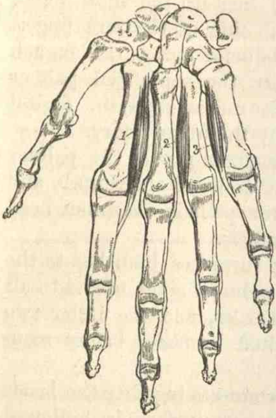
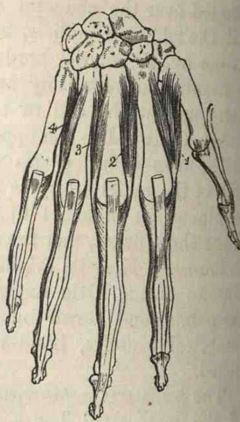


Fig. 61.†



Arrangement muscles are thus allotted to the digits:—two belong to the middle finger, a third is connected with the radial side of the fore, and the fourth with the ulnar side of the ring finger.

and action. *Action.* They may be considered abductors from the middle line of the second finger: thus the muscles attached to the fore and ring fingers will draw those digits from the middle one; and the two muscles of the middle finger will carry this digit to the right and left of a line passing through its centre.

First dorsal interosseous The first *dorsal interosseous* muscle (abductor indicis) *arises* from nearly the whole of the metacarpal bone of the index finger, and from the upper half of that of the thumb; and is *inserted* into the radial side of the first phalanx of the fore finger.

Much larger than the rest the muscle is in contact by the palmar surface with the adductor and flexor brevis pollicis; and is perforated by radial artery. by the opposite surface it is subcutaneous. The radial artery perforates it to enter the palm.

Dissection. *Dissection.* The attachments of the annular ligament to the carpal bones on each side are to be next dissected out, and the small muscles of the thumb and little finger to be taken from it. Before reading the description of this band, the ends of the cut ligament may be placed in apposition.

* The three palmar interosseous muscles: they are named numerically from the outer side.

† Dorsal interosseous muscles of the hand, which are numbered, like the palmar set, from the outer to the inner side.

The *anterior annular ligament* is a firm ligamentous band, which arches over and binds down the flexor tendons of the fingers. It is attached externally to the front of the os scaphoides, and to the fore and inner parts, and ridge of the os trapezium; and internally to the unciform and pisiform bones. By its upper border it is connected with the aponeurosis of the forearm; and by its anterior surface it joins the palmar fascia. On the cutaneous surface lie the palmaris longus and the ulnar artery and nerve. **Annular ligament of front of wrist.**

Dissection. Next follow the tendon of the flexor carpi radialis to its insertion into the metacarpal bones. **Dissection.**

The *tendon of the flexor carpi radialis*, in passing from the forearm to the hand, lies in the groove in the os trapezium between the attachments of the annular ligament to the bone, but outside the arch of that ligament; here it is bound down by a fibrous sheath lined by a synovial membrane. The tendon is *inserted* into the base of the metacarpal bone of the index finger, and sends a slip to that of the middle digit. **Insertion of flexor carpi radialis.**

Section VI.

THE BACK OF THE FOREARM.

Position. During the dissection of the back of the forearm the limb lies with the fore part undermost, and a small block is to be placed beneath the wrist for the purpose of stretching the tendons.

Dissection. The fascia and the cutaneous nerves and vessels are to be reflected from the muscles of the forearm, and from the tendons on the back of the hand; but in removing the fascia the student must be careful not to cut away the posterior interosseous vessels which are in contact with it along the outer edge of the extensor carpi ulnaris in the lower third. A thickened band of the fascia opposite the carpus (the posterior annular ligament) is to be left. **Take away the superficial vessels and the fascia.**

If the integument has not been taken from the fingers, let it be removed in order that the tendons may be traced to the ends of the digits. **Strip fingers.**

The several muscles should be separated from one another up to their origin, especially the two radial extensors of the wrist. **Separate muscles.**

The *posterior annular ligament* consists of the special aponeurosis of the limb, thickened by the addition of some transverse **Annular ligament be-**

hind the wrist. fibres, and is situate opposite the lower end of the bones of the forearm. This ligamentous band is connected at the outer part to the radius, and at the inner to the cuneiform and pisiform bones. From it are sent processes, which are fixed to the bones beneath, and confine the extensor tendons. The ligament will be subsequently examined more in detail.

Superficial layer has seven muscles, viz. SUPERFICIAL LAYER OF MUSCLES. The muscles are arranged in a superficial and a deep layer, as on the anterior part of the forearm. The superficial layer is composed of seven muscles, which arise mostly by a common tendon from the outer condyle of the humerus, and have the undermentioned position one to another from without inwards;—the long supinator, the two radial extensors of the wrist (long and short), the common extensor of the fingers, the extensor of the little finger, and lastly the ulnar extensor of the wrist. There is one other small muscle near the elbow, the anconeus.

Supinator longus The SUPINATOR RADII LONGUS (fig. 58, [8]) reaches upwards into the arm, and limits on the outer side the hollow in front of the elbow. arises from humerus, The muscle *arises* from the upper two thirds of the outer condyloid ridge of the humerus, and from the front of the external intermuscular septum. The fleshy fibres end about the middle of the forearm in a tendon, by means of which the muscle is *inserted* into the lower end of the radius close above the styloid process. inserted into radius.

Connections. In the arm the margins of the supinator are directed towards the surface and the bone, but in the forearm the muscle is flattened over the others, with its edges forwards and backwards. Its anterior border touches the biceps and the pronator teres; and the posterior is in contact with both radial extensors of the wrist. Near its insertion the supinator is covered by two extensors of the thumb. Is the guide to the radial artery. Beneath the muscle are the brachialis anticus and musculo-spiral nerve, the extensors of the wrist, the radial vessels and nerve, and the radius.

Use, *Action.* The chief use of this supinator is to bend the elbow joint. But if the radius is either forcibly pronated or supinated, radius free the muscle will put the hand into a state intermediate between pronation and supination, the thumb being brought into a line with the radius.

and fixed. If the radius is fixed as in climbing the muscle will bring up the humerus, bending in that way the elbow.

Extensor carpi longus. The EXTENSOR CARPI RADIALIS LONGIOR *arises* from the lower third of the outer condyloid ridge of the humerus, and the front of the contiguous intermuscular septum; and from the septum between it and the next muscle. From this fleshy attachment the muscle descends on the short radial extensor, being partly covered by the supinator longus; and its tendon passes beneath the extensors of the thumb, and through the annular ligament, to be *inserted* into the base of the metacarpal bone of the index finger. Along its outer border lies the radial nerve. Insertion.

Action. The long extensor straightens first the wrist, and bends next the elbow joint. Use, hand free

If the hand is fixed in climbing, it will act on the humerus like the long supinator. and fixed.

The EXTENSOR CARPI RADIALIS BREVIOR is attached to the outer condyle of the humerus by a tendon common to it and the three following muscles, viz. the common extensor of the fingers, the extensor of the little finger and the ulnar extensor of the wrist: it takes origin also from the capsular ligament of the elbow joint, and an aponeurosis on its under and inner sides. The tendon of the muscle is closely connected with the preceding, and after passing with it through the same compartment of the annular ligament, is *inserted* into the base of the metacarpal bone of the middle finger. Extensor carpi brevis. Origin. Insertion into metacarpal bone.

Concealed on the outer side by the two preceding muscles, this extensor rests on the radius and on some of the muscles attached to it, that is to say, on the supinator brevis, and the pronator teres. Along the inner side is the common extensor of the fingers; and the extensors of the thumb come out between the carpal and digital extensors. Both radial extensors of the carpus have usually a bursa at the insertion. Parts around it.

Action. This muscle resembles its fellow in extending the wrist, but differs from it in extending the elbow. Use.

The EXTENSOR COMMUNIS DIGITORUM is single at its origin, but is divided inferiorly into four tendons. It *arises* from the common tendon, from aponeurotic septa between it and the muscles around, and from the aponeurosis of the limb. Near the lower part of the forearm the muscle ends in three tendons, which pass through a compartment of the annular ligament with the indicator muscle. Escaping from the ligament, the most internal tendon divides into two, and all four are directed along the back of the hand to their insertion into the last two phalanges of the fingers. Common extensor muscle. Origin.

On the back of the fingers the tendons have the following arrangement:—Opposite the first two phalangeal articulations each tendon sends down lateral bands to join the capsule of the joint. On the dorsum of the first phalanx it forms an expansion with the tendons of the lumbricales and interossei muscles (fig. 59), and divides anteriorly into three parts:—the central one is fixed into the base of the second phalanx, whilst the lateral pieces unite at the front of the same phalanx, and are inserted into the base of the last. On the fore and little fingers the expansion is joined by the special tendons of those digits. Insertion into the phalanges.

This muscle is placed between the extensors of the wrist and little finger, and conceals the deep extensors. On the back of Connections of the muscle.

Bands to the tendons.

the hand the tendons are joined by cross pieces. Between the ring finger tendon and its collateral tendons the connecting bands are the strongest; they prevent the ring finger being raised during life if the other fingers are closed.

Use, on the fingers,

Action. The muscle straightens the three phalanges of the fingers from root to tip, and separates the four digits from each other. It can extend the nearest phalanx of each finger whilst the two farthest are kept bent by the flexors; and it can straighten the last two phalanges when the nearest is bent.

on elbow and wrist.

The digits being straightened, it will assist the other muscles in extending the wrist and the elbow.

Extensor of little finger.

The EXTENSOR MINIMI DIGITI is the most slender muscle on the back of the forearm, and appears to be but a part of the common extensor. Its *origin* is in common with that of the extensor communis, but it passes through a distinct sheath of the annular ligament. Beyond the ligament the tendon splits into two; one unites by a cross piece with the tendon of the common extensor, and both finally join the common expansion on the first phalanx of the little finger.

Origin. Termination.

Use.

Action. It extends the little finger and moves back the wrist and elbow; as the tendon is slit it can straighten its digit in spite of the union with the piece of the common extensor.

Extensor carpi ulnaris.

The EXTENSOR CARPI ULNARIS MUSCLE arises from the common tendon and from the aponeurosis of the forearm; it is also firmly fixed by the fascia to the posterior border of the ulna below the anconeus muscle (about the middle third). Its tendon becomes free from fleshy fibres near the annular ligament, and passes through a separate sheath in that structure to be *inserted* into the base of the metacarpal bone of the little finger.

Origin. Insertion.

Connections.

Beneath this extensor are some of the muscles of the deep layer, with part of the ulna. On the outer side is the extensor of the little finger.

Use.

Action. As the name expresses, the muscle puts back the wrist and inclines the hand towards the ulnar side. The hand being fixed, it can extend the elbow joint.

Anconeus has a distinct origin

The ANCONEUS is a small triangular muscle near the elbow joint. It *arises* from the outer condyle of the humerus by a tendon distinct from, and on the ulnar side of the common tendon of origin of the other muscles. From this origin the fibres diverge to their *insertion* into the outer side of the olecranon, and into the impression on the upper third of the posterior surface of the ulna.

and insertion;

joins the triceps.

The upper fibres are nearly transverse, and are contiguous to the lowest of the triceps muscle. Beneath the anconeus lie the supinator brevis muscle, and the recurrent interosseous vessels.

Use.

Action. Commonly it acts on the ulna, and assists the triceps in extending the elbow; but if that bone is fixed it moves back the humerus.

Dissection. For the display of the deep muscles at the back of the forearm, and the posterior interosseous artery and nerve, three of the superficial muscles, viz. the extensor communis, extensor minimi digiti, and extensor carpi ulnaris, are to be detached from their origin and turned aside: in this proceeding the small branches of the nerve and artery entering the muscles may be divided. Dissection of deep layer of muscles,

The loose tissue and fat are then to be removed from the muscles, and from the ramifications of the artery and nerve; and a slender part of the nerve, which sinks beneath the extensor of the second phalanx of the thumb about the middle of the forearm, should be traced beyond the wrist. and interosseous vessels and nerve.

The separation of the muscles should be made carefully, because the highest two of the thumb are not always very distinct from each other.

DEEP LAYER OF MUSCLES. In this layer there are five small muscles, viz. one supinator of the forearm, and four special extensor muscles of the thumb and forefinger. The highest muscle, surrounding partly the upper end of the radius, is the supinator brevis. Below this are the three muscles of the thumb in the following order:—the extensor of the metacarpal bone, the extensor of the first, and that of the second phalanx. On the ulna the indicator muscle is placed. Five muscles in the deep layer, viz.

The EXTENSOR OSSIS METACARPI POLLICIS (abductor pollicis longus) is the largest and highest of the extensor muscles of the thumb, and is sometimes united with the supinator brevis. It *arises* from the posterior surface of the radius for three inches below the supinator brevis; from a special impression of the ulna for the same distance, on the upper and outer part of the posterior surface; and from the intervening interosseous membrane. The tendon of the muscle is directed outwards over the radial extensors of the wrist, and through the outer compartment in the annular ligament, to be *inserted* mostly into the base of the metacarpal bone of the thumb, but also by a slip into the os trapezium. Extensor metacarpi pollicis. Origin. Insertion.

The muscle is concealed at first by the common extensor of the fingers; but it becomes cutaneous between the last muscle and the extensors of the wrist about two inches above the end of the radius. Opposite the carpus the radial artery winds backwards beneath its tendon. The ulnar attachment is higher than the radial, and begins close below the insertion of the anconeus. Between the contiguous borders of this muscle and the supinator brevis the posterior interosseous artery appears. The muscle is at first deep, but afterwards superficial,

Action. By this muscle the thumb is moved backwards from the palm of the hand, and the wrist is extended on the radial side. Use.

Extensor of first phalanx has a small origin.

The EXTENSOR PRIMI INTERNODII POLLICIS is the smallest muscle of the deep layer, and its tendon accompanies that of the preceding extensor. Its *origin*, about one inch in width, is from the radius and the interosseous membrane, close below the attachment of the preceding muscle. Its fibres end in a tendon, which passes through the same space in the annular ligament as the extensor of the metacarpal bone, and is *inserted* into the metacarpal end of the first phalanx of the thumb. With respect to surrounding parts this muscle has the same connections as the preceding.

Insertion.

Use.

Action. It extends first the nearest phalanx, and then the wrist like its companion.

Extensor of second phalanx. Origin. Course.

The EXTENSOR SECUNDI INTERNODII POLLICIS arises from the ulna for four inches below the supinator brevis, along the ulnar side of the extensor of the metacarpal bone; and from the interosseous membrane below for one inch. Its tendon of insertion, after passing through a sheath in the annular ligament distinct from that of the other two extensor muscles, is directed along the dorsum of the thumb to be fixed to the base of the last phalanx.

Insertion.

Is lower than the preceding two.

It is covered by the same muscles as the other extensors of the thumb, but it becomes superficial nearer the lower end of the radius. Below the annular ligament its tendon crosses the radial artery, and the tendons of the extensors of the wrist.

Use.

Action. Its use is similar to that of the extensor of the first phalanx. When the phalanges are straight, the two extensors will assist in carrying back the metacarpal bone.

Indicator muscle. Origin

The EXTENSOR INDICIS (indicator) arises from the ulna for three or four inches, usually beyond the middle, and internal to the preceding muscles; and from the interosseous ligament below. Near the annular ligament the tendon becomes free from muscular fibres, and passing through the ligament with the common extensor of the fingers, is applied to, and blends with the external tendon of that muscle in the expansion on the phalanx of the fore finger.

and insertion.

Until this muscle has passed the ligament it is covered by the superficial layer, but it is afterwards subaponeurotic.

Use.

Action. The muscle can point the fore finger even when the three inner fingers are bent, inclining it towards the others at the same time. And it will help the common extensor of the digits in pulling back the hand.

Dissection of supinator brevis.

Dissection. To lay bare the supinator brevis, it will be necessary to detach the anconeus from the external condyle of the humerus, and to cut through the supinator longus and the radial extensors of the wrist. After those muscles have been divided, the fleshy fibres of the supinator are to be followed forwards to their insertion into the radius; and that part of the origin of the flexor profundus digitorum, which lies on the outer side of the insertion of the brachialis anticus, is to be removed.

The SUPINATOR BREVIS arises from the orbicular ligament of the radius and the external lateral ligament of the elbow joint; from a depression below the small sigmoid cavity of the ulna, and from the external margin of the bone for two inches below that depression. From this origin the fibres pass outwards, and are *inserted* into the upper third or more of the radius except at the inner part, reaching downwards to the insertion of the pronator teres, and forwards to the hollowed anterior surface. Origin of short supinator; and insertion into the radius.

This supinator is concealed altogether at the posterior and external aspects of the limb by the muscles of the superficial layer; and anteriorly the radial vessels and nerve lie over it. The lower border is contiguous to the extensor ossis metacarpi pollicis, only the posterior interosseous artery intervening. Through the substance of the muscle the posterior interosseous nerve winds to the back of the limb. The upper part of the radius is surrounded by the fleshy fibres of the muscle, except at the tubercle and along a slip of bone below it. Overlying and contiguous parts.

Action. When the radius has been moved over the ulna as in pronation, the short supinator comes into play to bring that bone again to the outer side of the ulna. Use.

The *posterior interosseous artery* is an offset from the common interosseous trunk (p. 308), and reaches the back of the forearm above the ligament between the bones. Passing between the contiguous borders of the supinator brevis and extensor ossis metacarpi, the artery descends at first between the superficial and deep layers of muscles; and afterwards, with a superficial position in the lower third of the forearm, along the tendon of the extensor carpi ulnaris as far as the wrist, where it ends by anastomosing with the carpal and anterior interosseous arteries. It furnishes many *muscular* offsets, and the following recurrent branch:— Posterior interosseous artery between the layers of muscles, and superficial.

The *recurrent* branch springs from the artery near the commencement, and ascends on or through the fibres of the supinator, but beneath the anconeus, to supply the elbow joint, and to anastomose with the superior profunda artery in the last-named muscle, also with the recurrent radial. Its recurrent branch.

The *posterior interosseous nerve* takes its origin from the musculo-spiral trunk in front of the outer condyle of the humerus, and winds backwards through the fibres of the supinator brevis. Escaped from the supinator, the nerve is placed between the superficial and deep layers of muscles as far as the middle of the forearm. Much reduced in size at that spot, it sinks beneath the extensor of the second phalanx of the thumb, and runs on the interosseous membrane to the back of the carpus. Finally the nerve enlarges beneath the tendons of the extensor communis Interosseous nerve. Position to muscles. Termination on back of the carpus.

digitorum, and terminates in filaments to the ligaments and the articulations of the carpus.

Its muscular offsets. *Branches.* This nerve furnishes offsets to all the muscles of the deep layer; and to those of the superficial layer with the exception of the three following, viz., anconeus, supinator longus, and extensor carpi radialis longior.

Radial artery on back of wrist. RADIAL ARTERY AT THE WRIST. At the wrist the radial artery with its venæ comites winds below the radius to the back of the carpus, and enters the palm of the hand at the first interosseous space, between the heads of the first dorsal interosseous muscle. At first the vessel lies deeply on the external lateral ligament of the wrist joint, and beneath the tendons of the extensors of the metacarpal bone and first phalanx of the thumb; but afterwards it is more superficial, and is crossed by the tendon of the extensor of the second phalanx of the thumb.

Connections with parts around.

Offsets of the external cutaneous nerve entwine around the artery, and the radial nerve is superficial to it.

Branches are small. Its *branches* are numerous but inconsiderable in size:—

To back of carpus. The *dorsal carpal branch* passes transversely beneath the extensor tendons, and forms an arch with a corresponding offset of the ulnar artery; with this arch the posterior interosseous joins.

Dorsal interosseous. From the carpal arch branches descend to the third and fourth interosseous spaces, and constitute two of the three *dorsal interosseous arteries.* At the cleft of the fingers they communicate with the digital arteries; and behind they are joined by the perforating branches of the palmar arch.

Metacarpal branch. The *metacarpal* or *first dorsal interosseous branch* reaches the space between the second and third metacarpal bones, and anastomoses, like the corresponding arteries of the other spaces, with a perforating branch of the deep palmar arch. Finally it is continued to the cleft of the fingers, where it ends by joining the digital artery of the superficial palmar arch, and giving small dorsal branches to the index and middle fingers.

Dorsal arteries of thumb Two small *dorsal arteries of the thumb* arise opposite the metacarpal bone, along which they extend, one on each border, to be distributed on its posterior aspect.

and fore finger. The *dorsal branch of the index finger* is distributed on the radial edge of that digit.

Sheaths of annular ligament The different *compartments* of the *annular ligament* may be seen more completely by dividing the sheaths of the ligament over the several tendons passing beneath. There are six different spaces, and each is lubricated by a synovial membrane.

from without inwards. The most external one lodges the first two extensors of the thumb. The next is a large hollow for the two radial extensors of the wrist; and a very small space for the extensor of the second phalanx of the thumb follows on the ulnar side. Farther to the inner side is the common sheath for the extensor of the fingers, and that of the fore finger; and there is a separate compartment for the extensor of the little finger. Internal to all is the space for the extensor carpi ulnaris. The last muscle grooves the ulna; but the others lie in hollows in the radius in the order mentioned above, with the exception of the extensor minimi digiti which is situate between the bones. Bones grooved by the tendons.

Dissection. If the supinator brevis be divided by a vertical incision, and dissected from the radius, its attachment to the bone will be better understood. To see supinator brevis,

The posterior interosseous nerve, and the offsets from its gangliform enlargement, may be traced more completely after the tendons of the extensor of the fingers and indicator muscle have been cut at the wrist. interosseous nerve,

The dorsal surface of the posterior interossei muscles of the hand may be cleaned, so that their double origin, and their insertion into the side, and on the dorsum of the phalanges, may be observed. Appearing between the heads of origin of these muscles are the posterior perforating arteries. and interossei muscles.

Section VII.

LIGAMENTS OF THE ELBOW, WRIST, AND HAND.

Directions. The ligaments of the remaining articulations of the limb, which are still moist, may be examined at once; but should any of them have become dry, they may be softened by immersion in water, or with a wet cloth, whilst the student learns the others. Directions.

Dissection. To make the necessary dissection of the ligaments of the elbow, the brachialis anticus must be taken away from the front, and the triceps from the back of the joint. The muscles connected with the outer and inner condyles, as well as the supinator brevis and the flexor profundus, are to be removed. With a little cleaning the four ligaments—anterior, posterior, and two lateral—will come into view. Dissection of the elbow joint.

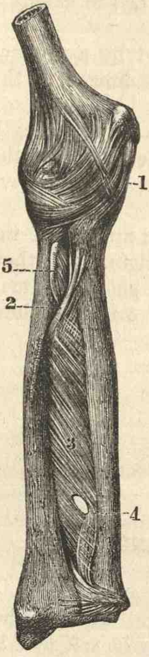
The interosseous membrane between the bones of the forearm will be prepared by the removal of the muscles on both surfaces.

The Elbow Joint (fig. 62). In this articulation the lower end of the humerus is received into the hollow of the ulna, so as to produce a hinge-like arrangement; and the upper end of the radius assists to form part of the joint. Where the bones touch the surfaces are covered with cartilage, and their articular ends are kept in place by the following ligaments:— Bones forming the elbow joint. The ligaments are

External lateral.

The *external lateral ligament* is a roundish fasciculus, which is attached by one end to the outer condyle of the humerus, and by the other to the orbicular ligament around the head of the radius. A few of the posterior fibres pass backwards to the external margin of the ulna.

Fig. 62.*



Internal lateral is wide:

inferior attachment.

The *internal lateral ligament* is triangular in shape. It is pointed at its upper extremity, and is connected to the inner condyle of the humerus. The fibres diverge as they descend, and are inserted in this way:—The anterior, which are the strongest, are fixed to the edge of the coronoid process; the posterior are attached to the side of the olecranon; whilst a few middle fibres join a transverse ligamentous band over the notch between the olecranon and the coronoid process. The ulnar nerve is in contact with the ligament; and a vessel enters the joint by an aperture beneath the transverse band.

A notch on inner side of the joint.

Anterior ligament is thin.

The *anterior ligament* is thin, and its fibres are separated by intervals in which masses of fat are lodged. By its upper margin the ligament is inserted into the front of the humerus, and by its lower into the front of the coronoid process and the orbicular ligament. The brachialis anticus muscle covers it.

Posterior ligament is weakest.

The *posterior ligament* is much thinner and looser than the anterior, and is covered completely by the triceps muscle. Superiorly it is attached to the humerus above the fossa for the olecranon; and inferiorly it is inserted into the olecranon. Some few fibres are transverse between the margins of the fossa before mentioned.

Dissection.

Dissection. Open the joint by an incision across the front near the humerus, and disarticulate the bones, in order that the articular surfaces may be seen.

Synovial membrane.

The *synovial membrane* lines the joint, and can be traced from one bone to another along the inner surface of the connecting ligaments. It projects between the radius and the orbicular ligament, and serves for the articulation of the head of that bone with the small sigmoid cavity of the ulna.

* The ligaments of the elbow joint, and of the shafts of the radius and ulna (Bourgery and Jacob).—1. Capsule of the elbow joint. 2. Oblique ligament. 3. Interosseous ligament. 4. Aperture for blood-vessels. 5. Tendon of the biceps.

Articular surfaces. The humerus presents inferiorly two distinct articular faces for the bones of the forearm. The one for the radius, on the outer side, consists of a rounded eminence (capitellum) on the front of the bone, which is covered with cartilage only on the anterior aspect. The surface in contact with the ulna is limited internally and externally by a prominent ridge, and hollowed out in the centre (trochlea). On the front of the humerus above the articular surface are two depressions which receive the coronoid process and the head of the radius during flexure of the joint; and on the posterior aspect is a large fossa for the reception of the olecranon in extension of the forearm.

Lower end of the humerus. One surface for radius, another for the ulna; fossæ for coronoid process and radius, and olecranon.

On the end of the ulna the large sigmoid cavity is narrowed in the centre, but expanded in front and behind (fig. 63). A slightly raised line extends from front to back, and is received into the hollow of the trochlea of the humerus in the motions of the joint. In the bottom of the cavity the cartilage is wanting completely, or for a greater or smaller distance across the articular hollow.

End of the ulna.

The end of the radius presents a circular depression with a raised margin. In the bent state of the joint the depression of the radius fits on the outer eminence of the humerus, and the bone is thus supported during rotation of the limb.

End of the radius.

Movement. This joint is like a hinge in its movements, and permits only flexion and extension.

Kind of motion:

In *flexion* the bones of the forearm move forwards, each on its own articular surface, so as to leave the back of the humerus uncovered. Its extent is checked by the meeting of the bones of the arm and forearm. Owing to the slanting surface of the humerus the hand falls inside the upper limb when the joint is freely bent.

bending,

The ligaments are relaxed, with the exception of the posterior, and the hinder part of the internal lateral.

state of ligaments;

In *extension* the ulna and radius are carried back over the articular surface of the humerus until they come into a line with the arm-bone. This movement is checked by the olecranon touching the humerus.

extending,

The anterior, and lateral ligaments (in part) are made tight, but the hinder fibres of the internal lateral are relaxed.

state of ligaments.

UNION OF THE RADIUS AND ULNA. The radius is connected with the ulna at both ends by means of distinct ligaments and synovial membrane; and the shafts of the bones are united further by interosseous ligaments.

Radius is joined to ulna.

Upper radio-ulnar articulation. In this joint the head of the radius is received into the small sigmoid cavity of the ulna, and is kept in place by the following ligamentous band:—

At the upper end by

The *annular* or *orbicular ligament* (fig. 63, [5]) is a band about a quarter of an inch wide, which is stronger behind than before;

orbicular ligament

around the head of the bone, it is placed around the prominence of the head of the radius, and is attached to the anterior and posterior edges of the small sigmoid cavity of the ulna. Its upper border, the widest, is connected with the ligaments of the elbow joint; but the lower is free, and is applied around the neck of the radius. In the socket formed by the ligament and the cavity of the ulna, the radius moves freely.

Fig. 63.*

and synovial membrane.

The *synovial membrane* is a prolongation of that lining the elbow joint; it projects inferiorly between the neck of the radius and the lower margin of the annular ligament.

Union of the shafts.

Ligaments of the shafts of the bones. The aponeurotic stratum connecting together the bones in nearly their whole length consists of the two following parts:—

Radius is joined in the middle by interosseous membrane. This is deficient above.

The *interosseous membrane* (fig. 62, [3]) is a thin fibrous layer, which is attached to the contiguous margins of the radius and ulna, and forms an incomplete septum between the muscles on the front and back of the forearm. Superiorly the membrane is wanting for a considerable space, and through the interval the posterior interosseous vessels pass backwards. Some small apertures exist in it for the passage of vessels; and the largest of these (4) is about two inches from the lower end through which the anterior interosseous artery turns to the back of the wrist. The membrane gives attachment to the deep muscles. Most of its fibres are directed obliquely inwards towards the ulna, though a few on the posterior surface have an opposite direction.

By round ligament.

The *round ligament* (fig. 62, [2]) is a slender band above the interosseous membrane, whose fibres have a direction opposite to those of the membrane. By one end it is fixed to the front of the coronoid process, and by the other to the radius below the tubercle. This ligament divides the space above the interosseous membrane into two parts. Oftentimes this band is not to be recognised.

The lower end after.

The lower radio-ulnar articulation cannot be well seen till after the examination of the wrist joint.

Kind of motion:

Movement of the radius. The radius rotates forwards and backwards around the ulna. The forward motion, directing the

* View of the orbicular ligament (5) of the radius, which retains the upper end of the bone against the ulna.—1. Olecranon, and 2. Coronoid process.

palm of the hand towards the ground, is called pronation; and the backward, by which the palm of the hand is placed upwards, is named supination.

pronation;

In *pronation* the upper end of the bone rotates within the band of the orbicular ligament without shifting its position to the ulna. The lower end, on the contrary, moves over the ulna from the outer to the inner side, describing half a circle; and the shaft crosses obliquely that of the ulna.

supination;

In *supination* the lower end of the radius moves backwards over the ulna; the shafts come to be placed side by side, the radius being external; and the upper end rotates from within out in its circular band.

rotation;

In these movements the radius turns round a line which, being placed internal to the shaft, is prolonged upwards through the neck and head of the bone, and downwards through the centre of the circle of which the small sigmoid cavity of the ulna is a segment (Ward).

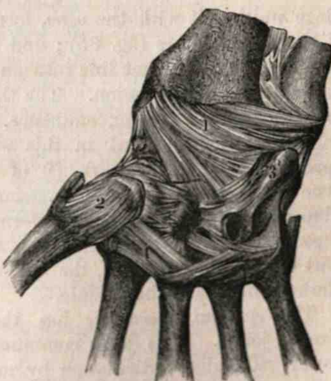
use of ligaments;

The upper end of the bone is kept in place by the orbicular ligament; the lower end by the triangular fibro-cartilage; and the shafts are united by the interosseous ligament which is tightened in supination, and is relaxed in pronation.

in fracture motion ceases.

In fracture of either bone the movements cease; in the one case because the radius cannot be moved in its totality; and in the other because the ulnar support is wanting for the revolving bone.

Fig. 64.*



Dissection.

Dissection. To see the ligaments of the wrist-joint, the tendons and the annular ligaments must be removed from both the front and back; and the fibrous structures and the small vessels should be taken from the surface of the ligaments.

Bones forming wrist

THE WRIST JOINT (fig. 64). The lower end of the radius, and the first row of the carpal bones except the os pisiforme, enter

* Front view of the articulations of the wrist joint, and carpal and metacarpal bones (Bourgery and Jacob).—1. Anterior ligament of the wrist joint. 2. Capsule of the joint of the metacarpal bone of the thumb with the os trapezium. 3. Pisiform bone, with its separate joint and ligamentous bands. 4. Transverse bands to the head of the metacarpal bones.

united by

into the wrist-joint. Four ligaments maintain in contact the osseous surfaces, viz. anterior and posterior, and two lateral. The ulna is shut out from this articulation by means of a piece of fibro-cartilage.

external lateral,

The *external lateral ligament* is a short and strong band, which intervenes between the styloid process of the radius and the upper part of the scaphoid bone.

internal lateral,

The *internal lateral ligament* is smaller than the external, but is longer than it. It is attached by one end to the styloid process of the ulna, and by the other to the rough, upper part of the cuneiform bone. Some of the anterior fibres are continued to the pisiform bone.

anterior and

The *anterior ligament* (fig. 64, [1]) takes origin from the radius and the fibro-cartilage, and is inserted into the first row of carpal bones, except the pisiform, at the anterior surface.

posterior ligament.

The *posterior ligament* (fig. 66, [1]) is membranous, like the anterior, and its fibres are directed downwards and inwards. Superiorly it is attached to the radius and the fibro-cartilage; and inferiorly it is fixed to the first row of carpal bones on the posterior aspect.

Dissection.

Dissection. To see the form of the articulating surfaces, the joint may be opened by a transverse incision through the posterior ligament, near the bones of the carpus.

Surface of radius.

Articular surfaces. The end of the radius, and the fibro-cartilage uniting it with the ulna, form an arch for the reception of the carpal bones (fig. 65); and the surface of the radius is divided by a prominent line into an external triangular, and an internal square impression. The three bones of the first carpal row constitute a convex eminence, which is received into the hollow before mentioned in this way;—The scaphoid bone is opposite the external mark ([4]) of the radius; the semi-lunar bone touches the square impression ([5]), and all the triangular fibro-cartilage; whilst the cuneiform bone is in contact with the capsule (Henle). Sometimes the os semilunare touches only part of the fibro-cartilage, the cuneiform being in contact with the remainder and the capsule.

Of first row of carpal bones.

Surfaces touching.

Synovial sac.

The *synovial membrane* has the arrangement common to simple joints. This joint communicates occasionally with the lower radio-ulnar articulation by means of an aperture in the fibro-cartilage separating the two.

Kind of motion:

Movement. The wrist is a condyloid articulation, and possesses angular motion in four different directions, with circumduction.

flexion;

Flexion and extension. In flexion the carpus rolls on the radius from before backwards, and projects behind, stretching the posterior ligament. In extension the row of carpal bones moves in the opposite direction, viz. from behind forwards, and

extension;

causes the anterior ligament to be tightened: the movement back is freer than that forwards.

Abduction. Adduction.

Abduction and *adduction*. The row of carpal bones moves transversely inwards in the former, and outwards in the latter state: on each side the motion is limited by the meeting of the styloid process with a carpal bone.

State of ligaments.

The lateral ligaments are put on the stretch, the inner in abduction and the outer in adduction.

Circumduction.

Circumduction. The hand describes a cone in this movement, whose apex is at the wrist and base at the digits; and it moves more freely in extension and abduction than in the opposite directions.

Lower ends of radius and ulna joined by

Lower Radio-ulnar Articulation. In this articulation the convexity of the end of the ulna is received into a concavity on the radius;—an arrangement just the opposite to that between the upper ends of the bones.

capsule.

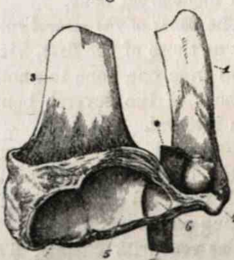
The chief bond of union between the bones is a strong fibro-cartilage; but a kind of *capsule* consisting of scattered fibres, surrounds loosely the end of the ulna.

Triangular fibro-cartilage.

Attachments and connections.

The *triangular fibro-cartilage* (fig. 65, [6]) is placed transversely beneath the end of the ulna, and is thickest at its margins and apex. By its base the cartilage is fixed to the ridge which separates the carpal from the ulnar articulating surface of the radius; and by its apex to the styloid process of the ulna, and the depression at the root of that process. Its margins are united with the contiguous anterior and posterior ligaments of the wrist joint; and its surfaces enter into different joints, viz. the wrist, and the lower radio-ulnar articulation. It serves to unite the radius and ulna, and to form part of the socket for the carpal bones. Occasionally it is perforated by an aperture.

Fig. 65.*



Synovial membrane.

The *synovial membrane* (membrana sacciformis) is very loose, from which circumstance it has received its name, and ascends between the radius and the ulna: it is separated from that of the wrist-joint by the triangular fibro-cartilage.

* The wrist-joint opened to show the arch formed by the bones of the forearm with the uniting fibro-cartilage.—1. Ulna; and 2, its styloid process. 3. Radius. 4. Surface of radius touching the scaphoid bone. 5. Surface of radius for part of the semilunar bone. 6. Triangular fibro-cartilage, corresponding with the semilunar bone, and sometimes with part of the pyramidal bone. An asterisk points to a piece of whalebone between the end of the ulna and the triangular fibro-cartilage.

Use.

The use of this articulation is referred to with the movements of the radius (p. 334).

Bones are joined into two rows.

UNION OF THE CARPAL BONES. The several bones of the carpus are united into two rows by dorsal, palmar, and interosseous bands; and the two rows are connected to each other by separate ligaments.

Dissection of carpal

Dissection. The articulation of the carpal bones with each other will be prepared by taking away all the tendons from the hand, and cleaning carefully the whole of the connecting ligamentous bands. Two distinct ligaments of the pisiform bone to the unciform and fifth metacarpal are to be defined.

and metacarpal joints.

At the same time the ligamentous bands uniting the metacarpal with the carpal bones and with one another should be dissected.

How first row is formed.

Bones of the first row (fig. 64). The os semilunare is united to the lateral bones, viz. scaphoid and cuneiform, by a *dorsal* and a *palmar* transverse band; as well as by an *interosseous* ligament at the upper part of the contiguous surfaces.

Separate ligaments of pisiform bone.

The pisiform bone is articulated to the front of the cuneiform by a distinct *capsule* and a *synovial* membrane (fig. 64, [3]). It has further two special ligaments;—one of these is attached to the process of the os unciforme, and the other to the base of the fifth metacarpal bone.

Second row is like first.

The *bones of the second row* are connected together in the same way as those of the first, viz. by a *dorsal* and a *palmar* band of fibres from one bone to another. Between the contiguous rough surfaces of the several bones are *interosseous* ligaments, one in each interval.

A gliding movement.

Movement. Only a very small degree of gliding motion is permitted between the different carpal bones, in consequence of the small flattened articular surfaces, and the interosseous ligaments uniting one to another.

The two rows are joined by

One row with another. The two rows of carpal bones are connected by an anterior and posterior, and two lateral ligaments.

anterior,

The *anterior ligament* (fig. 64) consists of irregular fibres, and intervenes between the two rows on the palmar aspect. The

posterior,

posterior ligament, which is longer and looser, and the greater number of whose fibres are transverse (fig. 66), has a corresponding attachment on the dorsal aspect of the bones.

and lateral ligaments.

Of the *lateral ligaments* the external is the best marked, and extends between the os trapezium and the scaphoid bone; the internal ligament reaches between the cuneiform and unciform bones.

Dissection.

Dissection. After the division of the lateral and posterior ligaments, the one row of bones may be separated from the other, so as to allow a sight of the articular surfaces.

Surface of

Articular surfaces. The first row of carpal bones (except pisiform) forms internally an arch, whose hollow is turned towards the second; and externally a prominence, which is received into a concavity in the other row. In the second row the os magnum and os unciforme present a condyloid projection, which is received into the arch before mentioned; but the two outer bones are much below the level of the others, and form a slight hollow for the reception of the outer part of the scaphoid bone. each row in contact.

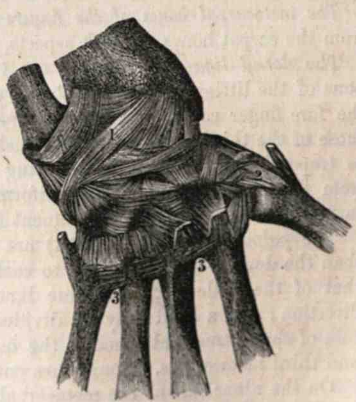
One *synovial membrane* serves for the articulation of all the carpal bones, except the pisiform with the cuneiform. Lining the joint between the two rows of the carpus, the membrane sends upwards and downwards prolongations between the individual bones. The offsets upwards are two, and they sometimes join the synovial membrane of the wrist joint; but the offsets in the opposite direction are three, and may be continued to all, or only some of the articulations between the four inner metacarpal with their carpal bones. One synovial membrane for the carpal bones, and four inner metacarpals.

Movements. Although the joint is partly condyloid, only forward and backward motion is permitted; all lateral and circumductory movement being arrested by the scaphoid striking against the os magnum. Kind of motion.

Flexion. As the hand is bent forwards the lower row of carpal bones moves backwards, and renders prominent the posterior ligament. This motion is freer than extension, and is also brought into play in full bending of the wrist. Flexion.

Extension. The backward movement is more limited. When the lower carpal row moves towards the palm, its progress is checked by the anterior ligament of the joint, and the strong flexor tendons. Extension.

Fig. 66.*



UNION OF THE METACARPAL BONES (fig. 66). The metacarpal bones of the four fingers are connected at their bases by the following ligaments:—A superficial *dorsal* and *palmar* fasciculus of fibres Metacarpal bones are joined by their bases

* Posterior ligaments of the wrist, and carpal and metacarpal bones (Bourgery and Jacob). 1. Posterior radio-carpal. 2. Carpo-metacarpal joint of the thumb.—3, 3. Transverse bands between the bases of the metacarpal bones.

passes transversely from one bone to the next; and the bands in the palm are the strongest (fig. 64). Besides, there is a short *interosseous* ligament between the contiguous rough surfaces of the bones.

by side union

Lateral union. Where the metacarpal bones touch they are covered by cartilage; and the articular surfaces are furnished with prolongations of the synovial membrane serving for their articulation with the carpus.

and by their heads.

At their anterior extremities the metacarpal bones are connected by the deep *transverse ligament*, which has been examined in the dissection of the hand (p. 321).

Gliding motion.

Movement. Scarcely any appreciable antero-posterior movement exists in the articulations of the bases of the metacarpal bones of the fingers; but the motion is rather greater at the opposite ends, where the bones do not touch, and are connected only by a loose fibrous band.

Joint between carpal and metacarpal bones;

UNION OF THE METACARPAL AND CARPAL BONES. The metacarpal bones of the fingers are articulated with the carpal bones after one plan. But the bone of the thumb has a separate joint with a synovial membrane.

that of the thumb;

The metacarpal bone of the thumb articulates with the os trapezium; and the ends of the bones are incased in a separate capsular ligament (fig. 64, [2]). The joint is supplied with a *synovial membrane* which is simple in its arrangement.

those of other fingers

The metacarpal bones of the fingers receive longitudinal bands from the carpal bones on both aspects, thus:—

through dorsal

The *dorsal ligaments* (fig. 66) are two to each, except to the bone of the little finger. The bands of the metacarpal bone of the fore finger come from the os trapezium and os trapezoides; those of the third metacarpal are attached to the os magnum and os trapezoides; the bone of the ring finger receives its bands from the os magnum and os unciforme; and to the fifth metacarpal bone there is but one ligament from the unciform.

and palmar bands.

The *palmar ligaments* (fig. 64) are weaker and less constant than the dorsal. There is one to each metacarpal bone, except that of the little finger. These ligaments may be oblique in direction; and a band may be divided between two, as in the case of the ligament attached to the os trapezium and the second and third metacarpals. Sometimes one or more may be wanting.

Lateral band.

On the ulnar side of the metacarpal bone of the middle finger is a longitudinal *lateral band*, which is attached above to the os magnum and unciforme, and below to the rough ulnar side of the base of the above mentioned bone. Sometimes this band isolates the articulation of the last two metacarpals with the unciform bone from the remaining carpo-metacarpal joint; but more frequently it is divided into two parts, and does not form a complete partition in the joint.

This band may be seen by opening behind the articulation between the unciform and the last two metacarpal bones; and by cutting through with care the transverse ligaments joining the third and fourth metacarpals so as to allow their separation. How seen.

Dissection. The articulating surfaces of the bones in the carpo-metacarpal articulation may be seen by cutting through the rest of the ligaments on the posterior aspect of the hand. Dissection.

Articular surfaces. The metacarpal bone of the fore finger presents a hollowed articular surface, which receives the prominence of the os trapezoides, and articulates laterally with the os trapezium and os magnum. The middle finger metacarpal articulates with the os magnum. The metacarpal bone of the ring finger touches the os magnum and the unciform bone. And the little finger bone is opposed to the os unciforme. Surfaces of the ends of the bones.

Synovial membranes. Usually two synovial membranes are interposed between the carpal and metacarpal bones, viz. a separate one for the bone of the thumb, and offsets of the common carpal synovial sac (p. 339) for the others. Sometimes there is a distinct synovial sac for the articulation of the os unciforme with the two inner metacarpals. Synovial sacs two or three.

Interosseous ligaments. The interosseous ligaments between the bases of the metacarpal bones may be demonstrated by detaching one bone from another, viz. a slender one on each side of the os semilunare in the first row, and stronger pieces between all the bones in the second row. Interosseous ligaments, and carpal.

Movements. In the four fingers there is a gliding from before back, and this is most marked in the little finger; but it is also greater in the ring than the other two digits. Kind of motion, in fingers,

The *thumb-joint* possesses angular movement in opposite directions with circumduction, thus :— in the thumb.

Flexion and extension. When the joint is flexed the metacarpal bone is brought into the palm of the hand, without the ball of the thumb being turned to the tips of the fingers. But as the joint bends, the metacarpal bone can be rolled by muscle so as to turn the ball of the thumb to the ball of each finger; this is the movement of opposition. Extension of the joint is very free, and by it the metacarpal bone is removed from the palm, and is carried back towards the forearm. Bending and opposition Extending.

Abduction and *adduction.* By these movements the metacarpal bone is placed in contact with, or removed from the fore finger. Lateral motion.

Dissection. For the examination of the joint between the head of the metacarpal bone and the first phalanx of the finger, it will be requisite to clear away the tendons and the tendinous expansion around it. A lateral ligament on each side, and an anterior thick band are to be defined. One of the joints may be opened to see the articular surfaces. Dissection of finger joints.

The same dissection may be made for the articulations between the phalanges of the finger.

Metacarpal bones and phalanges.

UNION OF METACARPAL BONE AND FIRST PHALANX. In this joint the convex head of the metacarpal bone is received into the glenoid fossa of the phalanx, and the two are retained in contact by the extensor and flexor tendons, and by the following ligaments :—

Lateral ligaments.

The *lateral ligament* is the same on both sides of the joint. Each is triangular in form ; it is attached by its upper part to the tubercle on the side of the head of the metarcarpal bone, and ends below by being inserted into the side of the phalanx and the anterior ligament.

Anterior ligament.

The *anterior ligament* is a longitudinal band, which is fixed firmly to the phalanx, but loosely to the metacarpal bone. It is fibro-cartilaginous in texture, and is grooved for the flexor tendon : to its sides the lateral ligaments are attached.

Capsule.

Covering the upper part of the joint is the extensor tendon; this takes the place of a dorsal ligament, and sends down an expansion on each side which serves as a capsule to the articulation.

Synovial membrane.

The *synovial* membrane of the joint is a simple sac.

Joint of thumb.

In the articulation of the thumb two sesamoid bones are connected with the anterior ligament, and receive most of the fibres of the lateral ligaments.

Kind of motion.

Movements. Motion in four opposite directions, and circumduction exist in these condyloid joints.

Extending.

Extension and flexion. The phalanx moves backwards in extension, so as to give an angle with the metacarpal bone. The anterior ligament and the flexor tendons are stretched, and control the movement.

Bending.

In flexion the phalanx glides forwards under the head of the metacarpal bone, and leaves this exposed to form the knuckle when the finger is shut. The lateral ligaments and the extensor tendon are put on the stretch as the joint is bent.

Lateral motion.

Abduction and *adduction* are the lateral movements of the finger from or towards its fellows. The lateral ligament of the side of the joint which is convex will be tightened, and the other will be relaxed.

Circumductory.

The *circumductory* motion is less impeded in the thumb, and the fore and little fingers than in the others.

Joints of the phalanges have

UNION OF THE PHALANGES. The ligaments of the first joint are similar to those in the metacarpo-phalangeal articulation, viz. two lateral and an anterior.

lateral and

The *lateral ligaments* are triangular in form. Each is connected by its apex to the side of the phalanx near the anterior part; and by its base to the contiguous phalanx and the anterior ligament.

anterior ligament.

The *anterior ligament* has the same mode of attachment between the extremities of the bones as in the metacarpo-phalangeal joint, but it is not so strong as in that articulation.

There is a simple *synovial membrane* present in the joint. Synovial sac.

The joint of the second with the last phalanx is like the preceding in the number and disposition of its ligaments; but all the articular bands are much less strongly marked. Second joint.

Articular Surfaces. The anterior end of each phalanx is marked by a pulley-like surface. The posterior end of the phalanx presents a transversely hollowed fossa, and is provided with a crest which fits into the central depression of the opposite articular surface. Surface of the bones.

Movements. The two phalangeal joints proper can be bent and straightened like a hinge. Kind of motion.

Flexion and extension. In flexion, the farther phalanx moves under the nearer in each joint, and the motion is checked by the lateral ligaments and the extensor tendon: in the joint between the middle and the metacarpal phalanx this movement is most extensive. In extension the farther phalanx moves backwards until it comes into a straight line with the nearer one, and the motion is stopped by the anterior ligament and the flexor tendons. Bending. Extending.

TABLE OF THE CHIEF ARTERIES OF THE UPPER LIMB.

The subclavian is continued in the arm by

- 1. Axillary artery . .
  - Superior thoracic
  - acromial thoracic . .
    - Muscular
    - inferior acromial
    - humeral thoracic.
  - long thoracic
  - alar thoracic
  - subscapular . . .
    - Dorsal artery . . .
      - Infrascapular.
    - muscular
  - external mammary
  - anterior circumflex
  - posterior circumflex.
- 2. brachial artery . .
  - To coraco-brachialis
  - superior profunda . .
    - Muscular to triceps and anconeus
    - anastomotic.
  - nutritious
  - inferior profunda . .
    - Muscular to triceps
    - anastomotic.
  - anastomotic
  - muscular.
- 3. radial artery . .
  - Recurrent
  - muscular
  - superficial volar
  - posterior carpal
  - anterior carpal
  - metacarpal
  - dorsal of the thumb
  - of the index finger
  - princeps pollicis
  - radialis indicis
  - deep arch . . .
    - Recurrent
    - perforating
    - interosseous
    - communicating
- 4. ulnar artery .
  - Anterior recurrent
  - posterior recurrent
  - interosseous . . .
    - Anterior . . . .
      - Nutritious
      - muscular.
    - posterior . . . . .
      - Recurrent
      - muscular.
  - muscular
  - dorsal of the hand, or metacarpal
    - Dorsal carpal
    - metacarpal or interosseous.
  - anterior carpal
  - superficial arch . .
    - Communicating
    - four digital branches
    - cutaneous
    - muscular.

TABLE OF THE SPINAL NERVES OF THE UPPER LIMB.

BRACHIAL PLEXUS gives off below the clavicle . .

- Anterior thoracic .
  - Superficial
  - deep.
- subscapular . .
  - Superior
  - inferior
  - long.
- circumflex . .
  - Articular
  - cutaneous
  - to teres minor
  - to deltoid.
- nerve of Wrisberg .
- internal cutaneous .
  - Small cutaneous
  - anterior of forearm
  - posterior of forearm.
- musculo-cutaneous .
  - To coraco-brachialis
  - biceps and
  - brachialis anticus
  - cutaneous external of fore-arm
  - articular to carpus.
- median . . .
  - To pronator teres
  - to muscles of forearm, except flexor ulnaris and part of profundus
  - anterior interosseous
  - cutaneous palmar
  - to muscles of thumb in part
  - five digital branches.
- ulnar . . .
  - Articular to elbow
  - to flexor carpi ulnaris
  - to flexor profundus in part
  - cutaneous branch of forearm and palm
  - dorsal cutaneous of the hand
  - superficial palmar division .
    - Communicating
    - two digital branches.
  - deep palmar nerve.
- musculo-spiral . .
  - Internal cutaneous
  - to triceps
  - and anconeus
  - external cutaneous
  - to supinator and extensor radialis longus
  - posterior interosseous . .
    - Muscular
    - articular.
  - radial . . . . . .
    - Cutaneous of back of thumb and of first two fingers and half the next.

CHAPTER IV.

DISSECTION OF THE THORAX.

SECTION I.

CAVITY OF THE THORAX.

Definition. THE cavity of the thorax is the space included by the spinal column, the ribs, and the sternum, and by certain muscles in the intervals between the pieces of the bony framework. Contents. In it the organs of respiration, and the heart with its great vessels are lodged: and through it the gullet, and some vessels and nerves are transmitted.

Dissection to open thorax. *Dissection.* When the parts covering in front the bony parietes of the thorax have been examined and taken away, the cavity is to be opened by removing a part of the anterior boundary. To make a sufficient opening into the thorax, the sternum is to be sawn through opposite the interval between the first two ribs, and again between the insertion of the cartilages of the fifth and sixth ribs. After detaching the lining membrane (pleura) from the inner surface of the chest, the student is to cut through the true ribs, except the first and seventh,* as far back as he can conveniently reach. The loose sternum and the ribs can be removed by dividing the internal mammary vessels, the triangularis sterni, and the intercostal muscles in the first and sixth spaces. The bag of the pleura being now opened, the cavity with its contents will be ready for examination.

Sternum to be kept. The sternum and the cartilages of the ribs will be required hereafter for the dissection of the ligaments.

Form in general. *Form.* The included cavity is irregularly conical, with the apex above and the base downwards; and it appears, from the collapsed state of the lungs, to be only partly filled by the contained viscera, but during life the whole of the now vacant space is occupied by the expanded lungs. On a cross section. On a horizontal section its

* The student must be mindful to leave those ribs uncut: the division of them will not be advantageous to his own part, and will injure the dissection of the neck and abdomen.

shape would appear somewhat cordiform; for the cavity is flattened on the sides, is diminished in the middle line by the prominent spinal column, and is projected backwards on each side of the spine.

Boundaries. The enclosing parts consist of the bones of the trunk, with certain accessory muscles both laterally and above and below, as in the following enumeration. **Parts bounding it**

On the sides the ribs with their intercostal muscles form the wall; whilst in front is the sternum; and behind is the spine. **on sides, in front, behind.**

The base is constructed at the circumference by the last dorsal vertebra behind, by the end of the sternum before, and by the ribs on the side; whilst the space included by the bones is closed by the diaphragm. **The base,**

The base is wider transversely than from front to back, and is on the whole convex towards the chest; though a closer inspection will show an undulating surface, and a different level at different points. Thus in the centre it is lower than at the sides, and is on a level with the base of the xiphoid cartilage. On the right side it rises to a level with the upper border of the fifth rib near the sternum; and on the left to the corresponding part of the upper border of the sixth rib.* From these lateral projections, the diaphragm slopes suddenly towards its attachment to the ribs, but more behind than before, so as to leave a narrow interval between it and the wall of the chest. The level of this attached part will be marked by an oblique line over the side of the chest from the xiphoid cartilage to the eleventh rib; but it differs slightly on the two sides, being rather lower on the left. **surface and height. Its side level.**

The apex of the space is continued higher than the osseous part of the wall, and reaches into the root of the neck. And the highest point is not in the centre, for there the windpipe, bloodvessels, &c. lie; but is prolonged on each side for an inch or an inch and a half above the first rib, so that the apex may be said to be bifid. Each point projects between the scaleni muscles, and under the subclavian bloodvessels. In the interval between the apices lie the several parts passing between the neck and the thorax. **Apex reaches into neck, is bifid. How bounded.**

Dimensions. The extent of the thoracic cavity does not correspond with the apparent size externally; for the space included by the ribs below is occupied by the abdominal viscera, and the cavity reaches above beyond the ribs into the neck. **Size of chest not that of cavity;**

In consequence of the arched condition of the diaphragm, the depth of the space varies greatly at different points. At the centre, where the depth is least, it measures about seven inches, **depth varies; before;**

* This is the height in the dead body. The level to which it may reach in great respiratory efforts during life will be stated with the account of the Diaphragm.

behind; on sides. but at the back as much again; and the other vertical measurements can be estimated by means of the data given of the level of the base to the wall of the thorax.

Size is altered in life; *Alterations in capacity.* The size of the thoracic cavity is constantly varying during life with the condition of the ribs and diaphragm in breathing.

transversely by ribs; The horizontal measurements are increased in inspiration, when the ribs are raised and separated from one another; and are diminished in expiration as the ribs approach and the sternum sinks.

in depth by diaphragm, An alteration in depth is due to the condition of the diaphragm in respiration; for the muscle descends when air is taken into the lungs, increasing thus the cavity; and ascends when the air is expelled from those organs, so as to restore the previous size of the space, or in violent efforts to diminish it. but unequally. But the movement of the diaphragm is not equal throughout, and some parts of the cavity will be increased more than others. For instance the central tendinous piece, which is joined to the heart-case, moves but slightly; but the lateral, bulging, fleshy halves descend freely, and add greatly to the size of the lateral part of the chest by their separation from the thoracic parietes.

Thorax lessened, how? The thoracic cavity may be diminished by the diaphragm being pushed upwards by enlargement, either temporary or permanent, of the viscera in the upper part of the abdomen; or by the existence of fluid in the latter cavity.

THE PLEURÆ.

Sac of the pleura. The pleuræ are two serous membranes, or closed sacs, which are reflected around the lungs in the cavity of the thorax. One occupies the right, and the other the left half of the cavity; they approach each other along the middle line of the body, forming a thoracic partition or mediastinum, though the two do not blend.

Form. Each pleura is conical in shape; its apex projects into the neck above the first rib, and its base is in contact with the diaphragm. Outer surface. The outer surface is rough, and is connected to the lung and the wall of the thorax by areolar tissue, but the inner surface is Inner surface. smooth and secerning. Surrounding the lung, and lining the interior of one half of the chest, the serous membrane consists Disposition in thorax. of a parietal part or pleura costalis, and of a visceral part or pleura pulmonalis.

Difference in sac of right and left side. There are some differences in the shape and extent of the two pleural bags. On the right side the bag is wider and shorter than on the left; and on the latter it is narrowed by the projection of the heart to that side.

The continuity of the bag of the pleura over the lung and the wall may be traced circularly from a given point to the same, in the following manner :—Supposing the membrane to be followed outwards from the sternum, it may be traced on the wall of the chest as far as the spinal column ; here it is directed forwards to the root of the lung, and is reflected over the viscus, covering its surface, and connecting together its different lobules. From the front of the root the pleura may be followed over the side of the pericardium to the sternum. Below the root the pleura gives rise to a thin fold, the *ligamentum latum pulmonis*, which intervenes between the inner surface of the lung and the side of the pericardium.

The continuity is here traced over the lung

If the serous sac be traced above the root of the lung, it describes a circle without deflection over that viscus.

and above it.

The mediastinum. The median thoracic partition, or the mediastinum, is formed by the approximation of the pleural bags along the middle line, and is constructed of two membranes,—one being derived from each sac. In front of the heart and behind it, the contiguous strata of the mediastinum approach near one another ; but about midway between the sternum and the spine they are widely separated by the heart. To the parts before and behind that viscus the terms "anterior and posterior mediastina" are sometimes applied.

Along middle the sacs form a partition.

The *part in front of the heart* (anterior mediastinum) extends from the pericardium to the back of the sternum, and is formed by the pleural bag of each side. Behind the second piece of the sternum the bags touch each other, but above and below that spot they are separated by an interval ; so that the interpleural space is narrowed at the centre, and is inclined below to the left of the middle line. In the upper part of the space are the remains of the thymus gland, and the origin of some of the hyoid and laryngeal muscles ; and in the lower part is some areolar tissue, together with the triangularis sterni muscle of the left side.

Part of septum in front of the heart.

Space of hour-glass shape.

Contents.

The *part behind the heart* (posterior mediastinum) intervenes between the back of the pericardium, the roots of the lungs, and the spinal column. Its lateral boundaries are the opposite pleural sacs, which are separated here by a larger interpleural interval than in front of the heart. If the pleura be divided behind the lung on the right side, the extent of the space and its contents will appear. In the space are contained the different bodies on the front of the spine, viz. the aorta, the vena azygos and the thoracic duct, the œsophagus with its nerves, the trachea, the splanchnic nerves at the lower part, and some lymphatic glands.

Part behind heart, and a larger space,

its contents.

Dissection. The pleura and the fat are now to be cleaned from the side of the pericardium.

Clean pericardium and

The root of the lung is to be dissected out by taking away

the root of the lung.

Trace the nerves, the pleura and the areolar tissue from its front and back, without injuring its several component vessels. In this dissection the phrenic artery and nerve will be found in front of the root, together with a few nerves (anterior pulmonary); the last are best seen on the left side. Behind the root of the lung is the vagus nerve, dividing into branches; and arching above it

and vein. is the large azygos vein.

For the present, the arch of the aorta and the small nerves on it may be left untouched.

CONNECTIONS OF THE LUNG.

Number and use. The lungs are two in number, and are contained in the cavity of the thorax, one on each side of the spinal column. In these organs the blood is changed in respiration.

Form. The lung is of a somewhat conical form, and takes its shape from the space in which it is lodged. It is unattached, except at the inner part where the vessels enter; and it is covered, as before said, by the bag of the pleura, except at the root. It presents for examination a base and apex, with two borders and two surfaces; it is divided also into lobes by fissures; and it has a root formed out of the vessels and nerves entering its inner surface.

Base touches diaphragm. Shape and level. The base of the lung is hollowed in the centre and thin at the circumference, and fits on the convexity of the diaphragm. Following the shape of that muscle, it is sloped obliquely from before backwards, and reaches in consequence much lower posteriorly than anteriorly. Its position with respect to the wall of the thorax may be ascertained externally by taking the level of the diaphragm as a guide (p. 347); and it will be a rib's breadth lower in front on the left, than on the right side. The

Apex is in the neck. apex is rounded, and projects an inch to an inch and a half above the first rib, where it lies beneath the clavicle, the anterior scalenus muscle, and the subclavian artery.

Anterior edge is thin. Position on right and left side. The anterior edge or border is thin, and overlays in part the pericardium. On the right side it lies along the middle of the sternum as low as the sixth costal cartilage. On the left side it reaches the mid-line of the chest as low as the fourth costal cartilage; but below that spot it presents a V-shaped notch, whose apex is opposite the outer part of the cartilage of the fifth rib. Two fissures are seen in this border of the right lung, but

Posterior edge is thick. only one in that of the left. The posterior border is as long again as the anterior, and projects inferiorly between the lower ribs and the diaphragm; it is thick and vertical, and is received into the hollow by the side of the spinal column.

External surface. The outer surface of the lung is convex, and is in contact with the wall of the thorax. A large cleft divides it into two pieces (lobes of the lung), and on the right side there is a second smaller fissure. The inner surface is flat when compared with the outer. Altogether in front is the hollow corresponding with the heart and its large vessels, which is greatest on the left lung. Behind this, but nearer the posterior than the anterior border, is a fissure about three inches long, *hilum pulmonis*, which receives the vessels forming the root of the lung. Internal surface gives attachment to the root.

Each lung is divided incompletely into two parts or lobes by an oblique fissure, which begins near the apex, and ends in the anterior border near the base. From the form of the lung and the direction of the fissure the lower lobe is necessarily the largest. In the right lung a second horizontal fissure is directed forwards from the middle of the oblique one to the anterior border, and cuts off a small triangular piece from the upper lobe: this is the third lobe of the lung. Occasionally there may be a trace of the third lobe in the left lung. Division into lobes. Left has two, and the right three lobes.

Besides the difference in the number of the lobes, the right lung is larger and heavier, and is wider and more hollowed out at the base than the left; it is also shorter by an inch. The increased length and the narrowness of the left lung are due to the absence below of a large projecting body like the liver, and to the direction of the heart to the left side. Difference in form and size of the lungs.

The *root of the lung* consists of the vessels entering the fissure on the inner surface. Being bound together by the pleura and some areolar tissue they form a foot-stalk, which fixes the lung to the heart and the windpipe. The root is situate at the inner surface, about midway between the base and apex, and about a third of the breadth of that surface from the posterior border of the lung. Root of the lung. Situation.

In front of the root on both sides, are the phrenic and the anterior pulmonary nerves, the former being at some little distance from it; and anterior to the right root is the descending cava. Behind on both sides, is the posterior pulmonic plexus; and on the left side there is, in addition, the descending aorta. Above on the right side is the vena azygos; and on the left side, the arch of the aorta. Below each root is the fold of pleura called ligamentum latum pulmonis. Connections.

In the root of the lung are collected a branch of the pulmonary artery, two pulmonary veins, and a division of the air tube (bronchus); small nutritive bronchial arteries and veins, and some nerves and lymphatics. These different parts have the following position to one another :— Constituents of the root;

On both sides the bronchus is most posterior, the pulmonary veins most anterior, and the pulmonary artery between the other two. In the direction from above downwards the position on the right side is, bronchus, pulmonary artery, and pulmonary veins; but on the left side the bronchus and artery have changed their relative position.

places, consequently the relative position will there be, artery, bronchus, and veins. This difference in the two sides may be accounted for by the left branch of the air tube being at a lower level than the right.

THE PERICARDIUM.

Pericardium.

The bag that contains the heart is named the pericardium. It is situate in the middle of the thorax, in the interval between the pleuræ of opposite sides.

Clean vessels of heart.

Dissection. Supposing the surface of the pericardium to be already cleaned, the student should next dissect out the nerves and the large vessels connected with the heart.

First aorta,

The large artery curving to the left above the heart is the aorta, which furnishes three trunks to the head and the upper limbs, viz. innominate to the right, then left common carotid, and left subclavian. By its side lies the pulmonary artery.

then innominate veins

Above the arch of the aorta a large venous trunk, left innominate, crosses over the three arteries before said, and ends by uniting on the right side with the right innominate vein in the upper cava. Several small veins, which may be mistaken for nerves, aescend over the aorta, and enter the left trunk.

and branches,

Define the branches of the left innominate vein, and especially that one crossing the aortic arch towards the left side, which is the left superior intercostal vein.

and upper cava.

The large vein by the side of the aorta which enters the top of the heart is the upper cava : look for the azygos vein opening into it behind.

Seek small nerves crossing arch of aorta.

Seek the following nerves of the left side which cross the arch of the aorta :—The nerve most to the left, and the largest, is the vagus ; the next largest in size on the right of the vagus is the phrenic. Between the preceding nerves, and close to the coats of the artery, are the two following,—the left superficial cardiac nerve of the sympathetic, and the cardiac branch of the left vagus ; of the two, the last is the smallest, and to the right of the other.

Dissect superficial plexus in arch of aorta.

The cardiac nerves from the left vagus and sympathetic are to be pursued onwards to a small plexus (superficial cardiac) in the concavity of the aorta. An offset of the plexus is to be traced downwards between the pulmonary artery and the aorta towards the anterior coronary artery of the heart ; and another prolongation is to be found coming forwards by the side of the arterial duct, from the deep cardiac, to the superficial plexus : this dissection is difficult, and will require caution.

When the pericardium is afterwards opened the nerves will be followed on the heart. Oftentimes these small nerves are destroyed in injecting the body.

The *pericardium* is larger than the viscus it contains. Occupying the interpleural space, it is situate behind the sternum, and projects below on each side of that bone, but much more towards the left than the right side. Somewhat conical in form, the wider part of the bag is turned towards the diaphragm, and the narrower part upwards to the large vessels of the heart. Size and position.

Laterally the pericardium is covered by the pleura, and the phrenic nerve and vessels lie in contact with it. Its anterior and posterior surfaces correspond with the objects in the interpleural space; and on the anterior aspect the bag is partly covered by the margins of the lungs, especially the left. Form. Connections.

The heart-case consists of a fibrous structure, which is lined internally by a serous membrane. Composition.

The *fibrous* part surrounds the heart entirely, and is pierced by the different vessels of that organ: it gives prolongations around the vessels, and the strongest of these sheaths is on the aorta. Inferiorly it is united by fibres to the central tendon of the diaphragm; but on the left side it extends beyond the limit of that tendon, and reaches the fleshy fibres of the muscle. Fibrous part gives sheaths to vessels. Joins diaphragm.

This membrane is thickest at the upper part, and is formed of fibres crossing in different directions, many being longitudinal. When the pericardium has been cut open, the serous lining will be discernible. Its structure.

The *serous sac* lines the interior of the fibrous pericardium, and is reflected over the surface of the heart. Like other serous membranes, the arachnoid for example, it has a parietal and a visceral part. After lining the interior of the fibrous case, to which it gives the shining appearance, the membrane is conducted to the surface of the heart by the different vessels. As it is reflected on the aorta and the pulmonary artery it contains those vessels in one tube, not passing between their contiguous surfaces; and at the posterior part of the pericardium it forms a pouch between the pulmonary veins of opposite sides. Serous layer lines fibrous, and covers surface of heart. Peculiarities in its reflections.

In front of the root of the left lung the serous layer forms a vertical band, the *vestigial fold of the pericardium* (Marshall), which includes the remains of the left innominate vein of the fetus. On separating the pulmonary artery and branches, the fold will be better seen. Vestigial fold.

The *vessels* of the pericardium are derived from the aorta, the internal mammary, the bronchial, the œsophageal, and the phrenic arteries. Vessels.

Nerves. According to Luschka the pericardium receives nerves from the phrenic, sympathetic, and right vagus. Nerves.

THE HEART AND ITS LARGE VESSELS.

The heart is a hollow muscular viscus, and is the agent in the This body is hollow.

propulsion of the blood through the body. Into it, as the centre of the vascular system, veins enter; and from it the arteries issue.

Form. *Form.* When the heart is distended, its form is conical, but it is rather flattened from before backwards, and rounded on the left side. Its surfaces and borders have the following differences; the anterior surface is slightly convex, whilst the posterior is nearly flat: the left border is thick and round, but the right is thin, sharp, and less firm.

Surfaces and borders.

Size and weight. *Size.* The size varies greatly, and in general the heart of the woman is smaller than that of the man. Its average weight is from ten to twelve ounces in the male, and from eight to ten in the female. The measurements may be said to be about four inches and three quarters in length, three inches and a half in width, and two inches and a half in thickness.

Situation in the chest; its axis, oblique, placed almost horizontally. *Position and Direction.* The heart lies beneath the lower two thirds of the sternum, and projects on each side, but more on the left than the right. Its axis is not parallel to, but is inclined obliquely across that of the body; and its position is almost horizontal with the base directed backwards and to the right, and the apex forwards and to the left side. The left margin of the viscus is undermost, whilst the right is foremost.

Only some parts touch the wall. In consequence of the direction of the heart in the thorax, only some parts can be near, or in contact with the parietes in front: thus the right half and apex will correspond with the thoracic wall, though mostly with lung intervening. The base is directed away from the sternum and the costal cartilages: and the left half will be undermost and deep in the cavity.

Limits of base and apex: *Limits.* The limits of the whole heart are the following: the base is opposite the spinal column, and corresponds with the interval between the fifth and eighth dorsal vertebræ. The apex strikes the wall of the thorax during life just below the fifth rib, near its junction with the cartilage; and at a spot on the surface, "two inches below the nipple and one on the sternal side" (Williams).

of upper margin, lower border. The upper limit would be shown by a line across the sternum on a level with the upper edge of the third costal cartilage. And the lower limit would be marked by a line over the junction of the sternum with the xiphoid cartilage, drawn from the articulations of the sixth and seventh cartilages of the right side to the spot where the apex touches.

Lateral limits. Its lateral limits are the following. On the right it projects from one to one inch and a half beyond the middle line of the sternum, and its increase in this direction is constantly varying with the degree of distension of the right half of the heart. On the left side the apex projects three inches to three inches and a half from the centre of the breast bone.

The heart is double. *Component parts.* The heart is a double organ, and is made up of two similar halves. In each half are two hollow portions, an auricle and a ventricle; these on the same side communicate, and are provided with vessels for the entrance and exit of the blood.

On the surface of the heart are circular and longitudinal grooves indicatory of this composition. Thus, passing circularly round the heart, nearer the base than the apex, is a groove which cuts off the thin auricular from the fleshy ventricular part. A longitudinal sulcus on each surface marks the situation of a median partition between the ventricles: this sulcus does not occupy the mid space either on the anterior or the posterior aspect, but is nearer the left border of the heart in front, and the right border behind; so that most of the anterior surface is formed by the right, and the greater part of the posterior surface by the left ventricle.

Grooves marking auricles and ventricles.

Partition between ventricles: how placed.

The right half receives black blood by the systemic veins, and sends the same to the lungs by means of the pulmonary artery; but the left half is supplied with red blood from the lungs by the pulmonary veins, and distributes it over the body through the aorta.

Use of halves.

The *auricles* are two (right and left); they are separated by a partition, and are placed so deeply at the base of the heart, behind the aorta and the pulmonary artery, that only the tip of the right one comes forwards to the sternum. They receive their appellation from the resemblance that the tips or appendices, which project forwards, bear to the dog's ears. The auricles are much thinner than the ventricles, and are recipients of blood from large veins. Of the two, the right is rather the larger and the more anterior.

Number and situation of the auricles.

Veins enter their cavities.

The *ventricles* constitute the fleshy part of the heart, and are thicker than the auricles, below which they lie: they are two in number, like the auricles. Their unequal extent on the aspects of the heart has been before alluded to:—thus the right ventricle forms the thin right border and the greater part of the anterior surface, and is prolonged upwards on the left into the pulmonary artery. The left ventricle enters alone into the apex, and constructs the left border, and most of the posterior surface of the heart: with its cavity the aorta is connected.

The ventricles. Number.

The right.

The left.

Dissection. Before opening the heart the coronary arteries are to be dissected on the surface, with the small nerves and veins that accompany them. The two arteries appear on the sides of the pulmonary artery, and occupy the grooves on the surface of the heart, where they are surrounded by fat. One branches over the right, and the other over the left side. With the anterior artery is a plexus of nerves, which is to be followed upwards to the superficial cardiac plexus; and with the remaining artery is another plexus.

Dissect coronary vessels and nerves,

In the groove at the back of the heart between the auricles

and coronary sinus.

and ventricles, the student will find the large coronary vein, and the dilated coronary sinus in which it ends: the last should be defined and followed to its ending in the right auricle.

Two arteries of the heart, viz.

The *coronary arteries* are two small vessels which are so named from their course around the heart; they are the first branches of the aorta, and arise opposite two semilunar valves. One is distributed mostly on the right, and the other on the left side of the heart:

right coronary,

The *right coronary* branch appears on the right side of the pulmonary artery, and is directed onwards in the depression between the right auricle and ventricle to end on the posterior aspect of the left half of the heart. In its course branches are distributed upwards and downwards to the right half of the viscus. Two of these are of larger size than the rest:—one runs on the anterior aspect of the right ventricle towards the free margin; the other descends on the back of the heart, along the septum between the ventricles towards the apex.

left coronary artery.

The *left coronary* branch is inclined first behind the pulmonary artery to the left side of that vessel, then in the groove between the left auricle and ventricle to the back of the same side of the heart. Like the preceding artery, it furnishes offsets to the substance of the auricle and ventricle of its side: the largest of these descends in the anterior sulcus over the septum ventriculorum towards the apex.

The larger offsets of these arteries do not anastomose with each other (Hyrtl).

Veins of the heart.

The *veins* of the substance *of the heart* (cardiac) are not the same in number, nor have they the same arrangement as the arteries. There may be said to be three sets, but for the most part they are collected into one large trunk, the coronary sinus, which opens into the right auricle.

Coronary sinus:

The *coronary sinus* (fig. 67, *e*) will be seen on raising the heart to be placed in the sulcus between the left auricle and ventricle.

extent;

About an inch usually in extent, it is joined on the one side by the great coronary vein; and on the other it opens into the right auricle. It is crossed by the muscular fibres of the left auricle. Inferiorly and at its inner termination it receives some branches from the back of the ventricles; and nearly at its outer extremity another vein,—the *oblique* vein of Mr. Marshall, which ascends along the back of the left auricle.

veins joining it.

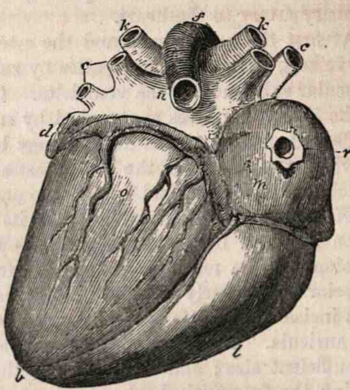
Valves in the veins.

On slitting the sinus with a scissors the openings of its different veins will be seen to be guarded with valves, with the exception of the oblique vein; and at its inner end is the large Thebesian valve of the right auricle.

Large cardiac vein is single,

The *great cardiac* or *coronary vein* (fig. 67, *d*) begins in front, near the apex of the heart, in the substance of the ventricles. From this origin the vessel turns to the posterior surface in the sulcus between the left auricle and ventricle, and opens into the coronary sinus. It receives collateral branches in its course, and its ending in the sinus is marked by two valves. and opens into sinus.

Fig. 67.*



Anterior and *posterior cardiac veins.* Some small veins on the anterior part of the right ventricle open separately, by one or more trunks, into the lower part of the right auricle. Similar small veins exist over the back of the ventricles; and one, larger than the rest, lies over the septum ventriculorum: they enter the coronary sinus by separate valved openings. Small anterior and posterior cardiac veins.

Smallest cardiac. A third set of veins (veins of Thebesius, venæ minimæ) lie in the substance of the heart, and are noticed in the description of the right auricle. Smallest cardiac.

Cardiac nerves. The nerves for the supply of the heart are derived from a large plexus (cardiac) around the roots of the aorta and the pulmonary artery. Part of this plexus is superficial to the pulmonary artery, and part beneath it; and an offset is sent from each with a coronary artery. Only the superficial part of the plexus can be now seen. Cardiac nerves.

The *superficial cardiac plexus* is placed by the side of the ductus arteriosus, and below the arch of the aorta. The nerves joining it are the left superficial cardiac of the sympathetic, the lower cardiac of the left vagus (p. 118), and a considerable bundle from the deep cardiac plexus. A small ganglionic mass is sometimes seen in the plexus. Inferiorly it sends off nerves, which run on the right coronary artery to the heart. A few filaments pass on the left division of the pulmonary artery to the front of the root of the left lung. Superficial plexus ends in anterior coronary.

The *anterior* or *right coronary plexus* passes from the plexus above described to the right coronary artery, and receives near Anterior coronary plexus,

* Back of the heart with its veins. *m.* Right auricle. *n.* Left auricle. *l.* Right ventricle. *o.* Left ventricle. *d.* Left auricular appendix, and under it is the great cardiac vein. *e.* The coronary sinus, joined by veins from the right side at its ending in the right auricle. *c.* Four pulmonary veins. *k.* Two pulmonary arteries. *f.* Aortic arch.

the heart a communicating offset from the right half of the deep cardiac plexus.

posterior plexus,

The *posterior* or *left plexus* is derived, as will be subsequently seen, from the deep cardiac plexus, and accompanies the left coronary artery to the heart.

ending in the heart.

At first the nerves surround the arteries, but they soon leave the vessels, and becoming smaller by subdivision, are lost in the muscular substance of the ventricles. On and in the substance of the heart the nerves are marked by small ganglia.

Four cavities of the heart.

The CAVITIES OF THE HEART may be examined in the order in which the current of the blood passes through them, viz. right auricle and ventricle, and left auricle and ventricle.

Dissection to open right auricle.

Dissection. In the examination of its cavities the heart is not to be removed from the body. To open the right auricle, an incision may be made in it near the free border, and from the superior cava nearly to the inferior cava; from the centre of that incision the knife is to be carried across the anterior wall to the auricula. By means of these cuts an opening will be made of sufficient size; and on removing the coagulated blood, and raising the flaps with hooks or pieces of string, the cavity may be learnt.

Form of right auricle.

The CAVITY OF THE RIGHT AURICLE is of an irregular form,* though when seen from the right side, with the flaps held up as above directed, it has somewhat the appearance of a cone, with the base to the right and the apex below and to the left.

Its base;

The *base* or wider part of the cavity is turned towards the right side, and at its extremities are the openings of the superior and inferior cavæ. Between those vessels the wall of the cavity projects a little, and presents a slight elevation in some bodies (tubercle of Lower).

apex.

The *apex* is prolonged downwards towards the junction of the auricle with the ventricle, and in it is the opening into the right ventricular cavity.

Anterior wall presents auricula.

The *anterior wall* is thin and loose. Near its upper part is an opening leading into the pouch of the appendix or auricula, which will admit the tip of the little finger. Around and in the interior of the appendix, are fleshy bands, named musculi pectinati, which run mostly in a transverse direction, and form a network that contrasts with the general smoothness of the auricle.

Posterior wall is marked by fossa ovalis.

The *posterior wall* corresponds for the most part with the septum between the auricles, in consequence of the position of the heart. On it, nearer the inferior than the superior cava, is a large oval depression, the fossa ovalis, which is the remains of an

* The term cavity of the auricle has been sometimes applied to the appendix, and the term sinus venosus to the rest of the space here named auricle.

opening between the auricles in the fetus. Inferiorly the fossa merges into the lower cava. A thin semitransparent structure forms the bottom of the fossa; and there is oftentimes a small oblique aperture at its upper part. Around the upper three fourths of that hollow is an elevated band of muscular fibre, called *annulus* seu *isthmus* Vieussenii, which is most prominent above and on the inner side, and gradually subsides inferiorly.

Annulus of Vieussens.

Altogether at the lower part of the posterior wall is the aperture of the coronary sinus. Other small apertures are scattered over this surface:—some lead only into depressions; but others are the mouths of veins of the substance of the heart (venæ cordis minimæ), and are named foramina Thebesii.

Apertures of sinus and veins of Thebesius.

The chief *apertures* in the auricle are those of the two cavæ, the coronary sinus, and the ventricle. The opening of the superior cava is in the front and top of the auricle, and its direction is downwards and somewhat forwards. The inferior cava enters the back part of the cavity near the septum, and is directed inwards and backwards to the fossa ovalis.

Situation of cavæ,

The opening into the right ventricle is the largest of all, and is situate at the lowest part of the cavity. Between this and the septum is placed the opening of the coronary sinus which is about as large as a turkey-quill.

of auriculo-ventricular opening, of coronary sinus.

All the large vessels, except the superior cava, have some kind of valve. In front of the inferior cava is a thin fold of the lining membrane of the cavity, the Eustachian valve, which in the adult is only a remnant of a much larger structure in the fetus. This valve in its perfect state is semilunar in form, with its convex margin attached to the anterior wall of the vein, and the other free in the cavity of the auricle. Its surfaces are directed forwards and backwards. In width the valve surpasses the vein opening, so that its extremities reach the surface of the auricle; and the left end is connected with the annulus, or the rim of the fossa ovalis. The free margin of the valve is often reticular.

Valves of chief apertures. Inferior cava is provided with Eustachian valve.

The aperture of the coronary sinus in the lower part of the auricle is closed by a thin fold of the lining membrane—valve of Thebesius. The auriculo-ventricular opening will be seen, in examining the right ventricle, to be provided with valves, which prevent regurgitation into the auricular cavity.

One to coronary sinus, and to auriculo-ventricular opening.

In the adult there is but one current of blood in the right auricle towards the ventricle. But in the fetus there are two streams in the cavity of the auricle; one of pure, and the other of impure blood, which cross one another in early life, but become more commingled as birth approaches. The placental or pure blood entering by the inferior cava, is directed by the Eustachian valve chiefly into the left auricle, through the foramen ovale in the septum; whilst the current of systemic or

Course of blood in auricle in adult, and in the fetus.

impure blood, coming in by the superior cava, flows downwards in front of the other to the right ventricle.

To open right ventricle.

Dissection. To see the cavity of the right ventricle, the student should pass the scalpel through it below the opening from the auricle, and cutting downwards bring the knife out inferiorly near the apex of the heart without injuring the septum ventriculorum. A flap is thus formed, like the letter V, of the anterior part of the ventricle. In the examination of the cavity of the right ventricle, both the flap and the apex of the heart should be raised with hooks or string, so that the space may be looked into from below.

Cavity of right ventricle.

The CAVITY OF THE RIGHT VENTRICLE is triangular in form, and has the base turned upwards to the auricle of the same side. On a cross section the cavity would appear semilunar in shape, with the septum between the ventricles convex towards the cavity.

Apex.

Base and its openings.

The *apex* of the cavity reaches the right border of the heart at a little distance from the tip. The *base* of the ventricle is sloped, and is perforated by two apertures; one of these, on the right, leading into the auricle, is the right auriculo-ventricular opening; the other on the left, and much higher, is the mouth of the pulmonary artery. The part of the cavity communicating with the pulmonary artery is funnel-shaped, and is named infundibulum or conus arteriosus.

Anterior and posterior wall.

The *anterior wall*, or the loose part of the ventricle, is comparatively thin, and forms most of the anterior surface of the ventricular portion of the heart. The *posterior wall* corresponds for the most part with the septum between the ventricles, and is much thicker.

Interior of the cavity is uneven.

On it there are three sets of fleshy columns.

Over the greater part of the cavity the surface is irregular, and is marked by projecting fleshy bands of muscular fibres, the *columnæ carneæ;* but near the aperture of the pulmonary artery the wall becomes smooth. The fleshy columns are of various sizes, and of three different kinds. Some form merely a prominence in the ventricle, as on the septum. Others are attached at each end, but free in the middle (trabeculæ carneæ). And a third set, which are fewer in number and much the largest, project into the cavity, and form rounded bundles, named *musculi papillares;* these give attachment by their free ends to the little tendinous cords of the valve of the auriculo-ventricular opening.

Opening from the auricle; position; form and size;

The *auriculo-ventricular orifice* is situate in the base of the ventricle, and is opposite the centre of the sternum, between the third costal cartilages. It is slightly larger than the corresponding aperture of the left side of the heart. It is oval from side to side, its shape being maintained by a strong fibrous band around it; and it measures one inch and a quarter in diameter.

Prolonged from the circumference of the opening is a thin membranous valve, which projects into the cavity of the ventricle. Near its attachment to the heart the valve is undivided, but it presents three chief points at its lower margin, and is named tricuspid; to this margin are attached small tendinous cords (chordæ tendineæ), which unite it to the muscular bundles of the ventricle. is guarded by the tricuspid valve.

The *tricuspid valve* is constructed by the lining membrane of the heart, which encloses fibrous tissue. Its three slips or tongues are thus placed :—one is at the front of the ventricle; another is in contact with the posterior wall; and the remaining part, the largest and most moveable, is interposed between the apertures into the auricle and pulmonary artery. The central part of each tongue is strong, whilst the edges are thin and notched; and between the primary pieces there are sometimes secondary points (Kürschner). Tricuspid valve: how formed: its pieces;

The *chordæ tendineæ* which keep the valve in position ascend from the musculi papillares into the intervals between the pieces of the valve, and are connected with both.* They end on the surface of the valve turned away from the opening in three different ways ;—some reach the attached upper margin of the pieces of the valve: others enter the central thickened part; and the rest, which are much finer, end in the thin point and edge of the tongues of the valve. attachment by tendinous cords.

During the contraction of the ventricle the valve is raised by the blood, so as to close the opening into the auricle, and takes part in producing the first sound of the heart; but the farther protrusion of it into the other cavity is arrested by the small tendinous cords. Its use.

The *mouth* of the *pulmonary artery* will be seen when the incision in the anterior wall of the ventricle is prolonged upwards into it. It is situate on the left of the opening into the auricle, and is opposite the inner end of the second intercostal space. Its diameter is rather less than an inch. Into it the funnel-shaped part of the right ventricle is prolonged, and in its interior are three semilunar or sigmoid valves. Mouth of pulmonary artery: position; has three valves:

Semilunar valves. Each valve is attached to the side of the vessel by its convex border; and is free by the opposite edge, in which there is a slightly thickened nodule that has been named the corpus Arantii. In the wall of the artery opposite each valve is a slight hollow, the *sinus* of *Valsalva*, which is better marked in the aorta. their attachment.

* The papillary muscles are collected into two principal groups, whose tendons enter the interval on each side of the right or anterior tongue of the valve. In the interval between the left and posterior segments of the valve the tendinous cords are very small, and are connected with the septum.

Structure of sigmoid valves. Arrangement of fibrous tissue.

The valves resemble the tricuspid in structure, for they are formed of fibrous tissue with a covering of the lining membrane. In each valve the fibres have this arrangement: there is one band along the attached margin; a second along the free edge, which is connected with the projecting nodule; and a third set of fibres is directed from the nodule across the valve, so as to leave on each side a semilunar interval near the free edge, which has been named *lunula*.

Their use.

The use of these little valves is obvious, viz. to give free passage to fluid in one direction, and to prevent its return by closing the area of the vessel. Whilst the blood is entering the artery the valves are placed against the wall; but when the vessel acts on the contained blood the valves are thrown towards the centre of the cavity, arresting the flow of the circulating fluid into the ventricle: they are concerned also in giving rise to the second sound of the heart.

To open left auricle.

Dissection. To open the cavity of the left auricle the apex of the heart is to be raised, and a cut is to be made across the posterior surface of the auricle from the right to the left pulmonary veins. Another incision should be made downwards in the auricle at right angles to the first. The apex of the heart must necessarily be raised during the examination of the cavity.

Shape of cavity of left auricle.

The CAVITY OF THE LEFT AURICLE (fig. 67) is smaller than that of the right side. Irregularly conical in shape, the wider part is turned towards the spinal column, and receives the pulmonary veins; and the narrowed part opens inferiorly into the left ventricle.

On anterior wall is auricula.

On the left side towards the upper part, is the aperture of the pouch of the auricula, which is narrower than that on the right side. In the interior of the pouch, as well as around the entrance, are fleshy fibres or the musculi pectinati, which resemble those before seen in the other auricle.

On septum remnant of foramen ovale.

On the part of the wall corresponding with the septum auricularum, is a superficial fossa of a semilunar form (fig. 68, *e*), the remains of the oval aperture through that partition; this is bounded below by a projecting ridge, concave upwards, which is the edge of the structure or valve that closed the opening in the fetus. This impression in the left auricle is above the fossa ovalis in the right cavity, because the aperture of communication between the two in the fetus is an oblique canal through the septum.

Openings: four pulmonary veins,

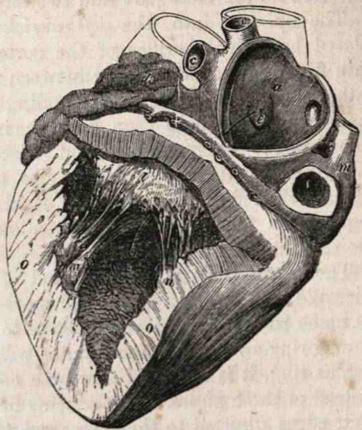
The *apertures* in this auricle are those of the four pulmonary veins, two on each side, together with the opening of communication with the left ventricle. The mouths of each pair of pulmonary veins are close to one another; those from the right

and to ventricle.

lung open into the extreme right of the auricle near the septum, and those from the left lung enter the opposite part of the cavity, near the auricula.

The pulmonary veins are not provided with valves. The aperture into the ventricle will be subsequently seen to have a large and complicated valve, as on the right side, to guard it. Valves.

Fig. 68.*



In the adult the blood enters this cavity from the lungs by the pulmonary veins, and passes to the left ventricle by the large inferior opening between the two. In the fetus the lungs are impervious to the air and the mass of the circulating fluid, and the left auricle receives its pure blood at once from the right auricle through the aperture in the septum (foramen ovale). Current of blood in adult; in fetus.

Dissection. The left ventricle may be opened by an incision along both the anterior and the posterior surface, near the septum; these are to be joined at the apex, but are not to be extended upwards so as to reach the auricle. On raising the triangular flap the interior of the cavity will be visible. How to open left ventricle.

The CAVITY OF THE LEFT VENTRICLE (fig. 68) is longer, and more conical in shape than that of the opposite ventricle; and is oval or almost circular, on a transverse section. Form of left ventricle.

The *apex* of the cavity reaches to the apex of the heart, for the fibres of the left ventricle form alone this part. The *base* is turned towards the auricle, and is not sloped like that of the right ventricle; in it are the openings into the aorta and the left auricle. Apex. Base with its openings.

The *walls* of this ventricle are thickest, and the anterior boundary is formed by the septum ventriculorum. Walls.

Its *surface* is irregular, like that of the right ventricle, in consequence of the projections of the fleshy columns, or the carneæ columnæ; but near the great artery (aorta) leading from the cavity the surface is smoother. There are three sets of fleshy Inner surface has fleshy columns,

* Left auricle and ventricle laid open. In the left auricle:—*a.* The septum auricularum. *c.* Four pulmonary veins. *e.* Fossa on the septum —the remains of the foramen ovale.

In the left ventricle:—*i.* Posterior flap of the mitral valve. *n.* The bundles of the musculi papillares. *o.* Thick wall of the ventricle.

and some very large. columns in this as in the right ventricle; but the set which projects into the cavity, and receives the small tendinous threads of the valve, is the most marked. The musculi papillares spring from the anterior and posterior walls of the cavity, and are collected for the most part into two large bundles.

Left auriculo-ventricular aperture. The *aperture* into the *left auricle* (auriculo-ventricular) is placed beneath the orifice of the aorta, but close to it, only a thin fibrous band intervening between the two. Form and size. This opening is rather smaller than the corresponding aperture of the right side, being somewhat more than an inch in diameter, and is longest Position. like it in the transverse direction. Placed, as before said, beneath It has a large valve. the aortic aperture, it extends also to the right, so as to lie beneath the left extremity of the right auriculo-ventricular opening. It is furnished with a membranous valve (mitral) that projects into the ventricle.

Mitral valve: The *mitral valve* is stronger and of greater length than the tricuspid, and has also firmer and more tendinous cords: it takes its name from a fancied resemblance to a mitre. Attached to a fibrous ring around the aperture, as well as in part to the aortic fibrous ring, it is divided below by a notch on each side into two segments, instead of three pieces. Its segments lie one before another, with their edges directed to the sides, and their surfaces towards the front and back of the cavity. The anterior tongue of the valve intervenes between the auricular and aortic openings, and is attached above to the fibrous band in that position; it is larger and looser than the posterior segment.

structure, The mitral resembles the tricuspid valve in its structure and office. Its segments consist of thicker and thinner parts; and in the notches at the sides there are also secondary pieces between attachment of cords. the two primary segments. The strong tendinous cords ascend to be attached to the valve in the notches between the tongues; and they end on the segments in the same way as in the tricuspid valve. Each of the large papillary muscles acts on both portions of the valve.

Use. When the ventricle contracts, the pieces of the valve are raised as on the right side, and meet to close the passage into the left auricle. This valve acts with the tricuspid in producing the first sound of the heart.

Aortic opening; The *opening of the aorta*, anterior to that of the auricle, is next the septum of the ventricles. position and form. By slitting up the aorta without cutting the pulmonary artery, its aperture will be found to be round, and rather smaller than that of the pulmonary artery; it measures about three quarters of an inch in diameter. It is situate opposite the lower border of the third left costal cartilage, behind the contiguous part of the sternum.

Is guarded by three sigmoid valves. In its interior are three *semilunar* or *sigmoid valves*, which are larger and stronger than the corresponding parts in the pulmonary artery, but have a like structure and attachment. The projection in the centre of each valve, viz. the corpus s. nodulus Arantii, is better marked. Opposite each valve the coat of the aorta is bulged as in the pulmonary artery, though in a greater degree, and presents a little hollow on the inner side named sinus of Valsalva. The apertures of the coronary arteries are placed behind two of the valves.

Like the valves in the pulmonary artery these meet in the middle line to stop the blood passing back into the ventricle, and combine with them in causing the second sound of the heart. **Use.**

Position of the ventricular apertures. Two openings have been seen in each ventricle,—one of the auricle of its own side of the heart, and one of an artery. **Relative position of the apertures;**

The apertures of the arteries (aorta and pulmonary) are nearest the septum; and as the two vessels were originally formed from one tube, they are close together, but the pulmonary artery is the more anterior of the two. The aperture of communication with each auricle is nearer the circumference of the heart, and is posterior to the artery issuing from the fore part of the ventricle. **of arteries and auricles**

The position of the openings to one another from before backwards, has been before referred to;—viz. the right is partly before the left auriculo-ventricular; and the opening of the pulmonary artery is anterior to that of the aorta, and rather higher than it. **from before back.**

STRUCTURE. The heart is composed of strata of muscular fibres, and of certain fibrous rings with a fibro-cartilage. **Structure of the heart.**

The structure may be studied in the heart of the sheep or ox, in which the fibres have been hardened and the connective tissue destroyed by boiling, so as to allow of the fibres being separated. The description of the structure of the heart may be omitted therefore till a suitable preparation of the fibres can be made. **Directions.**

The *fibrous structure* forms rings around the auriculo-ventricular and arterial orifices, and sends prolongations into the valves connected with those openings. **Fibrous bands**

The *auriculo-ventricular rings* give attachment to the framework of fibrous tissue in the tricuspid and mitral valves. These rings are distinct from the bands encircling the mouths of the arteries, except at the front of the left auriculo-ventricular opening, where the auricular and the arterial circles are blended. **form rings around auriculo-ventricular openings,**

An *arterial ring* surrounds each large artery (aorta and pulmonary), fixing those vessels, and giving attachment to some muscular fibres, and the semilunar valves. It is a circular band, with an uninterrupted edge towards the ventricle, and a toothed margin towards the artery. In the margin connected with the vessel there are three notches, which are filled by **and around arterial openings.** **To the last the sigmoid valves,** corresponding projections of the artery, and give attachment internally to the sigmoid valves along their semilunar edges.

and middle coat of the artery are fixed.

The artery is connected with the band of fibrous tissue in the following manner :—The middle coat presents three projecting convex pieces, which are received into the notches of the fibrous ring, but are united most intimately with the points ; and the junction between the two is strengthened externally by the outer coat and the pericardium, and internally by the endocardium.

Fibro-cartilage.

Behind the aortic aperture, between it and the auriculo-ventricular orifices, is a *piece* of *fibro-cartilage*, with which the fibrous rings are united.

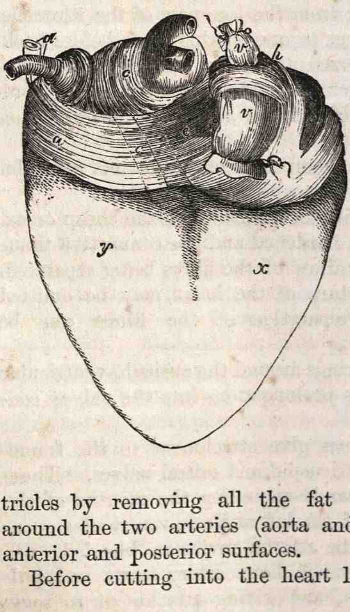
Muscular substance of heart is distinct in auricles and ventricles.

The *muscular fibres* belong to the involuntary class, though marked with transverse striæ, and form concentric layers, which enclose the cardiac cavities. In the auricles the fibres are separate from those in the ventricles.

Disposition in the auricles, where they are transverse, annular, and oblique.

In the *wall of the auricles* the fibres are mostly transverse (fig 69, *a*), and are best marked at the lower part, though they form there but a thin layer; and some of the fibres dip into the septum between the auricular cavities. Besides this set there are annular fibres around the appendages of the auricles and the endings of the different veins. Lastly a few oblique fibres (fig. 69, *c*, *h*) pass upwards over the auricles both in front and behind.

Fig. 69.*



Detach the auricles.

Dissection. The auricles having been learnt, separate them from the ventricles by dividing the fibrous auriculo-ventricular rings. Next clean the fleshy fibres of the ventricles by removing all the fat from the base of the heart around the two arteries (aorta and pulmonary), and from the anterior and posterior surfaces.

Before cutting into the heart let the student note that the

* Muscular fibres of the back of the auricles.—*x*. Right, and *y*, left side of the heart. *d*. Pulmonary veins, and *v*, venæ cavæ. *a*. Transverse fibres of the auricle entering the septum. *c*. Oblique or looped fibres of the left, and *h*, corresponding fibres of the auricle.

anterior surface is to be recognised by the fibres turning in at the septum, with the exception of a small band above about half an inch wide; and that at the posterior aspect the fibres are continued from the left to the right ventricle across the septum. Separate partly the ventricles in front along the septum by dividing the band near the base, and sinking the knife for about an inch into the groove between them. Disjoin then the aorta and pulmonary artery along the middle line, so as to leave one attached to each ventricle as in fig. 71. **Partly separate ventricles.**

To show the laminar composition of the left ventricle divide its fibres longitudinally near the septum, and transversely about half an inch below the left auriculo-ventricular opening; but the cut is to be very shallow, because seven layers, each about as thick as the thin end of the scalpel, are to be demonstrated. From the line of incision reflect the different layers downwards to the apex, upwards to the auriculo-ventricular aperture, and backwards into the septum. As the layers are raised the fleshy fibres will be seen to change their direction; and the outer three to be thinner than the three internal. **To show layers of left ventricle.**

The dissection of the wall of the right ventricle will follow after (p. 369).

The LEFT VENTRICLE is a hollow cone, and its wall is formed of layers of fibres, as if a flat muscle had been rolled up into a conical figure. Into the construction of the wall seven layers enter; and they are arranged into three external (1, 2, 3), three internal (7, 6, 5), and a central one (4). All are not prolonged equal distances on the ventricle, for the outermost and the innermost reach farthest towards apex and base; and the second external and its corresponding inner layer (sixth) extend farther than the third and the fifth. The fourth is the shortest of all. Consequently the wall is thickest about the middle third where all the layers are present, and gradually becomes thinner upwards and downwards, until there is only the outermost layer at the apex; and two at the base, viz. the most external and internal (1st and 7th). (Pettigrew, Phil. Trans. 1864.) **Layers of left ventricle. Number. Arrangement. Extent. Wall thickest, and thinnest.**

Direction of the fibres. Each stratum is formed of fleshy fibres with the undermentioned direction, supposing the ventricle standing on the apex, and the anterior surface towards the dissector. **Direction of fibres**

In the three external strata (1, 2, 3, fig. 70,) the fibres are inclined downwards from the base and septum to the apex of the ventricle, and become less vertical in each. **in the three outer,**

The fourth or mid layer (4) possesses transverse fibres; and it is nearer the outer than the inner surface of the wall. **middle,**

In the three inner strata the fibres change their direction, as is shown at 5, in fig. 70, and are directed upwards from the apex and septum to the base or the left auriculo-ventricular opening of the ventricle; so that they cross the fibres of the outer layers like **and three inner layers.**

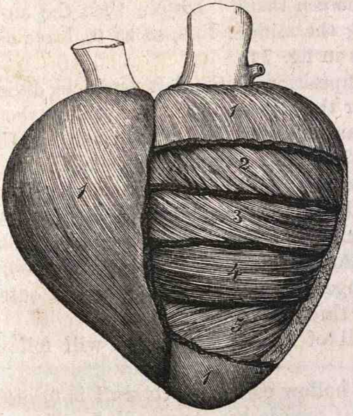
the legs of the letter X, and, becoming more oblique in each layer, are almost vertical in the internal.

Fibres continuous

Continuity of the fibres. With a piece of muscle rolled into a cone, as before said, the fibres of the different layers would be necessarily continuous at the apex; but in the heart they are united at apex and base. Thus the outermost layer is continuous at the apex and base with the innermost, the fibres being curved in at the tip and out at the base. In like manner the fibres of the second layer are united with those of the sixth, and the third stratum with the fifth.

at apex and base.

Fig. 70.*



Spiral course

Each of the three outer layers consists of two sets of fibres, which occupy the front and back of the ventricle. The anterior set issuing from the fore part of the septum-ventriculorum and the front and inner portion of the auriculo-ventricular opening, enter the apex posteriorly to end in the anterior wall of the ventricle. The posterior set, connected with the back of the septum and the posterior and outer part of the auriculo-ventricular aperture, wind forwards at the apex, and entering at that spot, terminate in the hinder portion of the ventricular wall. By the turning inwards of the two bundles on opposite sides of the apex, the wall is prevented from having a slanting side, like a piece of paper rolled into a cone.

in three outer layers

entering apex.

The common fibres behind.

Many of the fibres of the outer layers are attached in addition to the fibrous ring around the aorta; and from the three outer layers fibres are continued to the right ventricle at the back of the heart, forming the "common fibres."

Course in three inner

Each of the three inner layers is resolved above into two sets of fibres (anterior and posterior) which are inclined outwards at the base of the ventricle, and join, layer with layer, the anterior and posterior fibres in each of the three outer strata. In this way the sides of the auriculo-ventricular opening are made level like those of the apex.

* A diagram of the arrangement of the fibres in layers in the left ventricle.—1. First or external layer. 2. Second external. 3. Third external. 4. Central layer. 5. The outermost of the three inner strata.

The middle or fourth layer possesses also two sets of fibres; one is continued into the septum, and the other is connected with the auriculo-ventricular aperture. in central layer.

Dissection. To display the layers and fibres of the right ventricle, great care will be needed because of the thinness of the wall. The same number of layers exists in this, as on the other side of the heart, but they are not so thick. To show composition of right ventricle.

Make a vertical cut along the anterior aspect from the root of the pulmonary artery to the apex of the ventricle; and reflect forwards and backwards from that incision the several layers. As the three outer are raised let them be traced on the one hand into the part of the septum detached from the left ventricle; and on the other into the left ventricle through the continuity of the common fibres behind.

The RIGHT VENTRICLE possesses seven layers in its wall, like the left, though they are much thinner. They are arranged as in the other ventricle into three external, three internal, and a fourth or intermediate. In like manner the wall diminishes from the centre towards the base and apex, but at the tip it is thicker than the apex of the left half of the heart (Pettigrew). Number of layers. Thickness.

Direction of the fibres. The same change in the course of the fibres of the different layers takes place in this as in the other ventricles. Direction of fibres

In the three outer layers the fibres run down from the auriculo-ventricular opening to the fore part of the septum and the apex of the heart. The outer being most vertical. in three outer,

In the fourth stratum the fibres have a transverse direction, as in the corresponding layer of the fifth ventricle. central,

And in the three inner layers they are directed upwards from the apex to the base of the ventricle across the fibres of the three outer strata, the deepest being the most vertical. and three inner layers.

Continuity of the fibres. In the three outer layers the fibres are prolonged in each from the auriculo-ventricular opening, and from the "common fibres" behind and the septum. They are then continued forwards to the front of the septum ventriculorum, where they leave the surface, and bending back construct the right part of the septum: at the back of that partition they decussate with the fibres of the left ventricle, and blend with the "common fibres." At the apex they do not enter in a whorl as in the left ventricle; but at the base they are continuous with the three inner layers as on the other side of the heart. Course of the fibres in outer layers not spiral at apex.

Many of the fibres of the external layer are attached to the ring of the pulmonary artery; and the narrow slip from the right to the left ventricle, near the base in front, receives its fibres from the two outer strata. Common fibres in front

The fibres of the three outer layers form by their course one loop of a figure of eight, as if there had been originally one com- arranged in single loop.

mon cavity in the heart—the left ventricle, from which the right had been detached during the growth by a pushing inwards of a partition from the fore part.

Course in central,

The fourth layer fibres are continuous for the most part with the "common fibres" crossing the posterior groove.

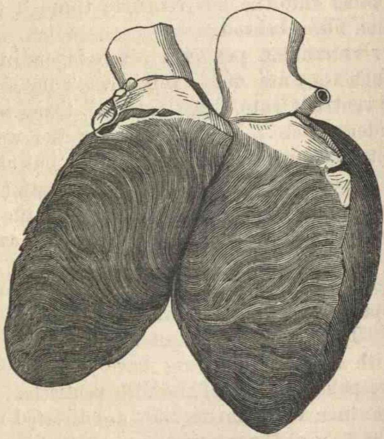
and inner layers.

The fibres of the three inner layers turn outwards at the base to join the three outer; but they are not continued into the left ventricular strata.

Septum of ventricles.

Septum ventriculorum. This partition between the two cavities has been divided anteriorly into a right and left part by the

Fig. 71.*



previous dissection; and the layers of the ventricles may be traced into them.

How formed.

The septum is formed by the fibres of both ventricles, and is rather thicker than the wall of the left ventricle. About one-third belongs to the right side, being joined by fibres of the right ventricle, and two-thirds are constructed by the left ventricle.

Course of fibres.

Where the two parts touch the fibres mingle and decussate; and altogether behind lie the common fibres of the two ventricles, which interlace with those of the right cavity.

Lining membrane of the heart

Endocardium. Lining the interior of the cavities of the heart is a thin membrane, which is named endocardium in opposition to the external investment or pericardium. It is continuous on the one hand with the lining of the veins, and on the other with

forms folds in the inte-

that of the arteries. Where the membrane passes from an auricle to

* The formation of the septum ventriculorum by the fibres of both ventricles is represented in this cut.

a ventricle, or from a ventricle to an artery, it forms duplicatures or valves, in which fibrous tissue is enclosed; and in the ventricles it covers the tendinous cords of the valves, and the projecting muscular bundles. rior containing fibrous tissue.

The thickness of the membrane is greater in the auricles than in the ventricles, and in the left than the right half of the heart. In its structure it resembles a serous membrane. Thickness and structure.

Great Vessels of the Heart. The arteries which take origin from the heart are the aorta and the pulmonary. The large veins entering the heart, besides the coronary, are the superior and inferior cava, and the pulmonary. Vessels of the heart.

The pulmonary artery is a short thick trunk, which conveys the dark or impure blood from the right side of the heart to the lungs. From its commencement in the right ventricle the vessel is directed upwards on the left of the aorta; and at a distance of an inch and a half or two inches from its origin, it divides into two branches of nearly equal size for the lungs. The trunk of the pulmonary artery is contained in the pericardium; and beneath it is the beginning of the aorta, together with the left auricle. On each side are the coronary artery and the auricular appendix. The pulmonary artery divides into two for the lungs Connections.

Near the bifurcation of the artery is a small ligamentous cord, the remnant of the arterial duct, which passes from the left branch of the vessel to the arch of the aorta, and is named ligamentum ductûs arteriosi. Ligament of arterial duct.

The *right branch* is longer than the left. In its course to the lung it lies beneath the aorta and the vena cava superior, and rests on the bronchus or piece of the air tube: and as it passes outwards it lies above the level of the right auricle of the heart. At the lung the artery divides into three primary branches, one for each lobe. Right branch is longest.

The *left branch* is rather smaller than the right; it is directed in front of the descending aorta and the left bronchus to the fissure of the root of the lung, where it divides into two branches for the two pulmonic lobes. Left branch.

As the right and left branches of the pulmonary artery pass outwards, they cross the tubes resulting from the division of the trachea, and enclose with them a lozenge-shaped space which contains some bronchial glands. Space at the bifurcation.

Ductus arteriosus. In the fetus the part of the pulmonary artery which is now ligamentous, was part of the trunk, and was larger than either branch to the lung. At that period the large vessel receives the name arterial canal or duct (ductus arteriosus, Botalli), and opens into the aorta rather beyond the origin from the arch of the last great vessel of the head and neck. Condition of the artery in the fetus.

As the lungs do not give passage to the mass of the circulating fluid before birth, the impure blood in the pulmonary Use.

artery passes through the arterial duct into the aorta below the attachment of the vessels of the head and neck, in order that it may be transmitted to the placenta to be purified. But after birth, when the function of the lungs is established, the current of blood is directed along the branches of the pulmonary artery instead of through the arterial duct; and this tube becoming gradually smaller, is obliterated before the eighth or tenth day, and forms finally the ligament of the arterial duct.

This great vessel extends

The AORTA is the great systemic vessel which conveys the blood from the heart to the different parts of the body. The vessel arches backwards at first to reach the spinal column, and is continued on the spine through the chest and abdomen. In the thorax the vessel is divided into two parts—arch of the aorta, and the descending or thoracic aorta.

through chest and abdomen.

Its first part is arched.

The extent

Arch of the aorta. The aorta has its origin in the left ventricle, close beneath, and internal to the junction of the cartilage of the third rib of the left side with the sternum. From that point it ascends, curving backwards over the windpipe and the gullet to the left side of the spinal column, and forms an arch which ceases at the lower border of the body of the third dorsal vertebra. The arch has its convexity upwards and to the right, and its concavity to the root of the left lung; and from it the large vessels for the supply of the upper part of the body take their origin. For the purpose of reducing to order the numerous connections of this portion of the aorta, it is divided into three parts—ascending, transverse, and descending.

and divisions of the arch.

First part:

The *first* or *ascending part* is about two inches in length, or slightly more, and is directed upwards behind, and close to the sternum: it reaches as high as the upper border of the cartilage of the second rib on the right side, and is contained nearly altogether in the pericardium. At first the pulmonary artery is superficial to the aorta; but, as the vessels take different directions, the latter is soon uncovered, and remains so to its termination. Behind it are the right branches of the pulmonary vessels. On the right side is the descending cava; and on the left, the pulmonary artery. Near the heart the vessel bulges opposite the semilunar valves; and there is sometimes another dilatation along the right side, which is named the great *sinus* of the aorta. Two coronary arteries arise from the swellings first alluded to.

length and connections.

Gives origin to coronary arteries.

Second part is transverse.

The *second* or *transverse portion* recedes from the sternum, and reaches from the second right costal cartilage to the left side of the body of the second dorsal vertebra. It rests upon the trachea above its bifurcation, as well as over the œsophagus and the thoracic duct. Lying in front of this part of the artery is the left upper intercostal vein, with the pneumo-gastric, phrenic, and superficial cardiac nerves of the left side; the first nerve sends backwards its recurrent branch beneath the vessel. Along

Connections.

the upper border is the left innominate vein; and to the lower border near the termination, the remnant of the arterial duct is attached. From this part arise three great vessels of the head and the upper limbs. Gives origin to large vessels.

The *third* or *descending part* of the arch is very short, extending only from the second to the lower edge of the third dorsal vertebra. It lies against the third vertebra, and the fibro-cartilage between this and the second; and it is covered by the pleura of the left side of the chest. Third part is without branches.

In the concavity of the arch of the aorta are contained the left auricle of the heart, the root of the left lung, the branching of the pulmonary artery with its arterial duct, and the left recurrent nerve. Deeper than these parts will be situate the œsophagus and the thoracic duct, with some lymphatic glands. Parts contained in the arch.

The *branches* of the arch of the aorta are five in number; two come from the ascending, and three from the transverse part. The first two are the coronary arteries of the heart, which have been already noticed (p. 356). The other three are much larger in size, and supply the neck, the head, and the upper limbs. First on the right is the large trunk of the innominate artery; close to it is the left carotid; and last of all comes the left subclavian, which is distant a short space from the preceding vessel. Five branches of the arch: two coronary, innominate, carotid, subclavian.

Peculiarities. The exceptions to the usual condition of the arch of the aorta, which the student may expect to find, are the following:— Peculiarities.

Height. The arch reaches commonly to about an inch from the upper part of the sternum, but it may ascend nearly to the top of that bone, or stop an inch and a half or more from it. Height and

Direction. Sometimes the aorta is arched over the root of the right instead of the left lung, as in birds; and is directed afterwards to its usual place on the spinal column, without change in the position of the other viscera of the body. Or, all the viscera of the cavities of the thorax and abdomen being transposed, the arch of the aorta may share the general disturbance in position. direction of the arch.

Position and *arrangement of branches.* The large branches of the neck may have their usual origin (the highest part of the arch) moved more to the right; or their distance from one another may be increased or diminished. Position of the primary branches;

When there is transposition of the arch there is likewise a change in the arrangement of the branches;—the innominate artery supplying the left side, and the carotid and subclavian vessels of the right side having separate attachments to the arch. transposition.

Occasional branches. Some smaller or *secondary arteries* take origin occasionally from the arch. The left vertebral artery arises most frequently from the arch, and is situate either between the left carotid and subclavian trunks, or beyond them. Occasionally the thyroid artery (lowest thyroid), or the right internal mammary, or both vertebrals, will be seen to spring from the arch of the aorta. Number increased by secondary branches.

The INNOMINATE ARTERY (brachio-cephalic) is the first and largest of the three branches, and measures from one inch and a Innominate artery ends in carotid and subclavian.

half to two inches in length. Ascending to the right beneath the sternum, it divides opposite the sterno-clavicular articulation into the right common carotid and the subclavian artery.

Length and connections.

The artery is crossed by the left innominate vein, and lies behind the upper piece of the sternum, and the origin of the hyoid and thyroid muscles. At first it rests on the trachea, but as it ascends it is placed on the right side of the air tube. On its right is the innominate vein of the same side, with the phrenic nerve. Usually no lateral branch arises from the artery.

Length may be altered;

Peculiarities. The *length* of the artery may exceed two inches, or it may be only one inch or less : in these different states the place of bifurcation will be altered, being in the one case beyond, and in the other below the level of the upper border of the clavicle.

branches from it.

Branches. The left carotid is frequently joined with this artery at its origin. Or a branch to the thyroid body (art. thyroidea ima), or to the thymic body, or to the root of the lung, may arise from it.

Position.

Position. The innominate artery belongs to the left side of the neck in cases of transposition of the arch.

Left common carotid arises from arch of aorta.

Left Common Carotid Artery. The common carotid artery of the left side of the neck is longer than the right by the distance between the arch and the top of the sternum.

Connections in the thorax.

In the thorax the artery ascends obliquely to the left sterno-clavicular articulation, but not close to the first piece of the sternum and the origin of the depressor muscles of the hyoid bone and larynx. In this course it passeth beneath the left innominate vein, and the remains of the thymus gland. At first it lies on the trachea, but it crosses afterwards to the left of that tube, so as to be placed over the œsophagus and the thoracic duct. To its outer side is the left vagus, with one or more cardiac branches of the sympathetic nerve.

In the neck the connections of the vessels of opposite sides are the same (p. 125).

Peculiarities in its origin.

Peculiarities in origin. The carotid is sometimes united with the innominate artery. Should the innominate artery be absent, the common carotids, right and left, arise usually by one trunk. Its junction with the left subclavian is rare, except with transposition of the arch.

In position.

In position. It seldom changes its relative position with respect to the other branches of the arch ; but if this is altered it tends generally towards the right.

Left subclavian artery.

The left subclavian artery ascends to the neck through the upper aperture of the thorax. Beyond the first rib the vessels of opposite sides are alike (p. 124).

Course and connections in the thorax.

The trunk is directed almost vertically from the arch of the aorta to the inner margin of the first rib. In the thorax the vessel lies deeply, resting at first on the œsophagus, and afterwards on the vertebral column and the longus colli muscle. It is invested by the left pleural bag in all its extent. On its inner side are the trachea and œsophagus, with the thoracic duct. Somewhat anterior to the level of the artery, though running in the same direction, are the vagus nerve and some of the cardiac nerves.

Peculiarities in origin. The left subclavian varies less than the other branches of the arch. Occasionally it arises in common with the left carotid, when the arch has its usual direction. Should there be transposition of the arch, the subclavian springs usually from an innominate trunk : but this is not a constant rule, for the subclavian, in such a condition of the vessels, may be the last on the arch, like the right, and cross the front of the spinal column to take its place in the neck. It may take origin, though rarely, from a dilatation connected with the remains of the arterial duct.

Variations in its origin not frequent.

Right artery from the arch. In some instances the right subclavian arises from the aorta ; and it may be placed first, second, or third, though most frequently it is last on the arch. To reach the inner margin of the first rib of the right side, when it is last on the arch (most to the left), the artery is directed between the œsophagus and the vertebral column ; or it may be, as in one instance, between the trachea and the œsophagus. The right subclavian may be also connected with a pouch,—the pervious part of the ductus arteriosus, in the same way as the left subclavian. (See the work of Mr. Quain, "The Arteries," &c., p. 159.)

Right subclavian may arise from the arch.

Its course.

VEINS OF THE HEART. In addition to the cardiac veins (p. 356), there are the superior and inferior cava, and the pulmonary veins :—the former are the great systemic vessels which return impure blood to the right auricle ; and the latter convey pure blood from the lungs into the left auricle.

Veins of the heart are

The SUPERIOR OR DESCENDING CAVA results from the union of the right and left innominate veins, and brings to the heart the blood of the head and neck, upper limbs, and thorax.

superior cava ;

Its origin is placed on the right side of the sternum, opposite the interval between the cartilages of the first two ribs. From that spot the large vein descends to the pericardium, perforates the fibrous layer of that bag about one inch and a half above the heart, and ends in the right auricle. On its outer surface the vein is covered by the pleura, and the phrenic nerve is in contact with it. To the inner side is the ascending part of the arch of the aorta. Behind the vein is the root of the right lung.

formed by innominate veins ;

ends in heart.

Connections.

When the cava is about to perforate the pericardium it is joined by the large azygos vein of the thorax ; and higher up it receives small veins from the pericardium, and the parts in the mediastinal space.

Its branches.

The *innominate veins* are united inferiorly in the trunk of the descending cava. They are two in number, right and left ; and each is formed near the inner end of the clavicle, by the union of the subclavian and internal jugular veins of the same side of the neck. The trunks differ in length and direction, and in their connections with the surrounding parts.

Innominate veins are right and left.

How formed.

The *right* vein is about one inch and a half long, and descends

Right, an

inch and a half long; vertically, on the right side of the innominate artery, to its junction with the vein of the opposite side. On the outer surface the pleura covers it, and along it the phrenic nerve is placed.

left, twice as long and oblique in direction. The *left* vein is twice as long as the right, and is directed obliquely downwards above the level of the arch of the aorta, to join its fellow in the superior cava. It crosses behind the sternum, and the remains of the thymus gland; and it lies on the three large branches of the aortic arch, as well as on the several nerves descending over the arch.

Their branches. The *branches* of the veins are nearly alike on the two sides. Each receives the internal mammary, the inferior thyroid, and the superior intercostal of its own side; and the left vein is joined in addition by some small thymic and pericardiac veins.

Sometimes they open separately into the heart. Sometimes the innominate veins are not united in the vena cava, but descend separately to the heart, where both have distinct openings in the right auricle. When such a condition exists, the right vein takes the course of the upper cava; but the left vein descends in front of the root of the left lung, and turning to the back of the heart, receives the cardiac veins, before it opens into the right auricle. A cross branch is found connecting the two above the heart.*

This usual in fetus. This occasional condition in the adult is a regular one in a very early period of the growth of the fetus; and two vessels are also persistent in some mammalia.

How two are changed into one. *Change of the two veins into one.* The changes that take place in the veins during the growth of the fetus, to produce the arrangement common in the adult, concern the trunk on the left side. The following concise description may serve as an outline of them. First the cross branch between the two trunks enlarges, and forms the future innominate vein. Next the left trunk below the cross branch disappears at its middle, and undergoes transformations at each end:—At the upper end it becomes converted into the superior intercostal vein. At the lower part it remains pervious for a short distance as the coronary sinus; and even the small oblique vein opening into the end of that sinus in the adult (p. 356), is a remnant of the part of the trunk of the vein that lay beneath the heart.

Forms coronary sinus.

Vestige in the pericardium. Mr. Marshall finds in the adult another vestige of the occluded vessel in the form of a fold of the serous membrane of the pericardium in front of the root of the left lung; this he names the *vestigial fold* of the pericardium (p 353).

Inferior cava. The INFERIOR OR ASCENDING CAVA enters the right auricle as soon as it has pierced the diaphragm. No branches join the vein in the thorax. The anatomy of this vein will be given with the vessels of the abdomen.

* An example of two large vessels, "double vena cava," opening into the right auricle in the adult, has been presented to the College Museum by Dr. Sharpey. An excellent treatise by Mr. Marshall on the development of the veins of the neck is published in the "Philosoph. Trans." for 1850.

The PULMONARY VEINS are two on each side. They issue from the fissure of the root of the lung, and end in the left auricle: their position to the other vessels of the root has been noticed at p. 351. Four pulmonary veins.

The right veins are longer than the left, and lie beneath the aorta and the right auricle of the heart. The superior receives its roots from the upper and middle pulmonic lobes, and the inferior vein is formed by branches of the lower lobe. Right veins longest.

The left veins cross in front of the descending aorta; and one springs from each lobe of the lung. Left veins.

Peculiarities in number. The number of the pulmonary veins may be diminished on the left side by their union into one; or may be increased on the right side by the want of union of the three trunks corresponding with the three lobes of the lung. Their number varies:

But other peculiarities may be found as to number, for six or seven veins, taking both sides together, have been met with; and a bronchial vein has been found opening into one of the left veins.

In the ending. The veins of the right side have been observed in an adult to open into the vena cava. may open into the cava.

NERVES OF THE THORAX.

The pneumo-gastric and the sympathetic nerves supply the viscera of the thorax. Through the cavity courses the phrenic nerve to the diaphragm. Nerves of the thorax.

Dissection. The phrenic nerve is sufficiently denuded for its examination; but the student should trace the vagus nerves through the thorax. To trace the nerves,

The vagus is to be followed, on both sides, behind the root of the lung, and its large plexus in that position is to be dissected out: a few filaments of the gangliated cord of the sympathetic coming forwards over the spinal column to the plexus, must be looked for. In front of the root, the nerve supplies a few pulmonary filaments, especially on the left side. Beyond the root the vagus is to be pursued along the œsophagus, by raising the lung and removing the pleura. particularly vagus.

The PHRENIC NERVE is a branch of the cervical plexus to the diaphragm (p. 78). In its course through the thorax it lies along the side of the pericardium, and at a little distance in front of the root of the lung, with a small companion artery. When near the diaphragm it is divided into branches: these perforate the fleshy fibres, and are distributed on the under surface. The nerves of opposite sides differ in length, and in their connections above the root of the lung. Phrenic nerve is derived from the cervical plexus, and passes through thorax to the diaphragm.

The *right* nerve is deeper at first in its position, and is also shorter and straighter than the left. In entering the chest it crosses behind the subclavian vein, but in front of the internal mammary artery; and it lies afterwards along the right side of Right nerve above root of lung.

the innominate vein and superior cava till it reaches the root of the lung.

Left nerve above root:

The *left* nerve crosses the subclavian artery, but has the same position as the right to the mammary vessels, when entering the cavity. In the thorax it is directed in front of the arch of the aorta to the root of the lung, and makes a curve lower down around the projecting heart. Before reaching the arch of the aorta the nerve is placed external to the left common carotid artery; and crosses the left vagus from without inwards, so as to be internal to that nerve on the arch.

is longer than right.

Some offsets.

Branches. Some small filaments are said to be furnished from the nerve to the pleura and pericardium; and occasionally the nerve is joined, near the upper part, by a twig from the nerve of the subclavius muscle.

Internal mammary artery

Internal mammary artery. A small part of this artery, which lies beneath the first rib, and winds round the phrenic nerve and the innominate vein to reach the side of the sternum, is now to be learnt. It gives the following offset:—

gives phrenic branch.

The *superior phrenic branch* (comes nervi phrenici) is a very slender artery, which accompanies the phrenic nerve to the diaphragm, and is distributed to that muscle, anastomosing therein with other branches from the aorta and the musculo-phrenic branch of the internal mammary.

Vagus nerve corresponds on both sides below root of lung.

The PNEUMO-GASTRIC CRANIAL NERVE (p. 116) passes through the thorax in its course to the abdomen. In the lower part of the thorax the nerves of opposite sides have a similar position, for they pass behind the root of the lung, each on its own side, and along the œsophagus to the stomach. But above the root of the lung, the right and left nerves differ much. Each supplies branches to the viscera, viz. to the heart, the windpipe and lungs, and the gullet.

Right vagus above the root,

The *right* vagus is posterior to the left in position. As the nerve appears in the thorax, it passes between the subclavian artery and the innominate vein. In the cavity it is directed obliquely backwards, over the side of the trachea, to the interval between this tube and the œsophagus: thus supported, the nerve reaches the posterior aspect of the root of the lung, where it gives rise to the posterior pulmonary plexus. From the plexus two large offsets are continued to the œsophagus, and unite near the diaphragm into one trunk, which passes behind the gullet to the posterior surface of the stomach.

and on the back of the œsophagus.

Left nerve above root of lung,

The *left* nerve enters the thorax to the outer side of the left common carotid artery, and courses between this and the left subclavian artery over the arch of the aorta. Next it is placed beneath the root of the lung, and forms there a larger plexus than on the right side. From the pulmonic plexus one or two branches pass to the front of the œsophagus, and join with cor-

and on front of the œsophagus.

responding branches of the right nerve in a plexus on that tube; but the pieces of the nerve are collected finally into one trunk, which is continued on the front of the œsophagus to the anterior part of the stomach.

The *branches* of the pneumo-gastric nerve in the thorax are the following:— **Branches are,**

The *recurrent* or *inferior laryngeal* nerve, arising on the right side on a level with the subclavian artery, and on the left at the lower border of the arch of the aorta, bends backwards to the trachea, along which it ascends to the larynx. On each side this branch is freely connected with the cervical cardiac branches of the sympathetic nerve, especially on the left side beneath the arch of the aorta. **recurrent laryngeal.**

Cardiac branches (thoracic). Besides the cardiac branches furnished by the vagus in the neck, other offsets are sent in front of the trachea to communicate with the cardiac plexus. On the right side they come from the trunk and the recurrent branch of the nerve, but they are supplied by the recurrent nerve alone on the left side. **Cardiac branches;**

The termination of the lower *cervical cardiac branch* of each vagus nerve (p. 118) may be now seen. The branch of the right vagus lies by the side of the innominate artery, and joins a cardiac nerve of the sympathetic of the same side from the neck; and the branch of the left vagus crosses over the arch of the aorta, to end in the superficial cardiac plexus. **lower cervical cardiac branch.**

Pulmonary branches. There are two sets of nerves for the lung, one on the anterior and the other on the posterior aspect of the root. **Pulmonary branches.**

The anterior branches are two or three in number, and small in size, and communicate with filaments of the sympathetic on the pulmonary artery: these nerves are best seen on the left side. **Small anterior.**

The posterior branches are the largest and much the most numerous. Forming a plexiform arrangement (posterior pulmonary plexus) behind the root of the lung by the flattening and splitting of the trunk of the nerve, they are joined by filaments from the third and fourth ganglia of the knotted cord of the sympathetic, and are conveyed into the lung on the divisions of the air tube. **Large posterior form a plexus.**

Œsophageal branches are furnished to the gullet all along the thorax, but in greatest abundance in the lower half. Below the root of the lung the branches of the pneumo-gastric nerves surround the œsophagus with a network, which has been named *plexus gulæ*. **Œsophageal branches form a plexus.**

Sympathetic Nerve. In the thorax the sympathetic nerve consists of a knotted cord along each side of the spinal column, which communicates with the spinal nerves: and of a large **Sympathetic in thorax consists of** prevertebral or cardiac plexus, which distributes branches to the heart and the lungs.

a gangliated cord,

The gangliated cord will be seen in a future stage of the dissection, after the heart and the lungs have been removed.

and a central cardiac plexus.

The CARDIAC PLEXUS lies at the base of the heart around the great bloodvessels. A part of this network, the superficial cardiac plexus, has been already described (p. 357). The remaining part, or the deep cardiac plexus, will be perceived beneath the arch of the aorta by means of the dissection given below.

Dissection of the plexus.

Directions. The cardiac plexus has been injured by the previous examination of the heart; but, by following the directions now given, the student will obtain such a knowledge of the nerves as will enable him to make a complete dissection of them before the heart is injured, when the opportunity offers.

To find the right part.

Dissection. The arch of the aorta is to be cut across near the heart and close above the pulmonary artery, and is to be drawn over to the left side without destroying the left upper intercostal vein: next, the upper cava is to be divided above the entrance of the vena azygos, and its lower part is to be thrown down. By the removal of some fibrous and fatty tissues and lymphatic glands, the right part of the plexus, in which the cervical branches of the sympathetic and pneumo-gastric nerves of the right side are united, will be seen in front of the trachea, above the right branch of the pulmonary artery. The offsets to the heart should be followed downwards on the trunk of the pulmonary artery; and those to the lung should be traced along the right branch of that vessel.

To expose the left.

To lay bare the part of the plexus into which enter the cervical branches of the sympathetic and vagus nerves of the left side of the body, the arch may be cut through a second time, to the left of the junction of the ligamentum arteriosum with it; and that ligament is to be divided, so as to allow the transverse part of the arch to be turned upwards with the great vessels attached. The lymphatic glands and the areolar and fatty tissue being cleared away from the plexus as on the opposite side, the nerves are to be followed downwards, chiefly to the posterior coronary plexus of the heart.

Deep cardiac plexus.

Its situation;

Deep cardiac plexus. This large centre is situate between the trachea and the arch of the aorta, above the branches of the pulmonary artery. In it are united the cardiac nerves of the ganglia of the sympathetic of both sides of the neck, except the highest nerve of the left side: and all the cardiac branches of the vagus nerves in the neck and chest, with the exception of the lowest cervical cardiac branch of the left side. From it nerves are furnished to the heart and lungs.

two parts, right and left.

The several nerves entering the plexus are not intermingled in a ganglionic mass in front of the trachea; but those of the right side unite together on the corresponding part of the air tube, and those of the left half of the neck have a like junction on their side.

The *right* part of the plexus is placed above the right branch of the pulmonary artery, and receives the nerves of the right side, viz. the cardiac nerves of the sympathetic in the neck; the cardiac branches of the trunk of the vagus, both in the neck and chest; and the cardiac offsets of the recurrent branch. Right part, how formed.

The branches of this half of the plexus are distributed mostly to the right side of the heart, and pass downwards before and behind the right branch of the pulmonary artery: those in front running on the trunk of the pulmonary artery to end in the anterior coronary plexus (p. 357); and the nerves behind supply the right auricle of the heart. Offsets are also sent laterally on the branch of the artery to the root of the lung. Branches to anterior coronary plexus. A few go to root of lung.

The *left* half of the plexus lies close to the ligamentum arteriosum, and rather on the left of the trachea. In it are collected the cardiac nerves of the sympathetic ganglia of the left side of the neck, except the highest; and numerous and large branches of the left recurrent nerve of the vagus. Left part: nerves entering it.

Nerves descend from it to the heart around the left branch and trunk of the pulmonary artery, and after supplying nerves to the left auricle, terminate in the posterior coronary plexus (p. 358). A considerable offset is directed forwards by the side of the ligamentum arteriosum to the superficial cardiac plexus; and some nerves reach the left anterior pulmonary plexus by passing along the branch of the pulmonary artery. Offsets end in left coronary plexus and in root of lung.

Termination of the *cardiac branches* of the gangliated cord of *the sympathetic nerve* of the neck (p. 122). Entering the chest on each side, over or beneath the subclavian artery, they join the deep cardiac plexus, with the exception of the left superficial cardiac branch. Other cardiac nerves from the neck.

On the right side. Usually there are only two cardiac nerves entering the thorax on this side, for the highest nerve is blended commonly with one of the others. The middle and inferior nerves pass beneath the subclavian artery to the right half of the deep cardiac plexus: they communicate with the branches of the recurrent laryngeal nerve of the vagus at the root of the neck, or in the upper part of the thorax, as well as with one another. Two right enter deep plexus.

On the left side the superficial or highest cardiac nerve passes for the most part over the arch of the aorta, and ends in the superficial cardiac plexus; it may give a branch beneath the arch to the deep plexus. Only one other nerve may be seen entering the left side of the deep cardiac plexus, for oftentimes the middle throws itself into the lower cardiac nerve. One left enters superficial, others the deep plexus.

THE TRACHEA AND THE LUNG.

To see the trachea and its divisions. *Dissection.* To see the bronchi or the divisions of the air tube in the root of the lung, it will be necessary to remove the pulmonary artery with its branches, and the pulmonary veins. When the transverse part of the arch of the aorta, which has been already cut through, is turned to one side, the dissector will be able to clear away the bronchial glands, the nerves, and the fibrous tissue from the part of the trachea in the thorax, and from the branches into which it bifurcates.

Trachea ends in bronchi. The TRACHEA, or the air tube, reaches from the larynx to the lungs, and lies on the front of the spinal column. The tube begins at the lower end of the larynx, opposite the fifth cervical vertebra; and it ends commonly at the third dorsal vertebra by dividing into two pieces (bronchi), one for each lung; but its point of splitting may be a vertebra lower.

In the neck. Its connections in the neck are described at p. 126, and its structure at p. 176. The part in the thorax remains to be studied.

Its connections in the thorax. In the thorax the trachea is situate with the great vessels in the space between the pleural bags. Here it is covered by the arch of the aorta, by the innominate and left carotid arteries, and by the cardiac plexus of nerves. Behind the air tube is the œsophagus, which is slightly inclined to the left near the arch of the aorta. On the right side are the vagus, and the innominate artery for a short distance after this has passed over the trachea; and on the left side lie the left subclavian artery, and the vagus with its recurrent branch.

Bronchi lie in the roots of the lungs; are like the trachea in form. The *bronchi*, or the branches of the air tube, are contained in the roots of the lungs, and are surrounded by vessels, glands, and nerves. Near the lung each is divided into as many primary pieces as there are lobes. In their structure and form the bronchi resemble the windpipe, for they are round and cartilaginous in front, but flat, and muscular and membranous behind. Their position behind the other pulmonary vessels has been described at page 351; but the characters of each are now to be noticed.

The right differs from the The *right* branch is about an inch in length, and is larger than the left; it passes outwards, on a level with the fourth dorsal vertebra, beneath the arch of the aorta and the upper cava, and above the right pulmonary artery: the vena azygos arches over it.

left branch. The *left* branch, about two inches long, is directed obliquely downwards through the arch of the aorta, and joins the root of the left lung a vertebra lower than on the opposite side. In this

Course and connections. course the tube lies on the œsophagus and thoracic duct, and the descending aorta; it is at first below the level of the corresponding pulmonary artery.

Dissection. The lungs are to be removed now from the body in order that their physical characters and their structure may be learnt: they can be detached as soon as the vessels of the root are cut through.

Remove the lungs.

The remains of the heart and pericardium are to be taken away afterwards. For their removal the inferior cava is to be divided, and the pericardium to be detached from the surface of the diaphragm; in removing the pericardium, the dissector should be careful not to injure the parts contained in the interpleural space in front of the spine.

Take away heart and pericardium.

PHYSICAL CHARACTERS OF THE LUNG. The surface of the lung is smooth and shining, and is invested by the pleura. Through the serous covering the mass of the lung may be seen to be divided by septa, into small irregularly-sized pieces or lobules. On looking closely at it, especially at a thin margin, the texture will be perceived to be composed of minute cells.

Surface of lung is smooth; is marked by lobules and small cells.

The tint of the lung varies with age. In infancy the colour is a pale red; but in the adult the texture becomes grayish, and presents here and there dark gray spots or lines of pigment, whose shade deepens with increasing age, and becomes even black in old people. After death, the colour of the posterior border may be bluish-black from the accumulation of blood.

Colour varies with age. Accidental colour.

To the touch the lung is soft and yielding, and on a section the pulmonary substance will appear porous and spongy; but the lung which is deprived of air by pressure has a tough leathery feel. In the ordinary condition of the lung, slight pressure with the thumb and finger drives the air from the containing cells through the pulmonary structure, and produces the noise known as crepitation. If the lung contains serum, a frothy red fluid will run out when it is cut.

Consistence. Crepitation,

The texture of the lung is very elastic; this elasticity causing the organ to diminish greatly when the thorax is opened, and to expel air that may be blown into it.

and elasticity.

The specific gravity of the lung varies with the conditions of dilatation and collapse, or of infiltration with fluid. When the pulmonary substance is free from fluid, and filled with air, it floats in water; but when it is quite deprived of air it is slightly heavier than water, and sinks in that fluid. The weight of the lung is influenced greatly by the quantity of fluid or other material contained in its texture; ordinarily it varies from eighteen to twenty-one ounces, and the right lung is about two ounces heavier than the left. In the male the lungs are larger, and slightly heavier than in the female.

Specific gravity, and weight of the lung.

Dissection. By tracing the large branches of the bronchi, and the bloodvessels and nerves into the lung, the mode of branching of the air tubes will be apparent; and by inflating a part of the lung, the cellular structure may be seen. But the arrangement

Follow bronchi and vessels into the lung.

of the small air cells about their tube, and the disposition of the different vessels, cannot be ascertained without fine injections and a microscope.

Outline of the elements of the lung.

STRUCTURE OF THE LUNG. The spongy pulmonary tissue consists of minute recesses or cells, in which the smallest branches of the air tube terminate; and the mass of the lung is formed by the collection of those cells into small groups or lobules, and by the aggregation of the lobules into larger masses or lobes. Each lobule is distinct from its fellows, and is furnished with its air tube and nerves, and with its own set of vessels concerned in the function and nutrition.

Covering and uniting layers.

The parts of the lung are united by a serous covering, prolonged continuously over the surface; and by a subserous layer of areolar tissue which penetrates into the interior, subdividing it into pieces. These several parts are examined more in detail below.

Serous covering and areolar tissue.

Serous and subserous coverings. The coat derived from the pleura is thin and transparent, and forms an entire capsule for the lung, except at the root where the vessels enter. The subserous areolar layer contains fibres of elastic tissue, and not only covers the surface, but extends inwards, establishing the division of the mass into lobules: where it separates the lobules it is named interlobular tissue, and is free from fat.

Branches of the bronchi in the lung, till they end in cells.

Bronchial branches in the lung. When a bronchus is followed into the pulmonary structure it is found to divide generally in a binary order, and to diminish in size at each subdivision, until one terminal offset appertains to a lobule. In the lobule the tube has a diameter of $\frac{1}{50}$ to $\frac{1}{30}$ of an inch. When this last degree of diminution is arrived at, the tube gives origin to the air cells.

Difference in tubes in form.

The larger bronchial branches have the same composition as the trachea, but they are round in the lung, instead of being hemispherical as in the trachea. The smallest branches want some of the elements found in the larger bronchi; and those from which the cells spring are irregular in shape, appearing to be spaces amongst the cells rather than tubes with continuous walls.

Changes in air tube in the lung.

Changes in the bronchi. The modifications of the component parts of the bronchial divisions are the following:—The *pieces of cartilage*, which are arranged in a line in the trachea, become broken up in the smaller bronchial tubes, and are scattered over the wall as irregular fragments. Becoming thinner and smaller as the subdivision of the air tube proceeds, they at last disappear, and are absent from the terminal branches. The *fibrous* and *elastic* tissues of the bronchial tubes are continued to the air cells. In the small cell-bearing branches, the bundles of elastic tissue are diffused; and much diminished in strength, blend with

Pieces of cartilage.

Fibrous and elastic tissue.

the fibrous or areolar to form the wall. The *muscular fibres* of the back of the trachea are diffused over the inner surface of the smaller bronchi, where they have an annular arrangement; they extend beyond the limit of the pieces of cartilage, but they cease where the cells begin to be formed. The *mucous membrane* becomes thinner as it extends onwards in the bronchial pieces, and is finally continued to the cells, where it is transparent. Its epithelium is columnar and ciliated in the bronchial tubes, but is changed to squamous or laminar in the air cells. Muscular fibres. Mucous membrane.

Lobules and lobes. A lobule is a cluster of air cells around a terminal branch of the air tube. Varying in size and shape, the lobule is invested by areolar tissue, and possesses its own offset of the air tube, as well as distinct branches of vessels and nerves. The larger masses of the lung, viz. lobes, are produced by the aggregation of the lobules. Lobules, how formed. Lobes.

The *air cells* are the little recesses or dilatations connected with the smallest branches of the air tube. They are polyhedral in form, except on the surface of the lung, and are distinct one from another, save through the channel of the air passage. The cells are clustered in groups around the terminal branches of the air tube, with which they communicate by large orifices; and are situate along the sides and at the extremity. In size these small spaces vary from $\frac{1}{200}$ to $\frac{1}{70}$th of an inch, but they are larger on the surface and at the edges than in the deeper parts of the lung. The cell wall is formed by areolar and elastic tissue, and is lined by a transparent mucous membrane possessing laminar epithelium.* Beneath the mucous lining is a network of capillaries of the pulmonary vessels. Nature and form of the air cells; position on air tubes. Size. Structure.

VESSELS OF THE LUNG. Two sets of vessels are furnished to the lung, one being concerned in its function, the other in the nutrition. The vessels conveying blood to the lung to be aërated, and carrying that fluid away after it has been subjected to the respiratory process, are named pulmonary. The vessels connected with the nutrition of the texture are called bronchial. Vessels of the lung.

The *pulmonary artery* divides like the bronchus which it accompanies to the lobule. At the lobule the arterial branch is minutely subdivided, and its ramifications enter the interlobular fissure to end in the cell wall in the following way:—Over the bottom of the cell they form a very fine capillary network, and at the circumference they give rise to a circular vessel; and the circles of several cells (about twelve) communicate with each other. Pulmonary artery

The *pulmonary veins* begin in the vascular network before mentioned. The twigs issuing from the several lobules are and vein.

* Some good observers deny the existence of an epithelial lining to the cells.

destitute of valves, and are united in larger tubes which course to the root of the lung. Although the small lobular branches of the arteries remain separate from one another, the corresponding veins anastomose together.

Bronchial artery. The *bronchial arteries* enter the lung on the air tube, and supply deep branches to the bronchial tubes and the contiguous glands, to the large bloodvessels, and to the interlobular areolar tissue of the lung. On the smallest air tubes minute branches anastomose with offsets of the pulmonary arteries.

Superficial offsets. Superficial tortuous offsets of the artery ramify beneath the pleura, forming a capillary network.

Bronchial vein. The *bronchial vein* begins by roots corresponding with the superficial and deep branches of the artery. Leaving the lung at the root, the vein ends differently on opposite sides of the body (p. 387).

Pulmonary nerves. *Nerves and lymphatics.* The lung receives *nerves* from the vagus and the sympathetic, and the offsets follow the branches of the air tube, but their ending is uncertain. Remak describes small ganglia on the sympathetic filaments. The *lymphatics* of the Lymphatics. lung are both superficial and deep, and enter the bronchial glands at the root of the lung.

PARTS ON THE SPINE AND THE SYMPATHETIC CORD.

In front of the spinal column are the several parts lying in the interpleural space of the posterior half of the mediastinum, viz., the aorta, azygos veins, thoracic duct, œsophagus, and splanchnic nerves.

Dissection of thoracic duct, *Dissection.* The thoracic duct should be found first near the diaphragm; here it is about as large as a crow quill, and rests against the right side of the aorta: this slender vessel may be injected with tallow.

of other objects, The areolar tissue is to be cleared away from the different parts before mentioned; and the azygos or intercostal veins, one on the right and two on the left of the aorta, should be dissected. Next follow the thoracic duct upwards beneath the arch of the aorta, and along the œsophagus beneath the pleura, till it leaves the upper aperture of the thorax.

and of sympathetic. After raising the pleura also from the inner surface of the ribs, the gangliated cord of the sympathetic nerve will be seen lying along the side of the spinal column. Branches are to be followed outwards from the ganglia to the intercostal nerves; and others inwards over the bodies of the vertebræ, the lowest and largest of these forming the three trunks of the splanchnic nerves.

Thoracic aorta. Extent. The DESCENDING THORACIC AORTA is the part of the great systemic vessel above the diaphragm. Its extent is from the lower border of the third dorsal vertebra (the left side), where the arch ceases, to the front of the last dorsal vertebra.

Course, and connections. Contained in the interpleural space in front of the spine, the vessel is rather curved, lying at its upper part on the left, but below on the front of the spinal column. Beneath it are the vertebræ and the smaller azygos veins. In front of the vessel is the root of the left lung with the pericardium. On the left side it is covered throughout by the pleura; and on the right side are the œsophagus and the thoracic duct, though near the diaphragm the gullet is placed over the aorta.

Branches. The *branches* of the vessel are distributed to the surrounding parts, and are named from their destination, viz. bronchial, pericardial, œsophageal, mediastinal, and intercostal.

Arteries of the lung. The *bronchial arteries* supply the structure of the lungs, but their number and place of origin are liable to vary. These vessels adhere to the posterior part of the bronchial tubes, and enter the lung, in which they ramify (p. 386); they give some twigs to the bronchial glands and the œsophagus. Distribution.

Two left, For the left lung there are two arteries (superior and inferior), which arise from the front of the aorta at a distance from each other.

one right. The artery of the right lung arises in common with one of the left bronchial arteries (superior), or from the first intercostal artery of the right side.

Vein of the lung. *Bronchial veins.* A vein issues from the root of each lung, and ends in the following manner:—the right joins the larger azygos vein; and the left ends in the superior intercostal vein of its own side.

Pericardial branches. The *pericardial branches* are some irregular twigs, which are furnished to the posterior part of the cardiac covering.

Œsophageal branches. *Œsophageal branches* arise at different points of the aorta, and are four or five in number. Ramifying in the gullet, the vessels anastomose with one another; above they communicate with branches of the inferior thyroid artery near the pharynx, and below, with twigs of the coronary artery of the stomach.

Mediastinal branches. Small *mediastinal branches* (posterior) supply the areolar tissue and the glands in the interpleural space.

Intercostal arteries. The *intercostal arteries* are commonly nine on each side, and are furnished to the same number of lower intercostal spaces: to the upper two spaces branches are supplied from the intercostal artery of the subclavian trunk. Number. These small vessels arise from the posterior part of the aorta, and run outwards on the vertebræ, beneath the cord of the sympathetic nerve, to the intercostal spaces, where each divides into an anterior and a posterior branch. Course to intercostal spaces. In this course the upper arteries have a somewhat oblique, and the lower a transverse direction; and as the aorta lies on the left of the spine the right vessels are the longest, and pass beneath the œsophagus, the thoracic duct, and the azygos vein. Right, longest. Many twigs are supplied to the bodies of the vertebræ on which they lie.

The anterior branch

The *anterior branch*, the larger of the two, continues onwards between the muscular strata nearly to the anterior third of the intercostal space, where it ends in two branches that anastomose with the intercostal arteries of the internal mammary (p. 270).

occupies intercostal space

At first the artery lies in the middle of the intercostal space, but near the angle of the rib it ascends to the upper boundary. It is placed beneath the pleura and a fascia between the intercostal muscles, and rests on the external intercostal layer.

with nerve and vein.

Accompanying the artery are the intercostal nerve and vein,—the vein being commonly above, and the nerve below it; but in the upper spaces the nerve is at first higher than the artery, though it soon takes its place below.

Offsets.

Branches are furnished to the layers of intercostal muscles and the ribs. About the centre (from front to back) of the intercostal space a superficial twig accompanies the cutaneous nerve.

Anastomoses.

The highest artery of the aortic set of intercostals anastomoses with the superior intercostal branch of the subclavian artery; and the lowest (below the true ribs) enter the abdominal wall, and anastomose with the arteries of that part.

Posterior branch turns to the back.

The *posterior branch* turns backwards between a vertebra and an ascending costo-transverse ligament, and is distributed in the back. As it passes by the intervertebral foramen it furnishes a small spinal branch to the vertebræ and the spinal cord. (See VESSELS OF THE SPINAL CORD.)

Intercostal vein.

The *intercostal vein* resembles closely the artery in its course and branching. Near the head of the rib it receives a contributing dorsal branch, and then joins an azygos vein.

Superior intercostal, subclavian.

The *superior intercostal artery* of the subclavian trunk is referred to in the dissection of the neck (p. 75). Descending over the neck of the first rib, external to the ganglion of the sympathetic, it supplies a branch to the first intercostal space: continuing to the second space, which it supplies in like manner, it ends by anastomosing with the upper aortic branch.

Supplies one or two spaces.

Each intercostal offset from it divides into an anterior and a posterior branch, like the arteries from the aorta.

Its vein

The *vein* accompanying the artery opens into the innominate vein of the same side.

on the right and left side.

On the left side the superior intercostal vein is formed by branches from the two or three highest spaces; it is joined by the left bronchial vein, and ends in the left innominate vein, after crossing the arch of the aorta.

Three azygos veins.

The INTERCOSTAL OR AZYGOS VEINS are two in number on the left, and one on the right side, and receive branches corresponding with the offsets furnished by the thoracic aorta.

Large azygos is on right side of spine,

The *right* or *larger azygos* begins in the lumbar veins on the right side of the spine, and its origin is described with the vessels of the abdomen. It enters the thorax through the aortic opening of the diaphragm, and ascends on the right side of the thoracic duct, over the intercostal arteries and the bodies of the vertebræ. Opposite the third intercostal space the vein arches forwards above the root of the right lung, and enters the superior cava as this vessel pierces the pericardium. Its valves are very incomplete, so that blood may flow either way; and the intraspinal and intercostal veins may be injected through it. and joins superior cava.

Branches. In this vein are collected the intercostals of the right side below the upper two spaces; some of the intercostals of the left side of the thorax, through the left azygos veins; and some small œsophageal, mediastinal, and vertebral veins, with the bronchial vein. Branches joining it.

By means of the right vein the inferior communicates with the superior cava, so that blood may reach the heart from the lower part of the body, or the opposite, if one of the cavæ should be obstructed. Use of vein.

The *left lower azygos vein* (smaller) begins in the abdomen in the lumbar veins of the left side of the vertebral column. Entering the thorax along with the aorta, or through the crus of the diaphragm, the vein ascends on the left of the aorta as high as the seventh or eighth dorsal vertebra, where it crosses beneath that vessel and the thoracic duct to end in the right azygos. It receives the four or five lower intercostal veins of the left side, and some œsophageal and mediastinal branches. Left lower, begins in abdomen, ends in larger azygos. Branches.

The *left upper azygos vein* (Breschet), is formed by offsets from the spaces between the superior intercostal and the highest branch of the lower azygos. Receiving three or four branches, the trunk either joins the lower azygos of its own side, or crosses the spine to open separately into the right vein. Left upper azygos vein.

The ŒSOPHAGUS or gullet is a hollow muscular tube which extends from the pharynx to the stomach. The cervical part of the tube has been described at page 127, and the thoracic part is now to be examined. Œsophagus

Entering the thorax rather to the left of the middle line, the gullet is directed beneath the arch of the aorta, and reaches the middle of the spine about the fourth or fifth dorsal vertebra. From that spot it is continued through the greater part of the interpleural space on the right of the aorta; but at the lower part of the thorax it takes a position over the aorta, to gain the œsophageal opening of the diaphragm. in the thorax where it lies in front of the spine, passes through diaphragm.

As far as the aortic arch the œsophagus lies beneath the trachea, though it is inclined somewhat to the left of the air tube; beyond the arch it is crossed by the left bronchus, and is concealed by the pericardium as far as the diaphragm. At the upper part of the thorax the gullet rests on the longus colli muscle and the vertebræ; but below the arch of the aorta it is separated from the spine by the intercostal vessels; and lastly it lies on the aorta. Laterally it touches the left pleura Parts covering it, beneath it.

above the arch, and both pleuræ below; but more on the right side than the left. Below the situation of the bronchus the pneumo-gastric nerves surround the œsophagus with their branches, and above the same spot the thoracic duct is in contact with it on the left.

and on sides.

Three coats are in it.

Structure. If a piece of the gullet be removed and distended with cotton wool, it will be easy to show a muscular, fibrous, and mucous coat, one within another.

A muscular coat of

voluntary and involuntary fibres.

The *muscular coat* is thick and strong, and consists of two layers of fibres; of which the external is longitudinal, and the internal circular in direction, like the muscular tunic of the other parts of the alimentary tube. In the upper third of the œsophagus the fibres are red, and have striated or voluntary muscular fibres mixed with involuntary; but below that spot the striated fibres gradually disappear, the colour becoming paler with their absence, and only involuntary muscular fibres remain.

External longitudinal

The *external layer* is formed of parallel longitudinal fibres, which form an entire covering, and end below on the stomach. The fibres begin opposite the cricoid cartilage (p. 138); and at intervals varying from half an inch to an inch and a half, they are connected with tendinous points ($\frac{1}{20}$ to $\frac{1}{10}$ of an inch long, and $\frac{1}{30}$ wide) like the fibres of the rectus abdominis muscle.

and internal circular fibres.

The *internal layer* of circular fibres is continuous above with the fibres of the pharynx; they are more oblique at the middle than at either end of the œsophagus.

Fibrous layer.

The *fibrous layer* is situate between the muscular and mucous coats, and attaches the one to the other loosely.

Mucous coat.

The *mucous coat* or lining will be seen, on cutting open the tube, to be firm, and reddish in colour above but pale below. It is very loosely connected with the muscular coat, and is thrown into longitudinal folds when the œsophagus is contracted.

Epithelium and papillæ.

Lining the interior is a thick layer of scaly epithelium; and the surface is studded with minute papillæ.

Some glands.

Some *compound glands* (œsophageal) are scattered along the tube; at the lower part of the gullet they are most numerous, and form a ring (cardiac) close to the stomach.

In the thorax, lymphatic glands and duct.

Lymphatics of the Thorax. In the thorax are lymphatic vessels of the wall and the viscera, which enter collections of glands, and end in one or other of the two lymphatic ducts. Besides these, the large thoracic duct traverses the thorax in its course from the abdomen to the neck.

Sternal glands.

Lymphatic glands. Along the course of the internal mammary artery is a chain of *sternal* or mediastinal glands, which receive lymphatics from the front of the chest, the thymus body, the pericardium, and the upper surfaces of the diaphragm and liver.

Intercostal.

On each side of the spine, near the heads of the ribs, as well as between the intercostal muscles, is a set of *intercostal* glands for the reception of the lymphatics of the posterior wall of the thorax.

Bronchial and cardiac. At the division and along the side of the trachea are numerous *bronchial* glands, through which the lymphatics of the lung pass; and beneath the arch of the aorta are a few *cardiac* glands, to which the lymphatics of the heart are directed.

Æsophageal. Along the side of the aorta and œsophagus is a chain of *œsophageal* glands, which are joined by the lymphatics of the œsophagus, and communicate with those of the lungs.

Thoracic duct begins in the abdomen and ends in neck. The *thoracic duct* is the main channel by which the lymphatic and lacteal fluid of the lower half of the body, and of the upper half of the left side of the body, is conveyed into the blood. The duct begins in the abdomen in an enlargement (chyli receptaculum), and ends in the left subclavian vein of the neck. It is about eighteen inches in length, and is contained in the thorax except at its origin and termination. It has the undermentioned connections :—

Connections in the thorax. Entering the cavity on the right of the aorta and through the same opening, the duct ascends on the right side of that vessel, as high as the arch. Opposite the second dorsal vertebra it passes beneath the aortic arch and the left subclavian artery, and is applied to the left side of the œsophagus, on which it is conducted to the neck. Lastly, at the lower part of the neck the duct arches outwards, as before described (p. 124), to open into the left subclavian vein.

May be divided. In this course the tube is oftentimes divided in two, which unite again ; or its divisions may even form a plexus. Near its termination it is frequently branched. Is furnished with valves. It is provided with valves at intervals, like a vein ; and these are in greatest number at the upper part. Occasionally the duct may be placed on the left instead of the right side of the aorta.

Receives most lymphatics. *Branches.* In the thorax the duct receives the lymphatics of the left half of the cavity, viz., from the sternal and intercostal glands; also the lymphatics of the left lung, left side of the heart, and trachea and œsophagus.

Right duct is in the neck. The *right lymphatic* duct, though not in the thorax, is formed mainly by the large branches received from the viscera of that cavity. It is a short trunk at the lower part of the neck, about half an inch in length, and opens into the angle of union of the subclavian and jugular veins of the same side (p. 76). Its opening is guarded by valves.

It receives lymphatics of one-fourth of the body. *Branches.* Into this trunk the lymphatics of the right upper limb, and right side of the head and neck pour their contents. In addition, the lymphatics of the right side of the chest, right lung and right half of the heart, and some from the right lobe of the liver, after passing through their respective glands, unite into a few large trunks, which ascend beneath the innominate vein to reach the duct in the neck.

Structure like the blood-vessels.

Structure of the ducts. The wall of each tube resembles that of the bloodvessels in structure (see p. 125). It has an external stratum of fibrous tissue; an inner layer of elastic fibres covered by epithelium; and a middle coat of circular fibres as in the arteries.

Thoracic cord of the sympathetic nerve

has twelve ganglia,

Cord of the Sympathetic Nerve. The thoracic part of each gangliated cord of the sympathetic nerve lies on the side of the spinal column, and is placed over the heads of the ribs and the intercostal vessels. The ganglia on it are usually twelve, one being opposite each dorsal nerve, but this number varies much. The upper ganglion is the largest; and the last two are rather anterior to the line of the others, being situate on the side of the bodies of the corresponding vertebræ. In the chest the sympathetic nerve is covered by the pleura; and it is continuous above and below with the cord in the neck and abdomen.

and is covered by pleura.

Branches

Each ganglion furnishes external branches to communicate with the spinal nerves, and internal for the supply of the viscera.

to join spinal nerves

External or *connecting branches.* Two offsets pass outwards from each ganglion to join a spinal nerve (intercostal). In the branches of communication both spinal and sympathetic nerve fibres are combined; but one consists almost entirely of spinal, and the other nearly altogether of sympathetic nerve fibres.

to supply viscera.

The *internal* or *visceral branches* differ in size and distribution, according as they are derived from the upper or lower six ganglia.

Upper six ganglia offsets are small,

The *upper six* are very small, and are distributed to the aorta, and the vertebræ with the ligaments. Mr. Swan describes a plexus as formed in front of the spine by the union of the branches of opposite sides. From the third and fourth ganglia offsets are sent to the posterior pulmonary plexus.

lower six, large, and form three nerves.

The *lower six* are larger and much whiter than the others, and are united to form visceral or splanchnic nerves of the abdomen: these are three in number (large, small, and smallest), and pierce the diaphragm to end in the solar and renal plexuses.

Great splanchnic

The *great splanchnic nerve* is a large white cord, which receives roots apparently from only four or five ganglia (sixth to the tenth), but its fibres may be traced upwards on the knotted cord as high as the third ganglion. Descending on the bodies of the vertebræ, it pierces the fibres of the crus of the diaphragm, and ends in the semilunar ganglion of the abdomen.

ends in semilunar ganglion.

At the lower part of the thorax the nerve may be divided into large bundles; and it may present a ganglion, or more than one on its fibres.

Small splanchnic

The *small splanchnic nerve* begins in the tenth and eleventh ganglia, or in the intervening cord; and in the thorax it communicates sometimes with the great splanchnic. It is transmitted inferiorly through the crus of the diaphragm, and enters the part of the solar plexus by the side of the cœliac artery. joins cœliac plexus.

The *smallest splanchnic nerve* springs from the last ganglion, and accompanies the other nerves through the diaphragm. In the abdomen it ends in the renal plexus. This nerve may be absent, and its place will be then taken by an offset of the preceding. Smallest splanchnic ends in renal plexus.

Parts in the upper aperture of the thorax. The relative position of the several bodies entering or leaving the thorax by the upper opening may be now observed. Parts in the upper aperture.

In the middle line lie the trachea and the œsophagus with the remains of the thymus gland. In front of those bodies are the lower ends of the sterno-hyoid and sterno-thyroid muscles with layers of the cervical fascia; and behind the gullet and windpipe is the longus colli muscle. Between the two tubes is the recurrent nerve of the left side. In middle line.

On each side the bag of the pleura and the apex of the lung project into the neck; and in the interval between the pleura and the trachea and œsophagus, are placed the vessels and nerves passing from the thorax to the neck, or in the opposite direction. Most anteriorly on both sides lie the innominate vein, and the phrenic and pneumo-gastric nerves; but further back the vessels and nerves next met with are different on the two sides:—On the right side come the innominate artery and the cardiac nerves; but on the left side are situate the left common carotid artery, the thoracic duct, and the left subclavian artery with the cardiac nerves in order. Lastly, altogether behind on each side are the first intercostal nerve, the cord of the sympathetic, and the superior intercostal artery. On each side. Partly the same on both sides, and partly not.

PARIETES OF THE THORAX.

Between the ribs forming part of the thorax, are lodged the two layers of intercostal muscles, with the intervening nerves and arteries; and inside them lies a thin fleshy layer behind, the infracostals. At the base of the thorax is the diaphragm, which bounds the cavity in this direction. Soft parts bounding the thorax.

The INFRACOSTAL MUSCLES are small slips of fleshy fibres, which are situate on the inner surface of the ribs, where the internal intercostals cease. Apparently part of the inner intercostals, they arise from the inner surface of one rib, and are attached to the upper border and internal surface of the rib next succeeding. Infracostal: position, attachments.

They are uncertain in number, but there may be ten: they are smaller above than below, and the upper and lower may pass over more than one space. Irregularities.

Action. This thin layer causes the ribs to approach one another, Use.

diminishing the size of the thoracic cavity, and acts thus as an expiratory muscle.

Intercostal muscles.

INTERCOSTAL MUSCLES. The anterior part of the muscles has been described in the dissection of the upper limb (p. 268). The posterior part of the same muscles may be now examined from the inner side.

Inner intercostal layer reaches angle of the rib.

The *inner muscle* is fixed to the margin of the ribs bounding the intercostal space. Beginning at the sternum, it reaches backwards only to the angle of the ribs in the middle spaces, but higher and lower the muscular fibres approach nearer the spine. Where the fibres cease, a thin fascia is continued backwards over the outer muscle.

Connections.

The inner surface is lined by the pleura, and the opposite surface is in contact with the intercostal nerve and vessels.

Outer intercostal layer extends back to head of the rib.

External muscle. Between the posterior border of the internal muscle and the spine, when the fascia and the infracostal muscles have been removed, the external intercostal muscle will be seen. Its borders are fixed to the contiguous margins of two ribs, and its fibres cross those of the inner intercostal layer. Whilst this muscle extends backwards to the tubercle of the rib, it does not reach farther forwards than the cartilages, as before said (p. 268).

Use.

Action. The use of the intercostal muscles in respiration is given in page 269.

Trace nerves.

Dissection. In a few spaces the internal intercostal muscle may be cut through, and the intercostal nerve and artery traced outwards.

Intercostal nerves are not joined in a plexus.

The INTERCOSTAL NERVES are the anterior primary branches of the dorsal nerves. Twelve in number, they occupy the intercostal spaces, without communicating in a plexus; and the last is placed below the twelfth rib.

Upper six are in spaces.

The following difference subsists between the upper and the lower nerves: the upper six lie between the ribs, and are confined to the wall of the thorax; whilst the lower six are prolonged into the abdominal wall where the ribs cease in front.

Connections with muscles; with the sympathetic.

Upper six. At first the nerves lie between the pleura and the external intercostal muscle, with an artery and vein; but they enter soon between the intercostals, and extend forwards to the middle line of the body. Near the head of the rib each is joined by filaments from the sympathetic. In its course each supplies *branches* to the intercostal muscles and the ribs, as well as cutaneous offsets to the surface; these are described in the dissections of the upper limb and wall of the abdomen.

Offsets.

Exceptions in first two.

There are some deviations in the first and second nerves from the general arrangement above specified.

First nerve enters mostly brachial plexus.

The *first nerve* ascends in front of the neck of the highest rib, and ends in the brachial plexus. Before it leaves the chest it supplies to the first intercostal space a branch which extends forwards in the place of the intercostal nerve, furnishing muscular offsets, and becomes cutaneous by the side of the sternum. There is not any lateral cutaneous branch from the first nerve, except in those cases in which the second is not as large as usual. Has not lateral cutaneous branch.

The *second nerve* may extend a considerable way on the wall of the chest before entering between the intercostal muscles, and may ascend even to the first space. It is remarkable in having a very large lateral cutaneous branch (p. 255). In front it ends like the others. Second nerve.

Upper surface of the diaphragm. The centre of the muscle is tendinous, and the sides are fleshy. In contact with the upper surface are the lungs on the sides, and the pericardium in the middle. The phrenic vessels and nerves enter this surface, external to the pericardium. In the diaphragm are the following apertures :—one for the œsophagus and the pneumogastric nerves, a second for the vena cava, a third for the aorta with the thoracic duct and the vena azygos, and a fourth for the splanchnic nerves. Beneath it the sympathetic passes into the abdomen. Upper surface of diaphragm. Parts in contact with it. Apertures in it.

The arch of the diaphragm towards the thorax has been before referred to (p. 347). Curve.

Directions. The dissector of the thorax now waits while the examination of the back is made. Afterwards he is to learn the ligaments of the ribs and spine: a notice of these will be found in the following Section. The dissection of the back is now made.

SECTION II.

LIGAMENTS OF THE TRUNK.

The ligaments of the vertebræ, ribs, and sternum, are included in this Section.

ARTICULATION OF THE RIBS. Each sternal rib is united to the spinal column on the one side, and the sternum on the other, by three sets of ligaments, viz., one between the head of the bone and the bodies of the vertebræ; a second from the neck and tubercle to the transverse processes of the vertebræ; and a third between the cartilage and the sternum. The asternal ribs will want the last articulation. A rib is united with the vertebræ and the sternum.

Dissection. For the purpose of examining the ligaments between the rib and the vertebræ, take a piece of the spinal column with three or four ribs attached. After removing the intercostal and other muscles, and the loose tissue from the surface of the bones, the student will be able to define the following undermentioned ligaments passing from the head and neck of the rib to the bodies and transverse processes of the vertebræ. To see ligaments of the vertebræ;

of rib and sternum.

The ligaments attaching the costal cartilage to the rib and sternum are to be dissected on the part of the thorax that was removed in opening the cavity.

Ligaments of head of rib are

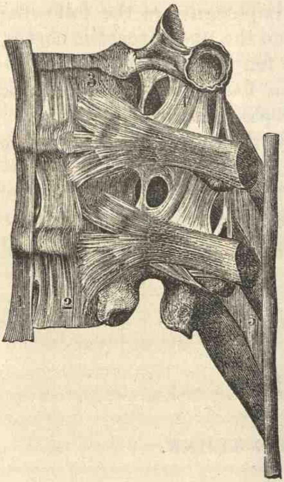
Ligaments of the Head of the Rib. Where the head of the rib is received into a hollow in the bodies of two contiguous vertebræ, the articulation is provided with two retaining ligaments—costo-vertebral and interarticular, and with two synovial sacs.

costo-vertebral or stellate,

The *costo-vertebral ligament* (fig. 72, [3]), named *stellate* from its form, is composed of radiating fibres, and is placed in front of the joint. Attached by one end to the rib, it is divided at the other into three sets of fibres:—The upper, the largest, ascends to the body of the vertebra above the rib head; the lower descends to the vertebra below the head; and the central part is united with the fibro-cartilage between the vertebræ.

attachments,

Fig. 72.*



Where the rib is in contact with only one vertebra, as in the first, eleventh, and twelfth, the ligament has but two sets of fibres. Directed forwards from the rib, its chief fibres in those three joints are fixed into the body of that vertebra which is touched by the costal head; whilst the ascending band is attached to the body of the vertebra immediately above, so that in the first rib-joint the ascending band is continued to the last cervical vertebra.

differs in certain ribs.

Inter-articular,

The *interarticular ligament* will be seen when the stellate is divided. It is a short thin band of fibro-cartilage, which is attached on one side to the ridge separating the articular surfaces on the head of the rib, and on the other to the fibro-cartilage between the vertebræ. In the joints of the first, eleventh, and twelfth, where the rib is not in contact with the intervertebral substance, the ligament is absent.

with two synovial sacs.

Synovial sacs. There are two sacs in the articulation, one on

* Ligaments of the ribs and vertebræ (Bougery).—1. Anterior ligament of the bodies of the vertebræ. 2. Lateral part of the anterior ligament of the spine. 3. Ligament (stellate) between the vertebræ and head of the rib. 4. Ascending costo-transverse ligament. 5. Interspinous ligament.

each side of the interarticular ligament. In the three joints before mentioned (1st, 11th, and 12th) there is but one sac.

Kinds of movement; degree.

Movements. In the costo-vertebral articulation there is a gliding of the rib up and down, and forwards and backwards. This movement is more limited in the seven first ribs which are fixed to the sternum than in the others; and is greatest in the last two, in consequence of the ribs being free anteriorly, and not fixed behind by a joint to the transverse process.

Motion of rib-body.

During the increase and decrease of the chest the body of the rib is rotated out and in, around a line subtending the arc of the circle of which its fore part is a segment. The degree of motion is greatest in the longest ribs.

Ligaments of neck of rib,

LIGAMENTS OF THE NECK AND TUBERCLE. Three ligaments (costo-transverse) pass from the neck and tubercle of the rib to two transverse processes. And there is a synovial sac between the rib and its transverse process.

anterior costo-transverse.

The *anterior costo-transverse* ligament (fig. 72, [4]) is larger and longer than the others. It ascends from the upper edge of the neck to the transverse process of the upper of the two vertebræ with which the head articulates: it is wanting in the first rib. Between this ligament and the vertebra the posterior branches of the intercostal artery and dorsal nerve pass backwards; and externally it is continuous with the fibrous membrane between the strata of the intercostal muscles.

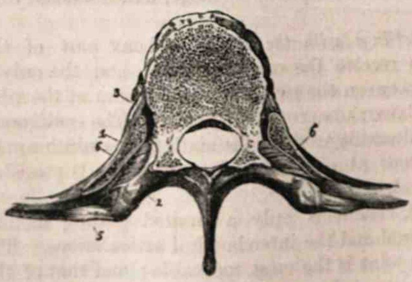
Posterior costo-transverse.

The *posterior costo-transverse* (fig. 73, [5]) is placed at the posterior aspect of the rib. It is a short band of fibres between the rough part of the tubercle and the tip of the transverse process of the lower of the two vertebræ touched by the rib-head. This band is longest in the lowest two articulations.

Middle costo-transverse.

The *middle* or *interosseous costo-transverse* is placed horizontally

Fig. 73.*



between the neck of the rib and the transverse process with

* The body of a dorsal vertebra and the inner end of a rib sawn through horizontally, to show the uniting ligaments.—1. The sawn rib. 2. The

which the tubercle articulates (fig. 73, [6]). It will be best seen by sawing horizontally through the rib and the transverse process. Its fibres are mixed with reddish areolar tissue.

In the two last ribs.

In the lowest two ribs the interosseous costo-transverse blends in one band with the posterior costo-transverse ligament.

Synovial sac,

Synovial sac. If the posterior ligament is divided, a *synovial membrane* will be exposed in the joint between the tubercle of the rib and the transverse process.

where absent.

In the lowest two ribs, which do not touch the transverse processes, the synovial sac is absent.

Motion.

Movement. In the motion of the rib, the bone glides upwards and downwards on the articular facet of the transverse process; and the degree will be limited by the surrounding costo-transverse ligaments.

Union of the costal cartilages.

LIGAMENTS OF THE COSTAL CARTILAGES. The costal cartilages of the true ribs are united to the sternum by a fibrous capsule, which covers a synovial membrane; and externally they are joined to the osseous part of the rib. Some of the lower cartilages touch each other and are connected together by fibrous bands with synovial membranes.

Cartilages with the sternum.

In the *chondro-sternal articulation* (fig. 38, [6]), the cartilages are received into the depressions on the side of the sternum, and are fixed in their position by a capsule of surrounding fibres. In front and behind the capsule are thickened bands, which have been described as *anterior* and *posterior ligaments.*

Synovial sac.

Between the cartilage and the bone is a *synovial* membrane.

Second cartilage has a double joint.

In the joint of the second cartilage there is an interarticular ligament, as in the head of the rib, which joins the cartilage between the pieces of the sternum. A synovial sac exists on each side of the interarticular ligament.

Costo-xiphoid ligament.

A separate band of fibres passes between the cartilage of the seventh rib and the xiphoid cartilage, and is named *costo-xiphoid ligament.*

Costal cartilage with rib.

Costal cartilage with the rib. The bony part of the rib is hollowed to receive the costal cartilage, and the only investing membrane between the two is the periosteum of the rib.

Cartilages with one another.

COSTAL CARTILAGES TO ONE ANOTHER. The contiguous surfaces of the costal cartilages from the sixth to the ninth are connected by ligamentous fibres; and each articulation is provided with a *synovial membrane.*

Motion in true

Movement. There is only a limited gliding motion in the chondro-sternal and the interchondral articulations. The second rib-cartilage joint is the most moveable; and that of the first is generally obliterated soon after manhood.

transverse process. 3. The stellate or costo-vertebral ligament. 5. Posterior costo-transverse ligament. 6. Middle costo-transverse or interosseous ligament.

The cartilages of the three first false ribs being united only by bands of fibrous tissue, are freer to move than those which are attached to the sternum; and the lowest two are the least fixed of all. and false cartilages.

ARTICULATION OF THE STERNUM. As the two pieces of the bone are united by cartilage without any synovial membrane, the kind of articulation is sometimes named synchondrosis. Union of pieces of sternum.

The upper piece of the sternum is connected to the lower by an intervening piece of cartilage, and the articulation is strengthened by anterior and posterior longitudinal fibres.

Movement. In articulations through the means of cartilage, as here and in the pelvis, there is very little motion to be perceived even when the osseous pieces are forcibly pulled by the hands. Motion slight.

ARTICULATION OF THE VERTEBRÆ. The vertebræ of the spinal column are united together by two sets of ligaments—one for the bodies and the other for the arch and processes. Two sets of ligaments unite the vertebræ.

Along the spinal column the ligaments have a general resemblance, and one description will suffice except for those between the first two vertebræ and the head, and in the pelvis.

Dissection. After the articulations of the ribs have been examined, the same piece of the spinal column will serve for the preparation of the ligaments of the bodies of the vertebræ. The anterior ligament of the bodies will be defined with very little trouble, by removing the areolar tissue. How to see the several ligaments.

It is supposed that the spinal canal has been opened to examine the spinal cord, and that the posterior ligament of the bodies of the vertebræ is laid bare; but if the canal should not be open, the neural arches of the vertebræ are to be removed by sawing through the pedicles.

The remaining ligaments between the neural arches, spines, and articular processes of the bones may be dissected on the piece taken away in opening the spinal canal.

LIGAMENTS OF THE BODIES OF THE VERTEBRÆ. The bodies of the moveable vertebræ, except the first and second, are united by an anterior and a posterior common ligament, with an intervening piece of fibro-cartilage. The bodies are united by:

The *anterior common ligament* (fig. 72, [1]) reaches from the atlas to the sacrum: it is widest opposite the lumbar vertebræ, and is narrowed upwards. Its outline is uneven, for it is broader over the bodies of the vertebræ ([2]), than on the intervertebral substance; and if the ligament be cut across at intervals it will be found to be thickest opposite the hollow part of the body of each vertebra. Anterior common ligament, width, and thickness:

Its fibres are longitudinal in direction, and consist of a superficial and a deep layer. By detaching parts of the ligament, the superficial fibres will be seen to reach three or more vertebræ, length, whilst the deep extend from bone to bone. A greater number of the fibres are attached to the intervertebral fibro-cartilages than to the bones; and more are fixed to the margins than the centre of the body.

attachment of fibres.

Posterior common ligament is wide at parts.

The *posterior common ligament* (fig. 74), is contained in the spinal canal, lying on the posterior surface of the vertebræ, and extends from the sacrum to the occipital bone. This ligament is wide above, and diminishes in size downwards, just the opposite of the anterior. In the neck it is loose, and extends all across the bodies. In the back and loins it is a thin narrow band, which sends off on each side a pointed process to be

Fig. 74.*

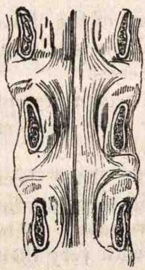
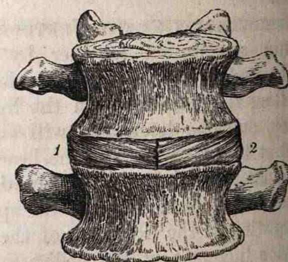


Fig. 75.†



Connections.

attached to the pedicle of the neural arch; and it is wider opposite the intervertebral discs than on the bodies, so that the margins are dentate in those regions of the spine. One surface of the ligament is in contact with the dura mater; and between the opposite surface and the vertebræ are large intraspinal veins.

Attachment of fibres.

Its fibres are superficial and deep as in the anterior ligament, and are more closely united with the intervertebral substance than with the bone.

To see the intervertebral substance.

Dissection. To see the intervertebral substance, the anterior and posterior common ligaments must be taken away. One vertebra should be detached from the fibro-cartilage to obtain a horizontal view of this structure; and two other vertebræ should be sawn vertically to see the difference in the consistence and arrangement of the laminæ.

Intervertebral substance

The *intervertebral substance* (fig. 75, [1]) is placed between the contiguous surfaces of the bodies of the vertebræ, from the axis to the sacrum. It forms a flattened disc between each pair of the

* Lumbar vertebræ, with the posterior common ligament of the bodies.

† Intervertebral substance of the lumbar region.—1. A superficial lamina. 2. A deeper layer. The difference in the direction of the fibres of the layers is seen.

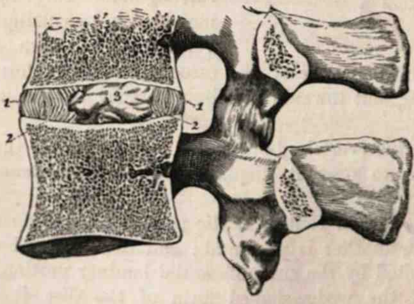
vertebræ, and its width is determined by the size of the bones. It is connected in front and behind with the anterior and posterior common ligaments, and on the sides with the stellate ligaments of the heads of the ribs. has the width of the bones.

These discs are thicker between the lumbar and cervical, than between the middle dorsal vertebræ; and where the spinal column is arched forwards, as in the loins and neck, they are deepest at the anterior edge, being wedge-shaped. The thinnest piece is situate between the second and third cervical vertebræ, and the thickest between the last lumbar and the sacrum. thickness; form;

By means of the dissections before made, the intervertebral substance may be observed to consist of two distinct parts; an external, firm and laminar, and an internal, soft and elastic (fig. 76). constituent parts;

The outer laminar part (fig. 77, [1]) forms more than half of the disc, and is composed of pieces of fibro-cartilage alternating with layers of fibrous tissue. All the strata are arranged one within another, like the scales of an onion, and are connected by their edges to the bodies of the vertebræ; but all have not a vertical position, for whilst the outer pieces are straight, the inner are bent with the convexity outwards (Humphry). The laminæ do not form complete rings, but those composed of fibrous tissue reach farther than those of fibro-cartilage: the free ends of both layers overlap. the outer laminæ, how arranged; all not vertical;

Fig. 76.*



Each layer is constructed of oblique fibres; and the fibres of one layer are directed across those of another like the parts of the letter X (fig. 75). This disposition of the fibres will be the fibres of the layers cross.

* Vertical section of the intervertebral substance, showing its laminar condition—1. Most external layers. 2. Innermost layers. 3. Central pulpy substance.

best seen on the discs between the lumbar vertebræ; and it may be rendered evident by dissecting layer after layer.

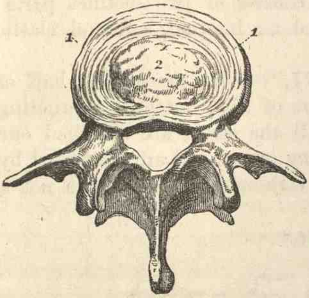
Inner part; The central or pulpy portion of the disc (fig. 76, [3]) is very soft and elastic, and projects when two vertebræ and the interposed mass are sawn through. Placed nearer the back than the front of the disc, it is more marked in the loins and neck than in the dorsal region.

situation, where largest.

Structure; It has a yellowish colour, and is deficient in the stratiform arrangement so conspicuous at the circumference. Towards the confines of the two portions of the intervertebral substance, there is an alternating arrangement of fibrous tissue and fibro-cartilage, though the former is gradually diminishing; but towards the centre a loose fibro-cartilaginous material preponderates, and amongst it are spaces containing fluid.

is fibro-cartilaginous.

Fig 77.*



Cartilage covering bones.

The surfaces of the vertebræ in contact with the discs, have a cartilaginous covering. This may be seen by cutting the intervertebral substance from the bone. Over the centre of the osseous surface it forms a continuous layer, but towards the circumference it consists of separate pieces.

Unites vertebræ,

Use. The intervertebral substance unites together the vertebræ so firmly as to prevent displacement of those bones without rupture of it.

admits movement,

By means of the central elastic part the revolving motion of one bone on another is produced; and the extent of the movement is limited by the circumferential laminar portion.

makes column convex,

Through the wedge-shaped form of the disc it is chiefly instrumental in giving rise to the convexity of the spinal column in the loins and neck; and through its elasticity it moderates the effect of jars or shocks transmitted from bone to bone.

and adds to the length.

The depth of its several pieces amounts to about a fourth of the total length of the spinal column; but as it yields under pressure, the height of the body will be shorter from half an inch to an inch in the course of the day, according to the fatigue undergone.

Several ligaments of the vertebral processes.

LIGAMENTS OF THE NEURAL ARCH AND PROCESSES. The several processes of the vertebræ have special uniting ligaments:—thus the articular processes are joined by a capsule and a synovial

* A horizontal cut through an intervertebral fibro-cartilage.—1. Laminar external part. 2. Pulpy central part of the fibro-cartilage.

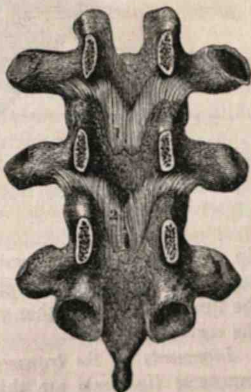
membrane; the neural arches are connected by yellow ligaments; the spinous processes have one band along the tip and another between their borders; and the transverse processes are provided with intervening bands of fibres.

Ligaments of Articular processes. Between the articulating processes there is a moveable joint, in which the bones are covered with cartilage, and are surrounded by a loose *capsular* ligament of scattered fibres enclosing a *synovial* membrane. In the cervical part of the spine the capsular ligaments are looser than in the dorsal or lumbar region. To the articular, capsule and sac.

Movement. With such flattened articular surfaces is united a gliding of one bone upon another. This movement is least limited in the neck, the loins, and the lower dorsal vertebræ. Motion, and degree.

By the difference in the shape of the articulating processes, the kind of motion in the spine is determined; and by their arrangement the degree is limited, and the vertebræ are partly maintained *in situ.* In dislocation of the spinal column they are generally broken before a vertebra can be dislodged from its imbricated position. How processes act.

Fig. 78.*



Ligaments of the arches. The *ligamenta subflava* (fig. 78, [2]), so named from their colour, are situate between the neural arches of the vertebræ, and close the spinal canal behind. Between each pair of arches are two somewhat square ligaments, one for each half of the arch, which approach one another along the middle line, and reach on each side from the articular process to the root of the spinous process. Those of the arches are two to each space. Attachments.

Each consists of elastic yellow tissue. It is attached above to the inner surface of the one, but below to the upper border and outer surface of the other neural arch. Structure.

Between the first two vertebræ and the skull there are special fibrous ligaments in the corresponding situation (see p. 182.)

Ligaments of the spines. Along the tips of the spinous processes of the dorsal and lumbar vertebræ is a longitudinal band of fibres (fig. 79, [1]),—the *supraspinous* ligament. It is thicker in the lumbar than in the dorsal region of the spine, and is formed by superficial and deep fibres; the former reach over three or Those of the spines are along their tip.

* An inner view of the neural arches of the vertebræ, with their interposed ligaments.—1. and 2. Ligamenta subflava. (Bourgery and Jacob.)

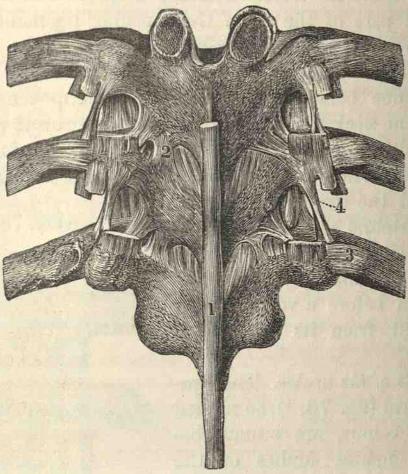
more spines, whilst the latter pass from bone to bone. It is closely united with the tendons of the muscles.

The band called ligamentum nuchæ, which is composed of fibrous tissue, takes its place in the neck.

and between them.

Along the spinal column there are also thin membranous *interspinous* ligaments (fig. 72,[5]), which reach from the root to the

Fig. 79.*



tip of the spinous processes. The strength of these bands is dependent upon the interval they fill; they are more marked in the lumbar than the other vertebræ, and they are least strong in the cervical region.

Those of the transverse processes.

Ligaments of the transverse processes. In the loins the *intertransverse ligaments* are thin membranous bands in the intervals between the processes. In the dorsal vertebræ they are round bundles of fibres (fig. 79, [4]). And in the neck the fibres exist only at the apex of the processes, or they may be wanting here and there.

Ligaments of special vertebræ.

LIGAMENTS OF SPECIAL VERTEBRÆ. The ligaments of the first two cervical, and of the sacral and coccygeal vertebræ, will be given with the dissections of the neck (p. 182) and the pelvis (Section vii.)

Kinds of motion.

MOVEMENTS OF SPINAL COLUMN. The spinal column can be bent forwards, backwards, and to each side; and can be rotated.

* Ligaments of the processes of the vertebræ, and of the ribs. (Bourgery.)—1. Supraspinous band of ligament. 2. Ligamentum subflavum. 3. Posterior costo-transverse ligament: on the opposite side the band has been removed and the joint opened. 4. Intertransverse ligament.

In *flexion* the vertebræ between the axis and sacrum are bowed forwards. The greatest movement takes place between the last two lumbar vertebræ and the sacrum (Humphry); there is an intermediate degree in the neck; and the least in the upper half of the dorsal region, where the ribs are united to the sternum.

Flexion; degree.

The bodies of the bones are brought nearer together in front, whilst they are separated behind. The inferior pair of articular processes of the second vertebra glide upwards on the upper of the third; the inferior of the third on the upper of the fourth; and so on throughout the moveable column.

Movement of bones.

The ligament in front of the bodies is loose, but the posterior, and those uniting the neural arches and processes are stretched. The fore part of each intervertebral disc is squeezed and thinner, and the back is widened and elongated.

State of ligaments.

In *extension*, the vertebræ are arched backwards, but not to so great a degree as when the spine is bent forwards. The motion is most in the neck; and is least in the dorsal vertebræ, which are fixed by the true ribs and the sternum, and are impeded by the overlapping spinous processes.

Extension; where most, and least.

The posterior parts of the vertebræ are approximated, whilst the anterior are separated; and the inferior pairs of articular processes of each (from the second cervical to the sacrum) glide downwards, on the upper of the next succeeding bone.

Movement of bones.

The condition of the ligaments is the opposite to that in flexion. Thus, the intervertebral discs are compressed behind and widened before; the spinous and subflaval are relaxed; the anterior common of the bodies is tightened, and the hinder band is slackened.

State of ligaments.

Lateral inclination. The spine can be curved to the right or the left side. Like the other movements, this is least in the more fixed upper dorsal vertebræ, and is greatest in the neck.

Side bending: extent.

On the concave side of the curve, say the right, the bodies are brought nearer together; and are carried away from each other on the opposite. The right inferior articular surface glides down, and the left up, in the joints with the vertebra beneath.

Movement of bones.

On the right side the ligaments and the intervertebral substance will be relaxed; and on the left they will be tightened so as to check the movement.

State of ligaments.

Rotation is the twisting of the bodies of the vertebræ around a line through their centres, the fore part being turned first to the right and then to the left. Its degree is greatest in the upper dorsal and the cervical vertebræ, but is absent in the lumbar part of the column.

Rotation: where present, and absent.

The vertebral bodies are directed horizontally, and the inferior pair of articular processes move differently on the two sides. Supposing the face turned to the right, the articular surface of

Motion in bones.

that side glides inwards towards, and the other outwards from the spinal canal.

State of ligaments.

The flat ligaments and intervertebral discs of the bodies, and the ligaments of the neural arches, will be less tight on the side to which the vertebra is directed than on the other.

Dislocation of spine, with fracture, and without.

Dislocation of one vertebra from another without fracture seldom occurs, in consequence of the way in which the bone is inserted between its fellows, the inferior pair of articular processes being placed behind the superior of the next following, like scales. In the cervical region, where the articular surfaces are so much more horizontal than below, simple displacement may occasionally take place.

CHAPTER V.

DISSECTION OF THE BACK.

Directions. According to the mode of dividing the body, the dissection of the back may be allotted to one student; or it may be undertaken conjointly by the dissectors of the head and upper limbs,—the former preparing the neck, and the latter making ready the parts in the dorsal and lumbar regions. Directions.

If the back should belong to more than one student, the dissector of the upper limb may attend chiefly to the paragraphs marked with an asterisk; and the dissector of the neck may study specially the paragraphs which are not so marked. But as many of the dissections in the earlier stages require the co-operation of the students employed on the same side of the body, a general attention may be given to the whole by each student.

The dissector of the abdomen is to examine the arrangement of the fascia lumborum, after the first layer of muscles has been learnt.

Position. For this dissection the body lies with the face downwards; and the trunk is to be raised by blocks beneath the chest and the pelvis, so that the limbs may hang over the end and sides of the dissecting table. To make tense the neck, the head is to be depressed and fastened with hooks. Position of body.

In the back the student will meet with successive strata of large muscles, five in all, amongst which vessels and nerves are interspersed. Strata in back.

Dissection. The first step in the dissection is to raise the skin in two flaps, by means of the following incisions:—One cut is to be made along the middle of the body from the occipital protuberance to the back of the sacrum. Another incision is to be carried from the last dorsal vertebra to the acromion process of the scapula. The flap of skin above the last cut is to be turned outwards by the dissectors of the head and upper limb. To raise the skin.

By another transverse incision opposite the iliac crest, the remaining piece of integument may be detached, and reflected by the dissector of the upper limb in the same direction as the other flap.

Under the upper flap of skin is placed the trapezius, and underneath the lower one the latissimus dorsi muscle.

Seek cutaneous nerves.

The cutaneous nerves may be now sought in the superficial fatty layer: they are accompanied by small cutaneous arteries which will guide the student to their position. The nerves vary much in size in the different parts of the back, and their number is also irregular: as a general rule, there is one opposite each vertebra. In the neck, and opposite the upper part of the thorax, they will be best found near the spines of the vertebræ, where they lie at first beneath the superficial layer of fat; but at the lower part of the thorax, and in the loins, they issue in a line with the angles of the ribs.

The cutaneous branches of the sacral nerves come into the dissection of the lower limb.

Cutaneous nerves how derived.

CUTANEOUS NERVES. The tegumentary nerves of the back are derived from the posterior primary branches of the spinal nerves. At first the trunks subdivide amongst the deep muscles into two branches, inner and outer, from which the cutaneous offsets are derived,—being at one spot from the external, and at another from the internal branch. Arteries accompanying the greater number of the nerves, bifurcate like them, and furnish cutaneous offsets.

In the neck.

Cervical nerves. In the neck the nerves are derived from the inner of the two pieces into which the primary trunks bifurcate:

Source.

they perforate the trapezius, and supply the neck and the back of the head. They are four in number, viz., one from each nerve, except the first and the three last.

Second

The *branch* of the *second nerve* is named large occipital, and accompanies the occipital artery to the back of the head (p. 8).

and third nerve.

The *branch* of the *third cervical nerve* supplies a transverse offset to the neck, and then bends upwards to the lower part of the head, where it is distributed near the middle line, and is united with the great occipital nerve.

In the dorsal region.

* *Dorsal nerves.* These are obtained from both the inner and outer offsets of the primary branches—the upper six from the inner, and the lower six from the outer. On the surface they are directed outwards in the integument over the trapezius and latissimus dorsi muscles.

Upper six.

The *upper six* perforate the trapezius near the spines of the vertebræ; and the branch of the second, which is larger than the

Lower six.

rest, reaches as far as the scapula. The *lower six* pierce the latissimus dorsi mostly in a line with the angles of the ribs; they are oftentimes uncertain in number.

In the loins.

* *Lumbar nerves.* In the loins the nerves are derived from the outer pieces of the primary branches, and only from the first three; they perforate the latissimus dorsi muscle in a line with the outer border of the erector spinæ, and crossing the iliac crest

of the innominate bone, are distributed in the integuments of the buttock.

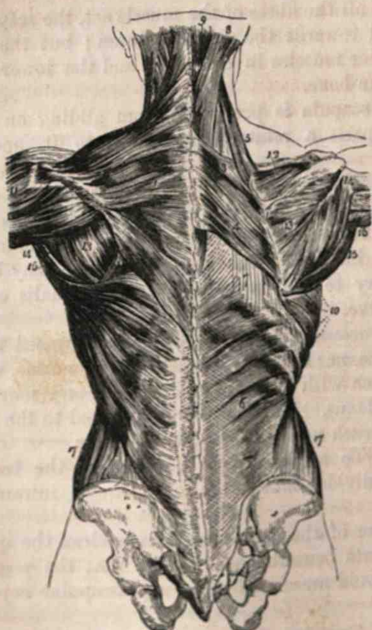
* First Layer of Muscles. Two muscles, the trapezius and the latissimus dorsi, are included in this layer. Two muscles in first layer.

Dissection. The superficial fatty layer is to be taken from the trapezius and latissimus dorsi in the direction of the fibres of each, viz., from the shoulder to the spinal column; and the upper limb is to be carried backwards or forwards according as it may be necessary to put on the stretch different portions of the muscles. Dissection.

Some of the cutaneous nerves may be left, in order that they may be traced afterwards through the muscles to their origin.

* The trapezius muscle (fig. 80, [1]) is triangular in shape, with the base towards the spine, but the two muscles have a trapezoid form. The muscle has an extensive aponeurotic *origin* along the middle line from the spines of the dorsal vertebræ and Trapezius. Origin aponeurotic.

Fig. 80.*



* Muscles of the back and scapula: on the left side is the superficial layer, and on the right some of the deeper layers.

their supraspinous ligament; from the spinous process of the seventh cervical vertebra; from the ligamentum nuchæ between the last point and the head; and lastly from the inner third of the superior transverse ridge of the occipital bone. From this origin the fibres are directed outwards, converging to the shoulder, and are *inserted* into the outer third of the clavicle, at its posterior aspect; into the upper or posterior border of the acromion; and into the upper edge of the spine of the scapula as far as to an inch of the root of that process, as well as into a rough impression on the surface of the spine near the hinder part.

Insertion chiefly fleshy.

Connections.

The muscle is subcutaneous. At the outer side the lowest fleshy fibres end in a small triangular tendon, which glides over the smooth surface at the root of the spine of the scapula. The anterior border bounds behind the posterior triangular space of the neck. By its insertion the trapezius corresponds with the origin of the deltoid muscle.

Use: scapula moveable,

Action. If all the fibres of the muscle act, the scapula is moved upwards and towards the spinal column; but the upper fibres can assist other muscles in elevating, and the lower will help in depressing the bone.

in rotation of bone.

When the scapula is prevented from gliding on the ribs, the trapezius imparts a rotatory movement to it, and raises the acromion.

Trace spinal accessory.

Dissection. The fibres of the trapezius are to be divided near the scapula, over the situation of the spinal accessory nerve, so that the ramifications of that nerve in the muscle, and its junction with the branches of the cervical plexus may be observed. A small artery to the trapezius (art. superficialis colli) accompanies the nerve.

Spinal accessory nerve in trapezius.

The *spinal accessory cranial nerve*, having crossed the posterior triangle of the neck, passes beneath the trapezius, and forms a plexiform union with branches of the third and fourth nerves of the cervical plexus. The nerve is distributed to the muscle, and its filaments reach nearly to the lower border.

Dissection to reflect trapezius;

Dissection. To see the parts covered by the trapezius, the pieces of the divided muscle are to be thrown inwards and outwards.

to prepare parts in the neck;

The dissector of the neck should now clean the splenius, and define the parts beneath the clavicle, viz., the posterior belly of the omo-hyoid muscle with the suprascapular nerve and ves-

Left side.—1. Trapezius. 2. Latissimus-dorsi. 17. External oblique of the abdomen.

Right side.—3. Rhomboideus minor. 4. Rhomboideus major. 5. Levator anguli scapulæ. 6. Serratus posticus inferior. 7. A part of the erector spinæ. 8. Splenius capitis. 9. Complexus. 10. Serratus magnus.

Shoulder muscles.—11. Deltoid. 12. Supra-spinatus. 13. Infra-spinatus. 14. Teres minor. 15. Teres major. 16. Long head of the triceps.

sels; the transverse cervical vessels; and the small branches of nerves to the levator anguli scapulæ, and rhomboid muscles. If the trapezius be detached along the middle line, the ligamentum nuchæ, from which it takes origin, will be brought into view.

Clean the scapular muscles. * The dissector of the upper limb should clean the fibres of the rhomboidei and levator anguli scapulæ muscles, which are fixed to the base of the scapula; and whilst this is being done, the scapula is to be drawn away from the trunk to make tense the fleshy fibres.

Parts covered by trapezius. * *Parts covered by the trapezius.* The trapezius conceals in the neck the splenius, a small part of the complexus, and the levator anguli scapulæ; in the dorsal region it covers the following muscles,—the rhomboidei, the erector spinæ, and the latissimus dorsi. Near the scapula it lies over the supraspinatus muscle.

Ligamentum nuchæ. The *ligamentum nuchæ* is a narrow fibrous band, which extends from the spinous process of the seventh cervical vertebra to the occipital protuberance. From the under part processes are sent down to be attached to the spines of the six lower cervical vertebræ, so that it serves as a partition between the muscles of opposite sides of the neck. In man it is not formed of elastic tissue.

Latissimus dorsi. * The LATISSIMUS DORSI, the widest muscle in the back (fig. 80, [2]), is thin, and is aponeurotic at its inner attachment or origin. **Origin is tendinous,** It *arises* along the middle line from the spinous processes of the six lower dorsal, all the lumbar, and the upper two sacral vertebræ, as well as from the supraspinous ligament. On the outer side it arises by an aponeurosis from the outer edge of the posterior half of the iliac crest; **and fleshy.** and by three or four fleshy processes from as many of the lower ribs, which digitate with pieces of the external oblique muscle of the abdomen. And between the outer and inner attachments it is inseparably blended below with the subjacent tendon of the multifidus spinæ. All the fibres converge to the inferior angle of the scapula, and after **Insertion into humerus.** crossing that point of bone, are continued forwards to be *inserted* by tendon into the bottom of the bicipital groove of the humerus (p. 261).

Connections. The muscle is subcutaneous, except a small part of the upper border which is covered by the trapezius. Near the scapula there is a space between the two, in which the ribs and the intercostal and rhomboid muscles appear. The lower or anterior border overlays the edge of the external oblique muscle of the abdominal wall in the interval between the last rib and the iliac crest, with the exception of a small part below. Frequently the latissimus has a distinct fleshy slip from the inferior angle of the scapula.

Use: on the limb when free, *Action.* If the arm is hanging loose the muscle can move it behind the back, rotating it in at the same time. If the limb is raised, the latissimus, combining with the pectoralis and teres, will depress the humerus. From its attachment to the scapula this bone can be depressed with the arm.

and fixed.

Supposing the arm fixed, the fibres may elevate the ribs as an inspiratory muscle; or they may assist the pectoralis major in drawing the moveable trunk towards the humerus, as in the act of climbing.

Dissection to reflect latissimus.

* *Dissection.* The latissimus is to be divided about midway between the spines of the vertebræ and the angle of the scapula, and the pieces are to be reflected inwards and outwards. In raising the inner part of the muscle, care must be taken not to destroy either the thin lower serratus with which it is united, or the aponeurosis continued upwards from the serratus. In the interval between the last rib and the iliac crest the latissimus is adherent to the aponeurosis of the transversalis abdominis muscle, and should not be detached from it.

Parts covered by the latissimus.

* *Parts covered by the latissimus.* The latissimus dorsi lies on the erector spinæ, the serratus posticus inferior, and the lower ribs with their intercostal muscles. As it rests on the angle of the scapula, it conceals the teres major, and part of the rhomboid muscle. Its position to the teres is worthy of note:—at the angle of the scapula it covers the posterior surface of the teres, but nearer the humerus it turns round the lower border of that muscle, and is inserted in front of it. Between the angle of the scapula and the humerus the latissimus forms part of the posterior boundary of the axilla.

Forms axillary wall.

Dissection of fascia lumborum.

Dissection of fascia lumborum. After the latissimus dorsi has been reflected, the dissector of the abdomen can look to the disposition of the posterior tendon of the transversalis abdominis (fascia lumborum) between the last rib and the innominate bone.

In the spot referred to are portions of the muscles left in the dissection of the wall of the abdomen. Firstly, a piece of the external oblique muscle may, or may not remain. After the removal of that muscle (supposing a part to be left), the internal oblique will be seen to be attached to a subjacent aponeurosis, and to the ribs and the iliac crest; its upper and lower attachments are to be cut through, and it is to be reflected backwards from the transversalis muscle towards the spine, as far as possible without entirely detaching it. Then the aponeurosis of the transversalis muscle (fascia lumborum) appears, and perforating it are two nerves:—one, the last dorsal with an artery near the last rib; and the other, the ilio-hypogastric, close to the iliac crest.

Reflect muscles.

Show two processes from it,

Two offsets are prolonged backwards from this fascia to the transverse processes. To see the more superficial prolongation which passes beneath the erector spinæ to the apices of the processes, the latissimus dorsi is to be cut through (both its aponeurosis and fleshy part) by a horizontal incision directed outwards from the spinous processes on a level with the third lumbar vertebra. On raising the outer border of the erector spinæ muscle which comes into view, the strong process of the fascia will be apparent. superficial,

After dividing transversely this first prolongation, another muscle (quadratus lumborum) will be seen; and on raising its outer border the second thin offset of the fascia will be evident on the abdominal aspect of that muscle. and deep.

The *fascia lumborum* is the posterior aponeurosis or tendon of the transversalis abdominis muscle, and occupies the interval between the last two ribs and the crest of the hip bone. By its cutaneous surface it gives attachment to the internal oblique muscle, and sometimes to the external oblique. The last dorsal and ilio-hypogastric nerves pierce it in their course from the abdomen. From the inner part of the aponeurosis two offsets are prolonged to the transverse processes of the lumbar vertebræ, and enclose the quadratus lumborum in a sheath. Fascia lumborum; has two offsets behind,

The more superficial of the two is the strongest; it lies beneath the erector spinæ in this position of the body, and is connected to the apices of the transverse processes, but it also fills the intervals between those pieces of bone: at the outer border of the erector spinæ it blends with the aponeurosis of the latissimus dorsi and inferior serratus. one to apex,

The deeper or anterior prolongation passes on the abdominal surface of the quadratus lumborum, and is fixed to the roots of the transverse processes, and the bodies of the vertebræ. the other to root of the transverse processes;

In like manner the erector spinæ lies in another sheath, which is formed by the vertebral aponeurosis and the tendons of the latissimus and serratus on the one side, and by the superficial of the two prolongations of the fascia lumborum on the other. which form sheaths for muscles.

* SECOND LAYER OF MUSCLES. This stratum contains the elevator of the angle of the scapula, and the large and small rhomboid muscles. Besides these is included the posterior belly of the omo-hyoid muscle, with some vessels and nerves turning backwards towards the scapula. Second muscular layer.

Dissection. By the reflection of the trapezius and latissimus, and the dissection made subsequently (p. 410), the several parts in this layer will have been sufficiently prepared for learning. Dissection.

* The LEVATOR ANGULI SCAPULÆ (fig. 80, [a]) arises by tendinous slips from the posterior or neural transverse processes of the upper three or four cervical vertebræ. The fibres form rather a roundish muscle, and are *inserted* into the base of the scapula between the spine and the superior angle. Elevator of angle of scapula. Attachments

At its origin the muscle lies beneath the sterno-mastoideus, and at its insertion beneath the trapezius; the rest of the muscle appears in the posterior triangular space of the neck. Beneath and connections.

it are some of the other cervical muscles, viz., splenius colli and cervicalis ascendens.

Use: on scapula. *Action.* The muscle raises the angle or the hinder part of the scapula, and depresses the acromion; but united with the upper part of the trapezius, which prevents the rotation down of the acromion, it shrugs the shoulder.

on the neck. When the shoulder is fixed, the neck can be bent laterally to the same side.

Rhomboid muscles are two. * RHOMBOIDEI MUSCLES. The thin muscular layer of the rhomboidei is attached to the base of the scapula, and consists of two pieces, large and small, which are separated by a slight interval.

Small muscle. * The *rhomboideus minor* (fig. 80, [3]) is a small narrow band, which *arises* from the spinous processes of the seventh cervical and first dorsal vertebræ, and the ligamentum nuchæ; it is *in-*

Attachments. *serted* into the base of the scapula, opposite the smooth surface at the root of the spine.

Large muscle. * The *rhomboideus major* (fig. 80, [4]) is larger than the preceding by the width of three or more spinous processes. It *arises*

Origin. from the spines of the upper four or five dorsal vertebræ below the rhomboideus minor, and from the supraspinous ligament; and its fibres are directed outwards and downwards to be fixed to the base of the scapula between the spine and the lower angle.

Insertion. Sometimes all the fibres do not reach the scapula directly, some ending on a tendinous arch near the bone.

Connections. The rhomboidei muscles are covered chiefly by the trapezius and latissimus; but a portion of the larger rhomboid is subcutaneous near the angle of the scapula.

Use: by themselves: *Action.* From the direction of their fibres both rhomboidei will draw the base of the scapula upwards and inwards, so as to

with others. depress the acromion. In combination with the lower part of the trapezius they will carry the scapula directly back; for as one tends to raise, and the other to depress the acromion, the bone will be moved in a direction between the two forces. By their united action the muscles help to fix the scapula.

Posterior belly of omo-hyoideus. The OMO-HYOID MUSCLE consists of two fleshy bellies, anterior and posterior, which are united by an intervening tendon. Only the posterior half is now seen (fig. 12, [3]).

Origin The muscle *arises* from the upper border of the scapula behind the notch, and from the ligament that converts the notch into a

and termination. foramen. The fibres form a thin, riband-like muscle, which is directed forwards across the lower part of the neck, and ends anteriorly in a tendon beneath the sterno-mastoideus (p. 67).

Connections. The fleshy belly of the muscle is placed partly beneath the trapezius; and is partly superficial in the posterior triangular space of the neck, where it lies above the clavicle and the subclavian artery. It crosses the suprascapular vessels and nerve near the scapula, and the brachial plexus.

Action. For the supposed use of the posterior belly of the omo-hyoideus, see page 67. **Use.**

The *suprascapular artery*, a branch of the subclavian trunk (p. 75), is directed almost horizontally outwards across the lower part of the neck to the dorsum of the scapula. The vessel lies behind the clavicle, and courses along that bone with the suprascapular nerve, but beneath the trapezius and omo-hyoid muscles, to the supraspinal fossa of the scapula. Before entering the fossa it furnishes a small branch (supra-acromial) to the upper surface of the acromion. **Suprascapular artery ends on back of scapula.**

The *suprascapular nerve* is an offset of the brachial plexus (p. 77), and is inclined backwards to the superior border of the scapula. It passes through the notch in the upper costa of the bone, and terminates beneath the supraspinatus in the muscles on the dorsum of the scapula (p. 279). **Suprascapular nerve.**

The *transverse cervical artery*, also a branch of the subclavian (p. 75), has the same direction as the suprascapular branch, viz., towards the upper part of the scapula, but it is placed at a greater height above the clavicle. Crossing the upper part of the space in which the subclavian artery lies, it passes beneath the trapezius, and divides into the two following branches—superficial cervical and posterior scapular:— **Transverse cervical artery divides into**

The *superficial cervical branch* is distributed chiefly to the under surface of the trapezius, though it furnishes offsets to the levator anguli scapulæ and the cervical glands. **superficial cervical and**

The *posterior scapular branch* crosses beneath the elevator of the angle of the scapula, and turns downwards along the base of the scapula beneath the rhomboid muscles. If the rhomboid muscles are divided, the artery will be seen to furnish branches to them; and to give anastomotic twigs to both surfaces of the scapula, which anastomose with the other arteries distributed on the bone. **posterior scapular.**

This branch arises very frequently as a separate artery from the third part of the subclavian trunk.

The *supra-scapular* and *transverse cervical veins* have the same course and branches as the arteries above described; they open into the external jugular near its junction with the subclavian vein. **Accompanying veins.**

Nerve to the rhomboid muscles. This slender nerve of the brachial plexus (p. 77) courses beneath the elevator of the angle of the scapula, and is lost in the rhomboidei on their under surface. Before its termination it supplies one or two twigs to the elevator of the scapula. **Nerve of rhomboid muscle.**

* THIRD LAYER. In this stratum are the following muscles:— the serratus posticus superior and inferior, with the splenius. **Third layer of muscles.**

* *Dissection.* By reflecting the rhomboidei muscles towards the spinous processes, and removing the loose areolar tissue, **Dissection.**

the thin upper serratus muscle beneath them will be laid bare.

The splenius and the inferior serratus have been previously exposed by the reflection of the trapezius and latissimus.

Serrati are two in number.

* The SERRATI muscles are very thin, and receive their name from their toothed attachment to the ribs. They are two in number, superior and inferior, and have aponeurotic attachments to the spines of the vertebræ.

Smaller at top of thorax.

Attachments.

* The *serratus posticus superior arises* from the ligamentum nuchæ, and from the spinous processes of the last cervical, and two or three upper dorsal vertebræ. The fleshy fibres are inclined down and out, and are *inserted* by slips into the second, third, and fourth ribs, external to their angles.

The muscle rests on the splenius, and is covered by the rhomboideus major.

Larger at bottom of thorax.

* The *serratus posticus inferior* (fig. 80, [6]) occupies the lumbar region, and is wider than the preceding muscle. Its aponeurosis of *origin* is inseparably united with that of the latissimus dorsi and the fascia lumborum, and is connected to the spinous processes of the last two dorsal and first three lumbar vertebræ.

Attachments.

The fleshy fibres ascend to be *inserted* by offsets into the last four ribs in front of their angles, each successive process extending further forwards than the one below.

Connections.

This muscle lies on the mass of the erector spinæ, and with its tendon the vertebral aponeurosis is united.

Use of both upper and lower.

Action. The superior serratus raises the upper ribs, and acts as an inspiratory muscle; and the inferior, depressing the lower ribs, becomes an expiratory muscle.

Theile supposes the inferior to be indirectly a muscle of inspiration, because, by fixing the lower ribs, it enables the diaphragm to act more efficiently.

Vertebral aponeurosis.

* The *vertebral aponeurosis* is a fibrous expansion, which is spread over the fourth layer of muscles, and confines the erector spinæ in the vertebral groove by the side of the spinous processes.

Attachments.

Above.

Inferiorly it is thickened by the tendons of the latissimus and lower serratus; but it is continued above beneath the splenius, without joining the upper serratus, and blends with the deep fascia of the neck.

Inside and outside.

Internally it is attached to the spinous processes. Externally it is connected to the posterior third of the iliac crest, uniting with the tendon of the latissimus; to the fascia lumborum, between the hip-bone and the ribs; and to the ribs and a thin fascia over the intercostal muscles.

Below.

Below, between the pelvic and vertebral attachments, it blends with the underlying tendon of the erector spinæ and multifidus.

Dissection.

* *Dissection.* The upper serratus is to be cut through, and the

subjacent vertebral aponeurosis to be taken away; and the part of the splenius muscle under the serratus should be cleaned.

The SPLENIUS muscle consists of cervical and cranial parts, which are named respectively splenius colli and splenius capitis: the two are united at their origin. Splenius has two parts:

The *splenius colli arises* from the spines of the three or four upper dorsal vertebræ above the sixth. Ascending in the neck, the muscle is *inserted* by tendinous slips into the posterior transverse processes of the upper three cervical vertebræ with, but behind the attachment of the elevator of the angle of the scapula. one to the neck. Attachments.

The *splenius capitis* (fig. 80, [8]) *arises* from the spines of the first two dorsal and last cervical vertebræ, and from the ligamentum nuchæ as high as the third cervical vertebra. The fleshy fibres ascend, and are *inserted* by a thin tendon into the apex and outer surface of the mastoid process, and into the bone behind it for about an inch and a half. One to the head. Attachments.

The splenius colli is smaller than the splenius capitis, and its fibres are more oblique. These muscles are situate beneath the trapezius, the rhomboidei, and the serratus superior; and the insertion into the occipital bone is beneath the sterno-mastoideus. The complexus muscle projects above the upper border of the splenius capitis. Their connections.

Action. The cranial parts of both muscles will carry the head directly back; and one will turn the face to the same side. Use of splenius capitis,

The splenius colli of both sides will bend back the upper cervical vertebræ; but one muscle will turn the face to the same side, being able to rotate the head by its attachment to the transverse process of the atlas. splenius colli.

* FOURTH LAYER. In this layer are included the spinalis dorsi; the erector spinæ, with its divisions and accessory muscles to the neck; and the complexus muscle. Most of the vessels and nerves of the back are to be learnt with this layer of muscles. Fourth layer of muscles.

Dissection. To lay bare the complexus muscle in the neck, the splenii must be detached from the spinous processes, and thrown outwards. Dissection of complexus.

And whilst the large erector spinæ is being displayed in the dorsal and lumbar regions by the dissector of the upper limb, two prolongations from it to the cervical vertebræ and the head are to be defined by the dissector of the neck: one, a thin narrow muscle, the cervicalis ascendens, is continued beyond the ribs from the sacro-lumbalis or outer piece of the erector, and is to be separated from the muscles around. The other is a larger offset of the longissimus dorsi or inner piece of the erector: blended at first with the fibres of the longissimus, it is divided afterwards, like the splenius, into a cranial part (trachelo-mastoid) and a cervical part (transversalis colli). Define offsets from the erector spinæ.

Show the erector spinæ and its divisions, viz.

* The serratus inferior is to be detached with the vertebral aponeurosis from the spines in the dorsal region, and the areolar tissue is to be cleaned from the surface of the large mass of the erector spinæ which now comes into view.

Sacro-lumbalis:

* Opposite the last rib is the beginning of an intermuscular interval, which divides the erector spinæ into an outer piece—the sacro-lumbalis, and an inner—the longissimus dorsi. By sinking the knife into this interval the sacro-lumbalis may be turned outwards, so as to uncover the fleshy slips of its accessory muscle, which are fixed to the angles of the ribs. A muscular slip (cervicalis ascendens) is prolonged from it to the neck.

offset to the neck.

Vessels and nerves.

* In preparing the sacro-lumbalis muscle, the external branches of the dorsal nerves with their accompanying arteries will be found.

Separate spinalis dorsi.

* Before the longissimus can be displayed, it will be needful to detach, and raise towards the spinous processes the thin muscular fasciculus of the spinalis dorsi, which lies between that muscle and the spines of the vertebræ in the dorsal region.

Longissimus dorsi:

* Then the attachments of the longissimus dorsi are to be traced out. Externally it has thin muscular processes of insertion into about the eight lower ribs. Internally it is inserted into the transverse processes of the lumbar and dorsal vertebræ by rounded tendons; and for the purpose of seeing these tendons, the longissimus should be drawn away from the spinous processes, and its superficial aponeurosis should be cut through below the ribs, along the line of separation between the muscle and the fleshy multifidus spinæ on the inner side. From this muscle, as from the sacro-lumbalis, a fleshy piece (transversalis colli and trachelo-mastoid) is continued into the neck.

offset to the neck.

Vessels and nerves.

* Between the longissimus and the multifidus spinæ are to be found the internal branches of the dorsal and lumbar nerves, and of the intercostal and lumbar arteries and veins.

Spinalis dorsi,

* The SPINALIS DORSI is placed by the side of the spines of the dorsal vertebræ, and is united with the longissimus dorsi. Inferiorly it *arises* by tendinous processes from the spines of the last two dorsal and first two lumbar vertebræ, and by fleshy fibres from the contiguous tendon of the longissimus. From this origin the fibres ascend, forming arches, whose concavity looks inwards, and are connected by tendinous processes to the spines of the dorsal vertebræ as low as the eighth or ninth, or only for half that extent.

along the dorsal vertebræ.

Spinalis cervicis:

Spinalis cervicis. A fleshy slip with this name, and resembling the spinalis in the dorsal region, lies along the side of the cervical spinous processes. Commonly continuous inferiorly with the spinalis dorsi, it is attached to the upper two dorsal or lower two cervical spines, and ends above on the spine of the

attachments;

axis, or on those of the second and third. Sometimes the muscle is absent.

Action. These muscles contracting will extend the dorsal and cervical regions of the spine. Perhaps the muscles of one side may tend to incline the spine laterally. use of both.

* The ERECTOR SPINÆ is the muscular mass on the side of the spine in the lumbar region. It is single and pointed below; and its cutaneous surface is covered near the sacrum by a wide and strong tendon, which is common to it and the multifidus spinæ. Erector spinæ is single at its origin.

* The muscle *arises* at the pelvis from the posterior fifth of the crest of the hip-bone at the inner aspect, except opposite the spinous processes: in the lumbar region by fleshy and tendinous pieces from the whole length of each transverse process; from the tubercle (process. accessorius) at the root; and from the layer of the fascia lumborum external to the process. Opposite the last rib it divides into sacro-lumbalis and longissimus dorsi. Attachments. Divides at the last rib into two.

* The SACRO-LUMBALIS OR ILIO-COSTALIS is the smallest of the two pieces resulting from the division of the erector spinæ. Its fibres end in six or seven flat tendons, which are connected together by their margins, and are inserted into the angles of as many of the lower ribs. The muscle is continued onwards to the other ribs and the neck by a fleshy part, which constitutes the two undermentioned muscles:— Sacro-lumbalis is inserted into six lower ribs.

* The *musculus accessorius ad sacro-lumbalem* begins by a series of tendinous and fleshy bundles on the angles of the lower six ribs, internal to the tendons of insertion of the ilio-costalis; and it ends in tendons, which are *inserted* into the remaining ribs (upper six) in a line with the ilio-costalis, and into the posterior transverse process of the seventh cervical vertebra. Musculus accessorius is attached to six upper ribs.

The *cervicalis ascendens* is a muscular slip that prolongs the accessorius into the neck. United with the preceding, this muscle is attached to four ribs (third, fourth, fifth, and sixth), and is inserted into the posterior transverse processes of three cervical vertebræ, viz. sixth, fifth, fourth. Cervicalis ascendens reaches the neck.

* The LONGISSIMUS DORSI gradually decreases in size as it ascends along the thorax. Internally the muscle is *inserted* into the transverse processes of all the dorsal vertebræ by a series of tendinous and fleshy bundles; and externally it is attached to the ribs, except the first two or three, by thin fleshy processes between the tubercle and angle. Its muscular prolongation to the neck is inseparably united with the upper fleshy fibres, and splits into the two following pieces:— Longissimus dorsi insertion; is continued to the neck by the

The *transversalis colli arises* from the transverse processes of the upper six dorsal vertebræ, and is *inserted* into the posterior transverse processes of the cervical vertebræ, except the first and last. transversalis colli, and to the head by the trachelo-mastoid.

The *trachelo-mastoid* muscle (transversalis capitis ?) *arises* in common with the preceding, and is attached besides by distinct tendons to the articular processes of the last three or four cervical vertebræ. The muscle is thin and is *inserted* beneath the splenius into the upper half of the posterior part of the mastoid process : its insertion is about three quarters of an inch wide.*

Connections of the erector spinæ in the lumbar,

* *Connections of the erector spinæ.* The erector spinæ and its prolongations occupy the lumbar, thoracic, and cervical parts of the back.

In the loins the muscle is contained in an aponeurotic sheath (p. 413), and has the multifidus spinæ on its inner side : its attachment on the inner surface of the innominate bone corresponds in greater part with the origin of the gluteus maximus on the outer side. The superficial tendon, which is common to it and the multifidus, will be described with the last mentioned muscle (p. 429).

dorsal,

Opposite the ribs the ilio-costalis and longissimus dorsi are concealed by the muscles of the other layers already examined.

and cervical regions.

In the neck its accessory small muscles lie underneath the splenius and the trapezius :—the cervicalis ascendens is attached in a line with, but below the splenius colli ; and the transversalis colli and trachelo-mastoid are more internal, or between the complexus and the splenius and cervicalis.

Use of both erectors :

Action. Taking their fixed point at the pelvis both erectors will keep the spine straight in sitting and standing ; and, in rising from stooping to the ground, they will bring the body into the erect posture.

of one on spine :

One muscle will incline the spinal column laterally and to its own side.

in breathing.

In laborious respiration, the spine being fixed, the muscles are able to depress the ribs and assist in the expulsion of the air from the thorax.

Use of accessory muscles :

The cervical prolongations of the erector act on the neck and head.

on neck, and ribs ;

The *cervicalis ascendens.* Taking their fixed point below, both muscles will extend the cervical part of the spine ; and acting from the transverse processes they will elevate the ribs. One muscle will give a lateral movement to the neck.

on neck,

The *transversalis colli* bends back the neck if the muscles of both sides contract together ; or laterally towards its own side, if only one is used.

* The anatomy of the prolongation from the longissimus might be simplified by describing it as the transversalis muscle with a double insertion, like the splenius, into the head and neck. In accordance with the nomenclature of the splenius the part to the head might be named *transversalis capitis,* and the part to the neck *transversalis colli,* as at present.

The *trachelo-mastoideus* will extend the head in concert with its fellow; or by itself will turn the face to its own side, and then help to approximate the head to the shoulder. on head.

Complexus. The COMPLEXUS is internal to the prolongations from the longissimus dorsi, and converges towards its fellow of the opposite side at the occipital bone. Narrow at its lower end, the muscle *arises* by tendinous pieces from the transverse processes of the upper six dorsal, and the last cervical vertebra; from the articular processes of the other cervical vertebræ as high as the third; and from the spines of one or two of the lower cervical vertebræ by a fleshy slip. From the processes of origin the fibres pass upwards, the inferior more vertically than the superior, to be *inserted* into an impression between the curved lines of the os occipitis, which reaches outwards nearly two inches from the occipital crest towards the trachelo-mastoideus. Origin. Insertion.

Its accessory piece. The *biventer cervicis* is but the inner part of the preceding, which is named from having two fleshy bellies with an intervening tendon. It is often described as a separate muscle.

Connections. The conjoined complexus and biventer cervicis are concealed by the splenius and trapezius: and the cutaneous surface is marked by a tendinous cross intersection towards the upper end. Two or three of the cervical nerves perforate the complexus. Along the inner side is the semispinalis muscle, with the ligamentum nuchæ. Beneath it are the small recti and obliqui muscles, the semispinalis, and the cervical nerves and vessels.

Use. *Action.* Both muscles will move the head directly back. One will draw the occiput down and back towards its own side.

Dissection of the nerves of the neck: *Dissection of vessels and nerves.* In the neck the nerves and vessels will be brought into view by detaching the complexus from the occipital bone and the spines of the vertebræ, and throwing it outwards carefully from the subjacent parts. Beneath the muscle is a dense fascia, in which are contained the ramifications of the cervical nerves, and the deep cervical and occipital vessels.

inner and outer branches. Each nerve except the first divides into an inner and an outer branch. Dissect out first the inner branches of the seven lowest, which lie partly above and partly beneath the fibres of the semispinalis muscle in the vertebral groove. The external branches are very small; they are given off between the transverse processes close to where the trunks appear, and enter the prolonged parts of the erector spinæ.

Find suboccipital; The first or suboccipital is the most difficult of the set to find: this little nerve is a short trunk, which is contained in an interval between the small recti and obliqui muscles near the head; it will be best found by looking for the small twigs furnished by it to the muscles around.

and the vessels. The deep cervical artery is met with on the semispinalis muscle; a part of the vertebral artery will be found in contact with the suboccipital nerve; and the occipital artery will be seen crossing the occipital bone.

Nerves and vessels in the dorsal region:

* Opposite the thorax the dorsal nerves and vessels will be readily displayed on the inner side of the longissimus dorsi muscle, on the removal of a little fatty tissue from between the transverse processes. External and internal branches are to be traced from each nerve and vessel into the muscles; some of the former have been seen in the interval between the sacro-lumbalis and longissimus dorsi.

in the lumbar region.

* The two branches of the lumbar nerves and vessels will be found in the same line as the dorsal; but the inner set are the most difficult to be discovered.

* The small sacral nerves are placed beneath the multifidus spinæ, and will be dissected after the examination of that muscle (p. 429).

Posterior branches of spinal nerves.

* Posterior Primary Branches of the Spinal Nerves. The spinal nerves, with a few exceptions in the cervical and sacral groups, bifurcate in the intervertebral foramina into anterior and posterior primary branches. The posterior supply the integuments and the muscles of the back, and are now to be learnt.

In the neck

In the neck. The posterior primary branches of the cervical nerves are eight in number, and issue, as a rule, between the transverse processes. But those of the first and second, which begin on the neural arches of the atlas and axis, cross those arches after leaving the common trunk. All, except the first, divide into internal and external branches.

they divide into two.

External branches are small.

None to the first.

The *external branches* are very inconsiderable in size, and end in the splenius, and the muscular prolongations from the erector spinæ. There is not any external branch to the first or suboccipital nerve.

Internal branches above three last,

give cutaneous offsets.

The *internal branches* are larger than the external. All are directed inwards towards the spinous processes, the three lowest nerves passing beneath the semispinalis, and the four next over that muscle. By the side of the spines of the vertebræ cutaneous branches are furnished to the neck and the head, but only by the nerves that are superficial to the semispinalis; these cutaneous offsets ascend to the surface through the splenius, the complexus, and the trapezius muscles, and are distributed as before seen (p. 408). In their course to the spine the nerves supply the surrounding muscles, viz., complexus, semispinalis, multifidus spinæ, and interspinales.

The *cutaneous branches* of the second and third nerves reach the head, and require a separate notice.

Second ends on head.

That of the second nerve, named *great occipital*, appearing beneath the inferior oblique muscle to which it gives offsets, is directed upwards through the complexus and trapezius to end on the occiput (p. 8).

The branch of the third nerve supplies an offset to the integuments of the neck; and ascending to the head through the trapezius, is distributed to the lower part of the occiput, internal to the great occipital nerve. Usually this nerve joins the preceding both beneath, and superficial to the trapezius. **Third supplies neck and head.**

The *posterior primary branch of the suboccipital* or first spinal *nerve* is very short, and appears in the interval between the recti and obliqui muscles. In passing from the spinal canal it is placed between the arch of the atlas and the vertebral artery. The following branches radiate from the extremity of the nerve:— **Suboccipital nerve has different branching;**

One enters the under surface of the complexus near the cranial attachment. A slender branch is furnished to each of the small muscles bounding the space in which the nerve is contained, viz., the rectus major and minor, and the superior and inferior oblique: the offset to the last muscle joins the inner branch of the second cervical nerve. Occasionally this nerve gives a cutaneous branch to the occiput. **ends in the muscles.**

Posterior cervical plexus. Sometimes there is an intercommunication between the suboccipital nerve and the internal branches of the next two cervical nerves beneath the complexus; this forms the posterior cervical plexus of M. Cruveilhier. **Posterior cervical plexus.**

* In the *dorsal region.* The posterior primary branches of the dorsal nerves are twelve in number, and appear between the transverse processes. Each nerve divides into an internal and an external piece; and these are distributed after the same plan as in the neck. Cutaneous offsets are furnished from certain branches. **Dorsal nerves have inner and outer branches.**

* The *external branches* increase in size from the first to the last, and are differently distributed above and below. The *upper six* or eight pass beneath the longissimus and its cervical prolongation, as far as the interval between the longissimus and the ilio-costalis, and end by supplying these muscles and the levatores costarum. The *lower six* or four have a similar arrangement and distribution with respect to the muscles; but, after reaching the interval between the ilio-costalis and the longissimus dorsi, they are continued to the surface through the serratus and latissimus muscles, nearly in a line with the angles of the ribs. **Outer branches of upper six, of lower six give cutaneous.**

* The *internal branches* decrease in size from above downwards, and are directed inwards between the semispinalis dorsi and multifidus spinæ muscles; offsets are supplied to the muscles between which they are placed. The *upper six* become cutaneous along the side of the spinous processes by perforating the serratus, rhomboideus, and trapezius. The *lower six* are small in size, and end in the multifidus spinæ muscle. **Inner branches of upper six have cutaneous offsets. Lower six not.**

* *In the loins.* The posterior primary branches of the lumbar **Lumbar nerves are**

divided into two. nerves, five in number, appear between the erector and multifidus spinæ. In their mode of dividing and general arrangement they resemble the dorsal nerves. Cutaneous offsets are furnished only by the external set of branches.

External branches give cutaneous from first three. * The *external branches* enter the fibres of the erector spinæ, and supply it and the small intertransverse muscles. The first three pierce the erector spinæ, and become cutaneous after perforating the aponeurosis of the latissimus. The branch of the last nerve is connected with the corresponding part of the first sacral nerve by an offset which lies near the bones.

Internal branches. * The *internal branches* are furnished to the multifidus spinæ muscle. Near their origin they are difficult to find, in consequence of being contained in grooves on the articular processes.

The vessels are * VESSELS IN THE BACK. The vessels now dissected are the occipital and the deep cervical; part of the vertebral; and the posterior branches of the intercostal and lumbar arteries of the aorta. Veins accompany the arteries for the most part.

in the neck. *In the neck.* The vessels in the neck are the occipital, the vertebral, and the deep cervical.

Part of the occipital artery, The *occipital artery* courses along the occipital bone. Appearing from beneath the digastric muscle, the vessel is directed backwards beneath the sterno-mastoideus, the splenius, and sometimes the trachelo-mastoideus, but over the obliquus superior and complexus muscles. Near the middle line of the body it perforates the trapezius, and ascends to the occiput, on which it is distributed (p. 6). It supplies the surrounding muscles, and which gives a furnishes the following branch to the neck :—

cervical branch. The *cervical branch* (ram. princeps cervicalis) distributes twigs to the under part of the trapezius, and passing beneath the complexus, anastomoses with the vertebral and deep cervical arteries.

Part of the vertebral artery. The *vertebral artery* lies on the neural arch of the first vertebra, behind the articulating process, and appears in the interval between the straight and oblique muscles. Beneath it is the suboccipital nerve. Small branches are given to the surrounding parts, and to anastomose with the contiguous arteries.

Deep cervical artery. The *deep cervical artery* is a branch of the superior intercostal (of the subclavian, p. 75), and resembles the posterior branches of the other intercostal arteries. Passing backwards between the transverse process of the last cervical vertebra and the neck of the first rib, it ascends between the complexus and semispinalis muscles, as high as the upper border of the latter, and anastomoses with the cervical branch of the occipital artery. The contiguous muscles receive branches from the deep cervical artery, and anastomoses are formed between its offsets and those of the vertebral.

Dorsal arteries are split into * *In the dorsal region.* The posterior branches of the intercostal vessels accompany the nerves between the vertebræ and the anterior costo-transverse ligaments. In the back they are divided like the nerves into inner and outer pieces.

* The *inner branches* end in the fleshy mass of the multifidus spinæ and semispinalis, and furnish small cutaneous offsets with the nerves. inner and

* The *external branches* cross beneath the longissimus dorsi, and supply it and the erector spinæ. Like the nerves, the lowest branches of this set are the largest and extend to the surface. outer branches,

As the dorsal branch of the intercostal artery passes by the intervertebral foramen, it furnishes a small *intraspinal artery* to the spinal cord and its membranes, as well as other twigs to the vertebræ. and give a branch to spinal cord.

* *In the loins.* The posterior branches of the lumbar arteries divide, like the intercostal, into internal and external pieces, as soon as they reach the interval between the longissimus dorsi and multifidus spinæ. Each gives also a *spinal branch* to the spinal canal, and to the spinal cord with the investing membranes. Lumbar arteries are also divided into

* The *internal branches* are small, and end in the multifidus spinæ muscle. inner and

* The *external branches* supply the erector spinæ, and offsets of them are continued onwards to the integuments with the superficial nerves. outer branches.

Veins. With the deep cervical artery is a large vein, *vena profunda cervicis,* which communicates with the occipital and other deep veins in this region, forming the posterior plexus of the neck, and passes forwards between the transverse processes, with its companion artery, to join the vertebral vein. Veins are deep cervical,

The *occipital vein* lies with its artery, and communicates sometimes with the lateral sinus of the skull through the mastoid foramen. occipital,

The *dorsal* and *lumbar* veins correspond in their branching and distribution with the arteries they accompany, and end in the intercostal veins. dorsal and lumbar,

In contact with the spinous processes and plates of the vertebræ is a deeper set of veins (*dorsi spinal.*), which anastomose freely together, and enter the veins in the interior of the spinal canal. and deep veins.

* Fifth Layer. In this layer are the following small muscles; —the recti and obliqui, the semispinales, interspinales, multifidus spinæ, and intertransversales. Muscles of the fifth layer.

Dissection. Most of the remaining muscles of the back are uncovered by the previous dissection. Between the first two vertebræ and the occipital bone the small straight and oblique muscles extend. Dissection of the last layer of muscles.

* In the cervical and dorsal regions the semispinalis muscle appears, with the small interspinales internal to it; and occu-

pying a corresponding position in the loins, is the multifidus spinæ.

* The small intertransverse muscles of the lumbar region will be found by removing the erector spinæ.

Rectus capitis major; attachments.

The RECTUS CAPITIS POSTICUS MAJOR is the largest of the muscles between the occipital bone and the first two vertebræ, and *arises* from the side of the spinous process of the axis. It is *inserted* into the outer part of the inferior curved line of the occipital bone for about an inch, as well as into the surface below it.

Connections.

Its upper attachment lies beneath the superior oblique muscle. This muscle is directed outwards very obliquely, and forms one side of the triangular space which contains the suboccipital nerve and the vertebral artery.

Use of both, and one muscle.

Action. By the action of both muscles the head will be put backwards. By one rectus the face will be turned to the same side; and after the head has been so rotated, the muscle will assist in extending the head.

Rectus capitis minor; attachments; connections:

The RECTUS CAPITIS POSTICUS MINOR is internal to the preceding, and is much smaller than it. *Arising* from the neural arch of the atlas, the muscle ascends to be *inserted*, close to the middle line, into the inferior curved ridge of the occipital bone, and between this and the foramen magnum.

they are interspinals.

This small muscle is fan-shaped, and is deeper than the rectus major: it covers the ligament between the atlas and the occipital bone. The two small recti muscles correspond with the interspinales between the other vertebræ.

Use.

Action. Both muscles, or one, will have the same use, viz., to approach the occiput to the atlas.

Obliquus inferior; attachments.

The OBLIQUUS INFERIOR takes a slanting position between the first two vertebræ. It *arises* from the spinous process of the axis, external to the rectus major muscle, and is *inserted* into the tip and the posterior transverse process of the atlas.

Use of one; of both.

Action. One muscle turns the face to the same side by rotating the atlas on the axis. If both muscles act at the same time they will assist in keeping the head straight.

Obliquus superior; attachments;

The OBLIQUUS SUPERIOR takes *origin* from the upper part of the transverse process of the atlas, where the preceding muscle terminates; and is directed inwards to be *inserted* between the curved lines of the occipital bone, near the mastoid process.

connections.

This muscle is concealed by the complexus and trachelo-mastoideus, and crosses the vertebral artery. Its insertion is beneath the splenius, but above the rectus major muscle.

Use of both; of one.

Action. With its fellow the upper oblique will assist in carrying backwards the head. By the action of one muscle the occiput will be inclined to the same side.

Semispinalis

The SEMISPINALIS occupies the vertebral groove in the dorsal and cervical regions, and extends from the transverse and articular processes to the spines of the vertebræ. The lower part of the fleshy mass is called semispinalis dorsi, and the upper part semispinalis colli. is divided into

The *semispinalis dorsi arises* from the transverse processes of the dorsal vertebræ, from the tenth to the sixth; and is *inserted* into the spinous processes of the upper four dorsal and the last two cervical vertebræ. semi-spinalis dorsi, and

The *semispinalis colli arises* from the transverse processes of the upper six dorsal vertebræ, and from the articular processes of the cervical vertebræ except the first three: it is *inserted* into the spines of the cervical vertebræ above the attachment of the semispinalis dorsi, the atlas not receiving any slip. semi-spinalis colli.

The semispinalis muscle is covered by the complexus, and by the deep cervical artery. Some of the cervical nerves are superficial, and others beneath it. To its inner side is the multifidus spinæ muscle. Connections.

Action. The muscles of both sides will act as extensors of the cervical and dorsal parts of the spine. One muscle will rotate the spine, so as to turn the face to the opposite side; and will assist others in inclining the spinal column to the same side. Use of both; of one muscle.

* The INTERSPINAL MUSCLES are placed, as their name expresses: they are arranged in pairs, one muscle being on each side of the interspinous ligament; and they are best seen in the neck and loins. Interspinal muscles in pairs.

In the *cervical region* the muscles are situate between most of the processes, but they are absent from the interval between the first two vertebræ. They are small round bundles, and are attached above and below to the bifurcated apices of the spines. in the neck;

* In the *dorsal region* the muscles are rudimentary; they exist between the first two, and the lowest two pairs of spinous processes, and between the last dorsal and the first lumbar vertebra. in the back;

* In the *lumbar region* they are thin flat muscles, which reach all along the spines. in the loins.

Action. By the approximation of the spinous processes these small muscles will help in extending the spine: necessarily the movement of each pair is very slight, but the aggregate of all would amount to perceptible motion. Use on the spine.

* The INTERTRANSVERSE MUSCLES lie between the transverse processes of the vertebræ; but only those in the loins and the back are now dissected. Inter-transverse muscles

In *the neck* they are double, like the interspinal muscles of the same vertebræ (p. 179). in the neck,

* In the *dorsal region* they are single rounded bundles, and are found only between the lower processes: their number varies from three to six. Between the upper processes tendinous bands take their place. in the dorsal region,

in the loins. * In the *lumbar region* the anterior set are four thin and fleshy muscular planes. The posterior set are rounded bundles, which are attached to the accessory points at the roots of the transverse processes: these have been named *interaccessorii.*

Use on the spine. *Action.* The small intertransversales help to incline laterally the spine by their approximating the transverse processes: the motion between a single pair of bones would be scarcely appreciable, as in the case of the interspinales.

Dissection of multifidus spinæ. *Dissection.* The multifidus spinæ muscle, which fills the hollow by the side of the spinous processes, may be now dissected. The upper part of the muscle is to be prepared and learnt by the

In the neck, dissector of the head and neck. It will be laid bare by cutting through the insertion of the semispinalis, and everting that muscle.

over sacrum and over ribs. * Over the sacrum the thick aponeurosis covering the multifidus and the erector spinæ must be removed. In the dorsal region the muscle will appear on detaching, and drawing aside the semispinalis from the spines.

Multifidus spinæ. * The MULTIFIDUS SPINÆ muscle extends from the sacrum to the second vertebra, and is much larger towards the pelvis than in the neck.

Origin on sacrum; On the back of the sacrum it takes *origin* between the central and external row of processes, as low as the fourth aperture; from the inner surface of the iliac spine (posterior superior) of the hip bone; and from the ligaments connecting this bone to the

in loins; sacrum. It is attached differently along its outer edge (origin)

in back. in the several regions of the spine. In the loins it *arises* by large fasciculi from the accessory and the articular processes. In the dorsal region, from the transverse processes. And in the neck, from the articular processes of the five lower vertebræ. From these attachments the fibres are directed obliquely inwards, some extending more than the length of one vertebra, to be

Insertion. *inserted* into the spines and the neural arches of the vertebræ from the second cervical to the third sacral.

Connections. This muscle fills chiefly the vertebral groove, and is concealed by the erector spinæ and the semispinalis. The internal branches of the vessels and nerves in the back lie along its outer border. The small muscles described below may be said to be parts of the multifidus.

Use of both, *Action.* By the use of the muscles of both sides, the spinal column can be extended; and by the contraction of one, the spine

and one muscle. will be rotated in the back and the neck, the face being turned to the opposite side. One muscle, combined with the semispinalis, will incline laterally the spine to its side.

Rotatores spinæ are parts of multifidus. * *Rotatores dorsi* (Theile). These are eleven small muscles beneath the multifidus spinæ in the dorsal region, and are separated from that muscle by fine areolar tissue. Each is attached inferiorily to the tip and upper edge of a transverse process, and superiorly to the lower border of the neural arch of the vertebra next above. The first springs from the transverse process of the second vertebra.

Action. These small rotators will assist the larger muscle (multifidus) in turning the spine to the opposite side. Use.

* The *aponeurosis* common to the multifidus and erector spinæ is fixed firmly to the surrounding bones, and furnishes attachment to the muscular fibres. In the middle line it is united with the spines of the lower lumbar vertebræ and sacrum. On the outer side it is attached to the posterior part of the iliac crest, and to the outer row of tubercles on the back of the sacrum, being connected at the last spot with the great sacro-sciatic ligament. Above, it is continued some way on the surface of the erector spinæ, but further on the longissimus dorsi than the iliocostalis. Below, the latissimus dorsi and the vertebral aponeurosis blend with its cutaneous surface (p. 411, 416). Aponeurosis of multifidus.

* *Dissection.* To find the branches of the sacral nerves, it will be necessary to remove the part of the multifidus spinæ which covers the sacrum. The first three are split into two each: their external branches will be found readily on the great sacro-sciatic ligament, from which they may be traced in; the inner branches are very slender and difficult to be recognised. Dissection of sacral nerves.

The lowest two nerves are very small, and are to be sought on the back of the sacrum, below the attachment of the multifidus spinæ. They are not bifurcated like the others, but unite together, and with the coccygeal nerve in loops. The fourth comes through a sacral aperture, the fifth between the sacrum and coccyx; and the coccygeal is still lower.

Sacral Nerves.—The posterior primary branches of the sacral nerves are five in number. Four issue from the spinal canal by the apertures in the back of the sacrum, and the fifth between the sacrum and the coccyx. The first three have the common division into inner and outer branches, like the other spinal nerves; but the last two are undivided. Five sacral nerves; are differently distributed.

* The *first three nerves* are covered by the multifidus spinæ, and divide regularly. First three have

The *inner branches* are distributed to the multifidus; and the last is very fine. inner and

The *outer branches* are larger, and have communicating offsets from one to another on the back of the sacrum: further, the outer branch of the first nerve is connected with the corresponding part of the last lumbar; and that of the third joins in a similar manner the sacral nerve next below. After this looping the branches pass outwards to the surface of the great sacro-sciatic ligament, where they join a second time, and then become cutaneous. (See Dissection of the Buttock.) outer branches; the last give cutaneous offsets.

Last two are undivided.

* *Last two nerves.* These nerves, which are below the multifidus, are much smaller than the preceding, and want the regular branching of the others: they are connected with each other and the coccygeal nerve by loops on the back of the sacrum. A few filaments are distributed to the back of the sacrum and the coccyx.

Coccygeal nerve.

Coccygeal nerve. Its posterior primary branch issues through the lower aperture of the spinal canal, and appears by the side of the coccyx. It is joined by a loop from the last sacral nerve, and ends on the posterior surface of the coccyx.

Small sacral arteries.

* SACRAL ARTERIES. Small branches leave the spinal canal with the sacral nerves; they supply the muscular mass of the erector spinæ, and anastomose with branches on the back of the sacrum from the gluteal and sciatic arteries.

Dissection of costal muscles.

* *Dissection.* The examination of the posterior part of the wall of the thorax may be made before the body is again turned. By removing, opposite the ribs, the ilio-costalis and longissimus dorsi, the small levatores costarum will be uncovered. The hinder part of the external intercostal muscle will be denuded at the same time.

Levatores costarum.

* The LEVATORES COSTARUM are twelve small fan-shaped muscles, which are connected with the hinder part of the ribs.

Attachments.

Each, except the first, *arises* from the apex and lower border of the transverse process of a dorsal vertebra; and is *inserted*, the fibres spreading out, into the upper border of the rib beneath from the tubercle to the angle. The muscles increase in size from above down, and their fibres have the same direction as the external intercostal layer.

The first.

The first is fixed above to the transverse process of the last cervical vertebra, and below to the outer border of the first rib.

Other elevator muscles.

Some of the four lower muscles are continued beyond one rib to that next succeeding: these longer slips have been named *levatores longiores costarum.*

Use of the muscles.

Action. The muscles raise the hinder part of the ribs, as the name signifies, and the lowermost draw the bones somewhat back.

Outer intercostal muscle.

* The *external intercostal muscle* is continued backwards along the ribs as far as the tubercle, and is overlaid by the elevator muscle. Beneath the muscle are the intercostal nerve and artery.

Dissection.

Dissection. To trace the anterior and posterior primary branches of the dorsal nerves to their common trunk, the elevator of the rib and the external intercostal muscle are to be cut through in one or more spaces. The intercostal artery with its posterior branch is laid bare by this proceeding.

Dorsal nerve has

* The *dorsal nerves* split in the intervertebral foramina into anterior and posterior primary branches.

* The *posterior* branches are directed backwards, internal to the anterior costo-transverse ligament, and have been already examined (p. 423). posterior

The *anterior* is named intercostal, and is continued between the ribs to the front of the chest. Its anatomy is learnt in the dissection of the thorax (p. 394). and anterior branch.

* The *intercostal artery* has an almost exact correspondence with the dorsal nerve in its branching and distribution. Intercostal artery.

CHAPTER VI.

THE SPINAL CORD AND ITS MEMBRANES.

Cord is contained in spinal canal, invested by membranes.

THE spinal cord (medulla spinalis) gives origin to the spinal nerves, and is lodged in the canal formed by the bodies and neural arches of the vertebræ. It is invested by prolongations of the membranes of the brain, which form sheaths around it, and is supported by them in its large canal.

Dissection to obtain the cord.

Dissection. To obtain the cord and its enveloping membranes, it will be necessary to open the spinal canal; but as a preparatory step all the muscles are to be taken from the arches and spines of the vertebræ. The canal may be opened by sawing through the neural arches, on each side, close to the articular processes; and the cuts of the saw should extend to the lower end of the sacrum, but not higher in the neck than the fourth cervical vertebra. As it is difficult to use the saw in the hollow of the lumbar region, a chisel and a mallet will be found useful to complete the division of the vertebral arches.

and the membranes.

When the loose bits of bone have been taken away, the tube of the dura mater will be seen to be covered by some veins and fat; and by a loose areolar tissue containing fluid sometimes, especially at the lower part. The fat may be scraped away with the handle of the scalpel, and lateral prolongations through the intervertebral foramina are to be defined.

Three membranes of the cord.

MEMBRANES OF THE CORD. Three membranes, like those of the brain, surround the cord, viz., an external tube of dura mater, an internal sheath of pia mater, and an intervening arachnoid or serous covering.

Dura mater surrounds cord loosely,

The *dura mater* forms a strong tube, and is continuous with the membrane lining the interior of the skull. Surrounding the cord and the nerves it extends along the spinal canal, and forms a loose sheath as far as the top of the sacrum; but beyond that point it is continued by a slender impervious cord to the back of the coccyx. The capacity of the sheath is much greater than is needed for its contents; and its size is larger in the neck and loins than in the back.

Size of sheath.

Connections.

On the outer aspect the dura mater is smooth, when a comparison is made between it and the part in the skull, for it does not act as a periosteum to the bones. Between it and the osseous surfaces are some vessels and fat; and it is connected to the posterior common ligament of the vertebræ by a few fibrous bands.

On each side the dura mater sends offsets along the spinal nerves in the intervertebral foramina; and these several offsets become gradually longer inferiorly, where they form tubes which enclose the sacral nerves, and lie for some distance within the spinal canal. In the midst of the tubes below is the slender before-mentioned impervious cord, which descends from the lower part of the sheath of the dura mater to the end of the spinal canal, and blends with the periosteum covering the back of the coccyx.

Offsets on spinal nerves,

central inferior piece.

Dissection. The spinal cord with the sheath of the dura mater is to be then removed from the body. For this purpose the lateral processes in the intervertebral apertures are to be cut; and one or two of them in the lumbar region should be followed outwards beyond the intervertebral foramen by cutting away the surrounding bone. The central prolongation may be now detached with care from the coccyx. Next, the cord and its membranes are to be divided opposite the lower cervical vertebræ, and to be removed by cutting the bands that attach the dura mater to the posterior ligament of the bodies of the vertebræ.

Dissection to remove cord,

When the cord is taken out, it is to be placed on a piece of board, or on a table, with the anterior surface uppermost, and the lateral offsets widely separated. To show the arachnoid covering, the dura mater is to be slit along the middle, on one or both aspects, as far as the small terminal fibrous cord before referred to; but the membrane is to be raised whilst it is being cut through, so that the loose arachnoid on the cord may not be injured. Lastly, the dura mater is to be fastened back with pins.

and see next covering.

The *arachnoid membrane* is the thin serous covering of the cord which is immediately beneath the dura mater. Like the corresponding membrane in the skull, it invests the nervous centre and lines the dura mater, and consists thus of a visceral and a parietal part.

Arachnoid membrane has a

The outer or *parietal* part is inseparably joined to the inner surface of the dura mater, and gives to the membrane a shining appearance.*

parietal or attached, and

The inner or *visceral* layer surrounds the cord loosely, so as to leave a considerable interval between the two (sub-arachnoid

loose or visceral layer.

* According to the view of Kölliker, the membrane is a simple tube corresponding with the *visceral* layer in the text.

Space beneath.

space). At the lower part of the spinal canal the loose sheath is largest, and envelops the mass of nerves forming the cauda equina. As the different spinal nerves extend to the intervertebral foramina, they receive loose tubes from the arachnoid, and lose the same when they perforate the dura mater.

To expose sub-arachnoid space.

Dissection. The subarachnoid space of the cord may be made evident by placing the handle of the scalpel beneath the visceral layer; or by putting a detached piece of the cord in water, with the posterior aspect uppermost, and blowing air beneath the serous membrane.

Sub-arachnoid space contains a fluid, and opens into cavities of brain.

The *subarachnoid space* is situate between the loose or visceral part of the arachnoid membrane, and the spinal cord invested by pia mater. Larger at the lower than at the upper part of the spinal canal, the interval contains a special fluid—*cerebro-spinal;* and it communicates with the cavity in the interior of the brain by an aperture in the fourth ventricle. Crossing the space at the posterior part of the cord, are bundles of fibrous tissue: in the neck the fibres are most marked, and are collected into an imperfect partition or septum along the middle line. In the space are contained the serrations of the ligamentum denticulatum, and the roots of the spinal nerves, with some vessels.

There is an imperfect septum behind.

Dissection of next covering.

Dissection. For the purpose of seeing the next covering of the cord with the ligamentum denticulatum, the arachnoid membrane is to be taken away.

Pia mater supports the cord, gives offsets.

The *pia mater* is much less vascular on the spinal cord than on the brain. Thicker and more fibrous in its nature, the membrane closely surrounds the cord with a sheath or neurilemma, and sends a thin prolongation into the anterior median fissure; it furnishes coverings to the roots of the spinal nerves.

Fibrous bands.

The outer surface of the pia mater is rough. Along the front is a central, anterior fibrous band (linea splendens, Haller); and on each side another fibrous band, the ligamentum denticulatum, is attached to it. Scattered through the membrane are branched pigment cells, which give frequently a darkish appearance in the cervical region where they most abound.

It ends inferiorly in a fibrous piece, the central ligament.

Where the medulla spinalis ceases, viz., about the lower part of the body of the first lumbar vertebra, the investing tube of the pia mater is suddenly reduced in size, and has the appearance of a round fibrous cord. This cord-like part is unprovided with nervous substance except above, and is blended with the central impervious prolongation of the dura mater on a level with the upper part of the sacrum. It serves to fix the lower end of the medulla spinalis, and has been named, from that circumstance, the *central ligament* of the cord (filum terminale). A vein and artery accompany this fibrous piece, and distinguish it from the surrounding nerves.

The dentate ligament,

The *ligamentum denticulatum* is the white, fibrous, toothed band on each side of the spinal cord. It is named from its serrated appearance; and it has the same structure as the dura mater, except that it wants an epithelial covering.

Situate between the anterior and posterior roots of the nerves, the band reaches upwards to the medulla oblongata, and ends inferiorly on the lower pointed extremity of the cord. Internally it is united to the pia mater. Externally it ends in a series of triangular or tooth-like projections, which are fixed at intervals into the dura mater, each being about midway, from above down, between the apertures of the roots of two spinal nerves. There are twenty or twenty one denticulations, of which the first is attached to the dura mater opposite the margin of the occipital foramen, between the vertebral artery and the hypoglossal nerve; and the last is inserted opposite the last dorsal or the first lumbar vertebra.

is fixed on one side to cord,

and on other to dura mater.

Number and attachment of points.

This fibrous band supports the spinal cord, and has been called a ligament from that circumstance.

Use.

Vessels and nerves of the membranes. The *dura mater* of the cord has but few vessels in comparison with that in the skull, for its office is different. Nerves are said to be furnished to it from offsets, on the vessels supplying the cord.

Vessels an nerves of dura mater,

The *arachnoid* is sparingly supplied with vessels like serous membranes in general, and proof of its containing nerves in man is yet wanting.

of arachnoid;

The *pia mater* has a network of vessels in its substance, though this is less marked than in the part on the brain, and from it offsets enter the cord. In the membrane are many nerves: these were supposed by Purkinje to be derived from the sympathetic, but Remak states that their chief source is the posterior roots of the spinal nerves.

of pia mater.

Dissection. The arachnoid membrane is to be taken from the fibrils of the roots of one nerve; and the roots of the nerve are to be traced outwards to their transmission through two apertures in the dura mater.

Dissection of roots of nerves,

One or more of the lumbar offsets of the dura mater, which have been cut of some length, are to be laid open to show the contained ganglion. The student should define one ganglion, showing its bifid condition at the inner end, and should trace a bundle of threads of the posterior root into each point. The anterior root, is to be followed over the ganglion to its union with the other beyond the ganglion.

and the ganglion.

Spinal Nerves. The spinal nerves are thirty-one in number, and are constructed by the blending together of two roots (anterior and posterior) in the intervertebral foramina (fig. 81).

Trunks of spinal nerves.

They are divided into groups corresponding with the regional subdivisions of the spinal column, viz., cervical, dorsal, lumbar, sacral, and coccygeal. In each group the nerves are the same

Number and groups.

in number as the vertebræ, except in the cervical region of the spine where they are eight, and in the coccygeal region where there is only one. In consequence of the number of nerves in the neck exceeding that of the vertebræ, the last is placed below the seventh vertebra; and the lowest nerve of each group, except the coccygeal, will be below its corresponding vertebra.

Last nerve of a group below the vertebra.

Each nerve divides into two, viz., anterior and posterior primary branches; the former of these is distributed to the front of the body and the limbs, and the latter is confined to the hinder part of the trunk.

Primary divisions.

Roots of the Nerves. Two roots or bundles of fibrils (anterior and posterior) attach the nerve to the spinal cord; and these unite together to form a common trunk in the intervertebral foramen. The posterior root is marked by a ganglion, but the anterior root is aganglionic.

Roots anterior and posterior.

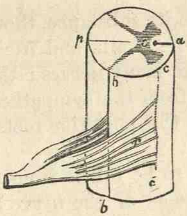
The *posterior* or *ganglionic roots* (fig. 81, *s*) surpass in size the anterior, and are formed by larger and more numerous fibrils. They are attached to the side of the cord between the posterior and lateral columns in a straight line, which they keep even to the last nerve.

Posterior larger than anterior:

In their course to the trunk of the nerve the fibrils converge to an aperture in the dura mater opposite the intervertebral foramen; as they approach that aperture they are collected into two bundles which, lying side by side, receive a sheath from the dura mater, and enter the two points of the intervertebral ganglion.

forms two bundles that enter the ganglion.

Fig. 81.*



The *intervertebral ganglia.* Each posterior root is provided with a ganglion. The ganglia are reddish in colour, and oval in shape whilst they are surrounded by the dura mater; and their size is proportioned to that of the root. By means of the previous dissection, the ganglion may be seen to be bifid at the inner end, where it is joined by the bundles of fibrils of the root; it might be said to possess two small ganglia, one for each bundle of fibrils, which are blended at their outer ends.

Number of ganglia, form, construction.

Each is bifid.

Sometimes the first or suboccipital nerve is without a ganglion.

The *anterior* or *aganglionic roots* arise from the side of the cord by filaments which are attached irregularly—not in a

Anterior root is

* A plan of the origin of the nerves and the fissures of the spinal cord—*r*. Anterior, and *s*. Posterior roots of the nerves.
a. Anterior fissure. *p*. Posterior fissure, and *b*. Lateral fissure; *c*. The line of attachment of the anterior roots. *e*. Central gray substance of the spinal cord.

straight line (*r*), and approach nearer the middle fissure at the lower end of the cord. without ganglion,

Taking the same direction as the posterior root to the intervertebral foramen, the fibrils enter a distinct opening in, and have a separate sheath of the dura mater. In their further course to the trunk of the nerve they are gathered into two bundles, and pass over the ganglion without joining it. Finally the anterior root blends with the posterior beyond the ganglion to form the trunk. pierces dura mater and joins posterior root beyond ganglion.

Characters of the roots. Besides variations in the relative size between the two roots, the following characters are to be noted : Characters of roots.

Union of the fibrils. The fibrils of contiguous anterior roots may be joined, and the fibrils of the neighbouring posterior roots may be connected in a like manner; but the anterior is never united with the posterior root, or the opposite. Some sets of fibrils join.

Relative size of the roots. The posterior root is larger than the anterior, except in the suboccipital nerve; and the number of the fibrils is also greater. Further, the posterior is proportionally larger in the cervical than in any other group. In the dorsal nerves there is but a very slight difference in favour of the hinder root. Posterior root largest, proportionally largest in neck.

Size of the roots along the cord. Both roots are larger where the nerves for the limbs arise, than at any other part of the cord; and they are greater in the nerves to the lower than in those to the upper limbs: so that the nerve roots increase from above down, except at the two following spots, viz., in the dorsal region where they are of much the same size from the second to the last, and at the lower extremity of the cord. Roots increase above down, except dorsal and sacral.

Direction and length. As the apertures of transmission from the spinal canal are not opposite the place of origin of the nerves, the roots must be directed more or less obliquely. This obliquity increases from above down; for in the upper cervical nerves the roots are horizontal, but in the lumbar and sacral nerves they have a vertical direction around the end of the medulla spinalis. The appearance of the long fibrils around the end of the cord resembles the extremity of a horse's tail, and bears appropriately the term *cauda equina*. Oblique in their course Most so inferiorly, and form cauda equina.

The length of the roots increases in proportion to the obliquity. Between the origin and the place of exit of the roots of the lower cervical nerve it amounts to the depth of one vertebra; in the lower dorsal nerve it equals the depth of two vertebræ; and in the lumbar and sacral nerves each succeeding root becomes a vertebra longer, for the cord does not reach beyond the first lumbar vertebra. Length increases from above down.

Place of union of the roots. Commonly the roots unite as before stated in the intervertebral foramina; and the trunk of the nerve bifurcates at the same spot into its anterior and posterior primary Union of the roots in intervertebral foramen, branches. But deviations from this arrangement are found at the upper and lower ends of the spinal column in the following nerves.

except in first two cervical

The roots of the first two cervical nerves join in each instance on the neural arch of the corresponding vertebra; and the anterior and posterior branches diverge from the trunk in that situation.

and the sacral

In the sacral nerves the union of the roots takes place within the canal; and the primary branches of the nerves issue by the apertures in the front and back of the sacrum.

and coccygeal nerves.

The roots of the coccygeal nerve are also united in the spinal canal; and the anterior and posterior branches of its trunk escape by the lower aperture of the canal.

Situation of ganglia.

Exceptions in cervical,

sacral, and

coccygeal.

Situation of the ganglia. The ganglia are placed commonly in the intervertebral foramina, but where the position of those apertures is irregular, as at the upper and lower extremities of the spinal canal, they have the following situation:—In the first two nerves they lie on the neural arches of the atlas and axis. In the sacral nerves they are contained in the spinal canal. In the coccygeal nerve the ganglion is also within the canal, and about the middle of the long posterior root (Schlemm).

Arteries of cord are

VESSELS OF THE SPINAL CORD. The arteries on the surface of the cord are anterior and posterior spinal. The veins do not resemble the arteries in their branching.

Anterior spinal, a single artery,

is continued onwards.

Termination.

Offsets.

The *anterior spinal artery* occupies the middle line of the cord beneath the fibrous band before alluded to in that position. It takes origin above by the union of two small branches of the vertebral artery (p. 191); and it is continued to the lower part of the cord by a series of anastomotic branches, which are derived from the vertebral and ascending cervical arteries in the neck, and the intercostal arteries in the back. Inferiorly it supplies the roots of the nerves forming the cauda equina, and ends on the central fibrous prolongation of the cord. The branches of this artery ramify in the pia mater, and are distributed to the substance of the cord, some entering the median fissure.

Posterior arteries are two;

are continued along cord like anterior,

lie on sides of cord.

The *posterior spinal arteries*, one on each side, are continued from the upper to the lower part of the cord, behind the roots of the nerves. These vessels begin superiorly by offsets from the vertebral artery, and their continuity is maintained by a series of anastomotic branches, which enter the canal along the spinal nerves, and are furnished from the same sources as the twigs reinforcing the anterior spinal artery. Dividing into small branches, the vessels of opposite sides form a free anastomosis around the posterior roots, and some offsets enter the fissure of the cord.

Veins.

The *veins* of the *spinal cord* are very tortuous, and form a plexus on the surface. At intervals larger trunks arise, which accompany the spinal nerves to the intervertebral foramina, and end in the veins outside the spinal canal. Near the top of the cord the veins, are united into two or more small branches; after communicating with the intraspinal veins, these join in the skull the inferior cerebellar veins, or the inferior petrosal sinuses. **Termination at top of cord.**

The SPINAL CORD (medulla spinalis) is the cylindrical elongated part of the cerebro-spinal centre, which is enclosed within the spinal canal. Invested by the membranes before examined, the medulla occupies about two thirds of the length of the vertebral canal, and is much smaller than the bony case surrounding it. **Situation of the cord.**

The extent of the cord is from the upper border of the atlas to the lower border of the first lumbar vertebra, but its termination inferiorly may be a little higher or lower than that spot. In the embryo before the third month the medulla reaches throughout the spinal canal, but it gradually recedes as the surrounding bones enlarge faster than it, until it takes the position it has in the adult. Its length is usually from fifteen to seventeen inches. **Extent varies below, and in the embryo. Length.**

Superiorly the cord joins the medulla oblongata; and inferiorly it becomes pointed, being sometimes marked by one or two swellings, and ends in the fibrous prolongation of the pia mater, named the central ligament of the cord. **Inferior termination in the adult.**

The size of the spinal cord is much increased where the nerves of the limbs are attached. There are therefore two enlargements on it:—one is opposite the lower part of the neck, reaching from the third cervical to the first dorsal vertebra; the other is smaller, and is on a level with the last dorsal vertebra. In the cervical enlargement the greatest thickness is from side to side; but in the lumbar swelling the measurement from before back rather exceeds the other. **Its size differs at spots.**

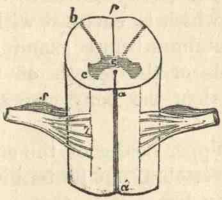
Whilst the pia mater remains on the cord, the anterior surface is distinguished from the posterior by the central fibrous band and the anterior spinal artery; and by the irregular line of the anterior roots, which approach the middle towards the lower end. **Anterior surface how known.**

Dissection. For the examination of the structure the student should possess a piece of the medulla which has been hardened in spirit, for the cord which is obtained from the spinal canal at this period, is not fitted for the purpose of dissection. Supposing the pia mater removed from the surface, without the roots of the nerves being detached, the student will be able to observe the following divisions in the medulla. **Dissection to see constituents of cord.**

FISSURES OF THE CORD (fig. 81). On the anterior and posterior aspects of the cord is a median longitudinal cleft—the anterior and posterior median fissures, which mark its division into halves; and along the line of the posterior roots of the nerves, in each half, is another slit—the lateral fissure. **Fissures of the cord are,** anterior median,

The *anterior median fissure* (fig. 82, *a*) is wider than the posterior, and penetrates about one third of the thickness of the medulla : it is lined by a piece of the pia mater, and is deepest towards the lower end of the cord. White medullary substance lines the fissure; and in the bottom of the cleft the white fibres are transverse, and are separated by apertures for bloodvessels.

Fig. 82.*



posterior median,

The *posterior median fissure* (fig. 82, *p*) is not so wide, nor so well marked as the anterior; but it is best seen at the upper part of the neck, and in the lower or lumbar enlargement. Vessels of the posterior surface of the cord enter this fissure.

and lateral fissure:

The *lateral fissure* is situate along the line of attachment of the fibrils of the posterior roots (fig. 81, *b*). It reaches inwards to the gray crescent in the interior of the medulla.

Supposed lateral fissure.

Sometimes another lateral fissure is described along the line of origin of the anterior roots, but there is not any cleft in that situation.

The cord is divided into

Segments of the Cord. Each half of the cord between the median fissures is divided into two parts by the lateral sulcus (fig. 81, *b*) : the piece in front of that slit and the posterior roots of the nerves is called the antero-lateral column ; and the piece behind, the posterior column. A central or commissural piece unites the halves of the medulla.

antero-lateral column,

The *antero-lateral column* (fig. 81, *a* to *b*) includes rather more than two thirds of the half of the cord, extending backwards to the posterior roots of the nerves, and gives attachment to the anterior roots.

posterior column,

The *posterior column* (fig. 82, *b* to *p*) is situate between the posterior roots of the nerves and the central fissure along the posterior aspect. Near the median fissure is a slight groove or furrow, which marks off a slender piece, the *posterior median column :* this portion is best seen in the cervical part of the cord.

and commissure.

The *commissure* of the cord is the central piece connecting the halves of the medulla, and limits the depth of the median fissures.

Different division.

Different division of the cord. Each half of the cord is divided sometimes into three parts or columns—anterior, lateral, and posterior (fig. 81), whose limits are the following :—The an-

* A plan of the segments and fissures of the cord.—*a.* Anterior, and *p.* Posterior fissure. *a* to *c.* Anterior column. *c.* to *b.* Lateral column. *b.* to *p.* Posterior column. *e.* Gray matter of the cord.

terior, *c*, reaches from the anterior roots of the nerves to the median fissure in front. The lateral column, *b*, is limited before and behind by the roots of the nerves. The posterior, *p*, with its small posterior median segment, is placed between the posterior roots and the median fissure behind.

CONSTITUENTS OF THE CORD. A horizontal section of the medulla shows more distinctly its division into halves, with the commissural or connecting piece between them. The same cut demonstrates the existence of a mass of gray matter in the interior, which is arranged in the form of two crescents (one in each half of the cord) united by a cross piece (fig. 82), and is surrounded by white substance. Cord consists of gray and white matter.

The *commissure* consists of two parts, viz. a transverse band of gray matter, and a white stratum in front.* The commissure.

The *gray commissure* (fig. 82, *e*), or the gray transverse band which connects the opposite crescents, consists of nerve cells, and of transverse nerve fibres derived from the halves of the cord and the roots of the nerves. Structure of the gray:

In its centre is the shrunken canal of the spinal cord (fig. 83, [4]) which is best seen in the fetus. It reaches the whole length of the medulla, and opens above in the floor of the fourth ventricle: a cross section of the cord shows the canal as a round spot. It is lined by a columnar epithelium (ciliated, Kölliker), and is obstructed by a granular material near the upper opening (Clarke). Its central canal lined by the epithelium;

The *white piece* of the *commissure* is formed partly by fibres of the anterior column; and partly by fibrils of the anterior roots of the nerves, which here decussate as they cross from the one half to the other. It is best marked opposite the enlargements on the cord, and least developed in the dorsal region. and of the white part.

The half of the medulla. In the half of the cord as in the commissure, gray and white portions exist; the former is elongated from before back, being crescentic in shape as before said, and is quite surrounded by the latter. The half of the cord.

The *gray crescent* is semilunar in shape, with the horns or cornua of the crescent directed towards the roots of the nerves, and the convexity to the middle line (fig. 82). The crescentic masses in the opposite halves of the cord are united by the gray commissure. The crescent.

The posterior cornu is long and slender (fig. 83, [1]), and reaches to the fissure along the attachment of the posterior roots (fig. 81, [2]). At its extremity, where it is rather enlarged, it is cased with a rather transparent stratum of small nerve cells, which has been named the *substantia gelatinosa* (fig. 83, [3]). Posterior cornu.

The anterior cornu (fig. 83, [2]) is shorter and thicker than the Substantia gelatinosa.

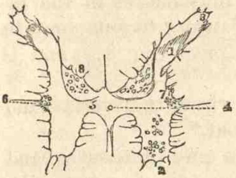
* A posterior white layer or commissure is described by some anatomists.

other, and projects towards the anterior roots without reaching the surface of the cord. Its end has an irregular or zigzag outline.

Special tracts.

Mr. Clarke * describes two special tracts in connection with the gray crescent; one on the outer and the other on the inner side, which extend through the cord below the cervical swelling, and with which the roots of the nerves are connected.

Fig. 83.†



Posterior vesicular column.

The inner tract or the *posterior vesicular column* (fig. 83, [8]) is close behind the gray commissure, and consists of central interlacing fibres (cylinder) derived from the posterior roots of the nerves; and of circumferential stellate nerve-cells of various sizes.

Construction,

size, and extent.

This column is largest at the upper part of the lumbar swelling of the cord. At the middle of the cervical enlargement the central part (cylinder) disappears, and only cells prolong it as far as the first pair of nerves.

Tractus intermedio-lateralis.

The outer or *intermediate tract* (fig. 83, [6]) (tractus intermedio-lateralis) is a collection of small and rather transparent but uniformly-sized cells, which is opposite the gray commissure, and projects into the lateral column of the cord. Its cells are reached by "both the posterior and anterior roots of the spinal nerves;" and other fibres are prolonged from it into the crescent, and through the gray commissure to the tract of the other side.

Cells in it joined by nerve roots.

Size and ending.

Largest in the upper part of the dorsal region, the tract ceases in the cervical enlargement of the cord. Above that spot there is a collection of cells in a line with it, and seeming to continue it upwards, which is traversed by the roots of the spinal accessory and the spinal nerves.

Accessory part

White substance of

The *white substance* of the *cord* is composed chiefly of nerve

* Further researches on the gray substance of the spinal cord. By J. Lockhart Clarke, F.R.S. Philosoph. Trans. of the Royal Society for 1859. Part i.

† A representation of the gray substance in the interior of the spinal cord, near the middle of the dorsal region (Clarke). Some figures have been inserted to explain Mr. Clarke's description of the crescent. 1. Posterior cornu (caput cornu, Clarke) of the crescent. 2. Anterior cornu. 3. Casing of the substantia gelatinosa. 4. Central canal of the cord. 5. Transverse commissure: the part in front of the canal is named anterior, and the part behind it posterior commissure by Mr. Clarke. 6. Tractus intermedio-lateralis. 7. Cervix cornu of Clarke, reaching from the anterior points of the substantia gelatinosa to the level of the canal. 8. Posterior vesicular column.

fibres disposed longitudinally in bundles, so as to give passage to intermediate vessels. By the projection of the cornua of the gray crescent towards the surface, each half of the cord is separated more or less completely into three parts—anterior, middle, and posterior, corresponding with the columns of the cord; but the anterior and middle portions are united, because the anterior cornu does not reach the surface. the half of the cord.

Modifications in the *gray* and *white substance.* The white substance exceeds the gray in quantity in the neck and back; but it is less abundant in proportion to the gray matter in the lumbar region. Gray and white substance vary.

The cornua of the gray crescents decrease in length from above down, especially the posterior, and towards the end of the cord they blend in one indented or cruciform mass. Crescents alter their shape.

ORIGIN OF THE NERVES. The deep origin of the spinal nerves is uncertain, like that of the cranial nerves, but the fibrils in each root enter the gray matter of the cord.* Deep origin of nerves uncertain.

The *anterior root* traverses the longitudinal fibres of the antero-lateral column in distinct bundles; and entering the anterior cornu of the gray crescent, it is resolved into three sets of fibres, external, internal, and middle. Anterior root enters crescent and lateral column,

The outer set penetrate into the anterior and lateral columns.

The inner set pass through the anterior column to the anterior median fissure, and cross to the opposite half of the cord, decussating with like fibres of the opposite side. anterior column of other side,

The middle set enter the substance of the crescent, and are lost in it and the cells of the intermediate tract. and the crescent.

The *posterior root* pierces chiefly the posterior column of the cord, its fibres interlacing therein, and enters the posterior cornu of the crescent; but a few fibres penetrate by the lateral fissure. It terminates in two bundles of fibres, which are specially connected with the vesicular column. Posterior root enters crescent,

One bundle courses round the outer side of the vesicular column, some fibres enclosing, and others interlacing in the part called cylinder; whilst the rest escape into the lateral column of the cord, becoming longitudinal. and joins by some fibres vesicular and lateral column:

The second bundle proceeds to the vesicular column along the inner side of the cornu. Some of its fibres interlace in the column. Others sweep round the outer side and are prolonged forwards into the crescent and the intermediate tract, as well as into the transverse commissure behind the central canal. Before the bundle reaches the vesicular column, a few fibres are reflected to the gelatinous substance, and escape into the lateral column of the cord. by other fibres, the gray commissure, the crescent, and lateral column.

* The description of the origin of the nerves embodies the opinions of Mr. Clarke. See Transactions of the Royal Society for 1851 and 1859.

Vessels of the spinal canal.

INTRASPINAL VESSELS. Arteries supply the cord and its membranes, and the bodies of the vertebræ. The veins form a remarkable plexus within the canal, but this will not be seen unless the veins have been specially injected.

Source of the intraspinal arteries.

The *intraspinal arteries* are derived from the vessels along the sides and front of the spinal column, viz. from the vertebral and ascending cervical in the neck, from the intercostal in the back, and from the lumbar and lateral sacral below. They are distributed after the following plan :—

Distribution to the vertebræ and the cord

As each artery enters the spinal canal by the intervertebral foramen, it divides into two branches, upper and lower. From the point of division the branches are directed, one upwards and the other downwards, behind the bodies of the two contiguous vertebræ, but outside the edge of the posterior common ligament, and join in anastomotic loops with offsets of the intraspinal artery above and below. And from the loops extending from one intervertebral foramen to another, offsets are furnished to the periosteum and the bodies of the vertebræ. Anastomotic twigs connect the arches across the vertebræ.

by loops ;

Besides forming loops, the intraspinal vessels produce a central longitudinal artery, like that on the front of the spinal cord, which lies on the bodies of the vertebræ, and is reinforced at intervals by offsets from the loops.

and a central vessel.

Intraspinal veins are large.

The *intraspinal veins* consist of two anterior longitudinal vessels, which extend the whole length of the spinal canal ; of veins inside the bodies of the vertebræ ; and of a plexus of veins beneath the neural arches.

Anterior longitudinal are on bodies of vertebræ.

The *anterior longitudinal* veins are close to the bodies of the vertebræ, one on each side of the posterior common ligament ; and they are irregular in outline, owing to certain constrictions near the intervertebral foramina. They receive opposite the body of each vertebra the veins from that bone ; and they send outwards, through the intervertebral foramina, branches of communication with the veins outside the spine in the neck, the dorsal region, the loins, and the pelvis.

Veins of the vertebræ.

Veins of the bodies of the vertebræ. Within the canals in the bodies of the vertebræ are large veins : these join on the front of each bone with veins in that situation. Towards the back of the body the veins are united in an arch, from which two trunks, one for each side, issue by the large apertures on the posterior surface. Escaped from the bone, the trunks diverge to the right and left, and open into the large longitudinal veins.

Posterior spinal veins are in contact with arches.

The *posterior spinal veins* form a plexus between the dura mater and the arches of the vertebræ. A large vein may be said to lie on each side of the middle line, which joins freely with its fellow, and with the anterior longitudinal vein by lateral branches. Into this plexus the small veins on the outside of the neural arches pour their contents. Branches from these vessels are directed to the intervertebral foramina, where they end in the veins at the roots of the transverse processes.

CHAPTER VII.

DISSECTION OF THE PERINÆUM.

Section I.

PERINÆUM OF THE MALE.

Before the dissection pass catheter.

Directions. The perinæum may be allotted with greatest advantage to the dissector of the abdomen. Its examination should be made before that of the abdomen, as the distinctness of many of the parts is destroyed soon after death. Before the body is placed in the position suited for the dissection, the student may practise passing the catheter along the urethra.

Place the body in position,

Position of the body. Whilst the body lies on the back it is to be drawn to the end of the dissecting table, till the buttocks project slightly over the edge; and a moderately-sized block is to be placed beneath the pelvis, to raise the perinæum to a convenient height. The legs are to be raised and kept out of the way by the following means:—After the knees have been bent, and the thighs bent upon the trunk, the limbs are to be fastened with a cord in their raised position. For this purpose make one or two turns of the cord round one bent knee (say the right); carry the cord beneath the table, and, encircling the opposite limb in the same manner, fasten it finally round the right knee. When the position has been arranged, let the student raise the scrotum, and place a small piece of cotton wool or tow within the anus, but let him avoid distending the rectum.

and fasten upwards the legs.

The surface, limits.

Superficial limits and marking. The perinæal space in the male is limited, on the surface of the body, by the scrotum in front, by the anus behind, and by the thighs and buttocks on the sides.

The anus,

This region is of a dark colour, and is covered with hairs. In it is the aperture of the anus, which is posterior to a line extended from the anterior part of the one ischial tuberosity to the other. In front of the anus the surface is slightly convex over the urethra, and presents a longitudinal prominent line or *raphé*, which divides this part of the space into two halves. Between the anus and the tuberosity of the hip bone the surface is some-

the raphé, hollow on side of anus,

what depressed over the hollow of the subjacent ischio-rectal fossa, especially in emaciated bodies.

The margin of the anal aperture possesses numerous converging folds, but these are more or less obliterated by the position of the body and the distension of the rectum; and projecting oftentimes through and around the opening are some dilated hæmorrhoidal veins (hæmorrhoids). and folds and veins around that opening.

Deep boundaries. The deep boundaries of the perinæal space will be ascertained, in the progress of the dissection, to correspond with the inferior aperture or the outlet of the pelvis. The limits may be made out by referring to a dry or prepared pelvis, on which the ligaments remain entire; and the student should trace on the body the individual boundaries with his finger. In front is the arch of the pubes; and at the posterior part is the tip of the coccyx, with the great gluteal muscles. On each side in front is the portion of the innominate bone which forms the pubic arch, viz., from the pubes to the ischial tuberosity; and still further back is the great sacro-sciatic ligament extending from the tuber ischii to the tip of the coccyx. This region sinks into the outlet of the pelvis as far as the recto-vesical fascia, which forms its floor. Bounding parts same as those of outlet of pelvis.

Form and *size*. The interval included within the boundaries above said has the form of a lozenge, and measures about four inches from before backwards, and three inches between the ischial tuberosities. Form of the space, and measurements.

Depth. The depth of the perinæum from the surface to the floor may be said to be generally about three inches at the anus, but this measurement varies in different bodies; and it amounts to about an inch near the pubes. Depth of the space.

Division. A line from the front of the tuberosity of one side to the corresponding point on the other, will divide the perinæal space into two triangular parts. The anterior half (urethral) contains the penis and the urethra, with their muscles and accessory parts. The posterior half (rectal) is occupied by the lower end of the large intestine, with its muscles, &c. A line between the tuberosities divides it into two.

POSTERIOR HALF OF THE SPACE.

This portion of the perinæal space contains the lower end of the rectum, surrounded by its elevator muscle and the muscles acting on the anus. The gut does not occupy however the whole of the interval between the pelvic bones; for on each side is a space, the ischio-rectal fossa, in which is contained much loose fat, with the vessels and nerves for the supply of the end of the gut. Contents and general position.

Dissection. The skin is to be raised from this part of the perinæum by the employment of the following cuts:—One is to be made across the perinæum at the front of the anus, and is to be Dissection extended rather beyond the ischial tuberosity on each side. A second is to be carried a little behind the tip of the coccyx in the same direction, and for the same distance. The two transverse cuts are to be connected by carrying the knife along the middle and around the anus.

of sphincter ani,

and subcutaneous muscle.

The flaps of skin thus marked out, are to be raised and thrown outwards from the middle line: in detaching the skin from the margin of the anus, the superficial subcutaneous and sphincter muscles may be injured without care, for they are close to the skin, without the intervention of fat. The dissector should trace the sphincter back to the coccyx, and forwards for a short distance beneath the remaining piece of skin; and define a fleshy slip at each side in front and behind to the subcutaneous fatty layer.

Difference in cleaning the ischio-rectal fossæ.

The next step is to bring into view the ischio-rectal hollow between the side of the rectum and the tuberosity of the hip bone: on the left side the fat is to be cleaned out of it without reference to the vessels and nerves, but on the opposite side a special dissection is to be made of them. To clean out the fat from the left fossa, begin at the outer margin of the sphincter, and proceed forwards and backwards. In front the dissection should not extend beyond the anus, whilst behind it should lay bare the margin of the gluteus maximus. On the inner side of the hollow the levator ani (sometimes very pale) and the coccygeus are to be dissected. On the outer boundary the pudic vessels and nerve should be denuded: they lie in a canal formed by fascia, and at some distance from the surface.

Dissection of left ischio-rectal fossa.

On right side, seek vessels and nerves.

On the right side it is not necessary to clean the muscular fibres, when following the vessels and nerves. If the student begins at the outer border of the sphincter, he will find the inferior hæmorrhoidal vessels and nerve, which he may trace outwards to the pudic trunks: some of the branches, which join the superficial perinæal and inferior pudendal nerves, are to be followed forwards. In the posterior angle of the space seek a small offset of the fourth sacral nerve; and external to it, one or more branches of the sciatic nerve and artery turning round the border of the gluteus. Near the front of the fossa is a superficial perinæal artery and nerve (of the pudic); and the last, after communicating with the hæmorrhoidal nerve, leaves the fossa. A second perinæal nerve with a deeper position may be found at the front of the hollow. The trunks of the pudic vessels and nerve may be laid bare on the outer wall.

Situation of fossa.

Form.

Dimensions.

The ISCHIO-RECTAL FOSSA is the space intervening between the rectum and the ischial part of the innominate bone. It is a somewhat conical interval open at the surface, which is larger behind than before, and diminishes in size as it sinks into the pelvis. Its width is about one inch at the surface, and its depth about two inches at the outer part. It is filled by a soft granular fat.

The inner or longest side of the space is very oblique, and is bounded by the levator ani and coccygeus muscles, and slightly by the sphincter; but the outer side is vertical, and is formed by the obturator muscle and the fascia covering it. In front it is limited by the triangular ligament (to be afterwards seen); and behind are the great sacro-sciatic ligament and the largest gluteal muscle. Towards the surface it is covered by the teguments, and is overlaid in part by the gluteus and sphincter externus, which diminish the opening. **Boundaries.**

Position of vessels. Along the outer wall lie the pudic vessels and nerve, which are contained in a tube of fascia; opposite the ischial tuberosity, they are situate an inch and a half from the surface, but towards the front of the space they approach to about half an inch from the edge of the pubic arch. Crossing the centre of the hollow are the inferior hæmorrhoidal vessels and nerve,—branches of the pudic. At the anterior part, for a short distance, are two superficial perinæal nerves (of the pudic); and at the posterior part is a small branch of the fourth sacral nerve, with cutaneous offsets of the sciatic vessels and nerve bending round the gluteus. **Pudic vessels on the outer wall, and nerves in the space.**

Into this space the surgeon sinks his knife in the first incisions in the lateral operation of lithotomy; and as he carries it from before backwards, he will divide the superficial hæmorrhoidal vessels and nerve. **First cut in lithotomy enters this space.**

MUSCLES. Connected with the lower end of the rectum are four muscles, viz. a thin cuticular muscle, and two sphincters (external and internal) with the levator ani. **Muscles of rectum.**

*Corrugator cutis ani.** This thin subcutaneous layer of involuntary muscle surrounds the anus with radiating fibres. Externally it blends with the subdermic tissue outside the internal sphincter; and internally it enters the anus and ends in the submucous tissue within the sphincter. **Corrugator cutis. Attachments.**

Action. By the contraction of the fibres the skin is raised into folds radiating from the anus, such as may be seen when that aperture is firmly closed. **Use.**

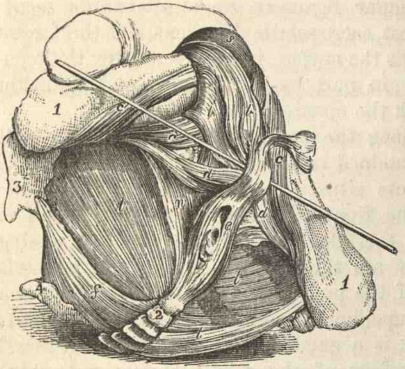
The EXTERNAL SPHINCTER (sphincter ani externus) is a flat, thin, orbicular muscle (fig. 84, *e*), which surrounds the lower part of the rectum. The fibres form ellipses around a central aperture, as in other orbicular muscles. It *arises* posteriorly by a fibrous band from the back of the coccyx near the tip, and by fleshy fibres on each side from the subcutaneous fatty layer. Its fibres pass forwards to the anus, where they separate to encircle that aperture; and having united in front of it, they are *inserted* **External sphincter surrounds rectum. Origin.**

* Illustrations of Dissections, p. 243. Lond. 1865.

Insertion. into the central point of the perinæum, and by a rather wide fleshy slip on each side into the superficial fascia.

Connections. The sphincter is close beneath the skin, and conceals partly the levator ani. The outer border projects over the ischio-rectal fossa, and the inner is contiguous to the internal sphincter.

Fig. 84.*



Use. *Action.* The muscle gathers into a roll the skin around the anus, and occludes the anal aperture: by its contraction it makes tense also the central point of the perinæum.

Usual state. Commonly the fibres are in a state of involuntary slight contraction, but they may be Unusual. firmly contracted under the influence of the will.

Internal sphincter a pale band The INTERNAL SPHINCTER (sphincter ani internus) is situate around the extremity of the intestine, internal to the preceding muscle, and its edge will be seen by removing the mucous membrane. The fibres of the muscle are pale, fine in texture, quite is part of fibres of intestine. separate from the surrounding external sphincter, and encircle the lower part of the rectum in the form of a ring. The muscle is a thickened band of the involuntary circular fibres of the large intestine, which is about half an inch in depth.

Use. *Action.* This sphincter assists the external in closing the anus; and its contraction is altogether involuntary.

Insertion of levator ani The LEVATOR ANI muscle (fig. 84, *l*) can be seen only in part; and the external sphincter should be detached from the coccyx, in order that its insertion may be more apparent. Lying in the perinæal space, the muscle descends from the inner aspect into coccyx, and tendon in front of it; of the hip bone, and is *inserted* along the middle line from the coccyx to the central point of the perinæum:—The most

* Muscles of the rectum, urethra, and penis (Santorini). 1. Lower part of the pubic arch. 2. Coccyx. 3. Ischial spine of the hip bone. 4. Side of the sacrum from which the sacro-sciatic ligaments are removed.

Rectal muscles. *e.* External sphincter: within it is the edge of the internal sphincter. *l.* Levator ani. *n.* Fascia covering its front. *f.* Coccygeus.

Urethral muscles. *b.* Ejaculator urinæ. *c.* Erector penis. *d.* Transversalis perinæi.

The probe lies beneath the central point of the perinæum, in which the rectal and urethral muscles are united.

posterior fibres are attached to the side of the coccyx; and between that bone and the rectum the muscles of opposite sides are united in a median tendinous line. The middle fibres are blended with the side of the intestine (rectum). And the anterior are joined with the opposite muscle, in front of the rectum, in the central point of the perinæum. into rectum, and the centre of the perinæum.

This muscle bounds the ischio-rectal fossa on the inner side, and unites with its fellow to form a fleshy layer convex downwards, through which the rectum is transmitted. Deeper than the muscle is the recto-vesical fascia. Along the hinder border is placed the coccygeus. Connections.

Action. Its action on the rectum is to elevate and invert the lower end of the gut after it has been protruded and everted in the passage of the feces. Use on rectum,

With the description of the muscle in the pelvis its action on the urethra will be referred to. on urethra.

ARTERIES. The pudic artery, the inferior hæmorrhoidal, and other small offsets of it and the sciatic are now visible. Arteries of the space.

The *pudic artery* is derived from the internal iliac in the pelvis, and ascending along the edge of the hip-bone to the genital organs, distributes offsets to the perinæum; one part will be laid bare in the hinder, and the other part in the anterior half of the perinæum. Pudic artery. Course.

As now seen the vessel enters the posterior part of the ischio-rectal fossa, and courses forwards along the outer wall at the depth of one inch and a half from the surface behind, but of only half an inch at the fore part of the hollow. It is contained in an aponeurotic canal which attaches it to the obturator fascia. The usual companion veins lie by its side; and two nerves accompany it, viz. the trunk of the pudic which is deeper, and the perinæal branch of the same nerve, nearer the surface. Posterior part in fossa. Depth and connections.

Its offsets in the posterior half of its course are the following. Offsets.

The *inferior hæmorrhoidal branch* arises internal to the ischial tuberosity; it sends offsets inwards across the ischio-rectal fossa to the tegument, and the sphincter and levator ani muscles. On the rectum this artery anastomoses with the upper hæmorrhoidal branch, and with the artery of the opposite side. In a well-injected body cutaneous branches may be seen to run forwards to the anterior part of the perinæum, and to communicate with the superficial perinæal branch. Inferior hæmorrhoidal.

Small *muscular branches* cross the front of the ischio-rectal fossa, and supply the anterior part of the levator ani muscle. Muscular offsets.

The *branches of the sciatic artery* appear on the inner aspect of the gluteus maximus at the back of the fossa; some end in that muscle, and others are continued round its border to the surface. Branches of the sciatic.

Veins accompany the different arteries, and have a like course and ramification: the pudic end in the internal iliac. Veins.

Nerves.

NERVES. The nerves to be learned in this part of the perinæum are, the trunk of the pudic and its inferior hæmorrhoidal and perinæal branches; an offset of the fourth sacral; and some branches of the small sciatic.

Pudic nerve. Course and connections.

The *pudic nerve* comes from the sacral plexus, and accompanies the artery through the perinæal space to the genitals. In the anal half of the perinæum it is placed deeper than the artery, and furnishes the two subjoined branches.

Perinæal branch.

The *perinæal branch* arises about half way along the fossa, and becomes superficial to the blood-vessels. It is larger in size than the continuation of the nerve to the penis, and divides into cutaneous, muscular, and genital offsets.

Its offsets to the teguments.

Its two cutaneous offsets (superficial perinæal) may be seen in part on the right side, where they are contained for a short distance in the ischio-rectal fossa.

Inferior hæmorrhoidal is with artery of same name. Termination.

The *inferior hæmorrhoidal branch* accompanies the artery of the same name across the ischio-rectal fossa, and reaches the margin of the anus, where it terminates in offsets to the integument and the sphincter muscle. Other cutaneous offsets of the nerve turn forwards over the fossa, and communicate with one of the superficial perinæal nerves, and with the inferior pudendal (of the small sciatic) on the margin of the thigh.

Branch of sacral nerve supplies sphincter and skin.

The *hæmorrhoidal branch* of the *fourth sacral nerve* reaches the ischio-rectal fossa by piercing the fibres of the levator ani. Appearing in the posterior part of the fossa, close to the coccyx, the nerve ends by supplying the external sphincter, and the integuments behind the anus.

Offsets of small sciatic.

One or two *cutaneous branches* of the *small sciatic nerve* turn round the lower border of the gluteus, in their course to the teguments on its surface.

ANTERIOR HALF OF THE PERINÆAL SPACE.

Contents and general position of parts.

In the anterior part of the perinæal space are lodged the crura of the penis, and the tube of the urethra as it courses from the interior of the pelvis to the surface of the body. Placed about midway between the bones, the urethra is supported by the fibrous triangular ligament of the perinæum and by the body of the penis.

Muscles are collected around it, to aid in the expulsion of the urine: some of these are superficial to, and some within the triangular ligament mentioned above.

The vessels and nerve lie along the outer side, as in the posterior half, and send inwards offsets.

Incisions to raise the skin.

Dissection. To raise the skin from the anterior part of the perinæum, a transverse cut is to be made at the back of the scrotum, and to be continued for a short distance (two inches) on each thigh. A second incision along the middle line will allow the flaps of skin to be reflected outwards.

After the removal of the skin the subcutaneous fat or the superficial fascia, which covers the front of the perinæal space, is to be blown up by means of a tube introduced beneath it at the posterior part. Each side is to be inflated to demonstrate one partition along the middle line, and another septum on the side between the perinæal space and the thigh, which prevents the air passing to the limb. **Blow up superficial fascia, and reflect it.**

The student is next to cut through the superficial fascia on the left side from the scrotum to the ischio-rectal fossa; and after reflecting it, and removing the loose fatty tissue, its line of attachment to the bones externally, and to the triangular ligament posteriorly, will be brought into view. The septum along the middle line should be also defined.

To demonstrate more completely the attachment of the superficial fascia to the pubic arch between the perinæal space and the thigh, it will be necessary to take away on the left side the fat from the fascia lata of the limb, external to the line of the bone before mentioned. **Define partition between thigh and perinæal space.**

In the fat of the thigh on the right side the student should seek the inferior pudendal nerve, which pierces the fascia lata one inch anterior to the tuber ischii, and about the same distance from the margin of the pubic arch; and should trace its junction in the fat with the inferior hæmorrhoidal nerve. Afterwards the nerve is to be followed forwards to where it enters beneath the superficial fascia in the middle line. **On right side seek inferior pudendal nerve.**

The *superficial fascia* of the anterior half of the perinæum is continuous with that of the adjoining regions; and its depth, and the quantity of fat in it, will vary with the condition of the body. It resembles the superficial fascia of the groin and upper part of the thigh, in consisting of two different looking parts. **Superficial fascia. Its thickness varies.**

One a subcutaneous fatty layer, continuous with that in other parts of the body, which loses its fat towards the scrotum, and contains there involuntary muscular fibres. **It has two layers.**

The other deeper, but more membranous layer, is of limited extent, and is connected with the firm subjacent structures. On the outer side it is fixed to the pubic arch of the hip-bone, external to the line of the crus penis and its muscle, extending as low as the ischial tuberosity. Posteriorly the stratum bends down to join the triangular ligament of the urethra. But in front it is unattached, and is continued to the scrotum and the penis. By means of similar connections on both sides, a space over the anterior half of the perinæum is inclosed by the superficial fascia. From the under surface of the fascia a septum dips downwards in the middle line, and divides posteriorly the sub- **Connections of deep layer. Forms a pouch, open in front: this divided by a septum.**

jacent space into two parts; but anteriorly this partition is less perfect or disappears.

Course of air and effused urine.

Air blown beneath the fascia passes forwards to the scrotum; and this direction is given to it by the connections of the deep layer with the parts around. Should urine be effused beneath the membranous part of the fascia, the fluid will necessarily be directed forwards, like the air, through the scrotum to the penis and the front of the abdomen.

Dissection of nerves and vessels on right side.

Dissection. The superficial vessels and nerves are to be dissected on the right side of the perinæum, by cutting through the superficial fascia in the same manner as on the left side.

The long slender artery now appearing is the superficial perinæal, which gives a transverse branch near its commencement: sometimes this artery is divided into two. Two superficial perinæal nerves course with the artery; and the inferior pudendal nerve is to be traced forwards to the scrotum. Communications are to be sought between these nerves anteriorly, and between one of the perinæal and the inferior hæmorrhoidal posteriorly; and all the nerves are to be followed backwards.

Superficial vessels of pudic.

ARTERIES. The arteries beneath the fascia, viz. superficial and transverse perinæal, are branches of the pudic, and are two or three in number.

Superficial perinæal

The *superficial perinæal* branch, arising from the pudic artery at the fore part of the ischio-rectal fossa, turns forwards over or under the transverse muscle, and runs beneath the superficial fascia to the back of the scrotum, where it ends in flexuous branches. As the vessel lies internal to the pubic arch, it supplies offsets to the muscles beneath: and in front it anastomoses with the external or superficial pudic branches of the femoral artery. Sometimes there is a second superficial perinæal branch.

ends in scrotum, and supplies the muscles.

Transverse artery.

The *transverse artery* of the perinæum arises from the preceding, or near the same spot, and is directed transversely to the middle of the perinæal space, where it is distributed to the integuments and the muscles between the urethra and the rectum. It anastomoses with the one of the opposite side.

Veins with the arteries.

Branches of *veins* accompany the arteries, and open into the trunk of the pudic vein: those with the superficial perinæal artery are plexiform at the scrotum.

Cutaneous nerves of scrotum.

NERVES. There are three long cutaneous nerves of the scrotum, viz. the inferior pudendal of the small sciatic, and two superficial perinæal branches of the pudic nerve.

Two superficial perinæal.

The *superficial perinæal nerves*, two in number, are named anterior and posterior from their relative position at their origin: both arise from the perinæal branch of the pudic nerve (p. 452).

Posterior crosses fossa to the scrotum,

The *posterior branch* appears near the front of the ischio-rectal fossa, and entering beneath the superficial fascia, is continued forwards with the artery of the same name to the back of the scrotum. Whilst in the fossa the nerve gives inwards an offset to the integuments in front of the anus, and this communicates with the inferior hæmorrhoidal nerve.

The *anterior branch*, appearing farther forwards than the other in the fossa, passes under the transverse muscle, and accompanies the posterior branch to the scrotum. At its origin muscular offsets are furnished to the levator ani muscle. **and anterior has same anatomy as posterior;**

The superficial perinæal branches communicate with one another, and the posterior is joined by the inferior pudendal nerve. At the scrotum they are distributed by long slender filaments, which reach as far as the under surface of the penis. In the female these nerves supply the labia pudendi. **both are joined and distributed to scrotum and penis.**

Other *muscular branches* of the pudic will be afterwards examined (p. 461). **Muscular branches;**

The *inferior pudendal nerve* is a branch of the small sciatic. It pierces the fascia lata about one inch in front of the ischial tuberosity, and coursing forwards along the inner part of the thigh, enters beneath the superficial fascia of the perinæum; finally, it passes forwards with the superficial perinæal nerves, and ends in the outer and fore parts of the scrotum. A communication takes place between this nerve, the inferior hæmorrhoidal, and the posterior of the two superficial perinæal branches. In the female the inferior pudendal nerve is distributed to the labium. **Inferior pudendal nerve ends in scrotum, and joins superficial perinæal.**

In the fat of the surface of the thigh some other *offsets* of the *small sciatic nerve* may be observed. **Other offsets of small sciatic.**

Dissection. For the display of the muscles, the superficial fascia, as well as the vessels and nerves of the left side must be taken away from the anterior half of the perinæal space. Afterwards a thin subjacent aponeurotic layer is to be removed from the muscles. Along the middle line lies the ejaculator urinæ; and in cleaning it the student is to follow two fasciculi of fibres which are prolonged from it on the same side, one in front, the other behind. On the outer part of the space is the erector penis. And behind, passing nearly horizontally between the other two, is the transverse muscle. **Dissection of muscles of the urethra and penis.**

The student should seek, on the right side, the branches of the two superficial perinæal nerves to the underlying muscles; and beneath the transversalis, the offset of the perinæal branch which supplies the deep muscles and the urethra. **Of nerves.**

Muscles. Superficial to the triangular ligament in the anterior half of the perinæal space, are three muscles, viz. the erector penis, the ejaculator urinæ, and the transversalis perinæi. Other muscles of the urethra are contained between the layers of the triangular ligament, and will be subsequently seen. **Three muscles over triangular ligament.**

Central point of the perinæum (fig. 84). Between the urethra and the rectum is a white fibrous spot, to which this term has **Central point:**

been applied. It occupies the middle line, being nearly in the centre of the pelvic outlet, and half an inch in front of the anus. In it the muscles acting on the rectum and the urethra are united; and it serves as a common point of support to the space.

where muscles join.

Erector penis.

The ERECTOR PENIS (fig. 84, *c*) is the most external of the three muscles, and is narrower at each end than in the middle.

Origin.

It covers the crus penis, and its fibres *arise* from the ischial tuberosity farther back than the attachment of the penis, and from the bone on each side of the crus. Superiorly the muscle

Insertion.

ends in an aponeurosis, and is *inserted* into the inner and outer surfaces of the crus penis. It rests on the root of the penis and the bone.

Use.

Action. The muscle compresses the crus penis against the subjacent bone, and retards the escape of the blood from that organ: in that way it will contribute to the continuance of distension.

Ejaculator urinæ.

The EJACULATOR URINÆ muscle (fig. 84, *b*) lies on the urethra in the middle line of the perinæum. The muscles of opposite sides unite through the interposition of a median tendon; and

Origin at middle line.

each is attached (its origin) to the tendon along the middle, and to the central point of the perinæum. The fibres are directed outwards, curving around the convexity of the urethra, and give rise to a thin muscle which has the following *insertion*:—The most posterior fibres are lost on the anterior surface of the tri-

Insertion by three parts.

angular ligament. The anterior fibres, which are the longest and best marked, are *inserted* into the penis on its outer aspect anterior to the erector; and, according to Kobelt,* they send a tendinous expansion over the dorsal vessels of the penis. Whilst the middle or intervening fibres turn round the urethra, extending as far forwards as to the union of the cavernous bodies of the penis, and join by a tendon the muscle of the opposite side.

Covers the urethra, and surrounds it as in a sling.

The ejaculator muscle covers the bulb and the urethra for two inches in front of the triangular ligament. If the muscle be cut through on the right side and turned off the urethra, the junction with its fellow above that tube will be apparent.

Use,

Action. The two halves acting as one muscle can diminish the urethra and eject forcibly its contents. During the flow of fluid in micturition the fibres are relaxed, but they come into use at

voluntary, and involuntary.

the end of the process, when the passage has to be cleared. Its action is voluntary in the expulsion of the urine, but involuntary in the emission of the semen.

Compressor of the bulb.

Some of the deeper fibres which immediately surround the bulb, have been described as a separate stratum by Kobelt. These are separated from the superficial layer by thin areolar

* Die Männlichen und Weiblichen Wollust-Organe, von G. L. Kobelt, 1844.

tissue, and join the corresponding part of the other muscle by a small tendon above the urethra. The name *compressor hemisphærium bulbi* has been proposed for it by that anatomist.

Transversalis perinæi.

The TRANSVERSALIS PERINÆI (fig. 84, *d*) is a small thin muscle, which lies across the perinæum opposite the base of the triangular ligament. *Arising* from the inner surface of the pubic arch near the ischial tuberosity, the fibres run inwards, and join in the central point of the perinæum with the muscle of the opposite side, and with the sphincter ani and the ejaculator urinæ. Behind this muscle the superficial fascia bends down to join the triangular ligament.

Origin. Ends in central point.

Accessory transversalis.

Sometimes there is a second small fleshy slip anterior to the transversalis, which has been named *transversalis alter;* this throws itself into the ejaculator muscle.

Use.

Action. From the direction of the fibres the muscle will draw backwards the central point of the perinæum, and help to fix it, preparatory to the contraction of the ejaculator.

A triangular space between the three muscles.

The three muscles above described, when separated from each other by the dissection, limit a triangular space, of which the ejaculator urinæ forms the inner boundary, the erector penis the outer side, and the transversalis perinæi muscle the base. In the area of this interval is the triangular ligament of the urethra, with the superficial perinæal vessels and nerves. Should the knife enter the posterior part of this space during the deeper incisions in the operation of lithotomy, it will divide the transverse muscle and artery, and probably the superficial perinæal vessels and nerves.

The knife may enter in lithotomy.

Dissection of triangular ligament.

Dissection. For the display of the triangular ligament, the muscles and the crus penis which are superficial to it, are to be detached in the following way:—On the left side the ejaculator urinæ is to be removed completely from the front of the ligament, and the erector muscle from the crus of the penis.

On the left side.

Next, the crus penis is to be detached from the bone on the same side; but this must be done with care so as not to cut the triangular ligament, nor to injure near the pubes the terminal parts of the pudic artery and nerve to the penis.

On the right side.

On the right side the dissector should trace out completely the deep offsets of the perinæal nerve to the muscles and the urethra, with the vessels accompanying them; and after these are prepared, he may reflect any of the muscles that interfere with a good view of the triangular ligament.

Triangular ligament of urethra.

The TRIANGULAR LIGAMENT OF THE URETHRA (perinæal aponeurosis) occupies the anterior part of the pubic arch, and supports the urethral canal. The ligament is triangular in form, with its base below; and it is about one inch and a half in depth.

Extent and form.

Attachments.

On each side it is fixed to the pubic arch beneath the [illegible] penis. Its apex is connected with the symphysis pubis. Its base is turned towards the rectum, and is partly attached and partly free;—in the middle line it is connected with the central point of the perinæum, whilst laterally it is sloped towards the bone, so that it is less deep at the centre than at the sides: connected with the lower border is a thin fascia which covers the surface of the levator ani muscle in the ischio-rectal fossa. Superficial to it are the muscles in the anterior half of the perinæal space; and the superficial fascia is united to it near the lower border.

Parts over it.

Apertures in it for urethra,

Perforating the fore part of the ligament, about one inch below the symphysis pubis, is the canal of the urethra; but the margin of the opening giving passage to that tube is blended with the tissue of the corpus spongiosum urethræ. About midway between the preceding opening and the symphysis pubis is the aperture for the dorsal vein of the penis; and external to this, near the bone on each side, the terminal parts of the pudic nerve and artery to the penis perforate the ligament by separate apertures.

for dorsal vein, and vessels and nerves.

Consists of strata.

The triangular ligament is composed of two layers of fibrous membrane (anterior and posterior) which are united below. The posterior layer is derived from the pelvic fascia. The anterior is a separate membrane formed chiefly of transverse fibres, but it is so thin as to allow the vessels and the muscular fibres to be seen through it. Between the layers of the ligament are contained the membranous part of the urethra, with its muscles, vessels and glands, and the bloodvessels and nerves of the penis.

Parts between.

Dissection.

Dissection. The muscles of the urethra between the layers of the ligament will be reached by cutting through with care, on the left side, the superficial stratum of the ligament near its attachment to the bone, and raising and turning inwards that piece of membrane. By a little cautious dissection, and the removal of some veins, the following objects will come into view with the undermentioned position:—

Parts in the triangular ligament.

Parts between the layers of the ligament. Near the base of the ligament is a narrow transverse muscle, which is directed to the bulb of the urethra. Higher up, and crossing inwards to the urethra from behind the pubic arch, is the fasciculus of fibres of the constrictor urethræ muscle, which surrounds the membranous part of the urethra. And below the urethra are the glands of Cowper. Beneath the bone are the pudic vessels and nerve, the former giving its branch to the bulb, and the latter being deeper in position; and below the pubes is the subpubic ligament. Deeper than all, the student will recognise the posterior layer of the ligament, continuous with the pelvic fascia, which separates these parts from the cavity of the pelvis.

Muscles of urethra.

MUSCLES. The muscles between the layers of the triangular ligament, which are connected with the membranous part of the urethra, are two in number, viz., a deep transverse muscle, and a constrictor of the urethral passage.

The DEEP TRANSVERSE MUSCLE of the perinæum (elevator urethræ, Santorini) is a thin flat band on a level with the base of the triangular ligament. It *arises* externally from the pubic arch of the innominate bone, and is directed inwards below the tip of the bulb and the membranous part of the urethra to the middle line, where it joins the muscle of the opposite side, and is *inserted* into the central point of the perinæum. **Deep transverse.** **Origin.** **Termination.**

The muscle conceals Cowper's gland, and is frequently placed over the artery of the bulb. The transverse muscle is not always separate from the following. **Connections.**

Action. Like the superficial muscle it will fix the central point of the perinæum. **Use.**

The CONSTRICTOR MUSCLE (constrictor isthmi urethralis) encloses the membranous part of the urethra (fig. 85), and consists of transverse fibres above and below the urethral tube. **Constrictor of urethral passage.**

The muscle *arises* by aponeurotic fibres from the pubic arch above the preceding, and from the posterior layer of the triangular ligament, but this attachment is not evident unless it has been dissected from behind. From this origin the fibres pass inwards, and separate near the urethra into two layers, of which one (fig. 85, 7) passes over, the other (8) under that canal; in the middle line they unite (sometimes by tendon) with the like parts of the muscle of the opposite side. **Transverse part arises from pubic arch,** **and ends in middle line.**

It may be considered a single muscle extending across the perinæum from one lateral attachment to the other, and enclosing the tube of the urethra like the sphincter ani encircles the rectum.* **Like a sphincter.**

Action. The muscles of both sides act as a single sphincter in diminishing the membranous part of the urethra, and ejecting the contents of the tube. **Use on urethra**

Like the ejaculator, they are relaxed whilst the urine is passing, but the two contract forcibly in expelling the last of that fluid. **in micturition.**

Involuntary circular fibres within the constrictor muscle surround the urethra from the bulb to the prostate, and form a layer about $\frac{1}{30}$th of an inch thick; they are not fixed to bone, and are continuous behind with the circular fibres of the prostate and bladder. **Circular fibres of urethra,**

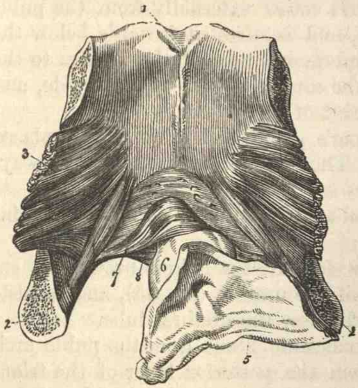
This layer is described commonly as part of the constrictor, **from the**

* Further information respecting this muscle may be obtained in the Septemdecim Tabulæ of Santorini; in a Paper by Mr. James Wilson, in the first volume of the Med. Chirur. Transactions; in the work of Mr. Guthrie, On the Anatomy and Diseases of the Neck of the Bladder and Urethra; and in the Treatise of J. Müller, Ueber die Organischen Nerven der erectilen Männlichen Geschlechts-Organe, &c.

prostate to bulb.

but its fibres are not transversely striated as in that muscle. It is a portion of the large involuntary orbicular muscle, of which the prostate is chief part, surrounding the beginning of the urethra.†

Fig. 85.*



Use.

Action. This involuntary layer assists in moving forwards the urine and the semen, and will deliver the same over to the action of the ejaculatory muscles.

Cowper's glands.

The *glands of Cowper* will be found by cutting through the transverse muscle. They are situate below the membranous part of the urethra, one on each side of the middle line, and close behind the bulb.

Situation, size, and structure.

Each gland is about the size of a pea, and is made up of many lobules; and the lobules are composed of small vesicles, which are lined by flattened epithelium.

Length and termination of the duct.

Connected with each is a minute duct, nearly an inch in length, which perforates obliquely the wall of the urethra (corpus spongiosum), and opens into the urethral canal about half an inch in front of the triangular ligament. Its aperture in the ordinary state does not admit a bristle. In the wall of the duct are unstriated muscular fibres; and the interior is lined by a columnar epithelium. The nature of the secretion of the gland is not known.

They vary in size.

These bodies are sometimes so small as to escape detection, and they appear to decrease in size with advancing age.

Dissection of the pudic vessels and nerve.

Dissection. The student may complete the examination of the perinæum by tracing out the pudic vessels and nerve, and their remaining branches. From the point of its division beneath the crus into two branches (dorsal branch of the penis, and branch of the corpus cavernosum), the artery is to be followed back-

* The symphysis pubis seen from behind with part of the urinary bladder and the tube of the urethra surrounded by the constrictor muscle (Santorini). 1. Symphysis pubis. 2. Sawn hip bone. 3. Internal obturator muscle. 5. The triangular part of the bladder seen from within. 6. Prostate gland. 7. Stratum of the constrictor above the urethra. 8. Stratum below the urethra.

† See a Paper on the Arrangement of the Muscular Fibres of the Urethra, &c., in vol. xxxix. 1856, of the Trans. of the Med. Chir. Society.

wards, along the pubic arch of the left side. The pudic nerve will be by the side of, but deeper than the artery. Should any of the branches of the vessel or nerve be cut away, the corresponding ones may be sought on the opposite side.

Pudic artery courses along pubic arch and ends on penis.

PUDIC ARTERY. The posterior half of this artery has been already dissected (p. 451). In the anterior half of the perinæum it ascends between the layers of the triangular ligament and along the pubic arch nearly to the pubes; there it perforates the superficial part of the ligament, and divides into the arteries of the body and dorsum of the penis. In this course it is placed beneath the constrictor urethræ, and is accompanied by venæ comites and the pudic nerve. Its offsets are subjoined.

Branches.

Artery of bulb in the triangular ligament.

The *artery of the bulb* of the urethra is a branch of considerable size, and arises near the base of the triangular ligament. Passing almost transversely inwards between the layers of the ligament, and about half an inch from the base, the artery reaches the bulb of the urethra, and enters the spongy structure. Near the urethra it furnishes a small branch to Cowper's gland.

Its situation varies.

The distance of this branch from the base of the ligament will be influenced by its origin nearer the front or back of the perinæal space. If the vessel arises farther behind than usual, it may be altogether below the base of the ligament, and cross the front of the ischio-rectal fossa; but if it arises more anteriorly, as when it comes from an accessory pudic branch (see below), its position will be higher than the level of the bulb. In the case first mentioned, it would be liable to be cut across in the operation of lithotomy, whilst in the last it would be altogether out of the way of the knife.

The importance of this in lithotomy.

Muscular branches.

Deep muscular branches. As the artery is about to enter between the layers of the triangular ligament it furnishes one or more branches to the levator ani and sphincter, and fine twigs through the base of the ligament to the constrictor and the urethra: sometimes these come from the transverse perinæal branch.

Artery of body of penis.

The *artery of the cavernous structure of the penis* (art. corporis cavernosi) is one of the terminal branches of the pudic. At first this small vessel lies between the crus penis and the bone, but it soon enters the cavernous structure, and ramifies in it.

Artery of dorsum of penis.

The *dorsal artery of the penis* is in direction and size the continuation of the pudic; it runs upwards like the preceding between the crus and the bone, and reaches the dorsum of the penis by passing through the suspensory ligament. Its distribution with the accompanying nerve is noticed at page 472. It is much smaller in the female than the male.

Accessory pudic artery.

Accessory pudic artery. In some cases the pudic artery is not large enough to supply the branches above described to the penis and the urethra. One or more offsets will be then contributed by an accessory vessel, which leaves the pelvis in front by piercing the triangular ligament. The source of this accessory artery is the internal iliac.

source.

Pudic veins.

The *pudic veins*, two in number, have the same connections as the artery; they receive similar branches, except that the dorsal vein of the penis does not join them.

Pudic nerve is with the artery and ends like it on penis.

The PUDIC NERVE has been examined in the ischio-rectal fossa (p. 452). In the anterior half of the perinæum it is much diminished in size, in consequence of the emission of the large perinæal branch, and courses with the artery between the layers of the triangular ligament; near the pubes it pierces the ligament, and is continued onwards to the dorsum of the penis with the dorsal branch of the pudic artery; its termination is described at page 472.

Muscular offsets.

Muscular branches. Offsets of the superficial perinæal nerves enter usually the three superficial muscles. The other muscles and the corpus spongiosum are supplied by the following.

Perinæal branch.

Perinæal branch (p. 452). Arising in the ischio-rectal fossa it ends near the base of the triangular ligament in several offsets. Some pass beneath the transversalis, and piercing the triangular ligament, supply the muscles within it. A long slender branch, *nerve of the bulb*, is distributed like the artery to the spongy structure investing the canal of the urethra: its filaments reach some way on the surface before disappearing in the corpus spongiosum urethræ.

Nerve of the bulb.

Superficial parts cut in lithotomy,

Parts cut in the lateral operation of lithotomy. In the external incision the knife is entered in the middle line of the perinæum, half an inch in front of the anus, and is drawn backwards on the left side as far as midway between the ischial tuberosity and the anus. The skin and superficial fascia, and the inferior hæmorrhoidal vessels and nerve lying across the ischio-rectal fossa, will be cut in the first stage of the operation; and the transverse perinæal muscle and artery, and, possibly, the superficial perinæal vessels and nerves, may be divided, if the first incision is begun farther forwards.

in reaching the staff

In the subsequent attempt to reach the staff, when the knife is introduced into the anterior part of the wound, the lower part of the triangular ligament, the deep transverse urethral muscle, and the fore part of the levator ani will be divided; and when the knife is placed within the groove of the staff, the membranous part of the urethra will be cut, with the muscular fibre about it.

and in running knife along staff.

Lastly, as the knife is pushed along the staff into the bladder, it incises in its progress the membranous portion of the urethra, part of the prostate with the large veins around it, and the neck of the bladder. When the last two parts are being cut the handle of the knife is raised; and the blade is depressed, and is

Direction of cut in prostate.

carried downwards and outwards in the direction of a line from the urethra through the left lateral lobe of the prostate, above the level of the ejaculatory duct.

Parts to be avoided. In the first incisions in the ischio-rectal fossa, the rectum may be cut if the knife is turned inwards across the intestine, instead of being kept parallel with it; and if the gut is not kept out of the way with the fore finger of the left hand. The pudic vessels on the outer wall of the ischio-rectal fossa can be wounded in a child near the anterior part of the hollow, where they approach the margin of the triangular ligament; but, posteriorly, they are very securely lodged inside the projection of the tuber ischii. **Parts to be avoided are rectum, pudic vessels,**

Whilst making the deeper incisions to reach the staff, the artery of the bulb lies immediately in front of the knife, and will be wounded if the incisions are made too far forwards; but the vessel must almost necessarily be cut, when it arises farther back than usual, and crosses the front of the ischio-rectal fossa in its course to the bulb of the urethra. **artery of bulb,**

In the last stage of the operation the neck of the bladder should not be cut to a greater extent than is necessary for the extraction of the stone, lest the recto-vesical fascia separating the perinæum from the pelvis should be injured, and the abdominal cavity opened. Too large an incision through the prostate may wound also an unusual accessory pudic artery on the side of that body. **recto-vesical fascia and accessory pudi artery.**

Directions. When the dissection of the perinæum is completed, the flaps of skin are to be fastened together after salt has been used, and the limbs are to be put down for the examination of the abdomen. **Directions.**

SECTION II.

PERINÆUM OF THE FEMALE.

The perinæum in the female differs from that in the male more in the external form than the internal anatomy; but it has special parts distinguishing it, viz. the aperture of the vagina surrounded by its sphincter, and the opening of the vulva with the labia. **Perinæum of female has special parts.**

Surface-marking. On the surface of the perinæal space in the middle line, there are the two apertures of the anus and vulva, which are separated from one another by an interval of about an inch. The anus is situate rather farther back than in the male. And the vulva is placed in the situation of the scrotum of the other sex, with the labia majora on the sides. **Along middle, apertures of anus and vulva.**

Parts within vulva.

Within the vulva at the upper part, is the clitoris, with two small membranous folds, labia minora, extending downwards from it. Below the clitoris is the small aperture of the urethra; and still lower down is the vagina, whose opening is sometimes partly closed by a thin piece of membrane, the hymen.

Boundaries alike in both sexes.

Deep boundaries. The deep boundaries of the perinæum are alike in both sexes; but in the female the outlet of the pelvis is larger than in the male.

Dissection.

Dissection. The steps of the dissection are much the same in both sexes, and the same description will serve, generally, for the male and female perinæum.

Take first ischio-rectal fossa.

First, the dissection of the ischio-rectal fossa is to be made. Afterwards the muscles, vessels, and nerves of the posterior half of the perinæal space are to be examined. (See description of the male perinæum, p. 448.)

Then examine anterior half of perinæum.

Next the skin is to be taken from the anterior half of the perinæal space, as in the male; and the transverse incision in front is to be made at the anterior part of the vulva. The attachments of the superficial fascia are then to be looked to, and the cutaneous vessels and nerves are to be traced beneath it (p. 452).

Superficial fascia.

Superficial fascia. The description of this fascia in the male will serve for the like part in the female with these modifications; that in the female it is interrupted in the middle line, and is of less extent, in consequence of the aperture of the vulva; and that it is continued forwards through the labia majora (the representative of the scrotum) to the inguinal region.

Dissection of the muscles.

Dissection. The labia and the superficial fascia are to be removed, to follow the sphincter muscle around the opening of the vagina. The two other muscles that are exposed at the same time (transversalis perinæi and erector clitoridis) resemble those in the male.

Sphincter vaginæ.

Origin.

The SPHINCTER VAGINÆ is an orbicular muscle around the orifice of the vagina, and corresponds with the ejaculator urinæ in the male. Posteriorly it is attached to the central point of the perinæum, where it mixes with the sphincter ani and transversalis muscles; and its fibres are directed forwards on each side of the vagina, to be *inserted* into the body of the clitoris.

Insertion.

Use.

Action. Like the other orbicular muscles the sphincter diminishes that part of the vagina which it encircles; and it assists in fixing the central point of the perinæum.

Erector clitoridis.

The ERECTOR CLITORIDIS resembles the erector of the penis in the male, though it is much smaller.

Transversalis.

The TRANSVERSALIS is similar to the muscle of the same name in the male. The one description will suffice for it in both sexes (p. 457).

To expose

Dissection. To see the triangular ligament of the urethra, the erector and the crus clitoridis are to be detached from the bone, and the outer fibres of the sphincter vaginæ are to be removed. triangular ligament.

The *triangular ligament* transmits the urethra, but is not quite so strongly marked as in the male; its extent is partly interrupted behind by the large aperture of the vagina. Triangular ligament.

Dissection. By cutting through the superficial layer of the ligament in the same way as in the male, the deep muscles, with the pudic vessels and nerve, and their branches, will be arrived at. To see muscles of urethra.

The DEEP TRANSVERSE MUSCLE (depressor urethræ, Santorini) has the same origin externally as in the male; and it meets its fellow at the middle line, like the muscle answering to it in the other sex. Santorini described the muscle as passing over, instead of below the urethra; hence the name given to it by its discoverer. Deep transverse muscle.

The CONSTRICTOR MUSCLE of the urethra resembles that of the male in its origin from the pubes, and its disposition around the urethra. Within it is a circular layer of involuntary fibres, as in the other sex. Constrictor urethræ.

The description of the *pudic artery* (p. 461) will serve for both sexes, except that the branch in the female, which is the representative of the artery of the bulb in the male, is furnished to the vagina. The terminal branches are much smaller in the female. Pudic vessels.

The *pudic nerve* has the same peculiarity as the artery with respect to the branch to the vagina, and the smaller size of the terminal part of the nerve on the clitoris. Pudic nerve.

CHAPTER VIII.

DISSECTION OF THE ABDOMEN.

SECTION I.

WALL OF THE ABDOMEN.

Directions for the dissection. IF the perinæum is allotted to the abdomen, the dissector is to keep in mind that he has not only to examine that region, but to proceed as far in the abdomen as the end of Section III. before the body is turned for the dissection of the back.

Position of the body. *Position.* The body will be sufficiently raised by the blocks placed beneath the thorax and head for the dissection of the upper limbs and neck, but the dissector should see that the chest is higher than the pelvis. After the abdomen has been inflated by an aperture through the umbilicus, let the markings on the surface be first attended to.

Appearances on the front of the abdomen. *Surface-marking.* On its anterior aspect the abdomen is for the most part convex, especially in fat bodies; but on the sides, between the ribs and the crista ilii, the surface is somewhat depressed. Along the middle line is a slight groove over the linea alba, which presents about its centre the hollow of the umbilicus. Inferiorly the groove ceases a little above the pelvis in the prominence of the pubes; and superiorly it subsides below the ensiform cartilage in a hollow named the epigastric fossa. On each side of the middle line is the projection of the rectus muscle, and this is intersected in young and well-formed bodies by two or three transverse depressions.

Projection of the pubes Underneath the eminence of the pubes the student will be able to recognise with his finger the symphysis pubis, and to trace outwards from it the osseous pubic crest which leads to the pubic spinous process. and Poupart's ligament. If the finger is carried upwards and outwards to the crest of the innominate bone, it will detect the firm band of Poupart's ligament between the abdomen and the thigh, and sometimes one or two inguinal glands.

Abdominal rings, Rather above and to the outside of the pubes, the opening of the external abdominal ring may be felt; and the prominence outer, of the spermatic cord descending through it to the testicle may be detected. The internal abdominal ring is still to the outer side, though it cannot be recognised on the surface with the finger; but its position may be ascertained by taking a point midway between the symphysis pubis and the crest of the innominate bone, and a little above Poupart's ligament. inner.

Attached to the front of the symphysis pubis in the male are the penis and the scrotum. Penis and scrotum.

Dissection. The requisite incisions for raising the skin from the sides and front of the belly are the following:—One cut is to extend outwards over the side of the chest from the ensiform cartilage to about midway between the sternum and the spine, if this has not been made already by the dissector of the upper limb. A second incision is to be begun in the middle line midway between the umbilicus and the pubes, and to be carried outwards to the iliac crest, and along the crest till it ends opposite the first cut. Lastly, the hinder extremities of the two incisions are to be connected along the side of the chest and the belly. The piece of skin thus marked out is to be raised towards the middle line but is not to be taken away; and the cutaneous vessels and nerves are to be sought in the fat at the side and middle line of the abdomen. Raise the skin from the front.

Along the side of the abdomen look for the lateral cutaneous nerves, five or six in number, which issue in a line with the corresponding nerves of the thorax. At first they lie beneath the fat, and divide into two: one offset is to be traced forwards, and another backwards with small cutaneous arteries. On the iliac crest, near the front, is a large branch from the last dorsal nerve; and still farther back on the crest, and deeper, is a smaller cutaneous branch of the ilio-hypogastric nerve. Position of cutaneous nerves, on the side:

Near the middle line the small anterior cutaneous nerves will be recognised with small arteries; these are uncertain in number and size, and are to be followed outwards in the integuments. and in front.

The piece of skin covering the lower part of the abdomen or the groin is next to be thrown downwards, on both sides, by means of an incision along the middle line to the root of the penis. After its reflection the cutaneous vessels and nerves are to be dissected on the right side, and the superficial fascia on the left. Take the skin from the groin.

To make the necessary dissection on the right side, all the fascia superficial to the vessels is to be raised in the same manner as the piece of skin. The vessels which will then appear are the superficial pudic internally, the superficial epigastric in the centre, and an offset of the superficial circumflex iliac artery externally. Some inguinal glands are seen along the line of the reflected fascia. Seek vessels

Two cutaneous nerves are to be sought:—one, the ilio-inguinal, comes through the abdominal ring, and descends to the thigh and scrotum; the other, ilio-hypogastric, appears in the and nerves in right groin.

superficial fascia above, and rather outside the abdominal ring.

Separate fascia in left groin into superficial

In the dissection of the fascia on the left side two strata or layers are to be made out, one over and one beneath the vessels. The layer that is superficial to the vessels is to be reflected by means of a transverse cut from the front of the iliac crest to the middle line, about two inches above Poupart's ligament; and by a vertical one along the middle line to the pubes. The subjacent vessels mark the depth of this layer; and when these are reached, a flap of the fascia like that of the skin, is to be thrown towards the thigh.

and deep layer.

To define the thinner under stratum, cut it across in the same manner as the other layer, and then detach it with the vessels from the tendon of the external oblique muscle. This stratum, like the preceding, is to be traced around the cord to the scrotum; and as the student follows it downwards, he will find it connected with Poupart's ligament, and inseparably joined with the fascia lata close below that structure.

Superficial fascia is divided into two layers.

The *superficial fascia*, or the subcutaneous fat, lies between the skin and the special fascia investing the muscles, and is a single layer over the greater part of the abdomen; but in the groin it may be said to be divided into a subcutaneous and a deeper stratum by the vessels and the glands.

The subcutaneous layer contains fat,

The *subcutaneous layer* contains fat, and varies therefore in appearance and thickness in different bodies; for it is sometimes divisible into strata, whilst at others it is very thin and somewhat membranous near the thigh. This layer is continuous with the cutaneous fatty covering of the thigh, and with that of the rest of the abdomen; and when traced to the limb, it is found to be separated from Poupart's ligament beneath by the superficial vessels and glands. Internally it is continued to the penis and the scrotum, where it changes its adipose tissue for involuntary muscular fibre; and after investing the testicle, the layer is prolonged to the superficial fascia of the perinæum.

except in the penis and scrotum.

Deeper layer is thin and membranous.

The *deeper layer* of the superficial fascia (aponeurosis of the fascia lata, Scarpa) is thinner and more membranous than the other, and is closely united to the tendon of the external oblique by fibrous bands, especially towards the linea alba. Like the subcutaneous part of the fascia, this layer is continued upwards on the abdomen, and inwards to the penis and the scrotum: in this last part it becomes very thin, and, having passed through the scrotum, reaches the perinæum, where it has attachments to the subjacent parts as before specified (p. 453). Towards the limb it extends only a very short distance, and ends a little below Poupart's ligament by joining the fascia lata across the front of the thigh; as it passes over the ligament it is closely joined to that band by fibrous tissue.

Special characters and disposition,

and ends on fascia lata.

Urine effused in the perinæum from rupture of the urethra will be directed through the scrotum and along the spermatic cord to the abdomen (p. 454). From the arrangement of the deeper layer of the fascia across the thigh, it is evident that the fluid cannot pass down the limb, though its progress over the front of the abdomen is uninterrupted. *Attachments determine course of effused urine.*

In the female the superficial fascia of the groin is separable into two layers, and the disposition of each is nearly the same as in the male; but the part that is continued to the scrotum in the one sex, enters the labium in the other in its course to the perinæum. In the female the round ligament of the uterus is lost in the superficial fascia of the groin. *Fascia in the female.*

CUTANEOUS NERVES. The nerves in the superficial fascia are derived chiefly from the trunks of the lower intercostal nerves: thus the lateral cutaneous branches along the side of the belly are offsets from five or six of those nerves; and the anterior cutaneous branches along the front are the terminal parts of the same trunks. Two other cutaneous offsets from the lumbar plexus, viz., the ilio-hypogastric and ilio-inguinal, appear at the lower part of the abdomen. *Cutaneous nerves are derived from two sources.*

The *lateral cutaneous nerves* of the abdomen (fig. 52) emerge between the digitations of the external oblique muscle, in a line with the same set of nerves on the thorax; and the lowest are the most posterior. As soon as they appear on the surface they divide, with the exception of the last, into an anterior and a posterior branch. *Lateral cutaneous of the intercostal,*

The *posterior branches* (3) are small in size, and are directed backwards to the integuments over the latissimus dorsi muscle. *which divide into*

The *anterior branches* (2) are continued in the superficial fascia nearly to the edge of the rectus muscle, and increasing in size from above down, supply the integuments on the side of the belly; they furnish offsets to the digitations of the external oblique muscle. *posterior and anterior branch.*

The *lateral cutaneous branch* of the *last dorsal nerve* is larger than the rest, and does not divide like the others. After piercing the fibres of the external oblique muscle, it is directed over the iliac crest to the surface of the gluteal region. *Last dorsal nerve.*

The *anterior cutaneous nerves* of the abdomen (fig. 52, [1]) reach the surface by piercing the sheath of the rectus: in the integuments they bend outwards towards the lateral cutaneous nerves. The number, and the place of exit of these small nerves from the abdominal wall, are very uncertain. *Anterior cutaneous nerves of intercostal.*

The *ilio-hypogastric nerve* is distributed on the surface by two pieces: one lies over the crista ilii (iliac branch), the other ramifies on the lower part of the abdomen (hypogastric branch). *Ilio-hypogastric of lumbar plexus.*

The *iliac branch* (fig. 52, [5]) lies close to the crest of the hip bone behind the last dorsal nerve, and enters the integuments of *Iliac branch.*

the gluteal region: its size and its position on the bone are dependent upon the development and the situation of the offset of the last dorsal nerve.

Hypogastric branch.

The *hypogastric branch* pierces the aponeurosis of the external oblique muscle above the external abdominal ring, and is distributed, as the name expresses, to the integuments of the lower part of the abdominal parietes.

Ilio-inguinal nerve of the plexus.

The *ilio-inguinal nerve* becomes cutaneous through the external abdominal ring, and having perforated the deeper layer of the superficial fascia, descends to the integuments of the scrotum, and upper and inner part of the thigh.

Vessels from two sources.

CUTANEOUS VESSELS. Cutaneous vessels are found with both sets of nerves on the abdomen:—with the lateral cutaneous nerves are branches from the intercostal arteries; and with the anterior cutaneous are offsets from the internal mammary and epigastric vessels. In the groin are three small superficial branches of the femoral artery, viz., pudic, epigastric, and circumflex iliac.

Both lateral

The *lateral cutaneous arteries* have the same distribution as the nerves they accompany. The anterior or chief offsets are directed towards the front of the abdomen, and end about the outer edge of the rectus muscle.

and anterior cutaneous.

The *anterior cutaneous* vessels are irregular in number and in position, like the nerves. After piercing the sheath of the rectus, they run outwards with the nerves towards the other set of branches.

From femoral artery three branches.

Branches of the femoral artery. Three cutaneous offsets ascend from the thigh between the layers of the superficial fascia, and ramify in the integuments of the genital organs and lower part of the abdomen. The greater portion of these vessels appears in the dissection of the thigh.

External pudic.

The *external pudic branch* (superficial) crosses the spermatic cord, to which it gives offsets, and ends in the integuments of the under part of the penis.

Superficial epigastric.

The *superficial epigastric branch* ascends over Poupart's ligament, near the centre, and is distributed in the superficial fascia nearly as high as the umbilicus. Its size varies very much.

Circumflex iliac.

The *circumflex iliac branch* lies usually below the level of the iliac crest, and sends only a few offsets upwards to the abdomen.

Veins.

Small *veins* accompany the arteries, and join the internal saphenous vein of the thigh.

Inguinal glands.

The abdominal group of the *glands of the groin* are three or four in number, and lie over the line of Poupart's ligament. They are placed between the strata of the superficial fascia; and receive the lymphatics from the abdomen, from the upper and outer portion of the thigh, and from the superficial parts of the genital organs. Their efferent ducts pass downwards to the saphenous opening in the thigh to enter the abdomen. Ducts enter thigh.

Dissection. After the examination of the superficial fascia with its vessels and nerves on the abdomen, the student may examine the cutaneous coverings of the penis and scrotum. The skin may be divided along the dorsum of the penis, and thrown to each side; and the skin of the scrotum is to be reflected by means of a vertical incision on the left side. Dissection of coverings of penis.

Cutaneous coverings of the penis and scrotum. The penis is attached to the front of the pubes by a suspensory ligament, and is provided with a tegumentary covering, with vessels and nerves. Tegumentary covering of penis

The tegumentary covering of the penis is continuous with that of the abdomen, but the superficial fascia loses its fat and acquires special characters. is thin, and without fat;

Around the end of the penis it forms the loose sheath of the prepuce in the following way:—When the skin has reached the extremity, it is reflected backwards as far as the base of the glans, constituting thus a double sheath—the *prepuce;* it is afterwards continued over the glans, and joins the mucous membrane of the urethra at the orifice on the surface. At the under part of the glans, and behind the aperture of the urethra, the integument forms a small triangular fold, *frænum præputii.* forms prepuce and frænum.

Where the integument covers the glans, it is inseparably united with that part, is very thin and sensitive being provided with papillæ, and assumes in some cases the characters of a mucous membrane. Behind the glans are some sebaceous follicles—*glandulæ odoriferæ.* Sebaceous glands.

In the scrotum the superficial fascia becomes thin, and of a reddish colour. If it is cut through the student will perceive that the prolongation sent around the cord on one side, does not communicate with that on the other side; and that the two pouches come in contact in the middle line, and form the *septum scroti.* Teguments in scrotum.

The superficial fascia in the scrotum, on the penis, and in the front of the perinæum contains involuntary muscular fibres, to which the corrugation of the skin is owing. This contractile structure is named the *dartoid tissue.* Muscular nature of fascia.

Dissection. By removing the fatty tissue from the root of the penis and the front of the symphysis pubis, the suspensory ligament will be defined. And the dorsal arteries and nerves, and the dorsal vein of the penis, which will be partly laid bare, are to be followed forwards in the superficial fascia. Dissection of vessels and nerves.

The *suspensory ligament of the penis* is a rather deep band of fibrous tissue, of a triangular form, which is attached by its apex to the front of the symphysis pubis near the lower part. Widening as it descends, the ligament is divided into two pieces, which are fixed to the upper surface of the body of the penis, and are Suspensory ligament of penis. Attachments.

Contains vessels and nerves. prolonged on it for some distance. In the interval between the pieces are contained the dorsal vessels and nerves of the penis.

Source of vessels and nerves. *Dorsal vessels and nerves.* The arteries and nerves on the dorsum of the penis are the terminal parts of the pudic trunks of both sides. The vein accompanying the arteries enters the front of the pelvis through the triangular perinæal ligament.

Dorsal artery of penis. The *dorsal artery*, one on each side, appears between the layers of the suspensory ligament, and extends forwards to the glans, where it ends in many branches for that structure : in its course the vessel supplies the integuments and the body of the penis. It may be derived from the accessory pudic (p. 461).

Dorsal vein ends in prostatic plexus. The *dorsal vein* is a single trunk, and commences by numerous branches from the glans penis and the prepuce. The course of the vein is backwards by the side of the artery, between the layers of the suspensory ligament, and then through the triangular ligament of the urethra, to join the prostatic plexus of veins. The vein receives branches from the erectile structure and teguments of the penis.

Dorsal nerve of pudic. Each *dorsal nerve* takes the same course as the artery, and ends like it in numerous branches to the glans penis. It furnishes a large branch to the corpus cavernosum penis, and other offsets to the integuments of the dorsum and sides, and the prepuce of the penis.

Vessels on clitoris. In the female these vessels are much smaller than in the male; they occupy the upper surface of the clitoris—the organ that represents the penis.

To expose external oblique muscle. *Dissection of the muscles.* The surface of the external muscle of the abdominal wall (fig. 86) is now to be freed from fascia on both sides of the body.

Precautions. It is not advisable to begin cleaning this muscle in front, because there it has a thin aponeurosis, which is taken away too readily with the fat; but behind, the muscle is thick and fleshy, and cannot well be injured. Beginning the dissection at the posterior part, the student is to carry the knife obliquely upwards and downwards in the direction of the fibres. The thin aponeurosis before referred to is in front of a line extended upwards from the anterior part of the iliac crest; and as the dissector approaches that spot, he must be careful not to injure it, more particularly at the upper part where it lies on the margin of the ribs, and is very indistinct.

To define abdominal ring. On the right side the external abdominal ring may be defined to show the cord passing through it; and on the left side a thin fascia (intercolumnar), which is connected with the margin of that opening, is to be preserved. Lastly the free border of the external oblique muscle should be made evident between the last rib and the iliac crest.

On the side MUSCLES OF THE ABDOMINAL WALL. On the side of the abdomen are three large flat muscles, which are named from their position to one another, and from the direction of their fibres. The most superficial muscle is the external oblique; the underlying one, the internal oblique; and the deepest is the transversalis. are three flat muscles,

Along the middle line the muscles are lengthened, and have a vertical direction. In front are the rectus and pyramidalis, and behind the quadratus lumborum; these are incased by sheaths derived from the aponeuroses of the lateral muscles. whose aponeuroses incase three vertical.

The EXTERNAL OBLIQUE MUSCLE (fig. 86, [9]) is fleshy on the side, and aponeurotic on the fore part of the abdomen. It *arises* by fleshy processes from the eight lower ribs; the five highest pieces alternating with similar parts of the serratus magnus, and the lowest three, with the latissimus dorsi muscle. From the attachment to the ribs the fibres are directed over the side of the abdomen in the following manner:—the lower fibres descend almost vertically to be *inserted* into the anterior half or more of the iliac crest, at the outer margin: and the upper and middle fibres are continued forwards, the former horizontally, and the latter obliquely, to the aponeurosis on the front of the belly. External oblique muscle. Origin from ribs. Insertion into pelvis and linea alba.

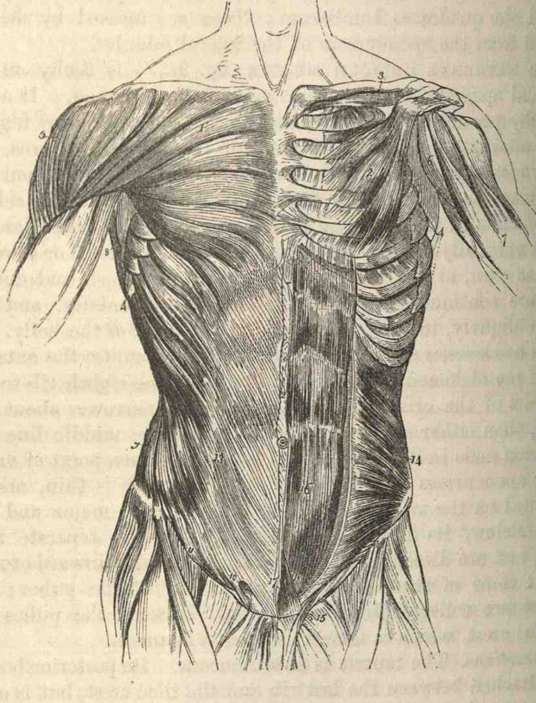
The *aponeurosis* of the muscle (fig. 86, [13]) occupies the anterior part of the abdomen, in front of a line from the eighth rib to the fore part of the crista ilii; and it is rather narrower about the centre, than either above or below. Along the middle line this expansion ends in the linea alba ([12])—the common point of union of the aponeuroses of opposite sides. Above, it is thin, and is continued on the rectus muscle to the pectoralis major and the ribs. Below, its fibres are stronger and more separate than above, and are directed obliquely downwards and inwards to the pelvis: some of them are fixed to the front of the pubes; and the rest are collected into a firm band between the pubes and the iliac crest, which is named Poupart's ligament. Aponeurosis covers front of the belly. Disposition above and below.

Connections. The muscle is subcutaneous. Its posterior border is unattached between the last rib and the iliac crest, but is overlaid commonly by the edge of the latissimus dorsi, except a small part below. Appearing through the aponeurosis, external to the linea alba, is a white line, the linea semilunaris, marking the outer edge of the rectus muscle; and crossing between the two are three or four whitish marks, the lineæ transversæ. Numerous small apertures in the tendon give exit to cutaneous vessels and nerves; and near the pubes is the large opening of the external abdominal ring ([10]), which gives passage to the cord in the male, and the round ligament in the female. Connections. Lines on the aponeurosis. Apertures in it. Abdominal ring.

Action. Both muscles taking their fixed point at the pelvis will bend the trunk forwards as in stooping; but supposing the spine fixed they will draw down the ribs as in laboured breathing; and if both the spine and ribs are immoveable they will diminish Use of both muscles, acting from pelvis, and thorax. the abdominal cavity. If they act from the thorax they will elevate the pelvis.

One muscle acting. Should one muscle contract it will incline the trunk or the

Fig. 86.*



pelvis to the same side, according as the upper or the lower attachment may be moveable.

PARTS OF THE APONEUROSIS. Besides the general arrangement of the aponeurosis over the front of the abdomen, the student is to examine more minutely the linea alba in the middle line;

* Superficial muscles of the abdomen and thorax on the right half of the figure, and the deep muscles on the left half. 1. Pectoralis major. 2. Pectoralis minor. 3. Subclavius. 4. Serratus magnus. 5. Deltoid. 6. Coraco-brachialis. 7. Biceps brachii. 8. Latissimus dorsi. 9. External oblique of abdomen, with 10, external abdominal ring; and 11, Poupart's ligament. 12. Linea alba. 13. Aponeurosis of external oblique. 14. Internal oblique muscle. 15. Cremaster muscle on the spermatic cord. 16. Rectus muscle. 17. Pyramidalis abdominis.

the external abdominal ring with the fascia prolonged from its margin; and the rounded border named Poupart's ligament.

In the linea alba the aponeuroses are united.

Linea alba (fig. 86, [12]). This white line on the front of the abdomen marks the place of meeting of the aponeuroses of opposite sides. It extends from the xiphoid cartilage to the pubes, and serves as a ligament between the chest and pelvis. Its breadth is wider above than below; and it is perforated here and there by small apertures, which allow pellets of fat to protrude in some bodies. A little below the centre is the umbilicus, which projects now beyond the surface, though before the skin was removed a hollow indicated its position.

In its middle is umbilicus.

Fig. 87.*

External abdominal ring.

External abdominal ring. This opening (fig. 86, [10]) is situate near the pubes between the diverging fibres of the aponeurosis.

Form and situation.

It is somewhat triangular in form, with the base at the crest of the pubes, and the apex pointing upwards and outwards.

Size.

The long measurement of the aperture is about an inch, and the transverse about half an inch.

Inner side or pillar.

Its margins are named pillars, and differ in form and strength. The inner one (fig. 87, [1]), thin and straight, is attached below to the front of the symphysis pubis, where it crosses the corresponding piece of the opposite side—that of the right muscle being superficial.

Outer margin.

The outer margin is the strongest (fig. 87, [2]), and is not straight like the inner, but is bent around the spermatic cord, so as to form a kind of groove for it: this margin is continuous with Poupart's ligament, and is attached

* View of the lower part of the external oblique muscle and of the upper part of the fascia lata of the thigh. 1. Inner pillar of the abdominal ring. 2. Outer pillar of the ring. 3. Intercolumnar fibres. 4. Fascia lata inside the saphenous opening. 5. Spermatic cord covered by cremaster. 6. Saphenous vein. 7. Fascia lata of the thigh.

A fascia prolonged from margin.

below to the pubic spine or tuberosity. A thin membrane (intercolumnar or spermatic fascia) covers the opening, and is derived from some intercolumnar or intermarginal fibres on the surface of the aponeurosis.

The cord in male,

and hernia pass through it.

The ring gives passage in the male to the spermatic cord, and in the female to the round ligament; and in each sex the transmitted part lies on the outer or lower pillar as it passes through, and obtains a covering from the intercolumnar fibres. Through the aperture the inguinal hernia protrudes from the wall of the abdomen.

Intercolumnar fibres.

Attachment inferiorly:

they produce intercolumnar fascia.

The *intercolumnar fibres* (fig. 87,[3]) form a layer over the aponeurosis, and bind together its parallel fibres, so as to construct a firm membrane. Inferiorly, where they are strongest, a bundle is connected with the outer third of Poupart's ligament, and is continued back to the crista ilii. At the external abdominal ring the fibres stretch from side to side, and, becoming stronger and aggregated together, close the upper part of that opening; and as they are prolonged on the cord from the margin of the ring, they give rise to the membrane named *intercolumnar fascia.* On the left side, where the fascia is entire, this thin covering will be manifest on the surface of the cord, or on the round ligament in the female.

To see insertion of Poupart's ligament.

Throw down piece of external oblique,

Dissection. To see the attachments and connections of Poupart's ligament, it will be necessary to reflect, on both sides of the body, the lower part of the aponeurosis towards the thigh, as in fig. 88. For this purpose an incision is to be carried through the aponeurosis from the front of the iliac crest nearly to the linea alba; and the tendon is to be detached from the subjacent parts with the handle of the scalpel. When the aponeurosis cannot be separated farther from the tendons beneath, near the linea alba, it is to be cut in the direction of a vertical line to the symphysis pubis.

and seek triangular ligament.

After the triangular piece of the aponeurosis has been thrown towards the thigh, the spermatic cord is to be dislodged from the surface of Poupart's ligament, to see the insertion of this band into the pubes, and to lay bare the fibres which ascend therefrom to the linea alba with the name of triangular ligament.

Poupart's ligament.

Outer and inner attachments:

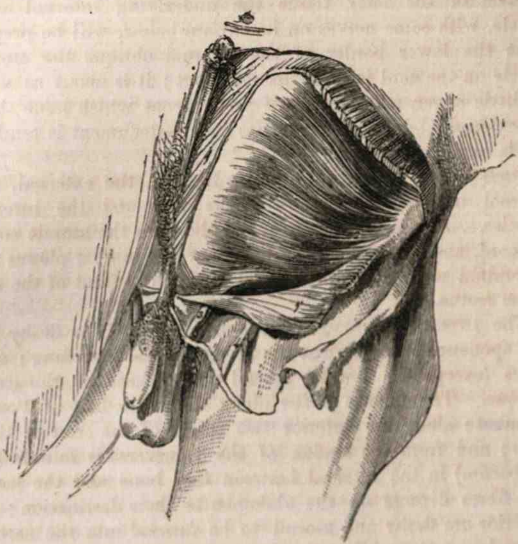
forms Gimbernat's ligament.

Poupart's ligament (fig. 87,[2]) is the lower border of the aponeurosis of the external oblique, which intervenes between the front of the crista ilii and the pubes. Externally it is round and cord-like, and is attached to the anterior superior iliac spine. Internally it widens as it approaches the pubes, and is inserted into the pubic spine and the pectineal line of the hip-bone for about three quarters of an inch, forming a triangular-looking piece with its base directed outwards, which is named *Gimbernat's ligament.*

Its direction,

Poupart's ligament is not straight between its outer and inner attachments, but is curved downwards to the thigh; and it retains this position as long as the fascia lata remains uncut. Its outer half is oblique, and is firmly united with the subjacent **and parts in contact with it.**

Fig. 88.*



iliac fascia: along the line of union of the two, the other lateral muscles of the abdominal wall are attached. Its inner half is placed over the vessels passing from the abdomen to the thigh.

Triangular ligament (fig. 88). From the insertion of Poupart's ligament into the pectineal line, some fibres are directed upwards and inwards beneath the inner pillar of the ring to the linea alba, where they blend with the other tendons. As the fibres ascend, they diverge and form a thin band, to which the above mentioned name has been given. **Triangular ligament.**

Dissection. The upper part of the external oblique is now to be taken away, on both sides of the body, to see the parts underneath. The muscle may be detached by carrying the scalpel through the digitations on the ribs back to the free border, and then through the insertion into the crista ilii. It may be thrown **Dissection to expose internal oblique.**

* Dissection to throw down the tendon of the external oblique, and to show the triangular ligament and internal oblique muscle. 1. Tendon of external oblique reflected: at its inner attachment to the pubes, fibres are directed upwards obliquely to the linea alba; these form the triangular ligament. 2. Internal oblique. 3. Spermatic cord.

forwards as far as practicable, after the nerves that cross the iliac crest are dissected out; but in raising it care must be taken not to detach the rectus muscle from the ribs above, nor to cut through the tendon of the internal oblique at the upper part. By the removal of the fatty tissue the underlying internal oblique muscle, with some nerves on its surface below, will be prepared.

Clean the cremaster.

At the lower border of the internal oblique the cremaster muscle on the cord is to be dissected out: it is about as wide as the little finger, and consists of fleshy loops which issue through the external abdominal ring. Its inner attachment is tendinous, and is easily taken away.

Parts covered by external oblique.

Parts covered by external oblique. Beneath the external, is the internal oblique muscle, with the ribs and the intercostal muscles. At the lower part of the abdomen the muscle conceals the cord, and the branches of nerves of the lumbar plexus in the abdominal wall. Its aponeurosis is placed in front of the sheath of the rectus.

Internal oblique muscle.

Origin from pelvis.

The INTERNAL OBLIQUE MUSCLE (fig. 86, [14]) is fleshy below and aponeurotic above, just the reverse of the preceding; and its fibres (except the lowest) ascend across those of the external oblique. The muscle *arises* along the outer half of Poupart's ligament; along the anterior two thirds of the crest of the hip bone; and from the tendon of the transversalis muscle (fascia lumborum) in the interval between that bone and the last rib. The fibres diverge on the abdomen to their destination:—The posterior are fleshy and ascend to be *inserted* into the cartilages of the lower three ribs, where they join the internal intercostal muscles of the lowest two spaces. The anterior or lower fibres arch downwards and inwards (from Poupart's ligament) over the spermatic cord (fig. 88), and end in the aponeurosis near the pubes. The intervening fibres pass obliquely to the aponeurosis.

Insertion into the ribs and linea alba, except lowest fibres.

Aponeurosis of the muscle divides to incase rectus.

Attachments to chest,

and the pelvis.

The *aponeurosis* of the muscle covers the fore part of the abdomen from the pelvis to the chest, and blends with its fellow along the middle line. For the most part it incases the rectus; but midway between the umbilicus and the pubes it is undivided, and lies in front of that muscle. Superiorly it is attached to the thorax after the following manner: The stratum superficial to the rectus is fixed to the ninth rib, and blends with the aponeurosis of the external oblique; and the stratum beneath the muscle joins the cartilages of the eighth and seventh ribs and the ensiform cartilage. Inferiorly its fibres become more distinct and separate, as in the external oblique, and are inserted into the front of the pubes, and into the pectineal line for half an inch, behind the attachment of Poupart's ligament.

Parts in contact with oblique.

Connections. The internal is covered by the external oblique muscle. It is attached on all sides, except between Poupart's ligament and the pubes where it arches over the cord, and has the cremaster muscle contiguous to it. The parts covered by the internal oblique cannot be seen till the muscle is reflected.

Action. Both muscles will have the same influence as the external oblique on the spinal column, the ribs, the abdominal cavity, and the pelvis, according as the pelvis and spine may or may not be fixed. Use of both muscles,

One muscle will incline the body laterally; and contracting with the external oblique of the other side (the fibres of the two having the same direction) it will rotate the trunk to the same side. of one.

The CREMASTER MUSCLE (fig. 86, [15]) is a fasciculus of fibres, which lies along the lower border of the internal oblique muscle, and is named from suspending the testicle. The muscle has attachments at the inner and outer sides similar to those of the internal oblique. Externally it is fleshy, and *arises* from Poupart's ligament below, and in part beneath the internal oblique, with which some of the fibres are connected; and here it may also join the transversalis. Internally it is small and pointed, and is *inserted* by tendon into the front of the pubes and the tendon of the internal oblique. Cremaster muscle. Attachments: external fleshy, internal tendinous;

Between the two points of attachment the fibres descend on the front and sides of the cord, forming loops with the convexity downwards which reach to and over the tunica vaginalis testis. The muscular fibres are united by areolar tissue so as to give rise to a covering on the front of the cord, which in hernia is named the *fascia cremasterica.* Occasionally the fibres may be behind as well as on the sides and front of the cord. forms loops over the cord, giving rise to cremasteric fascia.

Action. It elevates the testicle towards the abdomen under the influence of the will; but it may be induced to contract involuntarily by cold, fear, &c. Use.

Dissection. On the left side of the body the student is not to make any further dissection of the abdominal wall; and the layers that have been reflected in the groin should be replaced, until the examination of those parts in connection with hernia is returned to. In left groin replace the parts.

On the right side the dissection is to be carried deeper by the removal of the internal oblique and the cremaster. On right side reflect

The last muscle may be reflected from the cord by means of a longitudinal incision. cremaster

To raise the internal oblique, it will be necessary to cut it through firstly near the ribs; secondly near the crest of the hip bone and Poupart's ligament; and lastly at the hinder part, so as to connect the two first incisions. Its depth will be indicated by a fatty layer between it and the transversalis. In raising the muscle towards the edge of the rectus, the student must separate with great care the lower fibres from those of the transversalis, with which they are often conjoined; and must dissect and internal oblique.

out, between the two, the intercostal nerves and arteries, and the two branches of the lumbar plexus (ilio-hypogastric and ilio-inguinal) near the front of the crest of the hip bone. The offsets of the intercostals entering the muscle must be cut.

Parts covered by internal oblique.

Parts covered by the oblique. The internal oblique conceals the transversalis muscle, and the vessels and nerves between the two. Near Poupart's ligament it lies on the spermatic cord and the fascia transversalis. The rectus muscle is concealed by, and is partly incased in the aponeurosis.

Transversalis muscle.

The TRANSVERSALIS MUSCLE forms the third stratum in the wall of the abdomen, and differs from the two oblique in having a posterior as well as an anterior aponeurosis. Like the former muscle it is attached on all sides, except where the spermatic cord lies.

Origin from chest, loins, and pelvis.

At the pelvis it *arises* along the outer third of Poupart's ligament, and the anterior two thirds of the iliac crest. At the chest it takes origin from the lower six ribs, viz. by tendon from the lowest two, and by fleshy processes from the under surface of the cartilages of the four next above. And between the chest and the pelvis it is connected with the lumbar vertebræ by means of the posterior aponeurosis or the fascia lumborum.

Fibres end in aponeurosis.

Lowest arch down to pubes.

Most of the fibres are directed transversely to the aponeurosis in front; but the lower arch downwards above the spot at which the cord leaves the abdomen (fig. 89, [3]), and end in the aponeurosis internal to that aperture.

The aponeurosis passes beneath rectus except inferiorly.

Its *aponeurosis* is widest inferiorly, as in the most external muscle. Internally it is continued to the linea alba beneath the rectus as low as to midway between the umbilicus and the pubes, but beyond that spot it passes in front of the muscle to reach the middle line. Its attachment below to the pelvis is nearly the same as that of the aponeurosis of the internal oblique; for it is fixed to the front of the pubes, and to the pectineal line for about an inch, but beneath the oblique muscle.

Fibres to transversalis fascia.

At the insertion into the pubes some of the fibres are spent on the transversalis fascia, and are connected with a thickened band of that fascia beneath Poupart's ligament, which is called the deep crural arch.

Use by itself

with others.

Action. The chief action of the muscle will be applied to diminishing the capacity of the abdominal cavity; but it will assist the other broad muscles in bending the trunk, depressing the ribs, and elevating the pelvis.

At pelvis joins that of internal oblique in conjoined tendon.

Conjoined tendon. The aponeuroses of the internal oblique and transversalis muscles are united more or less near their attachment to the bone, and thus give rise to the conjoined tendon. The aponeurosis of the oblique muscle extends about half an inch along the pectineal line; whilst that of the transversalis reaches an inch along the bony ridge, and forms the greater part of the conjoined tendon.

The *posterior aponeurosis* of the transversalis, or the fascia lumborum, is described in the dissection of the Back, p. 413. **Posterior aponeurosis.**

Connections. Superficial to the transversalis are the two muscles before examined; and beneath it is the thin fascia transversalis, which separates it from the peritoneum. Its fleshy attachments to the ribs digitate with like processes of the diaphragm. The lower border is fleshy in the outer, but tendinous in the inner half, and is arched above the internal abdominal ring. Occasionally the muscle arises from Poupart's ligament as low down as the internal oblique, with which, and with the cremaster, it is then inseparably united. **Connections of transversalis muscle.**

Dissection. To remove the aponeurotic layer from the rectus muscle of the right side, make a longitudinal incision through the tendinous sheath, and turn it to each side. As the fascia is reflected, its union with three or more tendinous bands across the rectus will have to be cut through; and near the pubes a small muscle, the pyramidalis, will be exposed. The dissector should leave the nerves entering the outer border of the rectus. **Expose rectus and pyramidalis.**

On the left side of the body the rectus should not be laid bare below the umbilicus, for the sake of the hernia to be seen on this side. **Leave the left side.**

The RECTUS MUSCLE (fig. 86, [16]) extends along the front of the abdomen from the pelvis to the chest. The muscle is narrowest inferiorly, and is attached to the pubes by two tendinous processes;—one, internal to the other and the smallest, *arises* from the front of the symphysis, where it joins the muscle of the opposite side; and the external process is attached to the pubic crest. Becoming wider towards the thorax, the rectus is *inserted* by three large fleshy processes into the ensiform cartilage, and the cartilages of the last three true ribs, and into the bone of the fifth rib. **Rectus muscle. Attachments to pubes. Insertion into ribs.**

The muscle is contained in an aponeurotic sheath, except above and below; and its fibres are interrupted at intervals by irregular tendinous lines,—the inscriptiones tendineæ. **Has cross tendons.**

Action. It will draw down the thorax and the ribs, or raise the pelvis, according as its fixed point may be above or below. **Use on trunk,**

Besides imparting movement to the trunk, it will diminish the cavity of the thorax, and compress the viscera. **on abdomen.**

Sheath of the rectus. The sheath of the rectus is derived from the splitting of the aponeurosis of the internal oblique at the outer edge of the muscle. One piece passes before, and the other under the rectus; and the two unite at the inner border so as to enclose it in a sheath. Inseparably blended with the stratum in front of the muscle is the aponeurosis of the external oblique; and joined in a similar manner with that behind, is the aponeurosis of the transversalis. **Its sheath, how formed.**

The sheath is deficient behind, both above and below. Above, **Its extent.**

Deficient above and below.

the muscle rests on the ribs, without the intervention of the sheath which is fixed to the margin of the thorax. Below, midway between the umbilicus and the pubes, the internal oblique ceases to split to incase the rectus, and passes altogether in front of it with the other aponeuroses; at the spot where the sheath is wanting inferiorly, a white, and sometimes well-defined margin (the fold of Douglas) may be seen when the outer edge of the rectus is raised. Where the sheath is deficient the muscle is in contact with the fascia transversalis.

Lineæ transversæ are three or more. Situation.

The *lineæ transversæ*, or the transverse markings on the surface of the abdomen, are caused by the tendinous intersections of the rectus. They are usually three in number, and have the following position: one is opposite the umbilicus, another at the ensiform cartilage, and the third midway between the two. If there is a fourth it will be placed below the umbilicus. These markings seldom extend the whole depth or breadth of the muscular fibres, more particularly above and below.

Linea semilunaris is at edge of rectus.

Linea semilunaris. This line which was before alluded to with the aponeurosis of the external oblique muscle, corresponds with the outer edge of the rectus, and reaches from the eighth rib to the outer part of the pubic crest of the hip-bone: it marks the line of division of the aponeurosis of the internal oblique muscle.

Pyramidalis muscle. Attachment.

The PYRAMIDALIS MUSCLE (fig. 86, [17]) is triangular in form, and is placed in front of the rectus near the pelvis. The muscle *arises* by its base from the front of the pubes, and is *inserted* by tendon into the linea alba about midway between the umbilicus and the pelvis. This small muscle is often absent.

Use.

Action. The muscle renders tight the linea alba, and assists the rectus slightly in compressing the viscera.

Nerves in wall of abdomen.

NERVES OF THE ABDOMINAL WALL. Between the internal oblique and transversalis muscles are situate the intercostal nerves; and near the pelvis are two branches of the lumbar plexus. Some arteries accompany the nerves, but they will be referred to with the vessels of the abdominal wall (p. 487).

Intercostal nerves are between oblique and transversalis. Offsets.

The *lower six intercostal nerves* (p. 394) enter the wall of the abdomen from the intercostal spaces. Placed between the two deepest lateral muscles, the nerves are directed forwards to the edge of the rectus, and through this muscle to the surface near the middle line of the abdomen. About midway between the spine and the linea alba, the nerves furnish cutaneous branches to the side of the abdomen (lateral cutaneous, p. 469); and whilst between the abdominal muscles they supply muscular branches, and offsets of communication with one another. A greater part of the lower than of the upper nerves is visible, because of the shortness of the last intercostal spaces.

Last dorsal nerve.

The *last dorsal nerve* is placed below the twelfth rib, and therefore not in an intercostal space, but otherwise it has connections and a distribution like the preceding. As it extends forwards to the rectus it communicates sometimes with the ilio-hypogastric nerve. Its lateral cutaneous branch perforates the two oblique muscles (p. 469).

Branches of lumbar plexus.

Two *branches of the lumbar plexus*, viz., ilio-hypogastric and ilio-inguinal, are contained for a certain distance between the muscles of the wall of the abdomen, as they course forwards to the surface of the body.

Ilio-hypogastric lies near iliac crest:

The *ilio-hypogastric nerve* perforates the back of the transversalis muscle near the iliac crest, and gives off the iliac or lateral cutaneous branch. The nerve is then directed forwards above the hip bone, and is connected with its companion (ilio-inguinal) near the front of that bone. Perforating the fleshy part of the internal oblique near the iliac crest, and the aponeurosis of the external oblique near the linea alba, the nerve becomes cutaneous as before seen (p. 469).

cutaneous branch.

Its *iliac branch* pierces both oblique muscles close to the crista ilii, to reach the gluteal region.

Ilio-inguinal issues through ring.

The *ilio-inguinal nerve* perforates the transversalis near the front of the iliac crest, where it is connected with the preceding. It pierces afterwards the internal oblique, to which it supplies branches, and coursing over that muscle, reaches the surface of the thigh through the external abdominal ring (p. 470) : it furnishes offsets to the cremaster and the pyramidalis.

May be very small.

This nerve may be so small as to end by joining the ilio-hypogastric branch. In such cases the ilio-hypogastric furnishes an offset, which takes the place of the ilio-inguinal nerve, and corresponds in distribution with it.

Dissection of transversalis fascia.

Dissection. For the purpose of seeing the transversalis fascia, it will be necessary to raise, on the right side, the lower part of the transversalis muscle by two incisions ;—one of these is to be carried through the fibres attached to Poupart's ligament; the other, across the muscle from the front of the hip bone to the margin of the rectus. With a little care the muscle may be separated easily from the thin fascia beneath.

Fascia transversalis is best marked in the groin.

The *fascia transversalis* is a thin fibrous layer between the transversalis muscle and the peritoneum, which has been so named by Sir A. Cooper. In the groin or inguinal region (fig. 89, [4]), where it is unsupported by muscles, the fascia is considerably stronger than elsewhere, and is joined by fibres of the aponeurosis of the transversalis muscle ; but farther from the pelvis it gradually decreases in strength, until at the thorax it becomes an unimportant membrane.

Internal abdominal ring

In the part of the fascia now laid bare is the internal abdominal ring, which gives passage to the spermatic cord, or the round ligament, according to the sex ; this opening resembles the finger of a glove in being visible internally, but concealed externally by a prolongation from the margin. On the inner side of the ring the fascia is thinner than on the outer, and is fixed internally into the pubes and the pectineal line of the hip bone, behind the conjoined tendon with which it is united.

is partly joined to Poupart's ligament, and partly not.

When traced down to Poupart's ligament, the membrane will be found joined to the posterior margin of that band along the outer half; but along the inner half it is directed down to the thigh in front of the bloodvessels, to form the anterior part of a loose sheath (crural) around them.

Situation of abdominal ring.

Internal abdominal ring (fig. 89). This opening is situate midway between the symphysis pubis and the anterior superior iliac spine, and half an inch above Poupart's ligament. From its margin a thin tubular prolongation of the fascia is continued around the cord, as before said.

Dissection to follow process on cord.

Dissection. The tubiform prolongation on the cord may be traced by cutting the fascia transversalis horizontally above the opening of the ring, and then longitudinally over the cord. With the handle of the scalpel the thin membrane may be reflected to each side, so as to lay bare the subperitoneal fat.

Subperitoneal fat in the groin.

The *subperitoneal fat* forms a layer between the fascia transversalis and the peritoneum. Its thickness varies much in different bodies, but is greater at the lower part of the abdomen than higher up. A prolongation is sent from it along the cord. This structure will be more specially examined in the dissection of the wall of the abdomen from the inside.

Trace remains of peritoneum.

Dissection. After the subperitoneal fat has been seen, let it be reflected to trace the remains of a tube of peritoneum along the cord, in the form of a fibrous thread.

Peritoneum of the groin is prolonged on the cord;

The *peritoneum*, or the serous sac of the abdominal cavity, projects forwards slightly opposite the abdominal ring. Connected with it at that spot is a fibrous process, the remains of a prolongation to the testis in the fetus, which extends a certain distance along the front of the cord.

piece may be impervious,

There is great variety in the condition of the process. It is generally impervious, and can be followed in one body only a very short distance, whilst it may be traced in another as a fine thread to the tunica vaginalis of the testis.

or sacculated,

In other bodies the process may be partly open, being sacculated at intervals; or, in rarer cases, it may form a single large bag in front of the cord. These last two conditions can be explained by an arrest in the obliteration usually taking place in the piece of peritoneum prolonged in the fetus to the testis; for should the tube be closed only opposite the abdominal ring, one large pouch or sac would be left in front of the cord and testicle; and should it be obliterated here and there, the sacculated condition would result. Lastly, as a rare state, the tube of peritoneum may be found totally unobliterated, so that a coil of intestine could descend in it from the abdomen. or open.

In the female the fetal tube of peritoneum remains sometimes pervious for a short distance in front of the round ligament; then the unobliterated passage is named the *canal of Nuck*. In female partly open.

The SPERMATIC CORD extends from the internal abdominal ring to the testis, and consists mainly of the vessels and the efferent duct of the gland, united together by coverings from the structures by or through which they pass. Spermatic cord

In the wall of the abdomen the cord lies obliquely, because its aperture of entrance amongst, is not opposite its aperture of exit from the muscles; but escaped from the abdomen, it descends almost vertically to its destination. As it lies in this oblique passage named the inguinal canal, it is placed at first (beginning externally) beneath the internal oblique, and rests against the fascia transversalis (fig. 89); but beyond the lower border of the oblique muscle, it lies on the upper surface of Poupart's ligament, with the aponeurosis of the external oblique between it and the surface of the body, and the conjoined tendon behind it (fig. 88). is oblique in the abdominal wall, and vertical beyond. Connections.

Its several coverings are derived from the strata in the wall of the abdomen, except from the transversalis muscle. Thus, in proceeding from the abdominal cavity to the surface, the student will find the following layers around the constituents of the cord:—first, the subperitoneal fat; then the tube of the fascia transversalis; next the cremaster muscle continuous with the internal oblique; afterwards the intercolumnar fascia from the external oblique muscle; and lastly the superficial fascia and the skin. Coverings.

The *round ligament*, or the suspensory cord of the uterus, occupies the inguinal canal in the female, and ends in the integuments of the groin. Its coverings are similar to those of the spermatic cord, except it wants usually the cremaster. In female round ligament is in place of cord.

Dissection. The constituents of the cord will be displayed by cutting through longitudinally and turning aside the different surrounding layers, and removing the areolar tissue. The dissector should trace branches of the genito-crural nerve and epigastric artery into the cremasteric covering. Dissection.

Vessels and nerves of the cord. In the cord are collected together the spermatic artery and vein which convey the blood to, and take it away from the testis; nerves and lymphatics of the testicle; and the vas deferens or the efferent duct. Constituents of the cord.

The *spermatic artery* is a branch of the aorta. It enters the cord through the internal abdominal ring, and descends to the testis, in which it ends: it distributes branches to the excretory duct, viz. the vas deferens and epididymis. Spermatic artery;

offset of ovarian.

In the female a *branch* from the *ovarian artery* enters the round ligament.

Spermatic vein,

The *spermatic vein* leaves the posterior part of the testicle, and receives branches from the epididymis. Ascending in the cord, in front of the vas deferens, it divides and anastomoses, and

and plexus.

forms the *spermatic plexus:* finally it enters the abdomen by the internal ring, and ends in the inferior cava.

Artery and nerve of the coverings of the cord;

Cremasteric artery and nerve. The cremasteric covering of the cord has a separate artery and nerve. The *artery* is derived from the epigastric (p. 488), and is distributed to the coverings of the cord. The *genital branch* of the *genito-crural* nerve enters the cord by the internal abdominal ring, and ends in the cremaster muscle.

and cutaneous.

Cutaneous vessels and nerves are supplied to the teguments of the cord from the superficial pudic artery and the ilio-inguinal nerve.

Vas deferens.

The *vas deferens* reaches from the testicle to the urethra, and is placed behind the other constituents of the cord; it will be

Situation

easily recognised by its resemblance in feel to a piece of whip-cord, when it is taken between the finger and the thumb. As it

and course.

enters the abdomen through the opening in the fascia transversalis (internal ring), it lies on the inner side of the vessels of the testicle; and as it begins its descent to the pelvis, it winds behind the epigastric artery.

Dissection of deep arch

Dissection. By cutting through the spermatic cord near the pubes, and raising it towards the inner abdominal ring, a fibrous band below Poupart's ligament, the deep crural arch, will appear: it passes inwards to the pubes, and is to be defined with some care.

and of the vessels in the wall of abdomen.

The remaining vessels of the abdominal wall, viz., the epigastric and circumflex iliac, and the ending of the internal mammary artery, are to be next dissected. The epigastric and mammary arteries will be observed on raising the outer edge of the rectus, one above and the other below, ramifying in the muscle; and the epigastric with its earliest branches may be traced further, by removing the fascia transversalis from it near Poupart's ligament.

The circumflex iliac artery lies behind the outer half of Poupart's ligament, and should be pursued along the iliac crest to its ending.

Deep crural arch.

Deep crural arch. Below the level of Poupart's ligament is a thin band of transverse fibres, which lies over the femoral vessels, and has received the name deep crural arch from its position and resemblance to the superficial crural arch, or Poupart's ligament.

Attachments.

This fasciculus of fibres, beginning about the centre of the ligament, is prolonged inwards to the pubes, where it is widened, and is inserted into the pectineal line at the inner or deep aspect of the conjoined tendon of the broad muscles of the abdomen.* It is closely connected with the front of the crural sheath, and is arched down on the inner side of that tube to be fixed to the bone.

VESSELS IN THE WALL OF THE ABDOMEN. On the side of the abdomen are the intercostal and lumbar arteries with the intercostal nerves. In the sheath of the rectus are the epigastric and internal mammary vessels; and around the crest of the hip-bone is the circumflex iliac branch. **Vessels in abdominal wall.**

The *intercostal arteries* issue from the spaces between the ribs, and enter the abdominal wall between the transversalis and internal oblique muscles: they extend forwards with the nerves, supplying the contiguous muscles, and anastomose in front with the internal mammary and epigastric. Behind they communicate with the lumbar arteries. **Intercostal arteries:**

The lowest artery accompanies the last intercostal nerve below the last rib, and is distributed with the nerve in the abdominal wall. **lowest.**

The *internal mammary artery.* The abdominal branch of this vessel (p. 270) enters the wall of the abdomen beneath the cartilage of the seventh rib. Descending for a short distance in the sheath of the rectus, the vessel soon enters the substance of that muscle, and anastomoses in it with the epigastric artery. **Internal mammary.**

The *musculo-phrenic* part of the same artery appears on the under surface of the diaphragm at the ninth rib, and passes outwards along the margin of the thorax to the last intercostal space. It gives offsets to that muscle and the lower intercostal spaces. **Musculo-phrenic.**

The *epigastric artery* arises from the external iliac about a quarter of an inch above Poupart's ligament, and ascends in the sheath of the rectus above the umbilicus, where it divides into branches which enter that muscle, and anastomose with the internal mammary. **Epigastric anastomoses with internal mammary.**

As the artery courses to the rectus it passes beneath the cord, and on the inner side of the internal abdominal ring; and it is directed obliquely inwards across the lower part of the abdomen, so as to form the outer boundary of a triangular space close to the edge of the rectus. In this course the vessel lies at first beneath the fascia transversalis; but it soon perforates that fascia, and enters the sheath of the rectus over the defined border at the posterior aspect. **Connections in wall of abdomen.**

* Sometimes this structure is a firm distinct band, which is joined by some of the lower fibres of the aponeurosis of the external oblique. At other times, and this is the most common arrangement, it is only a thickening of the fascia transversalis with fibres added from the tendon of the transversalis muscle. In six bodies, both male and female, which I examined carefully, I found the deep arch to be formed only by a thickening of the fascia transversalis.

Branches. The *branches* of the artery are numerous, but inconsiderable in size :—

Pubic joins obturator by an offset. The *pubic branch* is a small transverse artery, which runs behind Poupart's ligament to the posterior aspect of the pubes, and anastomoses with a similar branch from the opposite side. Behind the pubes it communicates with a small offset from the obturator artery : the size of this anastomosis varies much, but its situation is internal to the crural ring.

Cremasteric. A *cremasteric branch* is furnished to the coverings of the cord as before mentioned.

Muscular. *Muscular branches* are given from the outer side of the artery to supply the abdominal wall, and to anastomose with the intercostal arteries. Other branches enter the rectus.

Cutaneous. Some *cutaneous offsets* pierce the rectus, and ramify in the integuments with the anterior cutaneous nerves.

Epigastric veins. Two *epigastric veins* are found with the artery; they join finally into one, and open into the external iliac vein.

Circumflex iliac The *circumflex iliac artery* arises from the outer side of the external iliac, opposite the epigastric, and then courses outwards

is in wall of abdomen, around the iliac crest, as the name expresses. Having pierced the tube of membrane around the upper part of the femoral vessels, the artery lies at first below Poupart's ligament, and passes next beneath the transversalis muscle to the middle of the

and anastomoses with ilio-lumbar. crest of the hip-bone. Here it pierces the transversalis, and is continued backwards between this and the internal oblique, to anastomose with the ilio-lumbar branch of the internal iliac artery. Its offsets are muscular and anastomotic.

Muscular offsets *Branches.* Near the front of the iliac crest a small branch ascends between the internal oblique and transversalis muscles (fig. 89), supplying them, and anastomoses with the epigastric and lumbar arteries.

and anastomotic. As the vessel extends backwards it gives lateral offsets, which supply the neighbouring muscles, and communicate on the one side with the ilio-lumbar, and on the other with the gluteal artery.

Circumflex vein. The *circumflex iliac vein* accompanying the artery is formed by the junction of two collateral branches, like the epigastric, and crosses the external iliac artery nearly an inch above Poupart's ligament, to open into the external iliac vein.

Section II.

HERNIA OF THE ABDOMEN.

The lower part of the abdominal wall, which has been reserved on the left side of the body, should be now dissected for the study of inguinal hernia. **Inguinal hernia.**

Dissection. The teguments and the aponeurosis of the external oblique having been thrown down in the previous examination of the wall of the abdomen, the necessary dissection of the inguinal region will be completed by raising the internal oblique muscle as in fig. 89, [2]. **The dissection in the left groin.**

To raise the oblique muscle, its origin from Poupart's ligament must be detached. For this purpose let one incision be made across the fleshy fibres from the iliac crest towards the linea alba; and after the depth of the muscle has been ascertained by the layer of areolar and fatty tissue beneath it, let the lowest fibres be carefully cut through at their attachment to Poupart's ligament. By raising the muscle cautiously, the student will be able to separate it from the subjacent transversalis, so that it may be turned upwards on the abdomen (fig. 89). The separation of the two muscles just mentioned is sometimes difficult in consequence of their fibres being blended together, but a branch of the circumflex iliac artery marks their intermuscular space. **Reflect inner oblique.**

The cremaster muscle is then to be divided along the cord, and to be reflected to the sides. **Cut the cremaster.**

Let the dissector clean the surface of the transversalis muscle, without displacing its lower arched border; and trace with care the conjoined tendon of it and the internal oblique to show its exact extent outwards. **Clean subjacent parts.**

The fascia transversalis and the spermatic cord should be likewise nicely cleaned.

Crossing the interval apparent below the border of the transversalis muscle, are the epigastric vessels, which lie close to the inner side of the internal abdominal opening, but beneath the fascia transversalis. A small piece of the fascia may be cut away to show the vessels on the side of the abdominal ring. **Show the epigastric vessels.**

Inguinal Hernia. A protrusion of intestine through the lower part of the abdominal wall near Poupart's ligament (the part answering to the inguinal region), is named an inguinal hernia. The escape of the intestine in this region is predisposed to by the deficiencies in the muscular strata, by the passage of **Situation of inguinal hernia.** **Predisposition naturally.**

the spermatic cord through the abdominal parietes, and by the existence of fossæ on the inner surface of the wall.

Course it follows. The gut in leaving the abdomen either passes through the internal abdominal ring with the cord, or is projected through the part of the abdominal wall between the epigastric artery and the edge of the rectus muscle.

Two kinds: external or oblique; The two kinds of hernia of this region are distinguished by the names external and internal, from their position to the epigastric artery; or they are called oblique and direct, from the direction they take through the abdominal wall. Thus the hernia protruding through the internal abdominal ring with the cord is called external from being outside the artery, and oblique from its slanting course; whilst the hernia between the edge of the rectus and the epigastric artery is named internal from being inside the artery, and direct from its straight course. internal or direct.

External or oblique. EXTERNAL OR OBLIQUE INGUINAL HERNIA leaves the cavity of the abdomen with the spermatic cord, and traversing the inguinal canal, makes its exit from that passage by the external abdominal ring.

Anatomy of parts concerned. *Anatomy of the external hernia.* To acquire a knowledge of the anatomy of this hernia it will be necessary that the space in which it lies (inguinal canal), the apertures by which it enters and leaves the wall of the abdomen (abdominal rings), and the coverings it receives in its progress to the surface of the body, should be studied.

Inguinal canal. The *inguinal canal* (fig. 89) is the interval between the flat muscles of the abdominal wall, which contains the spermatic cord in the male, and the round ligament in the female. Its direction is oblique downwards and inwards, being nearly parallel to, but above Poupart's ligament; and its length is about one inch and a half. Superiorly it communicates with the cavity of the abdomen by the internal abdominal ring; and inferiorly it ends at the external abdominal ring. Direction. Length. Openings.

Boundaries next surface; Towards the surface of the body the canal is bounded by the tegument, and by the two oblique muscles in this way:—The skin with the subjacent fatty layer, and the aponeurosis of the external oblique, reach the whole length of the passage, but the internal oblique extends only along its outer third (half an inch).

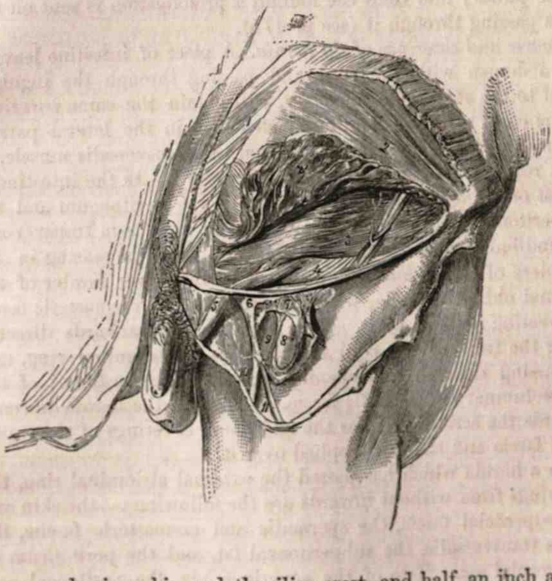
next the abdominal cavity. Towards the cavity of the abdomen the wall of the canal is constructed by the conjoined tendon of the internal oblique and transversalis, and by the deep membranous strata in the wall of the abdomen in this wise:—The conjoined tendon, placed in front of the other structures, reaches along the inner two thirds of the space (about an inch); and beneath or behind it come the fascia transversalis, the subperitoneal fat, and the peritoneum, in the order here mentioned, which are continued all along the passage. Occasionally the triangular ligament projects far enough outwards behind the external abdominal ring to take part in the formation of the posterior wall of the canal.

Along the lower part, or the floor, the canal is limited by the union of the fascia transversalis with Poupart's ligament, and by the fibres of the ligament inserted into the pectineal line; whilst along the upper part its extent is determined by the apposition of the muscles. **Flooring and roof of the canal.**

In the female, the canal has the same length and boundaries, though it is usually somewhat smaller. In that sex it lodges the round ligament. **Canal in the female.**

The *internal abdominal ring* (fig. 89, [4]) is an aperture in the fascia transversalis (p. 484), which is situate midway between **Internal abdominal ring.**

Fig. 89.*



the symphysis pubis and the iliac crest, and half an inch above Poupart's ligament. It is oval in form, the extremities of the **Situation. Form and**

* View of the inguinal canal, the external and internal oblique muscles being reflected. 1. External oblique. 2 and 2'. Internal oblique. 3. Transversalis muscle. 4. Transversalis fascia. 5. Spermatic cord covered by a tube from the transversalis fascia. 6. Upper end of the falciform border of the saphenous opening. 7. Crural sheath. 8. Femoral artery. 9. Femoral vein: and the small space inside it above is the crural canal. 10. Saphenous vein, with a branch 11.

margin. oval being directed upwards and downwards, and the fascia at its outer and lower parts is stronger than at the opposite sides.

Upper and inner boundary. Arching above and on the inner side of the aperture, is the lower border of the transversalis muscle, which is fleshy at the outer, but tendinous at the inner half. Below, it is bounded by Poupart's ligament. On the inner side lie the epigastric vessels.

Parts transmitted through it. This opening in the fascia transversalis is the inlet to the inguinal canal, and through it the cord, or the round ligament, passes into the wall of the abdomen. The external hernia leaves the abdomen at the same spot. All the protruding parts receive as a covering the prolongation from the margin of the opening.

External abdominal ring. Situation. The *external abdominal ring* (fig. 87) is the outlet of the inguinal canal, and through it the spermatic cord, or the inguinal hernia, reaches the surface of the body. This aperture is placed in the aponeurosis of the external oblique muscle, near the crest of the pubes; and from the margin a prolongation is sent on the parts passing through it (see p. 475).

The intestine, following the course of the cord, *Course and coverings of the hernia.* A piece of intestine leaving the abdomen with the cord, and passing through the inguinal canal to the surface of the body, will obtain the same coverings as the cord, viz., one from every structure in the lateral part of the wall of the abdomen, except from the transversalis muscle.

has coverings of the peritoneum and fat, fascia transversalis, It receives its investments in this order :—As the intestine is thrust outwards, it carries before it first the peritoneum and the subperitoneal fat, and enters the tube of the fascia transversalis (infundibuliform fascia) around the cord. Still increasing in size the piece of gut is forced downwards to the lower border of the internal oblique muscle, where it will have the cremasteric fascia cremaster, or covering applied to it. The intestine is afterwards directed along the front of the cord to the external abdominal ring, and spermatic fascia, superficial fascia, and skin. in passing through that opening receives the investment of the intercolumnar or spermatic fascia. Lastly, as the hernia descends towards the scrotum, it has the additional coverings of the superficial fascia and the skin applied over it.

Number. In a hernia which has passed the external abdominal ring, the coverings from without inwards are the following :—the skin and the superficial fascia, the spermatic and cremasteric fasciæ, the fascia transversalis, the subperitoneal fat, and the peritoneum or How produced. the hernial sac. Two of the coverings, viz. the peritoneal and subperitoneal, originate as the gut protrudes, but the rest are ready formed around the cord, and the intestine slips inside them. The different layers become much thickened in a hernia that has existed for some time.

Should a piece of intestine remain in the inguinal canal, the layers investing it will depend upon the spot to which it has extended.

How to distinguish it. *Diagnosis.* If the hernia is small and is confined to the wall of the belly, it gives rise to an elongated swelling along the inguinal canal. If it has proceeded farther, and entered the scrotum, it forms a flask-shaped tumour with the large end below, and the narrow neck occupying the inguinal passage.

Whilst efforts are being made to force back a piece of protruded intestine during life, the direction of the canal and the situation of the internal abdominal ring should be borne in mind. The taxis.

Seat of stricture. The protruded intestine may be constricted firstly at the internal abdominal ring by a fibrous band outside, or inside the neck of the sac; secondly, in the inguinal canal by the fleshy internal oblique muscle; and thirdly, at the external abdominal ring. Stricture where situate.

The stricture is placed usually at the inner abdominal ring, and may be produced in two ways, either by a constricting fibrous band outside the narrowed neck of the sac, or by a thickening and contraction of the peritoneum itself at the inner surface. Cause.

Division of stricture. To set free the intestine from its constriction, an incision is made down to the internal abdominal ring; and, all fibrous bands outside the peritoneum being divided, the intestine is returned into the abdomen by gentle pressure. To set free external

Supposing the intestine cannot be replaced in the abdomen after the previous steps have been taken, the surgeon proceeds to lay open the peritoneum, and to divide the internal stricture from within out, on a director placed beneath it. With the view of avoiding the surrounding vessels, the cut is directed upwards on the front and mid-part of the hernia. and internal structure.

Other designations. This kind of hernia has other names applied to it sometimes by surgeons, according as it has passed certain points in the wall of the abdomen. If the protrusion remains in the inguinal canal, the term *bubonocele* is applied to the swelling; but if it has extended into the scrotum, the appellation *scrotal rupture*, or *oscheocele*, is given to it. Terms applied to the inguinal hernia from its position.

Varieties of the external hernia. There are two varieties of the oblique inguinal hernia (congenital and infantile), which are distinguished by the condition of the peritoneal covering. Two varieties;

Congenital hernia. This kind is found for the most part in the infant and the child, though it may occur in the adult male. In it the tube of peritoneum, which accompanies the testicle from the abdomen in the fetus, remains unobliterated, and the intestine descends into a sac already formed for its reception, without protruding any fresh piece of the serous membrane. congenital hernia, how constituted.

As it takes the course of the inguinal canal, it will possess the coverings before enumerated for the external hernia; and it passes at the first to the bottom of the scrotum, instead of being arrested at the top of the testis, like that kind which has to elongate gradually the peritoneum. Coverings and course.

Diagnosis. With care it may be distinguished whilst it is of moderate size by its position in front of the testicle.

Stricture. For the seat, cause, and division of the stricture, refer to what is before said in external hernia.

Infantile hernia. *Infantile hernia* is much rarer than congenital, and cannot be distinguished from the common external during life. It was first recognised in the young child, and received its name from that circumstance; but, like the congenital, it may be met with in the adult.

How constituted. Its peritoneal covering has the following condition:—the tube of that membrane with the testicle in the fetus is closed only at the internal abdominal ring, instead of being obliterated from that point down to the testicle, so that a large serous sac will be situated in front of the spermatic cord, and may occupy the inguinal canal. With this state of the peritoneum, should an external hernia descend along the cord in the usual way, and with the usual coverings, it will pass behind the unobliterated sac, like a viscus into a serous membrane. In this way there will be two serous sacs; an anterior (the tunica vaginalis), containing serum, and a posterior enclosing the intestine.

How known and treated. The infantile hernia is first recognised during an operation by the knife opening the tunica vaginalis. The operator then proceeds to lay bare the neck of the hinder, or the hernial sac, and to treat the stricture of it as before described (p. 493).

Internal hernia. The INTERNAL OR DIRECT INGUINAL HERNIA escapes on the inner side of the epigastric artery, and has a straight course through the abdominal parietes and the external abdominal ring. Its situation and coverings, and the seat of stricture, will be better comprehended after the examination of the part of the abdominal wall through which it passes.

Anatomy of the internal hernia. At the lower part of the abdominal wall is a triangular space, bounded by the epigastric artery on one side, the outer edge of the rectus muscle on the other, and the inner half of Poupart's ligament below: it measures about two inches from above down, and one inch and a half across at the base.

It passes through a triangular space: size,

constituents, common external and common internal layers. The constituents of the abdominal wall in this spot are, the teguments; the strata connected with the muscles; and the layers lining the interior of the abdomen, viz., the fascia transversalis, subperitoneal fat, and peritoneum: the three last may be called the common internal layers, because they are concerned more or less with each kind of hernia. The common external and internal layers extend over the space, without having any apertures in them; but the strata connected with the muscles have the undermentioned arrangement:—

External oblique. The aponeurosis of the external oblique is pierced by an aperture (external abdominal ring) towards the lower and inner angle of the space through which the inguinal hernia is transmitted. The internal oblique and transversalis, which come next, are united together in the conjoined tendon; and as this descends to its insertion into the pectineal line, it covers the inner two thirds (about an inch) of the space, and leaves uncovered about half an inch between its outer edge and the epigastric vessels, where the fascia transversalis appears. Near Poupart's ligament the spermatic cord and the inner end of the cremaster muscle are placed over the conjoined tendon. **Internal and transversalis.**

Any intestine protruding in this spot must make a new path for itself, and elongate the different structures, because there is not any passage by which it can descend, as in the external hernia. Further, the coverings of the hernia, and its extent and direction in the abdominal wall, must vary according as the gut projects through the portion of the space covered by the conjoined tendon, or through the part external to that tendon. **Hernia in this space of two kinds.**

Course and coverings of the hernia. The common kind of the internal hernia (inferior) passes through that part of the triangular space which is covered by the conjoined tendon. **Coverings of the more common kind are**

The intestine in protruding carries before it the peritoneum, the subperitoneal fatty membrane, and the fascia transversalis; next it elongates the conjoined tendon, or, as may be the case in a sudden rupture, separates the fibres, and escapes between them. Then the intestine advances into the lower part of the inguinal canal, opposite the external abdominal ring, and meeting with the cord, it passes outwards through that opening, lying on the inner side of the cord, and receiving at the same time the covering of the fascia spermatica. Lastly it is invested by the superficial fascia and the skin. **peritoneum and subjacent fat, fascia transversalis, conjoined tendon, spermatic fascia, superficial fascia, and skin.**

In number the coverings of the internal hernia are the same as those of the external; and in kind they are the same, with this exception, that the conjoined tendon is substituted for the cremasteric fascia.

The position of the openings in the abdominal wall should be kept in mind during attempts to reduce this kind of hernia; and the straightness of the course of the internal in comparison with the external hernia should be remembered. **The taxis.**

Diagnosis. This rupture will be distinguished from external hernia by its straight course through the abdominal wall, and by the neck being placed close to the pubes. **How known from external:**

After the hernia has acquired a large size, an examination during life cannot determine whether it began originally in the triangular space or at the internal abdominal ring; for as an external hernia increases in size its weight drags inwards the internal ring into a line with the external aperture, and in this way the swelling acquires the appearance of an internal rupture. **impossible if it is large.**

Seat of stricture. The stricture in this form of hernia occurs **Stricture.**

Situation.

most frequently external to the neck of the sac, though it may be inside from thickening of the peritoneum; and it may occasionally be found at the external abdominal ring.

To free from stricture in general;

Division of the stricture. The neck of the tumour is to be laid bare, and all fibrous bands around it are to be divided without injury to the peritoneum; but if, after this has been done, the intestine cannot be put backwards into the abdomen, the sac is to be opened, and the internal constricting band is to be divided directly upwards on a director, as before explained.

in large hernia.

In the operation on a large rupture appearing to be internal, the operator should cut on the front and mid-part of the tumour, so as to avoid the epigastric vessels, whose position laterally cannot be known.

Rarer kind of internal hernia

Variety of internal hernia. Another kind of internal hernia (superior) occurs through that part of the area of the triangular space which is external to the conjoined tendon. Its existence is determined by the unusual position of the obliterated hypogastric artery inside the abdominal wall (p. 498).

is oblique in direction with the cord.

This hernial tumour protrudes through the wall of the abdomen close to the epigastric artery, and descends along nearly the whole of the inguinal canal to reach the external abdominal ring; so that the term "direct" would not apply strictly to the form of internal hernia now under consideration.

Coverings are same as in external hernia.

Coverings. As this internal hernia traverses nearly the whole of the inguinal canal, it has exactly the same coverings as the external hernia, viz., the skin and the superficial fascia, the spermatic and cremasteric fasciæ, the fascia transversalis, and the subperitoneal fat and the peritoneum.

Diagnosis not possible in life.

Diagnosis. This form of internal hernia would be considered external during life from its course and its form, and yet it must be remembered that the epigastric vessels are placed on the outer part of its neck, whilst in the hernia which it simulates they lie on the inner side. Its nature can be ascertained with certainty only by dissection after death.

Stricture at same spots as external.

Seat of stricture. The constriction of the intestine will take place from similar causes, and will be found at the same spots as in the external hernia.

Division of stricture.

Division of the stricture. From an inability to decide always in the living body whether a small hernia is internal or external, the rule observed in dividing the stricture of the neck of the sac is, to cut down upon the mid-part of the front of the tumour; and if it is necessary to open the peritoneum, to cut directly upwards, as in the other kinds of inguinal hernia.

Umbilical hernia.

Course.

Umbilical Hernia, or exomphalos, is a protrusion of the intestine through or by the side of the umbilicus. It is very variable in size, and its course is straight through the abdominal wall.

Coverings. The coverings of the intestine in a small hernia are thin, and few in number. They are the skin and the superficial fascia; a prolongation from the tendinous margin of the umbilical opening; together with coverings of the fascia transversalis, the subperitoneal fat, and the peritoneum. Coverings,

If the hernia is suddenly produced, it may want the investment that otherwise is derived from the tendon of the external oblique muscle. Over the end of the tumour the fat in the superficial fascia disappears, and this covering becomes blended with the other contiguous structures. changes in, become united over the tumour.

Seat of stricture. The stricture on the intestine is generally found at the margin of the tendinous opening in the abdominal wall; and it may be either in or outside the neck of the sac, as in the other kinds of hernia. It should be remembered that the narrowed neck is at the upper part, and not in the centre of the swelling. Stricture, where found.

Division of the stricture. The constriction may be removed by cutting externally the parts around the neck. Or if the sac is opened the knife may be carried upwards, but there is not any vessel to be injured in the operation.

Other Forms of Hernia. At each of the other apertures in the parietes of the abdomen, a piece of intestine may be protruded, so as to form a hernial tumour. For instance there may be *femoral hernia* below Poupart's ligament, with the femoral vessels; *obturator hernia* through the thyroid foramen, with the artery of the same name: and *ischiatic hernia* through the ischiatic notch. Other abdominal herniæ are femoral, obturator, ischiatic.

The femoral hernia, as the most important, will be noticed presently; but the student must refer to some special treatise for his information respecting the other abdominal herniæ.

Dissection. The abdomen may be now opened to see the cords and the depressions on the posterior surface of the abdominal wall. A transverse cut may be made through the umbilicus across the front of the abdomen; and on holding up the lower half of the wall the cords will be seen ascending to the umbilicus from the pelvis. Dissection.

Cords of the abdominal wall. In the middle line of the abdominal wall, at its posterior aspect, is the prominence of the remains of the urachus, which reaches from the summit of the bladder to the umbilicus. On each side is another cord, formed by the obliterated hypogastric artery; this is directed from the side of the pelvis to the umbilicus, and lies usually behind or close to the epigastric artery, near Poupart's ligament. Cords inside abdomen; one in middle line, another on each side,

Fossæ. When the disposition of the cords is such as above mentioned, two fossæ are seen near Poupart's ligament, one on each side of the obliterated hypogastric artery, which correspond with the situation of the internal and external abdominal rings, forming two fossæ.

and with the places where the external and the internal (common kind) hernia occur.

Sometimes last cord moved inwards,

But occasionally the cord of the obliterated hypogastric is moved inwards from the epigastric artery, to the line of junction of the outer with the inner two thirds of the triangular space through which the direct hernia comes. In this condition of the cord there will be a hollow or fossa on each side of it at the lower part of the abdomen, corresponding with the spots at which the two kinds of internal hernia escape.

causing three fossæ.

When the hypogastric cord has the unusual position last mentioned, there will be three fossæ, at each side, on the lower part of the abdominal wall; viz. an inner between it and the urachus, a middle one between it and the epigastric vessels, and an external outside the epigastric artery. And there may be one, two, or three kinds of inguinal hernia on each side, according to the depth of the fossæ, and the predisposition to protrusion of the intestine.

Number of the hernial protrusions.

Situation of the femoral hernia.

Femoral Hernia. In this hernia the intestine leaves the abdomen below Poupart's ligament, and descends in a loose membranous sheath around the femoral vessels. The course of the intestine, and the coverings that it receives, will be understood after the anatomy of the parts among which it passes has been learnt. Only so much of the structures will be described here as can be now seen, the rest are noticed fully in the dissection of the thigh.

Dissection of the parts concerned.

Dissection. The dissection for the femoral hernia is to be made on the left side of the body.

Divide wall

The lower portion of the abdominal wall is to be divided from the umbilicus to the pubes. The peritoneum is to be detached from the inner surface of the wall near Poupart's ligament, and from the iliac fossa. And the layer of the subperitoneal fat is to be separated in the same way, but before this can be done it will be necessary to cut through the spermatic cord at the abdominal ring. As the last layer is raised, some lymphatic glands will be laid bare by the side of the iliac vessels.

detach inner strata

take away fat.

Any loose tissue that remains is to be taken away to show the upper opening of the membranous crural sheath containing the femoral vessels, and the interval (crural ring) on their inner side. In this dissection the genito-crural nerve is seen on the iliac artery.

Afterwards the iliac fascia and the fascia transversalis are to be traced to Poupart's ligament, to see the part that each takes in the production of the crural sheath.

Anatomy of the structures.

Anatomy of femoral hernia. The structures concerned in the femoral hernia are, the peritoneum; the subperitoneal fat; the membranes (transversalis and iliac fascia) lining the interior of the abdominal cavity, with the sheath to which they give origin at Poupart's ligament; and lastly, the crural ring, or the space through which the hernia leaves the abdomen.

Peritoneal layer.

The *peritoneum* lines the inner surface of the abdominal wall, without having any aperture for the escape of the intestine; and its thinness and weakness are apparent now it is detached.

Subperitoneal fat,

The *subperitoneal fat* extends as a continuous layer beneath the peritoneum, but it is thickest and most fibrous at the lower part of the abdomen where the iliac vessels pass under Poupart's ligament. At that spot it extends over the upper opening of the membranous sheath around the vessels, instead of descending in it; and internal to the vein, it covers the space of the crural ring, as well as a lymphatic gland which occupies that space.

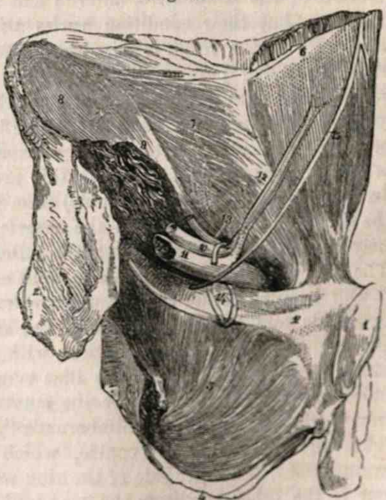
forms septum crurale.

The piece of the layer that stretches over the crural ring is named by M. Cloquet *septum crurale;* and it is described by him as being concave towards the abdomen, and convex towards the thigh. An inguinal gland is generally attached to its under surface.

Fascia transversalis.

The *fascia transversalis* (fig. 90, [7]) has been before described (p. 483). When traced down to Poupart's ligament, it may be seen to join the iliac fascia outside the situation of the large iliac artery; but internal to that spot it is continued downwards to the thigh in front of the femoral vessels, and forms the anterior part of the crural sheath.

Fig. 90.*



Iliac fascia.

The *iliac fascia* (fig. 90, [8]) covers the iliacus muscle, and lies beneath the iliac vessels. At Poupart's ligament its disposition is similar to that of the transversalis fascia; for external to the iliac vessels it joins the fascia transversalis along the line of the ligament; but internally it is prolonged behind the vessels into the posterior part of the crural sheath.

* Inner view of the abdominal wall and of the fasciæ constructing the crural sheath (Quain's Anatomy). 1, 2, and 4, refer to parts of the hip bone. 5. Internal obturator muscle. 6. Rectus abdominis. 7. Transversalis fascia

Sheath on femoral vessels formed by offsets of preceding.

The *crural sheath* is the loose membranous tube that encloses the femoral vessels as they enter the thigh, and is obtained from the membranes lining the abdomen. Its anterior half is continuous with the fascia transversalis, and its posterior part is derived from the fascia iliaca. The sheath is not filled by the vessels, for a space (crural ring) exists on the inner side of the vein (fig. 90), which contains a gland, and through which the intestine descends in femoral hernia.

A space on inner side of the vessels is the crural ring.

Size and boundaries.

The *crural ring* is described partly in the dissection of the thigh, but its boundaries are better seen in the abdomen. It is the interval in the sheath, at the inner side of the femoral vein (fig. 90), which is about half an inch wide, and is filled by a lymphatic gland. Bounding it internally, are Gimbernat's ligament and the conjoined tendon; and limiting it externally is the femoral vein without the intervention of the sheath. In front is Poupart's ligament with the deep arch; and behind is the pubes covered by the pectineus and the fascia lata. Along the front of the space, but at some little distance from it, lies the spermatic cord in the male, and the round ligament in the female.

Constricting boundaries, how relaxed.

Two of the boundaries, anterior and inner, are firm and unyielding, but their condition varies with the position of the limb; for if the thigh is raised and approximated to its fellow, those bounding parts will be relaxed. This change may be remembered with advantage in attempts to put back a hernia.

Usual vessels around ring.

Position of vessels around the ring (fig. 90). Commonly the crural ring is almost surrounded by vessels. On the outer side is the femoral vein; and above this are the epigastric vessels. In front is a small branch (pubic) from the epigastric artery to the back of the pubes; and the vessels of the spermatic cord may be said to be placed along the anterior aspect of the ring. The ring is bounded by vessels in front and on the outer side.

State of unusual vessels.

But in some bodies the obturator artery takes origin from the epigastric, and lies along a part of the ring as it passes to the pelvis. It may have two positions with respect to the ring:—either it is placed close to the iliac vein, and therefore on the outer side: or it arches over the aperture, descending on the inner side at the base of Gimbernat's ligament. If the artery takes the first-mentioned course, which is the most frequent arrangement, the inner side of the ring will be free from vessels; but in the other condition the ring will have an artery on the inner side, and will be encircled except at the posterior part.

covering the transversalis muscle. 8. Iliac fascia covering the iliacus muscle. 9. Psoas magnus muscle cut. 10. Iliac artery. 11. Iliac vein: the dark interval on its inner side indicates the crural ring. 12. Epigastric artery and its two veins. 13. Parts of the spermatic cord lying in the internal abdominal ring. 14. Obturator vessels with an unusual arrangement.

Course and coverings of femoral hernia. The intestine leaves the abdomen by the opening of the crural ring; and it descends internal to the vein in the large crural sheath on the vessels, as far as the saphenous opening in the thigh, where it projects to the surface.

Course and coverings of femoral hernia.

In its progress the intestine will push before it the peritoneum, and the subperitoneal fat (septum crurale); and it will displace, or cause to be absorbed the gland that fills the crural ring. Having reached the level of the saphenous opening, the intestine carries before it the inner side of the crural sheath, and a layer called the cribriform fascia; and, lastly, it receives coverings from the superficial structures of the thigh. The dissection of the thigh may be referred to for fuller detail.

From abdomen it has peritoneum and subperitoneal fat.

Inner part of sheath.

Seat of stricture. The stricture of a femoral hernia is placed around the neck of the sac, opposite the base of Gimbernat's ligament; or lower down at the margin of the saphenous opening in the thigh. But the constriction may be situate within the sac, being formed by the thickened peritoneum, as in inguinal hernia.

Stricture either at neck, or at saphenous opening.

Division of the stricture. To free the intestine from the constricting fibrous band arching over it, an incision is to be made down to the neck of the sac at the inner and upper part.

Incision to divide external

And to relieve the deep stricture within the neck of the sac, the peritoneal bag is to be opened and a director introduced, and the knife is to be carried horizontally inwards, or upwards and inwards through the thickened sac and a few fibres of the edge of Gimbernat's ligament.

and internal.

Danger to vessels. When the incision is made upwards and inwards to loosen the constricting band in the neck of the sac, there will not be any vessel injured unless the cut should be made so long as to reach the spermatic cord, or the small pubic branch of the epigastric artery.

Risk of wounding vessels in regular

And when the incision is made directly inwards with the same view, there is not in ordinary cases any vessel in the way of the knife on the inner side of the ring. But in some few instances (once in about eighty operations, Lawrence), the obturator artery takes its unusual course, lying in front of and on the inner side of the neck of the hernia, and will be before the knife in the division of the stricture. As this condition of the vessel cannot be recognised beforehand, the surgeon will best avoid the danger of wounding the artery by a cautious and sparing use of the knife.

and irregular condition of them.

Section III.

CAVITY OF THE ABDOMEN.

Definition

and contents.

The abdominal cavity is the space included between the spinal column behind, and the visceral arches of the vertebræ with their intervening muscles in front. It contains the digestive, urinary, and generative organs, with their vessels and nerves.

Dissection to open abdomen.

Dissection. To prepare the cavity for examination, the remainder of the abdominal wall above the umbilicus is to be divided by a cut along the left side of the linea alba as far as the xiphoid cartilage. The resulting flaps may be thrown to the sides.

Is largest cavity in the body.

Is oval.

Size and form. This space is the largest in the body. It is oval in form with the ends of the oval upwards and downwards, so that it measures more in the vertical than the transverse direction; and it is much wider superiorly than inferiorly.

Boundaries above and below.

Boundaries. Above it is limited by the diaphragm; and below by the recto-vesical fascia and the levatores ani, and the structures that close the outlet of the pelvis: both these boundaries are concave towards the cavity, and are in part fleshy, so that the space will be diminished by their contraction and flattening.

In front and on sides.

In front and on the sides the parietes are partly osseous and partly muscular:—thus towards the upper and lower limits is the bony framework of the skeleton, viz. the ribs in one direction and the pelvis in the other; but in the centre are stretched the muscles of the abdominal wall.

Behind is spine.

Behind is placed the spinal column with the muscles contiguous to it, viz. the psoas and the quadratus lumborum.

Depth is altered by action of diaphragm and levator ani.

Alterations in size. The dimensions of the cavity are influenced by the varying conditions of the boundaries. Its depth is diminished by the contraction and descent of the diaphragm, and the contraction and ascent of the levatores ani; and the cavity is restored to its former dimensions by the relaxation of those muscles.

Width by muscles in wall of abdomen.

The width is lessened by the contraction of the abdominal muscles; and it is enlarged, during their relaxation, by the action of the diaphragm driving outwards the viscera.

How excreta expelled.

The greatest diminution of the space is effected by the simultaneous contraction of all the muscular boundaries, as in the expulsion of the excreta.

Division of space.

Division of the space. An arbitrary division has been made of the space into the abdomen proper and the cavity of the pelvis.

Abdomen proper.

The *abdominal* portion reaches from the diaphragm to the brim of the pelvis, and lodges the alimentary tube and its appendages, together with the kidneys—the secretory organs of the urine. A serous membrane, the peritoneum, lines the space, and covers the viscera.

Pelvic portion.

The *pelvic* portion is situate below the brim of the pelvis, and contains chiefly the generative and urinary organs.

Abdomen proper here described. Pelvis after.

The following description concerns the part of the cavity between the diaphragm and the brim of the pelvis. Towards the end of the dissection of the abdomen, the pelvic portion will receive a separate notice.

Abdominal cavity is marked out into regions.

Regions. The large upper part of the abdominal cavity is divided artificially into regions by lines extended between certain points of the parietes.

If two circular lines are carried round the body, so that one shall be opposite the cartilage of the ninth rib, and the other on a level with the most prominent point of the crest of the hip bone, the abdominal cavity will be divided into three circles or zones, upper, middle, and lower.

Three lateral on each side, and three central.

Each of these circles has been further subdivided into three by a line on each side, from the cartilage of the eighth rib to the centre of Poupart's ligament. The piece marked off, on each side, from the three circles by the vertical line is named respectively, from above downwards, hypochondriac, lumbar, and iliac (right and left); whilst the central part of each circle is designated from above down, epigastric, umbilical, and hypogastric.

Subdivisions.

In addition, the middle and lower part of the hypogastric space is named pubic region, whilst its lateral portion is known as the inguinal region.

Parts in cavity.

Contents and their position. The alimentary tube and its accessory parts, the liver, pancreas, and spleen, occupy the upper division of the cavity of the abdomen. The kidney is situate also in the same part of the abdominal space.

General division of alimentary tube:

The alimentary tube presents differences in form, and is divided into stomach, small intestine, and large intestine; and the two last of these portions are further subdivided as it will afterwards appear. The several viscera have the following general position:—

position of several parts: of kidney.

The small intestine is much coiled, and occupies the greater part of the cavity; whilst the great intestine arches around it. Both are fixed in position by folds of the serous lining. Above the arch of the great intestine are situate the stomach, the liver, the spleen, and the pancreas; and below it is the convoluted small gut. Behind the large intestine on each side is the kidney with its excretory tube.

Parts of viscera seen without

Superficial view of the contents. On first opening the abdomen the following viscera appear:—On the right side is the liver, displacement. which is partly concealed by the ribs. On the left side a piece of the stomach is visible; but this viscus lies for the most part beneath the ribs, and is somewhat overlaid by the liver. Descending from the stomach is a fold of peritoneum (the large omentum), which reaches to the pelvis, and conceals the intestine. In some bodies the omentum is raised into the left hypochondriac region, and leaves the small intestine uncovered.

If the bladder is distended, a small part of it may come into view just above the pelvis.

Connections of viscera to be seen. Before the natural position of the viscera is disturbed, their situation in the different regions of the abdomen, and their connections with the surrounding parts should be examined.

CONNECTIONS OF THE VISCERA.

Position of stomach. *The stomach* (fig. 98) intervenes between the gullet and the small intestine, and is partly retained in position by folds of the serous membrane. It is somewhat of a conical form, with the larger end to the left side; and it occupies the left hypochondriac, the epigastric, and part of the right hypochondriac region.

Extremities, large At the left end it receives the œsophagus (fig. 98, °) by which it is firmly fixed to the diaphragm. Its large end lies beneath the ribs, and is in contact with the spleen, to which it is connected by a fold of peritoneum (splenic omentum): when this part of the stomach is distended it pushes up the diaphragm, and encroaches on the space for the heart and the left lung. and small. The right extremity ends in the small intestine, and reaches towards the gall bladder; it is in contact with the under part of the liver.

Surfaces. The anterior surface touches, from left to right, the diaphragm, the abdominal wall, and the liver; and the posterior surface corresponds with the pancreas, the pillars of the diaphragm, the aorta and vena cava, and the solar plexus.

Borders. The upper border is connected to the liver by a fold of peritoneum, the small omentum; and the lower border gives attachment to another peritoneal fold, the great omentum or epiploon, which floats freely over the intestine.

Connections altered by its distension. The form, and the connections of the stomach with the surrounding parts will be influenced by its condition. For when the viscus is empty its surfaces look forwards and backwards, and its borders upwards and downwards; but when distended, it becomes somewhat circular, and makes a rotatory movement, so as to bring forwards the border usually lowest, and to turn upwards that surface which is directed forwards at other times.

Alterations in position from disease, The position and connections of the stomach may be changed also by alterations in the size of any of the surrounding organs, or by accumulation of fluid in the chest, or in the belly. The stomach may be dragged down likewise by the great omentum entering a hernial sac; or it may be forced down towards the pelvis by the pressure of tight stays. In these different changes in its position, the right end moves more than the left, because it is attached mainly by peritoneum to the parts around. and other causes.

The small intestine (intestinum tenue) reaches from the stomach to the right iliac region, where it ends in the large intestine. It is divided into three parts, duodenum (twelve fingers' length), jejunum, and ileum: of the last two, one receives its name from its empty condition, and the other from its numerous coils. Small intestine. Situation and divisions.

The *duodenum* cannot be satisfactorily seen at present, and it will be examined afterwards (p. 521). Duodenum.

The *jejunum* and *ileum* (fig. 91, [1], [2]) begin on the left side of the second lumbar vertebra, without any distinct mark of separation from the duodenum. Two fifths of the intestine belong to the jejunum, and the remaining three fifths to the ileum. Jejunum and ileum.

This part of the intestinal tube forms many convolutions in the umbilical, hypogastric, lumbar, and iliac regions of the abdomen; and it descends oftentimes, but more especially in the female, into the cavity of the pelvis. In front of the convolutions is the great omentum; and posteriorly the small intestine (beyond the duodenum) is fixed to the spine by a fold of peritoneum named the mesentery, which contains the vessels and nerves. Surrounding the jejunum and ileum is the large intestine or colon; but on the left side of the body the large is concealed by the small intestine. Situation. Connections.

The large intestine, or the colon, is sacculated, and is less moveable than the jejunum and ileum. It begins in the right iliac region in a dilated part or head (caput cæcum coli), and ascends to the liver through the right iliac, lumbar, and hypochondriac regions. Crossing then the abdomen below the stomach, it reaches the left hypochondriac region; and it lies in this transverse part of its course between the epigastric and umbilical regions, or altogether in the latter. Finally, it descends on the left side through the regions corresponding with those it occupied on the right, forms a remarkable bend (sigmoid flexure) in the left iliac fossa, and enters the pelvis to end on the surface of the body. Large intestine how distinguished. Course and extent.

It takes an arched course around the small intestine, and is divided into six parts, viz. cæcum, ascending colon, transverse colon, descending colon, sigmoid flexure, and rectum. Divisions.

The *cæcum* (caput cæcum), or the commencement of the colon (fig. 91, [3]), is placed in the right iliac fossa, in which it is fixed by the peritoneum being stretched over it. In front usually are convolutions of the small intestine, but when it is distended it touches the abdominal wall. Behind, it rests on the iliac fascia, Cæcum, or head of colon. Situation and connections.

only fatty and areolar tissues intervening. On the inner side it is joined by the small intestine; and it presents inferiorly a worm-like piece—the vermiform appendix.

Sometimes the peritoneum surrounds the cæcum, and attaches it by a fold to the abdominal wall.

Ascending colon. The *ascending colon* (fig. 91, [4]) reaches from the cæcum to the under surface of the liver, on the right of the gall bladder. It lies against the quadratus lumborum inferiorly, but higher up it is placed in front of the kidney. To its inner side are the convolutions of the small intestine. The peritoneum fixes the colon immoveably to the wall of the abdomen, and surrounds commonly about two thirds of the circumference; but it may encircle the tube, and form a fold behind, as in the cæcum.

Parts around.

Connections of the transverse colon: The *transverse colon* (fig. 91, [5]) passes obliquely upwards and to the left, along the curvature of the stomach, as far as the spleen; in this course it is deeper at each end than in the middle, and, by being thus bent, forms the arch of the colon.

Above the arch are placed the liver and the gall bladder, the stomach and the spleen: and below is the small intestine. In front lies the great omentum; and behind is a fold of peritoneum, the transverse meso-colon, which attaches it to the back of the abdominal wall, and contains the vessels and nerves.

is most moveable piece of large intestine. The transverse colon is more moveable than any other part of the large intestine, its peritoneal fold allowing it to be raised on the margin of the ribs. Small pieces of peritoneum, containing fat, the *appendices epiploïcæ*, are attached along it.

Descending colon. The *descending colon* (fig. 93, [8]) commences below the spleen, and reaches to the left iliac fossa. At first it is placed deeply in the left hypochondriac region, and its whole course is deeper than that of the right colon. In front of it are the convolutions of the small intestine; and behind are the diaphragm, the outer part of the kidney, and the quadratus lumborum.

Situation.

Is covered by small intestine. This part of the intestine is smaller than either the right or the transverse portion; and it is less surrounded usually by the peritoneum fixing it to the abdominal wall.

Sigmoid flexure is in left iliac fossa. The *sigmoid flexure* of the colon (fig. 92, [3]) is lodged in the left iliac fossa, to which it is attached by a fold of the peritoneum, the sigmoid meso-colon, but it often extends partly into the cavity of the pelvis. The intestine makes two turns like the letter S, and has obtained its name from that circumstance. Its extent is from the crest of the hip bone to the junction of this with the sacrum, where it ends in the rectum. It is concealed by the small intestine, which is directed more to the left than to the right side.

Rectum. The *rectum* is the termination of the large intestine, which is contained in the pelvis: it will be examined in the dissection of that cavity.

The liver (fig. 93, [1]) is situate in the right hypochondriac, and epigastric regions, and reaches slightly into the left hypochondriac. Folds of peritoneum (ligaments) retain it in place. Position of the liver.

The upper surface, convex, is turned to the vault of the diaphragm, and is divided into two parts by the suspensory ligament; the right portion, more prominent than the left, reaches to the level of the fifth intercostal space. The under surface is in contact with the stomach and the duodenum, with the ascending colon, and with the right kidney and suprarenal body. Attached to this surface is a fold of the peritoneum (small omentum) containing the hepatic vessels. Surfaces: upper and under,

The anterior border is thin, and is constantly varying its position to the wall of the thorax according to the distension of the stomach, and the position of the body and the diaphragm. This edge, except a small part near the xiphoid cartilage, lies in adult males usually within the margin of the ribs, but in women and children it reaches below that line. The gall bladder projects beyond this edge. The posterior border is thick, and is connected to the diaphragm by certain ligaments or folds of the peritoneum; it lies on the large vessels (aorta and cava) and on the pillars of the diaphragm. Borders, anterior and posterior.

The liver changes its situation with the ascent and descent of the diaphragm in respiration; thus in inspiration it descends, and in expiration it regains its former level. In the upright and sitting postures this viscus descends lower than in the horizontal condition of the body; so that when the trunk is erect, the anterior border may be felt underneath the edge of the ribs, but when the body is reclined it is withdrawn within the margin of the thorax. Position is changed by diaphragm, by posture of body,

The connections of the liver with the surrounding parts may be changed by the growth of tumours, by collections of fluid in the chest or in the abdomen, or by constricting the space for its lodgment, as in tight lacing. and by disease in other parts.

The spleen (fig. 93, [3]) lies deeply in the left hypochondrium, between the stomach and the ribs, and is connected by peritoneum to the great end of the stomach on the one side, and to the diaphragm on the other. Its position is almost vertical. Situation of the spleen.

The outer surface is convex: it touches the diaphragm, and is opposite the ninth, tenth, and eleventh ribs. At the inner surface, which is concave, the vessels enter; and to it a fold of peritoneum, the gastro-splenic omentum, is attached: the part in front of the vessels touches the stomach; and the part behind them is in contact with the left crus of the diaphragm, the suprarenal capsule, and the tail of the pancreas. Surfaces, outer, and inner.

Below the spleen are the kidney and the beginning of the descending colon. When the stomach is distended the spleen is somewhat behind it. Below it.

Kidney

The kidney should be examined on the left side of the body, so that the duodenum may not be displaced. In order that it may be seen, the descending colon and the peritoneum must be separated from the abdominal wall.

occupies lumbar region.

This viscus is surrounded with fat, and is situate in the lumbar region opposite the last dorsal, and the upper two or three lumbar vertebræ. Its position is somewhat oblique, and the upper end is nearer than the lower to the spinal column.

Parts in front, behind, above, below, inside.

In front of the kidney are the peritoneum and the colon; and behind it are the quadratus lumborum and psoas muscles, with the diaphragm and the last rib. Above each kidney and resting on it, is the suprarenal capsule; and below each is the iliac crest. The inner border looks to the spine and receives the vessels; whilst the outer border projects towards the abdominal wall.

Two joined.

Sometimes the two are united in front of the aorta, and form the horse-shoe kidney.

Right highest.

Difference on opposite sides. The right kidney is placed rather lower than the left; it reaches as high as the lower border of the eleventh rib, whilst its fellow is opposite the upper border of the corresponding rib. In front of the right, in addition to the common connections before specified, is the duodenum; and before the left one is the lower end of the spleen. Above the right is the liver, and above the left the spleen.

Different parts before and above.

Pancreas after.

The *connections* of the *pancreas* may be omitted for the present. This viscus is described at page 522.

THE PERITONEUM.

Peritoneum

This is the largest serous membrane in the body. Like other membranes of the kind it is a closed sac in the male, but in the female its cavity is continuous with the canals of the Fallopian tubes. One part of it lines the wall of the abdomen (parietal layer), and another is reflected over the different viscera (visceral layer) except where the vessels enter. The inner surface is smooth; but the outer is rough, when it is detached from the parts with which it is naturally in contact. The membrane forms processes or folds as it passes from viscus to viscus along the vessels; and the folds attaching the viscera to the abdominal wall consist for the most part of two layers, one on each side of the vessels.

consists of a parietal and visceral layer,

and forms folds on vessels.

The continuity of the sac may be traced in a horizontal and a vertical direction.

Circle of the membrane opposite umbilicus.

Horizontal circle around the abdomen. The membrane, when followed outwards from the umbilicus, surrounds partly the large intestine and fixes it to the abdominal wall. From the colon it may be traced over the kidney as far as the middle line, where it is reflected along the front of the vessels supplying the small intestine, surrounds the intestine, and passes back to the spine along the same vessels. Lastly, it may be pursued outwards to the right kidney, and the colon which it encircles like the left, and then along the wall of the abdomen to the umbilicus.

The piece of membrane fixing the colon on each side to the abdominal wall, is named meso-colon, and that attaching the small intestine is the mesentery.

Vertical circle from above downwards. From the liver the peritoneum may be followed along the vessels at the under surface to the upper border of the stomach, one piece before and the other behind them, and the two forming the small omentum. At the stomach the two pieces separate, one going before, and the other behind it; but beyond that viscus they are applied to each other to form the great omentum or epiploon. After descending in contact to the lower part of the abdomen they bend backwards and upwards, separating to enclose the transverse colon like the stomach, and they are then continued to the spine, giving rise to the transverse meso-colon. At the attachment of the transverse meso-colon to the abdominal wall, the two companion pieces will be found to separate,—one passing upwards, the other downwards.

Circle from above down;

forms omentum,

Sometimes in the fetus and child, the two pieces ascend over the transverse colon, being slightly attached to it and the transverse meso-colon, as high as the pancreas before they separate. In that case the descending layer forms a distinct mesentery for the transverse colon, like that for the small intestine.

Different state sometimes.

The ascending piece is continued in front of the pancreas and the pillars of the diaphragm, forming the posterior part of a pouch behind the stomach, and blends with the peritoneum on the under surface of the liver.

ascending layer;

The descending piece or layer may be followed from the transverse meso-colon over the duodenum and the great vessels on the spine (aorta and cava), till it meets with the artery to the small intestine, along which it is continued to form the mesentery, as before explained in tracing the peritoneum in a circular direction.

descending layer passes to pelvis.

From the root of the mesenteric artery the peritoneum descends to the pelvis, and covers partly the viscera in that cavity. For instance, surrounding the upper part of the rectum, it attaches this to the abdominal wall by the meso-rectum; next, it is continued forwards between the rectum and the bladder in the male, or between the rectum and the uterus in the female, where it forms a pouch. Thence it passes from the pelvis over the back and sides of the bladder.

In the pelvic cavity,

Lastly, the serous membrane is continued to the inguinal region, where it presents the pouches before alluded to (p. 497);

on the front of abdomen.

and it can be traced upwards on the wall of the abdomen, and over the diaphragm and upper surface of the liver to the under surface of that viscus in front of the vessels.

Chief folds of the peritoneum. FOLDS OF THE PERITONEUM. After tracing the continuity of the serous sac over the viscera, the student is to learn the chief folds or processes of the membrane in connection with the alimentary tube. The pieces of the peritoneum fixing the liver will be examined afterwards: and the folds on the viscera of the pelvis will be seen with the dissection of that cavity.

On the stomach omenta. *Folds on the stomach.* The processes of the serous membrane connected with the stomach are named omenta. They are three in number:—one, small omentum, is attached to the upper curve; another, great omentum, to the lower curve; and the third, splenic omentum, is fixed to the great end of the viscus.

Small omentum. The *small* or *gastro-hepatic omentum* is stretched between the under surface of the liver and the upper border of the stomach,

Situation. and contains the vessels and nerves of the liver. It is formed by two pieces of peritoneum, as before explained, and presents a free border on the right side. Behind it is the space called

Attachments. foramen of Winslow. Its lower edge is fixed to the small curve of the stomach; whilst its upper border is attached to the transverse fissure, as well as the posterior half of the longitudinal fissure of the liver, blending behind with the left lateral ligament of that viscus.

Great omentum. The *gastro-colic* or *great omentum* is the largest fold of the peritoneum, and consists of two pieces, which are continuous

Attachments. with the membrane on the front and back of the stomach. It is attached above to the spleen and the lower border of the stomach, and descends in front of the large intestine, but lower

Forms a fold in front of small intestine. on the left than the right side of the body. At the lower part of the abdomen the fold is bent backwards, and returns to the spine, the pieces of which it is composed separating and enclosing the transverse colon.

Consists of two layers. Between its layers are contained some fat, and vessels and nerves; and the power of separating the one layer from the other diminishes with the increase of the distance from the stomach, until below they are not to be separated, and the membrane they form is thin and net-like.

The anterior part of the omental fold is separated from the posterior by a space (bag of the omentum), which extends a varying distance.

Bag of the omentum. *Cavity or bag of the great omentum.* When an opening is made through the great omentum near the stomach, and this viscus is raised, a space is seen to extend upwards to the liver, and downwards into the omentum. This is the omental bag. In front

Boundaries. the space is bounded by the small omentum, the stomach, and the anterior part of the great omentum. Behind it are the posterior part of the great omentum, the transverse colon, and the transverse meso-colon with its ascending layer. Above is the liver; and below is the doubling of the omental fold.

This space communicates with the rest of the peritoneal cavity, through the hole (foramen of Winslow), behind the small omentum. If the sack of the omentum were perfect, it could be inflated through the foramen; or if it were detached from the surrounding parts, it could be drawn through the same hole into the general bag of the peritoneum. **Opens into general cavity by foramen of Winslow.**

Supposing the sac to be detached and drawn out, the following parts would have pieces of the peritoneum taken from them, viz. the small omentum (posterior piece), the posterior part of the stomach, the great omentum (inner piece), the upper surface of the transverse colon, the transverse meso-colon (upper piece), the pancreas, the spine, and the posterior part of the liver. Should this piece of peritoneum be removed, there is not any membrane to prevent the vessels reaching the different viscera; and it may be readily conceived how the peritoneum could be replaced over the viscera, and around the vessels without being perforated by them. **Parts covered or formed by it.**

The *foramen of Winslow* is the space behind the small omentum, through which the bag of the great omentum opens into the general cavity of the peritoneum. In front of it is the small omentum, and behind are the vena cava and the spine. Above it is the liver (lobulus Spigelii), and below is the duodenum. Should this hole be closed, a dropsical effusion would be confined to the sac of the omentum. **Foramen of Winslow.**

The *splenic omentum* reaches from the great end of the stomach to the concave surface of the spleen, and does not consist usually of two strata or pieces, like the other omenta. It covers the vessels passing between the two viscera, and is continued inferiorly into the great omentum. **Splenic omentum.**

Folds on the large intestine. The large intestine is connected to the wall of the abdomen by folds of the peritoneum (meso-colic), which are formed of two pieces like the other processes. Each part of the colon has a separate meso-colon attaching it: thus there is an ascending, a transverse, a descending, and a sigmoid meso-colon. The cæcum is fixed by a meso-cæcum, and the rectum by a meso-rectum. **Peritoneum attaching large intestine forms**

The *meso-cæcum* attaches the caput cæcum coli to the right iliac fossa. Usually the peritoneum does not surround the gut so as to form a fold behind it, but in some bodies the serous membrane does give a suspensory process to this part of the intestine. **meso-cæcum;**

By the *ascending* and the *descending meso-colon* the ascending and the descending part of the colon are kept in place. In these folds, as in that of the cæcum, the peritoneum does not **ascending, descending meso-colon;**

commonly surround the intestine, though it may meet behind and form processes of some length.

pleuro-colic fold;

The upper end of the left colon has a distinct fold (pleuro-colic, Phœbus), fixing it to the wall of the abdomen. Attached by a wide part to the diaphragm opposite the eleventh or tenth rib, it passes transversely below the spleen, and forms the lower boundary of a hollow in which the spleen rests.

transverse meso-colon;

The *transverse meso-colon* is a more perfect fold than either of the others connected with the large intestine, and serves as a partition between the small intestine and the stomach, liver, and spleen. By one side it is fixed to the colon, and by the other side to the abdominal wall below the pancreas. It is formed of two layers of peritoneum, as before said, which enclose the vessels of the colon.

and sigmoid meso-colon.

The *sigmoid meso-colon* is a long process of the serous membrane, and attaches the sigmoid flexure of the colon to the left iliac fossa.

Meso-rectum.

The *meso-rectum* contains the hæmorrhoidal vessels, and connects the rectum to the front of the sacrum.

Appendices epiploïcæ.

Small processes of the peritoneum are attached along the tube of the great intestine, chiefly to the transverse colon; they are the *appendices epiploïcæ*, and contain fat.

Peritoneal covering of small intestine.

Folds of the small intestine. The small intestine is not enveloped by the peritoneum after the same manner through all its extent. For whilst the jejunum and ileum are attached to the abdominal wall by one fold (mesentery), the duodenum has special connections with the serous membrane.

Peritoneum on duodenum.

Serous covering of the duodenum. The first part of the duodenum is surrounded by peritoneum, like the stomach. The second part is covered only in front. And the last part, which crosses the aorta, is but slightly in contact with the serous membrane: for it lies at first between the strata of the transverse meso-colon, and then beneath the superior mesenteric vessels.

Mesentery.

Fold of the jejunum and ileum. The *mesentery* supports the rest of the small intestine, and is stronger than any other piece

Form.

of the serous membrane. Its inner end is narrow, and is attached to the spine from the left side of the second lumbar vertebra to the junction of the right hip bone with the sacrum.

Attachments.

The other end of the fold is wide, and is connected with the intestine. Between its two layers are the superior mesenteric

Parts contained in it.

vessels and nerves, with lymphatic glands and lacteals.

Peritoneal folds of the liver.

Ligaments of the liver. The reflections of the peritoneum between the liver and the wall of the abdominal cavity are named ligaments. Along the upper part is a suspensory fold containing the obliterated umbilical vein; and there is a coronary ligament along the posterior border.

The *suspensory* or *falciform ligament* is placed between the upper convex surface of the liver and the parietes of the abdomen. It is falciform in shape; and in the recumbent position of the body, its base looks forwards, and apex backwards. The lower border is concave, and is attached to the liver; whilst the upper border is convex, and is connected to the abdominal wall on the right side of the linea alba, and to the under part of the diaphragm. In its base or free part is contained the remains of the umbilical vein, which is named the *round ligament*. Suspensory ligament. Shape. Attachments. Contains round ligament.

This fold allows the passage of the umbilical vein to the liver without piercing the peritoneum; and with a little care the dissector will be able to detach the serous membrane from the vein, and to trace it continuously upwards on each side into the suspensory ligament. How formed.

The *coronary ligament* is a short but wide process of the peritoneum, which connects the hinder part of the liver to the diaphragm. It reaches all across the liver, but at each side it is enlarged, and forms a triangularly-shaped piece; to these larger pieces of it the terms right and left lateral ligaments have been applied. Coronary ligament

The *left lateral ligament* is attached to the liver above the edge of the left lobe, and is formed by two pieces of peritoneum, which are in contact; it lies in front of the œsophagean opening in the diaphragm. gives rise to left and

The *right lateral ligament* lies deeply in the hypochondriac region, in front of the vena cava inferior. It consists of two pieces of peritoneum like the other. right lateral ligaments.

MESENTERIC VESSELS AND SYMPATHETIC NERVE.

Directions. The vessels and nerves (mesenteric) which are distributed to the greater part of the alimentary tube, may be first dissected. After these have been examined, and the connections of the aorta and vena cava have been learnt, most of the intestine can be taken out to give room for the display of the viscera in the upper part of the abdomen. Examine first vessels to intestine.

Mesenteric Vessels. The superior and inferior mesenteric arteries are two large visceral branches of the aorta, which supply the intestine, except a part of the duodenum and the lower extremity of the rectum. Each is accompanied by a vein, and by a plexus of nerves of the same name derived from the sympathetic. Vessels of intestine.

Dissection. For the dissection of the superior mesenteric vessels and nerves, the great omentum and the transverse colon are to be placed on the margin of the ribs (fig. 91), and one layer (anterior) of the mesentery is to be removed. Whilst tracing the branches of the artery to the small intestine the student will Dissection of superior mesenteric, veins, meet with corresponding veins, and with offsets of the sympathetic nerve on the arteries : these last are removed in cleaning the vessels. Mesenteric glands and a few lacteal vessels will come into view at the same time.

The branches from the right side of the vessel to the large intestine are to be next followed.

and nerves. After all the branches have been cleaned, the trunk of the artery should be traced back beneath the pancreas (^{7}); and the plexus of nerves surrounding it should be defined.

Superior mesenteric artery. The *superior mesenteric artery* (fig. 91, A) supplies branches wholly to the small intestine beyond the duodenal part, and to half the large intestine, viz. as far as the end of the transverse colon (^{5}).

Courses to intestine in the mesentery. Arising from the aorta near the diaphragm, the vessel is directed downwards between the layers of the mesentery, where it forms an arch with the convexity to the left side, and terminates in offsets to the cæcum and the end of the small intestine.

Connections At first the artery lies beneath the pancreas and the splenic vein ; and as it descends to the mesentery it is placed in front of the duodenum and the left renal vein. This vessel is surrounded by the mesenteric plexus of nerves, and is accompanied by the vein of the same name.

and branches. *Branches.* Whilst the vessel is covered by the pancreas it gives a small branch to that body and the duodenum. Its other branches are intestinal : those from the left or convex side of the vessel (rami intestinales) are furnished to the jejunum and ileum ; and those from the opposite side supply the colon, and are named colic arteries.

Pancreatico-duodenal. The *pancreatico-duodenal branch* (inferior) is of small size (fig. 91, *e*) ; and after giving twigs to the pancreas, extends from left to right along the concavity of the duodenum, and anastomoses with the other duodenal branches.

Branches to small intestine. The *intestinal branches* to the jejunum and ileum (*a*) are about twelve in number, and pass from the left side of the artery between the layers of the mesentery to their destination. About

Number and arrangement in arches. two inches from their origin or sooner the branches bifurcate, and the resulting pieces unite with similar offsets from the collateral arteries so as to form a series of arches. From the convexity of the arches other branches take origin, which divide and unite in the same way. This process is repeated four or five times between the origin and the distribution of the intestinal arteries, but at each branching the size of the vessels

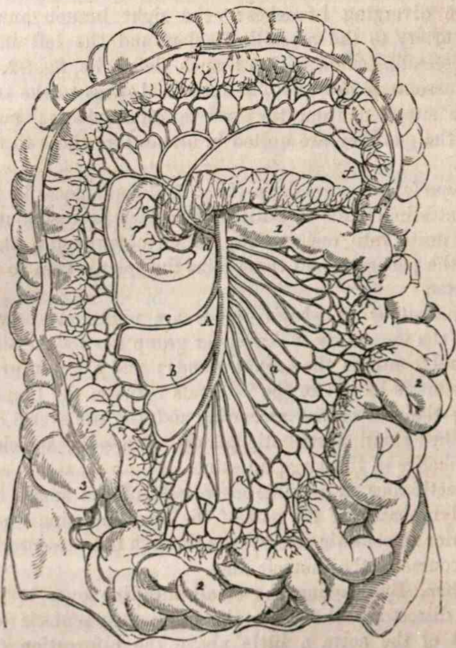
Distribution on the gut. diminishes. From the last set of arches twigs are sent to the intestine on both aspects of the tube, and anastomose round it supplying the structure.

Arteries of large gut. The *branches to the large intestine* are three in number, ileo-colic, right colic, and middle colic arteries.

Ileo-colic branch

The *ileo-colic* artery (*b*) arises from the right side of the mesenteric trunk. It descends to the cæcum, and divides into

Fig. 91.*



ends on cæcum.

branches that encircle the head of the colon. A descending offset is distributed to the lower part of the ileum, and to the cæcum and vermiform appendix; whilst an ascending offset supplies the beginning of the ascending colon, and anastomoses with the right colic artery.

Right colic branch supplies ascending colon.

The *right colic artery* (*c*) is commonly an offset of the preceding, instead of a separate branch from the trunk. Its course is to the right or ascending colon. Near the intestine it divides into an ascending and a descending piece, which anastomose with

* Superior mesenteric artery and its branches.—1 to 2. Jejunum and ileum. 3 to 6. Colon. 7. Pancreas. *A.* Trunk of the superior mesenteric artery. *a. a.* Intestinal branches from the left side. *b.* Ileo-colic branch. *c.* Right colic branch. *d.* Middle colic branch. *e.* Pancreatic branch.

the ileo-colic artery on the one side, and the middle colic on the other. This artery gives ramifications to the ascending colon.

Middle colic branch passes to transverse colon: The *middle colic branch* (*d*) springs from the upper part of the superior mesenteric artery, opposite the transverse meso-colon. Entering between the layers of that fold, the vessel divides into two large diverging branches:—the right branch anastomoses with the artery to the ascending colon, and the left inosculates on the descending colon with a branch (left colic, fig. 92, *e*) of the inferior mesenteric artery.

branches form arches. The intestinal twigs to the transverse colon are supplied from the two terminal pieces; but before entering the gut they are united in arches like those to the small intestine.

Superior mesenteric vein. The *superior mesenteric vein* (fig. 93, *e*) commences in that part of the intestinal tube to which the artery is distributed. Its radicles unite into one trunk, which accompanies the artery beneath the pancreas, and there joins the splenic vein to form the vena portæ.

Mesenteric glands. The *mesenteric lymphatic glands* are numerous between the layers of the mesentery. An upper group lies by the side of the artery, and contains the largest glands; and a lower group near the intestine is lodged in the intervals between the branches.

Meso-colic glands. Along the side of the ascending and the transverse colon are a few other small lymphatic glands, *meso-colic*, which receive the lymphatics of the large intestine.

Lymphatics entering them. The lactiferous or chyliferous vessels of the small intestine, and the lymphatics of the part of the large intestine supplied by the superior mesenteric artery, pass through the mesenteric glands in their course to the thoracic duct.

Dissection of inferior mesenteric. *Dissection.* By drawing the small intestine over to the right side, the dissector will observe the inferior mesenteric artery on the front of the aorta a little above the bifurcation (fig. 92). The peritoneum should be removed from it, and the branches should be traced outwards to the remaining half of the large intestine: a part of the artery enters the pelvis, but this will be dissected afterwards. On the artery and its branches is the inferior mesenteric plexus of nerves.

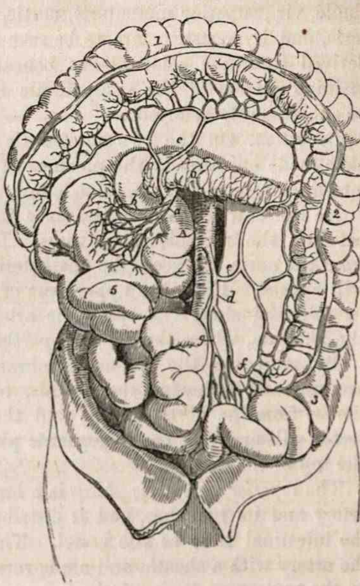
Mesenteric vein. The mesenteric vein is to be followed upwards away from the trunk of the artery to its junction with the splenic, or with the superior mesenteric vein.

Aortic plexus. On the aorta the dissector will meet with a plexus of nerves which is to be left uninjured.

Inferior mesenteric artery. The *inferior mesenteric artery* (fig. 92, *d*) supplies branches to the part of the large intestine beyond the transverse colon; and communicating with the superior mesenteric, assists to maintain the chain of anastomoses along the intestinal tube.

Origin, This vessel is of smaller size than the superior mesenteric, and arises from the aorta, from one to two inches above the bifurcation. At first the vessel descends on the aorta, and crosses the left common iliac artery as it courses to the pelvis, to end in branches for the rectum (superior hæmorrhoidal). The following *branches* are furnished by it to the descending colon and the sigmoid flexure. course, and branches.

Fig. 92.*



The *left colic artery* (*e*) ascends in front of the left kidney, and divides into an ascending and a descending branch for the supply of the descending colon. By the ascending offset it anastomoses with the middle colic branch of the superior mesenteric artery. Left colic branch to the descending colon.

The *sigmoid artery* (*f*) is distributed to the sigmoid flexure. Passing almost transversely outwards it divides into branches which anastomose above with the preceding colic branch, and below with the hæmorrhoidal. Here, as in the rest of the intestinal tube, arches are formed by the arteries before they reach the intestine. Sigmoid branch to sigmoid flexure.

The *superior hæmorrhoidal artery* (*g*) enters between the layers of the meso-rectum, and is distributed to the lower part of the great intestine: it will be described in the dissection of the pelvis. Branch to rectum.

The *inferior mesenteric vein* (fig. 93, *d*) begins in the part of the great intestine to which its companion artery is distributed, and ascends along the psoas muscle, away from the artery, to open into the splenic vein beneath the pancreas. Occasionally it joins the superior mesenteric vein. Inferior mesenteric vein.

Both mesenteric veins are without valves, and may be injected from the trunk to the branches like an artery. Veins of intestine no valves.

Lymphatic glands are ranged along the descending colon and Lymphatic glands.

* Inferior mesenteric artery and its branches.—1 to 4. Left half of the colon. 5. Small intestine. 6. Pancreas. *d*. Inferior mesenteric artery. *e*. Left colic branch. *f*. Sigmoid branch. *g*. Superior hæmorrhoidal branch. *a* to *c*. Superior mesenteric artery and its branches as in fig. 91.

the sigmoid flexure. The lymphatics from the intestine, after passing through those glands, enter the left lumbar lymphatic glands.

Some plexuses of the sympathetic to the viscera.

SYMPATHETIC NERVE. The following plexuses of the sympathetic, viz., superior mesenteric, aortic, spermatic, inferior mesenteric, and hypogastric, are to be seen with the vessels: they are derived from the solar plexus beneath the stomach. The remaining portion of the sympathetic nerve in the abdomen will be subsequently referred to.

Dissection.

Dissection. On the two mesenteric arteries the dissector will have made out already the plexuses of nerves distributed to the intestinal tube beyond the duodenum.

Aortic plexus.

He has now to trace on the aorta itself the connecting nerves between the mesenteric plexuses. By taking the peritoneum from the aorta between the mesenteric vessels, the aortic plexus will appear. From the upper part of this plexus an offset is to be followed along the spermatic artery; this may be done, on the left side, where the vessel is partly laid bare.

Hypogastric plexus.

By removing the serous membrane from the front of the sacrum, and following downwards, over the iliac arteries, the nerves from the aortic plexus and the lumbar ganglia, the dissector will arrive at the hypogastric plexus of the pelvis opposite the top of the sacrum.

Superior mesenteric plexus is on artery of same name.

The *superior mesenteric plexus* is a large offset on the mesenteric artery and its branches, and is distributed to the same extent of the intestinal tube as the vessel. The nerves surround closely the artery with a sheath, and are covered at first by the pancreas. In the mesentery some of the nerves leave the arteries near the intestine, and divide and communicate with others before entering the gut.

Its secondary plexuses.

Branches. The secondary plexuses are the same as the offsets of the artery, viz., intestinal nerves to the small intestine; and an ileo-colic, a right colic, and a middle colic plexus to the large intestine.

Aortic plexus is derived from solar plexus.

The *aortic plexus* is the network of nerves covering the aorta below the superior mesenteric artery. Superiorly it is continuous with the solar plexus; and inferiorly it ends on each side in branches, which cross the common iliac artery, and enter the hypogastric plexus of the pelvis. From it offsets are furnished to the two visceral branches of the aorta below the renal and superior mesenteric trunks, viz., to the spermatic and inferior mesenteric arteries.

Offsets.

This plexus is best marked on sides of aorta.

The aortic plexus is stronger on the sides than on the front of the aorta, in consequence of its receiving accessory branches from the lumbar ganglia, especially the left. At the upper part the plexus seems to be derived from an offset, on each side of the aorta, which is connected with the solar and renal plexuses.

The *spermatic plexus* is formed by roots from both the aortic and the renal plexus. The nerves from it run on the spermatic artery to the testicle; and in the cord they join other filaments on the vas deferens. **Spermatic plexus.**

In the female, the nerves on the ovarian (spermatic) artery are supplied to the ovary and the uterus. **In female.**

The *inferior mesenteric plexus* surrounds the trunk and branches of the artery of the same name, and supplies the part of the intestinal tube to which the artery is distributed. This plexus is furnished from the left part of the aortic plexus; and the nerves composing it are whiter and larger than in either of the preceding offsets of the sympathetic. Near the intestine (sigmoid flexure) the branching of the nerves, and the union of contiguous twigs, are well marked. **Inferior mesenteric plexus.** **Nerves join like the vessels.**

Branches. The following secondary plexuses are named from the arteries they accompany, viz., the left colic, the sigmoid, and the superior hæmorrhoidal plexus: they ramify on the vessels, and have a like distribution. **Secondary plexuses.**

On the intestinal tube the nerves of one plexus join those of another. Thus the superior mesenteric unites at the one end with the nerves to the duodenum, and at the other with the nerves to the large intestine from the inferior mesenteric plexus. And the inferior mesenteric nerves communicate below with branches to the rectum from the pelvic plexus. **Union of the nerves on the intestinal tube.**

The *hypogastric plexus*, or the large prevertebral centre for the supply of sympathetic nerves to the viscera of the pelvis, is situate in front of the upper part of the sacrum and beneath the peritoneum. It is developed more on each side than in the centre; and the nerves, which are large and flat, have a plexiform arrangement, but without any ganglionic masses on them. **Hypogastric plexus.** **Situation.**

By its upper part the plexus receives on each side the nerves on the aorta; and it is joined by some filaments from one or two of the upper sacral ganglia. Inferiorly the plexus ends in two parts, right and left, the last being the largest: each is continued forwards by the side of the internal iliac artery to the pelvic plexus of the same side and the viscera. **In it aortic plexus ends;** **and from it offsets are sent to pelvic viscera.**

CONNECTIONS OF AORTA AND VENA CAVA.

The connections of the *abdominal aorta* and the *vena cava* may be next learnt, before the viscera are removed from the body. **Parts around aorta and cava.**

Dissection. The part of the abdominal aorta below the origin of the superior mesenteric artery has been laid bare by the previous dissection. To see the vessel higher up, it will be necessary to detach the great omentum from the stomach, without injuring the gastro-epiploïc artery; and after raising the stomach and the spleen, to remove the peritoneum from the surface of the pancreas. **Dissection of aorta,** A short arterial trunk (cœliac axis) above the pancreas is not to be cleaned now, otherwise the nerves about it would be destroyed.

and vena cava.

The vena cava on the right side of the aorta may be followed as far as the posterior border of the liver, where it disappears. The connections of its upper part can be better observed after the dissection of the vessels of the liver.

Aorta lies in middle of spine.

The *aorta* enters the abdomen between the pillars of the diaphragm, and divides into iliac arteries opposite the left side of the fourth lumbar vertebra. At the beginning the vessel occupies the middle line of the spine, but it gradually inclines to the left as it descends.

Parts around.

In the abdomen the aorta lies behind all the viscera, but it is crossed more immediately by the pancreas and duodenum. Its connections are the following: at first it is covered by the solar plexus, and by the pancreas and the splenic vein; still lower (beyond the superior mesenteric artery) by the left renal vein and the duodenum; and thence to its termination by the peritoneum and the aortic plexus. The vessel lies on the lumbar vertebræ, with the pillars of the diaphragm embracing it at the beginning. To its right side is the vena cava.

Branches.

Its *branches* are furnished to the viscera and the wall of the abdomen, but these will be enumerated further on.

Vena cava; extent;

The *vena cava inferior* commences on the right side of the fifth lumbar vertebra by the union of the common iliac veins, and reaches from that spot to the heart.

connections; is by the side of the aorta, except above.

This venous trunk is placed on the right side of the vertebral column. It lies close to the aorta, and is concealed by the same viscera as high as the crus of the diaphragm; but above that spot it is inclined away from the artery, and ascending on the right of the crus of the diaphragm, is imbedded in the posterior part of the liver for an inch or more. Lastly, it leaves the abdomen by an aperture in the tendinous centre of the diaphragm, on the right of the aortic opening.

Arteries crossing it; vein and nerves.

Its connections with vessels are not the same as those of the aorta. Beneath it are the right lumbar, renal, capsular, and diaphragmatic arteries, and crossing over it below the kidney is the spermatic. Superficial to it beneath the pancreas is the beginning of the vena portæ. Offsets of the solar plexus of nerves descend on it, as on the aorta.

Branches.

The vena cava is joined by *branches* from some of the viscera, and by others corresponding with branches of the aorta supplied to the parietes of the abdomen.

CONNECTIONS OF THE DUODENUM AND PANCREAS.

Directions. The situation and the connections of the duodenum and pancreas should be looked to next.

Dissection. To see satisfactorily the duodenum and the pancreas the intestinal tube, beyond the duodenum, is to be removed in the following way:—a double ligature is to be placed on the upper part of the jejunum, another on the lower end of the sigmoid flexure of the colon, and the gut is to be cut through at the points at which it is tied. The detached piece of the intestinal tube is to be taken away by cutting through the vessels and the peritoneum connecting it to the wall of the abdomen; after it has been separated, it is to be set aside for future study whilst the body is turned. Remove intestine

To render the remaining viscera fit for examination, the student should moderately inflate the stomach and duodenum from the cut extremity of the latter, and remove the loose peritoneum and the fat; whilst cleaning them, he should be careful of the vessels and nerves. to see the duodenum,

On turning upwards the stomach the pancreas may be traced from the spleen on the one hand to the duodenum on the other; and on raising the duodenum, the common bile duct may be found posteriorly between the intestine and the head of the pancreas. and pancreas.

Duodenum (fig. 98, *d*). The first part of the small intestine, or the duodenum, begins at the pyloric end of the stomach, and crossing the spinal column, ends on the left side of the second lumbar vertebra. It makes a curve around the head of the pancreas, and occupies the right hypochondriac, right lumbar, and umbilical regions of the abdomen. Its peritoneal covering is incomplete and peculiar (p. 512). From its winding course around the pancreas it is divided into three parts—superior transverse, vertical, and inferior transverse. Extent of duodenum; course and situation. Division.

The *superior transverse part* is free and moveable, like the stomach; it measures about two inches in length, and is directed from the pylorus to the neck of the gall bladder, ascending slightly in its progress from the one point to the other. In front it is overlapped by the liver, as well as by the gall bladder when this is distended; and behind it are the bile duct and the vena portæ. First part is shortest, and is moveable.

The *vertical part* is fixed almost immoveably by the peritoneum and the pancreas. It is nearly three inches in length, and descends from the gall bladder as far as the third lumbar vertebra. Superficial to this part is the right bend of the colon; and beneath it are the kidney and its vessels. On its inner side is the head of the pancreas, with the common bile-duct. The ducts of the pancreas and liver pour their contents into this piece of the duodenum. Second part is fixed, and rests on the kidney.

The *inferior transverse part* is the longest of the three, and is continued across the spinal column to end in the jejunal portion of the small intestine. As it crosses the spine, it ascends The third part is the longest, and is moveable.

from the third to the level of the second lumbar vertebra, and lies between the layers of the transverse meso-colic fold of the peritoneum. It has the following connections with parts around :—

Parts around it.

In front of it are the superior mesenteric vessels with their plexus of nerves. Beneath it lie the aorta and the vena cava, with the pillars of the diaphragm ; and sometimes the left renal vein is between it and the aorta. Above it is the pancreas.

Form and situation of the pancreas.

PANCREAS (fig. 98, i). The pancreas is situate behind the stomach, and has numerous and complicated connections. Of an elongated form, it extends across the spine from the spleen to the duodenum, and occupies the left hypochondriac, the umbilical, and the right lumbar region of the abdomen.

Its connections by the surfaces,

The gland is covered anteriorly by the ascending layer of the transverse meso-colon. It is in contact posteriorly with the aorta, the vena cava, and the pillars of the diaphragm ; and it conceals likewise the splenic vein and the commencement of the vena portæ.

borders,

Projecting above the upper border, near the centre, is the arterial trunk of the cœliac axis ; to the left of that vessel, along the same border, is placed the splenic artery, whilst to the right of it lie the hepatic artery and the first part of the duodenum. At the lower border the superior mesenteric vessels emerge opposite the cœliac axis ; to the right of that spot lies the third part of the duodenum, and to the left of it is the inferior mesenteric ascending to join the splenic vein.

and extremities.

The left end or the tail of the pancreas (*t*) touches the spleen, and is placed over the left kidney. The right extremity or the head (*h*) is received into the concavity of the duodenum, the two being partly separated behind by the common bile duct, and in front by the pancreatico-duodenal artery. This part projects above and below the body of the gland, like the head of a hammer beyond the handle ; and the lower projecting piece is directed to the left along the duodenum as far as the superior mesenteric vessels, beneath which it passes.

CŒLIAC AXIS AND VENA PORTÆ.

Arteries of viscera.

A short branch from the aorta, viz., the cœliac axis, furnishes arteries to the stomach and duodenum, the liver, pancreas, and spleen ; it subdivides into three chief branches,—coronary, hepatic, and splenic, whose destination is expressed by their names.

Veins.

The veins corresponding with the arteries are collected into one trunk—the vena portæ.

Nerves.

The nerves are supplied from the vagus and sympathetic trunks.

How to dis-

Dissection. The vessels have been in part laid bare by the previous dissection, and the preparation of them will be completed by the removal of the loose tissue and the peritoneum from each. Before beginning this rather difficult task the student should take care that the liver is well raised; and whilst completing it he should spare the plexuses of nerves that surround the vessels. sect cœliac axis

Starting from the cœliac axis, he may first follow to the left side the small coronary artery, and show its branches to the œsophagus and the stomach. Next the hepatic artery, with the vena portæ and the bile duct, may be traced to the liver and the gall bladder; and a considerable branch of it should be pursued beneath the pylorus to the stomach, duodenum, and pancreas. Lastly, the splenic artery, which lies along the upper border of the pancreas, is to be cleaned; and its branches to the pancreas, stomach, and spleen should be defined: this is a difficult task without the aid of some one to hold aside the stomach and spleen. and its several branches.

The veins will be dissected for the most part with the arteries; and the origin of the vena portæ is to be made out beneath the pancreas, and in front of the vena cava. Veins.

The CŒLIAC AXIS is the first visceral branch of the abdominal aorta, and arises between the pillars of the diaphragm. It is a short thick trunk, about half an inch long, which projects above the upper border of the pancreas, and is surrounded by the solar plexus of the sympathetic. Its branches—coronary, hepatic, and splenic—radiate from the trunk (whence the name axis) to their distribution to the viscera in the upper part of the abdomen. This trunk supplies the three following branches:—

The *coronary artery* is the smallest of the three, and passes between the layers of the little omentum to the left end of the stomach. At that spot it furnishes some œsophageal branches, and turns from left to right, along the upper border of the stomach, to anastomose with a branch (pyloric) from the hepatic artery. Its offsets to the œsophagus and the stomach are thus distributed:— Coronary, which gives

The *œsophageal branches* ascend on the gullet through the opening in the diaphragm to supply that tube, and to anastomose on it with branches of the thoracic aorta. offsets to the œsophagus

The *gastric branches* are given to both sides of the stomach as the artery lies along it, and those on the left end communicate with twigs (vasa brevia) of the splenic artery. and to the stomach.

The *splenic artery* is the largest branch of the cœliac axis in the adult. It is a tortuous artery, and runs almost horizontally to the spleen, along the upper border of the pancreas. Near the spleen it divides into terminal branches, which are about seven in number (from four to ten), and enter that viscus by the concave surface towards the stomach. In its course the vessel is accompanied by the splenic vein, which is below it, and it distributes branches to the pancreas and the stomach. Splenic artery supplies the spleen, the pancreas by large and small twigs,

Pancreatic branches. Numerous small branches are supplied to the gland as the artery lies along it; and one of these, *art. pancreatica magna*, arises near the left end, and runs to the right with the duct in the substance of the viscus.

and the stomach

The *branches for the stomach* arise from the divisions of the artery near the spleen.

by vasa brevia;

Some of these, *vasa brevia*, turn upwards to the left end of the stomach, beneath or between the layers of the gastro-splenic omentum, and ramify in the coats of that organ.

and left gastro-epiploïc.

Another branch, *art. gastro-epiploïca sinistra*, which is larger than the others, turns to the right between the layers of the great omentum along the great curvature of the stomach, and inosculates with the right gastro-epiploïc branch of the hepatic artery. This artery distributes twigs to both surfaces of the stomach, and others between the pieces of peritoneum forming the great omentum.

Hepatic artery;

The *hepatic artery* is the largest in the fetus of the three branches into which the cœliac axis divides; but in the adult it is intermediate in size between the other two, and is encircled by the largest plexus of nerves. In its course to the liver the vessel is bent first to the right towards the small end of the stomach, where it supplies its principal branches (superior pyloric and gastro-epiploïc). It ascends then between the layers of the little omentum, on the left side of the bile duct and vena portæ, and divides near the transverse fissure of the liver into two large terminal arteries—the right and left hepatic.

courses to the liver,

in which it ends,

and supplies

Its *branches* are distributed not only to the liver, but freely to the stomach, the duodenum, and the pancreas, as below:

offsets to the stomach.

The *superior pyloric branch* descends to the upper border of the stomach, and running from right to left anastomoses with the coronary artery; it distributes small arterial twigs on both surfaces of the stomach.

Branches to the stomach, and duodenum, viz.—

The *right gastro-epiploïc branch** (art. gast. epiploïca dextra) is a trunk of considerable size, which descends beneath the duodenum near the pylorus, and turning from right to left along the great curvature of the stomach between the pieces of the omentum, inosculates with the left gastro-epiploïc of the splenic artery. To the surfaces of the stomach some offsets are given upwards; and others descend between the layers of the omentum. It furnishes the following named branches to the stomach, and the pancreas and duodenum:—

inferior pyloric,

Small *inferior pyloric* branches end in the small extremity of the stomach.

and pancreatico-duodenal.

The *pancreatico-duodenal branch* (superior) arises opposite the

* This artery is named commonly gastro-duodenal as far as to the spot where it gives off the branch to the duodenum and pancreas.

duodenum, and runs along the curve of the intestine, lying between it and the pancreas; it anastomoses below with the pancreatico-duodenal branch (inferior) of the superior mesenteric artery (fig. 91, *e*). Both the duodenum and the pancreas receive offsets from this vessel.

On the posterior aspect of the same viscera is another small offset of the pancreatico-duodenal with a similar position and distribution.

Branches to the liver, The *hepatic branches* (right and left) sink into the liver at the transverse fissure, and ramify in its substance :—

one for the right lobe and gall bladder, The *right branch* is divided when about to enter the transverse fissure, and supplies the following small artery to the gall bladder. The *cystic* artery, on reaching the neck of the gall bladder, bifurcates, and its two twigs ramify on the opposite surfaces.

and one for the left lobe. The *left branch* is smaller than the other, and enters the liver at the left end of the transverse fissure. A branch to the Spigelian lobe of the liver arises from this piece of the artery.

Three visceral veins, viz.— VEINS. The named visceral trunks of this part of the abdomen are three in number, viz., the superior coronary, the splenic, and the portal vein.

coronary from the stomach; The *superior coronary vein* (fig. 93) lies along the upper border of the stomach. It begins in the œsophagus and the left part of the stomach, and joins the vena portæ at the pylorus.

splenic from the spleen, The *splenic vein* (fig. 93, *b*) is large in size, and is formed by the union of branches from the spleen. It takes much the same course as, but lower than the artery, and runs beneath the pancreas to the front of the vena cava, where it joins the superior mesenteric vein to form the vena portæ.

stomach, pancreas, and intestine; Between its origin and termination it receives branches corresponding with the following arteries :—vasa brevia, gastro-epiploïc (*c*), and pancreatic. The inferior mesenteric vein, *d*, opens into it about its middle.

vena portæ, resembles an artery in its branching. The *vena portæ* (fig. 93, *a*) conveys to the liver the blood that has been circulated through the following viscera, viz., the alimentary canal, the pançreas, and the spleen. This vein commences by roots in the viscera above mentioned, like any other vein, but it is deficient in valves; and it ramifies through the structure of the liver in the same manner as an artery. Its radicles communicate with the systemic veins on some parts of the intestinal tube, but more particularly on the rectum.

Its origin, The vein is formed by the union of the splenic and superior mesenteric veins (p. 516); its origin is placed in front of the vena cava, but beneath the pancreas and two inches from the right end. **length,** This vessel is about four inches long, and is directed upwards in the small omentum, behind the bile duct and the hepatic artery, to the transverse fissure of the liver, where it divides into a right and a left branch. **and termination.**

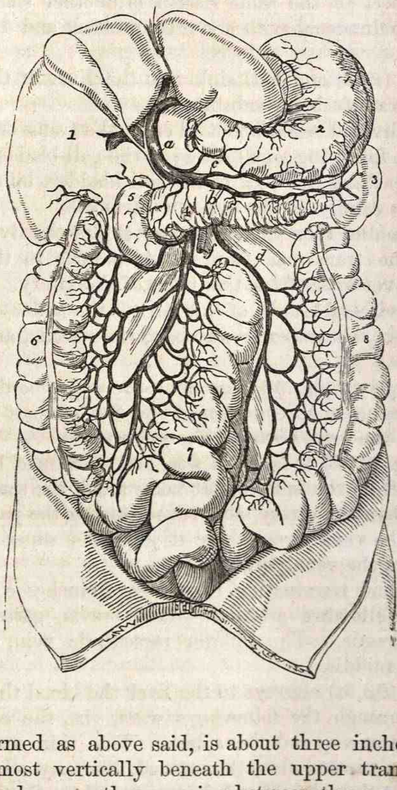
Accessory branches.

In its course it is joined by the coronary or gastric vein, and by the cystic vein near the liver.

Terminal branches.

The *right branch* is sometimes joined by the cystic vein, and enters the transverse fissure to ramify in the liver.

Fig. 93.*



The *left branch* is distributed to the left part of the liver, and gives a small branch to the Spigelian lobe.

Hepatic duct.

BILE DUCTS (fig. 93). Two *hepatic ducts* issue at the transverse fissure of the liver, one from each lobe, and unite to form the following;

Common hepatic duct;

how formed.

The *common hepatic duct* is an inch and a half long, and receives at its termination the duct of the gall bladder, the union of the two giving origin to the common bile duct.

Common bile duct;

length and course.

Termination.

The *common bile duct* (ductus communis choledochus), which is formed as above said, is about three inches long. It descends almost vertically beneath the upper transverse portion of the duodenum; then passing between the pancreas and the vertical piece of the duodenum, it opens into this part of the intestine at the inner side, and above the middle. Whilst in the small omentum the duct lies to the right of the hepatic artery, and somewhat before the portal vein.

* Vena portæ and its branches.—1. Liver. 2. Stomach. 3. Spleen. 4. The Pancreas drawn down so as to show the vein beneath it. 5. Duodenum. 6 to 8. Intestine.—*a*. Trunk of the vena portæ dividing into two at the liver. *b*. Splenic vein. *c*. Gastro-epiploïc vein. Between *c* and *a* is the coronary vein. *d*. Inferior mesenteric vein. *e*. Superior mesenteric vein by the side of the cut mesenteric artery, *f*.

Before piercing the coats of the intestine it is joined commonly by the pancreatic duct, but the two may enter the duodenum separately. Joined by pancreatic.

SYMPATHETIC AND VAGUS NERVES.

SYMPATHETIC NERVE. In the abdomen the sympathetic nerve consists, as in the thorax, of a gangliated cord on each side of the vertebral column; and of prevertebral centres or plexuses, which furnish branches to the viscera. General disposition of nerves.

Two prevertebral plexuses exist in the abdomen. One of these is the solar or epigastric plexus, which is placed behind the stomach, and supplies nerves to all the viscera above the cavity of the pelvis. The other, or the hypogastric plexus, is situate in the pelvis, and distributes nerves to the pelvic viscera. The offsets or the secondary plexuses of these centres accompany the bloodvessels to the viscera. Two large centres, solar and hypogastric.

The knotted or gangliated cord will be met with in a subsequent stage of the dissection; and only the great centre of the solar plexus with its offsets, is to be now prepared.

Dissection. To denude the great prevertebral centre (solar plexus), the following dissection is to be made :—After the air has been let out of the stomach and the duodenum, the portal vein, the common bile duct, and the gastro-epiploïc artery are to be cut through behind the pylorus; and the stomach, the duodenum, and the pancreas are to be drawn over to the left side. On raising the liver, and taking away some fatty tissue, the vena cava appears: the vein is to be cut across above the junction of the renal vein with it, and the lower end is to be drawn down with hooks. How to lay bare solar plexus,

Beneath the vein the dissector will find the large reddish semilunar ganglion of the right side. From its inner part he should trace the numerous nerves and ganglia of the solar plexus around the cœliac and superior mesenteric arteries; and should unravel the offsets around those arteries, with their secondary plexuses. From the outer part of the ganglion branches are to be traced to the kidney, the suprarenal body, and the diaphragmatic arteries. At its upper part it is joined by the large splanchnic nerve; and deeper than the last, one or two other smaller splanchnic nerves may be observed, which throw themselves into the cœliac and renal plexuses. and the semilunar ganglia.

Mixed up with the nerves of the solar plexus are numerous lymphatic glands and a dense tissue, which require to be removed with care. Glands.

The student should then trace the ending of the pneumogastric nerves on the stomach. The left nerve will be found in front near the upper border; and the right nerve will be seen at a corresponding point on the opposite aspect. Branches are Follow the ending of the vagus nerves.

to be traced from the right nerve to the plexus of the sympathetic by the side of the cœliac axis, and from the left to the hepatic plexus.

Solar plexus; appearance, extent; gives offsets on blood-vessels.

The EPIGASTRIC OR SOLAR PLEXUS is the largest of the prevertebral centres of the sympathetic, and furnishes nerves to all the viscera of the abdomen above the pelvis. It is a large network of nerves and ganglia, which lies in front of the aorta and the pillars of the diaphragm, and extends from the suprarenal capsule of one side to that of the other. It surrounds the cœliac axis and the superior mesenteric artery, and extends downwards to the pancreas. The plexus is connected on each side with the large and small splanchnic nerves; and it is joined also by a branch of the right pneumo-gastric nerve. Large offsets are furnished to the different viscera along the vessels.

Semilunar ganglia; situation; form. Nerves connected with each.

The *semilunar ganglia*, one on each side, are the largest in the body. Each is situate at the upper and outer part of the plexus, close to the suprarenal body, and on the side of the pillar of the diaphragm. The ganglion on the right side is beneath the vena cava. Irregular in shape, the mass is sometimes oval, and at other times divided into smaller ganglia. From the outer side nerves are directed to the kidney and the suprarenal capsule. At the upper end it is joined by the great splanchnic nerve.

Several offsets of the plexus.

Offsets of the plexus. The nerves supplied to the viscera are conveyed on branches of the aorta, forming plexuses around them; thus there are cœliac, mesenteric, renal, spermatic, and other plexuses. The diaphragmatic artery has also a separate plexus on it.

Plexus to the diaphragm

Diaphragmatic plexus. The nerves forming this plexus come from the upper and outer part of the semilunar ganglion. They are placed at first on the phrenic artery, but soon leave it to enter the substance of the diaphragm. A communication takes place between the phrenic nerve of the cervical plexus and the branches of the sympathetic.

has a ganglion on right side.

On the under surface of the diaphragm on the right side is a small ganglion where the plexus is joined by the spinal nerve, and from it filaments are supplied to the vena cava and the suprarenal body. The ganglion is absent on the left side. (Swan.)

Suprarenal nerves.

The *suprarenal nerves* are very large and numerous, in comparison with the size of the part supplied, and are directed almost horizontally outwards to the suprarenal body, which they enter at the upper part. One of the splanchnic nerves communicates with this plexus.

Renal plexus

The *renal plexus* is derived from the semilunar ganglion, and the outer part of the solar plexus; and it is further joined by the smallest splanchnic nerve. The nerves surround the renal artery, having small ganglia on them, and enter the kidney with the vessels. An offset is given from the renal nerves to the spermatic plexus (p. 519). **joins spermatic.**

The *cœliac plexus* is a direct continuation forwards of the solar plexus around the artery named cœliac axis. It is further joined by the small splanchnic nerve on each side, and by an offset from the right pneumo-gastric nerve. The plexus surrounds the artery, and divides like the vessel into three parts—coronary, splenic, and hepatic. **Cœliac plexus divides like the artery,**

The *coronary plexus* accompanies the artery of the same name to the upper border of the stomach, where it ends. It communicates with the left vagus nerve, and with the sympathetic on the pyloric artery. **into coronary,**

The *splenic plexus* surrounds its artery, and is conducted to the spleen. It furnishes offsets to the pancreas, and to the stomach along the left gastro-epiploïc artery. This plexus is joined by twigs from the left semilunar ganglion, and by an offset from the right pneumo-gastric nerve. **splenic,**

The *hepatic plexus* is continued on the vena portæ, the hepatic artery, and the bile duct to the transverse fissure of the liver, where it enters that viscus and ramifies on the vessels. Whilst ascending in the small omentum, the plexus is joined on the left side by offsets from the left vagus and phrenic nerves (Swan). The following secondary plexuses are furnished around the branches of the hepatic artery, and have the same name and distribution as the vessels :— **and hepatic. The last has secondary plexuses;**

A *pyloric* plexus is distributed to the upper border of the stomach. **pyloric,**

Two other plexuses—*gastro-epiploïc* (right) and *pancreatico-duodenal*, correspond in distribution with the branches of the artery : the former meets nerves from the splenic plexus, and the latter communicates with the superior mesenteric plexus on the end of the duodenum. **gastro-epiploïc, duodenal-pancreatic,**

A *cystic* plexus ramifies in the coats of the gall bladder with the artery. **and cystic.**

The remaining offsets of the solar plexus, viz. superior and inferior mesenteric, aortic, and spermatic, have been already referred to (p. 510); but the derivation of the superior mesenteric and aortic plexuses from the epigastric centre can be now seen.

Ending of the splanchnic nerves. The *large nerve* perforates the crus of the diaphragm, and generally ends altogether in the semilunar ganglion; but it may give filaments to the renal plexus and the suprarenal body. **Ending of large splanchnic nerve,**

The *small nerve* comes through the same opening in the diaphragm as the preceding, and ends in the cœliac plexus; but it enters the renal plexus if the smallest splanchnic nerve is absent. **small,** and smallest. The *smallest nerve*, after piercing the diaphragm, joins the renal plexus.

Ending of the vagus nerve. In the abdomen the pneumo-gastric nerves end mostly in the stomach.

Ending of left vagus The *left* nerve divides into branches, which extend along the small curvature and over the front of the stomach; these join the sympathetic, and send offsets to the hepatic plexus.

and right. The *right* nerve is distributed to the posterior surface of the stomach near the upper border; it communicates with its fellow, and with the cœliac and splenic plexuses.

Prepare for turning the body by *Dissection.* The viscera are now to be removed from the abdomen in order that the body may be turned for the dissection of the back, and the lower limbs.

removing the viscera. The stomach and the spleen with the duodenum and the pancreas are to be taken away together by cutting through the œsophagus near the diaphragm, and by dividing the vessels and nerves they receive. The liver is to be removed from the abdomen by cutting across its ligaments, and the vena cava between the posterior border and the diaphragm.

At the same time the left testicle, and the right kidney with the suprarenal body, should be removed for examination whilst the body is turned; the former can be taken out by cutting through the spermatic cord, and the latter by dividing their vessels about the middle.

Directions for the dissector. *Directions.* Supposing the body to be now turned for the dissection of the back, and to lie with the face downwards for the usual time, the dissector may look first to the fascia lumborum, which is described in the Dissection of the Back, p. 412.

The rest of the time he should occupy in learning the form and structure of the viscera in the following Section.

Section IV.

ANATOMY OF THE VISCERA OF THE ABDOMEN.

THE STOMACH.

Definition. The stomach is the dilated part of the alimentary tube between the œsophagus and the small intestine, into which the masticated food is received to be changed into chyme.

Separate and blow up the stomach. *Dissection.* To see the form, the stomach must be blown up moderately, and the surface should be cleaned; but previously let the student detach the spleen, and cut through the duodenum near the pylorus.

Form and Divisions. The stomach is somewhat conical in form (fig. 98, *s*), with the base or wider part to the left, and the apex to the right side; and it is directed obliquely across the abdomen. Its size varies much in different bodies, and is sometimes much diminished by a constriction in the centre. When it is moderately distended, it is about twelve inches long and four wide. The stomach presents for examination two ends, two orifices, two surfaces, and two borders or curves.

Form, direction, size, divisions.

Extremities. The left end or tuberosity (fundus ventriculi) is the largest part of the stomach, and projects about three inches to the left of the opening of the œsophagus. The right or pyloric end, much smaller than the other, is cylindrical, and forms the apex of the cone to which the stomach is likened.

Left end and right.

Openings. The left opening (cardiac), which communicates with the œsophagus, is at the highest part of the stomach, and is funnel-shaped towards the cavity of the organ. The right or inferior orifice (pylorus) opens into the duodenum, and is guarded internally by a muscular band: at the same spot the stomach is slightly constricted externally, where a firm circular ring may be felt.

Cardiac and pyloric openings; last has a valve.

Surfaces. The surfaces are somewhat flattened when the stomach is empty, but rounded when it is distended. The parts in contact with the sides have been referred to (p. 504).

Surfaces rounded or flat.

Borders. The upper border, or small curve of the stomach, is concave towards the left opening, but convex at the opposite end; and the lower border, or large curve, is convex, except near the right end, where it is concave—the concavity of the one border corresponding with the convexity of the other. An arterial arch and a fold of peritoneum (omentum) are found at each border.

Upper border: lower border, difference in outline.

STRUCTURE. In the wall of the stomach are four layers or coats, viz. serous, muscular, fibrous, and mucous; and belonging to these are vessels, nerves, and lymphatics.

Four strata in stomach.

Serous coat. The peritoneum gives a covering to the stomach, and is adherent to the surface except at each margin, where an interval exists corresponding with the attachment of the small and the large omentum: in those spaces are contained the vessels, nerves, and lymphatics of the stomach. During distension of the stomach the spaces above mentioned are much diminished.

The serous coat is thin and adherent.

The *muscular coat* will be laid bare by the removal of the serous covering. It consists of three sets of fibres, viz. longitudinal, circular, and oblique; these lie from without inwards in the order mentioned, and are involuntary or unstriated.

The muscular coat is made up of

The *longitudinal fibres* are derived from the œsophagus; they spread over the surfaces, without entirely covering them, and are continued onwards to the pylorus and the small intestine. The fibres are most marked along the borders, particularly the smaller

longitudinal,

one; and at the pylorus they are much stronger than in the centre of the stomach.

circular,

The *circular fibres* form the middle stratum of the muscular coat, and will be best seen by removing the longitudinal fibres near the pylorus. They reach from the left to the right end of the stomach; but at the pylorus they are most numerous and strongest, and form a ring or sphincter around the opening.

and oblique fibres.

The *oblique fibres* are continuous with the circular or deep layer of the œsophagus, and form only part of a layer in the gastric wall. On the left of the cardiac orifice they may be seen to arch over the great end of the stomach; and they spread out on the anterior and posterior surfaces, gradually disappearing on them.

The fibrous coat is thin, but firm.

Fibrous or submucous coat. By removing the muscular layer over a small space, the fibrous coat will appear as a white shining stratum. Formed of areolar tissue, this coat gives strength to the stomach, and serves as a bed in which the larger vessels and nerves ramify before their distribution to the mucous layer. If a small opening is made in this membrane, the mucous coat will project through it, supposing the stomach to be distended with air.

Mucous coat;

The *mucous coat* will come into view on cutting open the stomach, but the appearances about to be described can be recognised only in a recent stomach.

feel,

colour,

folds.

This coat is a thickish layer, smooth and soft to the touch, and is of a pale rose colour in the healthy condition soon after death; but in the empty state of the stomach the membrane is less vascular than during digestion. In infancy the natural redness is greater than in childhood or old age. When the stomach is contracted the membrane is thrown into numerous wavy ridges or *rugæ*, which become longitudinal along the great curve towards the pylorus.

Thickness;

disposition at pylorus.

The thickness of the mucous membrane is greatest near the pylorus; and at that spot it forms a fold, opposite the muscular ring, which assists in closing the opening. If this membrane and its submucous layer are removed from the pyloric part of the stomach, the ring of muscular fibres (sphincter of the pylorus) will be more perfectly seen.

On the surface are pits or alveoli;

their size,

shape,

and appearance near pylorus.

Microscopic structure of the mucous membrane. With the aid of a lens, the surface of the mucous membrane, when well washed, will be seen to be marked all over by shallow depressions or alveoli (fig. 94), which measure from $\frac{1}{200}$th to $\frac{1}{100}$th of an inch across. In the bottom of each depression are the apertures of minute tubes. Generally hexagonal or polygonal in outline, the hollows become larger and more elongated towards the small end of the stomach. Near the pylorus the margins of the alveoli project, and become irregular.

By means of a thin section under the microscope, the membrane may be seen to be formed almost altogether of minute vertical tubes which lie side by side, and project into the submucous tissue. Measuring from $\frac{1}{60}$th to $\frac{1}{30}$th of an inch in length, and $\frac{1}{500}$th to $\frac{1}{300}$th of an inch across, the tubes are closed at the deep end; but they open on the surface of the stomach both in the alveoli (fig. 94) and in the interalveolar spaces. Formed of a homogeneous membrane, they are for the most part straight, but towards the pylorus, where they increase in length, they are somewhat sacculated at the deep extremity, and some are divided into two, three, or more pieces.

The texture made up of tubes of small size ;

Fig. 94.*

closed at deep end.

At the pylorus the tubes are lined by columnar epithelium, and are supposed to secrete mucus. But in the tubes over the rest of the stomach only the upper part is lined by columnar epithelium, the lower end being filled with granular polygonal nucleated cells: in these, which are called peptic glands, the gastric fluid originates.

Lined by epithelium ; some secrete mucus, some gastric juice.

Scattered over the surface of the mucous membrane are small *lentiform follicles*, which have a depression over the centre, and correspond with the solitary follicles in the intestine. These are in greatest number near the pyloric end of the stomach, and are most marked in young children. They are frequently open (Thomson).

Follicles.

A columnar *epithelium*, with patches of the squamous kind, covers the surface of the mucous membrane, and enters the small tubes, as before mentioned.

Epithelial covering.

Bloodvessels. The *arteries* of the stomach, after supplying the muscular coat, ramify in the submucous tissue, and terminate in the mucous coat. From the anastomoses in the sub-mucous stratum, fine offsets are continued on the tubes to the inner surface of the mucous membrane, where they form a network. The *veins* begin in the mucous membrane, receive branches from the muscular coat, and deliver their blood into the portal system.

Arteries, veins,

Lymphatics. Two layers of lymphatics, superficial and deep, exist in the stomach: the latter begin in a plexus beneath the tubules, and communicating in the fibrous layer, leave the stomach like the others with the bloodvessels.

lymphatics,

Nerves. The nerves are derived from the pneumo-gastric and sympathetic, as before said, p. 530, and can be followed to the fibrous layer: small ganglia have been observed on them.

and nerves.

* Alveolar depressions of the mucous membrane of the stomach, magnified 32 diameters, with the minute tubes opening into them. (Sprott Boyd.)

SMALL INTESTINE.

Characters. The three parts into which the small intestine is divided, have the following characters :—

Length and fixedness. The *duodenum* measures as much as the breadth of twelve fingers, viz. about ten inches, and is more fixed than the rest of the intestinal tube. Width and thickness. It is wider than either the jejunum or the ileum, and its muscular coat is also thicker. Ducts entering it. Into it the common bile duct and the pancreatic duct pour their contents.

Length. The *jejunum* and the *ileum* together measure about twenty feet in length, and are connected with the mesentery. Division arbitrary. There is not any perceptible difference between the termination of the one and the commencement of the other, but two fifths of the length are assigned to the jejunum, and three fifths to the ileum. Differences at the ends. Between the ends, however, a marked difference may be observed; for the upper part of the jejunum is thicker and more vascular than the lower part of the ileum, and its width is also greater.

Wall has same strata as the stomach. STRUCTURE. In the small intestine the wall is formed by the same number of layers as in the stomach, viz. serous, muscular, fibrous, and mucous.

Dissection for them. *Dissection.* The different layers are to be examined on pieces taken from the duodenum, the upper part of the jejunum, the lower end of the ileum, and the middle of the small intestine. After the pieces of intestine have been cut off, they are to be distended with air, and the serous covering is to be removed for a short distance, to show the muscular fibres; in doing this, the external longitudinal fibres will be taken away without care.

Serous coat like that of the stomach, The *serous coat* is closely connected with the subjacent muscular layer. To the greater part of the small intestine (jejunum and ileum) it furnishes a covering, except at the attached part where the vessels enter: at this spot the peritoneum is reflected off to form the mesentery, and a space exists resembling that at the borders of the stomach. except in the duodenum. The peritoneum surrounds the duodenum only partly; this peculiarity has been described at p. 512.

Muscular coat is formed by a The *muscular coat* is constructed of two sets of fibres, a superficial or longitudinal, and a deep or circular. The fibres are pale in colour, and are not striated.

longitudinal The *longitudinal fibres* will be seen only after a careful removal of the peritoneum: they form a thin layer which is most marked at the free border of the gut.

and a circular layer. The *circular fibres* are much more distinct than the others, and give the chief strength to the muscular coat: they do not appear to form complete rings around the intestine.

Dissect fibrous coat. *Dissection.* On the removal of a part of the muscular stratum from the jejunum or the ileum, the submucous fibrous layer will come into view.

The *fibrous coat* has the same position and use as the corresponding layer in the stomach. Fibrous coat like that in stomach.

Dissection. In the upper part of the duodenum the student is to seek some small compound glands—those of Brunner, which are imbedded in the submucous tissue. They lie beneath the mucous membrane, and will be seen shining through the fibrous layer, when the muscular coat has been taken away. Glands of Brunner.

The pieces of intestine may be opened and washed to show the mucous coat, but the gut should be cut along the line of attachment of the mesentery, so as to avoid Peyer's glands on the opposite side. Show mucous coat.

Mucous coat. The lining membrane is thicker and more vascular at the beginning than at the ending of the small intestine. It is marked by numerous prominent folds (valvulæ conniventes). The surface of the membrane is soft, and is covered with small points (villi) like the pile of velvet. Occupying the substance of the mucous coat are numerous glands; and covering the whole is a columnar epithelium. Thickness, folds, villous surface, and epithelium.

The *valvulæ conniventes* (valves of Kerkring) are permanent folds of the mucous membrane, which are arranged circularly along the intestine, and project into the alimentary mass. Crescentic in form, they extend round the intestine for half or two thirds of its circle, and some end in bifurcated extremities. Larger and smaller folds are met with, sometimes alternating; and the larger are about two inches long, with one third of an inch in depth towards the centre. Each valve is formed of a doubling of the mucous membrane, which encloses vessels between the layers. Folds or valves: arrangement, length, size and depth; how formed.

The valves begin in the duodenum, about one or two inches beyond the pylorus, and are continued in regular succession to the middle of the jejunum; but beyond that point they become smaller and more distant from one another, and finally disappear about the middle of the ileum, having previously become irregular and rudimentary. The valvulæ are largest and most uniform beyond, and not far from the opening of the bile duct. Extent on the intestine.

The *aperture* of the *common bile* and *pancreatic ducts* is a narrow orifice, from three to four inches from the pylorus, and is situate in a small prominence on the mucous membrane at the inner and posterior part of the duodenum (p. 526). A probe passed into the bile duct will show the oblique or valvular course (half an inch) through the wall of the intestine. Sometimes the pancreatic duct opens by a distinct orifice. Opening of bile duct; where situate. Sometimes double.

Microscopic structure of the mucous membrane. With the use of the microscope, and with pieces of fresh intestine, the student Parts to be learnt in the intestine.

will be able to make out the nature of the villi, the glandular bodies, and the epithelium.

The villi cover the surface;

Villi. When a piece of the lower part of the duodenum, from which the mucus is washed away, is examined in water, the mucous membrane will be found studded over very thickly with small projections, like those on velvet. Existing along the whole of the small intestine, both on the valves and between them (fig. 96), these bodies are irregular in form, some being triangular, others conical or cylindrical with a large end. Their length is from $\frac{1}{40}$th to $\frac{1}{20}$th of an inch. They are best marked where the valvulæ conniventes are largest; and in the duodenum their number is estimated at 50 to 90 in a square line, but in the lower end of the ileum at only 40 to 70 over the same surface.—Krause.

their shape, and size, and number.

Composition of villus, artery and vein, lacteals, muscular layer.

Each villus is an extension of the mucous coat, and is covered by columnar epithelium. One or sometimes two arterial twigs form a capillary network on its surface beneath the mucous covering, and end generally in a single emerging vein. A single lacteal, or two forming a loop with cross branches, occupy the centre, and communicate with a plexus below the villus; and around the lacteals a thin layer of involuntary muscular fibre is arranged longitudinally (Brücke). Nerves have not been detected in the villus.

Several kinds of glands.

Glands. In the glandular apparatus of the small intestine are included the crypts of Lieberkühn, solitary glands, and Peyer's and Brunner's glands.

Simple tubes as in the stomach, but not so close; their size, and contents.

The *crypts of Lieberkühn* (fig. 95) are minute simple tubes, similar to those in the stomach, though not so closely aggregated, which exist throughout the small intestine. They open on the surface of the mucous membrane by small orifices between the villi, and around the larger glands; but at the opposite end they project into the submucous layer, are closed, and seldom branched. Their length is from $\frac{1}{70}$th to $\frac{1}{50}$th of an inch, and their diameter is $\frac{1}{500}$th of an inch. They are filled with a translucent fluid containing granules, and are lined by a columnar epithelium.

Fig. 95.*

Solitary simple glands; size and situation.

The *solitary glands* (fig. 95) are roundish white eminences, about the size of mustard seed if distended, which are scattered along the small intestine, but in greatest numbers in the ileum. Placed on all parts of the intestine, and even on or between the valvulæ conniventes, these bodies are covered by the villi of the

* A solitary gland of the small intestine enlarged. The villi and crypts of Lieberkühn are also represented (Boehm).

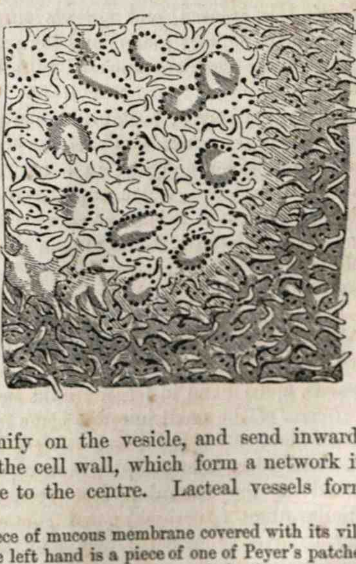
mucous membrane, and are surrounded at their circumference by apertures of the crypts of Lieberkühn. The glands are small fibrous sacs, which contain an opaque whitish fluid with cells and granules, but are not provided with any aperture into the intestine. Closed sacs.

The *glands of Peyer* (glandulæ agminatæ) are found chiefly in the ileum (fig. 96), in the form of oval patches, which measure from half an inch to two inches or more in length, and about half an inch in width. The groups of glands are situate on the part of the intestine opposite to the attachment of the mesentery, and their direction is longitudinal in the gut. Usually they are from twenty to thirty in number. In the lower part of the ileum the glands are largest and most numerous; but they decrease in number and size upwards from that spot, till at the lower part of the jejunum they become irregular in form, and may consist only of small roundish masses. Glands of Peyer; size; situation; number; peculiarities.

The mucous membrane over them is hollowed into pits, and is generally destitute of villi on the subjacent vesicles, but between the fossæ it has the same characters as in other parts.

A patch, when examined by the microscope, appears to be but a collection of the solitary glands, for it consists of a number of small flattened vesicles or sacs, which are round or oval in form, and are covered by the mucous membrane. Like the glands referred to, the vesicles contain a whitish consistent fluid with round nucleated cells, and nuclear bodies; they are commonly without any aperture, though openings into the intestine have been seen (Thomson). Around the vesicles is a ring of apertures of the crypts before described. Composition of a patch; a collection of solitary glands.

Fig. 96.*



Fine arterial twigs ramify on the vesicle, and send inwards capillary offsets through the cell wall, which form a network in the interior, and converge to the centre. Lacteal vessels form Arteries. Lacteals.

* A magnified view of a piece of mucous membrane covered with its villi and tubules (Boehm). On the left hand is a piece of one of Peyer's patches or glands, representing the vesicles of the glands, each having a ring of tubes at its circumference, and being destitute of villi.

plexuses around and beneath the vesicle, but do not penetrate the wall.

Compound glands, or Brunner's; composition. Apertures of their ducts.

The *Glands of Brunner* are small compound bodies, similar to the buccal and labial glands of the mouth, which exist in the duodenum. For a few inches near the pylorus they are most numerous, and there they are visible without a lens, being nearly as large as hemp seed. When examined more minutely the glands are found to consist of lobules, with appertaining little excretory tubes: and each ends on the surface of the mucous membrane by a duct, whose aperture is slightly larger than the mouths of the contiguous crypts of Lieberkühn. They secrete mucus, and in the small secretory cells of the gland the epithelium is laminar.

The epithelium is columnar.

Epithelium. The epithelial lining of the mucous membrane of the small intestine is of the columnar or cylindrical kind. For the villi it forms a very distinct covering of elongated or prismatic pieces. It sinks into the crypts of Lieberkühn, and ducts of the glands of Brunner, and gives them a lining, as before said.

How to see the areolar tissue.

Dissection. To demonstrate the areolar tissue between the coats of the intestine, a piece of the bowel turned inside out, is to be inflated forcibly; and to ensure the success of the attempt, a few cuts may be previously made through the peritoneal coat. The air enters the wall of the intestine where the peritoneal covering is injured, and spreads through the whole gut; but opposite the solitary glands and the patches of Peyer the mucous coat is more closely connected with the contiguous structures, and the subjacent portion will not be distended with the air. The intestine may be examined when it it is dry.

Arteries of the intestine; veins;

Vessels of the intestine. The branches of *arteries* ramify in the submucous layer, and end in a network of small twigs in the mucous membrane, which supplies the folds, the villi, and the glands. Opposite Peyer's patches the intestine is most vascular; and the vessels form circles around the vesicles, before supplying offsets to them. The *veins* have their usual resemblance to the companion arteries.

absorbents.

The *absorbents* consist of a superficial longitudinal set (lymphatics); and of a deep plexiform set (lacteals) in both the mucous and submucous layers; the two join by perforating vessels, and all end in larger trunks in the mesentery.

Nerves form plexuses with ganglia.

Nerves of the small intestine come from the upper mesenteric plexus, and entering the coats by the sides of the arteries form plexuses with interspersed ganglia. One such plexus is contained in the muscular coat between the longitudinal and circular fibres (Auerbach); and another is placed in the submucous layer (Meissner): they join freely by branches through the intestinal coats, and reach from the pylorus to the extremity of the alimentary tube.

Structure of the common bile duct. The bile duct consists of a strong fibrous coat, and of an internal or mucous coat which is lined by columnar epithelium. On the surface of the mucous membrane are the openings of numerous branched mucous glands, which are imbedded in the fibrous coat; some of them are aggregated together, and are visible with a lens. **Two coats in the bile duct; epithelium and glands.**

LARGE INTESTINE.

The large intestine is the part of the alimentary canal between the termination of the ileum and the anus. Its division into parts, and its attachment by peritoneum to the abdominal wall, have been described (p. 511). **Extent of the gut;**

In length this part of the alimentary canal measures about five or six feet,—one fifth of the whole extent of the intestinal tube. The diameter of the colon is largest at the commencement in the cæcum, and gradually decreases from that part as far as the rectum, where there is a dilatation near the end. **length size.**

When compared with the small intestine, the colon is found to be distinguished by the following characters:—it is of greater capacity, being in some parts as large again, and is more fixed in its position. It is also free from convolution, except in the left iliac fossa, where it forms the sigmoid flexure. Instead of being a smooth cylindrical tube, the colon is sacculated; and it is marked by three longitudinal muscular bands, which alternate with as many rows of dilatations. Attached to the surface at intervals, especially along the transverse colon, are processes of peritoneum containing fat,—the appendices epiploïcæ. **Compared with small gut, larger; more fixed; not coiled; sacculated with bands. Appendages.**

In the rectum, or the lower part of the large intestine, the surface is smooth, and the longitudinal bands have disappeared. **In the rectum.**

Dissection. For the purpose of examining the large intestine the student should cut off and blow up the cæcum, with part of the ileum entering it; he should prepare in a similar way a piece of the transverse colon, and a piece of the sigmoid flexure (about four inches of each). The areolar tissue and the fat are to be removed with care from each, after it has been inflated. **Take pieces of the large intestine.**

The CÆCUM, or the head of the colon (caput cæcum coli) is the rounded part of the large intestine which projects, in the form of a pouch, below the junction of the ileum with it. It measures about two inches and a half in length, and though gradually narrowing inferiorly, the cæcum is the widest part of the colon,—hence the name caput coli. At its inner side it is joined by the small intestine; and still lower there is a small worm-like projection—the vermiform appendix. **Definition of cæcum; length and width; receives ileum and appendix.**

Appendix vermiformis. This little convoluted projection is attached to the lower and hinder part of the cæcum, of which it was a prolongation at one period in the growth of the embryo. **Vermiform appendix: attachment;**

dimensions. From three to six inches in length, the appendix is rather larger than a goose-quill, and is connected to the inner part of the cæcum by a fold of peritoneum. It is hollow. It is hollow, and has an aperture of communication with the intestine. In structure it resembles the rest of the colon.

Dry the cæcum, open it to see the valves. *Dissection.* To study the interior of the cæcum, and the valve between it and the small intestine, the specimen now under examination should be dried. After the cæcum has been dried the following cuts should be made into it:—One oval piece is to be taken from the ileum near its termination; another from the side of the cæcum, opposite the entrance of the small intestine; and lastly the end of the colon included in the ligature is to be cut off.

Situation of the valve; two pieces in it. *Ileo-cæcal valve.* On looking into the intestine, the ileo-cæcal valve will be seen at the entrance of the ileum into the cæcum. It is composed of two pieces, each with a different inclination, which project into the interior of the cæcum, and bound a narrow, nearly transverse aperture of communication between the two differently-sized portions of the alimentary canal.

One ileo-colic; the other ileo-cæcal. The upper piece of the valve, *ileo-colic*, projects horizontally into the large intestine, opposite the junction of the ileum with the colon. And the lower piece, *ileo-cæcal*, which is the larger of the two, has a vertical direction between the ileum and the cæcum. These are joined at the ends, and form fræna. At each extremity of the opening the pieces of the valve are blended together, and the resulting folds extend transversely for some distance on the intestine, forming the *fræna* or *retinacula* of the valve.

Opening in the valve. The size of the opening between the pieces of the valve depends upon the distension of the intestine; for when the extremities or retinacula of the valve are stretched the margins of the opening are approximated, and may be made to touch.

The valve a prolongation of the wall of the gut. Each piece of the valve is formed by the circular muscular fibres of the intestinal tube, covered by mucous membrane; as if the ileum was thrust obliquely through the wall of the cæcum, after being deprived of its peritoneal coat and its layer of longitudinal fibres. This construction is easily seen on a fresh specimen by dividing the peritoneum and the longitudinal fibres, and gently drawing out the ileum from the cæcum.

Appendix opens into cæcum. The *opening of the appendix* into the cæcum is placed below that of the ileum. A small fold of mucous membrane partly closes the aperture, and acts as a valve.

Ridges in the cæcum; how formed. *Folds* or *ridges* are directed transversely in the interior of the gut, and correspond with depressions on the outer surface: these folds result from the doubling of the wall of the intestine, and the largest enclose vessels.

Four strata. STRUCTURE OF THE COLON. The coats of the large are similar to those of the small intestine, viz. serous, muscular, fibrous, and mucous. **in the wall of the gut.**

Serous coat differs along the intestine. *Serous coat.* The peritoneum does not invest the large intestine throughout in the same degree. It covers the front of the cæcum, and the front and sides of the ascending and descending colon; but in neither does it reach commonly the posterior aspect (p. 511). The transverse colon is incased like the stomach, and has an interval along each of the borders where the transverse meso-colon and the great omentum are attached.

Two layers of fibres; The *muscular coat* is formed by longitudinal and circular fibres, as in the small intestine.

longitudinal in three bands: which are spread out on appendix and rectum; The *longitudinal* set of fibres may be traced as a thin layer over all the surface, but they are collected for the most part into three longitudinal bands, each being about the third of an inch in width. On the vermiform appendix the fibres form a uniform layer; but they are continued thence in the form of bands along the cæcum and colon: on the rectum they are diffused over the surface. When the bands are divided the intestine elongates,—the sacculi, and the ridges in the interior of the gut, disappearing at the same time.

and circular. The *circular fibres* are spread over the whole surface, but are most marked in the folds that project into the intestine. In the rectum (to be afterwards seen) they form the band of the internal sphincter muscle.

Fibrous coat as in small gut. The *fibrous coat* resembles that of the small intestine. It will be exposed by removing the peritoneal and muscular coverings.

Mucous coat is without folds and villi. The *mucous coat*, which will be seen on opening the intestine, is smooth, and of a pale yellow colour. It is not thrown into special folds, except in the rectum. The surface is free from villi; and by this circumstance the mucous membrane of the large can be distinguished from that of the small intestine. This difference in the two portions of the alimentary tube is well seen on the ileo-cæcal valve; for the surface which looks to the small intestine is studded with villi, whilst the lower surface, covered by the lining membrane of the cæcum, is free from those small eminences.

Structure like that of small gut. *Microscopic appearances.* In a piece of fresh intestine the microscope will show the mucous membrane to possess small tubes or crypts, some larger solitary follicles, and an epithelial covering.

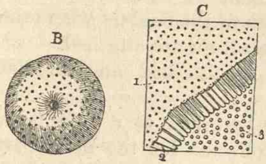
Tubes or crypts more numerous and longer than The *tubules* or crypts (fig. 97, C) occupy the whole length of the large gut, and resemble those of the small intestine, but are more numerous, and closer together. Their orifices on the surface are circular ([1]), and are more uniformly diffused than the apertures of the tubules in the small gut. A vertical section of the membrane ([2]) will show the tubes to extend vertically from the surface into the submucous coat, and to be of those of small intestine. greater length than the crypts of Lieberkühn in the jejunum and ileum; they measure from $\frac{1}{50}$th to $\frac{1}{40}$th of an inch in length, and $\frac{1}{200}$th to $\frac{1}{120}$th of an inch across.

Solitary glands most in the cæcum; The *solitary follicles* (fig. 97, B) are scattered here and there all through the large intestine; but they are in greatest number in the cæcum and vermiform appendix.

size They are whitish rounded bodies from $\frac{1}{20}$th to $\frac{1}{10}$th of an inch in diameter, and are situate in the submucous layer amongst the

and form. tubules. These follicular glands are simple sacs without opening, as in the small intestine, but over each is a depression in the mucous membrane simulating an aperture into it.

Fig. 97.*



Epithelium. The *epithelium* is of the columnar kind, as in the small intestine, and enters the tubules.

Vessels, *Vessels.* The distribution of the vessels in the wall of the large intestine is the same as in the smaller bowel.

nerves, and *Nerves.* In the coats of the large intestine the nerves have the same plexiform arrangement as in the small gut, as before said.

absorbents. The deep *absorbent vessels* form a plexus in the mucous and submucous layers beneath the tubules; after leaving the intestine, they join the lymphatic glands along the side of the colon.

THE PANCREAS.

Form and length; The pancreas (fig. 98) is a narrow flattened gland from six to eight inches in length, which is said to have some resemblance to a dog's tongue. It is larger at the right than the left end;

divisions. and it is divided into a head, tail, and body.

Situation. The head and tail; The *head*, or the right extremity (h), occupies the concavity of the duodenum; and the left extremity, or the *tail* (t), is rounded, and touches the spleen.

and the body. The *body* of the gland (i) is narrowest a little to the right of the vertebral column, and is thickest at the upper border; it measures about one inch and a half in breadth, and from half an inch to an inch in thickness. The connections of the pancreas with surrounding parts are described at p. 522.

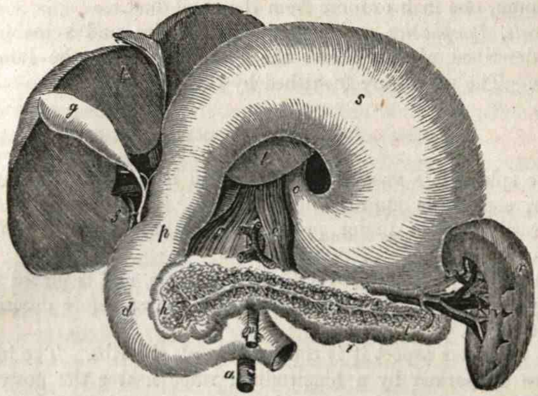
Trace out the duct. *Dissection.* Let the pancreas be placed on the anterior surface, and let the excretory duct be traced posteriorly from right to

* Enlarged view of a solitary gland and the tubules of the mucous coat (Boehm). B. A section of a follicle. C. Tubules of the mucous membrane. 1. Surface opening. 2. Side view of the tubes. 3. Pits for the closed ends of the tubes in the submucous tissue.

left by scraping away the substance of the gland. The duct will be recognised by its whiteness.

STRUCTURE. The pancreas is a compound gland, and is provided with a special duct. It is destitute of a distinct capsule; **It is a compound gland, without a distinct capsule.**

Fig. 98.*



but it is surrounded by areolar tissue, which projects into the interior, and connects together the lobules. The fluid secreted by it assists in the digestion of the aliment.

The glandular structure is soft and loose, and is of a reddish, or grayish white colour. It consists of lobules, which are united into larger masses by areolar tissue, vessels, and ducts. **Texture and colour;**

In analysing a lobule it will be found to consist ultimately, as in the parotid, of the branchings of the excretory duct, which end in closed vesicular extremities, and are surrounded by a plexus of vessels. In the vesicles the epithelium is flattened. **constitution like the salivary glands.**

The *duct* of the pancreas (canal of Wirsung) extends the entire length of the gland, and is somewhat nearer the lower than the upper border. It begins in the tail of the pancreas, where it presents a bifurcated extremity. As it continues onwards to the head of the gland, it receives many branches; and it finally ends by opening into the duodenum, either in union with, or separate from the common bile duct (p. 526). Of the tributary branches the largest is derived from the head of the pancreas. **The duct of the gland; extent; branches.**

* This cut shows the liver and gall bladder, the stomach raised, and the duodenum, pancreas, and spleen (Tiedemann). *l.* Liver. *g.* Gall bladder, and *f.* Common bile duct. *s.* Stomach. *o.* Œsophagus joining it, and *p.* Pylorus, and *d.* Duodenum. *i.* Pancreas. *h.* The head, and *t.* The tail of the same, with *e.* The pancreatic duct. *r.* The Spleen. *a.* Aorta. *n.* Superior mesenteric artery.

Size and structure. The duct measures from $\frac{1}{15}$th to $\frac{1}{10}$th of an inch in diameter near the duodenum. It is formed of a *fibrous* and a *mucous* coat: the latter is lined by a cylindrical *epithelium*, and is provided with small glands in the duct and its largest branches.

Epithelium and glands.

Peculiarities. Occasionally there are two pancreatic ducts. Or the branch from the head of the pancreas may open separately into the duodenum, one inch or more from the chief duct.

Vessels and nerves. *Vessels, lymphatics, and nerves.* The arteries and veins have been described already; and the lymphatics join the lumbar glands. The nerves are furnished by the solar plexus.

THE SPLEEN.

Consistence and colour of the spleen. The spleen is a vascular spongy organ of a bluish or purple colour, sometimes approaching to gray. Its texture is friable and easily broken under pressure. The use of the spleen is unknown.

Use.

Form and position. The viscus is somewhat elliptical in shape, and is placed vertically against the great end of the stomach, as before described (p. 507).

Surfaces. At the outer aspect it is convex towards the ribs. The inner surface is marked by a longitudinal ridge nearer the posterior than the anterior border, into which the vessels plunge to ramify in the interior. Before and behind the ridge, the surface is flattened or somewhat hollowed. The spot where the vessels enter is named the hilum of the spleen.

Borders. The anterior border is thinner than the posterior, and is often notched. Of the two extremities, the lower is more pointed than the upper.

Extremities.

Size and weight. The size of the spleen varies much. In the adult it measures commonly about five inches in length, three or four inches in breadth, and one inch or one inch and a half in thickness. Its weight lies between four and ten ounces, and is rather less in the female than the male.

Sometimes accessory spleens. Small masses or *accessory spleens* (splenculi) are found occasionally near the fissure of the spleen in the gastro-splenic omentum, or in the great omentum. Varying in size from a bean to a moderate sized plum, these bodies are commonly one or two in number; but they may be many more. In one instance they exceeded a score.

Two coats and special material in the spleen. STRUCTURE. Enveloping the spleen are two coverings, a serous and a fibrous. The mass of the spleen is formed by a network of fibrous or trabecular tissue, which contains in its meshes the proper splenic substance, with the Malpighian corpuscles. Throughout the mass the bloodvessels and the nerves ramify. No duct exists in connection with this organ.

Serous coat. The *serous or peritoneal coat* incases the spleen, and covers the surface except at the hilum and the posterior border. It is closely connected to the subjacent fibrous coat. **nearly complete.**

Fibrous coat sends inwards processes. The *fibrous coat* (tunica albuginea) gives strength to the spleen, and forms a complete case for it. At the fissure on the inner surface this investment passes into the interior with the vessels, to which it furnishes sheaths; and if an attempt is made to detach this coat, numerous fibrous processes will be seen to be connected with its inner surface. **Fibres that form it.** Its colour is whitish; and its structure is made up of areolar and elastic tissues.

Interior of spleen, *Dissection.* The spongy or trabecular structure will best appear, by washing and squeezing a piece of fresh bullock's spleen under water, so as to remove the grumous looking material.

and disposition of fibrous tissue in it. The *trabecular tissue* forms a network through the whole interior of the spleen, similar to that of a sponge, which is joined on the one hand to the external casing, and on the other to sheaths around the vessels. **To form an areolar structure.** Its processes or threads are white, flattened or cylindrical, and average from $\frac{1}{100}$th to $\frac{1}{30}$th of an inch: they consist of fibrous and elastic tissues. The interstices between the fibres communicate freely together, and contain the proper substance of the spleen, and the vessels.

Microscopic appearances. The characters of the substance of the spleen and of the Malpighian bodies cannot be ascertained without the aid of the miscroscope.

Splenic substance; colour, and composition. The *splenic pulp* is a soft semi-fluid, red-brown mass, which is lodged in the intervals of the venous plexus, and fills the areolæ of the trabecular structure. Under the microscope this material is composed of granular red bodies about as large as blood cells, with intermixed caudate and nucleated cells, and nuclear-looking bodies. In it are scattered large corpuscles containing blood-cells undergoing change.

Malpighian bodies; The *Malpighian corpuscles* are best seen in the human body after sudden death, or in children. **size;** They are small vesicular bodies, about $\frac{1}{60}$th of an inch in diameter, and are appended to **attachment;** the sheaths of the smallest branches of the arteries by arterial twigs which pierce their coat; they project into the pulp of the spleen, and are surrounded by it. Each is a closed sac, having a membranous case with contents.

constituents. The coat of the corpuscle is transparent, and is said to consist of the same tissue as the sheath of the small arteries. In the interior is a slightly tenacious whitish mass, with different sized pale cells, granular as well as nucleated, which resemble chyle corpuscles.

Splenic artery supplies corpuscles of spleen. *Bloodvessels.* The *branches* of the *splenic artery* are surrounded by sheaths of fibrous tissue, even to the terminal twigs. The chief branches do not join together; and they accompany the veins till they have a diameter of $\frac{1}{100}$th to $\frac{1}{20}$th of an inch. They then leave the veins, and, still surrounded by sheaths, end

Ends in capillaries.

in tufts of capillary vessels amongst the soft spleen substance; these last are incased in sheaths, and end directly in the plexus of veins, as well as, according to the view of some observers, in spaces in which the veins begin.

Vein begins by capillaries.

The *splenic vein* begins in the intertrabecular spaces by a fine plexus in the splenic pulp. From this plexus issue small branches, which unite into trunks larger than the arteries which they

Branches

accompany to the fissure of the spleen; and in their course they receive accessory branches, some joining at a right angle.

Lymphatics.

Nerves and lymphatics. The *lymphatics* are superficial and deep, and enter the glands in the gastro-splenic omentum; their

Nerves.

beginning in the spleen is unknown. The *nerves* come from the solar plexus, and surround the artery and its branches.

THE LIVER.

Office of the liver.

The liver secretes the bile, and is the largest gland in the body. Its duct opens into the duodenum with that of the pancreas.

Clean the vessels on the under surface;

Dissection. Preparatory to examining the liver, the vessels at the under surface should be dissected out. This proceeding will be facilitated by distending the vena cava and vena portæ with tow or cotton wool, and the gall-bladder with air through its duct. The several vessels and ducts are then to be defined, and the gall-bladder to be cleaned.

follow left piece of vena portæ.

On following outwards the left branch of the vena portæ to the longitudinal or antero-posterior fissure, it will be found connected anteriorly with the remains of the umbilical vein, and posteriorly with the remains of the ductus venosus.

Colour and consistence

The *liver* is of a red-brown colour and firm consistence; and weighs commonly in the adult from three to four pounds (fifty

weight;

to sixty ounces). Transversely the gland measures from ten to

measurements.

twelve inches; from front to back between six and seven inches; and in thickness, at the right end, about three inches; but this last measurement varies with the spot examined.

Form and divisions.

In shape the liver is somewhat square. It offers for examination two surfaces, two borders, and two extremities; and the under surface is further marked by lobes and fossæ, and by fissures which contain vessels.

The connections and the ligaments of the liver are described at pp. 507 and 512.

Upper surface smooth;

Surfaces. On the upper aspect the liver is convex: extending from front to back is the suspensory ligament, which divides the

under surface irregular.

upper surface into two unequal parts, of which the right is the larger. The under surface is irregular, and presents, as before said, lobes, fissures, and fossæ. In contact with this surface is the gall-bladder; and a longitudinal fissure divides it into a right and left lobe.

Borders. The anterior border is thin, and is marked by two notches: one is opposite the longitudinal fissure on the under surface before alluded to, and the other is over the large end of the gall-bladder. The posterior border is much thicker at the right than at the left end, and at the thickened part it touches the right kidney and the diaphragm. Opposite the vertebral column is a hollow in this border; and the vena cava is partly imbedded in it on the right of the spine.

Anterior border is thin and notched, posterior is thicker, and also notched.

Extremities. The right extremity is thick and rounded; and the left is thin and flattened.

Extremities.

Lobes. On the under surface the liver is divided primarily into two lobes, a right and a left, by the anterio-posterior or longitudinal fissure; and occupying the same surface of the right lobe are three others, viz. the square, the Spigelian, and the caudate lobe:—

Lobes are on under surface, and are five, viz.

The left lobe is smaller and thinner than the right, and has a slight depression inferiorly where it touches the stomach.

left,

The right lobe forms the greater part of the liver, and is separated from the left by the longitudinal fissure on the one aspect, and by the suspensory ligament on the other. To it the gall-bladder is attached below; and the following lobes are projections on its under surface:—

right; last subdivided into

The square lobe (lobulus quadratus) is situate between the gall-bladder and the longitudinal fissure. It reaches anteriorly to the margin of the liver, and posteriorly to the fissure (transverse) by which the vessels enter the interior of the viscus.

square,

The Spigelian lobe lies behind the transverse fissure, and forms a roundish projection on the surface. On its left side is the longitudinal fissure; and on its right, the vena cava inferior.

Spigelian,

The caudate lobe is a slight, elongated eminence, which is directed from the Spigelian lobe behind the transverse fissure, so as to form the posterior boundary of that sulcus. Where the fissure terminates this projection subsides in the right lobe.

and caudate lobe.

Fissures. Extending horizontally half across the right part of the liver between the Spigelian and caudate lobes on the one hand, and the square lobe on the other, is the transverse or portal fissure. It is situate nearer the posterior than the anterior border, and contains the vessels, nerves, ducts, and lymphatics of the liver. At the left end it is united at a right angle with the longitudinal fissure.

Three fissures, viz. portal or transverse,

The longitudinal fissure extends from the front to the back of the liver between the right and left lobes. In the part anterior to the transverse fissure (fissure for the umbilical vein) lies the remnant of the umbilical vein, which is called round ligament, and is often times arched over by a piece of the hepatic sub-

longitudinal;

stance (pons hepatis). In the part behind that fissure (fissure for the ductus venosus) is contained a small obliterated cord, the remains of the vessel named ductus venosus in the fetus.

one for the vena cava.

The fissure or groove for the vena cava is placed on the right side of the Spigelian lobe, and is frequently bridged over by the liver. If the cava be opened two large and some smaller hepatic veins will be seen entering it.

Fossæ beneath.

Fossæ. On the under surface of the right lobe are three depressions :—one for the gall-bladder to the right of the square lobe; another for the colon, near the anterior edge; and a third for the kidney near the posterior border.

Vessels in the transverse fissure.

Vessels of the transverse fissure. The vessels in the transverse fissure, viz. vena portæ, hepatic artery, and duct, have the following position :—the duct is anterior, the portal vein posterior, and the artery between the other two.

Hepatic duct.

The hepatic duct (fig. 93) is formed by two branches from the liver, one from each lobe, which soon blend in a common tube. After a distance of one inch and a half it is joined by the duct of the gall-bladder; and the union of the two gives rise to the common bile duct (*f*).

Hepatic artery.

The *hepatic artery* is divided into two, one for each lobe, and its branches are surrounded by nerves and lymphatics.

Vena portæ.

The *vena portæ* branches, like the artery, into two trunks for the right and left lobes, and gives an offset to the Spigelian lobe; its left branch is the longest.

Umbilical vein in the longitudinal fissure in the fetus;

Fetal condition of the umbilical vein. In the longitudinal fissure are the remains of the umbilical vein. Before birth the vein passes along that fissure to open posteriorly into the vena cava; and the part behind the transverse fissure receives the name *ductus venosus.* Branches are supplied from it to both lobes of the liver; and a large one, which is directed to the right lobe, is continuous with the left piece of the vena portæ. Purified or placental blood circulates through the vessel at that period.

condition after birth.

After birth the part of the umbilical vein in front of the transverse fissure is closed, and becomes eventually the round ligament. The part behind the transverse fissure, or the ductus venosus, is also obliterated, only a thin cord remaining in its place (the obliterated ductus venosus). Whilst the lateral branches, which are in the same line as, and continuous with the left branch of the vena portæ, remain open, and subsequently form part of the left division of the vena portæ. Occasionally the ductus venosus is found more or less pervious.

Lobular structure incased by two coats.

Structure of the Liver. The substance of the liver consists of a collection of small secreting bodies, called lobules or acini; together with vessels which are concerned both in the production of the secretion and in the nutrition of the organ. The whole is surrounded by a fibrous and a serous coat.

Serous coat. The peritoneum invests the liver almost completely, and adheres closely to the subjacent coat. At certain spots intervals exist between the two, viz. in the fissures occupied by vessels, along the lines of attachment of the ligaments, and at the surface covered by the gall-bladder. **Serous coat, where deficient.**

The *fibrous covering* is very thin, but it is rather stronger where the peritoneum is not in contact with it. It invests the liver, and is continuous at the transverse fissure with the fibrous sheath (capsule of Glisson) surrounding the vessels in the interior. When the membrane is torn from the surface, it is found to be connected with fine shreds that dip into the liver. **Fibrous covering is prolonged to the interior.**

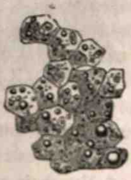
Size and form of the lobules. The lobules (fig. 100, *l*) constitute the proper secreting substance, and can be seen either on the exterior of the liver, or on a cut surface, or by means of a rent in the mass. As thus observed, these bodies are about the size of a pin's head, and measure from $\frac{1}{20}$th to $\frac{1}{10}$th of an inch in diameter. Closely massed together, they present a dark central point; and there are indications of lines of separation between them, though they communicate by their vessels. By means of transverse and vertical sections of the lobules, their form will appear flattened on the exterior, but many sided in the interior of the liver. They are clustered around the smallest divisions of the hepatic vein, to which each is connected by a small twig (intralobular vein) issuing from the centre, something like the union of the stalk with the body of a small fruit. **Lobules of the liver; size and appearance; form and investment. Position to veins.**

To study the minute structure of the lobules, a microscope will be necessary, and the different vessels of the liver should be minutely injected.

Constituents of the lobules. Each lobule is composed of minute hepatic cells, which are arranged web-like amongst the ducts and vessels; and is provided with a capillary network of vessels, and a plexus of the bile duct. **A lobule is a distinct gland.**

Cells of the lobules. The hepatic or *biliary* cells (fig. 99) form the chief part of the lobule; they are irregular in form, being rounded or many sided, and possess a bright nucleus, or even more than one. In size they vary from $\frac{1}{1000}$th to $\frac{1}{800}$th of an inch. They are of a yellowish colour, and enclose granular particles, together with fat and yellow colouring matter. These nucleated cells adhere together by their surfaces so as to form rows, with spaces between them for the bloodvessels and ducts. The cells are concerned in the secretion of the bile. **Biliary cells of the lobule. Situation and form; size and contents; connection with ducts.**

Fig. 99.*



Vessels of the lobule. The smallest branches of the *vena portæ*, **Arrangement of its**

* Hepatic cells of the lobules of the human liver.

vessels, viz. vena portæ,

after uniting in a circle around the lobule, where they are named *interlobular*, enter its substance, and form therein a network of capillaries near the circumference.

hepatic vein,

A small branch of the *hepatic vein* occupies the centre of the lobule; its radicles communicate with the portal network, and it issues from the base of the lobule as the *intralobular vein.*

and bile duct.

The *radicles* of the *bile duct* begin within the lobule in a fine intralobular plexus of ducts between the hepatic cells (Chrzonszczewsky); they leave the lobule at the circumference, and are joined together outside it in the smallest interlobular branches.

Use of the vessels.

From the facts above stated respecting the arrangement of the vessels, it would appear that the portal vein conducts the blood from which bile is secreted; that the hepatic vein carries away the superfluous blood; and that the secreted bile is received by the plexus of the biliary duct.

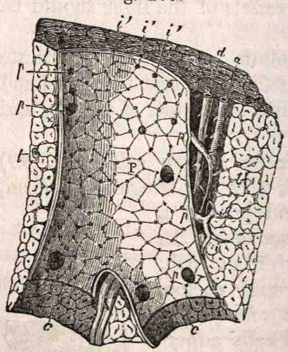
Arrangement of vessels in the liver.

VESSELS OF THE LIVER. Two sets of vessels ramify in the liver:—One concerned in the secretion and the nutrition of the organ enters the transverse fissure, and is directed transversely in spaces named portal canals, where it is enveloped by areolar tissue. The other set, consisting of the hepatic veins, runs from the anterior to the posterior border of the liver without a sheath. The ramifications of these different vessels are to be traced in the liver.

Capsule of Glisson, with vessels in transverse fissure.

The *capsule of Glisson* is a layer of areolar tissue, which envelops the vessels entering the liver through the transverse fissure. In this sheath the vessels ramify, and in it they are minutely divided before their termination in the lobules. If a transverse section is made of a portal canal, the vessels will retract somewhat into the loose surrounding tissue.

Fig. 100.*



Vena portæ

occupies portal canals,

The *vena portæ* ramifies in the liver like an artery; and the blood circulates through it in the same manner, viz., from trunk to branches. After entering the transverse fissure the vein divides into large branches; these lie in the portal canals or spaces with offsets of the hepatic artery, the hepatic duct, and the

* Vessels in a portal canal and the lobules of the liver (Kiernan).—*l, l.* Lobules of the liver. P. Branch of the vena portæ, with *p p*, vaginal branches which supply interlobular offsets, *i*. *a*. Hepatic artery. *d*. Hepatic duct. *i′, i′, i′*. Openings of interlobular branches of the portal vein.

nerves and lymphatics (fig. 100, P). The division is repeated again and again until the last branches of the vein (*interlobular*, *i*, *i*) penetrate between the lobules, around which they form a circle; and they end in the interior as before explained. **and supplies vaginal and interlobular branches.**

In the portal canals the offsets of the *vena portæ* are joined by small *vaginal veins*, which convey blood to them from branches of the hepatic artery. **Receives vaginal branches.**

The *hepatic artery* is consumed in the nutrition of the structure of the liver. Whilst surrounded by the capsule of Glisson (fig. 100, *a*), it furnishes *vaginal* branches which ramify in the sheath, giving it a red appearance in a well-injected liver, and supply twigs to the coats of the vena portæ and biliary ducts, and to the areolar tissue: from the vaginal branches a few offsets are sent to the capsule of the liver. **Hepatic artery nourishes the vessels, and joins vena portæ.**

Finally the artery ends in fine interlobular branches, from which offsets enter the lobule, and convey blood into the network between the branches of the vena portæ and hepatic vein (Chrzonszczewsky). **Ending in lobules.**

The *hepatic vein* (venæ cavæ hepaticæ) begins by a plexus in the interior of each lobule, and its smallest radicle issues from the base of the lobule as the *intralobular* vein, and is received into the *sublobular* branches. The sublobular twigs anastomose together, and unite into large vessels which cease to receive any intralobular veins. Finally, uniting with neighbouring branches to produce larger trunks, the hepatic veins are directed from before backwards to the vena cava inferior, into which they open by large orifices. **Hepatic veins without a sheath begin in the lobules,**

The venæ cavæ hepaticæ may be said to be without a sheath, for this is very slight only in the larger trunks: so that when they are cut across the ends remain patent in consequence of their close connection with the hepatic structure. **and end in the vena cava.**

Hepatic duct (fig. 100, *d*). The duct commences in the biliary plexus within the lobules. On leaving the lobules the ducts communicate by the interlobular branches; and the smaller ducts soon unite into larger *vaginal* branches, which lie in the portal canals with the other vessels. Lastly, the ducts are collected into a right and a left trunk, and leave the liver at the transverse fissure as before described. **Bile duct, beginning, branches.**

Aberrant ducts exist between the pieces of the peritoneum in the left lateral ligament of the liver, and in the pons bridging over the vena portæ and vena cava; they anastomose together, and are accompanied by branches of the vessels of the liver, viz., vena portæ, hepatic artery, and hepatic vein. **Aberrant ducts.**

Structure. The moderate-sized hepatic ducts consist of a fibrous coat lined by a mucous layer with cylindrical epithelium; and penetrating the wall is a longitudinal row of openings on each **Structure of medium-sized ducts,** side leading into sacs, and into branched tubes (biliary, Henle) which sometimes communicate.

and smallest ducts. In the fine interlobular ducts the coat is formed by a homogeneous structure, with columnar epithelium (Henle).

Lymphatics. Superficial, *Lymphatics* of the liver are superficial and deep. The superficial of the upper surface enter the lymphatics in the thorax by piercing the diaphragm, and end for the most part in the sternal glands; those on the under surface enter chiefly the glands by the side of the abdominal aorta, a few joining the deep lymphatics and the coronary of the stomach.

deep. The deep lymphatics accompany the vessels through the gland, and enter one of the large contributing trunks of the thoracic duct on the spine.

Nerves, source. *Nerves* come from the sympathetic and the pneumo-gastric, and ramify with the vessels; but their mode of ending is not ascertained.

THE GALL-BLADDER.

Use and situation; form; The gall-bladder (fig. 98, *g*) is the receptacle of the bile. It is situate in a depression on the under surface of the right lobe of the liver, and to the right of the square lobe. Conical in form, or pear-shaped, its larger end (*fundus*) is directed forwards beyond the margin of the liver; whilst the smaller end, or the neck, is turned in the opposite direction, and bends downwards to terminate in the cystic duct by a zigzag part.

size; In length the gall-bladder measures three or four inches, and in breadth rather more than an inch at the fundus or the widest part. It holds rather more than an ounce.

connections. By one surface the sac is in contact with the liver, and on the opposite it is covered by peritoneum. The larger end touches the abdominal wall opposite the tip of the cartilage of the tenth rib, where it is contiguous to the transverse colon; and the small end is in contact with the duodenum.

Structure of wall. *Structure.* The wall of the gall-bladder possesses a peritoneal, a fibrous and muscular, and a mucous coat.

Serous coat. The *serous coat* is stretched over the under or free surface of the gall-bladder, and surrounds the large end.

Fibrous and muscular stratum. The *fibrous coat* is strong, and forms the framework of the sac; intermixed with it are some involuntary muscular fibres, the chief being longitudinal, but others circular.

Mucous layer is areolar on surface, and covered by a The *mucous coat* is marked internally by numerous ridges and intervening depressions, which give an areolar or honeycomb appearance to the surface. On laying open the gall-bladder this condition will be seen, with the aid of a lens, to be most developed about the centre of the sac, and to diminish towards each extremity. In the bottom of the larger pits are depressions leading to recesses or follicles. The surface of the mucous membrane is covered by a columnar epithelium. columnar epithelium.

Where the gall-bladder ends in the cystic duct its coats project into the interior, and give rise to ridges that resemble the parietal eminences in the sacculated large intestine. Projections of the wall.

The *cystic duct* joins the hepatic duct at an acute angle, to form the ductus communis choledochus. It is about an inch and a half long, and is distended and somewhat sacculated near the gall-bladder. Duct of gall-bladder.

Structure. The coats of the duct are formed like those of the sac from which it leads, but the muscular fibres are very few. The mucous lining is provided with glands, as in the hepatic and common bile ducts (p. 539). Structure same as sac, and is provided with glands.

Valve of the gall-bladder. On slitting open the duct the mucous membrane is seen to form a series of semilunar projections (from nine to twenty), which are arranged obliquely around the tube, and increase in size towards the gall-bladder. This structure is best seen on a gall-bladder that has been inflated and dried; as in this state the parts of the duct between the folds are most stretched. Mucous coat like a screw.

Bloodvessels and nerves. The vessels of the gall-bladder are named *cystic.* The artery is a branch of the hepatic; and the cystic vein opens into the vena portæ near the liver. The *nerves* are derived from the hepatic plexus, and entwine around the vessels. The *lymphatics* follow the cystic duct, and join the deep lymphatics on the spinal column. Artery and vein, nerves and lymphatics.

THE KIDNEY AND THE URETER.

The kidney has a characteristic form :—flattened on the sides, it is larger at the upper than at the lower extremity, and is hollowed out at one part of its circumference. For the purpose of distinguishing between the right and left kidneys, let the excavated margin be supposed to be turned to the spinal column, whilst the ureter or the excretory tube is kept behind the other vessels; and let that end be directed downwards, towards which the ureter is naturally inclined. Use and form. To distinguish right from left.

With the special form above mentioned, the kidney is of a deep red colour, and presents an even surface. Its average length is about four inches, its breadth two, and its thickness about one inch; but the left is commonly longer and more slender than the right kidney. Its usual weight is about five ounces and a half in the male, and rather less in the female. Colour, size, and weight.

The upper extremity of the kidney is rounded, is thicker than the lower, and is surmounted by the suprarenal body. The lower end is flat and more pointed. The position with respect to the spinal column has been before detailed (p. 508). Extremities;

surfaces; On the anterior surface the viscus is rounded, but on the opposite surface it is flattened.

borders. The outer border is convex; but the inner is excavated, and is marked by a longitudinal fissure,—*hilum.* In the fissure the vessels are thus placed with respect to one another:—The divisions of the renal vein are in front, the ureter is behind, and the branches of the artery lie between the two. On the vessels the nerves and lymphatics ramify, and areolar tissue and fat surround the whole.

Contents of the fissure; their position.

Sinus. Opposite the fissure is a hollow in the interior of the kidney named *sinus*, into which the hilum leads, and in which the vessels and the duct are contained before they pierce the renal substance.

Open the kidney, and clean the vessels. *Dissection.* To see the interior it will be necessary to cut through the kidney from the inner to the outer border, and to remove the loose tissue from the vessels, and the divisions of the excretory duct. The hollow or sinus containing the bloodvessels now comes completely into view.

Renal substance divided into cortical and pyramidal. The *interior of the kidney* appears on a section to consist of two different materials, viz., of an external granular or cortical part; and of internal, darker coloured, pyramidal masses, which converge towards the centre, and are connected with the divisions of the excretory duct. But it will subsequently appear that these unlike-looking parts are constructed of urine tubes, though with a different arrangement.

Pyramids: number, The *pyramidal masses* (pyramids of Malpighi, medullary substance,) are twelve or eighteen in number, and converge to the sinus of the kidney.

apex, ends in papilla. The apex, which is free from cortical covering, is directed to the sinus, and ends in a smooth, rounded part, named *mamilla* or *papilla.* In it are the free openings of the urine tubes, which are about twenty in number, some being situate in a central depression and the others on the surface; and it is surrounded by one of the divisions (calyx) of the excretory tube. Occasionally two of the masses are united in one papillary termination.

Base resolved into pyramids of Ferrein. The base is embedded in the cortical substance, and is resolved into bundles of tubes (pyramids of Ferrein), which are prolonged vertically from it into the cortical covering.

Composition. Each conically-shaped mass is constructed of uriniferal tubes (tubes of Bellini) which open below at the apex of the papilla; and the cut surface has a grooved appearance indicatory of its construction; if the mass is compressed, urine will exude from the tubes through the apertures in the apex.

Extent of cortical substance; colour; The *cortical* or investing *part* forms about three-fourths of the kidney; it covers the pyramidal masses with a layer about two lines in thickness, and sends prolongations between the same nearly to their apices. Its colour is of a light red, unless the kidney is blanched; and its consistence is so slight that the mass gives way beneath the finger. In transverse sections the mass appears constituted of small bundles of vertical tubes (pyramids of Ferrein) surrounded by convoluted tubes; and in the injected kidney red points (Malpighian bodies) are scattered through the convoluted, giving it a granular appearance.

consistence. It contains two sets of tubes;

The vertical bundles of tubes, or the pyramids of Ferrein, are continuous below with the straight tubes in each pyramidal mass, and reach upwards nearly to the surface of the kidney. Each bundle is said to be formed by the aggregate branchings of one of the large tubes opening on the apex of the pyramid; and is described as being spherical or somewhat conical in form.

vertical or tubes of Ferrein,

The convoluted tubes surround the pyramids of Ferrein, intervening even between their upper ends and the investing coat of the kidney, and open into the straighter tubes of the pyramids, in the manner to be afterwards explained.

and convoluted, around the others.

In the human fetus, and in some animals, the kidney is divided into separate lobes; and each lobe consists of a pyramidal mass with its prolongations and a cortical envelope. With the growth of the human kidney the original divisions disappear, and the cortical covering of contiguous lobes is blended to produce the interpyramidal cortical part. But the uriniferous tubes and vessels of each pyramid of Malpighi, and its cortical portion, which correspond with one of the primary lobes, remain distinct in the adult.

Rudimentary condition of the kidney.

STRUCTURE OF THE KIDNEY. The kidney consists of a mass of minute secretory tubes, intermixed with blood-vessels, lymphatics, nerves, and an intertubular matrix. The whole is incased by a fibrous coat.

Secretory tubes are incased by a fibrous coat.

The *fibrous coat* is a white firm case, which is connected with the kidney by fine processes and vessels, but is readily detached from it by slight force. At the inner margin of the kidney it sinks into the hollow or sinus, and sends processes on the entering vessels: at the same spot it is continuous with the fibrous coat of the excretory duct.

Fibrous coat sends in offsets.

Stroma or *matrix*. Between the tubules and the vessels of the kidney is a uniting material, which surrounds and isolates them, and is most abundant in the cortical substance: in some spots it is fibrous. In its nature it somewhat resembles areolar tissue.

Matrix of kidney.

To obtain a knowledge of the anatomy of the secreting tubes, and to make out the disposition of the bloodvessels, the dissector will require a microscope and good fine injections of the part.

Secretory tubules. The *uriniferous tubes* (tubuli uriniferi) occupy successively between their beginning and ending, the Malpighian pyramid, the pyramids of Ferrein, and the cortical

Uriniferous tubes;

their arrangement.

substance; but they have a different arrangement in each part, like the secreting tubes of the testis.

In the Malpighian pyramid, size;

In the *Malpighian pyramid* the tubes are straight, and ascend from the aperture in the apex bifurcating repeatedly as far as the base, and forming a cone which resembles the stem and branches of a tree. Near the apex they measure $\frac{1}{300}$th of an inch across, but the subdivisions are only half that size, or $\frac{1}{600}$th of an inch.

mixed with loops of Henle, which are small.

Intervening between the straight tubes are the smaller looped tubes of Henle: these descend from the cortical substance nearly to the apex of the pyramid, where they turn upwards, forming loops with the convexity down, and ascend to open into the larger tubes. Their size is about a third of the others, and their upper ends are twisted and dilated like the other urine tubes.

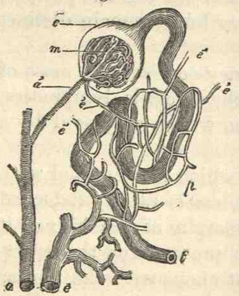
In the pyramids of Ferrein, they form bundles, and unite in loops.

In the *pyramids of Ferrein* the urine tubes are slightly wavy, and being collected into bundles ascend vertically, without diminution of size nearly to the surface of the kidney; there they alter their direction, and bending inwards unite with the neighbouring tubes (two and two Henle) so as to form anastomotic loops. With those loops the tubuli uriniferi in the cortical substance communicate.

In the cortical substance, are convoluted, and join the arches; mixed with looped tubes.

In the *cortical substance* the tubes are more numerous and very convoluted; they have an average width of $\frac{1}{600}$th of an inch, and are surrounded by a capillary plexus of bloodvessels (fig. 101, *p*). At the one end (farther) each tube is closed, and dilated into the Malpighian corpuscle; and at the other it joins a loop or arch at the base of a pyramid of Ferrein.

Fig. 101.*



The small looped tubes of Henle have the same arrangement as the larger tubuli uriniferi in the cortical substance before they descend amongst the tubes of the pyramid of Malpighi.

Structure.

The wall of the convoluted tubes consists of a thin membrane, and is lined by a thick, nucleated, and granular epithelium.

Malpighian bodies,

Malpighian corpuscles. These small bodies are appended to the free end of the convoluted tubes, one to each; and are arranged

* Plan of a urine tube provided with a terminal Malpighian body (Bowman).—*t.* The uriniferous tube. *c.* Dilatation or capsule of the Malpighian body continuous with the tube. *p.* Plexus of capillary vessels around the urine tube. *m.* Glomerulus. *a.* Branch of an artery; and *a′*, an offset from it (afferent vessel) to the Malpighian body. *e.* Branch of a vein, and *e′*, an artery coming from the Malpighian body (efferent vessel), and joining in the plexus, *p*, around the urine tube.

in double rows in the cortical substance between the pyramids of Ferrein, one row being on each side of an interpyramidal branch of artery, from which they receive twigs; each measures about $\frac{1}{120}$th of an inch, and consists of an incasing capsule with an enclosed tuft of bloodvessels (glomerulus).

position; size and composition.

The capsule is the closed and somewhat dilated end of the convoluted tube, and is perforated at the extremity by two small bloodvessels close together. Its wall consists of a thin homogeneous membrane, and is lined by a transparent laminar epithelium.

The capsule; how formed.

The glomerulus (fig. 101, *m*) is formed by the intercommunications of the two vessels piercing the capsule. One of the two vascular twigs, the afferent vessel (*a*), is an offset of the renal artery, and divides into convoluted loops of the fineness of capillaries, which form the exterior of the tuft. The other, the efferent vessel (*e′*), begins in the interior of the tuft by the union of the loops on the outer surface; and passing out is distributed in a close network of capillaries on the convoluted tubes, and in one with elongated meshes on the straight tubes in the pyramids of Ferrein. The office of the glomerulus is to secrete the watery part of the urine; and its surface was described by Bowman as being naked in the tube, but subsequent observers state that it is clothed with epithelium.

The bloodvessels, two, afferent, and efferent, which unite.

Use of glomerulus.

Bloodvessels. The artery and vein distributed to the kidney are very large in proportion to the size of the organ they nourish; and some small arterial branches have a peculiar disposition in the Malpighian bodies before they end in the veins.

Bloodvessels are large.

Renal artery. As the artery enters the kidney it divides into four or five branches, which are invested by sheaths of the fibrous capsule, and reach the bases of the pyramids of Malpighi where they form arches. From those arches arise small interpyramidal branches, which ascend towards the surface between the pyramids of Ferrein, and furnish the afferent twigs to the Malpighian bodies, whose arrangement has been referred to: other offsets are supplied to the capsule and matrix of the kidney; the former anastomose with the subperitoneal branches of the lumbar arteries.

Branches of the artery supply Malpighian bodies, and texture of the kidney.

Straight vessels descend amongst the tubes in the pyramids of Malpighi; they appear above between the pyramids of Ferrein, and some form loops like the tubes of Henle, whilst the rest end in capillaries. Their origin is doubtful: some inquirers trace it to offsets of the renal artery, and others to the efferent vessel of the glomerulus.

Straight vessels in pyramids.

Renal vein. This vein begins in the capillary plexuses on the convoluted urine tubes, and its small branches receiving twigs from the matrix and the fibrous coat unite into larger veins, which anastomose freely around the bases of the pyramids of

Veins begin around tubules; and in matrix;

anastomose around pyramids, and unite into one.

Malpighi. At this spot they are joined by offsets from the capillary plexuses in the pyramids; and the larger trunks then accompany the arteries to the sinus of the kidney. Finally all are united into one trunk, which opens into the vena cava.

Nerves.

Nerves. The ramifications of the sympathetic nerve may be traced to the smaller branches of the artery but not farther.

Absorbents.

The *absorbents* are superficial and deep:—Both unite at the hilum of the kidney and join the lumbar glands. The anatomy of the deep is not yet ascertained with certainty.

Ureter; office; length. Size varies.

The URETER is the tube by which the fluid secreted in the kidney is conveyed to the bladder. Between its origin and termination the canal measures from sixteen to eighteen inches in length. Its size corresponds commonly with that of a large quill. Near the kidney it is dilated into a funnel-shaped part, named *pelvis;* and near the bladder it is again somewhat enlarged, though the lower aperture by which it terminates is the narrowest part of the tube. Its relative anatomy must be studied afterwards, when the body is in a suitable position.

Course and connections.

In its course from the one viscus to the other, the ureter is close beneath the peritoneum, and is directed obliquely downwards and inwards along the posterior wall of the abdomen as far as the pelvis; here it changes its direction and becomes almost horizontal in the posterior false ligament of the bladder. At first the ureter is placed over the psoas, inclining on the right side towards the inferior vena cava, and about the middle of the muscle it is crossed by the spermatic vessels. Lower down it lies over the common or the external iliac artery, being beneath the sigmoid flexure on the left side, and the end of the ileum on the right side. Lastly, it is contained in the posterior ligament of the bladder, below the level of the obliterated hypogastric artery.

Sometimes double.

Sometimes the ureter is found divided into two for a certain distance.

Ureter dilated near the kidney, has calices, which embrace pyramids.

Part in the kidney. Near the kidney the ureter is dilated into a pouch called *pelvis;* and when traced upwards into that viscus, it is found to begin by a set of cup-shaped tubes, named *calices* or infundibula, which vary in number from seven to thirteen. Each cup-shaped part embraces the rounded end of a pyramidal mass, and receives the urine from the apertures in that projection: sometimes a calyx surrounds two or more apices or papillæ. The several calices are united together to form two or three larger tubes; and these are finally blended in the excretory duct or the ureter.

Two coats in ureter,

Structure. Besides an external fibrous layer the ureter consists of a muscular and a mucous coat.

muscular and mucous.

The *muscular* covering is composed of an external or longitudinal, and an internal or circular stratum.

The *mucous* coat is thrown into longitudinal folds during the contracted state of the ureter. Its epithelium is spheroidal, and consists of several layers of cells of different shapes; thus at the free and attached surfaces the cells are rounded, whilst in the intermediate strata they are cylindrical or branched (Kölliker). Epithelium many layers.

The *calices* resemble the rest of the duct in having a fibrous, muscular, and a mucous coat. Around the pyramid the enveloping tunic of the kidney is continuous with the calyx; and at the apex the mucous lining is prolonged into the uriniferal tubes through the small openings. The calices also two coats.

Vessels. The *arteries* are numerous but small, and are furnished by the renal, spermatic, internal iliac, and inferior vesical. The *veins* correspond with the arteries. Vessels.

The *lymphatics* are received into those of the kidney. Lymphatics.

THE SUPRARENAL BODY.

This small body, whose use is unknown, has received its name from its position to the kidney. Its vessels and nerves are numerous, but it is not provided with any excretory duct. Use unknown. No duct.

One on each side, it is situate on the upper extremity and the fore part of the kidney; and without care it may be removed with the surrounding fat, which it resembles. Its colour is a brownish yellow. It is like a cocked hat in form, with the upper part convex, and the base or lower part where it touches the kidney hollowed. Situation. Form and colour.

Its size in the adult is about one inch and a half in depth, and rather less in width; and its weight is between one and two drachms, but the left is commonly larger than the right capsule. Size and weight,

Areolar tissue attaches the suprarenal body to the kidney; and large vessels and nerves retain it in place. The connections with the surrounding parts are the same as those of the upper end of the kidney. Thus it rests on the diaphragm on both sides; whilst above the right body is the liver, and above the left the pancreas and the spleen. On the inner side of the right capsule is the vena cava, with part of the solar plexus; and internal to the left is the aorta, with the same plexus of nerves. Connections.

Structure. By means of a perpendicular section, the suprarenal body may be seen to be formed of a firm external or cortical part, and of an internal (medullary) soft and dark material. The whole is surrounded by a thin *fibrous capsule*, which sends processes into the interior and along the bloodvessels. Two different structures. Surrounded by a capsule.

With the aid of a microscope the structure of this body is found to consist of a mass of cells, which are lodged in spaces formed in a stroma of areolar tissue, with vessels and nerves. Each has stroma with cells.

Cortical part. Thickness. The *cortical* part, yellowish in colour and striated, forms about two thirds of the thickness of the whole body.

Its tissue forms spaces for masses of cells. Its *stroma* consists of fine areolar tissue which forms a thin surface layer, and is connected internally with processes or septa, which are so arranged as to build up spaces elongated from without inwards, and arranged vertically around the centre; but near the surface there are smaller oval spaces, some of them crossing the deeper and larger. The spaces or loculi are not lined by a limiting membrane; and in them columnar masses of cells are lodged, but slight force readily removes these from their containing hollows.

Medullary part. Thickness. Spaces in it. The *central* or medullary portion is rather red in colour, or it may be dark brown or black from the presence of blood. About half as thick as the cortical part, it possesses internally small round or oval spaces (venous spaces, Harley*).

Its tissue forms a network for cells. The areolar tissue of its *stroma* is very fine, and forms a network with small but regular meshes for the lodgment of cells, instead of lengthened intervals as in the external part; and the medullary is separated from the cortical portion by a layer of areolar tissue. Cells fill the meshes.

Characters of the cells in cortex, size; *Cells.* The cells filling the loculi of the fibrous stroma in the cortex, are nucleated and granular with oil globules, and being packed in masses they take on a polygonal form: they measure about the $\frac{1}{1700}$th of an inch, and have small nuclear-looking bodies mixed with them.

in medullary part. In the medullary portion the cells resemble those of the cortex, except that they do not contain oil particles; and they are rather larger, measuring about $\frac{1}{1000}$th of an inch.

Arteries. *Bloodvessels.* Numerous *arteries* are furnished to the suprarenal body from the diaphragmatic and renal vessels, and the aorta. In the interior those vessels ramify in the cortex along the fibrous septa between the cell masses, and frequently anastomosing together, end in a fine capillary network with elongated meshes around the loculi. In the medullary part the fine arteries are distributed through the stroma, and end in capillaries.

Veins. The *veins* originate in the capillary plexuses, and the several radicles, uniting in large branches which pass through the centre of the medullary part, are collected finally into a trunk, which opens on the right side into the vena cava, and on the left into the renal vein. Other smaller veins pass out through the cortex to the renal vein and the vena cava.

Nerves. *Nerves.* The nerves are very numerous and large: branching, they extend between the cortical and medullary parts in the layer of areolar tissue, and in the medullary substance they

* The Histology of the Suprarenal Capsules, by George Harley, M.D. Reprinted from *The Lancet*, 1858.

form a network in the areolar structure, but their ending is unknown.

Lymphatics are superficial and deep, and both join those of the kidney; the arrangement of the deep is undetermined.

THE TESTES.

The testes are the glandular organs for the secretion of the semen. Each is suspended in the scrotum by the spermatic cord and its coverings (p. 485), but the left is usually lower than the right; and each is provided with an excretory duct named vas deferens. A serous sac surrounds partly each organ. **Testes situated in the scrotum.**

Dissection. For the purpose of examining the serous covering of the testicle (tunica vaginalis), make an aperture into it at the upper part, and inflate it. The sac and the spermatic cord are then to be cleaned; and the vessels of the latter are to be followed to their entrance into the testicle. **To see the serous sac.**

The *tunica vaginalis* is a serous bag, which is continuous in the fetus with the peritoneal lining of the abdomen, but becomes subsequently a distinct sac in consequence of the obliteration of the part connecting the two. **Tunica vaginalis**

It invests the testicle after the manner of other serous membranes; for the testicle is placed behind it, so as to be partly enveloped by it, though not in its cavity. The sac, however, is larger than is necessary for covering the testicle, and projects some distance above it. Like other serous membranes, it has an external rough, and an internal secerning smooth surface; and like them it has a visceral and a parietal part. To examine its disposition the sac should be opened. **partly covers the testicle, and lines scrotum.**

The visceral layer (tunica vaginalis testis) covers the testicle except posteriorly where the vessels lie, and is inseparably united with the fibrous coat. On the outer side it extends farther back than on the inner, and forms a pouch between the testis and the arched body (epididymis) on this aspect of the organ. **Its visceral part,**

The parietal part of the sac (tunic. vagin. scroti) is more extensive than the piece covering the testicle, and lines the immediately contiguous layer of the scrotum. **and parietal.**

Form and position of the testis. The testicle is oval in shape, with a smooth surface, and is flattened on the sides. The anterior margin is convex; and the posterior, which is flattened, is pierced by the spermatic vessels and nerves. Stretching like an arch along the outer part of the testis is the epididymis, or the convoluted part of the excretory duct. **Testicle oval. Margins. Body on the testicle.**

Attached to the upper end of the testis is a small body two or three lines in length, (corpus Morgagni,) which is the remnant of the fetal duct of Müller; and occasionally other smaller projec- **Corpus Morgagni.**

tions of the tunica vaginalis are connected with the top of the epididymis.

Suspended obliquely.

The testis is suspended obliquely, so that the upper part is directed forwards and somewhat outwards, and the lower end backwards and rather inwards.

Dimensions and weight.

Size and weight. The length of the testis is an inch and a half or two inches; from before backwards it measures rather more than an inch, and from side to side rather less than an inch. Its weight is nearly an ounce, and the left is frequently larger than the other.

A dense tunic contains small secreting tubes.

STRUCTURE. The substance of the testicle is composed of a mass of minute secerning tubes, around which the bloodvessels are disposed in plexuses. Surrounding and supporting the delicate seminiferal tubes is a dense covering—the tunica albuginea. Its excretory or efferent duct is named vas deferens.

How to see the structure of the testis.

Dissection. With the view of examining the investing fibrous coat, let the testis be placed on its outer side, viz. that on which the epididymis lies, and let it be fixed in that position with pins.

The fibrous coat is to be cut through along the anterior part, and thrown backwards as far as the entrance of the bloodvessels. Whilst raising this membrane a number of fine bands will be seen traversing the substance of the testicle, and a short septal piece (mediastinum) may be found at the back of the viscus, where the vessels enter; but it will be expedient to remove part of the mass of tubes in the interior, to bring into view the mediastinum, and to trace back some of the finer septa to it.

Fibrous coat; characters; use.

The *tunica albuginea*, or the fibrous coat of the testicle, is of a bluish-white colour, and resembles in appearance the sclerotic coat of the eyeball. This membrane protects the soft secreting part of the testicle, and maintains the shape of the organ by its dense and unyielding structure. Besides determining the general form, it sends inwards processes to support and separate the masses of seminal tubes. These several offsets of the membrane are seen in the dissection that has been made; and one of them, which is larger than the rest, is placed at the back of the testicle, and is named the mediastinum.

Sends inwards processes, as the mediastinum

The *mediastinum testis* (corpus Highmorianum) projects into the gland for a third of an inch with the bloodvessels. It is situate at the back of the testis, extending from the upper nearly to the lower part, and is rather larger and deeper above than below. When cut across it will be seen to be formed of two lateral pieces, which are united anteriorly at an acute angle. To its front and sides the finer septal processes are connected; and in its interior are contained the bloodvessels behind, and a network of seminal ducts forming the rete testis in front.

and finer septa.

Of the *finer processes* of the tunica albuginea, which enter the testis, there are two kinds. One set round and cord-like, but of different lengths, is attached posteriorly to the mediastinum, and serves to maintain the shape of the testis. The other set forms delicate membranous septa, which divide the seminal tubes into masses named lobes, and join the mediastinum like the rest.

A vascular layer lines it (tunica vasculosa).

Tunica vasculosa. Within the tunica albuginea is a thin vascular layer, which has been named as above by Sir A. Cooper. It lines the fibrous coat, covering the different septa in the interior of the gland. It is formed of the ramifications of the blood-vessels united by areolar tissue, like the pia mater of the brain: in it the arteries are subdivided before they are distributed on the secerning tubes, and the veins in the interior are supported by it.

Seminal tubules: appearance and length.

Form and length of the seminal tubes (tubuli seminiferi). The secerning or seminal tubes are very convoluted, and are but slightly held together by fine areolar tissue and surrounding bloodvessels, so that they may be readily drawn out of the testis for some distance. Their length is said by Lauth to be two feet and a quarter.

Ending, size and structure. The size and the characters of the minute tubules can be learnt only with the aid of the microscope.

Communications; size; structure;

Within the lobes of the testis some tubes end in distinct closed extremities; but the rest communicate, forming loops or arches. The diameter of the tubules varies from $\frac{1}{200}$th to $\frac{1}{150}$th of an inch. The wall of the tubule is formed of a thin fibrous membrane, but it has considerable strength: lining the interior is a nucleated granular epithelium, with polygonal cells; and on the exterior is a plexus of bloodvessels.

Tubes change their name.

Names from the arrangement of the tubes. To different parts of the seminal tubes between the origin and the ending in the vas deferens the following names have been applied. Where the tubules are collected into separate masses, they form the lobes of the testis. As they enter the fibrous mediastinum they become straight, and are named tubuli recti. Communicating in the mediastinum, they produce the rete testis. And, lastly, as they leave the upper part of the gland they become convoluted, and are called coni vasculosi, or vasa efferentia.

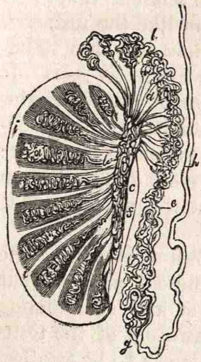
They form the lobes. Number of lobes. Shape.

The *lobes of the testis* (fig. 102, *a*) are formed by bundles of the seminiferal tubes; and they are situate in the intervals between the processes sent inwards from the tunica albuginea. Their number is differently stated:—according to one authority (Berres) they are 250; but according to another (Krause) 400 or more. They are conical in form, with the base of each at the circumference, and the apex at the mediastinum testis; and those in the centre of the testicle are the largest.

Tubes in them, and

Each is made up of one, two, or more tortuous seminal tubules; and the minute tubes in one lobe are united with those arrangement. in the neighbouring lobes. Towards the apex of each lobe the tubules become less bent, and are united together; and the tubuli of the several lobes are further joined at the same spot into larger canals that form the tubuli recti.

Fig. 102.*



Tubes next become straight (tubuli recti); *Tubuli recti.* The seminal tubes issuing from the several lobes unite together, becoming larger in size ($\frac{1}{60}$th of an inch) and straighter in direction, and are named tubuli recti or vasa recta (fig. 102, *b*): they are about twenty in number, and piercing the fibrous mediastinum enter into its interior.

afterwards join together (rete testis), *Rete testis.* In the mediastinum the seminal tubes have very thin walls, and are situate in the anterior part in front of the bloodvessels; they communicate freely so as to form the network of the rete testis (fig. 102, *c*).

and leave the gland as vasa efferentia. *Vasa efferentia.* About twelve or twenty seminal tubes issue from the top of the rete testis, and leave the upper part of the testicle as the vasa efferentia (fig. 102, *d*). These are larger than the tubes with which they are continuous, and end in the common excretory duct. Though straight at first they soon become convoluted, and have been named *coni vasculosi.* In the natural state they are about half an inch in length, but when unravelled they measure from six to eight inches; and they join the excretory duct at intervals of about three inches.

Structure. These small vessels have a muscular coat like that of the vas deferens they join, consisting of longitudinal and circular fibres; and the epithelium of the mucous lining is ciliated.

Excretory duct The EXCRETORY DUCT of the testis receives the vasa efferentia from the upper part of the gland, and extends thence to the urethra. Its first part, which is in contact with the testis, is very flexuous, and forms the epididymis: but the remainder is straight, and is named vas deferens.

is bent on the testicle forming epididymis: The *epididymis* extends in the form of an arch, along the outer side of the testis, from the upper to the lower end, and receives its name from its situation. Opposite the upper part of the testicle it presents an enlarged portion or head, the *globus major;* and at the lower end of that organ it becomes more pointed or named parts. tail-like—*globus minor*, before ending in the vas deferens. The

* Plan of the testicle as seen on a vertical section.—*f.* Fibrous coat of the testicle. *s.* Mediastinum. *i. i.* Processes of external coat, continued between the lobes. *a, a.* Lobes of the testis. *b.* Tubuli recti. *c.* Rete testis. *d.* Vasa efferentia. *f, e, g.* Coils of the tube forming the epididymis. *h.* Vas deferens.

intervening narrow part of the epididymis is called the body. Its head is attached to the testis by the vasa efferentia; and its tail or lower part is fixed to the tunica albuginea by fibrous tissue, and by the reflection of the tunica vaginalis.

After the removal of the serous membrane and some fibrous tissue, the epididymis may be seen to be formed of a single tube, bent in a zigzag way, whose coils are united into one mass by fibrous tissue. **Is but a single tube;**

This part of the tube, when uncoiled, measures twenty feet in length. The diameter of its canal is about $\frac{1}{70}$th of an inch, though there is a slight diminution in size towards the globus minor, but it is increased finally in the vas deferens. **length and size.**

The *vas deferens* begins opposite the lower end of the testis, at the termination of the globus minor of the epididymis. At first this part of the excretory duct is slightly wavy, but afterwards it becomes for the most part a firm round tube: near its termination it is enlarged again and bulged, but this condition will be referred to with the viscera of the pelvis. **Where it is straight it is the vas deferens;**

In its course to the urethra it ascends on the inner side of the testicle and along the bloodvessels of the spermatic cord, with which it enters the internal abdominal ring; it is then directed over the side of the bladder, and through the prostate to open into the cavity in the interior. **this opens into the urethra;**

The length of this part of the excretory duct is about two feet, and the width of its canal about $\frac{1}{30}$th of an inch. **length and size.**

Opening sometimes into the vas deferens, at the angle of union with the epididymis, is a small narrow cæcal appendage, the *vas aberrans* of Haller. It is convoluted, and projects upwards for two or three inches amongst the vessels of the cord. Like the epididymis, it is much longer when it is uncoiled, measuring sometimes fourteen inches; but it may not exceed an inch and a half in length. Its capacity is greatest at the free end. Its use is unknown. The vas aberrans may be divided or doubled. **Vas aberrans occasionally present: situation and size.**

Structure. The excretory duct of the testis is formed chiefly by a thick muscular coat, which is covered externally by fibrous tissue, and lined internally by mucous membrane. To the feel the duct is firm and wiry, like whip-cord. On a section its wall is dense and of a rather yellow colour, but it is thinnest at the head of the epididymis. **Two coats form the duct;**

The *muscular coat* is composed of longitudinal and circular fibres arranged in strata, so that both externally and internally is a longitudinal layer, the latter being very thin; and between them is the layer of circular fibres. **a muscular**

The *mucous membrane* is marked by longitudinal folds in the straight part of the canal, and by irregular ridges in the sacculated portion. A columnar epithelium, though not ciliated, covers the inner surface; but in the epididymis it is ciliated (Becker). **and a mucous.**

Vas aberrans like the duct. The vas aberrans resembles the vas deferens in structure.

Organ of Giraldès. *Organ of Giraldès.** In the spermatic cord of the fetus and child close above the epididymis, is a small whitish granular looking body ("Corps Innominé," Giraldès), about half an inch long, which is considered by its discoverer to be the remains of the Wolffian body of the embryo.

Remains of Wolffian body.

Constituents. With magnifying power its component white granules or specks are resolved into small vesicles, and convoluted tubes of varying shape, filled with a clear thick fluid, and with plexuses of bloodvessels ramifying on the exterior. Structure. The wall consists of a thin fibrous membrane, lined by flattened epithelium.

Spermatic artery. *Bloodvessels and nerves of the testicle.* The branches of the *spermatic artery* supply offsets to the epididymis, and pierce the back of the testicle to enter the posterior part of the mediastinum. Leaving the mediastinum, the vessels are finely divided in the vascular membrane lining the interior of the tunica albuginea; and offsets are continued on the fine septa between the lobes to the seminal tubules, on which they are distributed in capillary plexuses.

Spermatic vein. The *spermatic vein* begins by radicles in the plexuses around the seminal tubes, and issues from the gland at the posterior part, being there joined by veins from the epididymis. As it ascends along the cord, its branches form the spermatic plexus, and end in one trunk, which joins the vena cava on the right side, and the renal vein on the left (p. 576).

Lymphatics The arrangement of the *lymphatics* in the testicle is unknown; external to that body they ascend on the bloodvessels, and join the lumbar glands.

and nerves. The *nerves* are derived from the sympathetic, and accompany the arteries to the testis: their ending has not been seen.

Vessels of the duct. *Vessels of the vas deferens.* A special *artery* is furnished from the upper or lower vesical, and reaches as far as the testis where it anastomoses with the spermatic. *Veins* from the *epididymis* enter the spermatic vein. The *nerves* are derived from the hypogastric plexus.

Section V.

DIAPHRAGM WITH AORTA AND VENA CAVA.

Dissect bloodvessels and muscles. *Directions.* After the body is replaced in its former position on the back, the student should prepare first the diaphragm, next

* Sur un Organe placé dans le Cordon Spermatique, et dont l'existence n'a pas été signalée par les Anatomistes. Par F. Giraldès. Proceedings of the Royal Society for May, 1858.

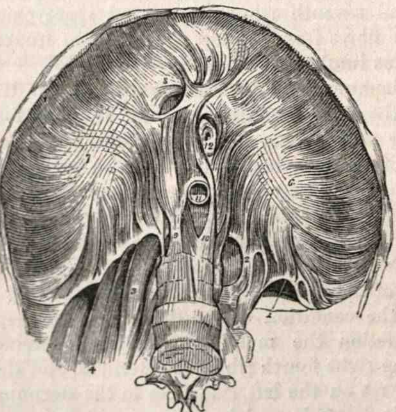
the large vessels and their branches, and then the deep muscles of the abdomen.

Dissection. For the dissection of the diaphragm it will be necessary to remove the peritoneum from its under surface, defining especially the central tendinous part, and the fleshy processes or pillars which are fixed to the lumbar vertebræ. Whilst cleaning the surface the student should be careful of the vessels and nerves on the under surface, and of others in and near the pillars. To see the diaphragm.

On the right side two aponeurotic bands or arches, which give attachment to the muscular fibres, should be dissected out:— one curves over the psoas muscle; the other extends over the quadratus muscle from the transverse process of the first lumbar vertebra to the last rib, and will be defined by separating it from the fascia covering the quadratus muscle below. Define arches.

The DIAPHRAGM (fig. 103) forms the vaulted moveable partition between the thorax and the abdomen. It is fleshy ex- Diaphragm. Situation and form.

Fig. 103.*



ternally, where it is attached to the surrounding ribs and the spinal column, and has its tendon in the centre.

The *origin* of the muscle is at the circumference, and is similar on each side of the middle line. Thus, beginning in front and Origin at the circumference.

* Under surface of the diaphragm.—1. External arched ligament. 2. Internal arched ligament. 3, 4. Psoas muscles. 5. Central part. 6. Left, and 7. Right piece of the cordiform tendon. 8. Opening for the vena cava. 9. Right crus. 10. Left crus. 11. Opening for the aorta. 12. Opening for the œsophagus.

Insertion of fibres into a central tendon.

passing backwards, the diaphragm is connected by fleshy fibres with the posterior part of the xiphoid cartilage and the inner surface of the six lower ribs; with two aponeurotic arches between the last rib and the spinal column—one being placed over the quadratus lumborum, and the other over the psoas muscle; and, lastly, it is connected with the lumbar vertebræ by a thick muscular part or pillar. From this extensive origin the fibres are directed inwards, with different degrees of obliquity and length, to the central tendon, but some have a peculiar disposition in the pillars which will be afterwards noted.

Parts in contact with the under surface, and with the upper. Attachment of border. Intervals in the muscle.

The abdominal surface is concave, and is covered for the most part by the peritoneum. In contact with it on the right side are the liver and the kidney; and on the opposite side the stomach, the spleen, and the left kidney: in contact also with the pillars is the pancreas, together with the solar plexus and the semilunar ganglia. The thoracic surface is covered by the pleura of each side and the pericardium, and is convex towards the thorax (p. 347). At the circumference of the midriff the fleshy processes of origin alternate with like parts of the transversalis muscle; but a slight interval separates the slips to the xiphoid cartilage and seventh rib, and a second space exists sometimes between the fibres from the last rib and those from the arch over the quadratus lumborum muscle.

Apertures.

In the diaphragm are certain apertures for the transmission of parts from the thorax to the abdomen, viz., one for the œsophagus, another for the vena cava, and a third for the aorta between the pillars of the muscle and the spinal column: moreover, the pillars are perforated by the splanchnic nerves.

Arch. Height in forced expiration and inspiration.

The muscle is curved across the interthoracic space, being convex towards the chest, and concave to the abdomen; and the arch reaches higher on the right than the left side (p. 347). The height of the arch is constantly varying during life with the change in the condition of the diaphragm in respiration. In forced expiration the muscle ascends and reaches the upper border of the right fourth rib at the sternum, and the upper edge of the fifth rib on the left side close to the sternum. In forced inspiration it descends, and its slope would be represented by a line drawn from the middle of the ensiform cartilage towards the tenth rib.

Use in respiration.

Action. The muscle moves up and down alternately during respiration, being depressed by the contraction of the fleshy fibres, which are attached to the ribs and spine, and being raised during their relaxation.

Form in inspiration

As the diaphragm descends it changes its shape. The central tendon which moves but slightly remains the highest part of the arch, whilst the sides which contract freely are sloped from the tendon to the wall of the thorax.

During the ascent the midriff retains a form resembling that in a state of rest, for the tendon is the lowest part of the arch, but the bulges on the sides reach rather higher. and in expiration.

With the movement of the diaphragm the size of the cavities of the abdomen and thorax will be altered. In inspiration the thorax is enlarged, and the abdomen diminished; and the viscera in the upper part of the latter cavity, viz., liver, stomach, and spleen, are partly moved from beneath the ribs, so as to be compressible by the abdominal muscles. In expiration the cavity of the thorax is lessened, and that of the abdomen is restored to its former size, and the displaced viscera return to their usual place. Effect on thorax and abdomen, and on viscera.

By the contraction of the fibres the aperture for the œsophagus in the fleshy part will be rendered smaller, and that tube may be compressed; but the other openings for the vena cava and aorta do not experience change. Influence on the apertures.

Preparatory to the making of a great muscular effort, the midriff contracts, and descends for the purpose of permitting a full quantity of air to enter the thorax, and of giving great surface attachment and steady support to the muscles inserted into the ribs. Till the effort is over the diaphragm remains in the same depressed position. State in muscular efforts.

Its action is commonly involuntary, but the movement can be controlled by the will at any stage. Action involuntary.

Parts of the diaphragm. The following named parts, which have been mentioned shortly in describing the muscle, are now to be noticed more fully, viz., the central tendon, the pillars, the arches, and the apertures. Special parts to be examined.

The *central tendon* (tendo diaphragmatis, cordiform tendon), occupies the middle of the diaphragm (fig. 103), and is surrounded by muscular fibres; the large vena cava pierces it. It is of a pearly white colour, and its tendinous fibres cross in different planes and different directions. In form it resembles a trefoil leaf; of its three segments the right (7) is the largest, and the left is the smallest. Central tendon, like a trefoil leaf.

The *pillars* (crura, appendices) are two large muscular and tendinous processes (fig. 103, 9, 10), one on each side of the abdominal aorta. They are pointed and tendinous below, where they are attached to the upper lumbar vertebræ, but large and fleshy above; and between them is a tendinous arch over the aorta. Two pillars, with certain resemblances.

In each pillar the fleshy fibres pass upwards and forwards, diverging from each other; and the greater number join the central tendon without intermixing. But the inner fibres of the two crura cross one another in the following manner:—Those of the right side (9) ascend by the side of the aorta, and pass to the left of the middle line, decussating with the fibres of the opposite Arrangement of fibres in each, as they ascend to tendon.

crus between that vessel and the opening of the œsophagus; having changed sides, the fibres are directed upwards to the central tendon around the œsophagean opening, which they limit on the left. The fibres of the other crus (10) may be traced in the same way, to form the right half of the œsophagean opening. In the decussation between the aorta and the œsophagus the fasciculus of fibres from the right crus is generally larger than that from the left, and commonly anterior to it.

Differences in the pillars.

The pillars differ somewhat on opposite sides. The right (9) is the larger of the two, and is fixed by tendinous processes to the bodies of the first three lumbar vertebræ, and their invertebral substance, reaching to the invertebral disc between the third and fourth vertebræ. The left pillar (sometimes absent) is situate more on the side of the spine (10), is partly concealed by the aorta, and does not reach so far as the right by the depth of a vertebra, or of an intervertebral substance.

Two arches,

The *arches* (ligamenta arcuata) are two fibrous bands on each side over the quadratus lumborum and psoas muscles, which give origin to fleshy fibres.

internal

The arch over the psoas (lig. arcuat. internum) is the strongest (2), and is connected by the one end to the tendinous part of the pillar of the diaphragm, and by the other to the transverse process of the first or second lumbar vertebra.

and external,

The external arch (1) over the quadratus lumborum (lig. arcuat. externum) is only a thickened part of the fascia covering that muscle, and extends from the same transverse process (first or second lumbar) to the last rib.

Apertures are—

Apertures. There are three large openings for the aorta, the vena cava, and the œsophagus; with some smaller fissures for nerves and vessels.

For the aorta; its contents.

The opening for the aorta (11) is rather behind than in the diaphragm, for it is situate between the pillars of the muscle and the spinal column: it transmits the aorta, the thoracic duct, and the vena azygos.

For œsophagus and nerves.

The opening for the œsophagus and the pneumo-gastric nerves (12) is rather above and to the left of the aortic aperture: it is placed in the muscular part of the diaphragm, and is bounded by the fibres of the pillars as above explained.

For the vena cava.

The opening for the vena cava (8) (foramen quadratum) is situate in the right division of the central tendon, or between the right and middle pieces, and its margins are attached to the vein by tendinous fibres except at the inner part.

Fissures in the pillars.

There is a *fissure* in each pillar for the three splanchnic nerves, and through that in the left crus passes also the small azygos vein. Sometimes the large azygos vein pierces the right pillar instead of accompanying the aorta.

Take away greater part

Dissection. After the diaphragm has been learnt, the ribs that support it on each side may be cut through, and the pieces of the ribs together with the fore part of the diaphragm may be taken away to make easier the dissection of the deeper vessels and muscles. But the posterior part of the diaphragm with its pillars and arches should be left, and the vessels ramifying on it should be followed back to their origin. of the diaphragm.

The large vessels of the abdomen, viz., the aorta and the vena cava, are to be cleaned by removing the fat, with the remains of the sympathetic, and the lymphatic glands; and their branches are to be followed to the diaphragm, to the kidney and the supra-renal body, to the testicle, and to the lumbar vertebræ and the spinal column. Clean aorta, cava, and branches,

In like manner the large iliac branches of the aorta and cava are to be laid bare as far as Poupart's ligament. The ureter and the spermatic vessels are to be cleaned as they cross the iliac artery; and on this large artery branches of a small nerve (genito-crural) are to be sought near the thigh. also iliac vessels.

The psoas, quadratus, and iliacus muscles are to be laid bare on the right side; but on the left side the fascia covering the muscles is to be shown, and the fat is to be cleared away from about the kidney. Dissect psoas.

The psoas muscle, the most internal of all, lies on the side of the spine, with occasionally the small psoas superficial to it: on its surface, and in the fat external to it, the following branches of the lumbar plexus will be found:—The genito-crural nerve lies on the front; and four other nerves issue at the outer border—the ilio-hypogastric and ilio-inguinal near the top, the external cutaneous about the centre, and the large anterior crural at the lower part. Along the inner border of the psoas the gangliated cord of the sympathetic is to be sought with a chain of lumbar lymphatic glands; and somewhat below the pelvic part of the muscle the obturator nerve may be recognised. Nerves of lumbar plexus.

External to the psoas is the quadratus lumborum muscle, and crossing it near the last rib is the last dorsal nerve, with an artery. Dissect quadratus lumborum

In the hollow of the hip-bone is the iliacus muscle which unites below with the large psoas. and iliacus.

The ABDOMINAL AORTA extends from the last dorsal vertebra to the left side of the body of the fourth lumbar vertebra, where it divides into the common iliac arteries. Its commencement is situate between the pillars of the diaphragm, and its termination is placed on the left side of the umbilicus, and nearly on a level with the highest part of the crest of the hip-bone. The connections of the vessel with surrounding parts have been before referred to (p. 520). Some of its branches remain to be examined. Extent of the aorta. Connections.

The *branches* of the aorta are numerous, and arise in the fol- Place of origin of the branches; lowing order:—First, are the diaphragmatic arteries, two in number, which leave the sides of the vessel immediately it appears in the abdomen. Close to the tendinous ring of the diaphragm the single trunk of the cœliac axis arises from the front; and about a quarter of an inch lower down, also on the front, the trunk of the superior mesenteric artery begins. Half an inch lower the renal arteries, right and left, take origin from the sides of the aorta. On the lateral part of the vessel, close above each renal, is the small capsular branch; and below the renal is the spermatic artery. From the front of the arterial trunk, one to two inches above the bifurcation, springs the inferior mesenteric artery; and from the angle of division the small middle sacral artery runs downwards. Four small lumbar branches on each side come from the posterior part of the vessel, opposite the bodies of the lumbar vertebræ.

their classification. The branches may be classified into two sets—one to the viscera of the abdomen (visceral), and another to the abdominal wall (parietal).

Visceral branches. The *visceral branches* are cœliac axis, superior and inferior mesenteric, renal, capsular, and spermatic. All this set, except the renal, capsular, and spermatic, have been examined.

Renal artery, The *renal arteries* leave the aorta nearly at a right angle, and are directed outwards, one on each side. Near the kidney each divides into four or five branches, which enter the renal substance between the vein and the ureter. Each artery lies beneath its companion vein, being surrounded by a plexus of nerves, and supplies small twigs to the suprarenal capsule (inferior capsular), to the ureter, and to the fatty layer about the kidney.

is beneath its vein;

gives offsets.

Difference between left and right. The arteries of opposite sides have some differences. The left is the shortest, owing to the position of the aorta. The right crosses the spine, and passes beneath the vena cava. Varieties in the number and place of origin of this artery are frequent.

Capsular artery. The *middle capsular artery* is a small branch which runs almost transversely outwards to the suprarenal body. This offset anastomoses with the other branches supplied to the suprarenal body by the renal and phrenic arteries. It is of large size in the fetus.

Spermatic artery is remarkable. The *spermatic artery* is destined for the testicle. It is remarkable for its small size in proportion to its length; for leaving the cavity of the abdomen; and for having the part in the abdomen straight, but that in the cord tortuous.

Course to the testicle. From its origin below the renal, the vessel passes downwards along the posterior wall of the abdomen to the internal abdominal ring, where it enters the spermatic cord, as before described (p. 484). In its course beneath the peritoneum the vessel runs first along the front of the psoas, crossing over the ureter; and as it leaves the abdomen it turns round the epigastric artery, but is separated from that vessel by the vas deferens. On the right side the artery crosses the vena cava. It is accompanied by the spermatic vein, and the spermatic plexus of nerves.

In the fetus before the testicle leaves the abdomen the spermatic artery is very short, but the vessel elongates as the part supplied is removed from its former site. **Condition in the fetus.**

In the female the corresponding artery (ovarian) descends into the pelvis to end in the ovary and the uterus. **In the female.**

The *parietal branches* of the aorta are the diaphragmatic, lumbar, and the middle sacral arteries. **Branches to wall of abdomen.**

The *diaphragmatic* or *inferior phrenic arteries* are directed upwards and outwards along the under surface of the diaphragm near the posterior part; the left artery passes behind the œsophageal opening, and the right behind the vena cava. **Inferior phrenic; course of left and right.**

Each ends in two branches:—One (internal) passes onwards towards the fore part of the diaphragm, and anastomoses with its fellow, and with the branch (superior phrenic) supplied to the diaphragm from the internal mammary (p. 378). The other (external) is larger, and is directed outwards to the side of the muscle, where it meets with the musculo-phrenic and intercostal arteries. **Distribution.**

Branches. Small offsets to the suprarenal body from the external division of this artery are named *superior capsular.* Some twigs are given by the left artery to the œsophagus, and by the right to the vena cava. **Small offsets.**

On the under surface of the diaphragm are two branches of the internal mammary artery; one (superior phrenic, p. 378) accompanies the phrenic nerve, and ramifies over the middle of the muscle; the other (musculo-phrenic, p. 487) appears at the margin of the thorax opposite the ninth rib. **Other arteries to diaphragm.**

The other parietal branches, viz., lumbar and middle sacral, are not learnt in this stage: the former will be seen after the lumbar plexus (p. 584), and the latter in the pelvis.

The COMMON ILIAC ARTERY is directed outwards from the bifurcation of the aorta, and divides into two large trunks opposite the fibro-cartilage between the base of the sacrum and the last lumbar vertebra:—one of these supplies the lower limb (external iliac), and the other enters the pelvis (internal iliac). **Common iliac: extent and termination.**

Placed obliquely on the vertebral column, the vessel measures about two inches in length. It is covered by the peritoneum, and is crossed by branches of the sympathetic nerve, and sometimes by the ureter. It is accompanied by a vein of the same name. Usually it does not furnish any named branch, but it may give origin to the ilio-lumbar, or a renal artery. On opposite sides the vessels have some differences. **Connections. Branches.**

The right artery is rather the longest, in consequence of the position of the aorta on the left side of the spine. To its outer **Difference between right** side at first is the vena cava, and near its termination is the psoas muscle. The companion vein is at first beneath, but becomes external to the artery at the upper part, where it enters the vena cava in that situation; and beneath the right artery also is the left common iliac vein.

and left vessel. The left artery is crossed by the inferior mesenteric vessels, and its companion vein is situate below it.

Place of origin; *Peculiarities.* The *place of origin* changes with the place of bifurcation of the aorta.

length; The *length* ranges from less than half an inch (in one case) to four inches and a half; but in the majority of instances it varies between one inch and a half and three inches (Quain).

place of division. The *place of division* varies between the middle of the last lumbar vertebra and the upper border of the sacrum; but occasionally it will be above or below those points. Generally the left artery divides lower than the right.

External iliac leads to lower limb. The EXTERNAL ILIAC ARTERY is the first part of the leading vessel of the lower limb, and is contained in the cavity of the abdomen.

Extent and direction. Its extent is from the bifurcation of the common iliac to the lower border of Poupart's ligament, where it becomes femoral. And its direction would be indicated, on the surface of the abdomen, by a line from the left of the umbilicus to the middle of the space between the symphysis pubis and the front of the iliac crest.

Connections with parts around, The vessel lies above the brim of the pelvis in its course to Poupart's ligament, and is covered closely by the peritoneum and the subperitoneal layer in all its extent. To the outer side of the vessel is the psoas, except at its termination under Poupart's ligament, where the muscle lies beneath it. A chain of lymphatic glands is placed along the front and inner side of the artery.

with other vessels Near its origin it is crossed sometimes by the ureter; and near Poupart's ligament the vas deferens bends down along its inner side, whilst the spermatic vessels and part of the genito-crural nerve lie on it for a short distance.

and veins, The position of the external iliac vein is not the same on both sides. The left vein is altogether internal to the artery; whilst the right, though internal in position on the pubes, afterwards lies beneath the arterial trunk. The circumflex iliac vein crosses it nearly an inch above Poupart's ligament.

Two branches. *Branches.* Two branches, epigastric and circumflex iliac, arise from the artery a few lines from its end, and are distributed to the wall of the abdomen (p. 487).

Unnamed offsets. Some small unnamed twigs are given by it to the psoas muscle and the lymphatic glands.

Origin varies. *Peculiarities in position of usual branches.* The epigastric and circumflex branches may wander over the lower inch and a half or two inches and a half of the artery; of the two the epigastric arises highest.

Unusual branches. Though the trunk of the vessel is commonly free from any unusual branch, it may be occupied between the middle and the end by the obturator artery, or by the internal circumflex artery of the thigh. Occasional branches from it.

Epigastric joined with obturator. Frequently the epigastric furnishes the obturator artery to the pelvis; in such cases the small communicating offset, which joins ordinarily the obturator, may be supposed to be enlarged. Or the epigastric may arise from the obturator—this having its usual course. Epigastric and obturator joined.

Iliac Veins and Vena Cava. The larger veins of the abdomen correspond so closely with the arteries, both in number, extent, and connections, as to render unnecessary the same detail in their description. As the veins increase in size from the circumference towards the centre of the body, those most distant from the heart will be first referred to. Veins of the abdomen, except vena portæ.

The *external iliac* is a continuation of the femoral vein beneath Poupart's ligament. It has an extent like the artery of the same name, and ends by uniting with the vein from the pelvis (internal iliac) to form the common iliac vein. Anatomy of external iliac. On the pubes it is inside its companion artery, and lies between the psoas and pectineus muscles; and the left vein remains internal to, but the right slips beneath its artery. Position to artery.

The veins opening into it are the epigastric and circumflex iliac (p. 488). Branches.

The *common iliac vein* ascends by the side of its accompanying artery, the right almost vertically, and the left obliquely, to the right side of the body of the fifth lumbar vertebra (the upper part), where it blends with its fellow in one trunk—the vena cava. Common iliac veins form cava.

The right vein is the shortest, and lies at first behind, but afterwards outside the artery of the same name. The left is altogether below the artery of its own side, and moreover crosses beneath the right common iliac artery. Difference in length and connections.

Each vein receives the ilio-lumbar, and the lateral sacral branch (sometimes): and the common iliac of the left side is joined by the middle sacral vein. Veins to it.

Instead of the common iliac veins uniting at the spot mentioned, they may be continued upwards, one on each side of the aorta, as high as the kidney, before the left crosses the spine to join the right and give origin to the vena cava. In these cases the left trunk receives the renal vein of the same side, and the two common iliacs are connected by a small intervening branch at the spot where they are usually united. Place where the veins join may change.

The vena cava inferior collects and conveys to the heart the blood of the lower half of the body. Taking origin, as before said, on the right side of the fifth lumbar vertebra, rather below Lower cava is by side of the aorta.

the bifurcation of the aorta, this large vein ascends on the right side of the vertebral column, and reaches the heart by perforating the diaphragm. Its connections with the surrounding parts have been already described (p. 520).

Extent and connections.

Branches from abdomen,

Branches. The cava receives parietal branches from the wall of the abdomen and the diaphragm, viz., lumbar and diaphragmatic; and visceral branches from the testicle, the kidney, the suprarenal body, and the liver.

except those of digestive apparatus.

The veins belonging to the digestive apparatus, viz., the intestinal canal, the spleen, and the pancreas, are united to form the vena portæ (p. 525); and the blood circulating in those veins reaches the cava by the venæ cavæ hepaticæ after it has circulated through the liver.

Spermatic vein

The *spermatic vein* enters the abdomen by the internal abdominal ring, after forming the spermatic plexus in the cord (p. 566). At first the vein consists of two branches in the abdomen, which lie on the sides of the spermatic artery; but these soon join into one trunk. On the left side it opens into the renal vein at right angles, and a small valve exists sometimes over the aperture; on the right side it enters the inferior cava below the renal vein.

ends differently on left and right sides.

Branches.

As the vein ascends to its destination, it receives one or more branches from the wall of the abdomen, and from the fat about the kidney.

Vein in the female.

In the female this vein (ovarian) has the same ending as in the male, and it forms a plexus in the broad ligament of the uterus. Valves are absent from this vein and its branches, but occasionally there is one at its union with the renal.

Renal vein;

The *renal* or *emulgent vein* is of large size and joins the vena cava at a right angle. It commences by many branches in the kidney; and the trunk resulting from their union is superficial to the renal artery.

position to artery;

difference on two sides.

The right is the shortest, and joins the cava higher up than the other. The left vein crosses the aorta close to the origin of the superior mesenteric artery: it receives separate branches from the spermatic and suprarenal veins of the same side.

Suprarenal ends differently on each side.

The *suprarenal vein* is of considerable size when it is compared with the body from which it comes. On the right side it opens into the cava, and on the left side into the renal vein.

Hepatic veins, before noticed.

The *hepatic veins* enter the cava where it is in contact with the liver. These veins are described in the dissection of the liver (p. 551).

Lumbar veins.

The *lumbar veins* correspond in number and course with the arteries of the same name: they will be dissected with those vessels.

Phrenic veins.

The *diaphragmatic veins* (inferior), two for each artery, spring from the under surface of the diaphragm. They join the cava either as one trunk or two.

Peculiarities in position of the vena cava. When transposition of the viscera exists, the vena cava is found on the left of the spine. But without transposition the vein may begin on the left of the spine, and remain on the same side of the aorta as high as the renal vein before it crosses that vessel to take its usual place. Vena cava may be on left side, or in part,

In ending. Instead of opening into the heart, the lower cava has been found to enter the upper cava; and in these rare instances it lies in the situation of the large intercostal or azygos vein. In this condition the inferior cava is wanting at the heart, and the blood from the lower part of the body is transmitted to the heart by the superior cava. When this deviation exists, the hepatic veins form a separate trunk, which opens into the right auricle in the situation of the inferior cava. or may end in the azygos vein.

DEEP MUSCLES OF THE ABDOMEN.

The deep muscles in the interior of the abdomen are the psoas, iliacus, and quadratus lumborum. Some fasciæ are to be seen in connection with the muscles.

The PSOAS MAGNUS reaches from the lumbar vertebræ to the femur, and is situate partly in the abdomen and partly in the thigh. Psoas magnus; situation.

The muscle *arises* from the front of the transverse processes of the lumbar vertebræ; from the bodies of the last dorsal and all the lumbar vertebræ by five fleshy pieces—each piece being connected with the intervertebral substance, and the borders of the two contiguous vertebræ; and from tendinous bands over the bloodvessels opposite the middle of the vertebræ. The fibres are directed downwards, and give rise to a roundish belly, which gradually diminishes towards Poupart's ligament. Inferiorly it ends in a tendon on the outer aspect, which receives fibres of the iliacus, and passes beneath Poupart's ligament to be *inserted* into the small trochanter of the femur. Origin. Direction of the fibres. Insertion.

The abdominal part of the muscle has the following connections:—In front are the internal arch of the diaphragm, the kidney with its vessels and duct, the spermatic vessels and the genito-crural nerve, and, near Poupart's ligament, the ending of the external iliac artery. Posteriorly the muscle is in contact with the transverse processes, with part of the quadratus lumborum, and with the innominate bone. Connections in front, behind.

The outer border touches the quadratus and iliacus; and branches of the lumbar plexus issue from beneath it. The inner border is partly connected to the vertebræ, and is partly free along the margin of the pelvis:—along the attached or vertebral part of this border lie the sympathetic nerve and some lumbar glands, with the cava on the right, and the aorta on the left side; along the free or pelvic part are the external iliac artery and vein, with the obturator nerve below it. Of outer border, of inner border along pelvis.

Use to bend the hip-joint

Action. If the femur is free to move it is raised towards the belly; and as the flexion proceeds the limb is rotated out by the attachment of the muscle to the trochanter minor. The psoas is always combined with the iliacus in flexion of the hip-joint.

with iliacus, or to bend trunk on the limb.

When the lower limbs are fixed the two muscles will draw down the lumbar part of the spine, and bend the hip-joints, as in stooping to the ground. One muscle under the same circumstances can incline the spine laterally.

Psoas parvus; origin.

The PSOAS PARVUS is a small muscle with a long and flat tendon, which is placed on the front of the large psoas, but is rarely present. Its fibres *arise*, like the large psoas, from the bodies of the last dorsal and first lumbar vertebræ, and the intervening fibro-cartilage. Its tendon becomes broader inferiorly, and is *inserted* into the ilio-pectineal eminence and the brim of the pelvis: the tendon is connected with the fascia covering the iliacus muscle.

insertion; often absent.

Use on spine

Action. If the spine is immoveable they will raise the pelvis and make tense the pelvic fascia.

and pelvis.

The pelvis being fixed the two muscles may assist in bending the lumbar part of the spinal column.

Iliacus has the form of the iliac fossa.

The ILIACUS MUSCLE occupies the hollow (iliac fossa) on the inner aspect of the hip-bone, and is blended inferiorly with the psoas. It is triangular in form, and has a fleshy *origin* from the iliac fossa and the ilio-lumbar ligament, from the base of the sacrum, and from the capsule of the hip-joint in front. The fibres pass inwards to the tendon of the psoas, uniting with it even to its *insertion* into the femur, and some reach separately that bone.

Origin; insertion.

Parts covering it on opposite sides.

Above Poupart's ligament the muscle is covered by the iliac fascia; but over the right iliacus is placed the cæcum, and over the left the sigmoid flexure. Beneath it are the innominate bone and the capsule of the hip-joint; but between it and the grooved anterior margin of the bone above the joint is a bursa. The inner margin is in contact with the psoas and the anterior crural nerve.

Beneath it.

The connections of the united psoas and iliacus below Poupart's ligament are given with the dissection of the thigh.

Use to bend hip and pelvis.

Action. The iliacus flexes the hip-joint with the psoas when the femur is moveable, and bends forwards the pelvis when the limb is fixed.

In consequence of its combination in use with the psoas, and its union with that muscle at the insertion, the two are described as the flexor of the hip-joint by Theile.

Quadratus lumborum. Origin.

The QUADRATUS LUMBORUM is a short thick muscle between the crest of the hip-bone and the last rib. About two inches wide inferiorly, it arises from the ilio-vertebral ligament, and from the iliac crest of the hip-bone for the same extent as, but behind that band. The fibres ascend to be inserted by distinct fleshy and tendinous slips into the apices of the transverse processes of the four upper or all the lumbar vertebræ, and into the body of the last dorsal vertebra, and the lower border of the last rib for a variable distance. **Insertion.**

This muscle is encased in a sheath derived from the fascia lumborum. Crossing the surface are branches of the lumbar plexus, together with the last dorsal nerve and its vessels. Beneath the quadratus is the mass of the erector spinæ muscle. **It is contained in a sheath.**

Occasionally there is a somewhat separate anterior stratum of fibres at the upper part, which is attached internally to the tips of the transverse processes of the three middle lumbar vertebræ, and externally to the lower border of the last rib. **Inner or anterior part.**

Action. Both muscles keep straight the spine (one muscle antagonising the other); and by fixing the last rib they aid in the more complete contraction of the diaphragm. If they act from the spine they may assist in raising the pelvis. **Use of both muscles,**

One muscle will incline laterally the lumbar part of the spine to the same side, and depress the last rib. **of one.**

Fascia of the quadratus. Covering the surface of the quadratus is a thin membrane, which is derived from the hinder aponeurosis of the transversalis abdominis (fascia lumborum, p. 412); it passes in front of the quadratus to be fixed to the roots of the transverse processes, to the ilio-lumbar ligament below, and to the last rib above. This fascia forms the thickened band called ligamentum arcuatum externum, to which the diaphragm is connected. **Fascia of the quadratus.**

Fascia of the iliacus and psoas. A fascia covers the two flexor muscles of the hip joint, and extends in different directions as far as their attachments. Over the iliacus muscle the membrane is thickest; and a strong accession is received from the tendon of the small psoas. Its disposition at Poupart's ligament, and the part that it takes in the formation of the crural sheath, have been before explained (p. 499). **Iliac fascia joined by tendon of small psoas; attachments below;**

Traced inwards over the psoas, the membrane will be found to be inserted into the brim of the pelvis for a short distance, and into the hip bone along the edge of that muscle. **internally both to pelvis**

When followed upwards it will be seen to become thin, and to be fixed on the one side to the lumbar vertebræ and the ligamentum arcuatum internum, but to be blended on the other with the fascia on the quadratus; at its attachment to the vertebræ it has an arched condition, joining the bands at the origin of the psoas. The fascia should be divided over the psoas on the left side, and reflected towards the brim of the pelvis. **and the vertebræ.**

Dissection. The student is now to clean the lymphatic glands that lie along the vertebræ, and to trace upwards some lymphatic vessels to the thoracic duct. **Trace the lymphatics,** To show the origin of the duct the diaphragm is to be divided over the aorta, and its pillars are to be thrown to the sides; then a piece may be cut out of the aorta opposite the first lumbar vertebra. The beginning of the duct (chyli receptaculum) and of the vena azygos may be well seen now; and the two may be followed upwards into the thorax.

and the receptaculum, and

On the left side the student may trace the splanchnic nerves and the small vena azygos through the pillar of the diaphragm, and show the trunk of the sympathetic nerve entering the abdomen beneath the arch over the psoas muscle.

splanchnic nerves.

Lumbar lymphatics of the abdomen

Lymphatic glands. A chain of glands is placed along the side of the external iliac artery, and along the front and sides of the lumbar vertebræ; they are connected by short tubes, which increase in size and diminish in number, until at the upper part of the lumbar vertebræ only three or four trunks remain to form the thoracic duct. Into these glands the lymphatics of the lower limbs, and of the viscera and wall of the abdomen, are received.

end in one duct.

Lymphatics entering glands.

Beginning of the thoracic duct,

Receptaculum chyli (Pecquet). The thoracic duct begins in the abdomen, by the union of three or four large lymphatic vessels. Its commencement is marked by a considerable dilatation, which is named receptaculum chyli, and is placed on the right side of the aorta, about opposite the first lumbar vertebra. The duct enters the thorax by passing through the diaphragm with the aorta.

at first lumbar vertebra.

Large azygos vein;

Beginning of the azygos veins. The right vein (vena azygos major) begins opposite the first or second lumbar vertebra by a small branch, which is continuous with a lumbar vein, or it may join the vena cava or the renal vein. However formed, the vein enters the thorax with the thoracic duct and the aorta, to the right of which it lies; it may pierce the crus of the diaphragm as it leaves the abdomen.

entrance into thorax.

Small azygos vein.

The left or small azygos vein begins on the left side of the spine, joining one of the lumbar veins or the renal vein; it passes through the pillar of the diaphragm, or through the aortic opening.

The anatomy of these veins is given in the description of the thorax, p. 388.

Section VI.

SPINAL AND SYMPATHETIC NERVES.

The spinal nerves of the loins resemble those in the lower part of the neck in being united in a plexus, and in supplying the limb and the contiguous parts of the trunk.

Dissection. The lumbar nerves and their plexus are to be learnt on the left side; and to bring them into view, the dissector should cut through the external iliac vessels, and afterwards scrape away the left psoas. For the most part the fleshy fibres may be removed freely; but a small branch (accessory of the obturator) should be first looked for at the inner border of the muscle. In the substance of the quadratus lumborum a communication may be sometimes found between the last dorsal and the first lumbar nerve. **Dissection of the lumbar plexus on left side,**

Branches of the sympathetic cord join the spinal nerves, and these are to be followed back along the lumbar arteries. **with sympathetic;**

On the right side the psoas is to be left untouched in order that the place of emergence of the different branches from it may be noticed. **on right.**

LUMBAR SPINAL NERVES. The anterior primary branches of the lumbar nerves enter into the lumbar plexus, with the exception of the last. Five in number, they increase in size from the first to the last, and are joined by filaments of the sympathetic near the intervertebral foramina. Before entering the plexus they supply branches to the psoas and quadratus lumborum muscles. **Four lumbar nerves enter the plexus, and supply muscles.**

The fifth nerve receives a communicating branch from the fourth, and descends into the pelvis to join the sacral plexus. After the two are united, the name *lumbo-sacral* is applied to the common trunk. **Fifth to the sacral plexus.**

The LUMBAR PLEXUS (fig. 104) is formed by the intercommunication of the first four lumbar nerves. Contained in the substance of the psoas near the posterior surface, it consists of communicating loops between the several nerves, and increases in size from above downwards, like the individual nerves. Superiorly it is sometimes united by a small branch with the last dorsal nerve; and inferiorly it joins the sacral plexus through the large lumbo-sacral cord. **Plexus how formed. Situation. Connections with nerves.**

The *branches* of the plexus supply the lower part of the abdominal wall and one of the coverings of the spermatic cord, the fore part of the thigh, and the inner side of the leg; they are six in number. **Six branches, viz.:**

Two cutaneous branches.

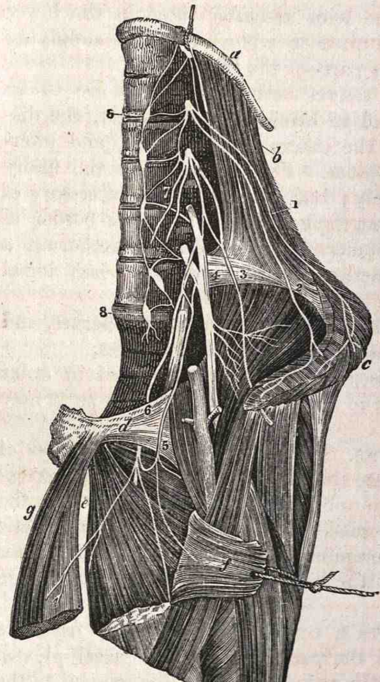
The first two branches (ilio-hypogastric and ilio-inguinal) end as cutaneous nerves of the buttock, and lower part of the abdomen and the scrotum.

Ilio-hypogastric.

The *ilio-hypogastric branch* (fig. 104, [1]) is derived from the first nerve, and appears at the outer border of the psoas muscle, near the upper part. It is directed over the quadratus lumborum to the iliac crest, and enters the wall of the abdomen by penetrating the transversalis abdominis. Its termination in the integuments of the buttock and abdomen, by means of an iliac and hypogastric branch, has been already mentioned (p. 483).

Course in abdomen.

Fig. 104.*



Ilio-inguinal arises with preceding,

The *ilio-inguinal branch* ([2]) arises with the preceding from the first nerve, and issues from the psoas nearly at the same spot. Of smaller size than the ilio-hypogastric, this branch courses outwards over the quadratus and iliacus muscles towards the front of the crest of the hip bone, where it pierces the transversalis abdominis. The farther course of the nerve in the abdominal wall, and its distribution over the scrotum and the groin, are before noticed (p. 483).

and accompanies it.

May be absent.

Its size depends upon that of the ilio-hypogastric branch; and the nerve may be absent if the latter is large.

* The lumbar plexus and branches (Schmidt).—*a.* Twelfth rib. *b.* Quadratus lumborum. *c.* Cut abdominal muscles. *d.* Front of the hip bone. *e.* Adductor brevis muscle. *f.* Pectineus cut and drawn aside. *g.* Adductor longus divided. 1. Ilio-hypogastric branch. 2. Ilio-inguinal branch. 3. External cutaneous branch. 4. Anterior crural nerve. 5. Accessory branch to the obturator. 6. Obturator nerve. 7. Genito-crural nerve—its two offsets coming separately from the plexus. 8. Lumbar part of the gangliated cord of the sympathetic nerve.

The *genito-crural nerve* (7) is distributed, as the name expresses, to the genital organs and the limb. It arises from the second lumbar nerve, and from the connecting loop between the first two; it pierces the fibres of the psoas, and descending on the surface of the muscle divides into a genital and a crural branch. Sometimes the nerve is divided in the psoas, and the branches perforate separately the muscle. **Genito-crural pierces psoas, and divides into**

The *genital branch* descends on the external iliac artery, and furnishes offsets around it: it passes from the abdomen with the spermatic vessels, and is distributed in the cremaster muscle. In the female the nerve is lost in the round ligament. **genital and**

The *crural branch* issues beneath Poupart's ligament to supply the integument of the thigh. (Cutaneous Nerves of the Thigh). **crural branch,**

The *external cutaneous nerve* of the thigh (3) arises from the second nerve of the plexus, or from the loop between it and the third, and appears about the middle of the outer border of the psoas. The nerve then takes an oblique course across the iliacus to the interval between the anterior iliac spinous processes, and leaves the abdomen beneath Poupart's ligament to be distributed on the outer aspect of the limb. **Course of external cutaneous nerve to reach the thigh.**

The *anterior crural nerve* (4) is the largest offset of the plexus, and supplies branches to the extensor muscles of the knee joint, and to the integuments of the front of the thigh and inner side of the leg. Taking origin from the third and fourth nerves, and receiving a fasciculus also from the second, this large trunk appears towards the lower part of the psoas, and lies between that muscle and the iliacus. It passes from the abdomen beneath Poupart's ligament; but before its final branching in the thigh, the nerve furnishes the following twigs:— **Origin of anterior crural nerve. Position in the abdomen; its branches**

Some small *branches* are supplied to the *iliacus* from the upper part of the nerve. **to iliacus,**

A *branch to the femoral artery*, whose place of origin varies much, is distributed around the upper part of that vessel. **to femoral artery.**

The *obturator nerve* (6) appertains to the adductor muscles of the thigh. Derived from the third and fourth nerves in the plexus, it is directed beneath the psoas to the inner or pelvic border; escaped from beneath the muscle the nerve crosses the pelvic cavity below the external iliac, but above the obturator vessels, and enters the thigh through the aperture in the upper part of the thyroid foramen. Occasionally the obturator gives origin to the following branch:— **Obturator nerve in the abdomen; ends in the thigh;**

The *accessory obturator nerve* (5) arises near the beginning of the trunk of the obturator, or from the third and fourth nerves of the plexus. Its course is along the inner border of the psoas beneath the investing fascia, and over the surface of the hip bone to the thigh, where it ends by joining the obturator nerve, and supplying the hip joint. **its accessory branch supplies hip joint.**

Sympathetic cord in the abdomen joins that in thorax; GANGLIATED CORD OF THE SYMPATHETIC. The lumbar part of the gangliated cord of the sympathetic in the abdomen is placed on the side of the spinal column (fig. 104, [8]); it is continuous upwards beneath the inner arch of the diaphragm with the thoracic part, and downwards with the pelvic portion of the same cord. It lies along the inner border of the psoas muscle, nearer the front of the vertebræ than in the thorax, and is somewhat concealed on the right side by the vena cava.

has four or five ganglia; The cord presents four or five oblong ganglia opposite the bodies of the vertebræ. Connecting branches to the spinal nerves, and visceral branches are supplied from them.

branches to the spinal nerves *Connecting branches.* From each ganglion two small branches are directed backwards along the centre of the body of the vertebra, with the lumbar artery; these unite with a spinal nerve near the intervertebral foramen, or they are often divided between two spinal nerves. The connecting branches are longest in the lumbar region in consequence of the cord being carried forwards by the psoas muscle to the fore part of the vertebræ.

and supplies the viscera. *Branches of distribution.* Most of the internal branches throw themselves into the aortic and hypogastric plexuses, and so reach the viscera indirectly. Some filaments enter the vertebræ and their connecting ligaments.

Last dorsal nerve. *Last dorsal nerve.* The anterior primary branch of the last dorsal nerve resembles the other intercostal nerves in its distribution, but differs from them in not being contained in an intercostal space. Lying below the last rib, the nerve is directed outwards across the upper part of the quadratus lumborum, and beneath the fascia covering that muscle. At the outer border of the quadratus it pierces the posterior aponeurosis of the transversalis abdominis (fascia lumborum), enters the wall of the abdomen, and ends in an abdominal and a cutaneous branch (p. 482). The lowest intercostal artery accompanies the nerve.

Course in wall of the abdomen.

Branch to muscle. Near the spine it furnishes a small branch to the quadratus muscle; and it may communicate by means of this with the first lumbar nerve.

Lumbar arteries five in number on each side. The LUMBAR ARTERIES are parietal branches of the aorta (p. 572), and are furnished to the spinal canal and the wall of the abdomen: they resemble the aortic intercostals in their course and distribution. Commonly four in number on each side, these arteries arise opposite the centre of each vertebra, and the vessels of opposite sides are sometimes joined in a common trunk; they then pass backwards beneath the pillar of the diaphragm and the psoas, to reach the intervals between the transverse processes, where each ends in an abdominal and a dorsal branch. The arteries of the right side lie beneath the vena cava.

Course: and termination in

a branch to the back, The *dorsal branch* continues onwards to the back between the transverse processes, and supplies an offset to the spinal canal. The distribution of the artery is described with the vessels of the back and spinal cord (p. 425 and 444).

The *abdominal branches* are directed outwards beneath the quadratus lumborum, and enter the posterior part of the abdominal wall, where they anastomose with the lower intercostal above, and the circumflex iliac and ilio-lumbar arteries below: these branches supply the psoas and quadratus muscles. The size of the last two varies inversely as that of the ilio-lumbar offset of the internal iliac artery.

and a branch to the wall of the abdomen.

The LUMBAR VEINS are the same in number, and have the same course as the arteries. Commencing by the union of a dorsal and an abdominal branch at the root of the transverse process, each trunk is directed forwards with the artery to the vena cava. They open into the posterior part of the cava, either singly, or conjointly with those of the opposite side. On the left side the veins are longer than on the right, and pass beneath the aorta.

The veins resemble the arteries, and open into the cava; left longest.

Around the transverse processes, and beneath the psoas muscle, the lumbar veins communicate freely with one another, with the ilio-lumbar, and sometimes with the common iliac, so as to form a plexus of veins. Issuing from the plexus is a venous trunk, the *ascending lumbar vein*, which joins the azygos vein of the corresponding side of the body.

A plexus around the transverse processes.

CAVITY OF THE PELVIS.

Definition of and situation.

THE cavity of the pelvis is but a part of the general abdominal space (p. 502), and is situate below the brim or inlet of the true pelvis.

Boundaries.

Boundaries. The space is surrounded by the firm bony ring of the pelvic bones, and therefore admits of little alteration in its form or capacity.

Behind and before.

Behind it is bounded by the sacrum and the coccyx, with the pyriformis muscles and the sacro-sciatic ligaments; and laterally and in front, by the innominate bones covered by the obturator muscles.

Below.

Inferiorly, or towards the perinæum, the cavity is limited by the fascia reflected from the wall to the viscera, and by the levatores ani and coccygei muscles: only in this last direction, where the bounding structures are moveable, can alterations be made in the size of the space.

Contents.

Contents. In the interior are contained the urinary bladder, the lower end of the large intestine or the rectum, and some of the generative organs according to the sex. All the viscera possess vessels, nerves, and lymphatics; and the serous membrane is reflected over them.

SECTION I.

PELVIC FASCIA AND MUSCLES OF THE OUTLET.

Outline of the fascia of the pelvis.

On the wall of the pelvis is a thin fascia (pelvic), which extends from the brim to the outlet, and covers the obturator muscle. At a certain level a visceral portion is directed inwards from it to the rectum and the bladder; and this is named recto-vesical fascia from the viscera with which it is connected.

Steps to define the pelvic fascia.

Dissection. To bring into view the parietal part, or the pelvic fascia, the internal iliac vessels, and the psoas (if this has not been removed in the dissection of the lumbar plexus), are to be taken away on the left side of the body.

In the pelvis,

The obturator vessels and nerve are to be cut through on the same side; and the peritoneum being detached from the wall of the pelvis, the fascia will be seen on scraping away with the handle of the scalpel a large quantity of fat.

But the membrane is now dissected only in its upper half, or as low as the situation of the piece that is prolonged inwards to the viscera. To learn the lower half, the student must raise the outlet of the pelvis, and look to it as it covers the outer wall of the ischio-rectal fossa: should the perinæum be undissected, the fat must be taken from that hollow. The lower part of the fascia will now appear on the outer side of the fossa, as it covers the obturator muscle; and if the scalpel be pushed upwards in the fossa, it will enter the pelvis where the visceral joins the parietal piece, and will mark the position of the levator ani muscle between the two. *and the perinæum.*

The PELVIC FASCIA is a thin membrane in close contact with the obturator muscle, and is fixed to the bone around the attachment of the fleshy fibres, so that it might be called the special fascia (obturator) of that muscle. *Fascia of the wall of the pelvis.*

Above, it reaches the brim of the pelvis for a short distance at the lateral aspect of the cavity; in front of that spot it does not extend so high as the brim, but following the attachment of the muscle is inserted into the bone around. *Its attachment above;* Inferiorly the fascia is united with the margin of the great sacro-sciatic ligament, and the side of the pubic arch; but below the pubes it is continued from the one hip bone to the other, so as to close the cavity of the pelvis in front for a short distance. *and below: partly closes aperture of pelvis in front;*

At a certain level, viz. that of a line prolonged from the lower part of the symphysis pubis to the ischial spine, the fascia sends inwards the recto-vesical piece to the viscera of the pelvis. The beginning of this offset is indicated by a whitish band, which marks the origin of the levator ani muscle beneath. *gives off recto-vesical piece.*

The outer surface of the fascia is in contact with the obturator muscle. The inner surface, above the recto-vesical piece, corresponds with the cavity of the pelvis, but below that, with the ischio-rectal fossa. At the posterior border of the obturator muscle it is joined by a thin membrane (fascia of the pyriformis) which is attached internally to the sacrum, and externally to the pelvic fascia and the hip bone, and passes over the sacral plexus and the pyriformis muscle, but beneath the iliac vessels, by branches of which it is perforated. *Connections of the fascia.*

The term "pelvic" is not always applied, as in the previous description, to the fascia between the brim and outlet of the pelvis, but the name "obturator" is given to the part of it below the recto-vesical piece. Those who make this distinction describe the pelvic fascia as dividing into the obturator and recto-vesical at the level of the line mentioned. *Different terms applied to the fascia.*

The *recto-vesical fascia* may be now seen in part; but it will *Recto-vesi-*

cal layer after. be better displayed after the hip bone has been taken away for the purpose of giving a side view of the pelvis.

To remove hip bone. *Dissection.* To obtain a side view of the pelvis it will be necessary to detach the left innominate bone. Detach fascia; The pelvic fascia is first to be separated from the bone and the obturator muscle, but without destroying before and behind the attachments of its white band marking the origin of the recto-vesical piece.

saw the bone, The innominate bone is next to be sawn through in front rather external to the symphysis, and behind at the articulation with the sacrum. After the hip bone has been pulled away somewhat from the rest of the pelvis, the ischial spine with the pelvic fascia attached to it may be cut off with a bone forceps; and divide soft parts; and the bone may be then removed by cutting through the pyriformis muscle, the vessels and nerves passing through the sacro-sciatic notch, and any other structure that may retain it.

then blow up bladder and distend other parts. A small block is afterwards to be placed beneath the pelvis. The bladder is to be moderately distended with air. Some tow is to be introduced into the rectum, also into the vagina if it is a female pelvis; and a small piece is to be placed in the pouch of the peritoneum between the bladder and the rectum. After the viscera are thus made prominent, the recto-vesical fascia and the ischial spine should be raised with hooks whilst the levator ani and coccygeus muscles below it are cleaned.

Outlet of pelvis is closed by *Parts closing the pelvis below.* In addition to the recto-vesical fascia, the following parts close on each side the pelvic cavity between the sacrum and the pubic symphysis.

pyriformis, by coccygeus, and sacro-sciatic ligaments, Beginning behind, the student will meet first with the pyriformis passing through the great sacro-sciatic notch, with the gluteal vessels and nerve above it. Next comes the coccygeus muscle, with the small sacro-sciatic ligament stretched between the ischial spine and the coccyx: one border of the muscle reaches towards the pyriformis, and the other to the levator ani. with vessels and nerves; Between the upper border of the last muscle and the pyriformis are placed the sacral plexus of nerves, and the sciatic and pudic vessels.

by levator ani, The greater part of the rest of the space is closed by the levator ani, which extends forwards from the coccygeus to the and by pelvic fascia below the pubes. posterior part of the symphysis pubis: it meets its fellow inferiorly, but the muscles of opposite sides are separated in front by the urethra and the prostate gland, and the interval between them is closed by the fascia lining the pelvis.

Coccygeus; origin The COCCYGEUS MUSCLE is flat and triangular, and assists to close the outlet of the pelvis. It *arises* by a narrow process from the upper part of the ischial spine, and some fibres are attached to the small sacro-sciatic ligament. Widening as it passes inwards the muscle is *inserted* into the side and the contiguous anterior surface of the coccyx, and into the side of the lower piece of the sacrum. and insertion.

The inner surface looks to the pelvis, and is in contact with the rectum on the left side; the opposite surface rests on the small sacro-sciatic ligament. The upper or hinder border is contiguous to the pyriformis muscle, only vessels and nerves intervening; and the anterior or lower border is parallel with the levator ani muscle. Connections of surfaces and borders.

Action.—Uniting in its action with the hinder fibres of the levator ani, the muscle will draw slightly forwards the coccyx. Use on the coccyx.

The LEVATOR ANI is a thin flat muscle, which is attached above to the side of the pelvis, and descends below into the outlet of the cavity, where it joins its fellow and supports the viscera. Levator ani; situation.

It *arises* anteriorly by fleshy fibres from an oblique line above the obturator internus, from the fascia on that muscle, and from the back of the triangular ligament. Posteriorly it is attached to the lower and inner surface of the ischial spine. And between those two points of bone the muscle takes origin from the under part of the recto-vesical fascia, along the line of the white band before alluded to (p. 587). All the fibres are directed downwards to the middle line, to be *inserted* after the following manner:—The anterior, the longest, descend by the side of the prostate and join, in front of the rectum, with the muscle of the opposite side in the central point of the perinæum; the middle fibres blend with the side of the rectum; whilst the posterior meet the opposite muscle behind the gut, and are attached in part to the side of the coccyx, as before described in the dissection of the perinæum (p. 450). Origin partly from bone, and partly from membrane. Insertion along middle line of the perinæum.

The anterior fibres of the levator are in contact with the triangular perinæal ligament; and the posterior are parallel to the coccygeus muscle. The upper surface is contiguous to the recto-vesical fascia and the viscera of the pelvis; and the under surface looks to the perinæum (ischio-rectal fossa). The two muscles, by their union, form a fleshy layer or diaphragm across the outlet of the pelvis, similar to that which separates the abdomen from the chest: this partition is convex below and concave above, and gives passage to the rectum. In front there is an interval between the two, which allows the urethra, together with the vagina in the female, to pass from the pelvis. Borders and surfaces. Two muscles form a fleshy diaphragm.

The anterior part of the muscle which descends by the side of the prostate, and unites with its fellow below the membranous part of the urethra, thus supporting that canal as in a sling, is named sometimes *levator seu compressor prostatæ*. Anterior fibres named levator prostatæ.

Action. By the union of the muscles of opposite sides below the urethra this tube can be raised and compressed during their contraction. Use on the urethra.

in micturition, Whilst the urine is flowing the fibres are passive, but towards the end of micturition they contract suddenly, and help the other muscles in clearing the passage.

and passage of semen: As the levatores descend by the side of the vesiculæ seminales and the prostate, they will compress and evacuate the contents of those viscera.

on coccyx. The hindmost fibres, which are fixed to the coccyx, will assist the coccygeus in moving forwards that bone.

Dissection for the recto-vesical fascia. *Dissection.* The recto-vesical fascia will be seen by detaching the fleshy fibres of the levator ani at their origin, and the coccygeus muscle from the ischial spine, and throwing both downwards. The thin membrane descends to the side of the prostate gland and the rectum, and sends downwards sheaths around those viscera. To demonstrate those sheaths one incision is to be made along the prostate, and another along the lower end of the rectum, below the attachment of the fascia; and the tubes are to be isolated from the viscera.

Recto-vesical fascia The *recto-vesical fascia* is derived from the pelvic fascia (p. 587) and supports and partly invests the viscera of the pelvis. Arising, as before said, on a level with the white band that extends from the pubes to the ischial spine, the fascia is directed inwards on the levator ani; and meeting that of the opposite side, forms a forms the floor of the pelvis. partition across the pelvis, like that of the levatores ani, which is perforated by the urethra and the rectum.

Form of its septum, The septum it forms is concave above and convex below, and divides the cavity of the pelvis from the perinæal space. It is and use; attached to, and supports the viscera which pierce it, forming for prolongations are, them ligaments; and from the under surface tubes are prolonged on the rectum and the prostate.

sheath on the rectum, The sheath on the rectum incloses the lower four inches of the intestine and gradually becomes very thin towards the anus; between it and the intestine are interposed the branches of the upper hæmorrhoidal vessels with a layer of fat.

and on prostate. On the prostate the sheath is thinner than on the rectum, and is continued forwards to the apex of that body, where it blends with the triangular ligament of the urethra: it is separated from the capsule of the prostate by a plexus of veins and some small arteries.

Fascia in the female. In the female the fascia has much the same arrangement as in the male; but the vagina, instead of the prostate, perforates the membrane, and receives a tube from it.

Ligaments of the fascia, The *true ligaments of the bladder* are two on each side, anterior and lateral, and are parts of the recto-vesical fascia.

form the anterior ligaments, The *anterior* reaches from the posterior part of the pubes to the upper surface of the prostate, and the neck of the bladder; it is a narrow white band, and encloses some muscular fibres of the bladder. Between the ligaments of opposite sides, the recto-vesical fascia dips down to reach the apex of the prostate and the triangular ligament, and closes the pelvis between the levatores ani.

The *lateral ligament* is a piece of the same fascia, which is fixed to the lateral part of the prostate gland, at the upper border, and farther back to the side of the bladder close above the vesicula seminalis: from this part of the fascia an offset is continued inwards around the vesicula seminalis, so as to join a like piece from the other side and form a sheath for both those bodies. **And lateral of the bladder.**

There are other ligaments of the bladder (false ligaments), which are derived from the peritoneum investing it, and will be described in the following section. **False ligaments of bladder.**

Ligament of the rectum. Attached to the rectum on each side is a strong wide piece of the fascia, which is connected externally to the ischial part of the hip bone, and supports that viscus like the bladder. The term ligament might be appropriately applied to it. **Ligament of rectum.**

Section II.

CONNECTIONS OF THE VISCERA IN THE MALE.

Directions. If the student should be dissecting a female pelvis, he will find the description of it at page 599.

Contents and *position.* The viscera in the cavity of the male pelvis are the lower end of the large intestine (rectum); the bladder with its excretory tube—the urethra; together with some generative organs, viz. the seminal canals and vesicles. These have the following relative situation:— **Contents of the pelvis.**

The rectum is behind all, and takes a curved course, with the convexity backwards, along the front of the sacrum and the coccyx. The bladder is placed in the concavity of the rectum, its neck being surrounded by the prostate gland; and the urethra curves forwards from it above the tube of the intestine. Beneath the bladder—between it and the rectum—are the little seminal sacs with the vasa deferentia (fig. 105). Some of these organs are partly surrounded by the peritoneum. **Outline of their position.**

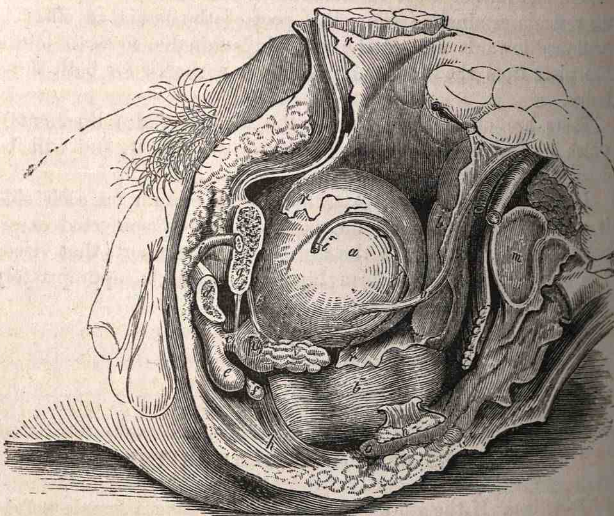
Dissection. All the recto-vesical fascia, except the anterior ligament of the bladder (fig. 105, [6]) may be taken from the viscera. The obliterated remnant of the internal iliac artery (hypogastric) should be next followed forwards along the bladder from the back of the pelvis; but the other branches of the same artery to the lower limb have been already removed. When the fat and the vessels have been cleared away, the pouch of the **Take away fascia and some vessels.**

peritoneum, in which tow has been placed, will be brought into view, with the ureter passing to the bladder.

The several viscera are to be cleaned.

The part of the bladder below the peritoneum is to be now

Fig. 105.*



cleaned, and the vas deferens, which lies on the lateral aspect of the viscus, is to be followed down to its seminal sac.

Clean prostate and vesicula.

Take away with care the remains of the sheaths of the prostate and vesicula seminalis, defining at the same time the vas deferens inside the latter.

Clean rectum.

Lastly, the layer of fascia is to be removed from the part of the rectum below the peritoneum, but the branches to the gut from the inferior mesenteric artery are to be preserved.

If the bladder has become flaccid, fill it moderately with air, in order that its connections may be afterwards studied.

The peritoneum

The *peritoneum* does not envelop the viscera of the pelvis so completely as those of the upper part of the abdomen.

covers partly the rectum;

After partly surrounding the upper portion of the rectum, and

* Side view of the male pelvis (Quain's Arteries).—*b.* Rectum. *a.* Bladder. *u.* Ureter; and *t.* Anterior ligament. *p.* Prostate. *c.* Membranous part of the urethra. *e.* Bulb of the urethra. *d.* Crus penis cut. *v.* Vesicula seminalis (left). *i.* Vas deferens of the same side (cut). *f.* Cowper's gland. *n.* Ischial spine of the left hip bone sawn off with the sacro-sciatic ligament. *r.* Pelvic part of the peritoneum. *r'.* Recto-vesical pouch.

fixing it by a process—*meso-rectum*, the membrane can be traced to the back of the bladder, where it projects for some way between this viscus and the rectum, forming the recto-vesical pouch. On each side of the rectum the serous membrane is arrested by the internal iliac artery, and gives rise to a fold, the posterior ligament of the bladder.

and partly the bladder,

Tracing the peritoneum upwards on the bladder, the student will find it covering all the posterior surface; and clothing the posterior part of each lateral region as far forwards as the obliterated hypogastric artery, but at that vessel it is reflected from the sides and summit of the bladder to the wall of the pelvis and abdomen. All the anterior surface of the bladder is therefore uncovered by peritoneum; and when the bladder is distended it rises above the pubes so as to allow of its being punctured in front without injury to the serous membrane.

leaving front and lower part uncovered.

Pouch between the rectum and bladder.

The *recto-vesical pouch* (fig. 105, *r*) is wide behind, where it corresponds with the interval between the iliac arteries, and is narrow in front between the rectum and the bladder. Anteriorly it extends into the interval between the vesiculæ seminales, reaching sometimes the prostate gland; it ends usually about one inch and a half from the tip of the coccyx. The distance of the pouch from the anus is commonly about four inches; but it will vary with the state of the bladder, for if this viscus is distended the peritoneum will be raised with it, and removed farther from the end of the intestine.

Extent and distance from the anus vary.

False ligaments of the bladder, viz.,—

False ligaments of the bladder. Where the peritoneum is reflected from the bladder to the wall of the cavity, it gives rise to a wide piece of membrane which constitutes the false ligaments of that viscus, though without any subdivision of it into parts. These are five in number:—two posterior, two lateral, and one superior.

two posterior,

The *posterior* ligament (one on each side) reaches from the back of the pelvis to the bladder, and contains the obliterated hypogastric artery, the ureter, and some vessels and nerves. Between these is the hollow of the recto-vesical pouch.

two lateral,

The *lateral ligament*, also one on a side, the widest, is reflected from the side of the bladder to the iliac-fossa and the wall of the pelvis. Along its line of attachment to the bladder is the obliterated hypogastric artery.

and one superior.

The *superior ligament* is prolonged from the upper part of the bladder to the abdominal wall, along the remains of the obliterated hypogastric vessel.

Extent of the rectum,

The RECTUM, or the lower part of the great intestine, extends from the articulation between the sacrum and the left hip bone to the anus, and is kept in place by the peritoneum and the recto-vesical fascia. The intestine is about eight inches long, and has a winding course, for it follows the curve of the sacrum

length,

and divisions. and coccyx: it is divided into three parts—upper, middle, and lower.

First piece most covered by peritoneum. The *upper part*, longer than the others, extends obliquely from the sacro-iliac articulation to the centre of the third piece of the sacrum. Surrounded almost entirely by the peritoneum which forms the meso-rectum behind it, it lies against the sacrum, and on the pyriformis muscle and the sacral plexus of the left side. In contact with it on the left are the branches of the internal iliac artery, and the left ureter. In some bodies this part of the intestine is much curved to the right side.*

Middle piece only covered in front. The *middle piece* lies beneath the bladder, and reaches to the tip of the coccyx: it is about three inches in length, and is covered at the upper part by peritoneum on the front and sides, but only in front at the lower part. Resting on it is the lower or triangular part of the bladder, with the vesiculæ seminales and vasa deferentia; and behind it are the sacrum and coccyx. On each side is the coccygeus muscle.

Last piece is uncovered. The *lower part* is about an inch and a half in length, and is curved from the tip of the coccyx to the anus: at first it is much dilated, but at the anus it is contracted. This end of the intestine is without peritoneal covering, and is supported by the lower part of the triangular ligament of the urethra, and by the levatores ani muscles.

Connections with parts around. Above the extremity of the rectum (in this position of the body) are the prostate, the membranous part of the urethra, and the bulb of the corpus spongiosum urethræ; but as the gut recedes gradually from the urethra there is an angular interval left between the two. The levatores ani muscles descend on its sides, and unite beneath it, supporting it in a sling; and the sphincter muscles surround the aperture. Sometimes dilated. Sometimes the end of the intestine within the anus is very much enlarged, especially in women and old men; and in that condition it rises up in the male on each side of the prostate.

Bladder is in pelvis when empty, The URINARY BLADDER (vesica urinaria) is situate in the fore part of the pelvis (fig. 105, *a*), and is the receptacle for the fluid secreted by the kidneys.

and projects above when full. When the bladder is contracted it is of a triangular form, and lies within the pelvis against the anterior wall of the cavity; but when distended it becomes of a conical shape, with the larger part directed towards the rectum, and the apex to the abdominal

* In the dissecting-room of the College in one Winter (1854—1855) I saw three examples of the rectum being placed on the right side of the sacrum. In two bodies the lower end of the left colon crossed the spine at the top of the sacrum, and the rectum descended through the pelvis, on the right of the middle line, to the end of the coccyx. In the third the large intestine crossed the spine twice, once at the top of the sacrum, and again about the middle of that bone.

wall. In great distension during life it is slightly curved over the anterior part of the pelvis as it projects beyond the bone.

If a line through its centre were prolonged, it would touch the abdominal wall somewhere (according to the distension) between the umbilicus and the pubes anteriorly, and the end of the sacrum or the coccyx posteriorly. **Axis.**

The organ is maintained in position by the recto-vesical fascia and the peritoneum, which form its ligaments (p. 590). For the purpose of studying its connections the bladder is divided into the following parts :—a summit and base, and a body and neck. **Divisions,**

The *summit* or apex of the bladder is rounded when moderately full, and from its anterior part three ligamentous cords are prolonged to the umbilicus; the central one of these is the remains of the urachus; and the two lateral are formed by the obliterated hypogastric arteries. If the bladder is distended the apex is above, but otherwise below the pubes. All the surface behind the obliterated vessels is covered by peritoneum. **Apex has cords on it.**

The *base* (fundus) is large, and rests on the middle piece of the rectum. In the state of emptiness of the bladder the base is scarcely prominent; but in distension of the viscus, it extends lower, and becomes widened. Connected with the under part of the bladder are the vesiculæ seminales and the vasa deferentia; and between these is a triangular space, from which the peritoneum is partly absent. **Base alters in shape; parts in contact with it.**

Surfaces of the body. The anterior part of the bladder is in contact with the posterior surface of the symphysis pubis, and with the lower part of the abdominal wall if it is distended, and is altogether free from peritoneum; whilst the posterior surface is entirely covered by the serous membrane, and is touched often by the small intestine. **Surfaces; anterior and posterior.**

Extending along the upper part of each lateral region is the obliterated hypogastric vessel; and running down behind this is the vas deferens, which passes internal to the ureter. Near the under part the ureter enters the bladder. All the side of the bladder behind the hypogastric vessel is covered by peritoneum, but the rest is uncovered. **Lateral surface.**

The *neck* (cervix) is the narrow anterior part of the bladder that joins the urethra: in the state of contraction it is the lowest part of the bladder, but in that of distension it is above the level of the fundus. It is surrounded by the prostate gland. **Neck.**

The position of the bladder in the pelvis, and the form, are not the same in early life as in the adult. For in the child this viscus rises above the brim of the pelvis into the hypogastric region of the abdomen, and the cervix is the lowest part. But in the adult the bladder is contained within the space enclosed by the pelvic bones, and the base or fundus projects inferiorly. **Position in pelvis varies with age.**

Ureter in pelvis, and entrance into bladder.

The *ureter* lies in the posterior ligament of the bladder, after crossing the common or the external iliac artery, and forms an arch below the level of the obliterated hypogastric vessel; it reaches forwards to enter the bladder near the lower part, and somewhat on the side, at the distance of one inch and a half or two inches from the prostate gland.

Position of the prostate; form; axis.

The PROSTATE GLAND (fig. 92, *p*) surrounds the neck of the bladder. It is placed about an inch below the level of the symphysis pubis, and is supported by the rectum. Its shape is conical with the base turned backwards, and its size equals nearly that of a large chesnut. In the present position of the pelvis, a line from the apex through the middle of the gland would be directed obliquely backwards and downwards towards the end of the sacrum; but in the erect state of the body, upwards and backwards from the triangular ligament.

Upper surface;

The *upper surface* is about an inch below the symphysis pubis, and is connected to it by the anterior ligaments of the bladder. On this surface are branches of the dorsal vein of the penis.

under surface.

The *under surface* has the greatest extent, and is contiguous to the rectum; this is the part that is felt by the finger introduced into the bowel through the anus.

Apex and base.

The *apex* touches the posterior layer of the triangular ligament; and the base surrounds the neck of the bladder, and the vesiculæ seminales with the vasa deferentia, limiting with these the triangular space at the fundus of the bladder.

It is contained in a sheath; size may increase.

The prostate is enveloped by a sheath obtained from the recto-vesical fascia (p. 590), and a plexus of veins (prostatic) surrounds it. Through the middle of the gland the urethra takes its course to the penis; and the ejaculatory ducts pierce it obliquely to open into the urethra. The size of the prostate alters much with increasing age, and in old people it may acquire a considerable magnitude.

Seminal vesicles, their connections.

The VESICULÆ SEMINALES (fig. 105, *v*) are two small sacculated bodies, each about two inches long, between the under part of the bladder and the rectum. Each is pyramidal in form, and has the larger end turned backwards towards the ureter, whilst the smaller is surrounded by the prostate. Along the inner side is the vas deferens. At the prostate gland the vesiculæ approach one another, only the vasa deferentia intervening; but farther backwards they diverge, and enclose with the pouch of the peritoneum a triangular space at the under aspect of the bladder. The vesiculæ are contained in a membranous sheath, which is derived from the recto-vesical fascia, and is lined by involuntary muscular fibres.

Vas deferens;

The VAS DEFERENS or the excretory duct of the testis (fig. 105, *i*) in its course to the urethra enters the abdomen by the internal abdominal ring; and crossing the obliterated hypogastric artery, is directed inwards along the side and under part of the bladder to the base of the prostate, where it forms the common ejaculatory duct by joining with the duct from the vesicula seminalis. The position of this tube to the external iliac artery has been noticed; on the bladder it may be seen to pass internal to the ureter and the vesicula of the same side. By the side of the vesicula the duct is much enlarged, and is sacculated. course; unites with duct from vesicula.

The URETHRA is the excretory passage for the urine and semen (fig. 105), and reaches from the bladder to the end of the penis. In length it measures about eight inches, and it presents one or two curves according to the state of the penis. At first the canal is directed forwards through the triangular ligament of the perinæum to the body of the penis, forming a large curve with the concavity to the pubes. Thence to its termination the urethra is applied to the penis; and whilst this body remains pendent the canal forms a second bend with the concavity downwards, but if the penis is raised it makes but one curve throughout. The canal is divided into three parts, prostatic, membranous, and spongy. The urethra; length; curved according to the condition of the penis; its divisionn.

The *prostatic part* (fig. 105, *p*) is contained in the prostate gland, and receives its name from that circumstance. Its length is about one inch and a quarter, and in the erect posture it is inclined downwards to the triangular perinæal ligament. Its connections are the same as those of the gland (p. 696). Prostatic.

The *membranous part* (fig. 105, *c*) is about three quarters of an inch long, and intervenes between the apex of the prostate and the front of the perinæal triangular ligament. It slants downwards in the erect posture to the fore part of the triangular ligament; and as the bulb of the next portion of the urethral tube is directed backwards below it, the under part measures only half an inch. Membranous.

Surrounding it are the muscular fibres of the constrictor urethræ; and close below it are Cowper's glands with the rectum. This division of the urethra is the weakest; but it is supported by the triangular ligament. Connections.

The *spongy part* is so named from its being surrounded by a cellular and vascular structure. It is applied to and assists to form the body of the penis, and terminates anteriorly in the orifice named meatus urinarius in the end of the glans. It is the longest part of the urethra, and measures about six inches. At its commencement this division of the excretory canal is surrounded for two inches by the ejaculator urinæ muscle. Spongy.

The *curve of the urethra* is the fixed bend at the inner extremity, which lies below the pubes. It extends from the bladder to an inch and a half in front of the triangular ligament, and consists of the prostatic and membranous portions with a fourth of the spongy part. Its convexity, which is turned downwards, Fixed curve of urethra: extent, where greatest.

is greatest at the fore part of the triangular ligament in the erect posture: and from this point it curves up and back to the bladder, and up anteriorly to the penis.

Voluntary and involuntary muscle surrounds it.

It is surrounded by voluntary and involuntary muscular fibres: thus, behind the ligament, by the involuntary muscular tissue of the prostate; within the ligament by the voluntary constrictor urethræ, with a thin involuntary layer inside it; and before the ligament by the voluntary ejaculator urinæ.

Size.

Its size is smallest where the tube pierces the perinæal ligament, and lies between the layers; and is largest in the middle of the prostatic part.

Dissection.

Dissection. All the tegumentary covering of the penis may be removed, to see the component parts of that body; and after its removal the spongy part of the urethra will be better seen.

Constituents and situation of the penis.

The PENIS is attached to the fore part of the pelvis, and hangs in front of the scrotum. It is constructed of two firm fibrous bodies named corpora cavernosa, which are filled with a plexus of vessels, and form the principal part of the organ. Below these is a soft spongy substance (corpus spongiosum) which surrounds the urethra, and forms the head or the glans penis. The tegumentary investment, which covers the whole, is noticed at p. 471.

Form and attachment of penis.

The *body* of the penis is grooved above and below along the middle line, and is covered anteriorly by the glans penis; along its under surface the urethra is conducted. Besides the attachment of the corpora cavernosa to the bone, the body of the penis is connected with the front of the symphysis pubis by the suspensory ligament.

Corpus spongiosum surrounds urethra, and swells into

The *corpus spongiosum urethræ* encloses the urethral canal in front of the triangular ligament, and forms the head of the penis. It is a vascular and erectile texture, like the corpora cavernosa, but is much less strong. Commencing posteriorly by a dilated part—the bulb, it extends forwards around the urethra to the extremity of the penis, where it swells out into the conical glans penis.

the bulb, which is lobed;

The *bulb* (fig. 105, *e*) is directed backwards slightly below the membranous part of the urethra, and is fixed by fibrous tissue to the front of the triangular ligament. The ejaculator urinæ muscles cover it. This enlargement presents usually a central depression, with a bulging on each side, and is subdivided into two lobes.

and the conical glans penis.

The *glans penis* is somewhat conical in form, and covers the truncated end of the corpora cavernosa. Its base is directed backwards, and is marked by a slightly prominent border—the *corona glandis*; it is also sloped obliquely along the under aspect, from the apex to the base. In the apex is a vertical slit, in which the urethral canal terminates; and below that aperture is an excavation which contains the frænum preputii.

Section III.

CONNECTIONS OF THE VISCERA IN THE FEMALE.

In the pelvis of the female are contained the lower end of the intestinal tube, and the bladder and the urethra, as in the male; but there are in addition the generative organs, viz., the uterus with its accessories, and the vagina. Contents of the female pelvis,

Position. The rectum is posterior to the rest as in the male pelvis, and forms a like curve. In the concavity of the bent intestine lie the uterus with its appendages, and the tube of the vagina. And in front of all are the bladder and the urethral canal. There are three tubes connected with the viscera in this sex; and all are directed forwards, one above another, to the surface, viz., the tube of the urethra, of the vagina, and of the rectum. and their situation.

Directions. The description in Section I. (p. 586) must be used for instructions respecting the removal of the innominate bone; for the anatomy of the fasciæ; and for the muscles of the outlet of the pelvis. Use description of male pelvis.

After the student has learnt the fasciæ and the muscles, which are nearly alike in both sexes, he may make the following special dissection of the viscera of the female pelvis.

Dissection. On taking away the recto-vesical fascia and much fat, the viscera will come into view. To maintain the position of the uterus, raise it up with a piece of string passed through the upper part. The reflections of the peritoneum on the viscera are to be preserved; and a piece of cotton wool is to be placed between the rectum and the uterus. Then clean the viscera of the female pelvis.

The obliterated part of the internal iliac artery is to be followed on the bladder; and the ureter is to be traced forwards by the side of the uterus to the bladder. Dissect vessels.

Afterwards the urethra, the vagina, and the rectum are to be cleaned and partly separated from one another at the anterior part of the pelvis; but the arteries on the rectum are to be preserved. Isolate viscera.

The *peritoneum* gives a partial covering to the viscera, as in the male pelvis. Investing the upper part of the rectum, and forming behind it the meso-rectum, the membrane is continued for a short distance on the front of the intestine to the posterior part of the vagina, and the back of the uterus; in the female the pouch between the rectum and bladder is small, because the vagina intervenes between the two, and arrests so to express it, the passing forwards of the peritoneum. Reflections of the peritoneum.

It covers the posterior, and the greater part of the anterior sur- Folds or ligaments are— face of the uterus, and can be traced to the bladder without again touching the vagina. On each side of the uterus it forms a wide fold (broad ligament), which attaches that viscus to the wall of the abdomen.

As the peritoneum is followed upwards it will be found to cover the posterior surface of the bladder, and the lateral part behind the position of the obliterated hypogastric artery.

In the pelvis the serous membrane forms the following ligaments for the uterus and bladder.

Broad ligament of the uterus, The *broad ligament of the uterus* passes from the side of the uterus to the wall of the abdomen, and supports that organ in the cavity of the pelvis. By its position across the pelvis, it divides the cavity into an anterior and a posterior portion: in the former are placed the bladder, urethra, and vagina; in the latter the upper part of the rectum, and the small intestine when it reaches the pelvis.

which is sub-divided into three parts.

Each ligament shows traces of a subdivision into three pieces, corresponding with the bodies contained between its two layers. Thus there is a posterior piece belonging to the ovary and its ligament; an anterior, near the upper part, which is appropriated to the round ligament; and a middle piece, the highest of all, surrounds the Fallopian tube. It is at the free extremity of the Fallopian tube that the peritoneum is continuous with a mucous membrane.

Anterior and posterior of uterus. *Anterior and posterior ligaments of the uterus.* As the peritoneum is reflected from the rectum to the uterus, and from the uterus to the bladder, it forms two anterior and two posterior folds or ligaments, one on each side. The anterior or *vesico-uterine* pair is smaller than the posterior or *recto-uterine.*

Recto-uterine pouch. The *recto-uterine pouch* corresponds with the recto-vesical in the male. On each side it is bounded by the obliterated hypogastric artery and the ureter: and below it reaches beyond the uterus, so as to touch the back of the vagina.

Five ligaments of the bladder. The *false ligaments of the bladder* are the same as in the male, and are five in number, viz. two posterior, two lateral, and a superior: they are all blended in one large piece of peritoneum that reaches from the bladder to the side and front of the pelvis. In the female the posterior ligament, containing the ureter and the vessels of the bladder, is less marked than in the male, because the uterus intervenes and pushes aside the vessels.

Connections of the rectum, viz., The RECTUM is not so curved in the female as in the male, and is generally larger. Descending along the middle of the sacrum and coccyx to the anus, the intestine is divided into three parts:—

of upper, The *first part* ends over the third piece of the sacrum, and is enveloped by the peritoneum, except posteriorly: its connections are similar to those of the rectum in the male.

The *middle part* reaches to the tip of the coccyx, and has the vagina above and in contact with it. The peritoneum extends on the front for a short distance. middle,

The *lower part* curves to the anus away from the vagina so as to leave between the two a space which corresponds, on the surface of the body, with the part of the perinæum between the anus and the vulva. The levatores ani are on the sides, and unite below it, and the sphincter muscles surround the extremity. and lower part.

The UTERUS is somewhat conical in shape, and is flattened from before backwards. Unless enlarged, it lies below the brim of the pelvis between the bladder and the rectum; and it is retained in place by the broad and other ligaments. Its wider end is free and placed upwards, and the lower end communicates with the vagina. Uterus: form and situation.

This viscus is directed forwards, so that its position is oblique in the cavity of the pelvis; and a line through its centre would correspond with the axis of the inlet of the pelvic cavity, but not with that of the vagina. Position to the brim of pelvis. Axis.

The *anterior flattened surface* is covered by peritoneum, except in the lower fourth where it is in contact with the bladder. The *posterior surface*, rounded, is invested altogether by the serous membrane. Surfaces.

The *upper end* (fundus vel basis uteri) is the largest part of the organ, and is in contact with the small intestine. The *lower end*, or the neck (cervix uteri) is received into the vagina. Extremities.

To each *side* are attached the broad ligament with the Fallopian tube, the round ligament, and the ovary. On the side are

The *Fallopian tube*, four inches long, is contained in the upper or free border of the ligament. One end is connected to the upper angle of the uterus, whilst the other is loose in the cavity of the pelvis. At the uterine end the tube is of small size, but at the opposite extremity it is dilated like a trumpet, and fringed, forming the corpus fimbriatum. Fallopian tube,

The *round* or suspensory *ligament* is a fibrous cord about five inches long, which is directed outwards through the internal abdominal ring and the inguinal canal to its ending in the groin. This cord lies over the obliterated hypogastric, and the external iliac artery; and it is surrounded by the peritoneum, which accompanies it a short way into the canal. round ligament,

The *ovary* is placed nearly horizontally, and bulges at the posterior aspect of the broad ligament; it is connected to the uterus at the inner end by a special fibrous band, one inch and a half in length, the *ligament* of the ovary. Its form is oval, and its margins are turned forwards and backwards. Its size is very variable. and the ovary and its ligament.

The VAGINA is the tube by which the uterus communicates with the exterior of the body. It is somewhat cylindrical in Vagina: extent and form;

length; axis. shape, though flattened on the front and back; and its length is about five inches. As it follows the bend of the rectum it is slightly curved, and its axis therefore corresponds at first with the centre of the outlet, but higher up with that of the cavity of the pelvis.

Connections. In front the vagina is in contact with the base of the bladder, and the urethra; and beneath or below it is the rectum. To each side is attached the recto-vesical fascia, which sends a sheath along the lower half of the tube. The upper end receives the neck of the uterus by an aperture in the anterior or upper wall; and the lower end is the narrowest part of the canal, and is surrounded by the sphincter vaginæ muscle. A large plexus of veins surrounds the vagina.

Lower end partly closed. In children, and in the virgin, the external aperture is closed by the hymen.

Bladder resembles that of the male, The BLADDER is placed at the anterior part of the pelvis, above the vagina and in contact with the back of the pubes. Its position and connections so closely resemble those of the bladder in the male body, as to render unnecessary any further description (p. 594). The chief differences in the bladder of the two sexes are the following:—

Differences in the two sexes. In the female the bladder is larger than in the male, and its transverse exceeds its vertical measurement. The base is of less extent, and is in contact with the vagina and the lower part of the uterus; and it does not reach below the level of the urethra, so as to form a pouch as in the male. On the side of the viscus there is not any vas deferens; and the prostate does not project around the neck.

Course of ureter. The *ureter* has a longer course in the female pelvis than in the male before it reaches the bladder. After crossing the internal iliac vessels, it passes by the neck of the uterus ere it arrives at its destination.

Urethra; length and form; The *urethra* is a small narrow tube about one inch and a half long, which curves slightly below the symphysis pubis, the concavity being upwards, and corresponds with the two hinder parts (prostatic and membranous) of the male urethra. Its situation is above the vagina, and its external opening is placed within the vulva.

connections with parts around. In its course to the surface it is embedded in the tissue of the vaginal wall, and perforates the triangular ligament of the perinæum; and it is surrounded by the muscular fibres of the constrictor and orbicularis urethræ (p. 459). A plexus of veins surrounds the urethra as well as the vagina.

SECTION IV.

VESSELS AND NERVES OF THE PELVIS.

This section is to be used by the dissectors of both the male and female pelvis.

In the pelvis are the internal iliac vessels, and their branches to the viscera; the sacral plexus and its nerves; and the sympathetic nerve, consisting of both a gangliated cord and offsets of the hypogastric plexus. **Vessels and nerves of the pelvis.**

Directions. The internal iliac vessels are to be dissected on the right side. But the air should be previously let out of the bladder; and this viscus and the rectum, with the uterus and the vagina in the female, should be drawn from their situation in the centre of the pelvis.

Dissection. The peritoneum and the loose tissue and fat are to be removed from the trunks of the vessels, as well as from the branches of the artery that leave the pelvis or supply the viscera; and the obliterated cord of the hypogastric artery is to be traced on the bladder to the umbilicus. **To dissect the vessels of the pelvis.**

With the vessels are offsets of the hypogastric plexus of nerves, but in the present state of the body these will probably not be seen; but in dissecting the vessels to the bladder and rectum, branches of the sacral spinal nerves will come into view. **Nerves.**

The veins in a general dissection may be removed to make clean the arteries. **Veins.**

When the vessels are quite prepared, the bladder may be again distended, and the viscera replaced.

The INTERNAL ILIAC ARTERY is one of the trunks resulting from the division of the common iliac artery, and furnishes branches to the viscera and the wall of the pelvis, to the generative and genital organs, and to the limb. **Destination of internal iliac artery.**

In the adult the vessel is a short trunk, of large capacity, which measures about an inch and a half in length. Directed downwards as far as the sacro-sciatic notch, the artery terminates in two large branches, from which the several offsets are furnished. From the extremity a partly obliterated vessel (hypogastric) extends forwards to the bladder. **Size and length; termination;**

In entering the pelvis the artery lies in front of the lumbo-sacral nerve, and is contained in the fold of peritoneum forming the posterior ligament of the bladder. It is accompanied by the internal iliac vein, which is posterior to it, and somewhat to the outer part on the right side. **position of vein; connections.**

The *branches* of the artery are numerous, and arise usually in the following manner:—From the posterior division of the **Branches.**

trunk arise the ilio-lumbar, lateral sacral, and gluteal branches. And from the anterior portion come the vesical (upper and lower), hæmorrhoidal, obturator, sciatic, and pudic. In the female there are in addition the uterine and vaginal branches.

Hypogastric artery in the fœtus,

Artery in the fœtus. In the fœtus the *hypogastric artery* takes the place of the internal iliac, and leaves the abdomen by the umbilicus. At that time it is larger than the external iliac artery; and, entering but slightly into the cavity of the pelvis, it is directed forwards to the back of the bladder, and then upwards along the side of that viscus to the apex.

Beyond the bladder the artery ascends along the posterior aspect of the abdominal wall with the urachus, converging to its fellow. Finally at the umbilicus the vessels of opposite sides come in contact with the umbilical vein, and, passing from the abdomen through the aperture at that spot, enter into the placental cord, and receive the name *umbilical.*

In the fœtus, as in the adult, similar branches are furnished by the artery, though their relative size at the two periods is very different.

and its transformation into that of the adult.

Change to adult state. When uterine life has ceased the hypogastric artery diminishes in consequence of the arrest of the current of blood through it, and finally becomes obliterated more or less completely as far back as an inch and a half of its commencement. The part that is unobliterated becomes the internal iliac; and commonly the rest of the obliterated hypogastric remains pervious by means of a very small canal as far as the upper part of the bladder, and gives origin to the vesical arteries.

Trunk varies in length,

Peculiarities. The *length* of the internal iliac artery varies from half an inch to three inches, its extreme measurements; but in two thirds of a certain number of bodies (Quain) it ranged from an inch to an inch and a half. The increased and diminished extent of the internal, is dependent upon the shortening and lengthening of the common iliac artery.

and in ending.

The *ending* of the vessel may be at any spot between the usual place of origin and termination.

Size.

Size. When the femoral trunk is derived from the internal iliac, and is placed at the back of the thigh, the parent vessel is larger than the external iliac.

Absence.

Absence. In one body the internal iliac was absent on the left side, and its usual offsets were obtained at intervals from the external iliac which dipped into the pelvis.

Branches of the posterior part.

The branches arising from the posterior portion of the internal iliac, are, ilio-lumbar, lateral sacral, and gluteal.

Ilio-lumbar has an

The *ilio-lumbar branch* passes outwards beneath the psoas muscle and the obturator nerve, but in front of the lumbo-sacral nerve, and divides into an ascending and a transverse branch in the iliac fossa.

ascending and

The ascending or *lumbar* offset, which is beneath the psoas, supplies that muscle and the quadratus lumborum, and anastomoses with the last lumbar artery: it sends a small *spinal* branch through the foramen between the sacrum and the last lumbar vertebra.

a transverse branch. The transverse or *iliac* part divides into branches that ramify in the iliacus muscle, some running over and some beneath it. At the iliac crest these branches anastomose with the lumbar and circumflex iliac arteries; and some twigs from the deep branches communicate with the obturator artery, and enter the innominate bone.

Lateral sacral arteries The *lateral sacral branches* are two in number, superior and inferior, but the upper is the largest: they correspond in situation with the lumbar arteries, and form a chain of anastomoses by the side of the apertures in the sacrum. These branches supply the pyriformis and coccygeus muscles, and anastomose with the foregoing, as well as with the middle sacral artery. A small *spinal branch* enters the spinal canal through each aperture in the sacrum.

supply spinal branch.

Gluteal artery, The *gluteal artery* is a short thick trunk, which appears to be the continuation of the posterior division of the internal iliac. Its destination is to the gluteal muscles on the dorsum of the innominate bone; and it is transmitted from the pelvis above the pyriformis muscle, with its accompanying vein and the superior gluteal nerve.

Small offsets. In the pelvis this artery gives small *branches* to the contiguous muscles, viz., the iliacus, pyriformis, and obturator, and a nutritious artery to the hip bone.

Branches of anterior part. The branches from the anterior portion of the internal iliac artery are the following:—

Vesical arteries; The *vesical arteries*, superior and inferior, are distributed to the upper and lower parts of the bladder.

upper, The *upper vesical*, three or four in number, arise at intervals from the partly obliterated hypogastric trunk; the lowest of these is sometimes called *middle vesical* branch. Offsets are furnished from those branches to all the body and the upper part of the bladder.

middle,

and lower, The *lower vesical* artery arises from the front of the internal iliac in common with a branch to the rectum, or with one to the vagina in the female. It is distributed to the base of the bladder, the vesiculæ seminales, and the prostate. A small offset from this artery, or from the upper vesical set, is furnished to the vas deferens, and ramifies on it.

with an offset to the rectum. The *branch to the rectum* (middle hæmorrhoidal) is commonly supplied by the inferior vesical, as before said, or by the pudic. It is spent on the anterior and lower part of the rectum, and on the vagina in the female; and anastomoses with the superior and inferior hæmorrhoidal arteries.

Obturator artery The *obturator artery* crosses the pelvis to reach the aperture of courses across pelvis. exit, and is distributed outside. The branch springs usually from the anterior trunk resulting from the division of the internal iliac artery, and is directed forwards below the brim of the pelvis to the aperture in the upper part of the thyroid foramen. Passing through that opening the artery ends in two branches, which join on the membrane closing the thyroid foramen, and lie beneath the muscle in that situation. In the pelvis the artery has its companion nerve above, and vein below it; and it gives origin to the following small branches:—

Offsets in pelvis;

iliac branch, *Iliac branch.* Amongst other small offsets, the obturator furnishes a twig to the iliac fossa to supply the bone and the iliacus muscle; this anastomoses with the ilio-lumbar artery.

pubic branch. The *pubic branch*, arising as the artery is about to leave the pelvis, ascends on the posterior aspect of the pubes, and communicates with the corresponding branch of the opposite side, and with an offset sent downwards from the epigastric artery. There may be more than one branch to the pubes.

Its origin from epigastric or iliac, or from both. *Peculiarities.* The obturator artery may arise at the front of the pelvis from the epigastric, instead of the internal iliac, and turn down almost vertically to the thyroid aperture. Or, it may begin by two roots, one from the epigastric, another from the internal iliac, the pieces varying in size in different instances. The position of the obturator to the internal crural ring, in the instances of its origin from the epigastric, has been before alluded to (p. 500).

From external iliac. In some bodies the obturator may be found to take origin from the external iliac artery

Frequency of the different origins. An account of the frequency with which these different peculiarities occur, will be found in Mr. Quain's work on the "Anatomy of the Arteries." Suffice it to say here, that the origin from the internal iliac is the most frequent; that from the epigastric next; and the origin from the two sources, and the external iliac artery, the least frequent.

Sciatic artery in the pelvis, and outside it. The *sciatic artery* is the next largest branch to the gluteal, and may be considered the offset by which the internal iliac artery terminates. The artery is continued over the pyriformis muscle and the sacral plexus to the lower part of the sacro-sciatic notch, where it leaves the pelvis between the pyriformis and the coccygeus. External to the pelvis it divides into branches beneath the gluteus maximus, and is distributed to the buttock. In the pelvis it supplies the pyriformis and coccygeus muscles.

Pudic artery in the pelvis. The *pudic artery* supplies the perinæum and the genital organs, and has nearly the same connections in the pelvis as the sciatic, from which it often springs. If the artery comes as a separate trunk from the internal iliac, it accompanies the sciatic, though external to it, and leaves the pelvis between the pyriformis and coccygeus. At the back of the pelvis it winds over the ischial spine of the hip bone, and enters the perinæal space. (See p. 451.)

Some small offsets. In the pelvic part of its course the artery gives some unimportant offsets, and frequently the middle hæmorrhoidal branch arises from it.

Accessory pudic (Quain). The pudic artery is sometimes smaller than usual, and fails to supply some of its ordinary perinæal branches, especially the terminal for the penis. In those cases the deficient branches are derived from an accessory artery, which takes origin mostly from the trunk of the pudic inside the pelvis, and courses forwards on the side of the bladder and the upper part of the prostate gland, to perforate the triangular perinæal ligament. It furnishes branches to the penis to supply the place of those that are wanting. **An accessory pudic branch.**

The branches of the internal iliac artery that are peculiar to the female are two, the uterine and vaginal. **Branches in the female.**

The *uterine artery* passes inwards between the layers of the broad ligament to the neck of the uterus. At that part the vessel changes its direction, and ascends to the fundus. Numerous branches enter the substance of the uterus, and ramifying in it, are remarkable for their tortuous condition. Hyrtl denies the anastomosis of the vessels of opposite sides in the child. **Uterine artery supplies uterus.**

At the neck of the uterus some small twigs are supplied to the vagina and the bladder; and opposite the ovary a branch bends outwards to anastomose with the ovarian artery (spermatic) of the aorta. The special vaginal artery may arise from it below. **Offsets to vagina, joins ovarian.**

The *vaginal artery* seldom arises separately from the internal iliac. Combined with the preceding, or with the branch to the rectum, this artery extends along the vagina, and ramifies in its wall as low as the outer orifice. **Vaginal artery.**

Other arteries in the pelvis. The remaining arteries in the pelvis, which are not derived from the internal iliac, are the ovarian, superior hæmorrhoidal, and middle sacral. **Branches of the aorta.**

The *ovarian artery* has been described in part with the branches of the aorta, and has been traced to the pelvis (p. 573). After passing the brim of the pelvis it becomes tortuous, and enters the broad ligament to be distributed to the ovary: it supplies an offset to the Fallopian tube, and another to the round ligament; and a large branch anastomoses internally with the uterine artery. **Ovarian artery: offsets.**

The *superior hæmorrhoidal artery* is the continuation behind the rectum of the trunk of the inferior mesenteric, and divides into two branches near the middle of the sacrum. From the point of division the branches are continued along the rectum, one on each side; and finally end in about six branches, which pierce the muscular layer of the gut three inches from the end, and terminate opposite the inner sphincter in anastomotic loops beneath the mucous membrane: they anastomose above with the middle, and below with the inferior hæmorrhoidal arteries. **Superior hæmorrhoidal ends in loops.**

Middle sacral, which

The *middle sacral artery*, a small branch from the bifurcation of the aorta, descends along the middle line over the last lumbar vetebra, the sacrum, and the coccyx, and terminates at the lower part of the spinal column where it anastomoses with the lateral sacral arteries.

has lateral offsets.

In its course the artery gives small branches laterally, opposite each piece of the sacrum, to anastomose with the lateral sacral arteries, and to supply the nerves, and the bones with their periosteum. Sometimes a small branch is furnished by it to the lower end of the rectum, to take the place of the middle hæmorrhoidal artery.

Internal iliac vein: position to its artery.

The INTERNAL ILIAC VEIN receives the blood from the wall of the pelvis and the pelvic viscera, by branches corresponding for the most part with those of the arteries. The vein is a short thick trunk, which is situate at first on the inner side of the internal iliac artery; but as it ascends to join the external iliac, it passes behind, and on the right side reaches even the outer aspect of its companion artery.

Its branches that are peculiar are

Branches. Most of the branches entering the trunk of the internal iliac vein, have the same anatomy as the arteries; but the following visceral branches,—the pudic and dorsal of the penis, the vesical and hæmorrhoidal, the uterine and vaginal, have some peculiarities.

pudic vein,

The *pudic vein* receives roots corresponding with the branches of its artery in the perinæum, but not those corresponding with the offsets of the artery on the dorsum of the penis. Its hæmorrhoidal branch communicates with a large plexus around the lower end of the rectum beneath the mucous membrane (plexus hæmorrhoidalis), in which the superior hæmorrhoidal vein commences.

dorsal vein of penis,

The *dorsal vein* of the penis receives roots from the corpora cavernosa and corpus spongiosum of the penis, and piercing the triangular ligament of the urethra, divides into two, a right and a left branch, which enter a plexus around the prostate.

vesical,

The *vesical veins* commence in a plexus about the lower part of the bladder, and anastomose with the prostatic and hæmorrhoidal veins.

uterine, and

The *uterine veins* are numerous, and form a plexus in and by the side of the uterus. This plexus inosculates above with the ovarian plexus, and below with one on the vagina.

vaginal veins.

The *vaginal veins* surround their tube with a large vascular plexus.

Parietal veins.

Parietal veins of the pelvis. The three internal veins of the wall of the pelvis, viz., the ilio-lumbar, lateral sacral, and middle sacral, open into the common iliac vein.

Dissection of the nerves

Dissection. To dissect the nerves of the pelvis on the right side it will be necessary to detach the triangular ligament with the urethra from the arch of the pubes; and to cut through on the right side the recto-vesical fascia and the levator ani, together with the visceral arteries, in order that the viscera may be drawn from the side of the pelvis. If the bladder is distended let the air escape from it. **of the pelvis.**

By means of the foregoing dissection the sacral nerves will be seen as they issue from the sacral foramina. The dissector should follow the first four into the sacral plexus; and some branches from the fourth to the viscera, and the fifth sacral nerve. A branch of nerve, superior gluteal, is to be shown arising from the lumbo-sacral cord, as this passes to the sacral plexus. **First four,**

The last sacral and the coccygeal nerve are of small size, and will be found coming through the coccygeus muscle close to the coccyx; these are to be dissected with care, and the student will find them best by tracing the connecting filaments which pass from one to another, beginning above with the offset from the fourth nerve. **last and coccygeal,**

Opposite the lower part of the rectum, bladder, and vagina is a large plexus of the sympathetic, the pelvic plexus, which sends branches to the viscera along the arteries. This plexus is generally destroyed in this stage of the dissection; but if any of it should remain the student may trace the offsets distributed from it, and the communicating branches with the spinal nerves. **sympathetic.**

SACRAL SPINAL NERVES. The anterior primary branches of the sacral nerves are five in number, and decrease suddenly in size from above downwards; for whilst the first two are large trunks, the last two are small and slender. Issuing by the apertures in the front of the sacrum (the fifth nerve excepted) they receive short filaments of communication from the gangliated cord of the sympathetic. The first three nerves and part of the fourth enter the sacral plexus, but the fifth ends on the back of the coccyx. **Sacral nerves are five;** **those that are peculiar are**

The coccygeal nerve and the peculiarities of the fourth and fifth sacral will be noticed before the plexus formed by the other nerves is described.

The *fourth nerve* divides into two parts, as above stated:— one communicates with the sacral plexus; the other distributes the following branches to the viscera and the surrounding muscles, and joins the fifth nerve. **fourth, which gives**

The *visceral branches* supply the bladder and the vagina, and communicate with the sympathetic nerve to form the pelvic plexus. Sometimes these branches come from the third sacral nerve. **visceral,**

The *muscular branches* are three in number. One rather long branch enters the levator ani on its visceral aspect; another supplies the coccygeus; and the third reaches the perinæum by piercing the levator ani muscle (p. 452). **and muscular offsets.**

Fifth is below apertures in sacrum; ends on coccyx.

The *fifth nerve* comes forwards between the sacrum and coccyx, and pierces the coccygeus muscle. As soon as it appears in the pelvis it receives the communicating branch from the fourth nerve; it is then directed downwards in front of the coccygeus, where it is joined by the coccygeal nerve, and perforates that muscle to end on the posterior surface of the coccyx near the tip.

Coccygeal nerve.

The *coccygeal nerve* (sixth sacral), after leaving the lower aperture of the spinal canal, appears through the coccygeus muscle, and joins the fifth sacral nerve in the maner above stated.

Sacral plexus; situation, and form.

SACRAL PLEXUS. This plexus is formed by the lumbo-sacral cord, the first three sacral nerves, and part of the fourth sacral nerve; and it is situate on the pyriformis muscle, beneath the sciatic and pudic branches of the internal iliac artery. The nerves entering it converge towards the large sacro-sciatic notch, and unite in a flat band. From that spot the plexus becomes gradually smaller towards the outer end; and, leaving the pelvis below the pyriformis, terminates in branches for the limb at the lower border of that muscle.

Branches to muscles inside the pelvis;

Branches. Most of the branches of the plexus arise outside the pelvis, and are distributed to the back of the lower limb. Only two internal muscles of the pelvis (pyriformis and obturator internus) receive nerves from it.

one to obturator,

The *nerve of the obturator internus muscle* arises from the part of the plexus formed by the union of the lumbo-sacral with the first sacral nerve; it leaves the pelvis with the pudic artery, and winding over the ischial spine of the hip bone and through the small sacro-sciatic notch, enters the muscle on the perinæal surface.

two to pyriformis.

The *nerves of the pyriformis* are commonly two in number, and arise from separate parts of the plexus: they enter the muscle at its visceral aspect.

Pudic nerve now seen at its origin.

The *pudic nerve*, like the artery of the same name, supplies the parts in the perinæum, and the genital organs. The nerve arises at the lower part of the plexus, and accompanies its artery through the small sacro-sciatic notch to its destination (p. 452).

Branches to the lower limb after.

The remaining branches of the plexus, viz., the small and great sciatic nerves, with muscular offsets to the gluteus, gemelli, and quadratus femoris, are described with the lower limb. See the Dissection of the Buttock.

Trace out the sympathetic.

Dissection. Besides the large plexus of the sympathetic by the side of the bladder, the student will have to dissect the part of the gangliated cord that lies in front of the sacrum: its several ganglia (three or four), and their branches, will come into view on the removal of the areolar tissue.

Sympa-

SYMPATHETIC NERVE. In the pelvis the sympathetic nerve consists of a gangliated cord on each side, and of two lateral plexuses for the supply of the viscera. **thetic in the pelvis.**

The gangliated cord joins that of opposite side below in a ganglion. The GANGLIATED CORD lies on the front of the sacrum and internal to the series of apertures in that bone. It is continuous superiorly with the lumbar part of the cord by a single or double internodal piece; whilst inferiorly it converges to its fellow, and is united by a loop with it in front of the coccyx, on which is situate a single median ganglion (*gang. impar*). Each cord is marked by ganglia at intervals, the number varying from three to five; from them branches of communication pass outwards to the spinal nerves, and some filaments are directed inwards in front of the sacrum. **Offsets of the ganglia**

to the spinal nerves. The *connecting branches* are two to each ganglion, gray and white, and are very short; and like those of the lumbar ganglia, they may enter two sacral nerves instead of one. The gray connecting cord unites the ganglion with the spinal nerve, but the white one is continued over the ganglion to the plexuses for the viscera (Beck).

To the hypogastric plexus and the viscera. The *internal branches* are small, and communicate in front of the sacrum, and around the middle sacral artery, with the branches of the opposite side. From the first, or first two ganglia, some filaments are furnished to the hypogastric plexus; and from the terminal connecting branches and the ganglion impar in front of the coccyx, offsets descend over that bone.

Plexuses of the sympathetic: situation; how formed. The VISCERAL OR PELVIC PLEXUSES (lateral inferior hypogastric) are two in number, right and left, and are continuous with the lateral prolongations of the hypogastric plexus (p. 519). Each is situate by the side of the bladder and rectum in the male, and by the side of the uterus and vagina in the female, and is united with offsets of the third and fourth sacral nerves. Numerous ganglia are found in the plexus, especially at the points of union of the spinal and sympathetic nerves.

Offsets to the viscera of the male, viz.— *Offsets.* From each plexus offsets are furnished to the viscera of the pelvis and the genital organs, along the branches of the internal iliac artery. These form secondary plexuses, and have the same name as the vessels on which they are placed; but as they will not be seen in the dissection, a mere enumeration of them will be sufficient.

to the rectum; The *inferior hæmorrhoidal plexus* is an offset to the rectum from the back of the plexus, and joins the sympathetic on the superior hæmorrhoidal artery.

to the bladder; The *vesical plexus* contains large offsets, with many white fibred or spinal nerves, and passes forwards to the side and lower part of the bladder. It gives one plexus to the vesicula seminalis, and another to the vas deferens.

to the prostate gland and the penis. The *prostatic plexus* leaves the lower part of the pelvic plexus, and is distributed to the substance of the prostate. At the front of the prostate an offset (cavernous) is continued onwards to the dorsum of the penis, to supply the cavernous structure. On the penis the cavernous nerves join the pudic nerve.

Offsets in the female: In the female there are the following additional plexuses for the supply of the viscera peculiar to that sex :—

to the ovary; *Ovarian plexus.* The principal nerves to the ovary are derived from the renal and aortic plexuses, and accompany the artery of that body; but the uterine nerves supply also some filaments to it.

to the vagina; *Vaginal plexus.* The nerves to the vagina are of large size, and are not plexiform, but consist in greater part of spinal nerve fibres; they end in the lower part of the tube.

and to the uterus: no ganglia, The *uterine nerves* are furnished to the uterus without direct admixture with the spinal nerves. The nerves ascend along the side of the uterus, and are, for the most part, long slender filaments, without ganglia or communications as far as their termination in the substance of the viscus. The Fallopian tube receives its branches from the uterine nerves.

except on vessels. Some few nerves surrounding the arteries of the uterus are plexiform and ganglionic (Beck).

Chain of glands in pelvis; lymphatics entering them. The *lymphatic glands* of the pelvis form one chain in front of the sacrum, and another along the internal iliac artery: their efferent ducts join the lumbar glands. Into these glands the deep lymphatics of the penis, those of the genital organs in the female, and the lymphatics of the viscera and wall of the pelvis are collected.

SECTION V.

ANATOMY OF THE VISCERA OF THE MALE PELVIS.

Directions. The bladder and the parts at its base, viz., the vesiculæ seminales and the prostate gland, are to be taken first for examination.

Take out the viscera. *Dissection.* To study the form and structure of the viscera, it will be necessary to remove them from the cavity of the pelvis. For this purpose the student should carry the scalpel around the pelvic outlet, close to the osseous boundary, so as to detach the crus of the penis from the bone, and to divide the parts con-

Separate rectum, nected with the end of the rectum. When the viscera are removed, the rectum is to be separated from the other organs; but the bladder, the penis, and the urethra are to remain united.

clean the bladder, After the bladder has been distended with air, the peritoneum and the areolar tissue are to be dissected from the muscular fibres. The prostate gland and the vesiculæ seminales are to be then cleaned ; and the duct of the latter, with the vas deferens, is to be followed to the gland.

If any of the integument has been left on the penis and the urethra it is to be taken away. and penis.

THE PROSTATE GLAND AND SEMINAL VESICLES.

PROSTATE GLAND. This is a firm muscular body with glands in it, which secretes a special fluid, and surrounds the neck of the bladder and the beginning of the urethra. Its connections with the surrounding parts have been enumerated (p. 595). Prostate gland: use and situation.

The prostate is conical in form like a chestnut, with the base or larger end directed backwards. Its dimensions in different directions are the following :—Transversely at the base it measures about an inch and a half; from apex to base an inch and a quarter; and in depth about three quarters of an inch or an inch : so that an incision directed obliquely outwards and backwards from the apex to the base, at the lateral part, will be the longest that can be practised in the half of this body. Its weight is about an ounce, but in this respect it varies greatly. Form, dimensions, and weight.

The upper surface of the prostate is narrow and rounded. The under surface, which is larger and flatter, is marked by a median hollow that indicates the division into lateral lobes. Surfaces;

The posterior part, or the base, is thick, and in its centre is an excavation which receives the common seminal ducts. The fore part or apex is pierced by the urethra. base, and apex.

Three lobes are described in the prostate, viz., a middle and two lateral, though there is no fissure in the firm mass. The *lateral* parts or lobes are similar on both sides, and are separated only by the hollow on the under surface; they form the chief part of the prostate, and are prolonged back, on each side, beyond the notch in the base. The *middle* lobe will be brought into view by detaching the vesiculæ seminales and the seminal ducts from the bladder; it is a small piece of the gland between the neck of the bladder and those ducts, which extends transversely between the lateral lobes. Oftentimes this middle lobe is enlarged in old people, and projects upwards into the bladder, so as to interfere with the flow of the urine from that viscus, or the passage of a catheter into it. Three lobes; two lateral and a central.

The urethra and the two common seminal ducts are contained in the substance of the prostate. The former is transmitted through the gland from base to apex; and the latter perforate it obliquely to terminate in the urethral canal. Gland contains three tubes.

Structure. On a section the gland appears reddish gray in colour, is very firm to the feel, and is scarcely lacerable. It is made up of a mass of involuntary muscular and fibrous tissues, Structure.

with interspersed glandular structure; and the whole is enveloped by a fibrous coat.

Fibrous case distinct from pelvic fascia;

Fibrous covering. This forms a thin investment for the gland, and sends offsets into the interior. It is quite distinct from the denser capsule derived from the pelvic fascia, and is separated from that sheath by a plexus of veins.

Muscular and fibrous tissue; how arranged.

Muscular tissue. The firm part of the gland consists of involuntary muscular fibres, intermixed with elastic and fibrous tissues. The muscular fibres are arranged circularly around the tube of the urethra: they are continuous behind with the annular fibres of the bladder, and in front with a thin layer of circular fibres around the membranous part of the urethra. They are said by Dr. Pettigrew to form one loop of a figure 8, the other loop being in the wall of the bladder.

At the lower and outer parts the texture is looser and more spongy, especially where the glands are situate, and the larger vessels enter (Roy. Med. Chir. Transactions. 1856). This arrangement will be better seen afterwards when the urethra has been opened.

Glands only few;

Glandular structure. Small racemose glands project from the tube of the urethra amongst the muscular fibres; they form but a small part of the prostate, and are most numerous in the middle lobe.

ending of ducts; on vesicles are vessels.

The ducts are branched as in other glands; and their final radicles are surrounded by small sessile vesicles, which open into them. On the exterior of the vesicles and the ducts the bloodvessels ramify; and lining the interior of the tubes is an epithelium of the columnar kind, which becomes laminar in the vesicles.

Ducts open into urethra.

The ducts of the glands are not collected into one excretory tube, but vary in number from twelve to twenty, and open into the prostatic part of the urethra (p. 621).

Arteries. Veins form a plexus.

Bloodvessels. The *arteries* are rather small, and are furnished by the inferior vesical and middle hæmorrhoidal (p. 605): they supply also offsets to the seminal vesicles. The *veins* are joined in a plexus around the gland, which communicates in front with the dorsal vein of the penis, and behind with the venous plexus at the base of the bladder. In old men this vascular intercommunication gives rise to considerable hæmorrhage in the operation of lithotomy.

Nerves.

The *nerves* are supplied by the hypogastric plexus.

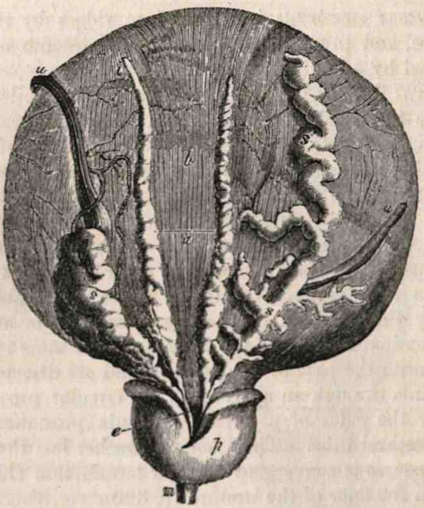
Lymphatics.

The *lymphatics* of this body and the vesiculæ seminales are received into the glands placed along the internal iliac artery.

Seminal vesicles. Definition. Situation.

VESICULÆ SEMINALES. These vesicles are two membranous sacs which serve as reservoirs for the secreted semen. They are placed on the under part of the bladder behind the prostate (fig. 106, *s*), and diverge from one another so as to limit laterally a triangular space in that situation: their form and connections have been already described (p. 596). Though sacculated behind, the vesicula becomes straight and somewhat narrowed in front Sacculated.

Fig. 106.*



(duct); and at the base of the prostate it blends with the vas deferens to form the common seminal or ejaculatory duct.

The vesicula seminalis consists, like the epididymis, of a tube bent into a zigzag form, so as to produce lateral sacs or pouches, which are bound together by fibrous tissue; this cellular structure will be shown by means of a cut into it. When the bends of the vesicle are undone, its formative tube, which is about the size of a quill, measures from four to six inches, and ends posteriorly in a closed extremity: connected with the tube at intervals, are lateral cæcal appendages (fig. 106). Formed of a coiled tube. Length and size.

Structure. The wall of the seminal vesicle has the same number of layers as the vas deferens (p. 565); but the proper coat is thinner. Vesicle has a special coat;

Within the casing of the recto-vesical fascia, the vesiculæ and vasa deferentia are covered by a muscular layer of transverse and longitudinal involuntary fibres. The transverse are the a covering of muscular fibres;

* View of the under part of the bladder with the vesiculæ seminales and vasa deferentia (Haller). *b.* Bladder. *u.* Ureter. *p.* Prostate. *i.* Left vas deferens. *s.* Vesicula seminalis: the same on the right side is unravelled. *e.* Left ejaculatory duct formed by the union of the vesicula seminalis with the vas deferens.

more superficial (the base of the bladder being upwards), are strongest near the prostate, and act most on the vasa deferentia. The longitudinal fibres, placed chiefly on the sides of the vesiculæ, are continued forwards with the common seminal ducts to the urethra.

and a mucous coat. The *mucous membrane* is thrown into ridges by the bending of the tube, and presents an areolar or honeycomb appearance: it is covered by a laminar epithelium.

End of vas deferens. *End of vas deferens* (fig. 106, *i*). Opposite the vesicula the vas deferens is increased in capacity, and is rather sacculated like the contiguous vesicle; but before it joins the tube of that body to form the common seminal duct, it diminishes in size, and becomes straight.

Glands and epithelium. In the mucous lining are numerous simple (sometimes branched) tubular glands like those of the intestine (Henle); and the epithelium is columnar as in the rest of the tube.

Seminal ducts, how formed. *Common seminal ducts* (*e*). These tubes (right and left) are formed by the junction of the narrowed part or duct of the vesicula seminalis with the vas deferens of the same side. **Extent, course, length, and termination.** They begin opposite the base of the prostate, and are directed upwards and forwards through an aperture in the circular prostatic fibres, and along the sides of a hollow (vesicula prostatica), to open into the urethral tube. Their length is rather less than an inch, and their course is convergent to their termination close to each together in the floor of the urethra (p. 620).

Structure. *Structure.* The wall of the common duct is thinner than that of the vesicula seminalis; but it possesses similar coats. It is surrounded by longitudinal involuntary muscular fibres, which blend in the urethra with the submucous stratum. **Glands and epithelium.** It possesses the same glands and epithelium as the dilated part of the vas deferens; but at the end of the tube the mucous membrane wants glands and is smooth (Henle).

THE BLADDER.

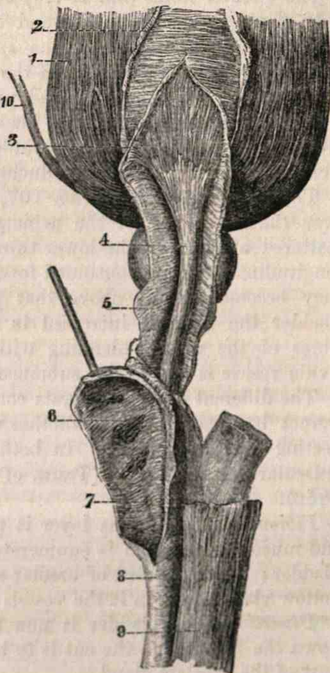
Bladder out of the body. After the bladder has been separated from the surrounding parts, its form, and the extent of its different regions can be more conveniently observed.

Form. Whilst the bladder is in the body, it is conical in shape, and rather flattened from before backwards. But out of the body it is more circular than when in its natural position, and it loses that arched form by which it adapts itself in distension to the curve of the pelvis.

Dimensions. If this viscus is moderately dilated, it measures about five inches in length, and three inches across (Huschke). Its capacity is greatly influenced by the age and sex, and by the habits of the individual. Ordinarily the bladder holds about a pint, and as a general rule it is larger in the female than in the male.

STRUCTURE. A muscular and a mucous coat, with an intervening fibrous layer, exist in the wall of the bladder: at certain parts the peritoneum may be also enumerated as a constituent of the wall. The vessels and nerves are large. Coats of the bladder.

Fig. 107.*



The imperfect covering of *peritoneum* has been described (p. 593), and has been removed. Peritoneal.

The *muscular* coat is formed of thin strata of unstriated muscular fibres, viz. an external or longitudinal, a middle or circular, and an internal or submucous. They are arranged, according to Dr. Pettigrew, in loops, like the figure 8, which point to apex and base; and consist of anterior and posterior and two lateral sets. In each set the loops are placed on one side of the viscus and the point of decussation on the other. Muscular has three strata;

The *longitudinal* fibres (fig. 107, [1]) form a continuous covering, with the usual plexiform disposition of the muscular bundles, and extend from the apex to the base. Above, some are connected with the urachus, and others are inserted into the subperitoneal fibrous tissue. Below, the posterior and lateral fibres enter the prostate becoming circular; whilst the anterior are attached to the fascia covering the prostate, with the exception external or longitudinal attachments

* Muscular fibres of the bladder, prostate, and urethra. 1. External or longitudinal fibres of the bladder. 2. Circular fibres of the middle coat. 3. Submucous layer. 4. Muscular layer around the urethra. 5. Circular fibres of the prostate and urethra continuous with the circular of the bladder. 6, 7. Septum of the corpus spongiosum. 8. Corpus spongiosum. 9. Corpus cavernosum. 10. Ureter.

of a fasciculus on each side, which is united to the back of the pubes through the anterior true ligament of the bladder. On the front and back of the bladder the muscular layer is stronger, and its fibres more vertical, than on the lateral parts. Sometimes this outer layer of fibres is called *detrusor urinæ* from its action in the expulsion of the urine.

forms detrusor urinæ;

internal or circular gives rises to sphincter; continuous with prostate.

The *circular* fibres (fig. 107, ²) are thin and scattered on the body of the bladder; but around the cervix they are collected into a thick bundle, called the *sphincter vesicæ*, and are continuous before with the fibres of the prostate. In some instances the fibres are hypertrophied, and project into the interior of the organ, forming the fasciculated bladder; and in other bodies the mucous coat may be forced outwards here and there between the fibres, in the form of sacs, producing the sacculated bladder.

sub-mucous layer.

Extent.

Fibres.

Addition to it.

The *submucous* stratum (fig. 107, ³) forms a continuous layer over the lower half of the urinary bladder, but its fibres are scattered above. In the lower third of the viscus the fibres are longitudinal, and are continued forwards around the urethra, but they become oblique above that point. At the back of the bladder the layer is increased in strength by the longitudinal fibres of the ureters blending with it. The projection of the uvula vesicæ is due to this submucous stratum.

Strata are joined.

The different muscular strata communicate freely, so that one cannot be separated from another without division of the connecting bundles of fibres. In both sexes the disposition of the muscular fibres is similar (Trans. of the Roy. Med. Chir. Society, 1856).

Fibrous coat.

Fibrous coat. A fibrous layer is placed between the muscular and mucous strata, and is enumerated as one of the coats of the bladder; it is composed of areolar and elastic tissues as in other hollow viscera, and in it the vessels and nerves ramify.

Open the bladder.

Dissection. The bladder is now to be opened by an incision down the front; and the cut is to be continued along the upper part of the prostate gland.

Mucous coat

has folds

except on one spot.

The *mucous membrane* of the bladder is continuous posteriorly with the lining of the ureters, and anteriorly with that of the urethra. It is very slightly united to the muscular layer in consequence of the intervention of the submucous fibrous stratum; and it is thrown into numerous folds in the flaccid state of the viscus, except over a small triangular surface behind the opening into the urethra.

Glands.

Epithelium.

The membrane is soft and smooth to the feel, and of a pale rose colour in the healthy state. Its surface is studded with mucous follicles and branched glands, particularly towards the neck of the bladder. In the *epithelium* covering the surface the superficial cells are roundish and flattened, but the deeper are conical or cylindrical (Kölliker).

Objects inside the bladder. Within the bladder are the following named parts, viz., the orifices of the ureters and urethra, with the triangular space (fig. 85).

Interior of the bladder.

Orifices. At the anterior part of the bladder is the orifice of the urethra, surrounded by the prostate gland. The mucous membrane presents here some longitudinal folds; and the aperture is partly closed by a small prominence below, *uvula vesicæ*, occasioned by a thickening of the submucous muscular and fibrous layer. This eminence is placed in front of the middle lobe of the prostate, and from its anterior part a slight ridge is continued on the floor of the urethra.

Opening of urethra, with the uvula.

About an inch and a half behind the orifice of the urethra, and rather more than that distance apart, are the two narrow openings of the ureters. These excretory tubes for the urine perforate the wall of the bladder obliquely, lying in it for the distance of half an inch, so that the reflux of fluid through them towards the kidney is prevented as the bladder is distended. They terminate on each side by a contracted slit-like opening in the centre of a prominence formed by subjacent muscular fibres.

Openings of the ureters.

Triangular surface. Immediately behind the orifice of the urethra is a smooth triangular part, which is named *trigone* (trigonum vesicæ). Its apex reaches the prostate, and its base the ureters. Its boundaries may be marked out by a line on each side from the urethra to the ureter, and by a transverse one behind between the openings of the ureters. This space corresponds with the interval, at the base of the bladder, between the prostate in front and the vesiculæ and vasa deferentia on the sides: and over it the mucous coat is more closely united to the fibrous and muscular, so as to prevent the accidental folds found in the other parts of the empty bladder.

Trigone of the bladder; how bounded; part corresponding externally.

Dissection. The arrangement of the fleshy fibres of the ureters will come into view on the removal of the mucous membrane from the lower third of the viscus: the fibres are best marked in a muscular bladder.

To expose muscles of ureters.

Ending of the fibres of the ureters. As soon as the ureter pierces the outer and middle coats of the bladder, its longitudinal fibres are thus disposed:—The more internal and strongest are directed transversely, and join the corresponding fibres of the other urine tube;[1] whilst the remainder are continued down over the triangular space and blend with the submucous layer.

Muscular fibres of ureters.

Bloodvessels and nerves. The source of the vesical *arteries*, and the termination of the *veins* are before detailed (p. 605). In the bladder the vessels are disposed in greatest number about the base and neck. Most of the *nerves* distributed to the bladder, though supplied from the pelvic plexus of the sympathetic (p. 611), are derived directly from the spinal nerves. *Lymphatics* enter the glands by the side of the internal iliac artery.

Arteries; veins; nerves of the bladder. Lymphatics.

THE URETHRA AND PENIS.

Urethra: extent and length; URETHRA. The tube of the urethra extends from the neck of the bladder to the end of the penis, and has an average length of eight inches and a half; but it is shorter by one inch during life (Thompson). This canal is supported by the prostate, the triangular ligament, and the spongy structure of the penis. The size of the urethra varies at different spots, and the tube is divided, as before said (p. 597), into a prostatic, a membranous, and a spongy part.

no special coat.

Division into parts.

How to open the urethra. *Dissection.* To open the urethra, let the incision through the upper part of the prostate be continued onwards to the extremity, so as to divide the body of the penis rather on one side of the middle line, and to leave uncut the septum in it.

Prostatic part. Dimensions and shape; The *prostatic* part is nearer the upper than the lower surface of the muscular mass surrounding it. It is one inch and a quarter in length, and is altogether the widest portion of the urethral canal. The form of this part of the tube is spindle-shaped, for it is larger in the middle than at either end. Its transverse measurement at the neck of the bladder is a quarter of an inch; at the centre a line or two more; and at the front rather less than at the back.

diameter.

On the floor is a crest. On the floor of the passage at the neck of the bladder is the eminence of the uvula vesicæ. In front of this is a central longitudinal ridge of the mucous lining, about three quarters of an inch in length and a line in depth, and larger behind than before, which is prolonged anteriorly towards the membranous part of the canal, and is named *crest* of the urethra (veru montanum, caput gallinaginis): it is formed like the uvula by a bundle of the submucous muscular and fibrous tissue. In that fold or crest of the mucous membrane, near its posterior extremity, is a slight hollow named *vesicula prostatica* or *sinus pocularis.*

In the crest is a pouch.

Vesicula projects into the prostate, The *vesicula prostatica* or *utricle*, is a cæcal appendage to the urethral canal, and is directed backwards and downwards in the substance of the prostate, for the distance of about a quarter of an inch, passing beneath the middle and between the lateral lobes. Its orifice in the urethra is about a line wide, and its closed extremity is dilated. In its wall, on each side, is contained the common seminal duct, which terminates by a narrow slit on or within the free margin of the mouth of the sac. Small glands open on the surface of the mucous membrane lining it. Some bristles should be introduced into the common seminal ducts behind the prostate, to render evident their position and apertures.

and in it are the ejaculatory ducts.

Prostatic On each side of the central ridge or crest is an excavation which is named the *prostatic sinus*. Into this hollow the greater number of the ducts in the prostate open; but the apertures of others are seen at the posterior part of the central ridge, behind the utricle in it. sinuses also in floor.

The *membranous part* of the urethra is three quarters of an inch in length, and intervenes between the apex of the prostate gland and the bulb of the corpus spongiosum urethræ. In its interior are slight longitudinal folds. This is the narrowest portion of the whole tube, with the exception of the outer orifice, and measures rather less than a quarter of an inch across. It is the weakest of the three portions of the canal, and is supported by a thin stratum of erectile tissue, by a thin layer of involuntary circular fibres (p. 459), and outside all by the constrictor urethræ muscle. Membranous part. Dimensions. Parts around.

The *spongy part* reaches onwards to the end of the penis. It is about six inches in length. And its strength depends upon a surrounding material named corpus spongiosum urethræ. Spongy part.

The average size of the canal is about a quarter of an inch in diameter, though at the vertical slit (meatus urinarius), by which it terminates on the glans penis, the tube is smaller than elsewhere. On a cross section it appears as a transverse slit, but in the glans, as a vertical interval. Two dilatations exist in the floor of the spongy portion :—One is close to the triangular ligament, being contained in the bulb or bulbous part of the urethra, and is named *sinus* of the bulb; the other is an elongated hollow situate in the glans penis, and has been called *fossa navicularis* from its shape. Dimensions. Two dilatations: one in bulb, one in glans.

Many small pouches or *lacunæ* exist along the floor of the canal, as far back as the membranous part, and have their apertures turned towards the outer orifice of the urethra. One of these, larger than the rest, *lacuna magna*, is placed generally on the upper boundary or roof of the urethra, opposite the fossa navicularis. Lacunæ. One larger than the rest.

The ducts of Cowper's glands are two in number, and terminate, one on each side, on the floor of the urethra near the front of the bulb, but in the ordinary examination they are seldom to be recognised. Ducts of glands of Cowper.

Mucous lining of the urethra. The mucous membrane of the urethra is continued into the bladder, as well as into the ducts opening into the canal, and joins in front the tegumentary covering of the glans penis. It is of a reddish colour in the spongy and membranous portions, but in the prostate it becomes whiter. In the spongy and membranous parts it is thrown into longitudinal folds during the contracted state of the penis. Mucous membrane: extent; colour; folds;

Its surface is studded throughout with follicles, and with the apertures of branched glands, which are lodged in the submucous tissue, and whose ducts are inclined obliquely forwards; glands;

and it is provided with papillæ towards the external orifice. Its *epithelial* covering is of the columnar kind, but near the meatus this becomes laminar.

epithelium.

Submucous tissue;

nature;

Submucous tissue. Beneath the mucous lining of the urethra is a stratum of longitudinal involuntary muscular fibres mixed with elastic and fibrous tissues. It is continuous behind with the submucous fibres of the bladder, and is joined in the prostate by the fibres accompanying the common seminal ducts.

arrangement in prostate, in membranous, and in spongy parts.

This stratum differs in quantity along the canal. It is most developed in the prostate, where it forms the projection of the crest, and blends with the circular fibres of that body. In the membranous portion of the canal the muscular structure is less abundant. In the spongy part the fibrous tissue forms the greater portion of the submucous layer.

Erectile tissue throughout.

In the prostatic and membranous divisions of the urethra there is, in addition, a thin enveloping layer of vascular or erectile tissue, which is continued backwards from the corpus spongiosum urethræ to the neck of the bladder.

Penis formed of two vascular erectile bodies.

STRUCTURE OF THE PENIS. The form and the connections of the penis having been described at page 598; the tissues of which it is composed remain to be noticed. The section already made through the penis shows this body to be made up of two masses of spongy and vascular tissue incased in fibrous coverings—one constituting the corpora cavernosa, the other the corpus spongiosum urethræ.

Corpora cavernosa, attached behind separately blend together in front; bulb.

Corpora cavernosa. These bodies form the bulk of the penis, and are two dense cylindrical tubes of fibrous tissue, containing erectile structure. Each is fixed behind by a pointed process, *crus penis* (fig. 105, *d*), to the upper part of the pubic arch for about an inch; and blends with its fellow in the body of the penis after a distance of an inch and a half. Near the junction of the two there is slight swelling on the crus, called the bulb of the corpus cavernosum (Kobelt).

The structures of which it consists.

Each corpus cavernosum is composed of a fibrous tunic, which encloses a cavernous or trabecular structure, with vessels in the intervals of the spongy mass. An incomplete median septum exists along the body of the penis between the corpora cavernosa.

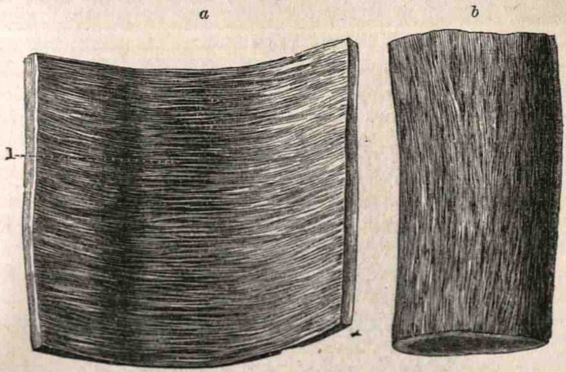
A case that sends in processes.

The *fibrous case* of the corpus cavernosum is a white, strong, elastic covering, from half a line to a line in thickness. Along the middle line of the penis a septal process is sent inwards from it; and numerous other finer bands, or the trabeculæ of the spongy structure, are connected with its inner surface.

Fibres form strata: inner forms septum.

It is formed of white shining fibres which are disposed in two layers, outer and inner. The outer stratum (fig. 108, *b*) is formed of longitudinal fibres with close meshes, arranged like involuntary muscular tissue. The inner stratum (fig. 108, *a*) consists of circular fibres (Wilson, James), with a like plexiform disposition; and the circular fibres of each cavernous body meeting in the middle line give rise to the septum penis. Both

Fig. 108.*



strata are inseparably united by communicating bundles, as in the intestine.

The *septal process* is placed vertically along the body of the penis, and is thicker and more perfect behind than in front. At the point of junction of the crura this partition separates the enclosed cavity of the organ into two parts; but as it reaches forwards it becomes less strong, and is pierced by elongated apertures (fig. 108, [1]), which give it the appearance of a comb, from which the name *septum pectiniforme* is derived. Through the intervals in the septum the vessels in the corpora cavernosa communicate. It is formed, as above said, by the circular fibres of the cavernous bodies.

One septal piece, **which is imperfect;** **how formed;**

The *cavernous* or *trabecular structure* is a network of fine cords, which fills the interior of the corpora cavernosa. The processes are thinner towards the centre than at the circumference of the fibrous case; and the areolar spaces are larger in the middle and at the fore part of the contained cavity, than at the circumference or in the crura of the penis. In addition to white fibrous tissue, the trabeculæ contain elastic fibres, and involuntary muscular fibres (Müller). The cellular structure may be demonstrated by sections of the penis after it has been distended with air and dried.

and numerous bands and cords to form a network. **In the cords some muscular fibres.**

Bloodvessels. The bloodvessels of the penis are large in size, and serve to nourish as well as minister to the function of the

Vessels.

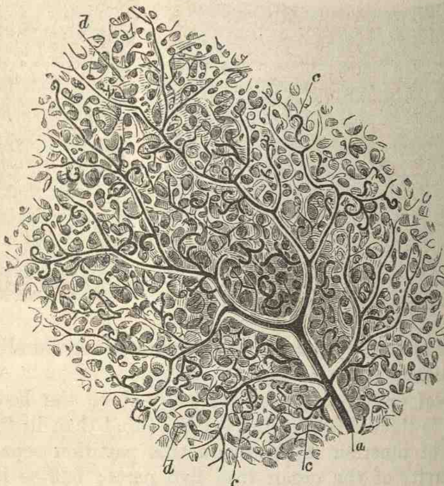
* *b.* View of the external or longitudinal layer of the corpus cavernosum. *a.* Inner or circular fibres of the corpus cavernosum. 1. The pectiniform septum.

organ. Having entered the cavernous mass, they ramify in the trabecular structure, and join by venous plexuses.

Source of the arteries,

The *arteries* of the corpora cavernosa are offsets of the pudic: the chief branch (art. corp. cavernosi) enters at the crus, and

Fig. 109.*

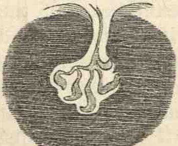


runs forwards through the middle of the cavernous structure, distributing offsets; and the rest pierce the fibrous case along the dorsum of the penis.

termination in dilated veins.

In the interior they divide into branches, which ramify in the trabeculæ (fig. 109, *a*), becoming finer and finer, until they terminate in very minute branches, which open into the veins in the intertrabecular spaces without the intervention of capillaries.

Fig. 110.†



Helicine arteries.

Others of the finest twigs end in tufts of short, slightly curled and dilated vessels—the *helicine* arteries of Müller (fig. 110), which project into the intertrabecular spaces, and are imbedded in the coat of the thin veins: with the extremities of these twisted vascular bodies fine fibrous processes are connected, but their nature is

* Magnified view of the trabecular structure and arteries of the penis (Müller). *a.* Branch of an artery and its ramifications in the bands of the spongy structure of the penis.

† A tuft of the twisted or helicine arteries (Müller). The dark shadowing around represents a vein incasing the bundle of vessels.

not ascertained. The helicine arteries exist in greatest number at the posterior part of each corpus cavernosum. **their ending.**

The *veins* fill the interspaces of the areolar structure, and anastomose freely together to form venous plexuses. In the spaces the wall of the veins is very thin, because support is received from the surrounding fibrous structure. Into those radicles of the veins the terminal branches of the arteries pour their contents; and the erectile condition of the corpus cavernosum is produced by the distension of the plexuses. By means of the apertures in the septum the veins of opposite sides communicate freely. **Veins are dilated and form plexuses.**

The chief veins of the corpus cavernosum escape at the crus penis with the artery, and join the pudic vein; and others issue along the upper and under aspects of the penis, to end in the dorsal vein and the prostatic plexus. **Ending of veins..**

Corpus spongiosum urethræ. This constituent part of the penis surrounds the urethra (p. 598), but not equally on all sides; for at the bulb only a thin stratum is above the canal, whilst the chief part of the glans penis, which is formed by it, is placed above the urethral tube. Posteriorly an offset of the corpus spongiosum is continued beyond the bulb around the urethra. **Spongy material of the penis,**

Structure. The tissue of the corpus spongiosum is similar to that of the corpus cavernosum: thus it consists of a fibrous tunic enclosing a trabecular structure and bloodvessels. **its structure like cavernous.**

The *fibrous covering* is less dense and strong than in the corpora cavernosa, and consists only of circular fibres. A *septal piece* projects inwards from it in the middle line, opposite the tube of the urethra; this is best marked for a short distance in front of the bulb, and assists in dividing that part into two lobes. The *trabecular bands* are much finer, and more uniform in size than in the corpora cavernosa. **The fibrous case. Imperfect septum. Trabeculæ.**

Bloodvessels. The arrangement of the bloodvessels in the erectile structure of the corpus spongiosum is similar to that in the corpora cavernosa; but the helicine terminations of the arteries are absent from the glans penis, where the veins form a very close and regular plexus. **Bloodvessels. Helicine arteries.**

The *arteries* are derived from the pudic on each side:—they are artery of the bulb and offsets of the dorsal artery; one enters the bulb behind, and several in front at the glans where they most abound. Kobelt describes another branch to the bulb at the upper aspect. **Source of arteries.**

Most of the *veins*, including those of the glans, end in the large dorsal vein of the penis, and some communicate with veins of the cavernous body: others issue from the bulb, and terminate in the pudic vein. **Termination of the veins.**

Nerves and lymphatics. The *nerves* of the penis are large and are supplied by both the spinal and sympathetic nerves. On **Nerves.**

the bulb of the urethra and the glans penis, they are furnished with Pacinian bodies (Fick).

Lymphatics. The superficial *lymphatics* of the integuments, and those beneath the mucous membrane of the urethra, join the inguinal glands; the deep accompany the veins beneath the arch of the pubes, to end in the lymphatic glands in the pelvis.

THE RECTUM.

To prepare the gut. *Dissection.* The rectum is to be washed out, and then distended with air; and the peritoneum and the loose fat are to be removed from it.

Rectum is smooth. The lower end of the large intestine, which is contained in the pelvis, is not sacculated like the colon, but is smooth on the surface.

Length; dimensions. It is about eight inches in length, and its average diameter is that of the sigmoid flexure of the colon. Its size is uniform till towards the lower extremity, where it is dilated, particularly in old people; but at the aperture of termination in the anus the gut is smaller than in any other part. The longitudinal bands of the colon are absent from this portion of the alimentary canal, and the fibres are spread over the surface.

Same coats as in the rest of the intestine. *Structure.* The rectum, like the rest of the large intestine, contains in its walls a peritoneal, a muscular, a mucous, and a submucous stratum; and the muscular and mucous layers have certain characters which distinguish this from other parts of the intestinal tube.

Peritoneum. The *peritoneum* forms but an incomplete covering, and its arrangement is referred to in the description of the connections of the pelvic viscera (p. 594).

Muscular coat, The *muscular* coat consists of two planes of fibres, as in the œsophagus, viz., a superficial or longitudinal, and a deep or circular: these fibres belong to the pale or unstriated kind.

has longitudinal The *longitudinal* are continuous with those in the bands on the colon, but are here diffused to form a stratum around the gut.

and circular fibres. The *circular* describe arches around the intestine, and become thicker and stronger towards the anus, where they are collected in the band of the internal sphincter muscle.

Mucous coat thick and vascular. The *mucous* coat is more moveable than that in the colon, and resembles in this respect the lining of the œsophagus; it is also thicker and more vascular than in the rest of the large intestine.

Folds in it: When the bowel is contracted the mucous lining is thrown into numerous accidental folds; but some near the anus are longitudinal, and form the columns of Morgagni.

some are permanent. There are three or four other permanent folds, described by Mr. Houston, which are half an inch or less in depth, and contain circular fibres of the gut. The most constant of these is about three inches from the anus, on the front of the rectum, opposite the base of the bladder; another is found on the right side of the intestine towards the top; and the third is on the left side, midway between the other two. Occasionally there is a fourth on the back of the rectum, about an inch from the anus. These folds will be seen by laying open the gut along the side, provided it is tolerably fresh.

The mucous membrane has the same general structure as in the colon, but towards the anus the secretory apparatus gradually disappears. **Structure.**

Bloodvessels. The *arteries* are supplied from three different sources, viz., from the superior hæmorrhoidal of the inferior mesenteric; from the middle hæmorrhoidal of the internal iliac artery; and from the inferior hæmorrhoidal of the internal pudic. All three sets anastomose on the lower end of the gut, and only the upper hæmorrhoidal, which is the largest, requires further notice. The branches of this artery (p. 607) about six in number pierce the muscular layer three inches from the anus, and descend between the mucous and muscular coats as far as the internal sphincter, where they end in loops like the veins, which form anastomotic arterial rings just within the anus. **Arteries, arrangement of superior hæmorrhoidal.**

The *veins* are deficient in valves, and communicate freely in a plexus between the muscular and mucous coats around the lower end of the gut. Above, they join the inferior mesenteric vein, and through it reach the vena portæ; and, posteriorly, they pour some blood into the internal iliac vein by branches corresponding with the middle hæmorrhoidal artery. **Veins are without valves.**

Nerves and lymphatics. The nerves for the intestine are obtained from the sympathetic; and those for the sphincter come from the spinal system. The lymphatics terminate in the chain of glands on the sacrum. **Nerves. Lymphatics.**

Section VI.

ANATOMY OF THE FEMALE VISCERA.

In the pelvis are contained the viscera common to both sexes, viz., the bladder, the urethra, and the rectum; and those special to the female, or the organs of generation. **Viscera in the pelvis.**

Dissection. The contents of the pelvis are to be removed together with the genital organs. In this proceeding the student should keep the scalpel close to the osseous boundary of the pelvic outlet, to avoid injuring the end of the rectum; and he should also detach the crus of the clitoris from the bone. **To remove the viscera,** and prepare them.

After the parts referred to are taken from the body, the rectum is to be separated from the uterus and the vagina, but the rest of the viscera may remain united until after the genital organs are examined.

The bladder may be moderately distended; and the fat and areolar tissue, and the vessels, are to be removed from the viscera.

GENITAL ORGANS.

External organs.

The genital organs consist of the following parts:—The mons Veneris and the external labia, the clitoris and the internal labia, and the vestibule with the meatus urinarius. Within the external labia is the aperture of the vagina, with the hymen or its remnant. Sometimes the term vulva or pudendum is applied to these parts as a whole.

Mons Veneris.

Mons Veneris and labia pudendi. In front of the pubes the integument is covered with hair, and is raised into a slight eminence,—mons Veneris, by a layer of subjacent fat.

Labia majora.

Extending downwards from the prominence are two folds of integument, the *labia pudendi* (labia majora), which correspond with the scrotum in the male. Above and below the labia are united, the points of junction being named commissures, but between them is an interval called rima. The labia decrease in thickness inferiorly; they are covered externally with a few hairs, but are lined internally with a mucous membrane. In them is a dartoid tissue resembling that in the male scrotum.

Fourchette and fossa navicularis.

Within the lower commissure of the labia is a small thin transverse fold of integuments named *fourchette*, or *frænulum;* and between this fold and the lower commissure is an interval—the *fossa navicularis.*

Clitoris;

Clitoris and nymphæ. Beneath the upper commissure of the labia majora is the projection of the clitoris, with the nymphæ or smaller labia descending from it.

dissection to see it.

Dissection. To see the clitoris, the integuments forming the upper commissure must be removed; and, after the body of the organ has been laid bare, the crura are to be followed outwards, one on each side.

It is like the penis;

The *clitoris* is a small erectile body, and is the representative of the penis. It has the same anatomy as the penis, with the exception that the urethra and the corpus spongiosum are not continued below it. Its anterior extremity is terminated by a rounded part or glans, and is covered by a fold of the skin corresponding with the prepuce of the male.

has a glans and prepuce.

Composition, corpora cavernosa,

In its composition this organ resembles the penis in the following particulars:—it consists of corpora cavernosa, which are attached by crura (one on each side) to the pubic arch; they are then blended in the body, along whose middle is an imperfect pectiniform septum. Further, it possesses a portion of corpus spongiosum, but this structure is limited to the glans clitoridis. corpus spongiosum,

Structure. The outer fibrous casing and the septum are alike in both penis and clitoris; and in the interior of the clitoris is an erectile tissue, like that in the male organ (p. 623). and erectile tissue.

The *nymphæ* (labia minora) are two folds of mucous membrane that descend from the end of the clitoris, one on each side of the orifice of the vagina: they are continuous above with the preputial covering of the clitoris, and extend down about one inch and a half. The inner surface is continuous with the lining of the vestibular space and vagina; and the outer, with the covering of the external labium. Bloodvessels are contained in each fold. Labia minora descend from prepuce.

Vestibule and orifice of the urethra. Within the nymphæ, between the clitoris above and the vagina below, is an angular interval, about one inch and a half deep, which is called the vestibule. In the middle line of the vestibular space is the round orifice of the urethra, which is placed in a median eminence about one inch below the clitoris, and near the aperture of the vagina. Vestibule. Opening of the urethra.

Orifice of the vagina, and the hymen. The aperture of the vagina is close below the meatus urinarius, and varies much in size. In the child and in the virgin state it is partly closed below by a thin semilunar fold of mucous membrane named the hymen. After the destruction of that membrane small irregularly-shaped projections, *carunculæ myrtiformes*, exist around the opening of the vagina. Aperture of the vagina. Hymen and carunculæ.

Mucous membrane. The mucous covering of the external genitals is furnished throughout with papillæ, but these are largest on the labia minora and the clitoris. Its epithelium is laminar. Mucous layer over genitals.

Sebaceous glands open on the contiguous surfaces of the labia majora and minora, and beneath the prepuce; and mucous glands and follicles exist on the vestibule and the inner surface of the nymphæ. Its papillæ, epithelium, and glands.

GENERATIVE ORGANS.

The generative organs are the uterus and vagina, and the ovaries with the Fallopian tubes.

Dissection. The viscera are now to be separated, so that the bladder and the urethra may be together, and the vagina and the uterus remain united. The bladder is to be set aside for subsequent use, and the other organs are to be learnt first. Separate vagina and uterus.

The surface of the vagina and lower part of the uterus should be cleaned, but the peritoneal investment of the latter is to be left untouched for the present. Clean vagina.

THE VAGINA.

Vagina: extent and curved course. The vagina is a dilatable tube, which is connected with the uterus at one end, and terminates in the vulva at the other. It has a curved course between the two points mentioned; and the anterior and posterior walls of the tube are not equal in length, for the former measures about four inches, and the latter about five or six.

Form and size. In the body the vagina is flattened from above downwards, so that the opposite surfaces may be in contact, but the upper end is rounded where it is joined to the uterus. Its size varies at different spots:—thus the external orifice which is surrounded by the constrictor vaginæ muscle is the narrowest part; the middle portion is the largest; and the upper end is intermediate in dimensions between the other two.

Interior has columns and rugæ. After the vagina has been laid open by an incision along the upper wall, the position of the uterus in that wall instead of the extremity of the passage may be remarked; and further, the tube may be seen to extend higher on the posterior than the anterior aspect of the cervix uteri. On the inner surface, towards the lower part, is a slight longitudinal ridge both in front and behind, named columns of the vagina. Before the tissue of the vagina has been distended, other transverse ridges or rugæ may be seen passing between the columns.

Thickness. The wall of the vagina is thicker anteriorly, where the urethra is situated, than at any other part of the canal.

An erectile structure in the wall. *Structure.* The vaginal wall is formed by a spongy erectile tissue, which is covered externally by a muscular layer, and lined by mucous membrane. At its lower end the tube is surrounded by a band of the fibres of the sphincter vaginæ muscle (p. 464).

Erectile tissue The *erectile* tissue is more abundant at the ends than the middle of the vagina, and is greatest in quantity below where it gives increased thickness to the wall.

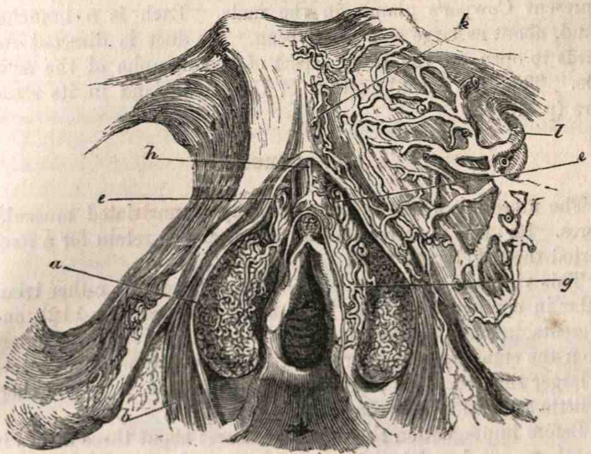
forms semi-bulbs. Two masses of the erectile tissue, one on each side of the opening of the vagina, have been described as the *semi-bulbs* by Taylor (*bulbi-vestibuli*, Kobelt, fig. 111, *a*). These are elongated masses of plexiform veins, enclosed in fibrous membrane; they

Connections. are about an inch in length from above down, and are situate one on each side of the vestibule, where they are covered on the outer side by the constrictor vaginæ (*b*). At the upper part each is pointed, and communicates with the vessels of the clitoris: and at the posterior rounded part it joins the venous plexus of the vagina.

They correspond with These bodies answer to the bulb of the corpus spongiosum urethræ in the male, but each lateral half is thrust aside towards the crus clitoridis by the large aperture of the vagina. **the bulb of the male.**

The *mucous membrane* is continued through the lower aperture to join the integument on the labia majora, and through the os uteri, at the opposite end, to the interior of the uterus. **Mucous membrane of the vagina.**

Fig. 111.*



Many muciparous glands and follicles abound on the surface, but these are in greatest abundance at the upper part. Conical and filiform papillæ exist on the surface; and a laminar *epithelium* gives a covering to the membrane.

The *muscular* layer is outside the erectile structure, and consists of longitudinal fibres. Some reach all along the vagina; others, and these are the strongest, only as far upwards as the recto-vesical fascia, to which they are attached on each side. Above they end in the superficial layer of the uterus and in the subperitoneal fibrous tissue; and below in the subdermic tissue. **Muscular stratum.**

Bloodvessels and nerves. The *arteries* are derived from the vaginal, uterine, and vesical branches of the internal iliac. The *veins*, corresponding with the arteries, form a plexus around the vagina, as well as in the external or genital organs, and open into the internal iliac vein. For a description of the *nerves* see page 612. **Arteries. Veins are plexiform. Nerves.**

* Veins and venous plexuses of the genital organs and opening of the vagina (Kobelt). *a.* Semi-bulbs or bulbus vestibuli. *e.* Venous plexus continuous with veins of the clitoris (pars intermedia, Kobelt). *f.* Glans clitoridis. *h.* Dorsal vein of the clitoris. *l.* Obturator vein. *b.* Sphincter vaginæ muscle.

Lymphatics. The *lymphatics* accompany the bloodvessels to the glands by the side of the internal iliac artery.

Two glands analogous to Cowper's. *Glands of Bartholine.* On the outer part of the vagina, near the aperture at the lower end, and before the transverse muscle, are two small yellowish glandular bodies, one on each side, which represent Cowper's glands in the male. Each is a branched gland, about as large as a small bean. Its duct is directed forwards to open on the inner aspect of the nympha of the same side. The duct resembles that of Cowper's gland in its structure (p. 460).

THE UTERUS.

Uterus. The uterus or womb is formed chiefly of unstriated muscular fibres. Its office is to receive the ovum, and to retain for a fixed period the developing fetus.

Form; This viscus in the virgin state is pear-shaped, or rather triangular in consequence of the body being flattened (fig. 112), and presents inferiorly a rounded narrow part or neck. Deviations how changed. from the standard shape are seen in the infant, where the neck is larger than the body; and in the aged female, in whom there is little separation between the same two parts.

Dimensions. Before impregnation the uterus measures about three inches in length, two in breadth at the upper part, and an inch in greatest thickness. Its weight varies from an ounce to an ounce and a half. But after gestation its size and volume exceed always the measurements here given.

Upper end. The *upper* end is convex (fig. 112, *a*), and is covered by peritoneum: the term *fundus* is applied to the part of the organ above the attachment of the Fallopian tubes.

The lower end is small; has an opening. The *lower* end is small and rounded, and in it is a transverse aperture of communication between the uterus and the vagina (*d*), named *os uteri* (*os tincæ*): its margins or lips (labia) are smooth, and anterior and posterior in situation, but the hinder one is the longest. Towards the lower part the uterus is constricted

Neck. (fig. 112, *c*) and this diminished portion is called the neck of the uterus (*cervix uteri*); it is surrounded by the vagina, and is covered by this tube to a greater extent behind than in front. The neck is about half an inch in length, and gradually tapers towards the extremity.

Body. The *body*, or the intervening part of the uterus, is more convex posteriorly than anteriorly, and decreases in size down to the neck. It is covered on both aspects by the peritoneum, except about half an inch at the lower part in front, where it is con-

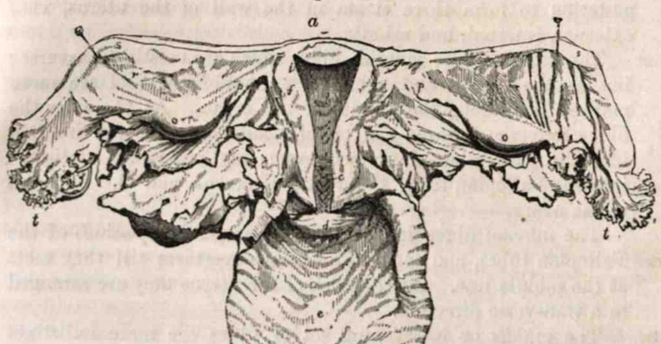
Sides and attached parts. nected to the bladder. To each side, which is straight, the parts contained in the broad fold of the peritoneum are attached:—viz., the Fallopian tube at the top (*s*), the round ligament rather below and before it, and the ovary (*o*), and its ligament (*p*) below and behind the others.

Dissection To examine the interior of the uterus, a cut is to be made along the anterior wall from the fundus to the os uteri; and then some of the tissue is to be removed on each side of the middle line to show the contained cavity. Open the uterus.

The *thickness* of the uterine wall is greatest opposite the middle of the body. It is greater at the centre than at the angles of the fundus (fig. 112), the wall becoming thinner towards the attachment of the Fallopian tubes. Its thickness.

Interior of the uterus (fig. 112). Within the uterus is a small In the interior

Fig. 112.*



space, which is divided artificially into two—that of the body, and that of the neck of the organ.

The space occupying the body of the viscus is triangular in form, and is larger than the other. Its base is at the fundus of the uterus, where it is convex towards the cavity, and the angles are prolonged towards the Fallopian tubes. The apex is directed downwards, and joins the cavity in the cervix by a narrowed circular part, *isthmus* (os uteri internum), which may be narrower than the opening of the uterus into the vagina. is a triangular space in the body, which is narrowed below;

The space within the neck terminates inferiorly at the os uteri (fig. 112, *c*); and it is continuous above, as before said, with the space within the body. It is larger at the middle and a spindle shaped space in the neck.

* Cavity of the uterus and vagina shown, with a posterior view of the broad ligament.—*a*. Fundus uteri. *b*. Body of the uterine cavity. *c*. Cervix with the arbor vitæ. *d*. Mouth of the uterus. *e*. Cavity of the vagina. *r*. Broad ligament of the uterus. *s*. Fallopian tube:—*i*. marking the inner opening, and *t* the outer or corpus fimbriatum. *o*. Ovary, and *p* ligament of the ovary.

In the neck are ridges or the arbor vitæ.

than at either end, being spindle-shaped, and is somewhat flattened like the cavity of the body. Along both the anterior and the posterior wall is a longitudinal ridge, and other ridges (*rugæ*) are directed obliquely from these on each side: this appearance has been named *arbor vitæ uterinus.* In the intervals between the rugæ are mucous follicles, which sometimes become distended with fluid, and give rise to the rounded clear sacs named the *ovula* of *Naboth.*

Uterus is a muscular organ.

STRUCTURE. The dense wall of the uterus is composed of layers of unstriated muscular fibre, intermixed with dense areolar and elastic tissues, and large bloodvessels. On the exterior is the peritoneum; and lining the interior is a thin mucous membrane.

There are three strata:

The *muscular fibres* can be demonstrated at the full period of gestation to form three strata in the wall of the uterus, viz., external, internal, and middle.

external,

The *external* layer contains fibres which are mostly transverse; but at the fundus and sides they are oblique, and are more marked than along the middle of the organ. At the sides the fibres converge towards the broad ligament; some are inserted into the subperitoneal fibrous tissue; and others are continued into the Fallopian tube, the round ligament, and the ligament of the ovary.

internal,

The *internal* fibres describe circles around the openings of the Fallopian tubes, and spread from these apertures till they meet at the middle line. At the neck of the uterus they are arranged in a transverse direction.

and middle.

The *middle* or intervening set of fibres are more indistinct than the others, and have a less determinate direction.

Mucous lining is

The *mucous* lining of the uterus is continued into the vagina at one end, and into the Fallopian tubes at the other.

covered with glands.

In the body of the uterus it is of a reddish-white colour, and is thin, smooth, and adherent, but without papillæ. Like the mucous membrane of the intestine, it possesses tubular *glands,* which may be either straight and simple, or may be twisted or branched; the minute apertures of these are scattered over the surface.

Follicles in the neck.

In the cervix uteri, between the rugæ, mucous *follicles* and glands are collected, and near the outer opening papillæ exist.

Epithelium.

The *epithelial* covering of the mucous membrane consists of a single layer of cells, which is columnar and ciliated throughout the cavity of the uterus.

Vessels are large.

The *bloodvessels* of the uterus are large and tortuous, and occupy canals in the uterine substance, in which they communicate freely together.

Arteries;

The *arteries* are furnished from the uterine and ovarian branches (p. 607).

veins;

The *veins* correspond with the arteries; they are large in size, and form plexuses in the uterus.

The *nerves* are derived from the sympathetic (p. 612), and are very small in proportion to the size of the uterus. External to the uterus they are not enlarged in pregnancy (Beck). nerves.

Lymphatics. One set accompanies the uterine arteries to the glands on the iliac artery. Another set issues from the fundus, enters the broad ligament, and accompanies the ovarian artery to glands on the aorta: the last are joined by lymphatics of the ovary and Fallopian tube. Lymphatics, two sets; their ending.

Round ligament of the uterus. This firm cord supports the uterus, and is contained partly in the broad ligament, and partly in the inguinal canal (p. 601). It is about four or five inches in length, and is attached to the upper part of the uterus close below, and anterior to the Fallopian tube. A process of the peritoneum accompanies the part of the cord in the inguinal canal, and remains pervious sometimes for a short distance. Round ligament ends in groin. Attachment to uterus;

The ligament is composed of unstriated muscular fibres, derived from the uterus, together with vessels and areolar tissue. how formed.

OVARIES AND FALLOPIAN TUBES.

OVARY. The ovaries are two bodies, corresponding with the testes of the male. They are contained in the broad ligaments of the uterus, one in each, and at the posterior aspect. Ovary: position.

Each ovary is of an elongated form, and somewhat flattened from above down. It is of a whitish colour, with either a smooth or a scarred surface. Its volume is variable; but in the virgin state it is about one inch and a half in length, half that size in width, and a third of an inch in thickness. Its weight is nearly a quarter of an ounce. Form and colour, dimensions and weight.

The ovary is connected with the broad ligament by its anterior margin, where the vessels enter the stroma. Its outer end is rounded and is connected with one of the fimbriæ at the mouth of the Fallopian tube. The inner extremity is narrowed, and is attached to the side of the uterus by a fibrous cord,—the ligament of the ovary, which is placed below the level of the Fallopian tube and the round ligament. Connections.

Structure. The ovary consists of a stroma of areolar tissue containing small bodies or ovisacs named Graafian, and the whole is enclosed within a fibrous tunic. The peritoneum surrounds it except at the attached margin. Glandular in structure.

The special *fibrous* coat (tunica albuginea) is of some thickness and of a whitish colour, whence its name, and is adherent to the contained stroma. Sometimes a yellow spot (corpus luteum) or some fibrous cicatrices may be seen in this covering. A fibrous coat surrounds stroma.

Stroma. The substance of the ovary is spongy, vascular, and fibrous. At the centre the fibres radiate from the hilum towards the circumference. But at the exterior is a granular material Stroma, fibrous and granular, with vesicles

which contains very many small, with other larger bodies—the Graafian vesicles.

Graafian vesicles.

The *Graafian vesicles* or follicles are round and transparent saccules, scattered through the granular stroma of the ovary. During the child-bearing period some are larger than the rest; and of this larger set ten to thirty, or more, may be counted at the same time; these vary in size from a pin's head to a pea.

Size and number.

The largest are situate at the circumference of the organ, and sometimes they may be seen projecting through the fibrous coat.

Coat;

Each consists of a transparent coat with a fluid inside. The coat of the vesicle named *ovi-capsule* (tunica fibrosa), is formed of fine areolar tissue, and is united to the stroma of the ovary by a network of bloodvessels (vascular layer), which ramifies in the wall. Lining it is a laminar series of nucleated granular cells—the *membrana granulosa* of Baer, which is thickened at one spot on the side towards the ovary, and surrounds the ovum as the *discus proligerus*, fixing it to the wall.

contents.

The fluid in the interior is transparent and albuminous; it contains the minute vesicular ovum, together with molecular granules.

Shedding of an ovum

When the Graafian vesicle is matured it bursts on the surface of the ovary, and the contained ovum escapes into the Fallopian tube.

and corpus luteum.

After the shedding of the ovum the ruptured vesicle gives origin to a yellow substance, *corpus luteum*, which finally changes into a cicatrix.

Artery;

Bloodvessels and nerves. The ovarian *artery* pierces the ovary at the anterior or attached border, and its branches run in zigzag lines through the stroma, to which and the Graafian vesicles they are distributed.

veins;

The *veins* begin in the vesicles and the texture of the ovary, and after escaping from its substance, form a plexus (*pampiniform*) near the ovary, and within the fold of the broad ligament.

nerves.

The *nerves* are derived from the sympathetic on the ovarian and uterine vessels.

Appendage to ovary.

Appendage to the ovary. (Parovarium, Organ of Rosenmüller.)

Situation.

On holding up the broad ligament of the uterus to the light, a collection of small tortuous tubules will be seen between the ovary and the Fallopian tube.

Form.

This mass is the remnant of the Wolffian body of the fetus; and it is about one inch broad with its base to the Fallopian tube, and apex to the attached part of the ovary.

Structure.

The small tubes are quite separate from the surrounding parts, and are about twelve to twenty in number. At the base or wider end they are joined more or less perfectly by a tube crossing the rest, and prolonged sometimes a short way into the broad ligament. Each tube is a closed fibrous capsule with a clear fluid within, and a lining of epithelium.

Fallopian tubes.

FALLOPIAN TUBES. These tubes convey the ova from the ovaries to the uterus, and correspond in their office with the vasa deferentia in the male.

The tubes are two in number, one on each side. Each is about four inches in length. Cord-like at the inner end, where it is attached to the upper part of the uterus, it increases in size towards the outer end, and terminates in a wide extremity, like the mouth of a trumpet. This dilated end is fringed, and the serrations of its circumference are called *fimbriæ*. When the fimbriated end is floated out in water, one of the processes may be seen to be connected with the outer end of the ovary. In the centre of the fimbriæ is a groove leading to the orifice of the Fallopian tube.

Length, and form. It is dilated externally, and fimbriated.

On opening the tube with care, the size of the contained space, and its small aperture into the uterus can be observed. Its canal varies in size at different spots :—the narrowest part is at the orifice into the uterus (ostium uterinum), where it scarcely gives passage to a fine bristle; towards the outer end it increases a little, but it is rather diminished in diameter at the outer aperture (ostium abdominale).

Size of the tube is least at the ends.

Structure. This excretory tube has the same structure as the uterus with which it is connected, viz., a muscular tunic, covered externally by peritoneum, and lined by mucous membrane.

A muscular structure.

The *muscular* coat is formed of an external or longitudinal, and an internal or circular layer; both these are continuous with similar strata in the wall of the uterus.

Fibres prolonged from uterus.

The *mucous membrane* forms some longitudinal folds, particularly at the outer end. At the inner extremity of the canal it is continued into the mucous lining of the uterus, but at the outer end it joins the peritoneal covering. A columnar and ciliated *epithelium* covers the surface, as in the uterus, and is said by Henle to be detected on the outer surface of the fimbriæ.

Mucous coat is continuous with peritoneum.

The *bloodvessels* and *nerves* are furnished from those supplied to the ovary and uterus.

Vessels.

THE BLADDER, URETHRA, AND RECTUM.

Bladder. The peculiarities in the form and size of the female bladder have been detailed in the description of the connections of the viscera of the female pelvis (p. 602). For a notice of its structure, the anatomy of the male bladder is to be referred to (p. 617).

Anatomy given before.

Dissection. To prepare the bladder, distend it with air, and remove the peritoneal covering and the loose tissue from the muscular fibres.

Preparation of it.

After the external anatomy of the bladder and urethra have been learnt, the receptacle for the urine and its excretory tube are to be slit open along the upper part.

Open it.

Urethra. The length and the connections of this excretory tube are given in page 602.

Length of urethra.

Size; The average diameter of the tube is rather more than a quarter of an inch, and the canal is enlarged and funnel-shaped towards the neck of the bladder. Near the external aperture is a hollow in the floor of the tube. In consequence of not being surrounded by resistant structures, the female urethra is much more dilatable than the corresponding passage in the male.

it can be much dilated.

Tube like that in the male. *Structure.* This tube, like the urethra of the male, consists of a mucous coat, which is enveloped by a plexus of bloodvessels, and by muscular fibre.

Muscular coat of circular fibres. The *muscular* coat extends the whole length of the urethra. Its fibres are circular, and continuous behind with the middle layer of the bladder. In the perinæal ligament this covering is placed between the constrictor urethræ and the submucous layer, as in the male (p. 459); and that on the tube in the pelvis will correspond with the prostatic enlargement in the other sex.

Mucous coat. The *mucous* coat is pale except near the outer orifice. It is marked by longitudinal folds; and one of these, in the floor of the canal, resembles the median crest in the male urethra (p. 620). Around the outer orifice are some mucous *follicles;* and towards the inner end are mucous *glands*, whose apertures are arranged in lines between the folds of the membrane. A laminar *epithelium* is spread over the surface, and beneath it are deeper conical cells as in the bladder.

A fold in the floor.

Follicles and glands.

Epithelium.

Submucous tissue. A *submucous* stratum of longitudinal elastic and muscular tissues lies close beneath the mucous membrane as in the male.

Preparation of rectum. *Dissection.* The rectum may be prepared for examination by distending it with air or tow, and removing the peritoneal covering and the areolar tissue from its surface.

Rectum like that of the male. Rectum. The structure of the rectum is similar in the two sexes; and the student may use the description in the Section on the anatomy of the viscera of the male pelvis (p. 625).

Section VII.

INTERNAL MUSCLES OF THE PELVIS.

Two muscles. Two muscles, the pyriformis and obdurator internus, have their origin within the cavity of the pelvis.

Define the muscles *Dissection.* Take away any fascia or areolar tissue which may remain on the muscles; and define their exit from the pelvis, the posterior (pyriformis) passing through the great sacro-sciatic notch, and the anterior (obturator) through the small notch of the same name. On the right side the dissector may look to

and the levator ani.

the attachment of the levator ani muscle to the pubic part of the hip-bone.

The PYRIFORMIS MUSCLE is fleshy within the pelvis, and gradually narrowing, is directed outwards through the great sacro-sciatic notch to the great trochanter of the femur. The muscle has received its name from its form. **Pyriformis.**

In the pelvis the pyriformis *arises* by three slips from the second, third, and fourth pieces of the sacrum between the anterior apertures, and from the lateral part of the bone external to those holes; as it passes from the pelvis, it takes origin also from the surface of the hip-bone forming the upper part of the large sacro-sciatic notch, and from the great sacro-sciatic ligament. From this origin the fibres converge to the tendon of *insertion* into the trochanter. (See Dissection of the Buttock.) **Origin in the pelvis.** **Insertion.**

The anterior surface is in contact with the rectum, but more on the left than the right side; with the sacral plexus; and with the sciatic and pudic branches of the internal iliac vessels. The opposite surface rests on the sacrum, and is covered by the great gluteal muscle outside the pelvis. The upper border is near the hip-bone, the gluteal vessels and the superior gluteal nerve being between; and the lower border is contiguous to the coccygeus muscle, only the sciatic and pudic vessels and nerves intervening. **Its connections with parts around.**

Action. The pyriformis belongs to the group of external rotators of the hip-joint; and its use will be given with the description of the outer half of the muscle in the dissection of the Buttock. **Use as an external rotator of hip joint.**

The OBTURATOR INTERNUS MUSCLE, like the preceding, has its origin in the pelvis, and its insertion at the great trochanter of the femur; but the part outside is almost parallel in direction with that inside the pelvis. **Obturator muscle is bent over pelvis.**

The muscle *arises* by a broad fleshy attachment from the obturator membrane, except a small part below; from the pelvic or obturator fascia covering the surface, and from the fibrous arch bounding the canal containing the obturator vessels and nerve; slightly from the surface of bone internal to the thyroid hole, but largely from the smooth inclined surface of the pelvis behind that aperture,—reaching upwards to the brim, downwards to the outlet, and backwards to the great sacro-sciatic notch of the pelvis, though opposite the small sacro-sciatic foramen a thin layer of fat separates the fleshy fibres from the bone. The fibres are directed backwards and somewhat downwards, and end in three or four tendinous pieces, which turn over the sharp pulley-like surface at the back of the hip-bone corresponding with the small sacro-sciatic notch. Outside the pelvis the tendons blend into one, which is *inserted* into the great trochanter. **Origin in the pelvis.** **Arching of its tendons over the hip bone.** **Insertion.**

The pelvic portion of the muscle is in contact by one surface with the wall of the pelvis and the obturator membrane; by the **Part of muscle is in pelvic cavity** other surface with the fascia lining the pelvis, and towards its lower border with the pudic vessels and nerve. Above the level

part in perinæal space.

of the levator ani, viz., a line from the lower part of the symphysis pubis to the ischial spine, the muscle corresponds with the cavity of the pelvis, but below that line, with the ischiorectal fossa.

Use as external rotator.

Action. The muscle draws towards the edge of the hip bone over which it bends, and is able to rotate out the hip joint. For a more detailed notice of its use, see the description of the external rotators in the dissection of the Buttock.

Coccygeus muscle.

COCCYGEUS MUSCLE. The position and the connections of this muscle may be now studied with advantage in the interior of the pelvis. The muscle is described at p. 588.

LIGAMENTS OF THE PELVIS.

Outline of the articulations.

The several bones of the pelvis have the following articulations with one another. The sacrum is joined by its base to the last lumbar vertebra, and by its apex to the coccyx. Laterally this central bone is united with the two innominate bones. And the innominate bones are connected together in front, as well as to the sacrum and the spinal column posteriorly.

Union of sacrum with last vertebra.

SACRO-VERTEBRAL ARTICULATION. The base of the sacrum is articulated with the last lumbar vertebra by ligaments similar to those uniting one vertebra to another (p. 399); and by one special ligament—the sacro-vertebral.

Dissection.

Dissection. For the best manner of bringing these different ligaments into view, the dissector may consult the directions already given for the dissection of the ligaments of the vertebræ (p. 399).

By ligaments as in the vertebræ,

The *common ligaments* for the bodies of the two bones are an anterior and a posterior, with an intervening fibro-cartilaginous substance. Between the neural arches lie the ligamenta subflava; and between the spines the supra and interspinous bands are situate. The articular processes are united by capsular ligaments with synovial membranes.

and by special band, sacro-vertebral.

The *sacro-vertebral* or intertransverse ligament (fig. 113 [1]) is a strong bundle of fibres, which reaches from the under surface of the tip of the transverse process of the last lumbar vertebra to the lateral part of the base of the sacrum (transverse process). Widening as it descends, the ligament joins the fibres in front of the articulation between the sacrum and the innominate bone.

Union of sacrum and coccyx.

SACRO-COCCYGEAL ARTICULATION. The bodies of the sacrum and coccyx are united by a fibro-cartilage, and by an anterior and a posterior common ligament. And there is a separate articulation for the cornua of the bones.

Dissection.

Dissection. Little dissection is needed for these ligaments.

When the areolar tissue has been removed altogether from the bones, the ligaments will be apparent.

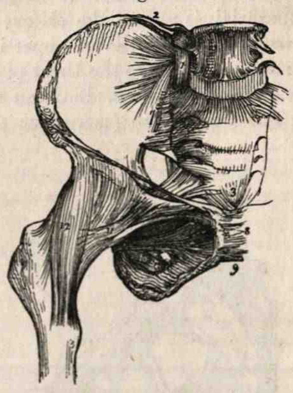
An anterior and

The *anterior ligament* (sacro-coccygeal) consists of a few fibres that pass between the bones in front of the fibro-cartilage.

a posterior ligament,

The *posterior ligament* is wide at its attachment to the last piece of the sacrum, but narrows as it descends to be inserted into the coccyx.

Fig. 113.*



and a fibro-cartilage.

The *fibro-cartilage* resembles that between the vertebræ, and is attached to the surfaces of the bones.

Union of the cornua.

Articulation of the cornua. The cornua of the first piece of the coccyx are united with the cornua of the last sacral vertebra by ligamentous bands, instead of joints as in the articular processes of the other vertebræ.

Motion.

Movement. Whilst the coccyx remains separate from the sacrum, there will exist a slight antero-posterior movement between them.

Union of bones of the coccyx.

Union of the bones of the coccyx. When the several pieces of the coccyx are not united by bone, their bodies are connected together by *anterior* and *posterior* bands, and by intervening thin *fibro-cartilages.* But in the adult male the bones are generally joined by ossific matter.

Union between the sacrum and hip bone.

Sacro-iliac Articulation. The irregular surfaces by which the sacrum and the innominate bone articulate, are united by cartilage, and are maintained in contact by anterior and posterior sacro-iliac ligaments. Inferiorly the bones are further connected, without being in contact, by the strong sacro-sciatic ligaments.

To dissect the ligaments.

Dissection. To see the posterior ligaments, the mass of muscle at the back of the sacrum is to be removed on the side on which the innominate bone remains. The anterior bands will be visible on the removal of some areolar tissue. The small sacro-sciatic ligament will be brought into view by removing the coccygeus; and the large ligament is dissected with the lower limb.

Anterior ligament.

The *anterior sacro-iliac* ligament (fig. 113, [7]) consists of a few

* Ligaments of the pelvis and hip joint.—1. Sacro-vertebral. 2. Ilio-vertebral or ilio-lumbar. 7. Anterior sacro-iliac. 8. Symphysis pubis. 9. Subpubic ligament. 10. Obturator ligament or membrane. 11. Hip joint capsule. 12. Ilio-femoral band.

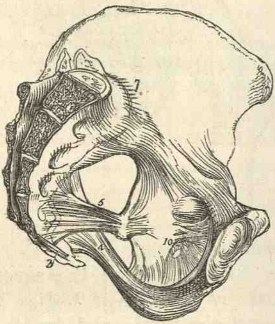
thin scattered fibres, which are attached to the sacrum and the hip bone near their articular surfaces.

Posterior ligaments; The *posterior ligaments* (sacro-iliac) are much stronger than the anterior, and the fibres are collected into bundles. These ligaments pass from the rough inner surface at the posterior end of the innominate bone to the first two pieces of the sacrum.

one more distinct, the oblique. One bundle, which is distinct from the others, and more superficial, is named the *oblique* or *long posterior* ligament; it is attached to the posterior upper iliac spinous process, and descends almost vertically to the third piece of the sacrum.

Articular cartilage. *Articular cartilage.* Between the irregular surfaces of the bone in this articulation (sacro-iliac synchondrosis) is a thin uneven layer of cartilage. It fits into the inequalities of the osseous surfaces, uniting them very firmly together; and in it there is said to be sometimes a hollow with irregular surfaces like that in the cartilage of the symphysis pubis. On separating the bones after the other ligaments are examined, the cartilage may be detached with a knife.

Fig. 114.*



Motion is very slight, *Movement.* There is scarcely any appreciable motion in the sacro-iliac articulation, even when the hip bone is seized by the hand, and forcibly pulled in different directions. **as security required;** The articulation seems designed for security and little movement, inasmuch as the surfaces are not in contact, are very irregular, and have a firm and inextensible piece of cartilage interposed between them. **sometimes more.** In some instances, and especially during pregnancy, there is a greater degree of motion perceptible.

Sacro-sciatic ligaments are two; Two *sacro-sciatic ligaments* pass from the lateral part of the sacrum and coccyx to the hinder border of the os innominatum, across the space between the bones at the back of the pelvis. The ligaments are named large and small.

large; The *large* ligament (fig. 114, [4]) reaches from the back of the hip bone, and from the side of the sacrum and coccyx to the ischial tuberosity. As this may have been cut in the examination of the gluteal region, no further notice is given here; but if it remains entire, see Dissection of the Buttock for its description.

small; The *small* ligament (fig. 114, [5]) is attached internally by a

* Great sacro-sciatic ligaments.—4. Large or posterior ligament. 5. Small or anterior ligament.

wide piece to the border of the sacrum and coccyx, where it is united with the origin of the preceding band. The fibres are directed outwards, and are inserted by a narrowed part into the ischial spine of the hip bone. Its pelvic surface is covered by the coccygeus muscle; and by the opposite surface it is in contact with the great sacro-sciatic ligament. Above it, between it and the hip-bone, is the large sacro-sciatic foramen; and below it is the small foramen of the same name, which is bounded by the two ligaments. attachments and connections.

By their position these ligaments convert into two apertures or foramina (sacro-sciatic), the large sacro-sciatic excavation in the dried bones: the openings, and the parts they give passage to, are described in the Dissection of the Buttock. Apertures formed by them.

LIGAMENTS OF THE INNOMINATE BONES. The innominate bones are united in front, at the pubic symphysis, by an interposed piece of cartilage and special ligaments; and behind, each is connected with the transverse process of the last lumbar vertebra by a special band (ilio-lumbar). In the centre of the bone is a membranous structure closing the thyroid aperture. Special ligments of hip bones.

The *ilio-lumbar* or *ilio-vertebral ligament* is triangular in form (fig. 113, [2]), and is divided into fasciculi. Internally it is attached to the tip of the transverse process of the last lumbar vertebra; externally the fibres spread out, and are inserted into the iliac crest, opposite the posterior part of the iliac fossa on the inner aspect of the hip bone. To the upper border of the ligament the fascia lumborum is attached. Its posterior surface is covered by the quadratus lumborum, and its anterior by the iliacus muscle. Ilio-lumbar fixes the bone behind.

The *thin obturator membrane* closes almost entirely the thyroid foramen (fig. 113, [10]), and is composed of fibres crossing in different directions. It is attached at the outer and upper part to the bony margin of the foramen, except above where the obturator vessels lie; and it is connected towards the lower part of the aperture to the pelvic aspect of the bone. The surfaces of the ligament give attachment to the obturator muscles. Branches of the obturator artery and nerve perforate it. Obturator membrane closes an aperture in front.

PUBIC ARTICULATION (symphysis pubis). The oval pubic surfaces of the hip bones are united by cartilage, and by fibres in front of, and above the bones: they are also connected by a strong subpubic ligament. Union at the pubes.

The *anterior pubic ligament* (fig. 113, [8]) is very strong and is formed of different layers of fibres. The superficial are oblique, and cross one another, joining with the aponeurosis of the external oblique muscle of the abdomen; but the deeper fibres are transverse between the surfaces of the bones. Some of the deepest fibres contain cartilage cells. Anterior band.

There is not any strong posterior band; but beneath the

Few fibres behind. periosteum are a few scattered fibro-cartilaginous fibres, as in front, in contact with the cartilage.

Upper band. The *superior ligamentous* fibres fill the interval between the bones above the cartilage.

Subpubic ligament. The *subpubic ligament* (ligam. arcuatum) is a strong triangularly-shaped band below the symphysis (fig. 113,[9]), and occupies the upper part of the pubic arch. Its fibres curve downwards, and are attached on each side to the bone. The apex of the ligament touches the articular cartilage, and the base, contained within the perinæal ligament, is turned towards the membranous part of the urethra and the muscle around it.

Cartilage, how seen; *Dissection.* The cartilage will be best seen by a transverse section which will show the disposition of the anterior ligament of the articulation, and the thickness of the cartilage, with its toothed mode of insertion into the bone; but when an opportunity offers, a longitudinal section may be also made.

disposition in the symphysis. *Cartilage.* The cartilage is firmly fixed to the ridged bony surfaces of the symphysis : it is wider above than below, and is generally as thick again before as behind. Variations in its size depend on the shape of the bones, and not on difference in sex.

Hollow in it. Towards the posterior part of the cartilaginous mass a hollow or narrow fissure is excavated with uneven walls and a synovial-looking fluid; and a fibrous structure with large interspersed compound cells is to be recognised in its wall. The space varies in size, and is said to increase in pregnancy. It extends usually the whole depth of the cartilage. In some bodies it reaches through the thickness of the cartilage from before back so as to divide this into two collateral pieces ; in others it projects through only a half or a third of the thickness.

Variations in size.

Motion small; *Movement.* As the bones are not in contact in the pubic symphysis, but are united by a thin intermediate cartilage, the motion is usually very slight, and is obtained by the compression of the connecting material. The kind of movement of the hip bone is inward and outward, so as to add to the increase or diminution of the pelvic cavity.

hip-bone moved in and out.

When greater, In the instances of division of the pubic cartilage into two by a larger central space than usual, greater freedom of motion is present in the articulation; and in pregnancy the looseness of the innominate bone is sometimes so great as to interfere seriously with locomotion.

and in pregnancy.

TABLE OF THE ARTERIES OF THE ABDOMEN.

The Abdominal Aorta gives off

- 1. Phrenic.
- 2. cœliac axis* .
  - Coronary . .
    - Œsophageal
    - gastric.
  - hepatic . . .
    - Superior pyloric
    - gastro-epiploïc . .
      - Inferior pyloric
      - pancreatico-duodenal.
    - left hepatic branch
    - right hepatic branch
      - Cystic.
  - splenic . .
    - pancreatic
    - vasa brevia
    - splenic
    - left gastro-epiploïc.
- 3. superior mesenteric* . .
  - Pancreatic
  - intestinal
  - ileo-colic
  - right colic
  - middle colic
- 4. middle capsular
- 5. renal
- 6. spermatic
- 7. inferior mesenteric* . .
  - Left colic
  - sigmoid
  - superior hæmorrhoidal.
- 8. lumbar
- 9. middle sacral*.
- 10. Common iliac .
  - External iliac .
    - Epigastric .
      - Pubic branch
      - anastomotic
      - cremasteric.
    - circumflex iliac
  - internal iliac .
    - Parietal branches .
      - Ilio-lumbar
      - lateral sacral
      - gluteal . .
        - Superficial
        - deep.
      - sciatic . . .
        - Coccygeal
        - comes nervi ischiadici
        - muscular.
      - pudic . .
        - Visceral
        - inferior hæmorrhoidal
        - superficial perinæal
        - transverse perinæal
        - artery of the bulb
        - to corpus cavernosum
        - dorsal artery.
      - obturator . .
        - Articular.
    - visceral branches .
      - Middle hæmorrhoidal
      - vesical
      - uterine.
      - vaginal.

* The branches marked with an asterisk are single.

TABLE OF THE VEINS OF THE ABDOMEN.

INFERIOR VENA CAVA receives

1. Common iliac . .
    - Internal iliac . .
        - Visceral branches .
            - Hæmorrhoidal plexus
            - vesico-prostatic plexus .
                - Vesical
                - dorsal of the penis
                - deep veins of the penis.
            - uterine
            - vaginal.
        - parietal branches .
            - Obturator
            - pudic . . .
                - Veins of corpus cavernosum
                - of the bulb
                - transverse perinæal
                - superficial perinæal
                - inferior hæmorrhoidal.
            - sciatic . .
                - coccygeal
                - comes nervi ischiadici
                - muscular.
            - gluteal.
    - external iliac . .
        - Epigastric
        - circumflex iliac.
    - ilio-lumbar
    - lateral sacral
    - middle sacral into the left.
2. vertebro-lumbar
3. right spermatic
4. renal . .
    - Right
    - left . . .
        - capsular
        - spermatic
5. right capsular
6. diaphragmatic
7. hepatic veins which bring blood from the vena portæ.

TABLE OF THE VEINS OF THE ABDOMEN—*continued.*

- VENA PORTÆ .
  - Splenic . . . .
    - Splenic branches
    - vasa brevia
    - pancreatic
    - left gastro-epiploïc
    - inferior mesenteric .
      - Left colic
      - sigmoid
      - superior hæmorrhoidal.
  - superior mesenteric
    - Intestinal
    - ileo-colic
    - right colic
    - middle colic
    - right gastro-epiploïc
    - pancreatic.
  - coronary
  - cystic

TABLE OF THE SPINAL NERVES IN THE ABDOMEN.

- LUMBAR SPINAL NERVES divide into .
  - Posterior branches .
    - Internal . . Muscular.
    - external .
      - Muscular
      - cutaneous.
  - Anterior branches: of these the four first end in the LUMBAR PLEXUS,* which supplies .
    - Ilio-hypogastric .
      - Cutaneous of the ilium
      - hypogastric branch.
    - ilio-inguinal
      - To integuments of the groin.
    - external cutaneous . .
      - To integuments of the thigh.
    - genito-crural . . .
      - Genital branch
      - crural branch.
    - anterior crural . . .
      - Branches inside the pelvis . .
        - To the iliacus muscle.
        - To the femoral artery.
      - Branches outside the pelvis
        - are noticed in the thigh.
    - obturator .
      - Accessory . .
        - Other offsets are described in the thigh.

* The lumbo-sacral gives off the superior gluteal nerve.

TABLE OF THE SPINAL NERVES OF THE ABDOMEN—*continued.*

- SACRAL SPINAL NERVES divide into .
  - Posterior branches unite together and give off . . .
    - Muscular and cutaneous filaments.
  - The anterior branches of the four superior unite with the lumbo-sacral in the SACRAL PLEXUS,* and furnish .
    - Branches inside the pelvis . .
      - Visceral
      - to levator ani
      - to obturator internus
      - to the pyriformis
    - branches outside the pelvis
      - pudic . . . .
        - Inferior hæmorrhoidal
        - superficial perinæal—(*anterior and posterior*)
        - muscular
        - to the bulb
        - dorsal of the penis.
      - inferior hæmorrhoidal (*sometimes*).
      - To the gluteus maximus
      - To the superior gemellus
      - to the inferior gemellus and the quadratus
      - articular
      - small sciatic
      - great sciatic
        - (To the gluteus maximus … great sciatic) these are described in the thigh.

* The other sacral nerves are described at p. 609.

TABLE OF THE SYMPATHETIC NERVE OF THE ABDOMEN.

- SOLAR PLEXUS † or prevertebral centre of the abdomen, furnishes the following plexuses:
  - Diaphragmatic
  - cœliac . . . .
    - Coronary plexus
    - hepatic . . .
      - Pyloric
      - right gastro-epiploïc
      - pancreatico-duodenal
      - cystic.
    - splenic . . .
      - Left gastro-epiploïc
      - pancreatic.
  - superior mesenteric. Offsets to small and large intestine.
  - suprarenal
  - renal . . . Spermatic plexus, filaments to the.
  - aortic . . . . . Hypogastric.
  - spermatic
  - inferior mesenteric .
    - Offsets to the large intestine
    - Superior hæmorrhoidal.

† This receives .
- Great splanchnic nerves
- part of small splanchnic
- offset of pnemo-gastric.

TABLE OF THE SYMPATHETIC NERVE OF THE ABDOMEN—*continued.*

HYPOGASTRIC PLEXUS* ends in the pelvic plexus on each side, which gives the following plexuses	inferior hæmorrhoidal	
	vesical . . .	Prostatic cavernous deferential to vesiculæ seminales.
	uterine vaginal.	
GANGLIATED CORD of the sympathetic in the abdomen supplies	External branches .	To the lumbar and sacral spinal nerves.
	internal . . .	To aortic plexus to hypogastric plexus to join round middle sacral artery between the cords on the coccyx, in the *ganglion impar.*

* This is joined above by .	The aortic plexus filaments from the lumbar ganglia.

PNEUMO-GASTRIC NERVE IN THE ABDOMEN.

Pneumo-gastric	Right. . .	Coronary branches to the back of the stomach filaments to join the cœliac and splenic plexuses.
	left . . .	Coronary branches to the front of the stomach and the hepatic plexus.

CHAPTER IX.

DISSECTION OF THE LOWER LIMB.

Section I.

THE FRONT OF THE THIGH.

Directions.

All the parts described in Section I. are to be examined before the time for turning the body arrives.

Position of the body.

Position. During the dissection of the front of the thigh the body should lie on the back, with the buttocks resting on the edge of the table, and with a block of suitable size beneath the loins. The lower limb should be supported in a half-bent position by means of a stool beneath the foot, and should be rotated outwards to make evident a hollow at the upper part of the thigh.

Objects on the surface.

Surface marking. Before any of the integument is removed from the limb, the student is to observe the chief eminences and hollows on the surface of the thigh.

Prominences limiting the thigh above.

The limit between the thigh and the abdomen is marked in front by the firm band of Poupart's ligament between the crest of the hip bone and the pubes. On the outer side the separation is indicated by the convexity of the iliac crest of the hip bone, which subsides behind in the sacrum and coccyx. On the inner side is the projection of the pubes, from which a line of bone (pubic arch) may be traced backwards along the inner and upper part of the limb to the ischial tuberosity.

Hollow of Scarpa's space.

On the anterior aspect of the thigh, and close to Poupart's ligament, is a slight hollow, corresponding with the triangular space of Scarpa, in which the larger vessels of the limb are contained; and extending thence obliquely towards the inner side of the limb, is a slight depression marking the situation of the femoral artery beneath.

Groove over femoral artery.

The position of the arterial trunk may be ascertained by a line on the surface from the centre of the interval between the symphysis pubis and the crest of the hip bone, to the inner condyle of the femur.

Position of great trochanter.

At the outer side of the thigh, about four inches below and behind the anterior spine of the iliac crest, the student will be able to recognise the well-marked projection of the great trochanter of the femur. In a thin body the head of the femur may be felt by rotating the limb inwards and outwards, whilst the thumb of one hand is placed in the hollow below Poupart's ligament, or the fingers behind the great trochanter. Head of the femur.

At the knee the outline of the several bones entering into the formation of the joint may be traced with ease. Thus, in front of the joint, when it is half bent, the rounded prominent patella may be perceived; this is firmly fixed whilst the limb is kept in the same position, but is moved with great freedom when the joint is extended so as to relax the muscles that are inserted into it. Bony eminence of knee. Patella.

On each side of the patella is the projection of the condyle of the femur, but that on the inner side is the largest. If the fingers are passed along the sides of the patella whilst the joint is half bent, they will be conducted by the condyles of the femur to the tuberosities of the head of the tibia, and to a slight hollow between the bones. Condyles of the femur. Tuberosities of the tibia.

Behind the joint is a slight depression over the situation of the ham or popliteal space; and on its sides are firm boundaries, which are formed chiefly by the tendons (hamstrings) of the flexor muscles of the leg. The ham behind.

Dissection. With the position of the limb the same as before directed, the student begins the dissection with the examination of the subcutaneous fatty tissue with its nerves and vessels. Dissection.

At first the integument is to be reflected only from the hollow on the front of the thigh close below Poupart's ligament. To raise the skin from this part an incision about four inches in length, and only skin deep, is to be made from the pubes along the inner border of the thigh. At the lower end of the first incision, another cut is to be directed outwards across the front of the limb to the outer aspect; and at the upper end of the first the knife is to be carried along the line of Poupart's ligament as far as the crest of the hip bone. The piece of skin included by these incisions is to be raised and turned outwards, without taking with it the subcutaneous fat. Take up the skin at the top of the thigh.

The subcutaneous fatty tissue, or the *superficial fascia*, forms a general investment for the limb, and is constructed of a network of areolar tissue, with fat or adipose substance amongst the meshes. As a part of the common covering of the body, it is continuous with that of the neighbouring regions, consequently it may be followed inwards to the scrotum or labium, and upwards on the abdomen. Superficial fascia, how formed.

Its thickness varies in different bodies, according to the quantity of fat deposited in it; and at the upper part of the thigh it is divided into two strata (superficial and deep) by some cutaneous vessels and inguinal glands. The superficial of the two layers Thickness varies; it is divided into two strata by vessels.

is apparent after the removal of the skin, but its connections will be made more evident by the following dissection.

To raise the superficial stratum.

Dissection. To reflect the superficial stratum of the fascia, incisions similar to those in the skin are to be employed, though they are not to reach so low on the thigh for a couple of inches; and the separation from the subjacent structures is to be begun at the lower part, where the large saphenous vein, and a condensed or membranous appearance on the under surface, will mark the depth of the stratum. The handle of the scalpel may be employed in raising the fascia along the middle line of the limb; but, where vessels and glands are not found, viz., along the outer and inner borders of the thigh, the separation of the superficial fascia into two layers cannot be easily made without using the edge of the knife.

Subcutaneous layer of the fascia

The *subcutaneous layer* of this fascia decreases in thickness near Poupart's ligament, becoming more fibrous at the same spot; and at its under aspect is a smooth and membranous surface. It conceals the superficial vessels and the inguinal glands, and is separated by these from Poupart's ligament, so that it is unconnected to that band as it passes upwards to the abdomen, and can be readily moved on it either upwards or downwards.

ununited with Poupart's ligament.

Dissection.

Dissection. The inguinal glands and the superficial vessels are to be next laid bare by the removal of the surrounding fat; but the student is to be careful not to destroy the deeper, very thin layer of the superficial fascia which is beneath them, and is visible chiefly on the inner side of the centre of the limb.

To see the superficial vessels,

Three sets of vessels are to be found in the dissection. One set (artery and vein) is directed inwards to the pubes, and is named external pudic; another, superficial epigastric, ascends over Poupart's ligament; and the third, or the superficial circumflex iliac, appears at the outer border of the limb. The large vein in the middle line of the thigh to which the branches converge, is the internal saphenous.

lymphatics,

Some of the small lymphatic vessels may be traced from one inguinal gland to another.

and nerves.

A small nerve, the ilio-inguinal, is to be sought on the inner side of the saphenous vein, and close to the pubes; and the branch of the genito-crural nerve, or an offset of it, may be found a little outside the vein.

The arteries from the femoral.

Superficial Vessels. The small cutaneous arteries at the top of the thigh are the first branches of the femoral artery, and are furnished by that trunk as soon as it enters the limb. They pierce the deep fascia (fascia lata), and are distributed in the integuments and the glands of the groin.

One external pudic artery;

The *external pudic* artery (superior) crosses the spermatic cord in its course inwards, and ends in the integuments of the penis and scrotum, where it anastomoses with offsets of the internal pudic artery.

Another external pudic branch (inferior) pierces the fascia lata at the inner border of the thigh, and ramifies also in the scrotum. In the female both branches supply the labium pudendi. another beneath the fascia.

The *superficial epigastric* artery passes over Poupart's ligament to the lower part of the abdomen (p. 470), and communicates with branches of the deep epigastric artery. Superficial epigastric.

The *superficial circumflex iliac* artery is the smallest of the three branches; and appearing as two or more pieces on the outer border of the thigh near the iliac crest, is distributed in the integuments. Superficial iliac.

A *vein* accompanies each artery, having the same name as its companion vessel, and ends in the upper part of the saphenous vein; but the description of these veins will be given in a subsequent page (655). Veins join the saphenous.

The *superficial inguinal glands* are arranged in two lines. One set lies across the thigh, near Poupart's ligament; and the other is situate along the side of the saphenous vein. In the lower or femoral group the glands are larger than in the upper, and the lymphatic vessels from the surface of the lower limb enter them. The upper or abdominal group is joined by the lymphatics of the penis, by those of the lower part of the abdomen, and by those of the buttock. The glands vary much in number and size, and not unfrequently the longitudinal set by the side of the vein are united together. Inguinal glands; two sets, which receive different lymphatics.

Dissection. The deeper layer of the superficial fascia is to be detached from the subjacent fascia lata. Internal to the saphenous vein a thin membrane can be raised, but external to that vessel there exists scarcely a continuous layer. Incisions similar to those for reflecting the subcutaneous stratum may be made across the front of the limb two inches from Poupart's ligament, and along the inner side of the part laid bare; and the handle of the scalpel being employed in the separation, the dissector is to endeavour to avoid injuring the nerves and vessels. In reflecting the stratum the margin of an aperture (saphenous) in the fascia lata will become apparent. Raise the deep stratum of the superficial fascia.

The *deeper layer* of the *superficial fascia* is a very thin membraniform stratum, which is most evident near Poupart's ligament, and on the inner side of the saphenous vein. About one inch below the ligament it conceals the large saphenous opening in the fascia lata, and is there pierced by the saphenous vein and some ducts of the lymphatic glands. As it stretches across the opening it is attached to the circumference,—internally by loose areolar tissue, but externally by firm fibrous bands; and it is also connected with the loose crural sheath of the subjacent vessels in the aperture. Deep part of the superficial fascia covers saphenous opening.

where it is named cribriform fascia.

The part of this stratum over the saphenous opening is perforated by many small apertures for the transmission of the lymphatics; and it has been named *cribriform* fascia from its sieve-like appearance. In a hernial protrusion through that opening the cribriform portion is projected forwards by the gut, and forms one of the coverings.

Dissection of the front of the thigh.

Dissection. When the student has observed the disposition of the superficial fascia near Poupart's ligament, he may proceed to examine the remainder of the subcutaneous covering of the thigh, together with the vessels and nerves in it.

Take away the skin,

To raise the skin from the front of the thigh, a cut is to be carried along the centre of the limb, over the knee joint, to rather below the tubercle of the tibia. At the extremity a transverse incision is to be made across the front of the leg, but this is to reach farthest on the inner side. The skin may be reflected in flaps inwards and outwards; and as it is raised from the front of the knee a superficial bursa between it and the patella will be opened.

and follow saphenous vein.

The saphenous vein is first to be traced out in the fat as far as the skin is reflected, but in removing the tissue from it the student should be careful of the branches of the internal cutaneous nerve.

Seek cutaneous nerves of front of thigh,

The cutaneous nerves of the front of the thigh are to be sought in the fat with small cutaneous arteries in the following positions:—On the outer margin below the upper third lies the external cutaneous nerve. In the middle, also below the upper third, the two branches of the middle cutaneous nerve are placed. At the inner margin lie the ramifications of the internal cutaneous nerve,—one small offset appearing near the upper part of the thigh; one or more about half way down; and one of the terminal branches (anterior) about the lower third.

and on side of the knee.

On the inner side of the knee three other cutaneous nerves are to be looked for:—One a branch of the great saphenous, is directed outwards over the middle of the patella. Another, the trunk of the great saphenous nerve, lies by the side of the vein of the same name, close to the lower part of the surface now dissected. And the third is a terminal branch (inner) of the internal cutaneous nerve, which is close behind the preceding, and communicates with it. Small cutaneous arteries accompany the several nerves.

Superficial veins.

VESSELS. All the veins on the anterior and inner aspects of the thigh are collected into one; and this trunk is named saphenous from its manifest appearance on the surface.

Internal saphenous vein in thigh

The *internal saphenous* vein is the cutaneous vessel of the inner side and front of the lower limb; and it extends from the foot to the upper part of the thigh. In the part of its course now dissected, the vessel lies inferiorly somewhat behind the knee joint; but as it ascends to its termination, it is directed along the inner side and the front of the thigh. Near Poupart's ligament it pierces the fascia lata by a special opening named saphenous, and enters the deep vein of the limb (femoral).

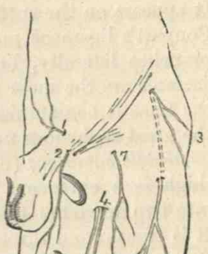
pierces fascia lata to join the femoral.

Superficial branches join it both externally and internally; and near Poupart's ligament the three veins corresponding with the arteries in that situation, viz., superficial pudic, epigastric, and circumflex iliac, terminate in it. Towards the upper part of the limb the veins of the inner side and back of the thigh are most frequently united into one branch, which enters the saphenous trunk near the aperture in the fascia lata; and sometimes those on the outer side of the thigh are collected together in a similar way. When this arrangement exists three large veins will be present on the front of the thigh near the saphenous opening. On the side of the knee the vein receives generally a deep branch from the joint.

Veins joining it

may form three trunks at the top of the thigh.

Fig. 115.*



Some unnamed *cutaneous arteries* are distributed to the integuments along with the nerves; and the superficial branch of the anastomotic artery (p. 670) sends offsets with the saphenous nerve and its branches near the knee.

Cutaneous arteries.

NERVES. The cutaneous nerves of the thigh are derived from branches of the lumbar plexus (p. 581), and are distributed in greater abundance on the inner than the outer margin.

Cutaneous nerves.

Ilio-inguinal. This nerve (p. 582) is small in size, and reaches the surface by passing through the external abdominal ring (fig. 115, [2]); it supplies the scrotum, and ends in the contiguous part of the thigh internal to the saphenous vein.

Ilio-inguinal is near scrotum.

Genito-crural. The *crural* branch of this nerve (p. 583) pierces the fascia lata near Poupart's ligament (fig. 115, [7]), rather external to the line of the femoral artery. After or before the nerve has become superficial it communicates with the

Genito-crural reaches the middle of thigh.

* Cutaneous nerves on the fore part of the thigh.—1. Ilio-hypogastric branch on the belly. 2. Ilio-inguinal nerve. 3. 3. External cutaneous—the two parts. 4. Middle cutaneous. 5. 5. Internal cutaneous: the lower figure marks the anterior branch of the nerve. 6. Saphenous nerve. 7. Crural branch of the genito-crural nerve.

middle cutaneous nerve; and it extends on the anterior aspect of the thigh as far as midway between the knee and the pelvis.

Unusual state. Occasionally this branch is of large size, and takes the place of the external cutaneous nerve on the outer side of the limb.

External cutaneous, The *external cutaneous* nerve (p. 583) is distributed on the outer aspect of the limb (fig. 115, [3]). At first it is contained in a prominent ridge of the fascia lata on the outer margin of the thigh, where it divides into an anterior and a posterior branch.

posterior, and The *posterior* branch subdivides into two or three others, which arch backwards to supply the integuments of the outer part of the thigh as low as the middle; and the highest offsets are crossed by branches of the last dorsal nerve.

anterior branches. The *anterior* branch extends to the lower half of the thigh. It appears on the surface of the fascia lata about four inches from Poupart's ligament and is continued to the knee; it distributes branches laterally, but those towards the outer and posterior surfaces are the most numerous, and the largest in size. Over the knee it communicates sometimes with the patellar branch of the great saphenous nerve.

Middle cutaneous *Middle cutaneous* (fig. 115, [4]). The nerve of the centre of the thigh is a cutaneous offset of the anterior crural, and divides into two branches that may pierce the fascia at separate spots. It is transmitted through the fascia lata about three inches from Poupart's ligament, and its branches are continued to the knee,

reaches the knee. where it communicates with the offset of the great saphenous nerve over the patella. In the fat this nerve is united with the genito-crural and internal cutaneous nerves.

In some instances the nerve is inclined to the inner side of the knee, and is substituted for a branch (anterior) of the following nerve.

Internal cutaneous. *Internal cutaneous.* Derived from the anterior crural trunk, this nerve is furnished to all the inner side of the thigh. It is divided into two branches (anterior and inner), which perforate the fascia in separate places.

The anterior branch The *anterior* branch becomes cutaneous in the lower third of the thigh in the line of the inner intermuscular septum (fig. 115, [5]), along or somewhat behind which it is continued to the knee.

extends to knee along the septum. This branch is distributed in the lower third of the thigh, as well as over the patella and the inner side of the knee joint, and is united with the patellar branch of the internal saphenous nerve.

Occasionally this part of the nerve is found below the level of the knee joint; and in that case it is larger than usual, and is joined by a small offset from the saphenous nerve.

The inner ends in upper part of the leg. The *inner* branch (fig. 118, [1]) perforates the fascia at the inner side of the knee behind the internal saphenous nerve, with which it communicates; it furnishes offsets to the inside of the knee, and to the upper half of the leg on the inner surface.

Other small offsets for the supply of the inner side of the thigh arise from the trunk, or from the anterior branch, and appear by the side of the saphenous vein. One or two come into view near the upper part of the vein, and reach as far as the middle of the thigh; and one, larger in size than the rest, appears where the others cease, and extends as far as the knee. These cutaneous offsets usually communicate. **Other small twigs to inner part of the thigh.**

The *internal saphenous* (fig. 115, [6]) is a branch of the anterior crural like the two preceding, and is continued to the foot, but only a little part of it is now visible. The nerve pierces the fascia on the inner side of the knee; and, after communicating with the inner branch of the internal cutaneous, gives forwards some offsets over the knee joint. Finally it accompanies the saphenous vein to the leg and foot. **Internal saphenous appears by the knee and passes to the leg.**

Its *patellar* branch appears on the surface of the fascia, higher than the trunk from which it springs, and is soon joined by the internal cutaneous nerve. It ends in many branches over the patella; these communicate with offsets from the saphenous and middle and external cutaneous nerves, and form an interlacement—*plexus patellæ*—over the joint. **A branch from it over the patella forms a plexus with others.**

When this branch is small its place is taken by the anterior piece of the internal cutaneous nerve.

Dissection. Let the fat and the inguinal glands be now removed from the surface of the fascia lata, the cutaneous nerves being thrown aside to be traced afterwards to their trunks. **Clean the surface of the fascia lata,**

At the upper part of the thigh the student is to define the saphenous opening by detaching the superficial fascia. The separation is easily made at the inner side. But the outer border is blended with the superficial fascia and with the subjacent crural sheath; and it is only after the uniting fibrous bands are broken or cut through, that its semilunar edge comes into view. The student must not expect to find it so defined as it is represented in drawings. **and define saphenous opening.**

The *fascia lata* is the deep aponeurosis of the thigh. It surrounds the limb with a firm sheath, and sends inwards septa between the different muscles. This membranous investment is of a bluish white colour, and in fat bodies is sometimes so slight as to be taken away with the subcutaneous fat. **Fascia lata surrounds limb;**

It is much stronger on the outer than the inner aspect of the limb, and receives the insertion of the tensor vaginæ femoris, and part of the gluteus maximus muscle. This thickened part (ilio tibial band) is attached above to the hip-bone and below to the bones of the leg, and helps to keep the knee-joint extended in standing, without the strong and continued action of the extensor muscle. **strength varies. Ilio-tibial band.**

Apertures in it.

Numerous apertures exist in the fascia for the transmission of the cutaneous nerves and vessels; and the largest hole is near Poupart's ligament, to permit the passage of the internal saphenous vein.

Processes between the muscles.

Processes prolonged from the under surface form septa between, and fibrous sheaths around the several muscles. Some of the processes are larger than the rest, and are named the intermuscular septa of the thigh:—Thus two, outer and inner, are fixed to the femur, so as to limit on the sides the extensors of the knee; and a third piece intervenes between the adductors of the thigh and the flexors of the knee. The position of these partitions is marked on the surface by white lines.

Connected with bone at upper part of thigh.

At the upper part of the thigh the fascia is fixed to the prominent borders of the pelvis. Thus it is connected externally with the iliac crest, and internally with the pubes and the pubic arch. In the middle line behind it is joined to the lower end of the sacrum and coccyx; and in front to Poupart's ligament between the pubes and the iliac crest.

Difference at lower part.

At the lower part of the thigh it passes uninterruptedly to the leg behind the knee joint; but in front of the articulation it blends with an expansion from the extensor muscle, and is continued over the joint and the patella, though separated from that bone by a bursa, to be inserted into the heads of the tibia and fibula.

Bands on sides of patella,

outer strong,

inner weak.

On each side of the patella is a band of almost transverse fibres (retinaculum) which is attached to and supports the knee-cap. The outer, thick and strong, is continuous externally with the ilio-tibial band, and at its inner attachment to the upper part of the patella, joins the insertion of the vastus externus: it guides the patella outwards when the joint is bent. The inner band of slight strength is fixed to the patella lower than the other and unites above with the insertion of the inner vastus, as will be afterwards seen.

Replace flaps of skin.

Directions. The flaps of skin that were removed from the front of the thigh, to follow the cutaneous vessels and nerves, are to be now stitched together to keep moist the subjacent parts; and the saphenous opening is to be learnt.

Saphenous opening: situation, form, and size.

The *saphenous opening* in the fascia lata (fig. 87) receives its appellation from transmitting the saphenous vein. This aperture is oval in form, and is situate rather to the inner side of the middle line of the thigh. It measures about half an inch in width and one inch and a half in length. Its upper extremity (superior cornu) is at Poupart's ligament; and its lower extremity (inferior cornu) is distant from that structure about one inch and a half, and presents a well defined margin.

Inner margin sharp below;

The inner part of the opening is posterior to the level of the femoral vessels. It is deficient above in a prominent edge, for the fascia constructing it is stretched over a flat subjacent muscle (pectineus); but it is marked below by a thin and sharp border.

The outer boundary is much stronger, and has a semilunar border when detached, whose concavity is turned downwards and inwards. This edge is named from its shape *falciform* border or margin of the saphenous opening (falciform process of Burns): it is superficial to the femoral vessels, and is connected by fibrous bands to the crural sheath, and the deeper layer of the superficial fascia. Traced upwards the outer edge reaches to the inner side of the femoral vein (fig. 89, [6]) and blends with the base of Gimbernat's ligament (part of Poupart): the upper end of this border, where it is internal to the vessels, has been known as the *femoral* ligament.

outer is firm, and semilunar when separate, and joins Gimbernat's ligament: femoral ligament.

The rigidity of the margin of the opening is much influenced by the position of the limb; for if the finger be placed beneath the upper part of the falciform border whilst the thigh is moved in different directions, the dissector will perceive that this band is most unyielding when the limb is extended and rotated out, and most relaxed when the thigh is bent and turned in the opposite direction.

Tenseness of the margins depends on the position of the limb.

Through the lower part of the opening the saphenous vein is transmitted: and through the upper part, close to the falciform edge, a femoral hernia projects. Lymphatics and one or two superficial vessels also pass through it.

Parts transmitted through the opening.

The pieces of the fascia on the opposite sides of the saphenous opening are sometimes named from their attachment to bone; the part on the outer side being called iliac from its insertion into the iliac crest; whilst that on the inner side, which is fixed to the pubes (fig. 87, [4]), is named pubic.

Names for fascia.

Parts concerned in Femoral Hernia.

To obtain a knowledge of the hernial protrusion in the thigh, the dissector has to study the undermentioned parts, viz. the crural arch and Gimbernat's ligament, the crural sheath, the crural canal and the crural ring, together with a partition (septum crurale) between the thigh and the abdomen.

Anatomy of parts concerned in femoral hernia.

Dissection. To examine Poupart's ligament and a loose membranous sheath around the femoral vessels, the piece of the fascia lata outside the saphenous opening is to be reflected inwards by the following incisions. One cut is to be begun near the edge of the falciform border, and to be carried outwards for one inch and a half, parallel and close to Poupart's ligament. Another is to be directed obliquely downwards and inwards from the termination of the first, to a little below the inferior cornu of the opening. When the fascia marked out by

Dissection to see a sheath around femoral vessels.

those incisions has been turned inwards, and the fat removed, the tube of membrane (crural sheath) will be brought into view as it descends beneath Poupart's ligament.

Define sheath.

With the handle of the scalpel the sheath is to be separated carefully from the fascia lata beneath, and from Poupart's ligament in front; and Gimbernat's ligament on the inner side of the sheath, to which the upper end of the falciform border is united, is to be defined.

The crural arch; attachments; form.

Poupart's ligament, or the crural arch, is the firm band of the aponeurosis of the external oblique muscle of the abdomen, which stretches from the front of the iliac crest to the pubes (p. 476). When viewed on the surface, the arch has not a straight direction between its bony attachments as long as the fascia lata is uncut, but is curved downwards towards the thigh. The outer half is oblique. But the inner half is almost horizontal, and widens as it approaches the pubes, where it is inserted into the spine, and the pectineal line of the hip bone for about an inch, forming Gimbernat's ligament.

Parts closing hollow beneath.

The space between the crural arch and the innominate bone is larger in the female than the male, and is closed by parts passing from the abdomen to the thigh. The outer half of the interval is filled by the fleshy psoas and iliacus muscles, to which the arch is closely bound by fascia; and the inner half is occupied by the femoral vessels and their sheath.

Gimbernat's ligament; form, situation, and connections;

Gimbernat's ligament is the part of the tendon of the external oblique muscle of the abdomen which is inserted into the pectineal line of the hip bone (p. 476). Viewing it as a separate structure, it is about one inch in length and triangular in shape. Its apex is at the pubic spine; whilst its base is in contact with the crural sheath, and is blended with the fascia lata,—the part that forms the outer side of the saphenous opening. By one margin (anterior) it is continuous with the crural arch, and by the opposite it is fixed to the pectineal line.

surfaces; is part of Poupart's.

In the erect position of the body the ligament is almost horizontal, and one surface is directed upwards to the abdominal cavity, whilst the other is turned towards the thigh. On forcibly raising the crural arch, the continuity of Gimbernat's ligament with that band will plainly appear.

Crural sheath. Shape and connections.

The *crural sheath* (fig. 89, [7]) is a loose tube of membrane around the femoral vessels. It has the form of a funnel sloped unequally on the sides. The wide part or base of the tube is upwards; and the narrow part ceases about two inches below Poupart's ligament by blending with the common areolar sheath of the bloodvessels. Its outer border is nearly straight, and is perforated by the genito-crural nerve. Its inner border is oblique, and is pierced by lymphatics, superficial vessels, and the saphenous vein; this part of the sheath appears in the saphenous opening, and is connected to the falciform margin and the superficial fascia. In front of the crural sheath and behind it is the fascia lata of the thigh.

How formed. The sheath is continuous with the fasciæ lining the abdomen in this way;—the anterior part is prolonged beneath Poupart's ligament into the fascia transversalis, and the posterior half is continued into the fascia iliaca (p. 499).

Deep crural arch. Crossing the front of the crural sheath below the arch of Poupart's ligament, is a thickened fibrous band, which has been named the *deep crural* arch. A notice of it is given with the description of the fascia transversalis (p. 486). This band is supposed to take part sometimes in producing the stricture of the subjacent intestine in a femoral hernia.

Open the crural sheath. *Dissection.* The student is to open the sheath by an incision across the front, and to raise the loose anterior part with hooks. Inside the tube are contained the femoral vessels surrounded by areolar tissue, with an inguinal gland; and if a piece of the areolar casing be cut out over both the artery and the vein, there will be an appearance of two thin partitions, the one being situate on the inner side of the vein separating it from the gland, and the other between the vein and the artery. A fatty stratum may be seen stretching over the upper aperture of the sheath, closing the tube towards the abdomen.

Contents of the sheath. *Interior of the crural sheath.* The sheath is said to be divided into three compartments by two partitions. The position of the so-called septa has been before referred to,—one being internal to the femoral vein, and the other between the two large vessels.

Space divided into three parts. In the outer compartment is contained the femoral artery, lying close to the side of the sheath (fig. 89, [8]); in the middle one is placed the femoral vein ([9]); and in the inner space (crural canal) only a lymphatic gland is situate.

Vessels have a sheath. The common covering of areolar tissue of the femoral vessels is distinct from the crural sheath above described.

The inner of the three spaces is the crural canal. The *crural canal* (fig. 89) is the innermost space in the interior of the crural sheath:—Its length is from half to three quarters of an inch, for it reaches from the base of Gimbernat's ligament to the upper cornu of the saphenous opening; and it decreases rapidly in size from above down.

Extent and parts around it. Anterior to the sheath, and consequently to the contained space, are Poupart's ligament and the upper end of the falciform margin of the saphenous opening; whilst behind it is the pectineus muscle, covered by fascia lata. On the outer side of the canal but in the sheath is the femoral vein. The aperture above by which the space communicates with the cavity of the abdomen is named the crural ring.

Hernia in it. Through this channel the intestine passes from the abdomen in femoral hernia.

Crural ring. Situation and form.

The *crural ring* is the opening of the crural canal into the abdominal cavity.* It is on a level with the base of Gimbernat's ligament, and is larger in the female than in the male. Oval in shape, its greatest measurement is from side to side, in which direction it equals about half an inch; and it is filled by a lymphatic gland.

Structures around.

The structures around the opening, and outside the crural sheath, are nearly similar to those bounding the crural canal, viz. in front the superficial and the deep crural arch, and behind, the pubes covered by the pectineus muscle and the fascia lata. Internally is Gimbernat's ligament with the conjoined tendon; and externally, but within the sheath, is the femoral vein. The position of vessels on the several sides of the ring is stated at page 500.

Crural septum; position; how formed.

Septum crurale. That part of the subperitoneal layer of fat which is placed over the opening of the crural ring, has been named crural septum from its position between the thigh and the abdomen (Cloquet). The situation of the septum is now visible, but its characters are ascertained in the dissection of the abdomen (p. 499).

Femoral hernia. Definition.

Femoral Hernia. This kind of hernia consists in a protrusion of the intestine into the thigh beneath Poupart's ligament. And the gut descends always in the crural sheath, being placed commonly on the inner side of the vein, though it may be occasionally on the outer side of the artery.

Course; first vertical, next directed forwards, and then upwards.

Course. At first the intestine takes a vertical direction in its progress from the abdomen to the surface of the body, and passes through the crural ring by the side of the gland, and along the crural canal as far as the saphenous opening. At this spot it changes its course, and is directed forwards to the surface where it becomes elongated transversely; and should the gut protrude still farther the hernia again alters its direction, and ascends on the abdomen in consequence of the resistance being less in this direction than on the front of the thigh.

By what means it is to be pushed back.

The winding course of the hernia must suggest to the dissector the direction in which attempts should be made to replace the intestine in the abdominal cavity. With the view of making the bowel retrace its course, it will be necessary if the protrusion is small to direct it backwards and upwards; but if the hernia is large it must be pressed down first to the saphenous opening, and afterwards backwards and upwards towards the crural canal and ring.

* Gimbernat used the name crural ring, and Mr. Lawrence proposes to call it femoral aperture. Might not the nomenclature be made to resemble more that used in describing inguinal hernia, by calling this opening the internal crural aperture, and the saphenous opening the external crural aperture?

The effect of the position of the limb in the foregoing dissection will have demonstrated the necessity of raising the thigh, and rotating it inwards during the manipulation to return the displaced intestine to its cavity, in order that the margin of the saphenous opening and the other parts may be relaxed. Size of canal altered.

Coverings. As the intestine takes the above specified course it is clothed by the following structures, which are elongated and pushed before it from within outwards. First is a covering of the peritoneum lining the abdomen, which forms the hernial sac. Next one from the septum crurale across the crural ring. Afterwards comes a stratum from the crural sheath, unless the hernia bursts through an aperture in the side. Over this is spread a layer of the cribriform fascia. And, lastly, there is an investment of the superficial fat or fascia, together with the skin. From without inwards the order of the different strata will be reversed. Coverings for the gut from the peritoneum, crural septum, crural sheath, cribriform fascia, fat and skin.

The coverings may vary, or be conjoined in different degrees according to the condition of the hernia. In some instances, as above said, the prolongation from the crural sheath is wanting. Further, in an old hernia the covering derived from the septum crurale is united usually with that from the crural sheath, so as to form one layer, the *fascia propria* (Cooper). In general, in an operation for the relief of the strangulated bowel, the surgeon, after dividing the subcutaneous fat, can recognise but little of the coverings enumerated by anatomists until he meets with that of the subperitoneal fat or septum crurale. The coverings may be altered. The surgeon does not find so many as the anatomist.

Diagnosis. This hernial tumour is generally smaller than inguinal, and does not extend into the scrotum or the labium; and if its neck can be traced down below Poupart's ligament it can be distinguished certainly from an inguinal hernia. Tumour how known.

Seat of stricture and division of it. The strangulation of a femoral hernia may be situate either outside or inside the neck of the sac. Place of stricture.

The external stricture may be found opposite the margin of the saphenous opening, or deeper in opposite Poupart's ligament. It may be removed by cutting down on the neck of the tumour at the inner side, and dividing the constricting band arching over the neck of the hernia in each situation, without opening the sac. How to cut the external,

The stricture inside the neck of the sac is occasioned by the thickening of the peritoneum. For its relief the neck of the sac is to be laid bare as if there was an external stricture; and if the intestine cannot be passed into the abdomen after division of all constricting bands on the exterior of the neck, the sac of the peritoneum is to be opened; and a director having been introduced through the constriction, a cut is to be made horizontally inwards for the extent of one or two lines. The and the internal stricture.

several vessels that may be wounded in attempting to relieve the deep stricture are enumerated at page 501.

Scarpa's triangular space.

Triangular space at top of the thigh;

This hollow is situate at the upper part of the thigh, and lies beneath the depression observable on the anterior aspect near Poupart's ligament. It corresponds with the axilla in the upper limb.

Clean out Scarpa's triangular space.

Dissection. The space will be prepared by removing the fascia lata near Poupart's ligament, and cleaning the parts that then come into view. The muscular boundaries on the sides may be first dissected.

Follow vessels.

Afterwards the remains of the crural sheath are to be taken away; and the femoral vessels are to be followed downwards as far as the sartorius muscle.

Seek nerves.

On the outer side of the vessels clean the divisions of the anterior crural nerve, together with the branches of an artery (profunda) which are buried in the fat.

Take away fat.

All the fat is now to be cleared out of the space; and in removing it from beneath the femoral artery, the student is to look for one or two small nerves to the pectineus muscle.

Contents.

This *intermuscular space* contains the trunks of the blood-vessels of the thigh, and the anterior crural nerve, with lymphatics and fat. It measures commonly three to four inches from above down: but the length varies with the breadth of the sartorius, and the height at which this muscle crosses inwards.

Extent.

Base, apex, and side boundaries.

The base of the space is at Poupart's ligament; and the apex is at the meeting of the sartorius with the adductor longus muscle. On the sides lie the two last muscles, the sartorius being external, and the adductor internal.

Roof and floor.

Towards the surface it is covered by the fascia lata, and by the teguments with inguinal glands and superficial vessels. The floor slopes towards the middle where it is deepest: it is constructed externally by the conjoined psoas and iliacus for about two inches; and internally by the pectineus and adductor longus muscles, and between and behind these near the large vessels, is a small part of the adductor brevis.

Femoral artery and branches.

The femoral artery runs through the centre of the hollow, and supplies small cutaneous offsets, as well as a large deep branch, the profunda: a small offset (external pudic) is directed from it to the scrotum across the inner boundary. On the inner side of the artery and close to it is placed the femoral vein, which is here joined by the saphenous and profunda branches. From a quarter to half an inch external to the vessel is situate the large anterior crural nerve, which lies deeply at first between the iliacus and

Vein.

Anterior crural nerve.

psoas, but becomes afterwards more superficial and divides into branches.

Deep lymphatics accompany the femoral vessels, and are continued into the iliac glands in the abdomen; they are joined above by the superficial lymphatics. Lymphatics.

Femoral Artery. This vessel is a continuation of the external iliac artery in the abdomen, and reaches from the lower border of Poupart's ligament to the margin of the opening in the adductor magnus muscle; at this spot it bends backwards into the ham, and takes the name popliteal. Occupying two thirds of the thigh, the course of the vessel will be indicated, during rotation outwards of the limb with the knee-joint half bent, by a line drawn to the inner side of the internal condyle of the femur, from a point midway between the symphysis pubis and the front of the iliac crest. Femoral artery; extent: course.

In the upper part of its course the artery lies rather internal to the head of the femur, and is comparatively superficial, being uncovered by muscle; but, in the lower part, it is placed along the inner side of the shaft of that bone, and is beneath the sartorius muscle. This difference in its connections allows of a division of the arterial trunk into two portions, superficial and deep. Position to the femur and parts around. Division into two parts.

The *superficial part of the artery*, which is now laid bare, is contained in Scarpa's triangular space, and is from three to four inches long. Its position in that hollow may be ascertained by the line of the vessel before mentioned. Superficial portion.

Incased at first in the crural sheath for about two inches, it is covered by the skin and the superficial fascia, and by the fascia lata and some inguinal glands. At its beginning the artery rests on the psoas muscle; and it is subsequently placed over the pectineus, though at some distance from it in this position of the limb, and separated from it by fat, and the profunda and femoral veins. Connection with parts around.

Its companion vein is on the inner side and close to it at the pubes, but is placed behind the artery at the apex of the space. Position of vein and

The anterior crural nerve lies on the other side, being distant nearly half an inch near Poupart's ligament; and the internal cutaneous branch of the nerve approaches the artery, or lies on it, near the apex of the containing space. Crossing beneath the vessels is the nerve of the pectineus. nerve.

The *branches* of the first part of the artery are the superficial epigastric and circumflex iliac, two external pudic, and the deep femoral branch. The cutaneous offsets have been seen (p. 652), with the exception of the following, which lies at first beneath the fascia lata. Branches of this part seen, except

The inferior *external pudic* artery arises separately from, or in common with the other pudic branch (superior) (p. 652). This one external pudic, beneath the fascia.

branch courses inwards over the pectineus muscle to end in the teguments of the scrotum or the labium pudendi, according to the

Fig. 116.*

sex ; and it perforates the fascia lata at the inner border of the

* Femoral artery and its branches with muscles of the thigh (from Quain's Arteries).—1. Femoral artery. 2. Profunda artery. 3. Internal

thigh to reach its destination: in the fat it anastomoses with branches of the superficial perinæal artery.

The *deep femoral* branch, or the *profunda*, is the largest offset of the femoral artery, and arises from the outer part of that trunk one inch to two inches (Quain) below Poupart's ligament. It is consumed in the muscles of the thigh, and its distribution will be afterwards ascertained. **Profunda. Origin**

In the present dissection it may be seen to lie over the iliacus muscle, where it gives the external circumflex artery to the outer part of the thigh; and it is then directed, with a large vein, beneath the trunks of the femoral vessels to the inner side of the limb.* **and position in Scarpa's triangle.**

FEMORAL VEIN. The principal vein of the limb, whilst in the triangular space in the upper part of the thigh, has almost the same relative anatomy as the artery. Its position to that vessel, however, is not the same throughout. Beneath Poupart's ligament it is on the inner side of the artery, and on the same level, and is supported on the pubes between the psoas and pectineus muscles; but it soon winds beneath the arterial trunk, and appears on the outer side opposite the upper border of the adductor longus muscle. In this space it receives the internal saphenous and deep femoral veins, and a small branch with the external pudic (inferior) artery. **Femoral vein: first inside the artery, afterwards outside it.**

Peculiarities in position. Four examples of transference of the main artery of the limb from the front to the back of the thigh have been recorded. In those cases the vessel passed from the pelvis through the great sacro-sciatic notch, and accompanied the great sciatic nerve to the popliteal space. **Peculiarities in place of artery.**

Origin of the profunda. The profunda branch, though arising commonly from the femoral artery between one inch and two inches from Poupart's ligament, may approach nearer to the ligament until it arrives opposite that band, or may even go beyond, and be fixed to the external iliac artery (one example, Quain). And the branch may recede farther and farther from the ligament, till it leaves the parent trunk at the distance of four inches from the commencement; but in this case the circumflex branches usually arise separately from the femoral. **Origin of profunda varies.**

In applying a ligature to the femoral artery in the upper part of the thigh, the thread should be placed four inches below Poupart's ligament, in order that the spot chosen may be free from the disturbing influence of so large an offset.

Position of the vein. The position of the vein with respect to the artery may be altered, for the venous trunk may be placed on the inner side of **Position of the vein varies; or the vein may be divided.**

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circumflex. 4. External circumflex. 5. Superficial circumflex iliac and epigastric branches. 6. External pudic artery. 7. Aponeurosis over the lower part of the femoral artery. 8. Anterior crural nerve. 9. Pectineus muscle. 10. Adductor longus. 11. Gracilis. 12. Vastus internus. 13. Rectus femoris. 14. Sartorius cut across.

* Some anatomists apply the term common femoral to the part of the trunk above the origin of the profunda, and give the names superficial and deep femoral to the nearly equal parts into which it divides.

that vessel through all the triangular space. Further the vein may be slit so as to present a large piece on each side of the artery for a greater or less extent, or one of the two may lie over the arterial tube.

DEEP PARTS ON THE FRONT OF THE THIGH.

Muscles on the front of the thigh.

The muscles on the front of the thigh are to be learnt next: they are the sartorius, and the extensor of the knee; and at the top of the thigh is the small tensor of the fascia lata. Several muscles are combined in the extensor, viz. the rectus, vastus externus, and vastus internus and crureus.

Vessels. Nerve.

A portion of the femoral artery lies amongst the muscles and supplies them with branches; and a large nerve, the anterior crural, furnishes offsets to them.

Take the fascia from the front of the thigh.

Dissection. To proceed with the deep dissection, the limb is to be retained in the same position as before, and the flaps of skin on the front of the thigh are to be thrown aside. The fascia lata is to be cut along the middle line of the thigh and knee, and to be reflected to each side nearly to the same extent as the skin. Over the knee joint the student is to note the attachment of its retinacula to the edges of the patella, and its union with a prolongation from the tendon of the extensor muscles of the leg.

Follow out sartorius, and fix it,

In raising the inner piece of the fascia the narrow muscle then appearing (sartorius) should be followed to its insertion into the tibia: and to prevent its displacement, it should be fixed with stitches along both edges. Care should be taken of the small nerves in contact with the sartorius; viz. a plexus between the saphenous, internal cutaneous, and obturator, beneath it at the middle of the thigh; two branches of the internal cutaneous below the middle, one crossing the surface, and the other lying along the inner edge of the muscle; and the trunk of the great saphenous escaping from beneath it near the knee, with the patellar branch of the same perforating it rather higher.

and preserve nerves in contact with it.

Dissect the adductors,

Internal to the sartorius some strong muscles (adductors) are inclined downwards from the pelvis to the femur. The student is to lay bare those muscles; and beneath the most superficial muscle (adductor longus), near where it touches the sartorius, he is to seek a branch of the obturator nerve to the plexus before mentioned in the middle of the thigh.

and clean the extensor muscles.

On the outer side of the sartorius is the large extensor of the knee. For the dissection of its fleshy parts the knee is to be bent to make tense the fibres; and an expansion below from the common tendon to the fascia lata and the knee joint is not to be removed now: its arrangement will be noticed after.

Dissect tensor of fascia.

The little muscle at the upper and outer part of the thigh,—tensor of the fascia lata, is to be cleaned; and a strip of the fascia, corresponding with its width, should be left along the outer aspect of the thigh. After this slip has been separated, the rest of the fascia is to be divided by one or two transverse cuts, and is to be followed backwards to its attachment to the femur.

The SARTORIUS is the longest muscle in the body, and extends from the pelvis to the leg. It arches over the front of the thigh, passing from the outer to the inner side of the limb, and lies in a hollow between the extensors on the one side, and the adductors on the other. **Sartorius;**

Its origin is tendinous from the upper anterior iliac spinous process of the hip bone, and from about half the interval between this and the inferior process. The fibres constitute a riband-like muscle, which ends in a thin tendon below the knee, and is *inserted* into the inner surface of the tibia,—mainly into a slight depression by the side of the tubercle for an inch and a half, but also by its upper edge as far back as the internal lateral ligament of the knee joint. **origin: course over the thigh; insertion.**

The muscle is superficial throughout, and is perforated by some cutaneous nerves and vessels. Its upper part is oblique, and forms the outer boundary of the triangular space containing the femoral artery: it rests on the iliacus, rectus, and adductor longus muscles, as well as on the anterior crural nerve and the femoral vessels. The middle portion is vertical, and lies in a hollow between the vastus internus and the adductor muscles as low as the opening for the femoral artery; but beyond that aperture, where it bounds the popliteal space at the inner side, it is placed between the vastus with the great adductor in front, and the inner hamstring muscles behind. The femoral vessels and their accompanying nerves are concealed by this portion of the muscle. The lower or tendinous piece rests on the internal lateral ligament of the knee joint, being superficial to the tendons of the gracilis and semitendinosus, and separated from them by a prolongation of their synovial bursa: from its upper border there is an aponeurotic expansion to join that from the extensors over the knee; and from its lower border is given another which blends with the fascia of the leg. Below the tendon the great saphenous nerve appears with an artery; and piercing it is the branch of the same nerve. **Connections of the first or oblique part; of the middle part; and of the lower part.**

Action. The tibia and femur being free to move the muscle bends the knee and hip-joints over which it passes, giving rise to rotation inwards of the former; and makes tense finally the fascia of the thigh. **Use: the limb free**

With the limbs fixed the two muscles will support the pelvis in standing, and will assist in bringing forwards the pelvis as in stooping. **and fixed:**

When standing on one leg the muscle will help to rotate the body so that the face may be turned to the opposite side. **standing on one leg.**

Divide the sartorius, *Dissection.* The sartorius is to be turned aside, or cut through if it is necessary, to follow the remaining part of the femoral artery.

show aponeurosis, and dissect the nerves Beneath the muscle is an aponeurosis between the adductor and extensor muscles; this is thin above, and when it is divided the internal saphenous nerve will come into view. Parallel to the upper part of the saphenous nerve but outside it, is the nerve to the vastus internus muscle, which sends an offset on the surface of the vastus to the knee joint: this may be traced now, lest it should be destroyed afterwards. The plexus of nerves on the inner side of the thigh may be more completely dissected in this stage.

and vessels. The femoral vessels and their branches are to be nicely cleaned. Where the femoral artery passes to the back of the limb its small anastomotic branch arises: this branch is to be pursued through the fibres of the vastus internus, and in front of the adductor magnus tendon to the knee; an offset of it is to be followed with the saphenous nerve.

Aponeurosis over the femoral artery; The *aponeurotic covering* over the femoral vessels exists only where these are covered by the sartorius. It is thin above, but below it is formed of strong fibres, which are directed transversely between the vastus internus and the tendons of the adductor muscles. ends below by a defined border. Inferiorly the membranous structure ceases at the opening in the adductor magnus by a defined border, beneath which the saphenous nerve and its vessels escape.

Deep part of femoral artery. The *deep part* of the *femoral artery* lies in a hollow between muscles (Hunter's canal) until it reaches the opening in the adductor magnus. Connections. Here it is covered by the sartorius muscle and the subjacent aponeurosis, in addition to the integuments and the superficial and deep fasciæ. Beneath it are the pectineus, adductor longus, part of the adductor brevis, and the adductor magnus. On the outer side is the vastus internus.

Position of veins and On the outer side of the artery and close to it is the femoral vein; and in the integuments oftentimes an offset of the saphenous passes over the arterial trunk.

saphenous nerve. Crossing over the artery from the outer to the inner side is the internal saphenous nerve, which is beneath the aponeurosis before noticed, but is not contained within the areolar sheath of the vessels.

Branches. *Branches.* Only one named branch, anastomotic, springs from this part of the artery, the other offsets belong to muscles.

Anastomotic; The *anastomotic branch* (arter. anastomotica magna) arises close to the opening in the adductor muscle, and splits at once into two parts, superficial and deep.

superficial and The *superficial* offset continues with the saphenous nerve to the lower border of the sartorius, and piercing the fascia lata, ramifies in the integuments.

The *deep* or anterior branch is concealed in the fibres of the vastus internus, and descends in front of the tendon of the adductor magnus to the inner side of the knee joint, where it anastomoses with the articular branches of the popliteal and anterior tibial arteries. A branch passes outwards from it in the substance of the vastus; this forms an arch in front of the lower end of the femur with an offset of the external articular artery, and supplies the joint. deep branch.

The two pieces of the anastomotic artery may be separate at their origin, and spring from distinct parts of the parent trunk.

Muscular branches. Branches for the supply of the muscles come mostly from the outer part of the femoral artery; they enter the sartorius, the vastus internus, and the adductor longus. Muscular branches.

The FEMORAL VEIN corresponds closely with the femoral artery in its connections with the parts around, and in its branches. The position with respect to the artery is, as above said, external to, and in contact with it. Femoral vein.

Peculiarities as to splitting of the artery. Occasionally the femoral artery is split into two below the origin of the profunda. Four examples of this peculiarity have been met with; but, in all, the trunks were blended into one above the opening in the adductor muscle. The femoral artery may be divided.

Position of the vein. The femoral vein may change its position here, as in the upper part (p. 667), and may be found on the inner side of the artery; or it may be divided into two trunks, which lie on the sides of its companion vessel. The vein may be inside the artery; or split;

Size of the vein. In some bodies this part of the femoral vein is very small in size, in consequence of the popliteal coursing along the back of the thigh to enter the profunda vein, instead of accompanying the main artery of the limb through the aperture in the adductor magnus. or very small.

Dissection. The femoral artery and vein are to be cut across below the origin of the profunda, and are to be thrown downwards, preparatory to the deeper dissection. Afterwards all the fat, and all the veins, are to be carefully removed from amongst the branches of the profunda artery and anterior crural nerve. Unless this dissection is completed, the upper part of the vastus internus and crureus will not be prepared for learning. To expose muscles on front of the femur.

The TENSOR VAGINÆ FEMORIS occupies the upper third of the thigh, and is the smallest and most external of the outer set of muscles. It takes *origin* from the front of the crest of the hip bone at the outer aspect; from the anterior upper iliac spine, and from part of the notch between this and the inferior spine, as far as the attachment of the sartorius. Its fibres form a fleshy belly about two inches wide, and are *inserted* into the fascia lata about three inches below, and rather anterior to the great trochanter of the femur. Tensor vaginæ femoris arises from pelvis, ends in fascia lata.

At its origin the muscle is situate between the sartorius and the gluteus medius. Beneath it are the ascending offsets of Parts around.

the external circumflex artery; and a branch of the superior gluteal nerve enters its under surface. A strong sheath of fascia surrounds the muscle.

Use on limb;

Action. Supposing the limb moveable the muscle abducts the thigh, making tense at the same time the fascia lata; and finally it will rotate inwards the femur.

on pelvis.

When the limb is fixed it will support the pelvis, and assist in balancing the same on the femur in walking.

Cut through the last muscle.

Dissection. After the muscle has been learnt, the slip of fascia extending from it to the knee may be cut through; and when it is detached from the muscles around, the head of the rectus muscle may be followed upwards to the pelvis.

Outline of muscles on front of thigh.

The TRICEPS EXTENSOR of the leg consists of three fleshy parts or heads, outer (vastus externus), inner (vastus internus), and middle (rectus), which are united below in a common tendon.

Rectus has an

The RECTUS FEMORIS or middle head forms a fleshy prominence on the front of the thigh (fig. 116, [13]), and reaches from the pelvis to the common insertion. At its *origin* from the pelvis the muscle consists of two tendinous pieces:—one arises from the anterior inferior iliac spinous process; the other (to be afterwards seen) is fixed into a depression on the back of the hip bone, close above the brim of the acetabulum. Fleshy fibres succeed to the tendon; and they terminate inferiorly in another tendon, which joining the aponeurotic parts of the other two muscles, is *inserted* with them into the upper border of the patella, and is continued finally into the head of the tibia.

origin at the pelvis, which is double, and an insertion into the head of the tibia.

The muscle is penniform, and superficial, except above.

The rectus is larger at the middle than at the ends; and its fibres are directed from the centre to the sides, as in a quill, and give rise to that condition called penniform. It is subcutaneous, except above where it is overlaid by the sartorius. It conceals branches of the external circumflex artery and anterior crural nerve, and rests on the muscular mass of the vastus and crureus. The upper tendon of the rectus reaches farthest on the anterior surface where the sartorius touches, whilst the lower tendon is most extensive on the posterior aspect, or towards the subjacent vasti.

Cut the rectus,

Dissection. To see the remaining muscles, cut across the rectus near the lower end, and raise it without injuring the branches of vessels and nerves beneath. The muscular mass on the front of the femur is to be divided, above, into two along the situation of some descending vessels and nerves: the part external to the vessels is the vastus externus, and the larger mass, internal to them, is composed of the conjoined vastus internus and crureus.

and separate the vastus externus above,

and below from inner vastus.

To make out the lower separation of the two, look to the outer aspect of the thigh about half way down, where the long and vertical fibres of the vastus externus cross over others (deeper), which are continued obliquely inwards, and belong to the inner vastus.

The VASTUS EXTERNUS or outer head of the triceps extensor muscle of the leg, has a very narrow attachment to the femur in comparison with its size and thickness. It takes *origin* by a piece from half an inch to an inch thick for the most part, along the upper half of the femur. Thus, beginning above, it is attached to the root of the neck of the femur, and the fore part and outer surface of the root of the great trochanter; to the line connecting the trochanter with the linea aspera; and to the upper half of the linea aspera, and the contiguous external intermuscular septum. Inferiorly the fibres of the muscle end in an aponeurosis which blends with the tendons of the rectus and vastus internus to form a common tendon, and sends a slip to the outer edge of the patella.

Vastus externus is thin at the origin;

The muscle is pointed at the upper part, but enlarged below where it produces the prominence on the outer side of the thigh. Its cutaneous surface is aponeurotic above, and is covered by the rectus, tensor vaginæ femoris, and gluteus muscles. The deep surface rests on the vastus internus and crureus, and receives branches of the external circumflex artery and anterior crural nerve.

but is thicker below, at its insertion.

Parts in contact with the surfaces.

The VASTUS INTERNUS and CRUREUS, inseparably united in one muscle (fig. 116, [12]), form the inner or large head of the extensor. The fleshy mass arises from the anterior and lateral surfaces of the shaft of the femur, and its limits may be thus indicated:—Upwards it reaches as far as the anterior intertrochanteric line; and downwards, to about two inches from the articular end of the femur. Outwards it extends to the vastus externus, to the margin of the lower half of the linea aspera, and to the line continued downwards from this to the condyle. Internally it reaches the linea aspera, the line prolonged upwards from this towards the small trochanter and the anterior intertrochanteric line, as well as the line continued downwards from the same ridge to the inner condyle; and some of the lowest fibres take origin also from the tendon of the adductor magnus. At the lower end of the muscle the fibres terminate in an aponeurosis that blends in the common tendon of insertion, and is attached to the patella lower than the vastus externus.

Vastus internus and crureus.

One mass on the front of the femur.

Its origin;

insertion by a common tendon.

The upper part of the muscular mass is buried beneath the sartorius and rectus muscles; but the lower part is superficial, and projects more than the vastus externus at the opposite side of the thigh: some of the lowest fibres are almost transverse, and will be able to draw inwards the patella. The adductor muscles are almost inseparably joined with the vastus along the attachment to the linea aspera.

Upper part deep, lower superficial.

Dissection. The common tendon of the extensor will appear

Lay bare the common

tendon of the extensor. by dividing along the middle line of the patella and tendon a thin aponeurotic layer which is derived from the lower fleshy fibres of the muscle, and covers the knee joint. On reflecting inwards and outwards that fibrous layer the common tendon will be laid bare to its insertion into the tibia.

Tendon of the extensor; The *tendon* of the *extensor muscles* of the leg is common to the rectus, the vastus externus, and the united vastus internus and crureus. It is placed in front of the knee joint, to which attachments. it serves the office of an anterior ligament. Wide above where the muscular fibres terminate, it narrows as it descends over the joint, and is inserted inferiorly into the prominence of the tubercle of the tibia and into the bone below it for an inch: Bursa beneath. close to its attachment to the tibia a synovial bursa is beneath it. In it the patella is situate, some few scattered aponeurotic fibres passing over the cutaneous surface, but none being continued over the deep or articular surface. (See Ligament of the Patella.)

Expansion over it. From the lower part of the muscle a superficial aponeurotic expansion is derived: this prolongation, which is strongest on the inner side, is united with the fascia lata and the other tendinous offsets to form a capsule in front of the joint, and is fixed below to the heads of the tibia and fibula.

Small subcrureus muscle; *Subcrureus muscle.* Beneath the united vastus and crureus, near the knee joint, is a thin layer of pale fibres. It is but a part of the large muscle on the front of the femur, which is ends on the synovial sac. separated from the rest by areolar tissue. Attached to the femur in the lower fourth, and often by an outer and inner slip, it ends in aponeurotic fibres on the synovial sac of the knee joint.

Use with tibia moveable: *Action.* All three heads extend the knee joint when the tibia is moveable; and the rectus can then flex the hip joint over which it passes. The fleshy bellies are strong enough to break transversely the patella over the end of the femur, or to rupture sometimes the common tendon in the act of falling.

with tibia fixed: When the tibia is fixed the vasti will bring forwards the femur, and straighten the knee as in walking or standing; and the rectus will prop the pelvis on the femur, or assist in bringing forwards the pelvis in stooping.

how subcrureus acts. The subcrureus contracts in extension of the knee, and elevates the synovial membrane above the patella.

Intermuscular septa are two. *Intermuscular septa.* The processes of the fascia lata, which limit laterally the extensor muscles of the knee, are thus named, and are fixed to the linea aspera and the lines leading from it to the condyles of the femur.

The outer is the strongest; The *external* septum is the strongest, and reaches from the outer condyle of the femur to the insertion of the gluteus maximus. It is situate between the vastus externus and the short head of the biceps, to which it gives origin; and it is perforated near the outer condyle by the upper external articular vessels and nerve.

The *inner* partition is very thin along the side of the vastus internus; and its place is supplied by the strong tendon of the adductor magnus between the inner condyle and the linea aspera. The internal articular vessels are transmitted through it below to the front of the knee joint. **the inner is indistinct.**

The EXTERNAL CIRCUMFLEX ARTERY is the chief vessel for the supply of the muscles of the front of the thigh. It arises from the outer side of the profunda (deep femoral) artery, and is directed horizontally outwards through the divisions of the anterior crural nerve, and beneath the sartorius and rectus muscles to the outer part of the thigh, where it ends in branches. Offsets are given from it to the rectus and sartorius; and its terminal muscular branches consist of ascending, transverse, and descending. **Artery to the muscles on the front of the thigh. Its branches are—**

The *ascending branch* is directed beneath the tensor vaginæ femoris to the back of the hip bone, where it anastomoses with the gluteal artery and supplies the contiguous muscles. **ascending,**

The *transverse*, the smallest in size, divides into two which perforate the vastus externus, and anastomose with arteries on the back of the thigh. **transverse,**

The *descending branch* is the largest, and ends in pieces which are distributed to the vasti muscles. One considerable branch enters the vastus externus, and reaching the knee, anastomoses on this joint with the external articular arteries; a small offset courses over the muscle with a nerve to the joint. **and descending.**

Peculiarities in the origin of this artery are very frequent. Thus the vessel may arise as one trunk from the superficial instead of the deep femoral artery. It may be represented by two pieces, which spring from the femoral trunk. Or it may be derived from the femoral and profunda—one piece being obtained from each: this last arrangement is very frequently found. **Varieties in this artery and branches**

The ANTERIOR CRURAL NERVE is derived from the lumbar plexus (p. 583), and supplies the muscles, and most of the integuments of the front of the thigh, and the integuments of the inner side of the leg. Soon after the trunk of the nerve leaves the abdomen it is flattened, and is divided into a superficial or cutaneous, and a deep or muscular part. **Nerve of the front of the thigh is divided.**

The *superficial* part ends in three branches:—the middle and internal cutaneous of the thigh, and the great saphenous. **From its superficial part arise—**

The *middle cutaneous nerve* perforates the fascia lata, sometimes also the sartorius, about three inches below Poupart's ligament, and extends on the surface of the thigh to the knee. Its cutaneous distribution is described at page 656. **middle cutaneous.**

Internal cutaneous, The *internal cutaneous nerve* sends two or more small twigs through the fascia lata to the integument of the upper third of the thigh, and then divides in front of the femoral artery, or on the inner side, into the two following branches, anterior and inner. Sometimes these branches in which the nerve ends arise from the anterior crural trunk at separate spots.

which has anterior and The *anterior* branch is directed to the inner side of the knee joint. As far as the middle of the thigh it lies over the sartorius, but it then pierces the fascia lata, and ramifies in the integuments as before said (p. 656).

inner branch; The *inner* branch is distributed in the integuments of the inner side of the leg, just below the knee, but it remains beneath the fascia lata as far as the knee (p. 656). Whilst underneath the fascia the nerve lies along the inner border of the sartorius, and joins in a plexus, about the middle of the thigh, with offsets of the obturator; and nearer the knee with a branch of the internal saphenous nerve.

the last small. When this branch is small it ends in the plexus just mentioned, and in twigs to the inner part of the thigh, instead of being continued onwards to the leg.

Internal saphenous nerve The *internal saphenous* nerve is the largest of the three superficial branches. It becomes cutaneous on the inner side of the knee, and accompanies the vein of the same name to the foot (p. 657). In the thigh the nerve takes the course of the deep bloodvessels:—thus, it approaches the femoral artery where this is concealed by the sartorius, and is continued along the outer side of that vessel, beneath the aponeurosis covering the same, as far as the opening in the adductor magnus muscle. At that spot the nerve passes from beneath the aponeurosis, and is prolonged under the sartorius muscle to the upper part of the leg, to become cutaneous as before said. It supplies two offsets whilst it is contained in the thigh beneath the fascia.

becomes cutaneous at the knee; has a communicating The *communicating branch* arises about the middle of the thigh or lower down, and crosses inwards beneath the sartorius to join in the plexus of the internal cutaneous and obturator, or with the internal cutaneous nearer the knee: this branch is sometimes absent.

and a patellar offset. The *patellar branch* springs from the nerve near the knee joint, and perforating the sartorius muscle and the fascia lata, ends in the integument over the knee (p. 657).

From the deep part arise The *deep* or *muscular* part of the anterior crural nerve gives branches to all the muscles of the front of the thigh, except the tensor vaginæ femoris; and it supplies also an offset to one of the adductor muscles, viz. the pectineus.

branches to pectineus; A slender *nerve* crosses beneath the femoral artery, and enters the anterior surface of the *pectineus*: sometimes there are two.

sartorius; *Branches* to the *sartorius* are furnished by the middle or the internal cutaneous nerve, whilst it is in contact with that muscle.

A *nerve* enters the under surface of the *rectus* muscle at the upper part, and divides into branches as it is about to penetrate the fibres. **rectus;**

The *nerve* to the *vastus externus* separates into two or more branches as it enters the muscle. From one of these an *articular* filament is continued downwards to the knee joint, which it enters on the anterior aspect. **vastus externus and knee joint;**

The *nerve* to the *vastus internus* is nearly as large in size as the internal saphenous, in common with which it often arises. To the upper part of the vastus it furnishes one or more branches, and is then continued as far as the middle of the thigh, where it ends in offsets to the muscle and the knee joint. **and vastus internus.**

Its *articular* branch is prolonged on or in the vastus, and on the tendon of the adductor magnus to the inner side of the knee joint; and it is distributed over the synovial membrane of the front of the articulation. This small nerve accompanies the deep branch of the anastomotic artery. **Articular offset to knee**

A *branch* of nerve to the *tensor vaginæ femoris* is derived from the superior gluteal; it enters the under surface of the muscle, and extends nearly to the lower end. **Nerve of tensor vaginæ.**

Directions. After the examination of the muscles of the front of the thigh, with their vessels and nerves, the student is to learn the adductor muscles and the vessels and nerves which belong to them. **Take next the adductors.**

PARTS ON THE INNER SIDE OF THE THIGH.

The muscles in this position are the three adductors,—longus, brevis, and magnus, with the gracilis and pectineus; these have the following position with respect to one another. Internal to all and the longest, is the gracilis. Superficial to the others, are the pectineus and the adductor longus; and beneath them are the short adductor and the adductor magnus. **The adductor muscles and their position.**

In connection with the muscles, and supplying them are the profunda artery (of the femoral) and its branches, with the accompanying vein. **Vessels.**

The obturator nerve lies amongst the adductor muscles, and furnishes branches to them. **Nerve.**

Dissection. To prepare the muscles, the investing fascia and tissue are to be taken from them; and the two superficial adductors are to be separated one from another. **Dissection of adductor muscles.**

Let the student be careful of the branches of the obturator nerve in connection with the muscles, viz., those offsets entering the muscular fibres, and one issuing beneath the adductor longus to join the plexus at the inner side of the thigh. **Nerves.**

Remove veins. Lastly, should any fat and veins be left with the profunda and its branches, they must be cleared away.

Gracilis The GRACILIS reaches from the pelvis to the tibia (fig. 116, [11]), and is fleshy and riband-like above, but tendinous below. The muscle *arises* by an aponeurosis, two or three inches in depth, from the lower or pubic border of the hip bone close to the margin, viz., opposite the lower half of the symphysis, and the upper part of the pubic arch. Inferiorly it is *inserted* by a flat tendon, about half an inch wide, into the inner surface of the tibia, beneath and close to the sartorius.

takes origin from the pelvis,

is inserted into tibia.

Position to other muscles. The muscle is superficial throughout. At the upper part of the thigh it is flattened against the adductors brevis and magnus, so as to have its borders directed forwards and backwards; and in the lower third it intervenes between the sartorius and semi-membranosus muscles, and forms part of the inner boundary of the popliteal space. At its insertion the tendon is nearer the knee than that of the semitendinosus, though at the same depth from the surface, and both lie over the internal lateral ligament; and from the tendon an expansion is continued to the fascia of the leg, as in the sartorius. A bursa separates the tendon from the ligament of the joint, and projects above it to the sartorius.

Use on knee joint and femur, *Action.* It bends the knee joint if the tibia is not fixed, rotating in that bone; and then brings the moveable femur towards the middle line with the other adductors.

on pelvis. Supposing the foot resting on the ground the gracilis will aid in propping the pelvis on the limb.

Pectineus. The PECTINEUS (fig. 116, [9]) is the highest of the muscles directed from the pelvis to the inner side of the femur. It has a fleshy origin from the ilio-pectineal line of the hip bone, and from the triangular smooth surface in front of that line; and it is *inserted* inferiorly by a tendon, about two inches in width, into the femur behind the small trochanter, and into the upper part of the line which extends from that process to the linea aspera.

Origin from pubes,

inserted into femur.

Muscle is twisted. The muscle is twisted, so that the surfaces which are directed forwards and backwards near the pelvis are turned inwards and outwards at the femur. One surface is in contact with the fascia lata; and the opposite touches the obturator muscle and nerve, and the adductor brevis. The pectineus lies between the psoas and the adductor longus; and the internal circumflex vessels pass between its outer border and the former muscle.

Surfaces.

Parts on the sides.

Use on femur free and fixed. *Action.* It adducts the limb and bends the hip-joint.

When the femur is fixed it can support the pelvis in standing; or it can draw forwards the pelvis in stooping.

Adductor longus extends from pelvis to femur. The ADDUCTOR LONGUS lies below the pectineus (fig. 116, [10]), and is triangular in form, with the apex at the pelvis and the base at the femur. It *arises* by a narrow tendon from the front of the pubes below the angle of union of the crest and the symphysis; and it is *inserted* into the inner margin of the linea aspera.

This muscle is situate between the gracilis and the pectineus, and forms part of the triangular space containing the femoral vessels. Its anterior surface is covered near the femur by the femoral vessels and the sartorius. The posterior rests on the other two adductors, on part of the obturator nerve, and on the deep femoral artery. Aponeurotic bands connect the tendon of the muscle at its insertion with the adductor magnus and vastus internus. **Its connections with muscles and vessels.**

Action. With the femur moveable it will flex the hip-joint, and with the aid of the other adductors will carry inwards the limb, so as to cross the thigh bones. In walking it helps the other adductors in projecting the limb. **Use on femur,**

With the femur fixed the muscle props and bends forwards the pelvis. **on pelvis.**

Dissection. Some of the deeper muscles, with the obturator nerve and the profunda vessels, will be arrived at by reflecting the two last muscles. **Dissection of**

On cutting through the pectineus near the pubes, and throwing it down, the dissector may find occasionally the small accessory nerve of the obturator which turns beneath the outer border; if this is present, its branches to the hip joint and the obturator nerve are to be traced out. **accessory obturator nerve.**

The adductor longus is then to be divided near its origin, and raised with care, so as not to destroy the branches of the obturator nerve beneath: its tendon is to be detached also from that of the adductor magnus beneath it, to see the branches of the profunda artery. **Cut adductor longus,**

Now the adductor brevis will be laid bare. A part of the obturator nerve crosses over this muscle to the femoral artery, and sends an offset or two to the plexus at the inner side of the thigh. A deeper part of the same nerve lies beneath this adductor. The muscle should be separated from the subjacent adductor magnus, where the lower branch of the nerve with an artery issues. In this last step of the dissection the student should seek a slender articular branch of the obturator nerve, which descends on and in the fibres of the adductor magnus to the knee joint. **adductor brevis; trace obturator nerve: and nerve to knee joint.**

The *accessory obturator nerve* * (Schmidt) is derived from the trunk of the obturator near the lumbar plexus (p. 583), and **Accessory obturator nerve**

* This small nerve is often absent; it was found only four or five times in nine or ten bodies which were examined by its discoverer. The name given to it by Schmidt refers to this irregularity, viz., nerv. ad obturatorem accessorius inconstans.—Commentarius de Nervis Lumbalibus.

passes from the abdomen over the brim of the pelvis. In the thigh (fig. 104,[5]) this branch turns beneath the pectineus, and joins the superficial part of the obturator nerve; it supplies an offset to the hip-joint with the articular artery, and occasionally one to the under surface of the pectineus. When the nerve is small, one or more of these offsets are wanting.

is often absent.

Adductor brevis is thin at the origin

The ADDUCTOR BREVIS has a thin fleshy and aponeurotic attachment about two inches in depth to the front of the hip bone with the gracilis. The muscle *arises* from the pubic border of the bone close to and outside the gracilis, reaching upwards as high as the adductor longus, and not quite so low as the gracilis. It is *inserted* behind the pectineus into all the line leading from the linea aspera to the small trochanter.

and wide at the insertion.

Parts in front,

In front of the muscle are the pectineus and the adductor longus, with the superficial piece of the obturator nerve, and the profunda artery; but it is gradually uncovered by the adductor longus below, and the contiguous borders of the two are side by side at their insertion into the femur. Behind the muscle is the adductor magnus, with the deep piece of the obturator nerve and a branch of the circumflex artery. In contact with the upper border is the obturator externus, and the internal circumflex artery passes between the two.

behind,

and at upper border.

Use on femur free,

Action. This muscle adducts the limb with flexion of the hip joint, like the pectineus.

and fixed.

And if it acts from below it will balance, or move forwards the pelvis on the femur.

Obturator nerve

The OBTURATOR NERVE is a branch of the lumbar plexus (p. 583), and supplies the adductor muscles of the thigh, as well as the hip and knee joints. The nerve issues from the pelvis through the aperture in the upper part of the thyroid foramen; and it divides in that opening into two parts, which are named superficial and deep from their position with respect to the adductor brevis muscle.

is divided into two.

The superficial part

The *anterior* or *superficial* part of the nerve is directed over the adductor brevis, but beneath the pectineus and the adductor longus to the femoral artery, on which it is distributed; at the lower border of the last muscle it furnishes an offset or two to join in a plexus with the internal cutaneous and saphenous nerves (p. 676), and supply the teguments. In addition the nerve gives branches to the hip joint and some of the surrounding muscles, and receives (sometimes) the communicating twig from its accessory branch.

ends on femoral artery, and

joins plexus in the thigh.

Branches are to hip joint.

Near the pelvis or in the aperture of exit, the nerve sends outwards an *articular* twig to the hip joint, with the artery to the same part.

Muscular to adductors.

Muscular branches are furnished to the adductor longus, the adductor brevis, and the gracilis.

In some bodies the superficial part of the nerve is of large size, and has a distribution similar to that of the inner branch of the internal cutaneous nerve (p. 656), whose place it takes. In such instances it joins freely in the plexus, and gives cutaneous offsets to the integuments of the thigh; and is then continued along the inner border of the sartorius to the side of the knee, where it perforates the fascia to end in the integuments. **This part may be large and extend to the knee.**

The *posterior* or *deep* part of the obturator nerve pierces the fibres of the external obturator muscle, and, continuing beneath the adductor brevis, is distributed chiefly in the adductor magnus. Offsets are given from it to the contiguous muscles, and one to supply the knee joint. **Deep part of the nerve**

Muscular branches enter the obturator externus as the nerve pierces it; others are furnished to the large, and sometimes also to the short adductor. **ends in adductor magnus,**

A slender *articular* branch enters the fibres of the adductor magnus towards the lower part, and passes through it near the linea aspera to reach the popliteal artery, by which it is conducted to the back of the knee joint: its termination is seen in the dissection of the popliteal space. **and gives branch to knee joint.**

Dissection. To prepare the profunda artery and its branches, supposing the veins and the fat removed, it will be requisite to follow backwards the internal circumflex artery above the upper border of the adductor brevis, and to trace the perforating branches to the apertures in the adductors near the femur. **Dissect profunda.**

The PROFUNDA (deep femoral) is the chief muscular artery of the thigh, and arises from the femoral trunk about one inch and a half below Poupart's ligament (p. 667). At its origin the vessel is placed on the outer side of the parent trunk; but it is next directed inwards beneath the femoral vessels to the inner side of the femur, and ends at the lower third of the thigh in a small branch that pierces the adductor magnus. **Profunda artery, origin, course, and ending.**

Where the vessel lies in the triangular space of the thigh (near its origin) it rests on the iliacus muscle. But on the inner side of the femur it lies parallel to the femoral artery, though deeper in position; and it is placed first over the pectineus and adductor brevis, and thence to its termination between the adductors longus and magnus. **Parts around.**

Its branches are numerous to the surrounding muscles on the front and back of the thigh, and maintain free anastomoses with other vessels of the thigh and leg. It is through these communications that the blood finds its way to the lower part of the limb when the tube of the chief artery is obliterated either above or below the origin of the profunda. **Branches to muscles of the thigh join freely.**

The named *branches* are these:—external circumflex to the extensor muscle of the knee; internal circumflex round the inner side of the femur to the back of the thigh; perforating **The named branches are—**

arteries through the adductors to the back of the limb and the extensor of the knee joint; and muscular offsets.

external circumflex; The *external circumflex* artery has been described in the dissection of the muscles of the front of the thigh (p. 675).

internal circumflex; The *internal circumflex* branch arises from the inner and posterior part of the profunda, and turns backwards along the tendon of the external obturator muscle, passing between the psoas and pectineus, but above the adductor brevis. Opposite

ends on back of thigh, the small trochanter it ends in two branches, which will be seen in the dissection of the buttock (p. 696). It supplies the undermentioned offsets to the inner side of the thigh:—

supplies hip joint and An *articular* artery enters the hip joint through the notch in the acetabulum.

muscles. At the border of the adductor brevis two *muscular* branches arise:—one ascends to the obturator and the superficial adductor muscles; the other, which is larger, descends with the deep piece of the obturator nerve beneath the adductor brevis, and ends in this and the largest adductor.

Origin variable. The origin of the internal circumflex is very variable. In one body it may be from the femoral artery above the profunda; in another from the external iliac artery; or from the epigastric and circumflex iliac branches.

Four perforating branches. The *perforating branches*, four in number, pierce the tendons of some of the adductor muscles close to the linea aspera of the femur. They supply the muscles on the back of the thigh, and wind round the thigh-bone to end in the vastus externus.

First. The *first* begins opposite the lower border of the pectineus, and perforates the short and large adductors.

Second gives nutritious artery. The *second* branch arises opposite the middle of the adductor brevis, and passes through the same muscles as the preceding: from it a *nutritious* vessel is supplied to the shaft of the femur.

Third. The *third* artery springs from the deep femoral trunk below the adductor brevis, and is transmitted through the adductor magnus.

And the ending is a fourth. The terminal branch of the profunda (fourth perforating) pierces the adductor magnus near the aperture for the femoral artery.

Anastomotic branches. *Muscular* or *anastomotic branches* to the back of the thigh (three or four in number) pass through the adductor magnus at some distance from the linea aspera, and end in a chain of anastomes in the hamstrings (p. 706).

Profunda vein The PROFUNDA VEIN results from the union of the different branches corresponding with the offsets of its companion artery. It accompanies closely the artery of the same name, to which it is superficial, and ends above in the femoral vein.

is sometimes joined by popliteal. Sometimes the vein is suddenly enlarged at the upper part by the union of a large trunk from the popliteal vein, which is directed upwards at first behind, and then through the adductor magnus.

Dissection. To bring into view the remaining muscles, viz., adductor magnus, obturator externus, and the psoas and iliacus insertion, the adductor brevis is to be cut through near the pelvis, and is to be thrown down. Then the investing layer of fascia and areolar tissue is to be removed from each. **Cut through adductor brevis.**

After the adductor magnus has been learnt, it will be needful to detach a few of the upper fibres to examine the obturator externus.

The ADDUCTOR MAGNUS is narrow at the pelvis, and wide at the femur, and is triangular in form: its base is directed upwards, with one side attached to the femur, and the other free at the inner part of the thigh. **Adductor magnus;**

The muscle arises from the pubic arch of the innominate bone, reaching from the symphysis to the lower part of the ischial tuberosity. The anterior fibres diverge from their origin, and construct almost a distinct part: they are horizontal above, but become more oblique below, and are *inserted* (from above down) into the lower end of the linea quadrati, and the line continued from the great trochanter to the linea aspera; into all the linea aspera; and into the line leading from that crest of bone to the inner condyle for about an inch. The posterior fibres from the ischial tuberosity are vertical in direction, and end about the lower third of the thigh in a tendon, which is inserted into the inner condyle of the femur, and is connected by a fibrous expansion to the inner condyloid ridge. **origin is narrow; fibres diverge to their insertion, some being horizontal, others vertical,**

The muscle consists of the two parts above described, which differ in their characters. The anterior or upper one, thin and fleshy, forms a septum between the other adductors and the muscles on the back of the thigh; but the inner or posterior piece, partly fleshy and partly tendinous, constitutes the inner thick margin of the muscle. On the anterior surface are the other two adductor muscles and the pectineus, with the obturator nerve and the profunda artery. The posterior surface touches the hamstring muscles and the great sciatic nerve. In contact with the upper border are the obturator externus and the quadratus femoris, with the internal circumflex artery; and along the lower or inner border are the gracilis and the sartorius. At its attachment to the femur the muscle is closely united with the other adductors, particularly the adductor longus, and is there pierced by apertures for the passage of the femoral and perforating arteries. **and form two parts. Connections of the anterior and posterior surfaces. Upper and lower borders. Insertion into femur.**

Action. This muscle is used chiefly as an adductor and projector forwards of the femur in walking: in the last office it receives help internally from the other adductors, and externally from the gluteus medius and minimus. **Use on femur** and pelvis. The femur being fixed it will act powerfully in keeping the pelvis erect on the head of the thigh bone.

Opening for the vessels; The *opening* in the adductor for the transmission of the femoral vessels into the popliteal space is tendinous at the anterior, but fleshy at the posterior aspect. It is situate at the point of junction of the middle with the lower third of the thigh, and is larger than is necessary for the passage of the vessels. On the boundaries. outside it is bounded by the vastus internus; and on the inside by the tendon of the adductor magnus, with some fibres added from the tendon of the long adductor.

Psoas and iliacus in the thigh. The PSOAS and ILIACUS arise separately in the abdomen (p. 577), but are united in the thigh. The conjoined portion of the muscles comes beneath Poupart's ligament. The psoas is Insertion into femur. *inserted* by tendon into the small trochanter of the femur; and the iliacus which is fleshy joins partly the tendon of the psoas, but is fixed by the rest of the fibres into a special triangular surface of the bone in front of and below that eminence.

Parts around. Beneath the ligament the muscles occupy the interval between the ilio-pectineal eminence and the anterior superior iliac spinous process,—the iliacus resting on a small bursa; and below the pelvis the mass covers the capsule of the hip joint and a larger intervening bursa. On the front of the psoas is the femoral artery, and between the two muscles lies the anterior crural nerve. The pectineus and the internal circumflex artery are contiguous to the inner border; and the sartorius and vastus internus touch the outer edge.

Use. *Action.* These muscles act as flexors of the hip joint, and their use is given with the description of their upper parts in the abdomen (p. 577).

Obturator externus; The OBTURATOR EXTERNUS is triangular in form, with the base at the pelvis and the apex at the femur. The fibres of origin, the muscle take *origin* from the outer surface of the obturator membrane for the anterior half; and from the inner half or more of the bony circumference of the thyroid foramen, the attachment being an inch wide opposite the symphysis pubis, but only half that width lower down. From the origin the fibres insertion. are directed obliquely outwards and backwards to be *inserted* by a tendon into the pit at the root of the great trochanter.

The adductors cover it, This muscle is concealed by the pectineus, and adductor brevis, and magnus. It covers the obturator membrane and vessels, and is pierced by part of the obturator nerve. As it courses and it touches hip joint. backwards it is in contact with the inner and lower parts of the hip joint. The insertion of the muscle will be seen in the dissection of the Buttock.

Use. *Action.* The muscle is an external rotator of the thigh: and its action will be given in full with the other muscles of the same group in the Buttock.

Dissection. By detaching a small part of the obturator muscle from the pelvis, the branches of the artery and nerve of the same name will be seen amongst its fibres. Less injury will be done to the part if the dissection of the vessel and nerve is deferred till after the limb is detached. **Detach obturator.**

The *obturator artery* is a branch of the internal iliac in the pelvis (p. 605), and enters the thigh through the upper part of the thyroid foramen. Whilst in its aperture the artery divides into two parts, which form a circle beneath the muscle around the obturator membrane. **Obturator artery divides into two,**

The *upper* branch extends along the inner half of the membrane; and the *lower*, perforating the membrane below the level of the other, turns downwards and forms a circle by uniting with the upper branch. An *articular* twig to the hip joint is supplied from the lower branch. **upper and lower branch; this gives articular twig, and**

Muscular offsets of the artery are furnished to the obturators; and some small twigs reach the upper part of the adductors. **muscular.**

Branches of *nerve* to the obturator muscle come from the deep portion of the obturator trunk, and perforate the membrane with the lower branch of the artery. **Branches of the nerve.**

Section II.

THE BUTTOCK, OR THE GLUTEAL REGION.

Position. During the dissection of the back of the thigh the body is placed with the face down; and the pelvis is to be raised by blocks until the lower limbs hang almost vertically over the end of the dissecting table. **Position of the body.**

Directions. Both this Section and the following one are to be completed by the student in the time appointed for the body to lie in its present position. **Directions.**

When the body is turned, the points of bone marking posteriorly the limit between the thigh and the abdomen (p. 650), can be better recognised.

Dissection. The integument is to be raised from the buttock by means of the following incisions:—One is to be made along the iliac crest of the hip bone, and is to be continued in the middle line of the sacrum to the tip of the coccyx. Another is to be begun where the first terminates, and is to be carried outwards and downwards across the thigh till it is about six inches below the great trochanter. The flap of skin thus marked out above and below is to be thrown down. **Take up the skin.**

Seek cutaneous nerves on the crest,

Some of the cutaneous nerves of this region will be found in or beneath the fat along the line of the iliac crest. Beginning in front, the student will meet first with branches of the external cutaneous rather below the crest, if these have not been cut in the dissection of the front of the thigh. Crossing the crest near the front, is a large offset of the last dorsal nerve; and farther back but close to the bone a smaller branch from the ilio-hypogastric nerve. In a line with the outer border of the erector spinæ of the back are two or three branches of the lumbar nerves.

and by side of sacrum.

By the side of the sacrum and coccyx are two or three offsets of the sacral nerves.

Other nerves of small sciatic below.

The remaining cutaneous nerves are derived from the small sciatic, and must be sought beneath the fat along the line of the lower incision, where they come from underneath the gluteus maximus. A few turn upwards over that muscle; the rest are directed down the thigh, and one (inferior pudendal) bends below the ischial tuberosity to reach the perinæal space.

Cutaneous arteries.

Cutaneous arteries accompany all the nerves, and will serve as guides to their situation.

Sources of the cutaneous nerves.

Cutaneous Nerves. The nerves distributed in the integuments of the buttock are small but numerous, and are derived from the spinal nerves (posterior primary branches); from branches of the lumbar and sacral plexuses; and from the last dorsal nerve.

From lumbar

Posterior branches of the lumbar nerves. The offsets of the posterior primary branches of the *lumbar nerves* are two or three in number, and cross the crest of the hip bone near the anterior edge of the erector spinæ: they ramify in the integuments of the middle of the buttock, and some branches may be traced nearly to the trochanter major.

and sacral nerves.

The *branches* of the *sacral nerves* perforate the gluteus maximus near the sacrum and coccyx, and are then directed outwards for a short distance in the integuments over the muscle. These offsets are usually three in number: the largest is opposite the lower end of the sacrum, the smallest near the iliac crest, and the other by the side of the coccyx.

From last dorsal nerve.

The *last dorsal nerve* supplies the buttock by means of its lateral cutaneous branch (p. 469). This offset perforates the muscles of the abdomen, and crosses the anterior part of the iliac crest to be distributed over the fore part of the gluteal region, as low as the great trochanter.

From lumbar plexus,

Nerves of the lumbar plexus. Parts of two nerves of the lumbar plexus, viz. ilio-hypogastric and external cutaneous, are spent in the integuments of this region.

through ilio-hypogastric, and

The *iliac branch* of the ilio-hypogastric crosses the iliac crest in front of the branches from the lumbar nerves, lying generally in a groove in the bone, and extends only a short distance below the crest: this branch is very variable in size, or it may be wanting.

external cutaneous.

Offsets of the *external cutaneous* nerve of the thigh bend backwards to the integuments above the great trochanter, and cross the ramifications of the branch of the last dorsal nerve.

From sacral plexus, through small sciatic.

Small sciatic. Only this nerve of the sacral plexus sends superficial branches to the buttock. Its cutaneous offsets appear along the lower border of the gluteus maximus, and are accompanied by superficial branches of the sciatic artery: two or three ascend round the edge of the muscle, and are lost in the integuments of the lower part of the buttock; the remaining branches descend to the thigh, and will be afterwards noticed on it.

Clean gluteus maximus.

Dissection. In the examination of this region the thin and unimportant deep fascia may be disregarded, in order that the great gluteal muscle, which is the most difficult in the body to make clean, may be well displayed. Supposing the student desirous to lay bare the muscle, let him turn aside the cutaneous nerves, and abduct and rotate inwards the limb to make tense the muscular fibres. Having cut through the fat and fascia from the upper to the lower border, let him carry the scalpel along one bundle of fibres at a time in the direction of a line from the sacrum to the femur, until all the coarse fasciculi are cleaned. If the student has a right limb, the dissection may be begun at the upper border; but if a left limb, at the lower margin of the muscle.

Mode of proceeding.

Fascia of the buttock is thin and unimportant.

The *fascia of the buttock* is a prolongation of that enveloping the thigh, and is fixed to the crest of the hip bone, and to the sacrum and coccyx. It is much thicker in front of, than on the gluteus maximus, and gives attachment anteriorly to the gluteus medius which it covers. At the edge of the gluteus maximus the fascia splits to incase the muscle.

Gluteus maximus.

The GLUTEUS MAXIMUS is the most superficial muscle of the buttock, and reaches from the pelvis to the upper part of the femur. Its origin from the pelvis is partly osseous and partly aponeurotic:—Thus, the muscle is attached from above down to the posterior third of the iliac crest, and a special impression on the hip bone below the crest; next, to the aponeurosis covering the multifidus spinæ muscle; then to the back of the lowest piece of the sacrum, the back of the coccyx, and the great sacro-sciatic ligament. From this origin the fibres are directed outwards to their *insertion*:—About two thirds of the upper fibres, and a few of the lowest fibres, end in the fascia lata of the outer part of the thigh. The remainder are fixed for three inches into the lower part of the line leading from the linea aspera to the great trochanter of the femur.

Origin above from pelvis;

inserted below into the femur.

Connections

The gluteus forms the prominence of the buttock, and resemof the surfaces bles the deltoid muscle of the arm in its situation and in the coarseness of its texture. Its cutaneous surface is covered by the common teguments and investing fascia of the limb, and by the superficial nerves and vessels. The parts in contact with the under surface will be seen when the muscle is cut through.

and borders. The upper border overlays the gluteus medius. And the lower edge, which is longer and thicker than the upper, forms the fold of the nates, and bounds posteriorly the perinæal space; beneath the lower border the hamstring muscles and the sciatic vessels and nerves issue.

Use on femur free, *Action.* With the femur hanging the muscle extends the hip joint by putting back that bone, and abducts and rotates out the limb.

and fixed. When the limb is fixed and the hip joint bent as in sitting, the gluteus acts as an extensor of the articulation by moving back the pelvis, and is the chief power employed in raising the body into a standing posture.

In standing, and stooping; In standing both muscles keep the pelvis balanced on its props; and in rising from stooping they are the active agents in bringing upright the pelvis.

standing on one leg. In balancing the body on one leg the muscle can draw the sacrum back towards the femur, so as to turn the face to the opposite side.

Divide the gluteus maximus. *Dissection.* The gluteus maximus is to be cut across near the pelvis but external to the sacral nerves perforating it, and without injury to the subjacent sacro-sciatic ligament to which the lower fibres are closely joined. The depth of the muscle will be ascertained by the fascia and some vessels beneath it. When this intermuscular layer is arrived at, the outer part of the gluteus is to be thrown towards its insertion, and the sciatic artery and nerves are to be detached from the under surface, though the branches entering the muscle must be cut.

Clean parts beneath. The loose fat is to be taken away from the hollow between the pelvis and the trochanter, without injuring the vessels and nerves; and the several muscles are to be cleaned, the fibres of each being made tense at the time of its dissection by rotating the femur. In removing the areolar tissue from the ischial tuberosity and the great trochanter, the bursa on each prominence of bone should be observed.

The vessels, nerves, and muscles of this region, which are to be defined, may be ascertained by referring below to the enumeration of the parts beneath the gluteus.

Dissect out sacral nerves. Lastly the origin of the muscle is to be removed. And the sacral nerves, when dissected out of the gluteus, are to be followed to the surface of the great sacro-sciatic ligament, where they will be afterwards seen.

Parts covered by *Parts beneath the gluteus.* At its origin the gluteus maximus rests on the pelvis, and conceals parts of the hip bone, sacrum, and coccyx, also the ischial tuberosity with the origin of the hamstring muscles, and the great sacro-sciatic ligament. At its insertion it covers the upper end of the femur, with the great trochanter and the origin of the vastus externus. Between the muscle and each prominence of bone, viz. the tuberosity and the trochanter, is a large, loose synovial membrane; and between it and the vastus externus is another synovial sac. **gluteus at its origin and insertion;**

In the hollow between the pelvis and the femur the muscle conceals, from above downwards, the undermentioned parts:— First, a portion of the gluteus medius; and below it the pyriformis, with the superficial branch of the gluteal vessels between the two. Coming from beneath the pyriformis are the sciatic vessels, and the large and small sciatic nerves, which descend to the thigh between the great trochanter and the ischial tuberosity; and internal to the sciatic are the pudic vessels and nerve, and the nerve to the obturator internus muscle, which are directed inwards through the small sacro-sciatic notch. Still lower down is the tendon of the obturator internus muscle, with a fleshy fasciculus—the gemellus—above and below it. Next comes the thin quadratus femoris muscle, with the upper part of the adductor magnus: at the upper border of the quadratus is the tendon of the obturator externus; and at the lower border, between it and the adductor, issues one of the terminal branches of the internal circumflex artery. **and by the intervening part of the muscle.**

Dissection. Tracing back the branches of the sacral nerves which perforate the gluteus, they will lead to the union of the outer branches of the first three nerves on the great sacro-sciatic ligament; and on removing a fibrous stratum which covers them their looped arrangement will appear. Finally the nerves may be followed inwards beneath the multifidus spinæ to the posterior sacral foramina. **Trace sacral nerves.**

Sacral nerves. The external offsets of the posterior primary branches of the first three sacral nerves, after passing outwards beneath the multifidus spinæ (p. 429), are joined by loops on the surface of the great sacro-sciatic ligament. **The sacral nerves are united beneath gluteus.**

Two or three cutaneous offsets are derived from this intercommunication, and pierce the fibres of the gluteus maximus to be distributed on the surface as before said (p. 686). **Cutaneous offsets.**

The GLUTEUS MEDIUS is triangular in form, with its base at the innominate bone, and apex at the femur. It *arises* from the outer surface of the hip bone between the crest and the superior curved line, except behind where there is a surface of bone free from muscular fibres; and many superficial fibres come from the strong fascia covering the anterior part of the muscle. The fibres converge to a tendon which is *inserted* into an impression across the outer surface of the **Gluteus medius arises from hip bone, and inserted** into trochanter. great trochanter, extending from the tip behind to the root in front.

Connections. The superficial surface is concealed in part by the gluteus maximus; and the deep is in contact with the gluteus minimus and the gluteal vessels and nerve. The anterior border lies over the gluteus minimus, and is in contact with the tensor of the fascia lata. The posterior is contiguous to the pyriformis, only the gluteal vessels intervening. A small bursa is interposed between the tendon of insertion and the trochanter.

Use with limb hanging, *Action.* The whole muscle abducts the hanging femur, and the anterior fibres rotate in the limb; and in walking it is combined with the adductors in moving forwards the femur.

both limbs fixed: Both limbs resting on the ground the muscles assist in fixing the pelvis.

standing on one leg. In standing on one leg this gluteus will aid in balancing the pelvis on the top of the femur; and the anterior fibres, assisted by the tensor vaginæ, will turn the fore part of the trunk and the face to the same side.

Detach gluteus medius to see gluteal vessels *Dissection.* When the gluteus medius is detached from the pelvis, and partly separated from the gluteus minimus beneath, the gluteal vessels and nerve will come into view. The two chief branches of the artery,—one being near the iliac crest, and the other lower down,—are to be traced through the fleshy fibres as the reflection of the gluteus is proceeded with; and

and nerve. the main part of the nerve is to be followed on at the same time to the tensor vaginæ femoris muscle. A branch of the artery to the gluteus maximus must be cut in removing that muscle.

Gluteal artery is The *gluteal artery* is the largest branch of the internal iliac (p. 605), and issues from the pelvis above the pyriformis muscle.

divided into two. On the dorsum of the hip bone it ends in offsets which supply the gluteal muscles and the bone. Its named branches are superficial and deep:—

Superficial branch. The *superficial* branch supplies offsets to the integuments, and sends inwards some deeper twigs over the sacrum; it ends in the gluteus maximus, into which it penetrates on the under surface.

Deep branch: The *deep branch* is the continuation of the artery, and subdivides into two pieces which run between the two smaller glutei. One (superior) courses along the origin of the gluteus minimus, supplying mostly the medius, to the front of the iliac

this has an upper crest, where it anastomoses with the ascending branch of the external circumflex artery. The other portion (inferior) is

and a lower piece. directed forwards over the middle of the smallest gluteal muscle with the nerve, towards the anterior lower iliac spine where it enters the tensor of the fascia lata, and communicates with the external circumflex branch: many branches are furnished to the gluteus minimus, and some offsets pierce that muscle to supply the hip joint.

Vein. The companion vein of this artery enters the pelvis, and ends in the internal iliac vein. Gluteal vein.

The *superior gluteal nerve* is a branch of the lumbo-sacral cord (p. 581). It accompanies the gluteal artery, and divides into two branches for the supply of the two smallest gluteal muscles: its lowest branch terminates anteriorly in the tensor vaginæ femoris. Superior gluteal nerve is muscular.

The GLUTEUS MINIMUS is triangular in shape, and *arises* from the dorsum of the hip bone between the superior and inferior curved lines, extending backwards as far as the middle of the hip joint. The fibres are collected on a tendon, which is *inserted* into an impression along the fore part of the great trochanter, where it is united inferiorly with the gluteus medius; and some fibres end on the capsule of the hip joint. Gluteus minimus. Attachments.

One surface is in contact with the gluteus medius, and the gluteal vessels and nerve; the other with the hip joint and the bone, and the outer head of the rectus femoris muscle. The anterior border lies by the side of the other gluteus; and the posterior is covered by the pyriformis muscle, beneath which it passes. A bursa is placed between the tendon and the bone. It is next the bone, its borders.

Action. It acts as an abductor and rotator out of the femur when this bone is hanging; and in walking it and the medius will be employed in bringing forwards the limb. Use on femur hanging,

Both legs being fixed the muscles are used in balancing the pelvis. In standing on one leg the gluteus pitches the pelvis over the supporting limb with the preceding muscle; and rotates the face to the opposite side. and fixed: standing on one leg.

Dissection. Cut through the smallest gluteal muscle near the innominate bone, and define the tendinous part of the rectus femoris underneath it close above the hip joint. Whilst detaching the gluteus from the parts beneath, the student cannot fail to notice the connection between its tendon and the capsule of the joint. Divide smallest gluteus.

The deep vessels to the articulation may be observed and followed after the muscle is removed. Trace deep vessels.

The *outer head* of the *rectus femoris* is a tendon about two inches long, which reaches outwards almost horizontally, and is fixed into the groove above the margin of the acetabulum. In front it joins the other tendinous piece of the rectus, which is attached to the anterior inferior iliac spine; and below, it is connected with the capsule of the hip joint. Outer head of the rectus; where attached.

The PYRIFORMIS *arises* in the pelvis from the front of the sacrum (p. 639), and leaves that cavity through the great sacro-sciatic notch. Outside the pelvis it ends in a rounded tendon, Origin of pyriformis in the pelvis.

Insertion into the femur; which is *inserted* into the upper border of the great trochanter between the two smaller glutei.

Lies in sacro-sciatic notch; As the muscle passes through the sacro-sciatic notch it divides that space into two parts: the upper of these gives passage to the gluteal vessels and nerve; and the lower transmits the sciatic and pudic vessels and nerves. Position to other parts. Its upper border is contiguous to the gluteus medius, and its lower edge to the gemellus superior. Like the other rotator muscles in this situation, it is covered by the gluteus maximus, and, in addition, by the gluteus medius at the insertion; it rests on the gluteus minimus, which separates it from the hip joint. Its tendon is united by fibrous tissue to that of the obturator and gemelli.

Use with femur hanging and raised. *Action.* The use of this muscle and the other external rotators is altered by the position of the femur. If that bone hangs the pyriformis rotates it out, and if the hip joint is bent the muscle abducts the limb from its fellow.

Both limbs on ground, Both limbs being fixed the muscles balance the pelvis, and help to make the trunk erect after stooping to the ground. only one. In standing on one leg, besides assisting to support the trunk, the pyriformis turns the face to the opposite side.

Dissect out the chief vessels and nerves, *Dissection.* The pyriformis may be cut across and raised towards the sacrum, to allow the dissector to follow upwards the sciatic and pudic vessels, and to trace their accompanying nerves to the origin in the lower part of the sacral plexus.

and muscular branches. Some small nerves to the obturator internus, the gemellus superior, and the hip joint, are to be sought in the fat at the lower part of the plexus.

A branch to the inferior gemellus and the quadratus will be found by raising the trunk of the great sciatic nerve; but it will be followed to its termination after the muscles it supplies have been seen.

The vessels come from the iliac. Sciatic and Pudic Vessels. The vessels on the back of the pelvis, below the pyriformis muscle, are branches of the internal iliac (p. 606).

Sciatic artery; The *sciatic artery* supplies the buttock below the gluteal. After escaping from the pelvis below the pyriformis, it descends with the small sciatic nerve over the gemelli and obturator course muscles, in the interval between the tuber ischii and the trochanter, as far as the lower border of the gluteus maximus; and ending. here the artery gives off many branches with the superficial offsets of its companion nerve, and much reduced in size is continued with the nerve along the back of the thigh.

Branches to joint and muscles. In this course it furnishes *muscular* offsets to the great gluteus and the rotator muscles, and some *articular* branches to the hip joint. It supplies also the following named branches:—

Coccygeal branch. The *coccygeal branch*, arising close to the pelvis, perforates the great sacro-sciatic ligament and the gluteus maximus, and ramifies in this muscle, and on the back of the sacrum and coccyx.

Branch to the sciatic nerve.

The *branch* to the great *sciatic nerve* (comes nervi ischiadici) is very slender, and entering the nerve near the pelvis, ramifies in it along the thigh.

Muscular branches.

Muscular branches enter the gluteus maximus, the upper gemellus, and obturator internus; and by means of a branch to the quadratus, which passes with the nerve of the same name beneath the gemelli and obturator internus, it gives branches to the hip joint and the inferior gemellus.

Branch to the quadratus.

Anastomotic branch.

Anastomotic branch. Varying in size this artery is directed outwards to the root of the great trochanter, where it anastomoses with the gluteal and internal circumflex.

Pudic artery crosses the ischial spine.

The *pudic artery* belongs to the perinæum and the genital organs; it is smaller than the sciatic, internal to which it lies. Only the small part of the vessel which winds over the ischial spine, is seen on the back of the pelvis, for it enters the perinæal space through the small sacro-sciatic notch, and is there distributed (p. 451).

It supplies a small branch over the back of the sacrum, which anastomoses with the gluteal and sciatic vessels; and a twig from it accompanies the nerve to the obturator internus muscle.

Veins.

The *veins* with the sciatic and pudic arteries receive contributing twigs corresponding with the branches of the arteries at the back of the pelvis, and open into the internal iliac vein.

Nerves come from sacral plexus.

Sciatic and Pudic Nerves. The nerves appearing at the back of the pelvis below the pyriformis are branches of the sacral plexus to the lower limb (p. 610); they are furnished mostly to parts beyond the gluteal region, but a few are distributed to the muscles at the back of the pelvis.

Small sciatic is chiefly a cutaneous nerve;

The *small sciatic* may be considered a cutaneous nerve of the back of the thigh, for it supplies only one muscle of the buttock —the gluteus maximus. It springs from the lower part of the sacral plexus generally by two parts, and takes the course of the sciatic artery as far as the lower border of the great gluteus, where it gives many cutaneous branches upwards and downwards: much diminished in size at that spot, the nerve is continued along the back of the thigh beneath the fascia, and ends below the knee in the integuments of the back of the leg. The branches which are distributed on or near the buttock are muscular and cutaneous.

ends in the leg;

gives branches to gluteus.

The *muscular branches* (inferior gluteal) enter the under surface of the gluteus maximus near the lower border.

Cutaneous,

The *cutaneous branches* are directed upwards and downwards at the border of the gluteus :—

ascending:

The *ascending* set are distributed in the superficial fascia over the lower part of the muscle.

descending, The *descending* set supply the integument of the upper third of the thigh at the inner and posterior aspects. One of these branches, which is larger than the others, is distributed to the genital organs, and is named *inferior pudendal* (p. 455); as it courses to the perinæum, it turns below the ischial tuberosity, and perforates the fascia lata at the inner part of the thigh to end in the scrotum. Sometimes the inferior pudendal is a distinct branch of the plexus.

inferior pudendal branch.

Great sciatic nerve; outline of, The *great sciatic* is the largest nerve in the body. It is the source of all the muscular, and most of the cutaneous branches distributed to the limb beyond the knee, as well as of the muscular branches at the back of the thigh.

and ending. At its origin it appears to be a prolongation of the sacral plexus. After leaving the pelvis it is directed through the buttock to the posterior part of the thigh, where it divides into two branches for the leg. In the part of its course now dissected, viz., to the lower border of the gluteus maximus, it lies in the hollow between the tuber ischii and the great trochanter, and rests on the external rotator muscles below the pyriformis. Commonly it does not supply any branch to the buttock, but it may give origin to one or two filaments to the hip joint.

Course in the buttock.

No branch in this part.

Frequently the nerve is divided into two large trunks at its origin, and one of them pierces the fibres of the pyriformis muscle.

Pudic nerve. The *pudic nerve* winds over the small sacro-sciatic ligament by the side of its companion artery, and is distributed with this vessel to the perinæum and the genital organs (p. 452). No branch is supplied to the buttock.

Muscular branches. *Muscular branches* of the *sacral plexus* are furnished to the gluteus maximus and the external rotators, except the obturator externus, as below.

Branches of gluteus. One or more branches of the upper part of the plexus enter the top of the gluteus maximus.

Branches of pyriformis. The *branches* of the *pyriformis* have been seen with the sacral plexus in the pelvis (p. 610).

Nerve of obturator, The *nerve* to the *obturator internus* arises from the upper part of the plexus, and is directed to its muscle through the small sacro-sciatic notch with the pudic nerve: its termination is seen in the dissection of the pelvis.

of superior gemellus. The *nerve* to the *superior gemellus* is a very small twig, and arises separately from the following: it enters the inner end of the muscle on the superficial surface.

Nerve to gemellus and quadratus. The *nerve* to the *inferior gemellus* and the *quadratus* is a slender branch, which passes with a companion artery beneath the gemelli and the obturator internus, to end in the two muscles from which it receives its designation. This nerve will be seen more fully in a subsequent dissection, when *articular* filaments from it to the hip joint may be recognised.

Some fine *nerves* to the *hip joint* perforate the back of the capsular ligament. **Nerves to the hip;**

Dissection. To see the remaining small rotator muscles, hook aside the great sciatic nerve, and take away the branches of the sciatic artery if it is necessary. In cleaning these muscles the limb should be rotated inwards. The gemelli are to be separated from the tendon of the obturator internus. **Clean rotator muscles.**

The SUPERIOR GEMELLUS is the highest of the two muscular slips along the sides of the tendon of the obturator muscle. Internally it is attached to the outer and lower part of the ischial spine, and externally it is *inserted* with the obturator into the great trochanter. Oftentimes this muscle is absent. **Superior gemellus.**

The INFERIOR GEMELLUS is larger and more constant than its hollow. Its *origin* is connected with the upper and hinder part of the ischial tuberosity, along the lower edge or lip of the hollow for the obturator internus muscle; and its *insertion* is the same as that of the obturator tendon. This muscle is placed between the obturator internus and quadratus muscles, but near the femur the tendon of the obturator externus comes into contact with its lower border. **Inferior gemellus inserted with obturator.**

Action. These small fleshy slips seem to be but accessory bands of origin to the internal obturator, with which they combine in use. **Use to help obturator.**

The OBTURATOR INTERNUS arises inside the pelvis (p. 629), and passes to the exterior through the small sacro-sciatic notch. Escaped from the pelvis, the muscle is directed outwards over the articulation of the hip, and is *inserted* by a tendon with the gemelli into the upper part of the great trochanter, in front of the pyriformis, as well as into the contiguous portion of the neck of the femur. **Obturator internus has part inside and part outside pelvis;**

Outside the pelvis the obturator is mostly tendinous, and is embraced by the gemelli muscles in the following way: near the pelvis the gemelli meet beneath, but near the trochanter they cover the tendon. Beneath the obturator is a synovial sac. Crossing the muscle are the large and small sciatic nerves, and the sciatic vessels; and covering the whole is the gluteus maximus. On cutting through the tendon and raising the inner end, it will be found divided into three or four pieces as it turns over the margin of the pelvis; at this spot the pelvis is marked by ridges of fibro-cartilage, which correspond with the intervals between the tendons, and the surfaces are lubricated by a synovial membrane. **latter part lies over hip joint. Its tendon is divided on the edge of the pelvis.**

Action. Taking its fixed point at the hinder border of the pelvis round which it turns, it resembles the pyriformis in position, and has a like action. Thus it rotates out or abducts the **Use like pyriformis on limb,** pelvis; and in rotation.

femur according as this bone may be hanging or raised. It will erect the pelvis after stooping, and will balance the same in standing; and it will rotate to the opposite side the trunk supported on one limb.

Quadratus femoris; origin; insertion;

The QUADRATUS FEMORIS has the form expressed by its name, and is situate between the inferior gemellus and the adductor magnus. Internally it *arises* from the outer border of the tuber ischii, along the side of the origin of the semi-membranosus and adductor magnus; externally it is *inserted* into a tubercle in the posterior intertrochanteric ridge, and into a line about two inches long on the upper end of the femur, above the attachment of the great adductor.

parts above and beneath it, and at lower border.

By one surface it is in contact with the sciatic vessels and nerves, and the gluteus. By the other surface it rests on the obturator externus, the internal circumflex artery, and the small branches of the nerve and vessels supplying it. Between its lower border and the adductor magnus one of the terminal branches of the internal circumflex artery issues. Between it and the small trochanter is a bursa, which is common also to the upper part of the adductor magnus.

Use with limb free,

Action. Though the muscle has but slight power it will be associated with the other muscles on the back of the pelvis in rotation out of the pendent femur, and in abduction of the femur when the hip joint is bent.

and fixed.

And its femoral attachment being fixed, it will support the pelvis; or will turn the face to the opposite side, the body being supported on one limb.

Dissect circumflex artery.

Dissection. The quadratus and the gemelli muscles may be now cut across, in order that their small nerve and artery, the ending of the internal circumflex artery, and the obturator externus may be dissected out.

Internal circumflex artery ends in two branches.

The *internal circumflex* branch of the profunda artery (p. 682) divides finally into two parts. One ascends beneath the quadratus in this position of the body to the pit of the trochanter, where it anastomoses with the gluteal and sciatic arteries, and supplies the bone. The other passes between the quadratus and adductor magnus to the hamstring muscles, and communicates with branches of the profunda artery.

Obturator externus is inserted into pit of trochanter.

The OBTURATOR EXTERNUS has been dissected at its origin in the front of the thigh (p. 684). In the part of its course now laid bare, the muscle winds backwards below the hip joint, and ascends to be *inserted* into the pit at the root of the great trochanter.

Connections.

On the back of the pelvis the obturator externus is covered by the quadratus, except near the femur where the upper border is in contact with the inferior gemellus. As it turns back to its insertion it supports the hip joint.

Action. Like the other muscles of the same group it rotates out the hanging limb, but it differs from them in having the same action even when the hip is bent. Use on hanging and bent limb.

With the limb fixed, Theile supposes it to help in bending the hip-joint in stooping, instead of raising and balancing the trunk like the other external rotator muscles. Limb immoveable.

The SACRO-SCIATIC LIGAMENTS pass from the innominate bone to the sacrum and the coccyx; they are two in number, and are named large and small. Sacro-sciatic ligaments.

The *large* or *posterior* ligament is attached internally to the posterior part of the hip-bone, and to the side of the sacrum and coccyx; and externally it is inserted into an impression on the inner and anterior part of the ischial tuberosity, and sends upwards a prolongation along the pubic arch. It is wide next the sacrum, but is contracted towards the middle, and is expanded again at the tuberosity. On the cutaneous surface are the branches of the sacral nerves; and the gluteus maximus conceals and takes origin from it. Branches of the gluteal and sciatic arteries perforate it. Attachments of the large one. Form; gives a prolongation.

The *small ligament* will be seen on dividing the other near the hip bone. At the sacrum and coccyx it is united with the large band, but at the opposite end it is inserted into the ischial spine. It is less strong than the superficial ligament, by which it is concealed; and it rests on the coccygeus muscle. Small ligament attachments.

By their attachments these ligaments convert the large sacro-sciatic notch of the dried pelvis into two apertures or foramina. Between their insertion into the spine and tuberosity of the innominate bone, is the small sacro-sciatic foramen, which contains the internal obturator muscle with its nerve, and the pudic vessels and nerve. And above the smaller ligament is the large sacro-sciatic foramen, which gives passage to the pyriformis muscle, and several vessels and nerves; viz. the gluteal vessels, and the superior gluteal nerve above, and the sciatic and pudic vessels and nerves, with some muscular branches of the sacral plexus, below the muscle. They give rise to two notches: small, with contents: large, and parts passing through it.

SECTION III.

THE BACK OF THE THIGH.

Directions. The ham or the popliteal space may be taken after the buttock, in order that it may be seen less disturbed than if it was dissected after the examination of the muscles at the back of the thigh. When this space has been learnt the student will return to the dissection of the thigh. Directions.

Position.

Position. The limb is to remain in the same position as in the dissection of the buttock.

Take the skin from over the ham.

Dissection. To remove the skin from the popliteal region let an incision be made behind the knee for the distance of six inches above, and four inches below the joint. At each extremity of the longitudinal cut make a transverse incision, and raise the skin in two flaps, the one being turned outwards and the other inwards.

Seek the cutaneous nerves.

In the superficial fascia some small cutaneous nerves and vessels may be found, viz., one or two twigs in the middle line of the limb from the small sciatic nerve and its artery beneath the fascia; and some offsets of the internal cutaneous nerve towards the inner part. After the fat is removed, the special fascia of the limb will be brought into view.

Fascia of the limb over the ham.

Fascia lata. Where this fascia covers the popliteal space it is strengthened by transverse fibres, particularly on the outer side; and it is connected laterally with the tendons bounding that interval. The short saphenous vein perforates it sometimes opposite the knee, but usually at a spot lower down.

Remove fascia,

Dissection. The fascia over the ham is now to be removed without injuring the small sciatic nerve with its artery, and the short saphenous vein, which are beneath it. A large quantity of fat may be next taken out of the space without injury to the several vessels and nerves in it. After the ham has been cleaned, the sartorius and the gracilis are to be replaced in their natural position on the inner side.

and take the fat from the ham.

Seek the nerves in the space.

In cleaning the space the student will come upon the large internal popliteal nerve in the middle line; and nearer the outer side, on the external popliteal. Both nerves give branches; and the numerous offsets of the inner will be recognised more certainly by tracing them from above down along the trunk of the nerve, than by proceeding in the opposite direction: in fat bodies the two small nerves from the inner popliteal trunk to the knee joint are difficult to find. Under cover of the outer boundary, and deep in the space, is an articular nerve from the external popliteal, which sometimes arises from the great sciatic.

Clean the vessels;

In the bottom of the space are the popliteal vessels, the vein being more superficial than the artery. The student is to seek an articular branch (superior), on each side, close above the condyle of the femur. Numerous other branches of the vessels to the muscles around, especially to those of the leg, are to be cleaned.

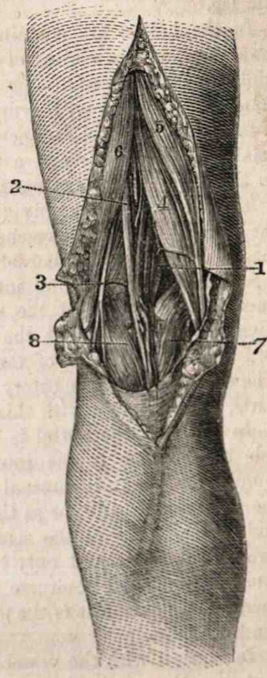
find obturator nerve, and glands.

On the upper part of the artery, the branch of nerve from the obturator to the knee joint may be found: and on the sides of the artery are three or four lymphatic glands in the fat.

The ham;

The POPLITEAL SPACE, or the ham, is the hollow behind the knee. It allows of the free flexion of the joint, and contains the large vessels of the limb. When dissected, this interval has the form of a lozenge, and extends upwards along one third of the femur, and downwards along one sixth of the tibia; but in the natural condition of the parts the sides are approximated by the fascia of the limb, and the space is limited, apparently, almost to the region of the joint. situation and extent.

Fig. 117.*



This hollow (fig. 117) is situate between the muscles on the back of the limb; and the lateral boundaries are therefore formed in part by the muscles of the thigh (hamstrings), and in part by those of the leg. Thus, on the outer side, is the biceps muscle ([6]) as far as the joint; and the plantaris and the external head of the gastrocnemius ([8]) beyond that spot. On the inner side, as low as the articulation, are the semimembranosus ([4]) and semitendinosus ([5]) muscles, with the gracilis and sartorius between them and the femur; and beyond the joint is the inner head of the gastrocnemius ([7]). The upper point of the ham is limited by the apposition of the inner and outer hamstrings in the middle line of the thigh; and at the lower point the heads of the gastrocnemius touch each other. Boundaries; outer and inner. Limit above and below.

Stretched across the cavity are the fascia lata and the teguments. Forming the deep boundary, or the floor, are the following parts,—the lower end of the posterior surface of the femur included between the lines to the condyles, the posterior ligament of the knee joint, and part of the popliteus muscle with the upper end of the tibia. Superficial and deep boundaries.

* View of the popliteal space (from Quain's Arteries). 1. Popliteal vessels. 2. Internal popliteal nerve. 3. External popliteal nerve. 4. Semimembranosus muscle. 5. Semitendinosus muscle. 6. Biceps muscle. 7, 8. Inner and outer heads of the gastrocnemius muscle. The superficial vein on the gastrocnemius is the short saphenous, which enters the popliteal.

Greatest width and depth.

The popliteal space is widest opposite the femoral condyles, where the muscles are most drawn to the sides; and is deepest above the articular end of the femur. Above and below it communicates beneath the muscles with the back of the thigh and leg.

Contents.

In the hollow are contained the popliteal vessels and their branches, and the ending of the external saphenous vein; the popliteal divisions of the great sciatic nerve, and some of their branches; together with lymphatic glands, and a large quantity of fat. The small sciatic nerve and its vessels are placed superficially in the ham; and a branch of the obturator nerve lies on the artery in the bottom of the space.

Popliteal artery; extent;

part is in the ham.

and part beyond.

The POPLITEAL ARTERY (fig. 117, [1]) is the continuation of the femoral trunk, and reaches from the opening in the adductor magnus to the lower border of the popliteus muscle, where it terminates by bifurcating into the anterior and posterior tibial vessels. A portion of the vessel lies in the ham, and is uncovered by muscle; but the rest is beneath the gastrocnemius, and beyond the limits of the popliteal space as above defined. The description of the artery may be divided therefore into two parts, corresponding with this difference in the connections.

The part in the space;

course and connections.

In the ham the vessel is inclined obliquely from the inner side of the limb to the interval between the condyles of the femur, and it is then directed along the middle of the space over the knee joint. As far as the inner condyle the artery is overlaid by the belly of the semimembranosus muscle, but thence onwards it is covered only by the fat, the fascia lata, and the integuments; and is situate between the heads of the gastrocnemius. Beneath it is the femur with the posterior ligament of the knee joint.

Position of vein

In contact with the vessel and somewhat on the outer side at first, lies the popliteal vein, so that, on looking into the space, the arterial trunk is almost covered; but lower down, in the interval between the heads of the gastrocnemius, the vein and its branches conceal altogether the artery. Below the knee the short saphenous vein and the muscular branches of the artery are laid over the popliteal trunk.

and of the nerve.

More superficial than the large vessels, and slightly external to them in position, is placed the internal popliteal nerve, which with its branches lies over the artery, like the vein, between the heads of the gastrocnemius. In the bottom of the hollow the small obturator nerve runs on the artery to the joint.

Cut the head of the gastrocnemius.

Dissection. To see the deep part of the artery the inner head of the gastrocnemius should be cut through, and raised from the subjacent parts. On removing the areolar tissue the vessels and nerves will appear. The lower articular branches of the vessels and nerve are now brought into view;—the inner artery is below the head of the tibia, and the outer higher up between the tibia and fibula, each with a vein, and the first has a companion nerve.

Whilst the *artery* is *beneath* the *gastrocnemius* it sinks deeply into the limb ; here it is crossed by a small muscle—the plantaris, and the ending is concealed by the soleus. It rests on the popliteus muscle. **Connections of the artery farther on.**

Both the vein and the nerve (internal popliteal) change their position to the artery, and gradually cross over it, so as to lie on its inner side at the lower border of the popliteus. **Positon of vein and nerve.**

Branches are furnished by the artery to the surrounding muscles, and to the articulation ; those that belong to the joint are five in number, and are called articular, viz., two superior, inner and outer ; two inferior, also inner and outer ; and a central or azygos branch. **Branches.**

The *muscular branches* are upper and lower. The upper set three or four in number arise above the knee and end in the semimembranosus and biceps muscles, communicating with the perforating and muscular branches of the profunda. The lower set (sural) are furnished to the muscles of the calf, viz. gastrocnemius, soleus, and plantaris. **Muscular branches**

One *superficial* or cutaneous *branch* arises near the knee joint, and accompanies the external saphenous nerve over the muscles of the leg to end below in the teguments. **and cutaneous.**

The *superior articular* arteries arise from the popliteal trunk, one from the inner and one from the outer side, above the condyles of the femur ; they are directed almost transversely beneath the hamstring muscles, and turn round the bone to the front of the joint. **Branches to the joint are five. Two superior,**

The *external* one perforates the intermuscular septum, and divides in the substance of the vastus externus. Some of the branches end in that muscle, and anastomose with the external circumflex (of the profunda) ; others descend to the joint ; and one offset forms an arch across the fore part of the bone with the anastomotic artery. **external ;**

The *internal* artery, oftentimes very small, winds beneath the tendon of the adductor magnus, and terminates in branches in the vastus internus, which supply this and the knee joint, and communicate with the anastomotic artery. **internal.**

The *inferior articular* branches lie beneath the gastrocnemius, but are not on the same level on opposite sides of the limb ; for the inner one descends below the head of the tibia, whilst the outer one is placed above the fibula. Each lies beneath the lateral ligament of its own side. **Two inferior ;**

The *external* branch supplies the outer side of the knee joint, anastomosing with the other vessels on the articulation, and with the recurrent branch of the anterior tibial artery : it sends **external ;**

an offset beneath the ligament of the patella to join a twig from the lower internal branch.

internal; The *internal artery* ascends at the anterior border of the internal lateral ligament, and after taking its share in the free anastomoses over the joint, ends in offsets for the articulation and the head of the tibia.

and one central artery. The *azygos* branch enters the back of the joint through the posterior ligament, and is distributed to the ligamentous structures, the fat, and the synovial membrane of the interior.

Popliteal vein. The POPLITEAL VEIN originates in the union of the venæ comites of the anterior and posterior tibial vessels, and has the same extent and connections as the artery it accompanies.

Position to the artery. At the lower border of the popliteus muscle the vein is internal to the arterial trunk. Between the heads of the gastrocnemius it is superficial to that vessel. And thence to the opening in the adductor magnus it lies to the outer side, and close to the

Branches. artery. It is joined by branches corresponding with those of the artery, as well as by the short saphenous vein (fig. 117).

Popliteal artery may divide soon. *Peculiarities in the division of the artery.* The chief peculiarity of the popliteal artery consists in its early division into terminal branches. In some bodies the artery is divided as high as the back of the knee-joint; and in such instances the anterior tibial artery may lie beneath the popliteus muscle.

Vein may leave the artery *Course and position of the vein.* Occasionally the vein will be placed on the inner instead of the outer side of the artery. And the popliteal vein may pass through the adductor magnus at a spot higher than the common opening, and enter the profunda vein.

or be split. *Double vein.* There may be a venous trunk on each side of the artery for a certain distance, in consequence of the venæ comites of the tibial arteries not blending together as soon as is usually the case.

Popliteal nerves are two, The POPLITEAL NERVES are the two large trunks derived from the division of the great sciatic in the thigh; they are named internal and external from their relative position. In

inner and outer. the popliteal space each furnishes cutaneous and articular offsets, but only the inner one supplies branches to muscles.

The internal nerve in the space. The INTERNAL POPLITEAL NERVE (fig. 117, [2]) is larger than the external, and occupies the middle of the ham. Its connections are similar to those of the artery, that is to say, it is partly superficial and partly covered by the gastrocnemius. Like the vessel it extends through the back of the leg, and retains the name popliteal only to the lower border of the popliteus muscle. Its position with reference to the vessels

Branches are has been already noticed. The branches that arise from it here are the following:—

two or three articular; Two small *articular* twigs are furnished to the knee joint with the vessels. One which accompanies the lower internal articular artery to the fore part of the articulation is of considerable size; and another takes the same course as the azygos artery, and enters the back of the joint with it. Occasionally a third may be found with the upper internal articular artery.

Muscular branches arise from the nerve between the heads of the gastrocnemius. One supplies both heads of the gastrocnemius and the plantaris. Another descends beneath the gastrocnemius, and enters the cutaneous surface of the soleus. And a third penetrates the popliteus at the under aspect, after turning round the lower border. muscular;

The *external saphenous* nerve (ram. communicans tibialis) is the largest branch, and is a cutaneous offset to the leg and foot. It lies on the surface of the gastrocnemius, but beneath the fascia, as far as the middle of the leg, where it becomes cutaneous, and will be afterwards seen (p. 713). external saphenous nerve.

The EXTERNAL POPLITEAL NERVE (peroneal) lies along the outer boundary of the ham as far as the knee joint; at that level it leaves the space (fig. 117, [3]) and follows the biceps muscle for a distance of two inches about to the head of the fibula. There it enters the fibres of the peroneus longus, and divides beneath that muscle into three,—musculo-cutaneous, anterior tibial, and recurrent articular. Its branches whilst in the popliteal space are cutaneous and articular. External popliteal nerve. Branches;

The *articular* nerve, arising high in the space, runs with the upper external artery to the outer side of the knee, where it sends a twig along the lower articular artery: both enter the joint. articular.

The *peroneal communicating* branch (ram. communicans fibularis) is a cutaneous nerve, and joins the external saphenous branch of the internal popliteal about the middle of the leg (fig. 118, [5]). It soon pierces the deep fascia; and cutaneous offsets are given by it to the back of the leg. Communicating branch.

One or two *cutaneous* nerves are furnished by the external popliteal to the integument on the outer part of the leg in the upper half. Cutaneous offsets.

The *articular branch* of the *obturator nerve* perforates the adductor magnus, and is conducted by the popliteal artery to the back of the knee joint. After supplying filaments to the vessels, the nerve enters the articulation through the posterior ligament. Articular nerve of the obturator.

The *lymphatic glands* of the popliteal space are situate around the large arterial trunk. Two or three are ranged on the sides; whilst one is superficial to, and another beneath the vessel: they are joined by the deep lymphatic vessels of the lower limb, as well as by the superficial set accompanying the saphenous vein. Lymphatic glands around the artery.

THE BACK OF THE THIGH.

Dissect the back of the thigh.

Dissection. Now the anatomy of the popliteal space has been learnt, the student may proceed with the dissection of the back of the thigh. The piece of skin therefore between the buttock and the popliteal space should be divided and reflected to the sides.

Seek out cutaneous nerves.

In the fat on the sides of the limb offsets of the internal and external cutaneous nerves of the front of the thigh may be found, if they have been preserved in front; and along the middle line some filaments from the small sciatic nerve pierce the fascia.

Clean muscles and nerves.

Remove the deep fascia of the limb, taking care of the small sciatic nerve and its artery. Lastly, clean the hamstring muscles, and trace out the perforating arteries to the front of the thigh, and the branches of the great sciatic nerve and profunda artery to the muscles.

Three muscles on back of thigh.

MUSCLES. The muscles behind the femur act mainly as flexors of the knee joint. They extend from the pelvis to the bones of the leg, and are named hamstrings from their cord-like appearance on the sides of the ham: they are three in number, viz., biceps, semitendinosus, and semimembranosus. The first of these lies on the outer, and the others on the inner side of the popliteal space.

Situation.

Biceps arises by a long

and a short head;

is inserted into the fibula and tibia.

The BICEPS has two heads of origin, long and short, which are attached to the pelvis and the femur. The long head *arises* from an impression on the back of the ischial tuberosity, in common with the semitendinosus muscle. The short head is fixed to the femur below the gluteus maximus, viz., to all the linea aspera, and nearly the whole of the line leading inferiorly to the outer condyle; and to the external intermuscular septum. The fibres are collected together to form the belly of the muscle; and end inferiorly in a tendon, which is *inserted* into two prominences on the head of the fibula by slips which embrace the external lateral ligament, and slightly into the head of the tibia.

Connections of the muscle.

The muscle is superficial, except at the origin where it is covered by the gluteus; and it rests on the upper part of the semimembranosus, on the great sciatic nerve, and on the adductor magnus muscle. On the inner side is the semitendinosus muscle as far as the ham. Its tendon gives offsets to the deep fascia of the limb.

Use on knee

and hip joints;

Action. It can bend the knee if the leg-bones are not fixed, and then rotate out the tibia; and the long head which passes upwards beyond the femur will extend the hip joint when the knee is straight.

on pelvis

The leg being fixed on the ground, the long head will assist in balancing or erecting the pelvis, and the short head will draw down and back the femur so as to bend the knee in stooping. and femur.

The SEMITENDINOSUS is a slender muscle, and receives its name from its appearance. It *arises* from the tuberosity of the hip bone with the long head of the biceps, and by fleshy fibres from the tendon of that muscle. Inferiorly it is *inserted* into the inner surface of the tibia, close below the gracilis, and for a similar extent. Semi-tendinosus is attached to pelvis and tibia.

This muscle, like the biceps, is partly covered by the gluteus maximus. About its middle a tendinous intersection may be observed. It rests on the semimembranosus, and on the internal lateral ligament of the knee-joint. The outer border is in contact with the biceps as far as the popliteal space. As the tendon turns forwards to its insertion, an expansion is continued from it to the fascia of the leg; and it is attached with the gracilis below the level of the tubercle of the tibia, the two being separated from the tendon of the sartorius by the bursa before referred to (p. 669). Surrounding parts in contact with it.

Action. If the leg is moveable the muscle bends the knee; and continuing to contract, rotates inwards the tibia. Supposing the knee-joint straight but the hip bent, the femur will be depressed, and the hip extended by the semitendinosus and other hamstrings. Use on knee and hip joints;

Should the limbs be fixed on the ground, the muscles will assist in balancing the pelvis, or in erecting the trunk from a stooping posture. on the pelvis.

The SEMIMEMBRANOSUS muscle is tendinous at both ends, and its name is taken from the membraniform appearance of the upper tendon. The muscle is attached above to the highest impression on the back of the tuber ischii, above and external to the semitendinosus and biceps; and it is *inserted* below into the hinder and inner part of the head of the tibia. Semimembranosus reaches from pelvis to tibia.

The muscle presents a thick fleshy belly inferiorly, where it bounds the popliteal space. On it lies the semitendinosus, which is lodged in a hollow in the upper tendon; and beneath it is the adductor magnus. Along the outer border is the great sciatic nerve; and below the place of division of that nerve, is the internal popliteal trunk. Between its tendon and the inner head of the gastrocnemius is a large bursa. The insertion of the muscle will be dissected with the tendons in connection with the knee-joint. Parts around it.

Action. This hamstring is united with the preceding in its action, for it bends the knee and rotates in the tibia; and with the knee straight but the limb moveable, it will limit flexion of the hip, or even extend the joint as in walking backwards. Use on knee, and hip joints;

When the foot rests on the ground, the semimembranosus acts altogether like the semitendinosus on the pelvis. on pelvis.

Great sciatic nerve in the thigh

The GREAT SCIATIC NERVE lies on the adductor magnus muscle between the buttock and its ending, and divides into the two popliteal nerves about the middle of the thigh, though its point of bifurcation may be carried upwards as far as the pelvis. In this extent the nerve lies along the outer border of the semimembranosus, and is crossed by the long head of the biceps.

supplies flexor and adductor muscles.

Branches. At the upper part of the thigh it supplies large branches to the flexor muscles, and a small one to the adductor magnus.

Small sciatic in the thigh;

SMALL SCIATIC NERVE. Between the gluteus maximus and the ham this small nerve is close beneath the fascia, but it becomes cutaneous below the knee, and accompanies the external saphenous vein for a short distance.

cutaneous offsets.

Small *cutaneous* filaments pierce the fascia of the thigh, and the largest of these arises near the popliteal space.

Detach the hamstrings.

Dissection. To see the posterior surface of the adductor magnus, and the branches of the perforating and muscular arteries, the hamstring muscles must be detached from the hip bone and thrown down, and the branches of arteries and nerves they receive are to be dissected out with care. All the parts are to be cleaned.

Posterior surface of adductor magnus.

ADDUCTOR MAGNUS MUSCLE. At its posterior aspect the large adductor is altogether fleshy, even to the opening for the femoral artery; and the fibres from the pubic arch appear to form a part almost distinct from those connected with the tuberosity of the hip bone. In contact with this surface are the hamstring muscles and the great sciatic nerve.

Number of arteries.

Ending of the perforating arteries. These branches of the profunda are four in number, and the spots at which they pierce the adductor muscles have been referred to before (p. 682).

Course to vastus,

Appearing through the adductor magnus close to the femur, they are directed out through the short head of the biceps and the outer intermuscular septum to the vastus externus; but as the first branch is placed higher than the attachment of the

and ending;

biceps, it pierces the gluteus maximus in its course. In the vastus they anastomose together, and with the descending branches of the external circumflex artery.

offsets to biceps and the skin.

Muscular branches are furnished by the perforating arteries to the heads of the biceps; and a cutaneous offset is given by each to the teguments of the outer part of the thigh, along the line of the outer intermuscular septum.

Anastomotic branches;

Muscular branches of the profunda pierce the adductor magnus internal to the preceding, and at some distance from the femur.

number and course,

Three or four in number, the highest appears about five inches from the pelvis, and the rest in a line at intervals of about two inches from one another: they are distributed to the hamstring muscles, especially the semimembranosus, and communicate below with offsets of the popliteal trunk.

The HIP JOINT (fig. 113). This articulation is a ball and socket joint, in which the head of the femur is received into the acetabulum or the cup-shaped hollow of the innominate bone. Connecting the bones are the following ligaments:—one to deepen the receiving cavity, which is named cotyloid; another between the articular surfaces of the bones,—the interarticular; and a loose capsule around all. **Hip joint how formed; its ligaments.**

Dissection. The muscles are to be taken away from the back of the hip joint, and the upper and lower attachments of the capsular ligament are to be especially observed. **Lay bare the capsule behind,**

Next the front of the joint should be cleaned and examined in the same manner, with the body turned over for a short time, if this change in the position does not interfere with the other dissections. **and in front.**

In the capsule itself the student has to define a wide thick part in front, and a transverse band close to the neck of the femur behind. **Define its fibres.**

The *capsular ligament* (fig. 118, [11]) is a thick fibrous case, which is strong enough to check the movements of the joint. Its upper margin is attached to the circumference of the acetabulum at a short distance from the edge, as well as to a transverse ligamentous band over the notch at the inner side of the cavity. Its lower margin is inserted in front into the anterior intertrochanteric line; and behind, by a very thin layer, into the neck of the femur about a finger's breadth from the small trochanter and the posterior intertrochanteric line, but at a less distance from the great trochanter, till it blends above with the insertion of the ilio-trochanteric part of the capsule. **Capsule. Attachments above and below.**

The capsule differs much in strength and in the arrangement of the fibres at the fore and hinder parts. On the front it is strengthened by a wide layer of longitudinal fibres, which is limited internally and externally by a prominent ridge. **Capsule thickened in front**

The central part of the thickened portion, or the *ilio-femoral* band, is fixed above by a narrow piece to the lower anterior iliac spinous process, and below where it widens, into the anterior intertrochanteric line. By its strength it can arrest extension of the joint; and the femur being fixed it will prop the pelvis. **by a central band, use;**

The outer ridge (ilio-trochanteric band) extends from the hip bone opposite the outer head of the rectus, to the upper and fore part of the great trochanter and neck of the femur; its use is to check adduction of the femur. **by an outer, band, use;**

The inner band (pubio-femoral) is attached superiorly to the prominent portion and the pubic ridge of the hip bone inside the acetabulum, and inferiorly to a roughened surface at the lower part of the neck of the femur on a level with, and nearly **and by inner band.**

a finger's breadth in front of the small trochanter. This band controls the abductory movement of the joint.

Use.

At back of capsule is a transverse band.

At the back of the capsule close to the neck of the femur is a band of transverse fibres about as wide as the finger, which extends between the ilio trochanteric and pubio-femoral bands, and arches like a collar over the neck of the bone. By its lower edge it is united to the cervix femoris by a thin layer of fibrous tissue and synovial membrane; at the upper edge it is joined by the longitudinal capsular fibres. In front and behind its fibres are lost amongst those of the thickened bands of the capsule. It gives insertion to the longitudinal fibres of the back of the capsule, and prevents that restriction of the swinging movement which would result from the insertion of strong fibres into the hinder part of the neck.

Arrangement of its fibres.

Use.

Muscles around.

Posteriorly the joint is covered by the external rotator muscles; and anteriorly by the psoas and iliacus, a bursa being between it and them. Above is the gluteus minimus, whose tendon is united with the upper and outer band of the capsule; and below is the obturator externus.

Cut open the capsule.

Dissection. The capsular ligament is to be now divided over the prominence of the head of the femur, and this bone being disarticulated, the cotyloid and interarticular ligaments inside it will appear.

Define round ligament.

The interarticular or round ligament is attached to the acetabulum by two pieces; and to bring these into view, the synovial membrane and areolar tissue must be removed from them, and the transverse ligament over the notch is to be defined.

Cotyloid ligament

The *cotyloid ligament* is a narrow band of fibro-cartilage, which is fixed to the margin of the acetabulum, and is prolonged across the notch on the inner side, so as to form part of the transverse ligament. Its fibres are not continued around the acetabulum, but begin at the margin of the cavity, and cross one another in the band. It is thickest at its attachment to the bone, and becomes gradually thinner towards the free margin, where it is applied to the head of the femur.

attached around acetabulum.

Use.

This ligament fills up the hollows in the rim of the acetabulum, and deepens the socket for the femur in the same manner as the glenoid ligament increases the surface for the reception of the head of the humerus.

Transverse ligament,

The *transverse ligament* is a firm but narrow band, which reaches across the upper part of the notch at the inner side of the acetabulum. It consists partly of deep special fibres that are attached to the margins of the notch, and partly of a superficial bundle from the cotyloid ligament. Beneath it is an aperture by which vessels enter the acetabulum to supply the synovial membrane, and the fat in the bottom of that hollow.

forms a hole with bone.

Round ligament

The *interarticular* or *round ligament* (ligam. teres) is a slight band about an inch long, connecting the femur with the innominate bone.

One extremity is roundish, and is inserted into the pit in the head of the femur.

The other is flattened, and divides into two parts opposite the transverse ligament. The upper or anterior piece (pubic) is attached with the transverse ligament to the pubic edge of the notch. The lower or posterior part (ischial) is inserted behind the transverse ligament into the ischial border of the cotyloid notch.

is divided internally.

Attachments.

Dissection. To see its condition in the different movements of the articulation, it should be examined in a joint in which the ligaments are whole, and the bottom of the acetabulum has been cut out with a chisel inside the pelvis.

How to see its action.

Use. When the joint is in the extended state, the ligament is generally lax, the two attachments being near each other; but if the femur is adducted, the ischial part of the ligament is rendered tight by that movement, because the head of the femur rises.

State in extension,

In flexion of the joint, the ligament is tighter than in extension, as the femoral insertion is removed from the acetabular; and if, in the bent state, the femur be rotated out or adducted, the round ligament will then be stretched most.

and flexion and adduction.

A *synovial membrane* lines the capsular ligament, and is continued along it to the acetabulum and the head of the femur. In the bottom of the cotyloid cavity it is reflected over the fat in that situation; and it surrounds the ligamentum teres.

Synovial membrane.

Dissection. To see the surface of the acetabulum the lower limb is to be separated from the trunk by dividing the interarticular ligament, and by cutting through any parts that connect it to the rest of the body. In this stage the attachments of the round ligament to the pelvis can be better seen.

Detach the limb.

Surfaces of bone. The articular surfaces of the bones are not completely covered with cartilage.

Articular surfaces of the bones.

In the head of the femur is a pit into which the round ligament is inserted.

Femur.

The acetabulum is coated with cartilage at its circumference, except opposite the notch; and by this part it touches the head of the femur. This articular surface is about one inch and a half deep above, but gradually diminishes towards the notch, becoming rather less than an inch wide.

Acetabulum cartilaginous externally.

Within the cartilage and close to the notch, is a mass of fat, forming about one third of the area of the cotyloid cavity, which constitutes the gland of Havers: it communicates with the fat of the thigh beneath the transverse ligament.

Fat in the bottom.

Movement. In this ball and socket joint, there are the same kinds of movement as in the shoulder, viz., flexion and exten-

Kinds of motion.

sion or to and fro movement, abduction and adduction, circumduction, and rotation.

Swinging movement.

Flexion and *extension*. In the swinging movement forwards and backwards flexion is freer than extension, the thigh being capable of such elevation as to touch the belly.

Motion of head of femur.

During the swinging the head revolves in the bottom of the acetabulum, rotating around a line corresponding with the axis of the head and neck; and the rapidity and extent of the movements do not endanger the security of the joint, because the head of the bone has not any tendency to escape.

State of ligaments.

In flexion, the back of the capsule and the ilio-trochanteric band are put on the stretch; and in extension, the strong ilio and pubio-femoral bands are tightened.

Lateral movement.

Abduction and *adduction* are produced by the femur being removed from or brought towards the middle line of the body. Of the two, abduction is the most extensive, because the limb soon meets its fellow when it is moved inwards, though if it is carried in front of the other adduction is considerable.

Motion of the head.

In both states the head moves in the opposite direction to the shaft. Thus, as the femur is abducted, the head descends, and the greater part of the articular surface projects below the acetabulum; and when the limb is raised to its utmost, the great trochanter comes to rest on the margin of the acetabulum, and limits farther motion. As the limb descends and approaches the other, the head rises into the socket of the hip-joint, and is securely lodged, finally, in the deepest part of the cavity.

State of the ligaments.

In abduction, the lower and inner band of the capsule is distended over the projecting head of the femur, the upper part being relaxed. And in adduction, the upper band of the capsule is rendered tense enough to arrest the movement.

How dislocation is produced in the lateral movements;

Dislocation may take place in both these lateral movements. In both the edge of the cotyloid cavity serves as the fulcrum by which force applied to the shaft of the femur lifts the head of the bone out of the hollow; in the one case (adduction) the neck of the femur resting on the brim of the acetabulum, and in the other (abduction) the great trochanter being supported on the margin of the joint-socket.

position after reduction.

After a dislocation has been reduced, the state of adduction, with the knees fastened together, is the securest position in which the limb can be placed, inasmuch as the head of the femur then occupies the deepest part of the acetabulum.

Kind of movement;

In *circumduction*, the four kinds of angular motion above noticed take place in succession, viz., flexion, abduction, extension, and adduction; and the limb describes a cone, whose base is at its extremity, and apex at the union of the neck with the shaft.

less free than in shoulder.

This movement is less free than in the shoulder-joint, because of the greater bend between the neck and shaft of the femur.

There are two kinds of *rotation*, internal and external; in the former, the great toe is turned in, and in the latter, which is the more extensive of the two, it is moved outwards. What rotation is.

In rotation inwards, the head of the femur rolls forwards horizontally across the acetabulum, the great trochanter being put forwards; and the shaft of the bone revolves around a line inside it, which passes from the head to the inner condyle. Rotation in. Motion of bone.

During this movement the posterior half of the capsule is put on the stretch, and the anterior is relaxed. State of ligaments;

In rotation out the head of the bone rolls back across the cotyloid cavity, and the great trochanter is brought backwards, whilst the shaft of the femur moves round the line on its inner side before noticed. Rotation out. Motion of bone.

The fore part of the capsule is now put on the stretch, and the hinder is rendered loose. State of ligament;

The movement of rotation depends upon the angle formed at the junction of the head with the neck of the femur, and is destroyed by fracture of the neck of the bone. Its degree is proportioned to the length of the neck, and is therefore greater in the femur than in the humerus. on what depends, and why greatest.

Use of angle of femur. By means of the angle at the union of the neck with the shaft, greater security is given to the joint in the rapid movements of flexion and extension, as it allows the whole of the articular head to be buried in the socket all the time of their execution. It permits also greater surface contact between the head of the femur and the hip bone, since the whole head can be lodged in the cotyloid cavity in progression; whereas, if the neck and shaft of the bone were in a line, only half of the articular surface could enter the socket of the innominate bone in walking, running, or standing. The important movement of rotation is also due to this angle; and greater space is obtained through it for the location of the adductor muscles on the inner side of the femur. Angle of femur gives security; greater surface-contact, rotation; and greater space for muscles.

Dissection. After the limb is removed, the attachments of all the muscles in the thigh are to be examined more minutely. The muscles should not be removed from the femur, but about two inches of each should be left for after examination. Examine attachment of muscles.

SECTION IV.

THE BACK OF THE LEG.

Directions. Before the dissection of the leg is begun, the student should make himself acquainted, as in the thigh, with Examine the surface.

the prominences of bone and muscle on the surface, and with the markings which lead to the position of the larger vessels.

In the leg the tibia and fibula are superficial.

Prominences of bone. The bones of the leg can be traced beneath the skin from the knee to the ankle joint. On the inner side is the tibia, which is subcutaneous in all its extent, and is limited in front and behind by a sharp ridge: above, it presents in front a prominent tubercle into which the ligament of the patella is inserted; and below, it ends on the inner side of the ankle in the internal malleolar projection. On the outer side of the leg the lower half of the fibula may be felt with ease, but the upper half with more difficulty, in consequence of the prominence of the muscles of the calf. The head of this bone may be recognised below the knee; and the lower end forms the projection (malleolus) on the outer side of the ankle-joint.

Ankle-joint.

On the side of the ankle-joint are the prominent malleoli; and when the joint is extended, the head of the astragalus projects below the border of the tibia.

Behind is calf of the leg, tendo Achillis, and tibial vessels.

Muscles and vessels of the leg. On the back of the leg is the projection of the calf: this is formed by the superficial muscles, and from it descends the firm band of the tendo Achillis, by which those muscles are connected with the heel. Between the tendon and the edge of the tibia, but nearest the former, is placed the superficial part of the posterior tibial artery. In front between the tibia and fibula are the flexor muscles of the foot and the extensors of the toes, amongst which the anterior tibial artery lies deeply; the position of the vessel will be indicated by a line from the centre of the ankle-joint to the inner side of the head of the fibula.

Line of anterior tibial vessels.

Inner border of the foot.

Prominences of the foot. At the inner border of the foot, about an inch in front of the internal malleolus, is the prominent scaphoid bone pointing out the spot at which an amputation (Chopart's) is practised; whilst farther forwards by about one inch and a half, is a slight depression that marks the articulation between the internal cuneiform and the metatarsal bone of the great toe. About the centre of the outer border of the foot is the eminence of the tarsal end of the fifth metatarsal bone. A line over the dorsum of the foot, from the centre of the ankle joint to the interval between the inner two toes, will lie over the position of the main artery.

Outer border.

Dorsal artery.

Position of the part.

Position. For the dissection of the back of the leg, the limb is to be placed on its front, with the foot over the side of the dissecting-table; and the muscles of the calf are to be put on the stretch by fastening the foot.

Take away the skin.

Dissection. For the removal of the skin, one cut may be made along the middle of the leg to the sole of the foot, where a transverse incision is to be carried over the heel. The two resulting flaps of skin may be raised; the outer one is to be detached as far as the fibula, and the other as far as the inner margin of the tibia.

In the fat the cutaneous nerves and vessels are to be followed. On the inner side, close to the tibia, is the internal saphenous vein with the nerve of the same name, together with twigs of the internal cutaneous near the knee. In the centre of the leg lies the external saphenous vein, with the small sciatic nerve as its companion above the middle, and the external saphenous nerve below the middle of the leg. On the outer side in the upper third the cutaneous offsets of the external popliteal nerve will be met with. **Seek cutaneous nerves in the fat.**

The *superficial fascia*, or the fatty layer of the back of the leg, is least thick over the tibia. Over the line of the superficial vessels it may be separated into two layers as in the thigh. **Superficial fascia.**

SUPERFICIAL VEINS. Two veins appear in the dissection of the back of the leg, which are named saphenous—inner and outer. **Two superficial veins.**

The *internal saphenous* vein begins in an arch on the dorsum of the foot. Ascending along the leg in front of the inner ankle, and then behind the inner edge of the tibia, it reaches the thigh where it has been already noticed (p. 654). In the leg the vein is joined by superficial branches, and by deep roots from the tibial veins. **Internal saphenous.**

The *external saphenous* vein begins at the outer end of the arch on the dorsum of the foot, and appears below the outer ankle. The vein then courses along the back of the leg to the ham, where it ends in the popliteal vein. It receives large branches about the heel, and others on the back of the leg, and joins the internal saphenous. **External saphenous.**

Cutaneous arteries accompany the superficial veins and nerves of the leg. **Cutaneous arteries.**

CUTANEOUS NERVES. The nerves in the subcutaneous fat of the back of the leg are prolongations of branches already examined in part, viz. the internal and external saphenous, the cutaneous offset of the external popliteal, the small sciatic nerve, and offsets of the internal cutaneous of the thigh. **Cutaneous nerves.**

The *internal saphenous* nerve, which has been traced before to the knee (p. 676), accompanies the vein of the same name in the leg (fig. 121, [1]) and terminates at the middle of the inner border of the foot. In the leg the nerve gives off lateral cutaneous offsets, and the outer of these turn over the tibia to the anterior aspect. **Internal saphenous. Termination.**

The *external saphenous* nerve (fig. 118, [4]) is a branch of the internal popliteal (p. 703). Perforating the deep fascia about the middle of the leg, it is continued with the external saphenous vein below the outer ankle, and is distributed to the outer side of the foot and little toe. As soon as the nerve appears **External saphenous ends on the foot;**

it is joined by the communicating branch of the external popliteal; and near the heel it gives large and long branches to the integuments.

branches to the leg.

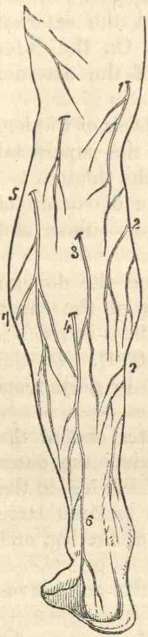
Branches of the popliteal;

communicating

and cutaneous.

Cutaneous nerves of the external popliteal. One branch of the external popliteal trunk, viz. *communicating peroneal* (p. 703), joins the external saphenous nerve about the middle of the leg: but not uncommonly this branch extends as a distinct nerve, unconnected with the other, as far as the heel.† One or two other small *cutaneous* offsets of the external popliteal terminate over the fore part and outer side of the leg in the upper half.

Fig. 118.*



Termination of small sciatic.

The *small sciatic* nerve (fig. 118, [3]) perforates the fascia near the popliteal space, and reaches with the external saphenous vein to about the middle of the leg: it ramifies in the integuments, and joins the external saphenous nerve.

Termination of internal cutaneous.

Offset of the internal cutaneous (fig. 118, [1]). Behind the internal saphenous nerve, near the knee, is the inner branch of the internal cutaneous of the thigh (p. 676); it extends to the middle of the leg, and communicates with the internal saphenous nerve.

Take away the fat.

Dissection. The deep fascia will be seen by removing the fat. The superficial vessels and nerves may be either cut or turned aside.

Deep fascia.

Continuation

and attachments.

The special or *deep fascia* on the posterior aspect of the leg covers the muscles, and sends a thick process between the deep and superficial layers. Above, it is continuous with the investing membrane of the thigh, and receives offsets from the tendons about the knee; and below, it joins the internal annular ligament. Externally it is continued uninterruptedly from the one aspect of the limb to the other, but internally it is fixed to the edge of the tibia. Veins are transmitted through it from the deep to the superficial vessels.

Take away the fascia.

Dissection. The fascia is to be divided along the centre of the leg as far as the heel, and is to be taken from the surface of the gastrocnemius muscle. By fixing with a stitch the inner cut head of the gastrocnemius, the fibres of the muscle will be more easily cleaned.

* Cutaneous nerves of the back of the leg.—1. Inner branch of the internal cutaneous. 2. Branches of the internal saphenous. 3. Small sciatic, giving higher up a branch through the fascia. 4. External saphenous. 5. Peroneal communicating branch of the external popliteal.

† Occasionally the junction may take place in or near the popliteal space.

SUPERFICIAL LAYER OF MUSCLES. In the calf of the leg there are three muscles, gastrocnemius, soleus, and plantaris, which extend the ankle. The two first are large, giving rise to the prominence on the surface, and end below by a common tendon; but the last, inconsiderable in size, is chiefly tendinous. **Muscles in superficial layer.**

The GASTROCNEMIUS is the most superficial muscle, is tendinous along the middle, and has above two distinct pieces or heads, which connect it with the condyles of the femur. The inner head of *origin* is attached by a large tendon to an impression at the posterior aspect of the inner condyle, behind the insertion of the adductor magnus, and by fleshy fibres to the line above the condyle. The outer head is fixed by tendon to a pit on the outer surface of the corresponding condyle, above the attachment of the popliteus muscle, and also to the upper and back part of the same condyle. These pieces or heads are united along the middle line by a narrow thin aponeurosis, and terminate inferiorly with the soleus in the common tendon of insertion. **Gastrocnemius arises by two heads from the femur, ends below in tendo Achillis.**

One surface is covered by the fascia. The other is in contact with the soleus and plantaris, and with the popliteal vessels and the internal popliteal nerve. The heads, by which the muscle arises, assist to form the lateral boundaries of the popliteal space,: and the fleshy inner head descends lower than the outer. In the tendon attached to the outer condyle fibro-cartilage or a sesamoid bone may exist. **Parts covered by it.**

Action. When the foot is unsupported, the gastrocnemius extends the ankle; and when the toes rest on the ground, it raises the os calcis and the weight of the body, as in standing on the toes, and in progression. **Use with the foot free, and fixed.**

Taking its fixed point at the os calcis, the muscle draws down and back the femur so as to bend the knee-joint. **Acting from below.**

Dissection. To see the soleus, the gastrocnemius is to be reflected by cutting across the remaining head, as well as the vessels and nerves it receives. After the muscle has been thrown down, the soleus and the plantaris must be cleaned. **Detach gastrocnemius.**

The SOLEUS is a large flat muscle, which is attached to both bones of the leg, and terminates, like the gastrocnemius, in the strong common tendon. It *arises* from the head, and the upper third or half of the posterior surface of the shaft of the fibula; from the oblique line across the tibia, and from the posterior edge of this bone in the middle third; and between the bones from an aponeurotic arch over the large bloodvessels. Its fibres are directed downwards to the lower tendon. **Soleus is attached to the bones of the leg, and joins below the tendon.**

The superficial part of the soleus is in contact with the gastrocnemius; and the opposed surfaces of the two are aponeurotic. Beneath the muscle lie the bones of the leg, the deep layer of flexors, and the vessels and nerves. **Parts over and under it.**

TENDO ACHILLIS. The *common tendon* of the gastrocnemius **Tendo Achillis.**

Extent. and soleus is one of the strongest in the body. About three inches wide above, it commences at the middle of the leg, though it receives fleshy fibres on the under surface nearly to the lower end: and below it is narrowed, and is *inserted* into the lower half of the tuber calcis at the posterior aspect. A bursa intervenes between it and the upper part of the calcaneum. The tendon is close beneath the fascia; and lying along its outer side, but superficial to it, are the external saphenous vein and nerve.

and insertion.

Use, the foot free, and fixed. *Action.* In its action on the foot the soleus is like the gastrocnemius in extending the ankle and pointing the toes when the foot is free to move, and in raising the heel if the toes rest on the ground.

Rupture of tendon. By the sudden and powerful contraction of the fibres of both muscles, the common tendon is sometimes broken across.

Acting from below. If it acts from the os calcis, it will draw back the bones of the leg into a vertical position over the foot as the body is raised to the erect posture after stooping.

Plantaris The PLANTARIS is remarkable in having a tendon the longest in the body, which takes the appearance of a riband when it is stretched laterally. The short fibres of the muscle *arise* from the line above the outer condyle of the femur, and from the posterior ligament of the knee-joint; and the tendon in which they end is *inserted* into the os calcis with or by the side of the tendo Achillis, or into the fascia of the leg.

arises from the outer condyle, and joins common tendon.

Position of the muscle. The belly of the muscle, about three inches in length, is concealed by the gastrocnemius, but the tendon appears on the inner side of the tendo Achillis about the middle of the leg. This little muscle crosses the popliteal vessels, and lies on the soleus.

Use like gastrocnemius. *Action.* It assists the gastrocnemius to extend the ankle if the foot is not fixed; and to bend the knee-joint if the foot is immovable.

Detach soleus, *Dissection.* The soleus is to be detached from the bones of the leg, and the vessels and nerves entering it are to be divided; but in raising it the student should take care not to injure the thin deep fascia and the vessels and nerves beneath. The superficial muscles may be next removed by cutting through their tendons near the os calcis.

and clean the deep fascia. The piece of fascia between the muscles of the superficial and deep layers is then to be cleaned; and the integuments between the inner ankle and the heel are to be taken away to lay bare the annular ligament, but a cutaneous nerve to the sole of the foot, which pierces the ligament is to be preserved.

Lastly the student should open the bursa between the tendo Achillis and the os calcis, if this has not been done.

Deep part of *Deep part of the fascia.* This intermuscular layer of the fascia of the leg is fixed to the tibia and fibula, and binds down the deep layer of flexor muscles. Beneath the soleus it is thin and indistinct; but lower in the limb it is much stronger, and is marked by some transverse fibres near the malleoli, which give it the appearance and office of an annular ligament in that situation. Inferiorly it joins the internal annular ligament between the heel and the inner ankle. **The fascia of the leg.**

Dissection. The deep layer of muscles, the posterior tibial nerve, and the trunk and offsets of the posterior tibial vessels, will be laid bare by the removal of the fascia and the areolar tissue. A muscle between the bones (tibialis posticus) is partly concealed by an aponeurosis which gives origin to the two muscles (flexor communis and flexor pollicis) on the sides; and it will not fully appear until after the membrane covering it has been divided longitudinally, and reflected to the sides. **Clean the deep muscles.**

To prepare the peroneal vessel, evert and partly divide the flexor pollicis in which it is contained, and follow below its branches to the fore part of the leg, the outer side of the foot, and to join the posterior tibial artery. **Dissect peroneal artery.**

Deep Layer of Muscles. The deep flexor muscles at the back of the leg are four in number, viz., popliteus, flexor longus pollicis, flexor longus digitorum, and tibialis posticus. The first of these is close to the knee-joint; it crosses the bones, and is covered by a special aponeurosis. The flexors lie on the bones, the one of the great toe resting on the fibula, and that of the other toes on the tibia. And the last muscle covers the interosseous membrane. **Four muscles in the deep layer.** **Position and**

With the exception of the popliteus, all enter the sole of the foot, and have a fleshy part parallel to the bones of the leg, and a tendinous part beneath the tarsus. **destination.**

The popliteus arises by tendon within the capsule of the knee joint from the fore part of an oblong depression on the outer surface of the external condyle of the femur, below the external lateral ligament; and external to the capsule of the joint, some fleshy fibres arise from the posterior ligament. The tendon piercing the capsule ends in fibres which radiate to be *inserted* into the tibia above the oblique line on the posterior surface. **Popliteus arises within knee joint.** **Inserted into tibia.**

The muscle lies on the tibia, and is covered by a fascia derived in great part from the tendon of the semimembranosus muscle. On it lie the popliteal vessels and nerve, with the gastrocnemius and plantaris. Along the upper border are the lower articular vessels and nerve of the inner side of the knee; and the lower border corresponds with the attachment of the soleus on the tibia. The origin will be seen with the dissection of the ligaments of the knee-joint. **Parts around it.**

Action. The leg being free, the muscle bends the knee-joint, and then rotates inwards the tibia. The foot resting on the **Use with tibia free,** and fixed. ground, it will support the knee. According to the view of Theile, it retracts the external semilunar fibro-cartilage.

Flexor longus policis is attached to fibula. The FLEXOR LONGUS POLLICIS arises below the soleus from the lower half or two thirds of the posterior surface of the shaft of the fibula; from the intermuscular septum between it and the peronei muscles; and from the aponeurosis over the tibialis. Inferiorly the tendon of the muscle enters a groove in the astragalus, and crosses afterwards the sole of the foot to its insertion into the great toe.

Is partly superficial. In part the muscle is covered by the soleus; but in part it is superficial, and is in contact with the fascia. It rests on the fibula and the lower end of the tibia, and conceals the peroneal vessels. Muscles and vessels on sides. Along the inner side are the posterior tibial nerve and vessels; and contiguous to the outer margin, but separated by the fascia, are the peronei muscles.

Use, the toes being free, *Action.* The foot being unsupported, the flexor bends the last phalanx of the great toe, and extends then the ankle: it may bend the second and third toes through its union in the foot with the tendon of the common flexor.

and fixed. The foot resting on the ground, the muscle raises the heel, and moves back the fibula as the body rises from stooping.

Flexor longus digitorum lies on tibia; The FLEXOR LONGUS DIGITORUM (flexor perforans) is attached to the posterior surface of the tibia, extending from the attachment of the soleus to about three inches from the lower extremity; and it takes origin also from the aponeurosis covering the tibialis posticus. enters annular ligament. Its tendon enters a partition in the annular ligament, which is superficial to the sheath of the tibialis; and, escaped from the ligament, it divides in the sole of the foot into tendons for the four outer toes.

Part is superficial below soleus. The muscle is narrow and pointed posteriorly, and is placed beneath the soleus; but in the lower half it is in contact with the fascia, and the posterior tibial nerve and vessels lie on it. The deep surface rests on the tibia and the tibialis posticus.

Use, with foot free, *Action.* The muscle bends the farthest phalangeal joints of the four smaller toes, and then extends the ankle.

and fixed. If the toes are in contact with the ground, the flexor helps to raise the heel in walking; and to move back the tibia in the act of rising from stooping.

Tibialis covers interosseous membrane. The TIBIALIS POSTICUS occupies superiorly the interval between the bones of the leg, but it crosses over the tibia inferiorly to reach the inner side of the foot. Origin: The muscle *arises* from the aponeurosis separating it from the contiguous muscles, and from all the interosseous membrane, except about one inch below; from an impression along the outer border of the tibia, which reaches from the head of the bone to rather beyond the lower attachment of the flexor longus digitorum; and from the adjacent inner surface of the shaft of the fibula as far as the lower fifth of its length. In the lower part of the leg this muscle is directed beneath the flexor digitorum; and its tendon entering the inner space in the annular ligament, reaches the inner side of the foot to be inserted into the scaphoid and other bones (p. 734). **crosses beneath the flexor of the toes. Insertion.**

The tibialis is concealed by the aponeurosis before mentioned, and is overlapped by the neighbouring muscles; but in the lower part of the leg it is placed between the tibia and the long flexor of the toes. On the muscle are the posterior tibial vessels and nerve. The upper part presents two pointed processes of attachment—that to the tibia being the highest—between which the anterior tibial vessels are directed forwards. **Muscles and vessels in connection with it.**

Action. Its action on the moveable foot is to extend the ankle-joint and to raise and move inwards the inner border of the foot, so as to turn inwards the sole; and the toes being immoveable it will aid the muscles of the calf in raising the heel in the progression of the body. **Use, with foot free, and fixed:**

In standing, the muscle can raise the inner border of the foot with the tibialis anticus, so as to throw the weight of the body on the outer edge. **in standing,**

As the body rises from stooping, the tibialis draws back the bones of the leg, with the soleus. **in rising up.**

The *aponeurosis* covering the tibialis is attached laterally to the bones, but has a defined border inferiorly over the muscle. By one surface it gives origin to the flexors of the toes, and by the other to the tibialis. **The muscle covered by an aponeurosis.**

The POSTERIOR TIBIAL ARTERY is one of the branches resulting from the bifurcation of the popliteal trunk. The vessel extends from the lower border of the popliteus muscle to the lower part of the internal annular ligament of the leg, where it ends in two plantar branches for the sole of the foot. **Posterior tibial artery. Extent.**

At its origin the artery lies midway between the tibia and fibula, but as it approaches the lower part of the leg it gradually inclines inwards; and at its termination it is placed below the tibia, near the centre of the hollow between the heel and the inner ankle. **Course.**

As far as the middle of the leg (in length) the vessel is concealed by two muscles of the calf, viz., gastrocnemius and soleus; but below that spot, as it lies between the tendo Achillis and the inner edge of the tibia, it is covered only by the integuments and the deep fascia. At its termination it is placed beneath the annular ligament. For the upper half of its extent the arterial trunk lies over the tibialis posticus, but afterwards on the flexor digitorum, and on the lower end of the tibia and the ankle-joint. On the outer side is the flexor pollicis. **Parts covering the upper and lower half. Parts beneath it.**

Between the heel and the ankle, the artery lies between the tendons of the common flexor of the digits and special flexor of the great toe. **Beneath annular ligament.**

Veins. Nerve. Venæ comites closely surround the vessel. The posterior tibial nerve is at first internal to the artery; but at the distance of one inch and a half it crosses to the outer side, and retains that position throughout.

Branches. This artery supplies *branches* to the muscles and the tibia, and a large peroneal trunk to the outer side of the leg.

Muscular. *Muscular branches* enter the deep layer of muscles and the soleus; an offset from a branch to the latter muscle pierces the attachment to the tibia, and ascends to the knee-joint.

Nutritious to tibia. A *nutritious artery* of the *shaft* of the *tibia* is uncertain in its place of origin: penetrating the tibialis, it enters the canal on the posterior surface of the bone, and ramifies in the interior.

Communicating. A *communicating* branch to the peroneal arises opposite the lower end of the tibia, and passes outwards beneath the flexor pollicis, to unite in an arch with a corresponding offset of the peroneal artery.

Articular branches. *Articular branches* arise from the artery opposite the ankle-joint, and enter the articulation.

Cutaneous offsets. *Cutaneous offsets* appear through the fascia in the lower half of the leg; and the largest of these pierces the annular ligament, and accompanies the cutaneous plantar nerve to the sole of the foot.

Peroneal artery is contained in flexor policis. The PERONEAL ARTERY is often as large as the posterior tibial, and arises from that vessel about one inch and a half from the beginning. It takes the fibula as its guide, and lying close to the bone in the fibres of the flexor pollicis, reaches the lower part of the interosseous membrane. At this spot it sends forwards a branch to the front of the leg (anterior peroneal); and it is directed onwards over the articulation between the tibia and fibula and along the outer side of the foot to the heel, where it

Termination. terminates in branches, and anastomoses with offsets of the posterior tibial, and the tarsal and external plantar arteries.

Veins and nerve. Two companion veins surround the artery; and the nerve to the flexor pollicis lies on it generally.

Branches. *Branches.* Besides the anterior peroneal, it furnishes muscular, nutritious, and communicating offsets.

Muscular. *Muscular* branches are distributed to the soleus, tibialis posticus, and flexor pollicis, and some turn round the fibula to the peronei muscles, lying in grooves in the bone.

Nutritious to fibula. The *nutritious* artery is smaller than that to the tibia, and is transmitted through the tibialis posticus to the aperture about the middle of the fibula.

Anterior peroneal to front of foot. The *anterior peroneal* branch passes forwards through an opening in the lower part of, or below the interosseous membrane, and is continued to the dorsum and the outer part of the foot: on the front of the leg and foot it anastomoses with the external malleolar and tarsal branches of the anterior tibial artery.

A *communicating* offset near the ankle joint joins in an arch, as before mentioned, with a similar branch of the posterior tibial. Sometimes there is a second arch between the same vessels. **Communicating.**

Peculiarities. The *posterior tibial artery* may be smaller than usual, or absent. Its place will be then supplied in the foot by a large peroneal artery, which is directed inwards at the lower end of the tibia, and either joins the small tibial vessel, or runs alone to the sole of the foot. **Size of tibial changes.**

The *peroneal artery* may arise from the popliteal, or from the anterior tibial artery. And its anterior peroneal branch may take the place of the anterior tibial artery on the dorsum of the foot. **Origin and ending vary.**

A compensating principle may be observed amongst the arteries of the foot as in those of the hand, by means of which the deficiency in one is supplied by an enlarged offset of another. **Substitutions.**

The POSTERIOR TIBIAL VEINS begin on the inner side of the foot by the union of the plantar veins: they ascend, one on each side of the artery, and unite with the anterior tibial trunks at the lower border of the popliteus, to form the large popliteal vein. They receive the peroneal veins, and branches corresponding with the offsets of the artery: branches connect them also with the saphenous veins. **Posterior tibial veins.**

The POSTERIOR TIBIAL NERVE is a continuation of the internal popliteal, and reaches, like the artery, from the lower border of the popliteus muscle to the interval between the os calcis and the inner malleolus. Whilst beneath the annular ligament, or somewhat higher than it, the nerve divides into the internal and external plantar branches of the foot. **Posterior tibial nerve. Extent**

Its connections with surrounding parts are the same as those of the artery; but its position to the vessel changes, for it lies on the inner side of the posterior tibial artery above the origin of the peroneal offset, but on the outer side thence to the termination. **and connections. Position to the artery.**

Its branches are muscular and cutaneous. **Branches.**

Muscular branches enter the deep flexors, and arise either at separate points along the trunk, or together from the upper part of the nerve. There is an offset for each of the muscles except the popliteus; but the branch for the tibialis is the largest, and that for the flexor pollicis lies on the peroneal artery. **Muscular to the deep flexors.**

A *cutaneous nerve* of the *sole* of the *foot* begins above the os calcis, and piercing the internal annular ligament as two or more pieces, ends in the integuments of the inner and under parts of the heel; this nerve will be followed to its termination in the dissection of the foot. **Cutaneous of the foot.**

The *internal annular ligament* is placed between the heel and the inner ankle, and serves to confine the tendons of the deep layer of muscles of the foot and toes. Attached by a pointed part to the internal malleolus, the fibres diverge and are inserted into the os calcis. One border (upper) is continuous with the fascia of the leg; and the opposite gives attachment to the abductor pollicis muscle of the foot. **Internal annular ligament. Attachments.**

Sheaths: their position.

Beneath it are sheaths for the tendons which are contained in subjacent osseous grooves. When the sheaths are opened, the innermost will be found to inclose the tibialis posticus, lodged in a groove in the malleolus. Immediately behind this is another space for the flexor digitorum. And about three quarters of an inch nearer the os calcis is the interval in which the flexor pollicis lies, resting in a groove in the astragalus. Each sheath is lined by a synovial membrane.

SECTION V.

THE SOLE OF THE FOOT.

Position of the part.

Position. The foot is to be placed over a block of little thickness with the sole towards the dissector, and the part is to be made tense by fixing the heel with hooks, and by fastening down and separating the toes.

Raise the skin

Dissection. The skin is to be raised as two flaps, inner and outer, by means of one incision along the centre of the sole from the heel to the anterior part; and by another across the foot at the root of the toes. Afterwards the skin is to be removed from each toe, and the digital vessels and nerves on its sides are to be dissected out at the same time.

and dissect cutaneous nerves.

In the fat near the heel the student should follow the cutaneous nerve of the sole of the foot (p. 721); and he may trace out, at a little distance from each border of the foot, some small branches of the plantar nerves and arteries.

Subcutaneous fat.

The *subcutaneous fat* of the sole of the foot is very abundant, and forms the thickest cushion over the parts of the surface that press most on the ground in standing, viz., over the os calcis, and the line of the metatarso-phalangeal articulations.

Lay bare the plantar fascia,

Dissection. The fat should be now removed, and the plantar fascia laid bare. Beginning the dissection near the heel, follow forwards the fascia towards the toes, to each of which a process is to be traced.

and the digital vessels and nerves.

In the intervals between these processes the digital nerves and arteries will be detected amongst much fatty and fibrous tissues; but the vessels and nerves to the inner side of the great toe and outer side of the little toe, will be found to pierce the fascia farther back than the rest.

Define the ligament of the toes.

The student is next to define a transverse fibrous band between the toes, over the digital vessels and nerves; and when this has been displayed he may remove the superficial fascia from the toes to see the sheaths of the tendons.

Plantar fascia. PLANTAR FASCIA. The special fascia of the sole of the foot is of a pearly white colour and great strength, and sends septa between the muscles. Its thickness varies in different parts of the foot; and from this circumstance, and the existence of longitudinal depressions over the two chief intermuscular septa, the fascia is divided into a central and two lateral parts.

Division into parts.

Central part The central part, which is much the thickest, is pointed at its attachment to the os calcis, but widens and becomes thinner as it extends forwards. A slight depression, corresponding with an intermuscular septum, marks its limit on each side. Opposite the heads of the metatarsal bones it divides into five processes, which send bands to the integuments near the web of the foot, and are then continued onwards to the toes, one to each. Where the pieces separate from each other, the digital vessels and nerves and the lumbricales muscles become superficial; and transverse fibres arch over them.

divides into five pieces.

Arched fibres over vessels.

Termination of the pieces. If one of the processes be divided longitudinally, and its parts reflected to the sides, it will be seen to join the sheath of the flexor tendons, and to be fixed also on the sides into the margins of the metatarsal bone, and into the transverse metatarsal ligament.

Inner part of the fascia; The lateral parts of the fascia are thinner than the central piece. On the inner margin of the foot the fascia has but little strength, and is continued to the dorsum; but on the outer side it is increased in thickness, and presents a strong band between the os calcis and the projection of the fifth metatarsal bone.

outer part.

Expose the septa. *Dissection.* To examine the septa, a longitudinal incision may be made along the middle of the foot through the central piece of the fascia, and a transverse one near the calcaneum. On detaching the fascia from the subjacent flexor brevis digitorum, by carrying the scalpel from before backwards, the septal processes will appear on the sides of that muscle.

Two intermuscular septa. The *inter muscular septa* pass down on the sides of the flexor brevis digitorum, and thus isolate the central muscle in the superficial layer of the sole of the foot. A piece of fascia reaches across the foot from the one septum to the other, beneath the short flexor.

Inner The *inner* septum lies between the flexor perforatus and the abductor pollicis, and the internal plantar nerve and vessels, and the tendon of the flexor pollicis longus pass through it.

and outer. The *outer* partition between the short flexor of the toes and the abductor minimi digiti, is pierced by the digital nerve and vessels for the outer side of the little toe.

Transverse ligament of the toes. The *superficial transverse ligament* crosses the roots of the toes, and is contained in the skin forming the rudimentary web of the foot. The band of fibres is attached at the extremities to the sheath of the flexor tendons of the great and little toes, and is connected with that of each of the others as it passes over. Beneath it the digital nerves and vessels issue.

Sheaths of flexor tendons.

The *sheaths* of the *flexor tendons* are similar to those of the fingers, though not so distinct, and serve to confine the tendons against the grooved bones. The sheath is weak opposite the articulations between the phalanges, but is strengthened by a band opposite the centre of both the metatarsal and the next phalanx. Each is lubricated by a synovial membrane, and contains tendons of the long and short flexor muscles.

Dissect first layer of muscles.

Dissection. In the sole of the foot the muscles are numerous, and have been arranged in four layers. To prepare the first layer all the fascia must be taken away; but this dissection must be made with some care, lest the digital nerves and vessels, which become superficial to the central muscle towards the toes, should be injured.

The tendons of the short flexor muscle are to be followed to the toes, and one or more of the sheaths in which they are contained should be opened.

Muscles in the first layer.

First layer of Muscles. In the layer first visible are three muscles, viz., the flexor brevis digitorum, the abductor pollicis, and abductor minimi digiti. The short flexor of the toes lies in the centre of the foot; and each of the others is in a line with the toe on which it acts.

Abductor pollicis; origin;

The abductor pollicis is the most internal of the muscles of the superficial layer. It takes *origin* from the inner part of the larger tubercle on the under surface of the os calcis; from the lower border of the internal annular ligament, and the fibrous structures on the inner side of the foot as far as the scaphoid bone; and from the plantar fascia. In front the muscle ends in a tendon, which is joined by fibres of the short flexor, and is *inserted* with it into the inner side of the base of the metatarsal phalanx of the great toe.

insertion;

connections.

The cutaneous surface of the muscle is in contact with the plantar fascia; and the other touches the tendons of the tibial muscles, the plantar vessels and nerves, and the tendons of the long flexors of the toes with the accessorius muscle.

Use, as flexor and abductor.

Action. This abductor acts chiefly as a flexor of the metatarso-phalangeal joint of the great toe, but it will abduct slightly that toe from the others.

Flexor brevis digitorum

The flexor brevis digitorum (flexor perforatus) *arises* posteriorly by a pointed process from the inner part of the larger tubercle of the os calcis, and by fibres from the plantar fascia and the septa. About the centre of the foot the muscle ends in four small tendons, which are directed forwards over the tendons of the long flexor, and entering the sheaths of the four smaller toes, are *inserted* into the middle phalanges. In the sheath of the toe, the tendon of this muscle lies at first (in this position of the foot)

divides into tendons for the toes.

on the long flexor; but opposite the middle of the metatarsal phalanx it is slit for the passage of the other, and is attached by two processes to the sides of the middle phalanx. Insertion.

The short flexor of the toes is contained in a sheath of the plantar fascia, and occupies the middle of the foot. It conceals the tendon of the long flexor of the toes, the accessory muscle, and the external plantar vessels and nerve. Connections.

Action. It bends the nearest phalangeal joint of the four smaller toes, like the flexor sublimis in the upper limb, and approximates the toes at the same time. After the two farther phalangeal joints are bent by the short and long flexor, the metatarso-phalangeal joint will be flexed by the indirect action of both. Use on the phalangeal joints.

The ABDUCTOR MINIMI DIGITI has a wide *origin* behind from the outer tubercle of the os calcis, from the fore part of the inner or larger tubercle, and from the plantar fascia and the external intermuscular septum. It ends anteriorly in a tendon which is *inserted* into the outer side of the base of the metatarsal phalanx of the little toe. Abductor of the little toe. Origin and insertion.

The muscle lies along the outer border of the foot, and conceals the flexor accessorius, and the tendon of the peroneus longus. On its inner side are the external plantar vessels and nerve. Sometimes a part of the muscle is fixed into the projection of the fifth metatarsal bone. Is at side of the foot.

Action. Though it abducts the little toe from the others, as the name signifies, its chief use is to bend the metatarso-phalangeal joint. Use as abductor and flexor.

Dissection. To bring into view the second layer of muscles and the plantar vessels and nerves, the muscles already examined must be reflected. Cut through the flexor brevis at the os calcis, and as it is raised, notice a branch of nerve and artery to it. Dividing the abductor minimi digiti near its origin, and turning it to the outer side of the foot, seek a small nerve and vessel to it close to the calcaneum. The abductor pollicis can be drawn aside if it is necessary, but it should remain uncut till afterwards. Dissect the next muscular layer, and

Next the internal plantar vessels and nerve are to be followed forwards to their termination, and backwards to their origin; and the external plantar vessels and nerve, the tendons of the long flexors of the toes, the accessory muscle, and the small lumbricales, should be freed from fat. plantar vessels and nerves.

The PLANTAR ARTERIES are the terminal branches of the posterior tibial trunk, and supply digital offsets to the toes. They are two in number, and are named external and internal from their relative position in the sole of the foot. Of the two the external is the larger, and forms the plantar arch of arteries. Two plantar arteries; inner and outer.

The *internal* artery is commonly inconsiderable in size, and Internal small:

accompanies the internal plantar nerve. It is continued forwards under cover of the abductor pollicis as far as the hinder part of the first interosseous space, where it becomes superficial, and is directed out with the median nerve over the tendons of the short flexor of the toes as far as the third interosseous space. At this spot it ends by communicating with the third digital artery. (Illustrations of Dissections, p. 437.)

course

and ending.

Branches to muscles;

Branches. In this course the artery furnishes muscular branches, like the median nerve, to the abductor pollicis and flexor digitorum perforatus, and to the flexor brevis pollicis and the two internal lumbricales; it gives also the following superficial digital branches to the toes with the digital branches of the median nerve:—

and superficial digital,

first, second, third, fourth.

The *first* reaches the inner side of the foot and great toe; the *second* lies over the first interosseous space; the *third* corresponds with the interval of the second space; and the termination of the artery is placed over the third space.

At the roots of the toes they end (except the first) by joining the deeper digital arteries of those three spaces.

External artery has curved course;

The *external* artery has an arched course in the foot, with the concavity of the arch turned inwards as it is extended forwards to the toes. From the inner part of the foot the vessel is directed outwards across the sole, and then obliquely inwards towards the root of the great toe, so that it crosses the foot twice. In the first half of its extent, viz. from the inner side of the calcaneum to the base of the metatarsal bone of the little toe, the artery is comparatively superficial; in the other half, between the little and the great toe, it lies deeply in the foot, in contact with the interosseous muscles, and forms the plantar arch.

partly superficial, partly deep.

Superficial part.

Only the first part of the artery is now laid bare; the remaining part, supplying the digital branches, will be noticed after the examination of the third layer of muscles (p. 731).

Connections.

As far as the metatarsal bone of the little toe, the vessel is concealed by the abductor pollicis and the flexor brevis digitorum; and for a short distance near its termination it lies in the interval between the last muscle and the abductor minimi digiti. In this extent it is placed on the os calcis, and the flexor accessorius: and it is accompanied by venæ comites, and the external plantar nerve.

Veins and nerve.

Branches.

It supplies offsets to the muscles between which it lies, and some branches to the outer side of the foot for anastomosis with the peroneal artery.

Plantar nerves also two.

The PLANTAR NERVES are derived from the bifurcation of the posterior tibial trunk behind the inner ankle. They are two in number, like the arteries, and have the same anatomy as those vessels, for each accompanies a plantar artery; but the larger nerve is found with the smaller bloodvessel.

The *internal plantar* nerve courses with its artery between the short flexor of the toes and the abductor pollicis, and giving but few muscular offsets, divides into four digital branches for the supply of both sides of the inner three toes, and half the fourth; it resembles thus the median nerve of the hand in the number and distribution of its branches. **Internal nerve to three toes and a half.**

Muscular offsets are given by it to the short flexor of the toes (perforatus) and the abductor pollicis; and a few superficial twigs perforate the fascia. **Other branches.**

The four *digital* nerves have a numerical designation, and the first is nearest the inner border of the foot. The branch to the inner side of the great toe is undivided, but the others are bifurcated at the clefts between the toes. **Digital nerves are divided except first;**

Muscular branches are furnished by these nerves before they reach the toes; thus, the first (most internal) supplies the flexor brevis pollicis; the second, the inner lumbrical muscle; and the third, the next lumbrical muscle. **muscular branches;**

Digital nerves on the toes. Each of the outer three nerves, being divided at the spot mentioned, supplies the contiguous sides of two toes, whilst the first belongs to the inner side of the great toe; all give offsets to the teguments, and the cutis beneath the nail, and articular filaments are distributed to the joints as in the fingers. **give cutaneous and articular offsets.**

The *external plantar* nerve is spent chiefly in the deep muscles of the sole of the foot, but it furnishes digital nerves to both sides of the little toe, and the outer side of the next. It corresponds in its distribution with the ulnar nerve in the hand. **External nerve to one toe and a half;**

It has the same course as the external plantar artery, and divides at the outer margin of the flexor brevis digitorum into a superficial and a deep portion:—the former gives origin to two digital nerves; but the latter accompanies the arch of the plantar artery into the foot, and will be dissected afterwards. **has superficial and deep parts.**

Whilst the external plantar nerve is concealed by the short flexor of the toes, it gives muscular branches to the abductor minimi digiti and the flexor accessorius. **Branches.**

The *digital branches* of the external plantar nerve are but two, and resemble those of the ulnar nerve in the hand. **Two digital branches.**

One nerve is undivided; it is distributed to the outer side of the little toe, and gives branches to the flexor brevis minimi digiti, and the interosseous muscles of the fourth space. **One single.**

The other bifurcates at the cleft between the outer two toes, and supplies their collateral surfaces: this nerve communicates in the foot with the last digital branch of the internal plantar nerve. **One divided.**

On the sides of the toes the digital nerves have the same distribution as those from the other plantar trunk, and end like them in a tuft of fine branches at the extremity of the digit. **Distribution like others.**

Lay bare second layer of muscles.

Dissection. To complete the preparation of the second layer of muscles, the origin of the abductor pollicis should be detached from the os calcis, and the muscle should be turned inwards. The internal plantar nerve and artery, and the superficial portion of the external plantar nerve, are to be cut across and thrown forwards; but the external plantar artery and the nerve with it are not to be injured. All the fat, and loose tissue and fascia, are then to be taken away near the toes.

Second layer.

SECOND LAYER OF MUSCLES. In this layer are the tendons of the two flexor muscles at the back of the leg, viz. flexor longus digitorum and flexor longus pollicis, which cross one another. Connected with the former, soon after it enters the foot, is an accessory muscular slip; and at its division into pieces four slender muscles, named lumbricales, are added to it.

Tendon of the flexor of the toes

The tendon of the FLEXOR LONGUS DIGITORUM, whilst entering the foot beneath the annular ligament, lies on the internal lateral ligament of the ankle joint. In the foot it is directed obliquely towards the centre, where it is joined by the tendon of the flexor longus pollicis and the accessory muscle, and divides into tendons for the four outer toes.

divides into four.

These pierce the other tendons.

Each tendon enters the sheath of the toe with, and beneath a tendon from the flexor brevis. About the centre of the metatarsal phalanx the long flexor tendon is transmitted through the other, and passes onwards to be *inserted* into the base of the ungual phalanx.

Ligaments to tendons.

United with the phalanges of the toes there are ligamentous bands (lig. brevia) of the flexor tendons as in the hand, and the one fixing the flexor perforans is provided also with elastic tissue. See page 317.

Use on the digits with others, and without.

Action. The manner in which the toes are bent by this and the short flexor has been before stated (p. 725). If it acted by itself it would tend to bring the toes somewhat backwards and inwards, in consequence of its oblique position in the foot.

Four lumbricales.

Attachment to toes and long flexor.

The *lumbricales* are four small muscles between the tendons of the flexor longus digitorum. Each *arises* from two tendons, with the exception of the most internal, which is connected with the inner side of the tendon to the second toe. Each is *inserted* by a slip into the tibial side of the base of the metatarsal phalanx in the four outer toes, and by an expansion into the aponeurotic covering on the dorsum of the phalanx. These muscles decrease in size from the inner to the outer side of the foot.

Use on the phalanges.

Action. These small muscles assist the two flexors in bending the metatarso-phalangeal joint of the four outer toes, but before they contract the tendon of the flexor profundus requires to be fixed.

Flexor accessorius

The *accessorius muscle* has two heads of origin:—One is mostly tendinous, and is attached to the under or the outer surface of the os calcis and the ligamentum longum plantæ; the other is large and fleshy, and springs from the inner or concave surface of the calcaneum. The fibres end in aponeurotic bands, which join the tendon of the flexor longus digitorum about the centre of the foot, and contribute slips to the pieces of that tendon going to the second, third, and fourth digits (Turner). is joined with flexor longus.

The muscle is bifurcated behind, and the heads of origin are separated by the long plantar ligament. On it lie the external plantar vessels and nerve, and the flexor brevis digitorum conceals it. Connections.

Action. By means of its offsets to the tendons of certain digits the muscle assists in bending those toes. Use on the toes,

And from its position on the outer side and behind the long flexor to which it is united, it will oppose the inward action of that muscle, and will bend the toes directly back with the aid of the flexor brevis. on long flexor.

The tendon of the FLEXOR LONGUS POLLICIS is deeper in the sole of the foot than the flexor longus digitorum; to this last it is united by a strong tendinous process which, joined by bands of the accessorius, is continued into the pieces of the long flexor tendon which belong to the second and third toes (Turner). Finally directed to the root of the great toe, it enters the digital sheath, and is *inserted* into the base of the ungual phalanx. Insertion of tendon of flexor pollicis.

Between the calcaneum and the internal malleolus this tendon lies in a groove in the astragalus; and in the foot it occupies a groove below the inner projection (sustentaculum tali) of the os calcis, being enveloped by a synovial membrane. Connections.

Action. For the action of this muscle on the great toe, see page 718. Use on first

Through the slip that it gives to the tendons of the flexor longus to the second and third toes, it will be able to bend those digits with the great toe. and other toes.

Dissection. For the dissection of the third layer of muscles, the accessorius and the tendons of the long flexor are to be cut through near the calcaneum, and turned towards the toes. Whilst raising the tendons the external plantar nerve and artery are not to be interfered with; and two small nerves to the outer two lumbricales are to be looked for. Afterwards the areolar tissue is to be taken from the muscles now brought into view. Dissect third layer of muscles.

THIRD LAYER OF MUSCLES. Only the short muscles of the great and little toes enter into this layer. On the metatarsal bone of the great toe the flexor brevis pollicis lies, and external to it is the adductor pollicis; on the metatarsal bone of the little toe is placed the flexor brevis minimi digiti. Crossing the heads of the metatarsal bones is the transversalis pedis muscle. Third layer of muscles consists of

The fleshy mass between the adductor pollicis and the short flexor of the little toe consists of the interossei muscles of the next layer.

Flexor brevis pollicis. Origin. Insertion. The FLEXOR BREVIS POLLICIS muscle is tendinous and pointed at the posterior part, but bifurcated in front. It is attached posteriorly to the inner border of the cuboid bone, and to a prolongation from the tendon of the tibialis posticus to the outer two cuneiform bones. Near the front of the metatarsal bone of the great toe it divides into two heads, which are inserted into the sides of the base of the metatarsal phalanx.

Connections. Resting on the muscle at one part, and in the interval between the heads at another, is the tendon of the flexor longus pollicis. The inner head joins the abductor, and the outer is united with the adductor pollicis. A sesamoid bone is developed in the tendon connected with each head.

Use on the digit. *Action.* By reason of its attachment to the first phalanx it flexes the metatarso-phalangeal joint of the great toe.

Adductor pollicis joins outer head of short flexor. The ADDUCTOR POLLICIS, which is larger than the preceding muscle and external to it, *arises* from the sheath of the tendon of the peroneus longus, and from the bases of the second, third, and fourth metatarsal bones. Anteriorly the muscle is united with the outer head of the short flexor, and is *inserted* with it into the base of the metatarsal phalanx of the great toe.

Covers plantar arch. To the inner side is the flexor brevis; and beneath the outer border the external plantar artery and nerve are directed inwards.

Use on toe. *Action.* Its first action will be to adduct the great toe to the others, and it will assist afterwards in bending the metatarso-phalangeal joint of the toe.

Transversalis pedis. Origin. Insertion. The TRANSVERSALIS PEDIS is placed transversely over the heads of the metatarsal bones. Its *origin* takes place by fleshy bundles from the fibrous capsule of the phalangeal articulations of the four outer toes (frequently not from the little toe), and from the fascia covering the interossei muscles. Its *insertion* into the great toe is united with that of the adductor pollicis.

Connections. The cutaneous surface is covered by the tendons, and the nerves of the toes; and the opposite surface is in contact with the interossei muscles and the digital vessels.

Use on the toes. *Action.* It will adduct the great toe to the others, and then approximate the remaining toes.

Flexor minimi digiti is like an interosseous. The FLEXOR BREVIS MINIMI DIGITI is a small narrow muscle; it lies on the metatarsal bone of the little toe, and resembles one of the interossei. Attached to the metatarsal bone, and to the sheath of the peroneus longus behind, it blends with the inferior ligament of the metatarso-phalangeal articulation, and is *inserted* with it into the base of the metatarsal phalanx of the toe, as well as by fleshy fibres into the fore part of the metatarsal bone.

Action. Firstly it bends the metatarso-phalangeal joint, and nextly it draws the fore part of the fifth metatarsal bone down and in. **Use: it bends and adducts.**

Dissection. In order that the deep vessels and nerves may be seen, the flexor brevis and adductor pollicis are to be cut through at the posterior part, and thrown towards the toes; but the nerves supplying them are to be preserved. Beneath the adductor lie the plantar arch, and the external plantar nerve, with their branches; and in the first interosseous space is the part of the dorsal artery of the foot that enters the sole. All these vessels and nerves with their branches require careful cleaning. **Dissect the deep vessels and nerves.**

The muscles projecting between the metatarsal bones are the interossei; the fascia covering them should be removed and the intervals between the several muscles may be defined.

The PLANTAR ARCH is the part of the external plantar artery that reaches from the base of the metatarsal bone of the little toe to the back of the first interosseous space: internally the arch is completed by a communicating branch from the dorsal artery of the foot (p. 732). It is placed across the tarsal ends of the metatarsal bones, in contact with the interossei, but under the adductor pollicis, to which it gives many branches,—lying between the third and fourth layers of muscles in the foot. **Arch of the plantar artery.** **Extent and connections with muscles.**

Venæ comites lie on the sides of the artery, and the external plantar nerve accompanies that vessel. **Veins and nerve.**

From the front or convexity of the arch the digital branches are supplied, and from the opposite side small nutritive branches arise. **Branches.**

Three small arteries, the *posterior perforating*, are given off from the under part: these pass to the dorsum of the foot through the three outer intermetatarsal spaces, and anastomose with the interosseous branches of the anterior tibial artery. **Posterior perforating.**

The *digital branches* are four in number, and supply both sides of the three outer toes, and half of the next. One to the outer side of the little toe is single; but the others lie over the interossei in the outer three metatarsal spaces, but beneath the transversalis pedis, and bifurcate in front to supply the contiguous sides of two toes. **Digital branches to three toes and a half.**

Whilst they are placed on the interossei they give fine offsets to those muscles and the transversalis pedis; and at the point of division they send small communicating branches—*anterior perforating*, to join the interosseous arteries on the dorsum of the foot. **Muscular and anterior perforating offsets.**

The *first digital* runs on the outer side of the little toe, supplying the flexor brevis minimi digiti, and distributes small arteries to the teguments of the outer border of the foot. **First.**

The *second* belongs to the sides of the fifth and fourth toes, and furnishes a branch to the inner lumbrical muscle. **Second.**

Third. The *third* is distributed to the contiguous sides of the fourth and third toes, and emits a branch to the third lumbricalis.

Fourth digital. The *fourth*, or most internal, corresponds with the second interosseous space, and ends like the others on the third and second digits; it may assist in supplying the third lumbricalis.

Distribution on the toes. On the sides of the toes the disposition of the arteries is like that in the hand. They extend to the last phalanx, where they unite in an arch, and give offsets to the sides and ball of the toe; and the artery on the second digit anastomoses with a branch from the anterior tibial artery. Near the front of both the metatarsal and the next phalanx, they form anastomotic loops beneath the flexor tendons, from which the phalangeal articulations are supplied.

Ending of the dorsal artery of the foot; The DORSAL ARTERY OF THE FOOT enters the sole at the posterior part of the first (inner) intermetatarsal space, and ends by inosculating with the plantar arch. By a large digital artery it furnishes branches to both sides of the great toe and half the next, in the same manner as the radial artery in the hand is distributed to one digit and a half.

its digital branches, The *digital branch* (art. magna pollicis) extends to the front of the first interosseous space, and divides into collateral branches for the contiguous sides of the great toe and the next; and near the head of the metatarsal bone it sends inwards, beneath the flexor muscles, a digital branch for the inner side of the great toe.

on the digits. These arteries have the same arrangement along the toes as the other digital branches; and that to the second digit anastomoses with a branch of the plantar arch.

External plantar nerve ends in the deep muscles. EXTERNAL PLANTAR NERVE. The *deep branch* of this nerve accompanies the arch of the artery, and ends internally in the adductor pollicis. It furnishes branches to all the interossei, one or both in the external space excepted; to the transversalis pedis; and to the external two lumbrical muscles.

Like ulnar nerve. This part of the nerve corresponds very closely with the deep or terminal portion of the ulnar nerve in the hand.

Dissection. *Dissection.* It will be needful to remove the transversalis pedis muscle, to see a ligamentous band across the heads of the metatarsal bones.

Transverse metatarsal ligament. The *transverse metatarsal ligament* is a strong fibrous band, like that in the hand (p. 321), which connects together the anterior extremities of all the metatarsal bones. A thin fascia covering the interossei muscles is connected to its hinder part. It is concealed by the transversalis pedis, and by the tendons, vessels, and nerves of the toes.

Dissect the last layer of the muscles. *Dissection.* To complete the dissection of the last layer of muscles, the flexor brevis minimi digiti may be detached and thrown forwards. Dividing then the metatarsal ligament between the bones, the knife is to be carried directly backwards for a short distance in the centre of each interosseous space except the first, in order that the two interossei muscles may be separated from each other. All the interossei are visible in the sole of the foot.

The fascia covering the muscles should be taken away; and the branches of the external plantar nerve to them should be dissected out.

Fourth layer of muscles.

FOURTH LAYER OF MUSCLES. In the fourth and last layer of the foot are contained the interossei muscles, and the tendons of the tibialis posticus and peroneus longus.

Interossei, are plantar and dorsal.

The INTEROSSEI MUSCLES are situate in the intervals between the metatarsal bones. They consist of two sets, plantar and

Fig. 119.*

Fig. 120.†

dorsal, like the interossei in the hand. Seven in number, there are three plantar and four dorsal; and two are found in each space, except the innermost.

Three plantar for three outer toes.

The *plantar interossei* belong to the three outer metatarsal bones (fig. 119), and are slender fleshy slips. They *arise* from the under and inner surfaces of those bones; and are *inserted* partly into the tibial side of the base of the metatarsal phalanx

* The plantar interosseous muscles of the foot—the figures refer to the three muscles.

† The four dorsal interossei muscles are indicated by the figures.

of the same toes, and partly by an expansion from each to the extensor tendon on the dorsum of the phalanx. These muscles are smaller than the dorsal, and are placed more in the sole of the foot.

Action.

Use. By their action they approximate the three outer to the second toe.

Four dorsal between the bones.

The *dorsal interossei*, one in each space, *arise* from the lateral surfaces of the two bones between which they lie; and are *inserted* like the others into the side and on the dorsum of the metatarsal phalanx of certain toes:—Thus, the inner two muscles are attached to the second toe, one to each side; the next to the outer side of the third toe; and the remaining one to the outer side of the fourth toe.

Attachments.

Connections.

The interossei are crossed by the external plantar artery and nerve and their branches, and lie beneath the transversalis pedis and the metatarsal ligament. The posterior perforating arteries pierce the hinder extremities of the dorsal set; these last will be partly seen on the dorsum of the foot.

Use of the muscles.

Action. The dorsal muscles act as abductors from the middle line of the second digit:—the outer two muscles will draw their respective toes from that digit; and the two connected with the second toe will move it to the right or the left of the line referred to.

Trace out the deep tendons.

Dissection. Following the tendon of the tibialis posticus muscle from its position behind the inner malleolus to its insertion into the scaphoid bone, trace the numerous processes that it sends forwards and outwards. Open also the fibrous sheath of the tendon of the peroneus longus, which crosses from the outer to the inner side of the foot.

Insertion of tendon of tibialis posticus

The tendon of the TIBIALIS POSTICUS is continued forwards over the internal lateral ligament of the ankle joint, and over the articulation between the astragalus and the os scaphoides, to be *inserted* into the prominence of the latter bone. From its insertion processes are continued to many of the other bones of the foot.

into tarsus

One is directed backwards to the margin of the groove in the os calcis for the tendon of the flexor longus pollicis. Two offsets are directed forwards:—one is prolonged to the internal cuneiform bone; the other, much the largest, is attached to the middle and outer cuneiform, to the os cuboides, and to the bases of the second, third, and fourth metatarsal bones. In other words bands are fixed into all the tarsal bones except one (astragalus); and into all the metatarsal bones except two (first and fifth).

and metatarsus.

Where the tendon is placed beneath the articulation of the astragalus, it contains a sesamoid bone, or fibro-cartilage.

Insertion of tendon of

The tendon of the PERONEUS LONGUS MUSCLE winds round the cuboid bone, and placed in the groove on the under surface, is continued inwards to be *inserted* into the internal cuneiform bone, and the base of the metatarsal bone of the great toe; and sometimes by a slip into the base of the second metatarsal bone. peroneus longus.

In the sole of the foot (fig. 119), it is contained in a sheath which is covered, towards the outer part, by the fibres of the long plantar ligament prolonged to the tarsal ends of the third and fourth metatarsal bones; but internally only by areolar tissue. A separate synovial membrane lubricates the sheath. Connection.

Where the tendon turns round the cuboid bone it is thickened, and contains fibro-cartilage or a sesamoid bone.

Section VI.

THE FRONT OF THE LEG.

Position. The limb is to be raised to a convenient height by blocks beneath the knee, and the foot is to be extended in order that the muscles on the front of the leg may be put on the stretch. Position of the limb.

Dissection. To enable the dissector to raise the skin from the leg and foot, one incision should be made along the middle line from the knee to the toes, and this should be intersected by cross cuts at the ankle and the web of the foot. Raise the skin.

After the flaps of skin are reflected, the cutaneous vessels and nerves are to be looked for (fig. 121). At the inner part of the leg are some filaments from the great saphenous nerve; and at the outer side others, still smaller, from the cutaneous ramifications of the external popliteal nerve. Perforating the fascia in the lower third, on the anterior aspect, is the musculo-cutaneous nerve, whose branches should be pursued to the toes. Seek the cutaneous nerves in the leg;

On the dorsum of the foot is a venous arch, which ends at the sides in the saphenous veins. On the outer side is the external saphenous nerve; and about the middle of the instep the internal saphenous nerve ends. In the interval between the great toe and the next is the cutaneous part of the anterior tibial nerve. The digital nerves should be traced to the ends of the toes by removing the integuments. on the foot both vessels and nerves.

After the several vessels and nerves are dissected, the fat is to be taken away, in order that the fascia may be seen. Clean the fascia.

The *venous arch on the dorsum of the foot* has its convexity turned forwards, and receives digital branches from the toes; at its concavity it is joined by small veins from the instep. Internally and externally it unites with the saphenous veins. Cutaneous veins.

Internal saphenous.

The *internal saphenous vein* begins at the inner side of the great toe, and in the arch of veins. It ascends along the inner side of the foot, and in front of the inner ankle to the inside of the leg, where it has been before seen (p. 713). Branches enter it from the inner side and sole of the foot.

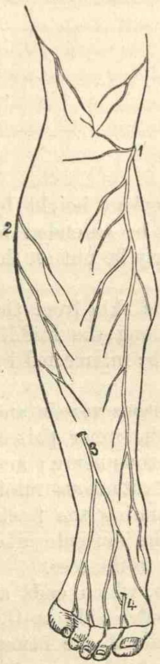
External saphenous.

The *external saphenous vein* begins on the outside of the little toe and foot, as well as in the venous arch; and it is continued below the outer ankle to the back of the leg (p. 713).

Source of the cutaneous nerves.

CUTANEOUS NERVES. The superficial nerves on the front of the leg and foot are derived mainly from branches of the popliteal trunks, viz. from the musculo-cutaneous and anterior tibial nerves of the external popliteal, and from the external saphenous nerve of the internal popliteal. Some inconsiderable offsets ramify on the sides of the leg from the internal saphenous and external popliteal.

Fig. 121.*



Musculo-cutaneous supplies certain toes;

The *musculo-cutaneous nerve* (fig. 121, [3]) has a cutaneous termination, and its destination is the dorsum of the foot and toes. Perforating the fascia in the lower third of the leg with a cutaneous artery, it divides into two principal branches (inner and outer), which give digital nerves to the sides of all the toes, except the outer part of the little toe and the contiguous sides of the great toe and the next. The digital branches may be traced in the integument as far as the end of the last phalanx.

divides into

inner and

The *inner branch* communicates with the internal saphenous nerve, and supplies the inner side of the foot and great toe: it joins also the anterior tibial nerve.

outer branch.

The *outer branch* divides into three nerves; these lie over the three outer interosseous spaces, and bifurcate at the web of the foot for the contiguous sides of the four toes corresponding with those spaces: it joins the external saphenous nerve on the outer part of the foot.

Anterior tibial, where found.

The *anterior tibial nerve* (fig. 121, [4]) becomes cutaneous in the first interosseous space, and is distributed to that space, and the opposed sides of the great toe and the next. The musculo-cutaneous nerve joins it, and sometimes assists in supplying the same toes.

* Cutaneous nerves of the front of the leg and foot.—1. Internal saphenous when superficial. 2. Offsets of the cutaneous branch of the external popliteal. 3. Musculo-cutaneous. 4. Anterior tibial.

The *external saphenous nerve* comes from the back of the leg below the outer ankle, and is continued along the foot to the outside of the little toe; all the outer margin of the foot receives nerves from it, and the offsets to the sole are larger than those to the dorsum. Occasionally it supplies both sides of the little toe and part of the next, or even more digits. External saphenous.

Internal saphenous nerve. A part of this nerve is continued along the vein of the same name to the middle of the instep where it ramifies in the integuments, and some branches pass through the deep fascia to end in the tarsus. Internal saphenous.

The *fascia of the front of the leg* is thickest near the knee joint, where it gives origin to muscles. It is fixed internally and externally into the tibia and fibula. Intermuscular septa are prolonged from the deep surface; and one of these, which is attached to the fibula, separates the muscles on the front from those on the outer side of the leg. Superiorly the fascia is connected to the heads of the leg bones, but inferiorly it is continued to the dorsum of the foot. Deep fascia of the leg; attachments;

Above and below the ankle joint it is strengthened by some transverse fibres, and gives origin to the two parts of the anterior annular ligament; and below the end of the fibula it forms another band, the external annular ligament. transverse fibres at the ankle.

Dissection. The fascia is to be removed from the leg and the dorsum of the foot, but the thickened band of the annular ligament above and below the end of the tibia is to be left. In separating the fascia from the subjacent muscles, let the edge of the scalpel be directed upwards. Take away the fascia.

In like manner the fascia may be taken from the peronei muscles on the outside of the fibula, but without destroying the band (external annular ligament) below that bone. Leave ligamentous bands.

On the dorsum of the foot the dorsal vessels with their nerve are to be dissected, and the tendons of the short and long extensors of the toes are to be traced to the ends of the digits. In the leg the anterior tibial nerve and vessels are to be followed from the dorsum into their intermuscular space, and are to be then cleaned. Clean nerves and vessels.

The *anterior annular ligament* consists of two parts, upper and lower, which confine the muscles in their position:—the former serving to bind their fleshy parts to the bones of the leg, and the latter to keep down the tendons on the dorsum of the foot. Anterior annular ligament;

The *upper part*, above the level of the ankle-joint, is attached laterally to the bones of the leg; it possesses a separate sheath with synovial membrane for the tibialis anticus. Its upper

The *lower part* is situate in front of the tarsal bones. It is inserted externally by a narrow part into the upper surface of the os calcis, in front of the interosseous ligament; and inter- and lower part.

nally, where it is thin and widened, into the plantar fascia and the inner malleolus.

Sheaths differ in each.

In this part of the ligament there are three sheaths:—the inner one for the tibialis anticus; the next for the extensor pollicis; and the outer one for the extensor longus digitorum and peroneus tertius. Separate synovial membranes line the sheaths.

External annular ligament.

The *external annular ligament* is placed below the fibula, and is attached on the one side to the outer malleolus, and on the other to the outer surface of the os calcis. Its lower edge is connected by fibrous tissue to the sheaths of the peronei muscles on the outer side of the os calcis.

It contains the two lateral peronei muscles in one compartment; and this is lined by a synovial membrane which sends two processes below into the sheaths of the peronei muscles.

Muscles on the front of the leg

The MUSCLES ON THE FRONT OF THE LEG are three in number. The large muscle next the tibia is the tibialis anticus, and that next the fibula, the extensor longus digitorum; whilst a small muscle, apparently the lower part of the last, with a separate tendon to the fifth metatarsal bone, is the peroneus tertius. The muscle between the tibialis and extensor digitorum, in the lower half of the leg, is the extensor pollicis.

and foot.

On the dorsum of the foot only one muscle appears, the extensor brevis digitorum.

Tibialis anticus;

The TIBIALIS ANTICUS reaches the tarsus: it is thick and fleshy in the upper, but tendinous in the lower part of the leg.

origin,

It *arises* from the outer tuberosity and the upper half or more of the tibia; from the contiguous part of the interosseous ligament; and from the fascia of the leg and the intermuscular septum between it and the next muscle. Its tendon begins below the middle of the leg, and passes through the innermost

insertion.

compartments in the pieces of the annular ligament to be *inserted* into the inner surface of the internal cuneiform bone, and by a small process into the metatarsal bone of the great toe.

Parts beneath the muscle and on the sides.

The muscle is subaponeurotic. It lies at first outside the tibia, resting on the interosseous membrane, but it is then placed successively over the end of the tibia, the ankle joint, and the inner line of the tarsal bones. The outer border touches the extensor muscles of the toes, and conceals the anterior tibial vessels.

Use on the foot, free

Action. Supposing the foot not fixed, the tibialis bends the ankle, moves the great toe towards the middle line of the body, and raises the inner border of the foot.

and fixed;

If the foot is supported it can lift the inner border from the ground with the tibialis posticus, and support the foot on the outer edge.

on the tibia in walking.

If the tibia is slanting backwards, as when the advanced limb reaches the ground in walking, it can bring forwards and make steady that bone.

The EXTENSOR PROPRIUS POLLICIS is deeply placed at its origin between the former muscle and the extensor longus digitorum, but its tendon becomes superficial on the dorsum of the foot. The muscle *arises* from the middle three-fifths of the narrow anterior part of the inner surface of the fibula, and from the interosseous ligament for the same distance. At the ankle it ends in a tendon, which comes to the surface through a sheath in the lower part of the annular ligament, and continues over the inner part of the tarsus to be *inserted* into the base of the last phalanx of the great toe. **Extensor pollicis attached to fibula, and great toe.**

The anterior tibial vessels lie to the inner side of the muscle as low as the sheath in the ligament, but afterwards to the outer side of its tendon, so that they are crossed by it beneath the ligament. **It crosses the vessels.**

Action. It straightens the great toe by extending the phalangeal joints, and afterwards bends the ankle. **Use on great toe;**

When the foot is fixed on the ground and the tibia slants backwards, the muscle draws forwards that bone. **on tibia.**

The EXTENSOR LONGUS DIGITORUM (fig. 122), like the tibial muscle, is fleshy in the leg and tendinous on the foot. Its *origin* is from the external tuberosity of the tibia; from the head and three-fourths of the narrow part of the inner surface of the fibula; from a small part (about an inch above) of the interosseous membrane; and from the fascia of the leg and the intermuscular septum on each side. The tendon enters its sheath in the annular ligament with the peroneus tertius, and divides into four pieces. Below the ligament these tendons are continued to the four outer toes, and are *inserted* into the middle and ungual phalanges. **Extensor longus arises from fibula; inserted into four outer toes.**

On the phalanges of the toes the tendons have the same arrangement as in the hand. For instance, on the metatarsal phalanx the tendons of the long and short extensor join with prolongations from the interossei and lumbricales to form an aponeurosis; but on the little toe there is not any tendon from the short extensor in the expansion. At the further end of this phalanx the aponeurosis is divided into three parts—a central and two lateral; the central piece is inserted into the base of the middle phalanx, while the lateral unite at the front of the middle, and are fixed into the ungual phalanx. **Arrangement of the tendons on the toes.**

In the leg the muscle is placed between the peroneus on the one side, and the tibialis anticus and extensor proprius pollicis on the other. It lies on the fibula, the lower end of the tibia, and the ankle joint. On the foot the tendons rest on the extensor brevis digitorum; and the vessels and nerve of this part are internal to them. **Connections of the muscle.**

Use on toes, and ankle, *Action.* The muscle extends the joints of the four outer toes from root to tip, as in the fingers; and still acting, bends the ankle joint.

on the tibia. If the tibia is inclined back, as when the foot reaches the ground in walking, it will be moved forwards by this and the other muscles on the front of the leg.

Peroneus tertius. The *peroneus tertius* is situate below the extensor longus digitorum, from which it is seldom separate at its origin. It

Origin. *arises* from the lower fourth of the narrow part of the inner surface of the fibula, from the lower end of the interosseous ligament, and from the intermuscular septum between it and

Insertion. the peroneus brevis muscle. And it is *inserted* by a tendon into the upper surface of the metatarsal bone of the little toe near the tarsal end.

This muscle has the same connections in the leg as the lower part of the long extensor, and is contained in the same space in the annular ligament.

Use on ankle, *Action.* This muscle assists the tibialis in bending the ankle,

and leg. and in drawing forwards the tibia in the leg advanced to make a step in walking.

Anterior tibial artery; The ANTERIOR TIBIAL ARTERY extends from the bifurcation of the popliteal trunk to the front of the ankle joint. At this spot it loses the name tibial, and is called the dorsal artery of the foot.

course and extent. The course of the artery is forwards through the aperture in the upper part of the interosseous membrane, and then along the front of that membrane and the tibia to the foot. A line

Direction. from the inner side of the head of the fibula to the centre of the ankle will mark the position of the vessel.

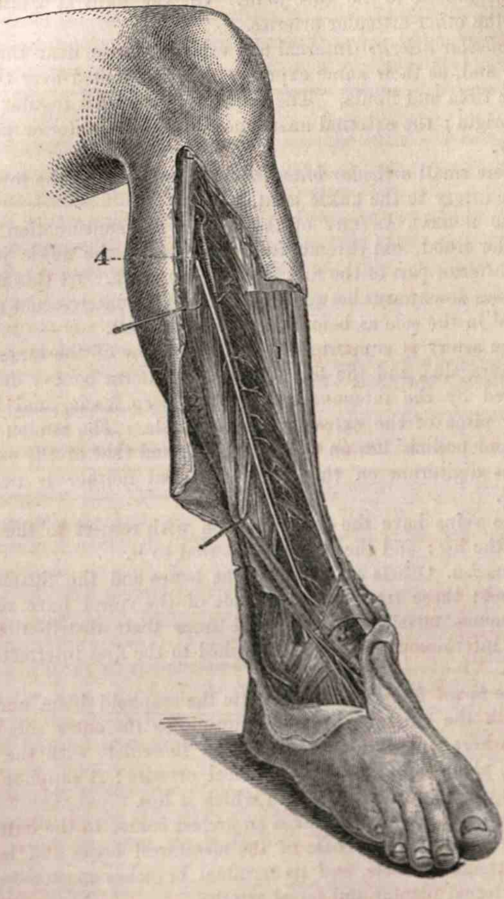
Connections with parts around. For a short distance (about two inches) the artery lies between the tibialis anticus and the extensor longus digitorum; and it is placed afterwards between the tibial muscle and the extensor proprius pollicis, but towards the lower end of the vessel the last muscle becomes superficial, and crosses to the inner side. The artery rests on the interosseous membrane in two thirds of its extent, and is overlapped by the fleshy bellies of the contiguous muscles, so that it is at some depth from the surface; but it is placed in front of the tibia and the ankle joint in the lower third, and is comparatively superficial, for it there lies between the tendons of the muscles.

Position of veins Venæ comites entwine around the artery, covering it very closely with cross branches on the upper part. The anterior

and nerve. tibial nerve approaches the tibial vessels about the middle third of the leg, and continues with them, crossing once or twice. At the lower end of the artery the nerve lies on the outer side.

Branches. *Branches.* In the leg the anterior tibial artery furnishes mostly *muscular* offsets, but near the knee and ankle joints other named **Muscular.** branches take origin.

Fig. 122.*



Cutaneous branches arise at intervals; and the largest accom- **Cutaneous.**

* Anterior tibial vessels and muscles (from Quain's Arteries). — 1 Tibialis anticus muscle. 2. Extensor pollicis and extensor longus digitorum drawn aside. 3. Part of the anterior annular ligament, 4. Anterior tibial artery: the nerve outside it is the anterior tibial.

panies the musculo-cutaneous nerve, and supplies the contiguous muscles.

Recurrent. A *recurrent branch* leaves the trunk as soon as this appears above the interosseous membrane, and ascends in the tibialis anticus muscle to the knee joint. On the joint it anastomoses with the other articular arteries.

Malleolar, inner and outer. *Malleolar arteries* (internal and external) arise near the ankle joint, and, as their name expresses, are distributed over the ends of the tibia and fibula. The internal is the least regular in size and origin; the external anastomoses with the anterior peroneal artery.

Articular. Some small *articular branches* are supplied from the lower end of the artery to the ankle joint.

Dorsal artery. Extent and course. The DORSAL ARTERY of the foot is the continuation of the anterior tibial, and extends from the front of the ankle joint to the posterior part of the first interosseous space. At this interval it passes downwards between the heads of the interosseous muscle, to end in the sole as before described (p. 732).

Connections. The artery is supported by the inner row of the tarsus, viz., the astragalus, and the scaphoid and cuneiform bones; and it is covered by the integuments and the deep fascia, and by the inner piece of the extensor brevis muscle. The tendon of the extensor pollicis lies on the inner side, and that of the extensor longus digitorum on the outer side, but neither is near the vessel.

Position of veins and nerve. The veins have the same position with respect to the artery as in the leg; and the nerve is external to it.

Branches. *Branches.* Offsets are given to the bones and the ligaments of the foot: those from the outer side of the vessel have received the names tarsal and metatarsal from their distribution. A small interosseous branch is furnished to the first intermetatarsal space.

Tarsal. The *tarsal branch* arises opposite the scaphoid bone, and runs beneath the extensor brevis digitorum to the outer side of the foot, where it divides into twigs that inosculate with the metatarsal, plantar, and anterior peroneal arteries: it supplies offsets to the extensor muscle beneath which it lies.

Metatarsal, The *metatarsal branch* takes an arched course to the outer part of the foot, near the base of the metatarsal bones and beneath the extensor muscle, and its terminal branches anastomose with the external plantar and tarsal arteries.

which gives interosseous, From the convexity of the arch of the metatarsal branch, which is turned forwards, three *dorsal interosseous* arteries are furnished to the three outer intermetatarsal spaces; and the outer of these sends a branch to the outer side of the little toe: they supply the interossei muscles, and divide at the cleft of the toes into two dorsal digital branches.

At the fore part of the space each interosseous artery joins a digital artery in the sole of the foot by means of the *anterior perforating branch;* and from the beginning of each a small branch, *posterior perforating*, descends to the plantar arch. and perforating.

The *first interosseous branch* (arteria dorsalis pollicis pedis) arises from the trunk of the artery as this is about to leave the dorsum of the foot; it extends forwards in the space between the first two toes, giving offsets to it, and is distributed by dorsal digital pieces like the other interosseous offsets of the metatarsal branch. First interosseous.

The ANTERIOR TIBIAL VEINS have the same extent and connections as the artery they accompany. They take their usual position along the artery, one on each side, and form loops around it by cross branches; they end in the popliteal vein. The branches they receive correspond with those of the artery; and they communicate with the internal saphenous vein. Anterior tibial veins.

Peculiarities in size. The anterior tibial may be small, or even wanting, in which case the place of its diminished or deficient part will be supplied by the posterior tibial or the peroneal artery. Varieties in anterior tibial

Position. On the dorsum of the foot the artery is often removed farther outwards than the line from the centre of the ankle to the posterior part of the first interosseous space.

Substitution. The place of the dorsal artery of the foot may be taken by a large anterior peroneal artery. and dorsal artery.

Dissection. To examine the extensor brevis digitorum on the dorsum of the foot, cut through the tendons of the extensor longus and peroneus tertius below the annular ligament, and throw them towards the toes. The attachment of the muscle to the os calcis should be defined. Divide extensor longus.

The EXTENSOR BREVIS DIGITORUM is a short muscle on the dorsum of the foot. It *arises* from the outer surface of the os calcis in front of the sheath for the peroneus brevis muscle, and from the lower band of the anterior annular ligament. At the back of the matatarsal bones the muscle ends in four tendons, which spring from as many fleshy bellies, and are *inserted* into the four inner toes. The tendon to the great toe has a distinct attachment to the base of the metatarsal phalanx; but the rest are united to the outer side of the tendons of the long extensor, and assist to form the expansion on the metatarsal phalanx (p. 739). Extensor brevis sends tendons to four inner toes.

The muscle lies on the tarsus, and is partly concealed by the tendons of the long extensor. Its inner belly crosses the dorsal artery of the foot. Connections.

Action. Assisting the long extensor it straightens the four inner toes from root to tip, separating them slightly from each other. As the slip to the great toe is so distinct from the others, may it not act independently? Use on the toes.

Cut through extensor brevis,

Dissection. The branches of artery and nerve which are beneath the extensor brevis will be laid bare by dividing that muscle near its front, and turning it upwards.

and annular ligament.

By cutting through the lower band of the annular ligament over the tendon of the extensor pollicis, and throwing outwards the external half of it,—the different sheaths of the ligament, its attachment to the os calcis, and the origin of the extensor brevis digitorum from it may be observed.

Follow up the nerves.

The anterior tibial and musculo-cutaneous nerves are to be followed upwards to their origin from the external popliteal; and a small branch to the knee joint from the same source is to be traced through the tibialis anticus.

Nerves of the front of the leg.

Nerves to the front of the leg. Between the fibula and the peroneus longus muscle the external popliteal nerve divides into the recurrent articular, musculo-cutaneous, and anterior tibial branches.

Recurrent.

The *recurrent articular branch* is small, and takes the course of the artery of the same name through the tibialis anticus muscle to the knee joint.

Musculo-cutaneous

The *musculo-cutaneous nerve* is continued between the extensor longus digitorum and the peronei muscles to the lower third of the leg, where it pierces the fascia, and is distributed to the dorsum of the foot and the toes (p. 736). Before the nerve becomes cutaneous it furnishes branches to the two larger peronei muscles.

supplies peronei.

Anterior tibial is with the artery.

The *anterior tibial nerve* (interosseous) is directed inwards beneath the extensor longus digitorum (fig. 122), and reaches the tibial artery about the middle third of the leg. From this spot it takes the course of the vessel along the foot to the first interosseous space, in which it ends on the surface (p. 736). In the leg it crosses the anterior tibial vessels once or more, but its position on the foot is generally external to the dorsal artery.

Branches to muscles.

Branches. In the leg the nerve supplies the anterior tibial muscle, the extensors of the toes, and the peroneus tertius. On the dorsum of the foot it furnishes a considerable branch to the short extensor; this becomes enlarged, and gives offsets to the articulations of the foot.

External muscles of the leg.

Muscles on the outer part of the leg. Two muscles occupy this situation, and are named peronei from their attachment to the fibula; they are distinguished by terms (longus and brevis) expressive of their relative length. Intermuscular processes of fascia, which are attached to the fibula, isolate these muscles from others, viz., from the soleus and flexor pollicis behind, and from the extensor longus digitorum in front.

Peroneus longus.

The peroneus longus, the more superficial of the two muscles, passes into the sole of the foot round the outer border to end in the cuneiform and metatarsal bones. It *arises* from the head and anterior or outer surface of the shaft of the fibula for about two thirds of the length, gradually tapering downwards; from the posterior border nearly to the malleolus; and from the fascia and the intermuscular septa. Inferiorly it ends in a tendon which is contained, with that of the peroneus brevis, in the groove at the back of the external malleolus, and in the sheath of the external annular ligament; and is then continued in a separate sheath, below the peroneus brevis, along the side of the os calcis and through the groove in the outer border of the cuboid bone, to the sole of the foot. Its position in the foot, and its *insertion* into the tarsal and metatarsal bones are described before (p. 734). **Origin from the fibula; insertion into bones of the foot.**

In the leg the muscle is immediately beneath the fascia, and lies on the peroneus brevis. Beneath the annular ligament it is placed over the middle piece of the external lateral ligament of the ankle with the peroneus brevis, and is surrounded by a single synovial membrane common to both. The extensor longus digitorum and the soleus muscles are fixed to the fibula laterally with respect to it, one being on each side. **Position in the leg.**

Action. With the foot raised the muscle extends the ankle; then it depresses the inner, and raises the outer border of the foot. **Use on foot free,**

When the foot rests on the ground it assists to lift the hinder part and the weight of the body as in standing on the toes, or in walking. And in rising from a stooping posture it draws back the fibula. **and fixed; on the leg.**

The PERONEUS BREVIS reaches the outer side of the foot, and is smaller than, and inferior in position to the preceding muscle. It *arises* from the anterior surface of the shaft of the bone for about the lower two thirds, extending upwards by a pointed piece internal to the other peroneus; and from the intermuscular septa. Its tendon passes with that of the peroneus longus though the external annular ligament, and is placed next the fibula as it turns below this bone. Escaped from the ligament, the tendon enters a distinct fibrous sheath, which conducts it along the tarsus to its *insertion* into the projection at the base of the metatarsal bone of the little toe. **Peroneus brevis is attached to fibula, and bone of the little toe.**

In the leg the muscle extends in front of the peroneus longus. On the outer side of the os calcis it is contained in a sheath above the tendon of the former muscle; and each sheath is lined by a prolongation from the common synovial membrane behind the outer ankle. **Connections.**

Action. If the foot is unsupported this peroneus extends the ankle, and moves the foot upwards and outwards. **Use on foot, free,**

Like the long muscle it is able if the foot is supported to raise the heel, and to bring back the fibula as the body rises from stooping. **and fixed and on the leg.**

Section VII.

LIGAMENTS OF THE KNEE, ANKLE, AND FOOT.

Examine first the knee joint.

Directions. In examining the remaining articulations of the limb, the student may take first the knee joint, unless this has become dry; in that case the ankle joint and the ligaments of the foot may be dissected whilst the other is being moistened.

Dissection to see

Dissection. For the preparation of the ligaments of each articulation, it is sufficient to detach the muscles and tendons from around it, and to remove the areolar tissue or fibrous structure that may obscure or conceal the ligamentous bands.

a capsule and the external ligaments.

In the knee joint a kind of capsule is to be defined around the articular surfaces of the bones; and there are four other ligaments, anterior and posterior, internal and external, which are situate at opposite points of the articulation.

Some tendons, namely, those of the biceps, popliteus, adductor magnus, and semimembranosus, are to be followed to their insertion, and a part of each is to be left.

Bones in the knee joint.

Articulation of the knee. The knee is the largest hinge joint in the body, and is formed by the contiguous ends of the tibia and femur with the patella. The articular surfaces of the bones are covered with cartilage, and are maintained in apposition by the following ligaments.

Capsule,

Capsule of the joint. A membrane partly ligamentous and partly aponeurotic surrounds the ends of the bones, and incloses the synovial sac.

partly ligamentous,

partly aponeurotic;

At the back of the joint between the lateral ligaments the capsule is tolerably well marked, though a fibrous band is added to it from the tendon of the semimembranosus. On the front of the articulation an aponeurosis, derived from the extensor and flexor tendons, unites with the fascia lata to take the place of the capsule: this expansion is not closely applied to the synovial membrane; it covers the anterior and the external lateral ligament, and joins the internal lateral.

is pierced by popliteus.

Posteriorly the capsule is pierced by the popliteus, and laterally it is united with the interarticular fibro-cartilages.

To define the ligaments; how to proceed.

Dissection. The posterior and the internal lateral ligament will appear on the removal of areolar tissue from their surfaces; but the anterior and the external lateral are covered by the aponeurosis on the fore part of the joint, and will not be laid bare till this has been cut through. If there is a second external lateral band present, it is not concealed by the aponeurosis.

External lateral liga-

The *external lateral ligament* (fig. 123, [2]) is round and cord-like. It is attached to the outer condyle of the femur below the tendon of the gastrocnemius, and descends vertically between two pieces of the tendon of the biceps to a depression on the upper ment is small.

Fig. 123.*

Fig. 124.†

and outer part of the head of the fibula. Beneath the ligament are the tendon of the popliteus, and the external lower articular vessels and nerve.

A second fasciculus, *short external lateral* ligament, is sometimes found behind the other; it is connected above with the head of the gastrocnemius, and below with the tip of the posterior prominence of the head of the fibula. Occasional band.

The *tendon* of the *biceps* is inserted into the two points on the upper part of the head of the fibula by two pieces, and from the anterior of these there is a prolongation to the head of the tibia. The external lateral ligament passes between the pieces into which the tendon is split. Tendon of the biceps is divided.

The *tendon* of the *popliteus* may be followed to the femur by dividing the capsular ligament. It arises from the fore part of the oblong depression on the outer surface of the external condyle of the femur. In its course to the outside of the joint, it crosses the external semilunar fibro-cartilage and the upper tibio-peroneal articulation. When the joint is bent, the tendon lies in the hollow on the condyle; but slips out of that groove when the limb is extended. Tendon of the popliteus is attached to outer condyle.

* External ligaments of the knee joint (Bourgery).—1. Anterior ligament. 2. External lateral ligament. 3. Interosseous ligament. 4. Part of the capsule.

† Internal ligaments of the knee joint (Bourgery).—1. Tendon of the extensor muscle ending below at 2 in the ligament of the patella. 3. Internal lateral ligament. 4. Lateral part of the capsule.

Adductor magnus.

The *tendon* of the *adductor magnus* is inserted into a tubercle on the inner surface of the internal condyle above the attachment of the internal lateral ligament.

Internal lateral ligament; attachments;

The *internal lateral ligament* (fig. 124, [3]) is attached to the condyle of the femur, and blends with the capsule, but is separate behind opposite the head of the tibia; and becoming thicker below, it is fixed for about an inch into the inner surface of the tibia, below the level of the ligamentum patellæ.

is joined by semimembranosus.

The tendons of the sartorius, gracilis, and semitendinosus muscles lie over the ligament; and the tendon of the semimembranosus, and the internal lower articular vessels are beneath it. To the posterior edge some fibres of the tendon of the semimembranosus are added.

Insertion of the semimembranosus.

The *tendon* of the *semimembranosus* muscle is inserted beneath the internal lateral ligament into an impression at the back of the inner tuberosity of the head of the tibia. Between it and the bone is a synovial bursa. The tendon sends some fibres to the internal lateral ligament; it gives also a membranous prolongation to join the fascia on the popliteus muscle, and another to the posterior ligament of the knee joint.

Posterior ligament.

Two sets of fibres.

The *posterior ligament* (ligament of Winslow) is formed in part by the capsule, and in part by the fibres from the tendon of the semimembranosus, which are directed across the joint to the outer side. Numerous apertures exist in it for the passage of vessels and nerves to the interior of the articulation.

Anterior ligament, or tendon of the extensors.

The *anterior ligament* (ligamentum patellæ) (fig. 124, [2]), or the tendon of insertion of the extensor muscles of the leg (p. 674), is about two inches long. Superiorly it is attached to the lower part of the patella and the depression on the inner surface of the apex; and inferiorly it is inserted into the tubercle of the head of the tibia, and an inch of the bone below it. The expansion of the vasti covers it; and a bursa intervenes between it and the top of the tubercle of the tibia.

Open the knee joint

Dissection. To see the reflections of the synovial membrane raise the knee on blocks, and open the joint by an incision on each side from the front to the back above the patella. When the anterior part of the capsule with the patella is thrown down, a fold (mucous ligament) will be seen extending from the intercondyloid fossa of the femur to a mass of fat at the front of the joint below the patella. On each side of the knee-pan is a similar fold (alar ligament) over some fat.

and dissect crucial ligaments.

The limb is afterwards to be laid flat on the table, and part of the posterior ligament is to be removed, to lay bare the strong crucial ligaments beneath it at the back of the joint, and to show the pouches of the synovial membrane which project upwards over the condyles of the femur; but the limb is to be replaced in the former position before the parts are learnt.

The *synovial membrane* lines the interior of the capsule, and is continued to the articular ends of the bones. It invests the interarticular cartilages after the manner of serous membranes, and sends a pouch between the tendon of the popliteus and the external fibro-cartilage and the head of the tibia: it is also reflected over the strong crucial ligaments at the back of the joint. **Synovial membrane**

There are three named folds of the synovial membrane. One in the centre of the joint is the mucous ligament, which contains a small vessel and some fat, and extends from the interval between the condyles to the fat below the patella. Below and on each side of the patella is another fold—alar ligament, which is continuous with the former below the patella, and is placed over a mass of fat. Sometimes the inner is prolonged farther than the outer by a semilunar fold of the serous membrane. **thrown into folds named ligaments.**

At the back and front of the articulation pouches are prolonged from it beneath the tendons of muscles. Behind there are two, one on each side, between the back of the condyle of the femur and the tendinous head of the gastrocnemius. On the front of the femur the sac projects under the extensor muscle one inch above the articular surface; and if it communicates with the bursa in that situation, as is often the case, it will reach two inches above the joint-surface of the femur. When the joint is bent there is a greater length of the serous sac above the patella. **Pouches, two behind and one before.**

Fat around the joint. Two large masses are placed above and below the patella, and some fat is located around the crucial ligaments. **Articular fat**

The infra-patellar mass, the largest of all, fills the interval between the patella and its ligament and the head of the tibia, and gives origin to the folds of the synovial membrane. From it a narrow slip is continued around the patella; and the piece at the inner margin of the bone is larger than that on the outer side, and overhangs the inner perpendicular facet. During extension of the joint this pad is applied to, and lubricates the articular surfaces of the femur. **below the patella; use;**

The supra-patellar pad is interposed between the triceps extensor and the femur around the top of the synovial sac, and is greater on the outer than the inner side. **above the patella.**

Dissection. The ligamentous structures within the capsule (see below) will be brought into view, whilst the limb is still in the same position, by throwing down the patella and its ligament, and clearing away the fat behind it. In this step the student must be careful of a small transverse band that connects anteriorly the interarticular cartilages. **Dissect internal ligaments.**

The remains of the capsule and the synovial membrane are next to be cleared away from the front and back of the crucial ligaments, and from the interarticular cartilages : whilst cleaning the most posterior crucial be careful of a band behind or before it from the external fibro-cartilage.

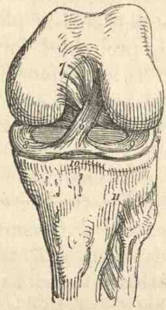
Ligaments within the capsule.

Ligaments within the capsule. The remaining ligamentous structures within the capsule consist of the crucial ligaments in the middle line, and of two plates of fibro-cartilage on the head of the tibia.

Two crucial ligaments.

The *crucial ligaments* (fig. 125) are two strong fibrous processes between the ends of the tibia and femur, which maintain in contact the bones. They cross one another somewhat like the legs of the letter X, from which circumstance they have received their name. One is much anterior to the other at the attachment to the tibia.

Fig. 125.*



Anterior is oblique.

Its attachments.

The *anterior* ligament (6) is oblique in its direction, and is smaller than the posterior. Inferiorly it is attached in front of the spine of the tibia, close to the inner articular surface, and reaches back to the inner point of the spine; superiorly it is inserted by its posterior short fibres into the back part of the outer condyle of the femur, and by anterior or long into the upper and hinder part of the intercondyloid fossa.

Posterior is vertical.

Its attachments.

The *posterior* ligament (7) is almost vertical between the bones at the back of the joint. By the lower end it is fixed to the hindermost impression of the hollow behind the spine of the tibia, near the margin of the bone; and above, its posterior shorter fibres are inserted into the inner condyle along the anterior two thirds, whilst the anterior and longer reach the fore part of the intercondyloid fossa.

The use,

The *use* of these ligaments in the movements of the joint, after the other ligaments have been cut through, may now be studied.

of anterior,

The anterior prevents the tibia being moved too far forwards by the extensor tendon, or by force; and it is brought into action at the end of extension, because there is a tendency to carry the tibia in front of the femur. Its action is shown by cutting it across, and leaving the posterior entire, for then the tibial articulating surfaces can be placed in front of the

* Internal ligaments of the knee joint.—6. Anterior crucial. 7. Posterior crucial ligament. 8. Internal semilunar. 9. External semilunar fibro-cartilage. 10. Transverse ligament. 11. Anterior ligament to the upper peroneo-tibial articulation.

femoral in the half bent state of the joint, but they cannot be put farther back than when it was whole.

The posterior arrests the too great movement backwards of the tibia by the flexors or by force; and it is stretched in extreme flexion, in which an attempt is made to push back the tibia from the femur. This use will be exemplified by cutting across the posterior and leaving entire the anterior; when this has been done the articular surfaces of the tibia can be carried nearly altogether behind the condyles of the femur, though they cannot be moved farther forwards than when it was untouched. and posterior crucial.

Both ligaments are involved in flexion and extension in this way:— Both act

At the beginning of flexion the anterior is lax so as to permit at that time the inward rotation of the tibia; but as the movement proceeds the short and then the long fibres become tense. At the end of flexion both crucials are stretched. in flexion

During the first stage of extension the posterior crucial is lax, but it is gradually tightened as the joint is straightened. Towards the end of extension both crucial ligaments are rendered tight, and the anterior more especially in the outward rotation of the tibia. and extension.

Rotation in of the tibia is stopped by the anterior crucial, though in the beginning of the movement that ligament is relaxed. Rotation out is not checked by either ligament; for the bands uncross in the execution of the movement, and will permit the tibia to be put hind foremost. Rotation checked by anterior.

As long as both ligaments are whole the bones cannot be separated from each other. Both join the bones.

The *interarticular* or *semilunar fibro-cartilages* (fig. 125) partly cover the articular surface of the tibia. Semilunar cartilages are two.

They are thickest at the outer margin, where they are united by fibres to the capsule; and are hollowed on the upper surface so as to assist in giving depth to the fossæ for the reception of the condyles of the femur. Inserted into the tibia at their extremities, they are coarsely fibrous at their attachments to the bone, like the crucial ligaments; and they become cartilaginous only where they lie between the articular surfaces. The synovial membrane is reflected over them. Common characters.

The *internal* cartilage ([a]) is ovoid in form, and is a segment of a larger circle than the external. In front it is attached by a pointed part to an impression in a line with the anterior margin of the head of the bone, and before the anterior crucial ligament. At the back, where it is much wider, it is fixed to the inner lip of the hollow behind the spine of the tibia, between the attachment of the other cartilage and the posterior crucial ligament. Internal is semi-circular.

The *external* cartilage ([b]) is nearly circular in form, and is connected to the bone within the points of attachment of its External nearly circular in form.

fellow. Its anterior part is fixed to the bottom of the depression in front of the spine of the tibia, close to the outer articular surface, and opposite the anterior crucial ligament with which it is joined; and its posterior extremity is inserted between and rather behind the two osseous points of the spine, and a slip is continued forwards to join the hinder border of the anterior crucial ligament. This fibro-cartilage is less closely united to the capsule than the internal, for the fore part is in the centre of the joint, and the tendon of the popliteus muscle separates it behind from that membrane.

The fibro-cartilages are provided with two accessory bands:—one intervenes between them at the fore part; the other ascends from the outer disc to the inner condyle of the femur.

Transverse ligament.

The anterior or *transverse ligament* is a narrow band of fibres between the semilunar cartilages at the front of the joint. Sometimes it is scarcely perceptible.

Posterior band.

The *posterior* or *ascending band*, thicker and stronger than the other, springs from the back of the outer fibro-cartilage, and is inserted into the femur with the posterior crucial, either as a single band which is situate in front of, or as two bands on opposite aspects of that cross ligament, one being before and the other behind.

Use of fibro-cartilages.

Use. The fibro-cartilages deepen the sockets of the tibia for the reception of the condyles of the femur, and fill the space between the articular surfaces of the bones at the circumference of the joint; they moderate the effect of pressure of the one bone on the other, and cause the force of shocks to be diminished in their transmission.

State in flexion and extension,

In flexion and extension they move forwards and backwards with the tibia. During flexion they recede from the fore part of the tibia, and surround the condyles of the femur; but in extension they are flattened out on the surface of the tibia. Of the two cartilages the external moves the most in consequence of its being less fixed to the capsule.

and in rotation.

In rotation the fibro-cartilages follow the tibial movements, but the posterior is most displaced by the projecting outer condyle of the femur.

Use of accessory bands.

The accessory bands in front and behind serve to retain in place the least fixed external fibro-cartilage; thus the anterior ligament keeps forwards the fore part of that cartilage in flexion, and the posterior secures the back of the same from displacement in rotation.

Surfaces of bone.

Articular surfaces of the bones. The end of the femur is marked by a patellar and two tibial surfaces.

On femur, patellar

The patellar is placed in the middle line and above the others; it is hollowed along the centre with a slanting surface on each side, the outer being the largest.

The tibial surfaces, two in number, occupy the ends of the condyles; they are separated from the patellar in front by an oblique groove, and diverge slightly from each other as they extend backwards. On the centre of each condyloid part of the femur is a somewhat flattened surface which is in contact with the tibia in standing; and at the posterior third is a more convex portion which touches the tibia in rotation of this bone. and tibial; characters.

The articular surface on the inner condyle reaches farthest forwards, and increases in width behind; and that on the outer condyle, widest in front, decreases posteriorly. Articular surfaces vary.

The inner condyle is curved at its anterior third, and the concavity is directed out and back, forming the "oblique curvature;" but it is nearly parallel to the outer condyle in the hinder two thirds, so that the course of the tibia over it will be oblique in front and straight behind. Along the inner margin of the curved part of this condyle is a semilunar facet, which touches the perpendicular surface of the patella in flexion. Condyles differ; peculiarities of inner.

On the head of the tibia are two slight articular hollows, the inner being the deeper and larger, which rise towards the middle of the bone in the points of the tibial spine; and towards the circumference of each is a slight impression corresponding with the fibro-cartilage. Articular surfaces of tibia.

The joint-surface of the patella presents the following impressions for contact with different parts of the femur in the movements of the bone. Close to the inner edge is a narrow perpendicular facet, and along the lower edge is a similar transverse mark. Occupying the rest of the bone is a squarish trochlear surface, which is subdivided by a vertical and a transverse line into two pairs of marks—upper and lower. (Goodsir, Edinb. Med. Jour., 1855.) Subdivision of joint-surface of patella.

Movements of the joint. The usual movements of the knee are two in number, bending and straightening, like the elbow; but there is in addition rotation of the tibia when the joint is bent. Kinds of movement.

Flexion and extension. Each of these movements may be divided into three stages for the purpose of particularizing changes in its direction.

In *flexion* the tibia with its fibro-cartilages moves backwards round the end of the femur; and its extent is limited by the extensor muscle, and the meeting of the calf of the leg with the thigh. Flexion. Movement of tibia;

For the anterior third of the movement the tibia is directed down and in along the oblique curve of the inner condyle, giving rise to rotation inwards of that bone around a vertical axis; but for the posterior two thirds the tibia passes straight back over the two condyles. change in direction.

All the external ligaments are relaxed except the anterior; State of ligaments.

and both crucials are put on the stretch towards the end of flexion.

Extension movement of tibia; In *extension* the tibia is carried forwards until it comes into a straight line with the femur, when the uniting ligaments prevent its farther progress.

course changes. In the hinder two thirds of the movement the tibia has a straight course over the two condyles; but in the anterior third it is rotated out as it ascends over the oblique curve of the inner condyle.

State of the ligaments. All the external ligaments except the anterior are tightened, and the crucial bands limit extreme extension.

Two kinds of rotation. *Rotation.* A half bent state of the knee is necessary for this movement, to relax the anterior crucial and the external ligaments; and the foot must be free. Then the tibia with its fibro-cartilages rotates around a vertical axis, the great toe being turned in and out.

Rotation in. Movement of tibia. During *rotation in* the inner articular surface of the tibia touches the condyle of the femur and moves backwards, and the outer articular surface, separated by a slight interval from the thigh bone, passes forwards.

State of ligaments. Both lateral ligaments are loose; and the anterior crucial is gradually tightened, and stops finally the motion.

Rotation out. In *rotation out* the opposite movement of the tibia takes place,—the inner articular surface being directed forwards, and the outer backwards.

State of ligaments. The internal lateral ligament controls the movement by its fibres being made tense. The crucials have not any influence on the motion (p. 751).

Movement of patella. *Movement of the patella.* When the knee passes from flexion to extension the patella crosses it obliquely from the outer to the inner side, touching in succession different parts of the femoral articular surfaces.

In flexion, In complete flexion the knee-pan lies on the outer side of the joint below the femur, where it is scarcely perceptible, and is fixed in its situation. what it touches. It touches the semilunar surface on the inner condyle by its perpendicular facet, and the under part of the outer condyle by its upper and outer trochlear mark.

When passing from flexion to extension the upper pair of trochlear impressions of the bone, and then the lower pair rest successively on the pulley-surface of the femur.

In extension, In complete extension the patella is situate at the upper and inner part of the knee joint, where it is very prominent, with its apex and the ligament of the patella directed down and out to the tibia. position to femur, For the most part the articular surface is raised above the trochlea of the femur, which it touches only at the upper edge by its lower transverse facet.

Articulation PERONEO-TIBIAL ARTICULATIONS. The tibia and fibula are united by ligamentous bands at the extremities, where they touch; and by an interosseous ligament between the shafts of the bones. of tibia and fibula.

Dissection. The muscles are to be taken away from the front and back of the interosseous ligament; and the loose tissue is to be removed from a small band in front of, and behind the upper and lower articulations between the tibia and fibula. Dissection of the ligaments.

The UPPER ARTICULATION, like the lower, is almost immovable, and therefore the structures between the ends of the bones are slight and simple. Only two small bands, anterior and posterior, are present between the bones. Upper articulation,

The *anterior ligament* extends over the joint from the outer tuberosity of the tibia to the head of the fibula. The *posterior* ligament, thinner than the anterior, is attached to corresponding parts of the bones behind the joint. It is covered by the tendon of the popliteus muscle and a prolongation of the synovial membrane of the knee joint. by anterior and posterior band.

The articular surfaces are covered with cartilage; and a *synovial membrane* lines the articulation, projecting backwards so as to touch that of the knee joint. Synovial sac.

The LOWER ARTICULATION possesses an anterior and a posterior band, together with an inferior ligament between the ends of the bones. Lower articulation has

The *anterior ligament* reaches obliquely from the lower end of the tibia to that of the fibula; and the *posterior* has attachments behind the articulation similar to those of the band in front. anterior, posterior,

The *inferior ligament* closes the space between the contiguous ends of the tibia and fibula, and consists of transverse yellowish fibres distinct from the posterior ligament. It is fixed on one side to the end of the fibula above the pit; and on the other it is inserted into the contiguous part of the tibia, as well as into the posterior edge of the articular surface, so as to assist in deepening the hollow into which the astragalus is received. and inferior ligament.

The *interosseous ligament* fills the interval between the bones of the leg, and extends downwards to about an inch from the end of the tibia: it serves as an aponeurotic partition between the muscles on the front and back of the leg. Its fibres are directed downwards for the most part from the outer border of the tibia to the ridge on the inner surface of the fibula: but some few cross in the opposite direction. Interosseous ligament between the bones.

Both superiorly and inferiorly is an aperture which transmits vessels. The upper opening, about an inch in length, lies along the neck of the fibula, and gives passage to the anterior tibial vessels. The lower aperture is close to the fibula, about an inch above the lower edge, and is only large enough for small vessels—the anterior peroneal. Apertures.

Some strong irregular bundles of fibres, which constitute the Inferior ligament.

inferior interosseous ligament, extend between the bones below the aperture for the anterior peroneal artery: these take different directions, like the fibres of the rest of the interosseous membrane. It may be seen after the examination of the ankle joint by sawing longitudinally the lower ends of the leg bones.

Motion slight between tibia and fibula,

Movement. Very little movement is allowed in the tibio-peroneal articulations, as the chief use of the fibula is to give security to the ankle-joint and attachment to muscles of the leg.

in upper joint

and lower articulation.

In the upper joint there is a slight gliding from before back. In the lower articulation the ligaments permit a slight yielding of the fibula to the pressure of the astragalus, as when the weight of the body is thrown on the side of the foot; but if the force is violent the bone will be fractured above the malleolus sooner than the ligaments will give way.

Bones in the ankle joint.

ARTICULATION OF THE ANKLE. Like the knee the ankle is a ginglymoid or hinge joint. In this joint the upper surface of the astragalus is received into an arch formed by the lower ends of the tibia and fibula; and the four ligaments belonging to this kind of articulation connect together the bones.

Dissection of the ankle joint.

Dissection. To make the dissection required for the ligaments of the ankle joint, the fibrous tissue and vessels must be removed from the front and back of the articulation.

For the purpose of defining the lateral ligaments, the limb must be placed first on one side and then on the other. The internal ligament is wide and strong, and lies beneath the tendon of the tibialis posticus. The external is divided into three separate pieces; and to find these the peronei muscles, and the remains of the annular ligament below the outer malleolus, should be taken away.

Anterior ligament is thin and imperfect.

The *anterior* or tibio-tarsal *ligament* is a thin fibrous membrane, which is attached to the tibia close to the articular surface; and to the upper part of the astragalus near the articulation with the scaphoid bone. The ligament is not usually a continuous membrane, for in it are some rounded intervals and apertures for vessels. On the sides it joins the lateral ligaments.

Posterior ligament.

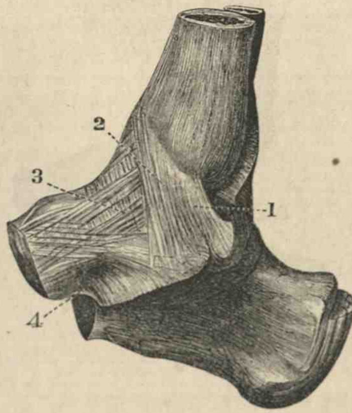
The *posterior ligament* is thinner internally than externally; and it is inserted into the tibia and the astragalus, close to the articular surfaces of the bones. Towards the outer part it consists of transverse fibres which are attached to the hollow on the inner surface of the external malleolus.

Internal or deltoid;

attachments.

The *internal lateral* or deltoid *ligament* (fig. 126) is attached by its upper or pointed part to the inner malleolus, and by its base to the astragalus, the os calcis, and the scaphoid bone by fibres which radiate to their insertion in this manner:—The posterior (^{1}) are directed to the hinder part of the inner surface of the astragalus; the middle (^{2}) pass vertically to the side of the sustentaculum tali of the os calcis; and the anterior (^{3}), which are thin and oblique, join the inferior calcaneo-scaphoid ligament and the inner side of the scaphoid bone. The tendons

Fig. 126.*



of the tibialis posticus and flexor longus digitorum are in contact with this ligament.

The *external lateral ligament* (fig. 127) consists of three separate pieces, anterior, middle, and posterior, which are attached to the astragalus and the os calcis. The *anterior* piece (1) is a short flat band, which is directed from the fore part of the malleolus to the side of the astragalus in front of the lateral articular surface. The *middle* portion (3) is flattened, and descends from the tip of the malleolus to the outer surface of the os calcis, about the middle. The *posterior* part (2) is the strongest, and is almost horizontal in direction; it is connected externally to the pit on the inner surface of the malleolus, and is inserted into the posterior part of the astragalus behind the articular surface, extending to the groove for the flexor pollicis tendon. **External has three parts; anterior, middle, and posterior.**

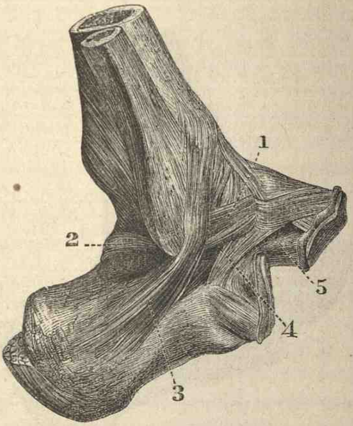
The posterior and middle fasciculi are placed beneath the peronei muscles. The middle part is but slightly in contact above with the synovial membrane of the ankle joint; and both it and the posterior piece touch the synovial membrane between the astragalus and the os calcis. **Connections.**

Dissection. Dividing the ligaments of the ankle joint, separate **Open the ankle joint.**

* Internal lateral ligament of the ankle (altered from Bourgery).—1. Posterior piece. 2. Middle piece. 3. Anterior piece of the inner ligament. 4. Inferior calcaneo-scaphoid ligament.

the astragalus from the bones of the leg, to see the osseous surfaces entering into the joint.

Fig. 127.*



Synovial sac.

The *synovial membrane* of the joint lines the capsule, and is simple in its arrangement.

Surfaces of the bones in the joint.

Articular surfaces. On the tibia there are two articular faces, one of which corresponds with the end of its shaft, and the other with the malleolus. On the fibula the surface of the malleolus which is turned to the astragalus, is tipped with cartilage.

The astragalus has a central articular surface, wider before than behind and trochlear shaped, which touches the end of the tibia: and on its sides are articular impressions for contact with the malleoli, but the outer one is the largest.

Kinds of motion.

Movement. Only the movements of flexion and extension are permitted in the ankle: in the former state the toes are raised towards the fore part of the leg; and in the latter, they are pointed towards the ground.

Flexion, moving bone.

In *flexion* the astragalus moves backwards so as to project at the back of the joint; and all further motion is arrested by the meeting of the anterior edge of the tibia and the astragalus.

State of ligaments.

The posterior ligament is stretched over the projecting head of the astragalus, and the posterior and middle parts of the internal lateral, and the posterior piece of the external lateral are made tense.

* External lateral ligament of the ankle (altered from Bourgery).—1. Anterior part. 2. Posterior part. 3. Middle part of the outer ligament. 4. Interosseous of astragalus and os calcis. 5. External calcaneo-scaphoid ligament.

In *extension* the astragalus moves forwards over the end of the tibia, and projects anteriorly. A limit to the movement is imposed by the meeting behind of the astragalus with the tibia. Extension, moving bone,

The lateral ligaments are partly made tight as in flexion, for instance the anterior piece of the external, and the fore and middle parts of the internal. state of ligaments;

When the joint is extended so that the small hinder part of the astragalus is brought into the arch of the leg bones, a slight movement of the foot inwards and outwards may be obtained; but if the foot is forcibly extended the portions of the lateral ligaments attached to the astragalus prevent this movement by their tightness. slight lateral motion.

Dissection. All the joints of the foot will be demonstrated by removing from both the dorsum and the sole all the soft parts that have been examined, and then cleaning the ligaments. Between the different tarsal bones bands of ligament extend, which will be defined by removing the areolar tissue from the intervals between them (fig. 129). Dissection for the joints of the tarsus.

It will be more advantageous for the student to clean all the ligaments before he proceeds to recognise any, than to prepare only the bands of the individual articulation he may be learning.

ARTICULATION OF THE ASTRAGALUS AND OS CALCIS. These bones are kept together by two joints and a strong interosseous ligament; and there are also thin bands at the outer side and behind. Astragalus with os calcis by

The *posterior ligament* consists of a few fibres between the bones, where they are grooved by the tendon of the flexor pollicis; and the *external ligament* is connected to the sides of the astragalus and os calcis, near the middle piece of the external lateral ligament of the ankle joint. posterior, external, and

The *interosseous ligament* consists of strong vertical and oblique fibres, which are attached above and below to the depressions on the contiguous surfaces of the two bones. This band extends across the bones, and its depth is greatest at the outer side. interosseous ligament.

When the astragalus is removed subsequently, articular surfaces will be seen between the bones, viz., one behind the interosseous ligament, and one or two in front of it. Articular surfaces.

Two *synovial membranes* exist between the bones, one for each articulation; and the one in front of the interosseous ligament is continued between the head of the astragalus and the scaphoid bone. Synovial membranes.

Surfaces of bones. The form of the articular surfaces will be noticed after (p. 763) when the astragalus has been detached from the os calcis. Articular surfaces after.

Movement. Under the influence of the weight of the body, as in standing, the astragalus moves down and in (not straight forwards) with flattening of the arch of the foot, so that the head Motion in standing, projects against the calcaneo-scaphoid ligament. In this state the interosseous ligament is put on the stretch.

and when pressure removed.

When the pressure of the leg is removed the astragalus is carried up and out by the tightened ligaments, and the arch of the foot is restored.

Astragalus with scaphoid bone.

ASTRAGALUS WITH THE SCAPHOID BONE. The head of the astragalus is received into the hollow of the scaphoid bone, and is united to it by a dorsal ligament; but the place of a plantar and an external lateral ligament is supplied by strong bands between the os calcis and the scaphoid bone, which will be noticed below.

Dorsal ligament.

The *dorsal* or *astragalo-scaphoid ligament* (fig. 129) is attached to the astragalus close to the articulation, and to the dorsal surface of the scaphoid bone: its attachments will be better seen when it is cut through.

To lay bare the other ligaments.

Dissection. The external ligament of the articulation may be seen on the dorsum of the foot in the hollow between the os calcis and the scaphoid bone. Supposing the tendon of the tibialis posticus removed, the inferior ligament will be defined in the sole of the foot by cutting some fibro-cartilaginous substance from it (fig. 126, [4]); and its upper surface, together with the outer ligament, will be brought into view by sawing off the part of the astragalus in front of the interosseous ligament.

Inferior and

The *inferior ligament* (calcaneo-scaphoid) is attached by the hinder extremity to the fore part of the sustentaculum tali of the os calcis, and by the other to a groove on the under surface of the scaphoid bone. In the upright posture of the body the tendon of the tibialis posticus is beneath the ligament in the sole of the foot; and on it the head of the astragalus rests.

external ligament.

The *external calcaneo-scaphoid* (fig. 127, [5]) is placed outside the head of the astragalus, and serves as a lateral ligament to the astragalo-scaphoid articulation; it is about three quarters of an inch deep, except at the centre, where it is narrowed. Behind, it is fixed to the upper part of the os calcis, between the articular surfaces for the cuboid bone and astragalus; and in front it is inserted into the outer side of the os scaphoides.

Synovial sac.

A *synovial membrane* serves for this articulation, and sends back a prolongation to the joint between the fore part of the os calcis and astragalus.

Surface of bone.

Articular surfaces. The head of the astragalus which has been cut off has two articular faces; a smaller, below for the os calcis; and a larger one, elongated transversely and larger externally than internally, for the scaphoid bone. The scaphoid bone is hollowed, and is widest externally.

Movement.

Movement. This is oblique as in the calcaneo-cuboid articulation, the scaphoid moving down and in over the transversely elongated head of the astragalus, or up and out in the opposite direction.

As the bone is forced downwards, the upper and external ligaments of the joint are brought into use to check it; and when the scaphoid is moved in the opposite way the strong inferior ligament is put on the stretch. State of ligaments.

THE OS CALCIS WITH THE CUBOID BONE. The ligaments in this articulation are plantar and dorsal, the former being much the strongest; and there is also an internal band. Os calcis with cuboid bone, by

The *dorsal ligament* (superior calcaneo-cuboid) is a thin fasciculus of fibres (fig. 129), which is attached to the upper surfaces of the contiguous ends of the os calcis and the cuboid dorsal,

Fig. 128.*

Fig. 129.†

bone; it is sometimes divided into two parts, or it may be situate at the outer border of the foot.

At the inner side of the os cuboides is a rather strong *internal band* from the os calcis: this is fixed behind to the upper part of the os calcis, external to the outer band to the scaphoid bone; and in front it joins the contiguous inner part of the os cuboides. internal,

* Plantar ligaments of the foot (Bourgery and Jacob).—1. Long plantar ligament. 2. Deep portion of the inferior calcaneo-cuboid ligament. 3. Tendon of the peroneus longus muscle.

† The several ligamentous bands uniting the bones of the foot on the dorsal aspect are here delineated (Bourgery and Jacob).

and inferior ligaments.

The *inferior calcaneo-cuboid ligament* in the sole of the foot (fig. 128) is much the strongest, and is divided into a superficial and deep part :—

The last is strongest, and divided into two parts. Superficial.

The superficial portion, named *ligamentum longum plantæ* (1), is attached to the under surface of the os calcis from near the posterior to the anterior tubercle, and its fibres pass forwards to be connected in part with the ridge on the under surface of the cuboid bone ; but some of the inner fibres are prolonged over the tendon of the peroneus longus muscle, assisting to form its sheath, and are inserted into the bases of the third and fourth metatarsal bones.

Deep band.

The deep piece of the ligament (2) will be seen, on division of the superficial, to extend from the tubercle and the pit in front of it on the fore part of the under surface of the os calcis, to the portion of the cuboid bone internal to the ridge.

Synovial sac.

A simple *synovial membrane* belongs to the articulation.

Surfaces of bone.

Articular surfaces. Both bones are flattened towards the outer part of the articulation ; but at the inner side the os calcis is hollowed with a ridge at the edge, and the os cuboides is convex to fit into the other.

Movement.

Movement. The joint possesses two kinds of movement, viz., an oblique one down and in, and up and out.

State of ligaments.

In the downward movement the internal lateral and upper ligaments are made tight ; and in the upward movement the calcaneo-cuboid ligaments of the sole are stretched.

Transverse joint of tarsus.

TRANSVERSE TARSAL ARTICULATION. The two joints before described of the astragalus with the scaphoid, and os calcis with the cuboid bone, form a transverse joint across the foot in which the movements of inversion and eversion take place.

Kind of movement.

Movement. In those articulations the fore part of the foot undergoes a twisting motion around a longitudinal axis, being turned in and out.

Inversion.

In *inversion* the great toe is adducted, the inner border of the foot is shortened, and is raised from the ground so that the sole looks inwards, whilst the outer border is depressed.

Movement of bones.

The scaphoid bone passes down and in over the head of the astragalus, being approximated near to the inner malleolus ; and the cuboid bone moves down and in on the os calcis. The cuneiform bones are raised and contribute to the movement (p. 764).

State of ligaments.

The ligaments connected with both joints on the dorsum of the foot are tightened.

Eversion.

In *eversion* the inner border of the foot descends and lengthens, the outer border is raised, and the great toe is abducted from the middle line of the body.

Bones and

The same two tarsal bones are directed up and out, and the cuneiforms sink.

The ligaments in the sole of the foot of both joints now come into use to prevent over movement. **ligaments.**

Dissection. The interosseous ligament uniting the astragalus and the os calcis is now to be cut through, to demonstrate the articular surfaces, the synovial sacs, and the attachment of the ligament. **Dissection.**

Articular surfaces of the two hinder tarsal bones. There are two articular surfaces anterior and posterior between the astragalus and the os calcis. The hinder one of the os calcis is convex transversely and the anterior is concave; but sometimes the last is subdivided into two. The surfaces of the astragalus will have a form exactly the reverse of that of the os calcis, viz., the hinder one concave and the anterior convex; the anterior is seated on the head of the astragalus. **Surfaces of os calcis** **and astragalus.**

Dissection. The calcaneo-cuboid joint may be opened to see the articular surfaces: and the student is to keep in mind that all the other articulations of the foot are to be opened for the like purpose, even when directions for that step are not given.

ARTICULATIONS OF THE SCAPHOID BONE. The scaphoid bone articulates in front with the three cuneiform bones, and laterally with the os cuboides, by dorsal and plantar bands. **Union of the scaphoid bone**

In the *articulation* with the *cuneiform bones* there are three longitudinal *dorsal ligaments*, one to each bone; but the innermost is the strongest and widest, and extends round the inside of the articulation into the sole of the foot. **to the cuneiform.**

The place of *plantar* bands is supplied by processes of the tendon of the tibialis posticus.

A *synovial membrane* (common of the tarsus) lines the articulation, and sends forwards prolongations between the cuneiform bones. **Synovial sac.**

In the *articulation* with the *os cuboides* there is a *dorsal* oblique band of fibres between the contiguous surfaces of the bones; a *plantar* transverse band, which is concealed by the tendon of the tibialis posticus; and a strong *interosseous* ligament. **To the cuboid bone.**

When the two bones touch, the surfaces are tipped with cartilage, and are furnished with a prolongation from the common *synovial membrane* of the tarsus. **Synovial sac.**

ARTICULATIONS OF THE CUNEIFORM BONES (fig. 129). These bones are united to one another by cross bands, and the external one articulates with the os cuboides after a similar manner. **Union of the cuneiform bones**

The three *cuneiform bones* are connected together by short transverse *dorsal* bands between the upper surfaces. Similar *plantar* ligaments are wanting, except between the two innermost. There are also *interosseous* ligaments between the contiguous surfaces of the bones. Laterally there are articular surfaces between the bones, with offsets of the common synovial membrane. **one with another,** and with the cuboid bone.

Where the external cuneiform touches the cuboid bone the surfaces are covered with cartilage. A *dorsal* ligament passes transversely between the two; and a *plantar* ligament takes a similar direction. Between the bones there is also an *interosseous* ligament.

Synovial sac.

This joint is furnished with either a distinct synovial sac, or a prolongation of the common tarsal synovial membrane.

Common synovial sac.

The *synovial membrane* of the articulations of the cuneiform bones is common to many of the bones of the tarsus. Placed between the scaphoid and the three cuneiform, it sends one prolongation forwards between the inner and middle cuneiform to the joints of the second and third metatarsal bones; another outwards to the articulation of the scaphoid with the cuboid bone; and sometimes a third to the joint between the external cuneiform and the os cuboides.

Surfaces of bones.

Articular surfaces. On the scaphoid are three articular facets, the inner being rounded, and the other two flattened. The three cuneiforms unite in a shallow elliptical hollow, which is most excavated internally.

Motion in inversion and eversion.

Movement. The cuneiform bones glide up and in on the scaphoid in inversion of the foot, and down and out in eversion; and the inner one moves more than the others in consequence of the shape of the articular surfaces, and the attachment to it of the tibialis anticus.

State of the ligaments.

When the bones pass down the dorsal ligaments are made tight; and as they rise the interosseous and transverse plantar bands will keep them united.

State of the joints in progression.

In standing and in progression these bones are separated somewhat from each other with diminution of the arch of the foot, and stretching of the transverse ligaments which connect them.

Union of the metatarsus by

ARTICULATION OF THE METATARSAL BONES. The bases of the four outer metatarsal bones are connected together by dorsal, plantar, and interosseous ligaments; and where their lateral parts touch, they are covered with cartilage, and have offsets of a synovial sac.

dorsal, plantar, and interosseous ligaments.

The *dorsal ligaments* (fig. 129) are small transverse bands from the base of one metatarsal bone to the next. The *plantar* ligaments are similar to the dorsal (fig. 128). The *interosseous* ligaments are short, transverse fibres between the contiguous rough lateral surfaces; they may be afterwards seen by forcibly separating the bones.

Lateral union.

Lateral union. The four outer bones touch one another laterally; the second lies against the internal and external cuneiform; and the fourth is in contact internally with the outer cuneiform. The articulating surfaces are covered with cartilage; and the joints are provided with synovial membrane, which is derived from the sacs serving for the articulation of those metatarsal with the tarsal bones. Synovial sacs.

The metatarsal bone of the great toe, like that of the thumb, is not united at its base to the others by any intervening bands. Great toe separate.

The digital ends of the four outer metatarsal bones, and that of the great toe, are united by the *transverse metatarsal ligament;* this has been described in page 732. Anterior ligament.

TARSAL WITH METATARSAL BONES. These articulations resemble the like parts in the hand in having a separate joint for the great toe metatarsal bone, and a common one for the four outer metatarsals. Articulation of the tarsus and metatarsus.

Articulation of the great toe. The articular ends of the bones are incased by a *capsule*, and have an *upper* and a *lower longitudinal band* to give strength to the joint: the lower band is placed between a prolongation from the tendon of the tibialis anticus and that of the peroneus longus. Joint of great toe separate from rest.

A simple *synovial membrane* serves for the articulation. Synovial sac.

The *articular surfaces*, on opening the joint, are oval from above down, curved inwards, and constricted in the middle; that of the great toe is excavated, and the other is convex. Form of bones.

Movement. There is an oblique motion of the metatarsal bone down and in and up and out, like that of the internal cuneiform with the scaphoid bone; and this will contribute to the movements of inversion and eversion of the foot. Motion up and down,

The joint possesses likewise an abductory and an adductory movement. and lateral motion.

Articulation of the four outer toes. Here the three outer tarsal bones of the last row correspond with four metatarsals;—the middle cuneiform being opposite the second toe bone, the external cuneiform touching that of the third toe, and the os cuboides carrying the two outer metatarsal bones. The bones are tipped with cartilage where they are in contact, and have longitudinal dorsal, plantar, and lateral ligaments, with oblique in the sole. Joints of four outer toes.

The *dorsal ligaments* (fig. 129) are thin bands of fibres, which are longitudinal or somewhat oblique as they extend from the tarsal to the metatarsal bones. Each metatarsal bone receives one ligament, except that of the second toe, to which there are three;—the three fasciculi to the second come from all the cuneiform bones, one from each; the third bone obtains a ligament from the external cuneiform; and the fourth and fifth have a fasciculus to each from the os cuboides. Dorsal ligaments.

Plantar ligaments. There is one *longitudinal band* from each cuneiform to its corresponding metatarsal bone; but between the cuboid and its metatarsal bones there are only some scattered fibres. Plantar.

The *lateral ligaments* are longitudinal; they lie deeply between the bones, and are connected with the second and third meta- Lateral ligaments.

tarsal: they will be better seen by partly cutting the transverse bands joining the bases of the bones. To the bone of the second toe there are two bands, one on each side:—the inner is strong and is attached to the internal cuneiform; and the outer is fixed into the middle or the outer cuneiform bone. The metatarsal bone of the third toe is also provided with one lateral slip on its outer side, which is inserted above into the external cuneiform bone.

Oblique plantar.

Oblique plantar ligaments. A fasciculus of fibres extends from the front of the internal cuneiform to the second and third metatarsals; and from the external cuneiform there is another slip to the metatarsal bone of the little toe.

Line of the articulation across the foot.

Line of the articulation. The line of the articulation between the tarsus and metatarsus is zigzag, in consequence of the unequal lengths of the cuneiform bones. To open the articulation the knife should be carried obliquely forwards from the tuberosity of the fifth to the base of the second metatarsal bone; then about two lines farther back for the union of the second metatarsal with the middle cuneiform; and finally, half an inch in front of the last articulation for the joint of the internal cuneiform with the first metatarsal bone.

Two synovial membranes.

The *synovial membranes* in this tarso-metatarsal articulation are generally two in number.

There is one between the cuboid and the two outer metatarsals, which serves for the adjacent lateral articular surfaces of the bones: this is not always separate from the following.

The second is placed in the joint between the external and middle cuneiforms with their metatarsal bones (second and third), and is an offset of the common synovial membrane belonging to the articulation of the scaphoid with the cuneiform bones (p. 764): prolongations from it are furnished to the lateral articular parts of the second, third, and fourth (inner side) metatarsals.

Form of the bones.

Articular surfaces. The surfaces of the bones are not flat; for the metatarsal are undulating, and the tarsal are uneven to fit into the others.

Motion from above down,

Movement. From the wedge-shaped form of the metatarsal bones a slight movement from above down is obtainable, and this is greatest in the little toe and the next.

with abduction and adduction.

In the little toe there is an abductory and adductory motion; and a small degree of the same exists in the fourth toe.

Motion at farthest ends.

At the phalangeal ends of the metatarsal bones the slight movements of the tarsal ends are increased by the length of the bones.

Separate the bones to see interosseous ligaments.

Dissection. All the superficial ligaments having been taken away, the interosseous ligaments of the tarsus and metatarsus may be seen by separating forcibly the cuneiform bones from one another and from the os cuboides; the latter bone from the os scaphoides; and the bases of the metatarsals from one another. The dissector will find that, in using force, the bones will sometimes tear sooner than the ligaments.

METATARSUS WITH PHALANGES. These are condyloid joints, in which the head of the metatarsal bone is received into the cavity of the phalanx. Union of metatarsus and phalanges, by

Each articulation has two *lateral* and an *inferior ligament*, as in the hand; and the joint is further strengthened above by an expansion derived from the tendons of the extensors of the toes. two lateral ligaments, and inferior. A distinct *synovial membrane* exists in each joint. Synovial sac.

In the articulation of the great toe there are two sesamoid bones, which are connected with the inferior and lateral ligaments.

All these structures are better seen in the hand, where they are more distinct; and their anatomy is more fully described with the dissection of that part. (See page 342.) See the hand.

Surfaces of bone. The metatarsal bone has a rounded head, which is longest from above down, and reaches farthest on the plantar surface. On the end of the phalanx is a cup-shaped cavity. Form of bones.

Movement. In this condyloid joint as in the hand, there is angular motion in four different directions with circumduction. Kind of motion.

Flexion and extension. When the joint is bent the phalanx passes under the head of the metatarsal bone; and when it is extended the phalanx moves back beyond a straight line with the metatarsal bone. Bending and extending.

A limit to flexion is set by the meeting of the bones, by the fore part of the lateral ligaments, and by the extensor tendon; and to extension by the inferior ligament, by the hinder part of each lateral ligament, and by the flexor tendons. State of ligaments.

Lateral movement. The phalanx passes from side to side across the end of the metatarsal bone. Its motion is checked by the lateral ligament of the side from which it moved, and by the contact with the other digits. Lateral motion.

Circumduction, or the revolving of the phalanx over the rounded head of the metatarsal bone, is least impeded in the great toe joint; but these movements in the foot are not so free as in the hand. Circular motion limited.

ARTICULATIONS OF THE PHALANGES. There are two phalangeal joints to each toe, except the first.

Ligaments similar to those in the metatarso-phalangeal joints, viz., two *lateral* and an *inferior*, are to be recognised in these articulations. The joint between the last two phalanges is least distinct; and oftentimes the small bones are immovably united by osseous substance. Union of the phalanges same as before described in the hand.

Synovial sac.

A simple *synovial membrane* exists in each phalangeal articulation.

These ligaments receive a more particular notice with the dissection of the hand (p. 343).

Form of bones.

Articular surfaces. In both phalangeal joints, the nearest phalanx presents a trochlear surface ; and the distal one is marked by two lateral hollows or cups with a median ridge.

Kind of motion,

Movement. Only flexion and extension are permitted in the two phalangeal joints of the toes, as in the hand.

movement of bone.

In *flexion* the farther phalanx glides under the nearer; and in *extension* the two are brought into a straight line.

State of ligaments.

The bending is checked by the lateral ligaments and the extensor tendon ; and the straightening, by the inferior ligament and the flexor tendons.

TABLE OF THE ARTERIES OF THE LOWER LIMB.

The FEMORAL ARTERY gives off

- External pudic . . .
  - Superior
  - inferior.
- superficial epigastric
- superficial circumflex iliac.
- Profunda . . .
  - External circumflex
    - Ascending
    - descending
    - transverse.
  - internal circumflex . .
    - Muscular
    - articular
    - ascending } final branches.
    - transverse } final branches.
  - first perforating
  - second perforating . nutritious.
  - third perforating
  - terminal branch.
- Muscular
- Anastomotic .
  - Superficial
  - deep branch.
- Popliteal . .
  - Muscular
  - upper internal
  - upper external articular
  - lower internal
  - lower external articular
  - azygos articular
  - sural.
  - Anterior tibial . .
    - Recurrent
    - cutaneous
    - muscular
    - internal malleolar
    - external malleolar
    - articular
    - tarsal
    - metatarsal . .
      - three interosseous.
    - first interosseous communicating to deep arch
    - digital . . . .
      - To great toe and half the next.
  - Posterior tibial . .
    - Peroneal . . . .
      - Muscular
      - nutritious to fibula
      - anterior peroneal.
    - nutritious to tibia
    - communicating to peroneal .
    - articular
    - internal plantar
    - external plantar
      - Muscular
      - plantar arch. .
        - Muscular
        - posterior perforating
        - digital, for three toes and a half
        - anterior perforating.

N.B. The branches of the internal iliac artery that end in the limb, will be found in the table of the arteries of the abdomen.

TABLE OF THE VEINS OF THE LOWER LIMB.

The Femoral Vein, continued from the popliteal, receives

- Popliteal . .
  - Posterior tibial . . .
    - External plantar
      - Muscular
      - plantar arch . .
        - Posterior perforating
        - digital from three toes and a half.
        - anterior perforating.
    - internal plantar
    - articular
    - communicating to saphenous
    - nutritious
    - peroneal . . .
      - Anterior peroneal
      - muscular
      - nutritious.
  - Anterior tibial . . .
    - Communicating to deep arch .
      - Digital from great toe and half the next.
    - interrosseous
    - metatarsal . .
      - Three interosseous.
    - tarsal
    - malleolar
    - communicating to saphenous
    - muscular
    - recurrent.
  - External saphenous . .
    - Branch from dorsal arch of foot
    - plantar
    - veins from outer side of os calcis
    - cutaneous in the leg.
  - sural
  - articular
  - muscular
- Anastomotic .
  - Superficial
  - deep branch.
- Muscular
- Profunda . .
  - Terminal branch
  - first perforating
  - second perforating . . Nutritious.
  - third perforating.
  - External circumflex . .
    - Ascending
    - transverse
    - descending
  - Internal circumflex . .
    - Muscular
    - articular
- Internal saphenous . .
  - Branch from dorsal arch of the foot
  - plantar
  - veins about os calcis
  - communicating with posterior and anterior tibial
  - communicating with deep veins of thigh
  - cutaneous from outer and inner parts of thigh
  - external pudic
  - superficial epigastric
  - superficial circumflex iliac.

TABLE OF THE NERVES OF THE LOWER LIMB.

- **Nerves of the Lumbar Plexus in the Limb.**
  - 1. External cutaneous
    - Posterior and anterior branches.
  - 2. Obturator
    - Accessory . . .
      - To obturator trunk
      - to pectineus
      - to hip joint.
    - to obturator externus
    - to articulation
    - superficial division . . .
      - Muscular . . .
        - To gracilis
        - to adductor longus.
      - to plexus in the thigh and artery
    - deep division .
      - To adductor brevis and magnus
      - articular.
  - 3. Anterior crural . .
    - Superficial portion . . .
      - Muscular . . .
        - To sartorius
        - to pectineus
      - middle cutaneous
      - internal cutaneous . . .
        - Anterior and inner branches.
    - deep part . .
      - Muscular . . .
        - To rectus
        - to vastus externus—articular
        - to vastus internus and crureus . . — articular.
      - internal saphenous . . . .
        - Branch to plexus over patella to leg and foot.
  - 4. Branch of genito-crural . .
    - To integuments.
- **Nerves of the Sacral Plexus in the Limb.**
  - 1. Small sciatic . .
    - Inferior gluteal
    - inferior pudendal
    - cutaneous to gluteal region, thigh, and leg.
  - 2. Great sciatic . .
    - Articular to hip
    - to hamstrings.
    - external popliteal . . .
      - Articular
      - cutaneous
      - peroneal communicating
      - recurrent articular
      - musculo-cutaneous . . .
        - To peronei
        - cutaneous to foot and toes
      - anterior tibial .
        - Muscular
        - articular
        - cutaneous to two toes.
    - internal popliteal . . .
      - Articular
      - muscular
      - short saphenous
      - posterior tibial
        - Muscular to flexors
        - internal plantar
          - Cutaneous of the sole
          - muscular
          - four digital
          - communicating branch
          - articular to the toes.
        - external plantar
          - Superficial part . .
            - Muscular
            - two digital
            - articular
          - deep part .
            - Muscular
            - articular.
  - 3. To gluteus
  - 4. To quadratus and gemelli .
    - Articular.
  - 5. Superior gluteal .
    - To glutei
    - to tenser vaginæ femoris.

CHAPTER X.

DISSECTION OF THE EYE.

Situation of the eyeball.

THE eyeball is the organ of vision. It is lodged in the orbit; and supported in that hollow on a mass of fat, it is surrounded by muscles which impart movement to it. Two lids or shields protect the eyeball from external injury, and moderate the degree of light admitted into the interior; and the anterior or exposed surface is covered by a mucous membrane (conjunctiva).

Parts around and in front of it.

The dissection to be made on the eye of the ox.

Directions. In the absence of specimens of the human eye, the structure must be learnt on the eye of some large animal, as the ox or pig for example. Let the student therefore procure half a dozen or more eyes of the ox for the purpose of dissection. One or two shallow basins will be needed; and some wax or tallow in the bottom of one, or of a deep plate, will be useful.

Detach the muscles.

Dissection. To see the general form of the ball of the eye, and the outer surface of the external coat, the attachment of the different muscles should be taken away; and the loose mucous membrane should be removed from around the anterior part.

Form of the ball.

The *ball of the eye* is roundish in form, and consists of two parts, which differ greatly in appearance, viz., an opaque posterior portion, forming five-sixths of the whole, and a smaller transparent portion (cornea) in front; these are segments of different-sized spheres, and the anterior belongs to the smaller sphere. To the back of the globe the optic nerve is attached, rather to the inner side of the axis of the ball; and around it the nutritive vessels and the nerves enter.

Position of optic nerve.

Diameter.

The antero-posterior diameter of the ball amounts to nearly an inch ($\frac{19}{20}$ths), but the transverse exceeds the other by about half a line.

Outline of the constituents of the organ of vision.

The organ of vision is composed of certain delicate central parts, and of others requisite for their protection and support. Its fundamental constituent (retina) is continuous with the optic nerve. Within the nervous layer are central transparent parts to bring the rays of light to a focus on it; and in front of these is a moveable curtain (iris), suspended in a fluid, which regulates the admission of light into the interior. To defend such delicate structures, certain denser strata are arranged around them; and to absorb the superabundant rays of light entering the eyeball, one of them is provided with dark pigment.

The coats of the eyeball, forming three strata, are posited one within another, and are named sclerotic, choroid, and retina. The transparent media in the interior are likewise three, viz., the lens, the aqueous humour, and the vitreous body. **Number of coats and central parts.**

Dissection. To obtain a general idea of the structures to be dissected, the student may destroy one eyeball for that purpose by cutting through it circularly: he will be then able to recognise generally the arrangement of the parts mentioned above, and their strength and appearance; and will be better prepared to follow the directions that are afterwards given. **Dissection.**

FIBROUS COAT OF THE EYEBALL. The outer casing of the eye consists of an opaque hinder part called sclerotic, and of an anterior transparent part or cornea. **Fibrous coat.**

The SCLEROTIC COAT (cornea opaca) is the firm, whitish, and opaque part of the external stratum of the eyeball, which supports the more delicate structures within. **Sclerotic part.**

Dissection. To examine the inner and outer surfaces of this coat, and the cornea, it will be necessary to cut circularly with a scissors through the cornea close to the sclerotic, and to remove the cornea from the front of the eyeball; on piercing the cornea the aqueous fluid escapes from the containing chamber. The other structures may be then abstracted from the interior of the sclerotic covering; and the central parts of the ball may be set aside for subsequent use. **Dissection to see the interior.**

The *sclerotic* tunic of the eye is bell-shaped, and extends from the entrance of the optic nerve to the margin of the cornea, forming about five sixths of the ball. **Form and extent.**

At its posterior part and a little to the inner side of the centre (one tenth of an inch), the optic nerve is transmitted through an aperture in it: this opening decreases in size from without inwards, and is cribriform when the nerve is drawn out—the lattice-like condition being due to the union with its margin of the bundles of fibrous tissue between the funiculi of the nerve. Other smaller apertures for the passage of the nutritive vessels and nerves are situate around that for the optic. **Apertures behind.**

In front the opaque or sclerotic part is continuous with the transparent cornea. **Ending in front.**

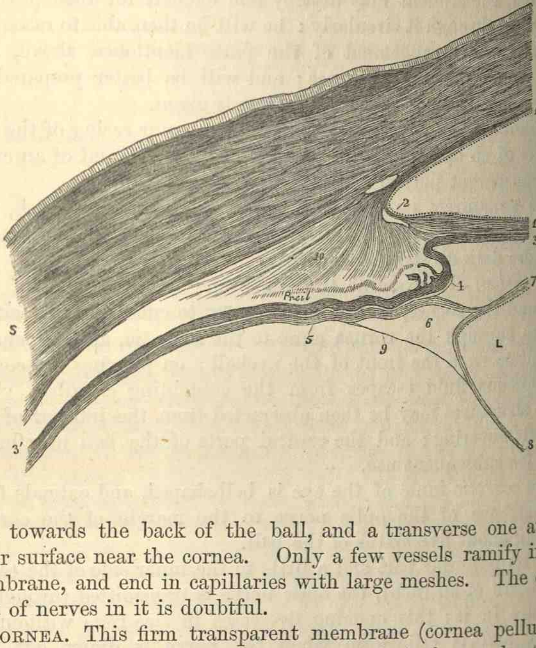
On the outer surface this coat is smooth, except where the muscles are attached; but on the inner aspect it is covered with flocculi of fine areolar tissue, and with the ends of ruptured vessels and nerves, and is of a dark colour. **Outer and inner surface.**

The sclerotic covering is thickest at the back of the eyeball, but it becomes thinner and whiter about a quarter of an inch from the cornea, where it is visible as the "white of the eye." Where it joins the cornea it becomes again somewhat thickened. **Thickness.**

Formed of white and yellow fibrous tissue.

Structure. The sclerotic coat is formed of layers of white fibrous tissue, collected into bundles, and mixed with a fine network of yellow or elastic fibres. In it are scattered nucleated cells fusiform in shape or possessing rays. Though interlaced with one another (fig. 130, *c*), the fibres have rather a longitudinal direc-

Fig. 130.*



tion towards the back of the ball, and a transverse one at the outer surface near the cornea. Only a few vessels ramify in the membrane, and end in capillaries with large meshes. The existence of nerves in it is doubtful.

Vessels and nerves.

Cornea: form, size, extent.

CORNEA. This firm transparent membrane (cornea pellucida) fits into the front of the eyeball, of which it forms about one sixth, and measures about half an inch transversely, but rather less from above down. Its shape is circular; though, when viewed in front, it appears largest in the transverse direction in consequence of the opaque sclerotic structure reaching further on it above and below than on the sides.

* Enlarged vertical section of the eyeball, representing the parts near the union of the sclerotic coat and the cornea (Kölliker).—s. Sclerotic.—c. Cornea. L. Lens. 1*. Posterior layer of the cornea. 1. Iris. 2. Pillars of the iris. 3. Posterior pigmentary layer of the iris.—Pr. cil. Ciliary process. 4. Layer of cells on the inner surface of the process, continuous behind with the retina. 10. Ciliary muscle outside the processes. 7, 8. Anterior and posterior layers of the capsule of the lens. 5. Suspensory ligament of the lens. 6. Canal of Petit. 9. Hyaloid membrane, blending with the hinder part of the lens capsule.

It is smooth and soft to the touch, is convex anteriorly, but concave posteriorly, and is of equal thickness throughout. Its anterior is of rather less extent than its posterior surface. At the circumference it is blended with the sclerotic coat by continuity of tissue.

Curve. Surfaces.

This clear and diaphanous structure, resembling in appearance the glass of a watch, bounds the anterior chamber of the eyeball, and gives passage to the rays of light entering the organ. When the cornea is supported by the aqueous humour, it deflects the rays of light transmitted to the eye, and thus influences by its greater or smaller convexity the different degrees of sight at a distance. After death it becomes flaccid from the transudation of the aqueous humour; or if it is immersed in water it is rendered opaque by infiltration of the tissue by that fluid.

Situation in front of the sclerotic. Its action on the rays of light.

Structure (fig. 131, A). The cornea is laminar in texture. It is constructed of a special, thick part called *cornea proper:* in front of this is a thin elastic layer with an epithelial stratum; and behind it is another fine elastic membrane covered by an epithelium. The two structures in front of the proper cornea constitute the conjunctiva: and the two behind form the membrane of Demours.

Composed of layers.

In the healthy condition *bloodvessels* do not permeate its structure, but cease in capillary loops at the circumference. *Nerves* ramify in it in great abundance (Schlemm), after losing their opacity at the circumference.

Has not blood-vessels. Nerves.

The *cornea proper* (lamellated cornea) is made up of a series of superposed layers, about sixty in number in a section at a given spot, which join one another at numerous points, and cannot therefore be detached for any distance.* This structure possesses great toughness; and its transparency depends upon the parallelism of the different strata, and their distance from one another being duly maintained, for if they are disarranged by compression or other means, the translucency is destroyed. The laminæ are formed of fibrous tissue, continuous with that of the sclerotic, and containing ramified nucleated corpuscles; but in the cornea they are flattened into membranous layers, arranged one over another. The tissue when boiled gives chondrin.

Cornea proper is formed of layers, with intervals between. Its tissue continued into that of the sclerotic.

The membrane at the back of the cornea (fig. 131)—*membrane of Demours*—consists of a basement layer (posterior elastic lamina, Bowman) covered by epithelium.

Layer behind cornea.

The *posterior elastic layer* (*d*) may be peeled off after a cut has been made across the cornea. It is a thin, but dense and hard layer, $\frac{1}{3000}$th to $\frac{1}{2000}$th of an inch in thickness, which tears readily when an attempt is made to separate it, and curls up with

Posterior elastic layer:

* The facts stated in the description are obtained chiefly from Mr. Bowman's "Lectures on the Eye," and from the "Physiological Anatomy," part third, 1847, of Dr. Todd and Mr. Bowman.

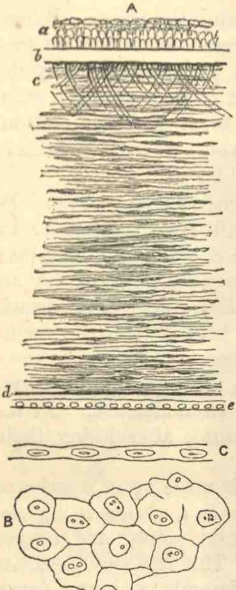
characters;

the attached surface innermost when it is free. It is always transparent, and remains so after boiling, after the action of acids, and even after maceration.

attachment at margin;

At the edge of the cornea this lamina breaks up into processes ("pillars of the iris") which turn backwards, and blend with the outer margin of the iris, and with the choroid and sclerotic coats. Though very elastic, this membrane is apparently without a definite structure.

Fig. 131.*



has an epithelium.

A laminar *epithelium*, like that on serous membranes, clothes its free surface (fig. 131, B).

Layer in front of cornea.

The *conjunctiva* in front of the cornea (fig. 131) has also a basement layer (anterior elastic lamina, Bowman), with an epithelial covering in front.

Anterior elastic layer is part of conjunctiva;

The *anterior elastic layer* (*b*) is a transparent structure, similar in its properties to the posterior, but thicker than it (from $\frac{1}{2000}$th to $\frac{1}{1200}$th of an inch), which extends over the front of the cornea, and seems to be the basement membrane of the conjunctiva. From its posterior surface fine shreds (*c*) are continued into the cornea proper.

has an epithelium.

The *epithelium* is formed of three or four layers of scales (*a*), the deeper being columnar, but the superficial laminar in form.

Choroid coat is vascular.

VASCULAR COAT OF THE EYEBALL. The next covering (fig. 134) is situate within the sclerotic, and is formed chiefly of blood-vessels and pigment cells. Its strength is but slight, and it is lined by a pigmentary membrane.

Components.

It may be divided into three parts;—a posterior (choroid) corresponding with the sclerotic; an anterior (iris) opposite the cornea; and an intermediate ring (ciliary ligament and muscle) on a level with the union of the sclerotic and cornea.

Dissection to see the choroid coat.

Dissection. Supposing the cornea of an eye cut through circularly near the anterior part, as before directed (p. 773), it will be necessary, in order that the choroid coat may be laid bare, to take away the rest of the sclerotic. With the point of

* Vertical section A of the cornea.—*b*. Anterior elastic layer with the conjunctival epithelium on it. *c*. Oblique fibres from it to the layers of the cornea. *d*. Posterior elastic lamina: *e*. Epithelium on it (membrane of Demours). B. Surface view, and C. side view of the epithelium of the membrane of Demours.

the scalpel or a shut scissors detach the fore part of the sclerotic from the front of the choroid by breaking through a thin structure uniting them. Then the eye being put into water the outer coat is to be removed by cutting it away piece-meal with a scissors; in taking it off some slight connections are to be broken through with the handle of the scalpel, but the slender vessels and nerves are to be preserved.

The white ring around the eye in front, which comes into view during the dissection, forms the ciliary ligament and muscle, which limit the extent forwards of the black choroid coat.

For the purpose of obtaining an anterior view of the ciliary processes connected with the anterior termination of the choroid coat, let the cornea be removed on another eyeball as before; and after two or three cuts have been made in the sclerotic towards the optic nerve, the resulting flaps may be pinned to the wax in the plate, so as to support the eye in an upright position. Then on removing with care the iris, taking it away from the white ring of the ciliary muscle and ligament, the ciliary processes beneath will be displayed. **To show the ciliary processes by an anterior**

On another ball, in which the fore part of the choroid is shown by incising the sclerotic as above directed, a posterior view of the processes is to be prepared. In this proceeding the iris is to be left untouched, but the choroid coat is to be divided circularly with a scissors a little behind the ring of the ciliary muscle, and is to be raised with that ligament and the attached iris in one piece. By gently washing the pigment from the back of the iris the small processes will be made manifest. **and a posterior view.**

By means of this dissection the interior of the choroid coat may be seen. **To see the interior,**

The structure of the membrane may be examined on a fragment obtained from the eye destroyed in making the preparation of the sclerotic coat. **and the structure.**

If a vertical section is made of another eyeball, it will show the ciliary processes in their natural position, and will demonstrate the relative situation of all the parts. This section, which it is difficult to make, should be attempted in water with a sharp large knife, and on a surface of wax or wood, after the cornea and sclerotic have been cut with a scissors. When the eye has been divided, the halves should remain in water. **To make a vertical section.**

The CHOROID COAT (fig. 134) is a thin membrane of a dark colour, and forms a segment of a sphere. Like the sclerotic stratum, it extends from the optic nerve to the fore part of the eyeball. **Form and extent.** When viewed on the eye in which the ciliary ligament is entire, it appears to terminate at the ligament; but it may be seen in the other dissections to bend inwards behind that ring, and to end in a series of projections (*pars plicata*) behind the iris. **Anterior termination.**

This covering is rather thicker and stronger behind than in front. It is supported at the bottom of the eyeball by its close connection to the sclerotic coat, and in front by the ciliary ligament. Posteriorly it is pierced by a round aperture for the passage of the optic nerve; and anteriorly it is united with the ciliary muscle and iris.

Opening.

Outer surface rough;

The outer surface is flocculent, and is covered by the remnants of a pigmentary areolar tissue (membrana fusca) between it and the sclerotic coat: on it may be seen small veins (*f*) arranged in parallel arches as they open into larger trunks; and lying on its surface are the ciliary arteries and nerves (*e*). The inner surface is smooth, and is lined by a thin pigmentary epithelial layer (membrana pigmenti), though in the eye of the ox it shines through that layer with a metallic lustre.

inner smooth.

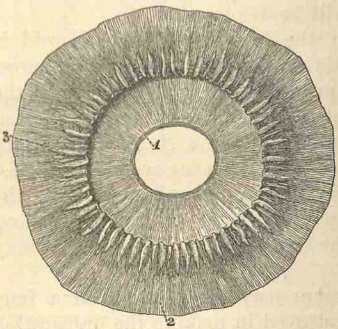
Ciliary processes.

The *ciliary processes* (fig. 132, ³) or the plaits in front on the inner surface of the choroidal coat, are arranged around the lens, like the many petals of a flower, forming a circle (corpus ciliare). These processes, about 85 in number, lie side by side, and consist of larger and smaller eminences, but the differently sized pieces do not alternate regularly. At their inner extremities they are united by loops or transverse ridges.

Position.

Two kinds; small, and large.

Fig. 132.*



The processes, about $\frac{1}{10}$th of an inch in length, are thin externally, but increase in depth internally, becoming convex, and project around the lens. By their free ends they bound circumferentially the space (posterior chamber) behind the iris. They are closely connected with the membrane (suspensory ligament) on the front of the vitreous humour, and fit into hollows between eminences on the anterior surface of that membrane. In front they correspond with the back of the iris towards their free ends, but are separated from it by pigment.

Connections with parts around.

Parts entering into the structure.

Structure. The choroid coat and its ciliary processes are formed

* Inner view of the front of the choroid coat with its ciliary processes, and the back of the iris.—1. Iris with the fibres radiating from the inner to the outer edge: the circular band at the inner edge is the sphincter of the pupil. 2. Front of the choroid coat. 3. Ciliary processes inside the anterior terminal part of the choroid: the processes are connected at their inner ends by loops.

principally of bloodvessels, whose branches are arranged differently on the outer and inner parts. Ramified pigment cells make up the rest of the coat.

In the outer part (fig. 134) the larger branches of both arteries and veins are contained; and the veins (*f*) form parallel curves (*vasa vorticosa*) as they end in four or five chief efferent trunks. In the interspaces of the vessels towards the outer surface there are ramified irregular pigment cells (fig. 133, A), which contain a nucleus and molecular grains of dark brown colouring matter. The offsets of these cells unite together, and form a fibrous web or stroma for this tunic (Kölliker).

A plexus of blood-vessels. with large meshes and pigment cells externally.

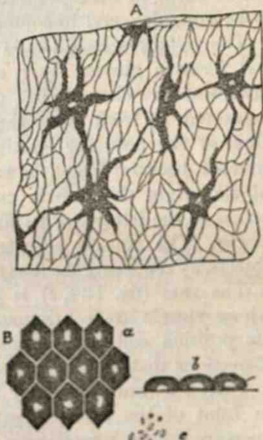
In the inner part of the choroid the vessels form a network of capillaries with meshes smaller than elsewhere, whose interstices are rather less towards the back than the front of the eyeball: this part of the choroidal coat is described sometimes as a separate layer (*tunica Ruyschiana*).

Capillaries internally.

The *stroma* or web of the choroid is formed by the outrunners of the cells before mentioned, and is very fine at the inner part of the choroid where the pigment cells are absent from it.

Its stroma.

Fig. 133.*



In the ciliary processes there is a similar texture of ramified bloodvessels though with larger capillary meshes than in the choroid; and the intermixed pigment cells lose their colouring matter towards the tips of the folds.

Structure of ciliary processes.

The *pigmentary membrane* (choroidal epithelium). On the inner surface of the choroid coat and ciliary processes is a pigmentary lining, which is easily detached. It consists in great part of a single stratum of six-sided nucleated cells with granular contents (fig. 133, B), which are applied to each other by their edges. It has this constitution as far forwards as the ciliary processes, but in front of that line it is several layers deep, and the cells are rounded. This dark layer absorbs the superabundant rays of light entering the eyeball.

Pigmentary layer formed of cells that contain pigment.

* Pigment cells of the eyeball (Kölliker).—A. Ramified pigment cells of the choroid coat. B. Front view of the hexagonal cells of the pigmentary membrane. *b.* Side view of the same. *c.* Pigment of the cells.

Pigment absent.

In the eye of the ox the colouring matter is absent from the cells in the bottom of the eye, and allows the tissue of the choroid (*tapetum*) to shine through it; and in the albino the pigment is altogether deficient in the cells of this layer and the choroid, so that the vessels give a red appearance to the interior of the eye.

Ciliary ligament.

CILIARY LIGAMENT AND MUSCLE. In the eye from which the sclerotic coat has been removed, the white band of the ciliary ligament, with the muscle close behind it (*annulus albidus*), may be seen in its natural position outside the front of the choroid coat.

Situation.

Ciliary ligament. This narrow circle, about $\frac{1}{40}$th of an inch thick, surrounds the iris, and is situate in the ball of the eye nearly opposite the junction of the cornea with the sclerotic tunic. It may serve the purpose of supporting the other coats at the fore part of the eye.

Connections with other parts. Fibres.

Externally it is connected with the sclerotic, but a small interval or venous canal, the *sinus circularis iridis* exists between the two. Its fibres are circular; they are stiff, and resemble elastic tissue in their properties, but they are supposed by some to be muscular, and to compress the lens.

Ciliary muscle. Attachments.

The *ciliary muscle* (fig. 130, [10]) consists of unstriated fibres, and forms a grayish layer, about $\frac{1}{10}$th of an inch wide, on the surface of the choroid coat, close to the ciliary ligament. It is connected in front with the sclerotic coat, and the radiating fibres of the posterior elastic layer of the cornea; its fibres are directed backwards and inwards, and end on the choroid coat. At its origin the muscle conceals the ciliary ligament. The nerves to the iris pierce its fibres.

Action.

Use. The muscle adjusts the eye for the vision of near objects, by rendering the lens more convex in some way not known.

Iris is vascular and muscular.

The IRIS (fig. 134, *c*) is a vascular and muscular structure, whose vessels are continuous with those of the choroidal coat. Its position and connections may be observed in the different dissections that have been prepared.

Situation. Form.

Placed within the ciliary ligament, it is suspended vertically in front of the choroid coat (fig. 130, [1]), and is pierced by an aperture for the transmission of the rays of light. It is circular in form, is variously coloured in different persons, and is immersed in the aqueous humour.

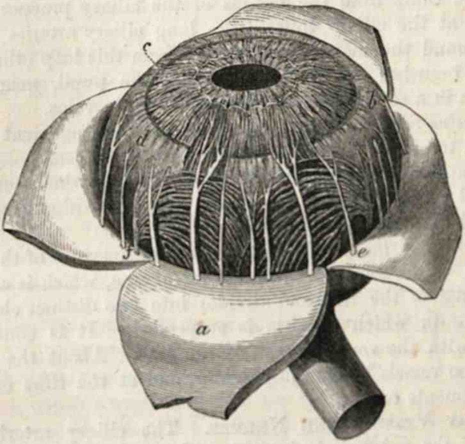
Attachment. Anterior surface; posterior.

By its circumference the iris is connected with the posterior elastic layer of the cornea and the ciliary ligament; and by means of the last body with the sclerotic coat close to the cornea. The anterior surface is free in the aqueous humour, and is marked by lines converging towards the pupil. The posterior surface is also free, and is covered with a thick layer of pigment, to which the term *uvea* has been applied (fig. 130, [3]).

The aperture in it is named the *pupil* of the eye; this is slightly internal to the centre, and is nearly circular in form, but its size is constantly varying (from $\frac{1}{20}$th to $\frac{1}{3}$rd of an inch) by the contraction and relaxation of the muscular fibres, according to the degree of light acting on the optic nerve. Situation and size of the central aperture.

Structure. The stroma of the iris is composed chiefly of fibres of areolar tissue, arranged in bundles, which are directed like Component structures.

Fig. 134.*



rays towards the pupil. In it are involuntary muscular fibres, both circular and radiating, together with pigment cells. Vessels and nerves ramify through the tissue.

Muscular fibres. The *sphincter of the pupil* (fig. 132) is a narrow band about $\frac{1}{30}$th of an inch wide, which is close to the pupil on the posterior aspect. The *dilator of the pupil* is said to begin at the outer border of the iris, and its fibres, collected into bundles, join one another and end internally in the sphincter. Muscular fibres: sphincter and dilator of pupil.

Action. Enlargement of the pupil is supposed to be effected by shortening of the radiating fibres; and diminution, by contraction of the circular ring. The movements of the iris are involuntary and regulate the admission of light. How they act.

The *pigment cells* are spread out in the stroma, and are dis- Position and form of pigment cells.

* View of the front of the choroidal coat and iris—external surface (Zinn).—*a.* Sclerotic coat cut and reflected. *d.* Choroid coat. *c.* Iris. *b.* Ciliary muscle: and the circular band between it and the iris represents the ciliary ligament. *e.* Ciliary nerves between the two outer coats. *f.* Veins of the choroid coat.

posed also on both surfaces. In the substance of the iris they are ramified and irregular, as in the choroid (fig. 133, A), and may contain yellow, brown, or very dark pigment. On the fore part of the iris they are ovalish or rounded, but still ramified; and behind it, where there is a thick layer (uvea), the cells are rounded and filled with granules. The colour of the iris is dependent upon the colour and position of the pigment.

Pigment gives colour.

Arteries are looped.

The *arteries* of the iris have a looped arrangement: they are derived chiefly from the long and the anterior ciliary branches, but some come from the vessels of the ciliary processes. On arriving at the ciliary muscle the long ciliary arteries form a circle around the margin of the iris; from this loop other anastomotic branches are directed towards the pupil, near which they join in a second arterial circle, and end in veins.

Veins.

The *veins* resemble the arteries in their arrangement in the iris, and terminate in the veins of the choroidal coat.

Nerves of the iris.

The *nerves* of the iris divide into branches, which communicate, and extend towards the pupil; they are without dark outline, and their ending is not known.

Membrane of the pupil in the fetus.

Membrane of the pupil. In the fetus the aperture of the pupil is closed by a vascular transparent membrane, which is attached to the edge of the iris, and divides into two distinct chambers the space in which the iris is suspended. It is continuous behind with the vascular case of the lens. About the eighth month the vessels become impervious, and at the time of birth only fragments remain.

Situation; time of disappearance.

Arteries of the eyeball are

CILIARY VESSELS AND NERVES. The ciliary arteries are offsets of the ophthalmic (p. 48), and supply the choroid coat, the ciliary processes, and the iris. They are classed into posterior and anterior, and two of the first set are named long ciliary; but they will not be seen without a special injection of the vessels of the eye.

posterior at the back;

The *posterior* (short) *ciliary* branches (fig. 134) pierce the sclerotic coat around and close to the optic nerve, and running forwards on the surface of the choroid membrane enter its substance at different points.

two of them named long ciliary.

Two of this set (long ciliary) are directed forwards to the ciliary ligament, one on each side of the eyeball, and form a circle around the iris in the ciliary muscle, as before explained, before being distributed in it. In the eye the outer one lies rather above, and the inner rather below the level of the middle of the ball.

Anterior ciliary at the front.

The *anterior ciliary* arteries, five or six in number, are smaller than the posterior, and arise at the front of the orbit, chiefly from muscular branches; they pierce the sclerotic coat about a line behind the cornea, supply the ciliary processes, and join the arterial circle of the long ciliary vessels before they end in the iris. In inflammation of the iris these vessels are enlarged, and form a ring around the cornea.

The *posterior ciliary veins* leaving the choroid coat are commonly four in number, and the branches entering these trunks form arches (vasa vorticosa) on the surface (fig. 134, *f*): they perforate the sclerotic layer at separate points, midway between the cornea and the optic nerve, and end in the ophthalmic vein. **Posterior ciliary;**

Anterior ciliary veins begin in a plexus within the ciliary muscle, and accompany the arteries through the sclerotic to join the ophthalmic: they communicate with the sinus venosus. **anterior ciliary veins.**

The *ciliary nerves* (fig. 134) are derived from the lenticular ganglion, and from the nasal nerve (p. 46). Entering the back of the eyeball with the arteries, they are continued forwards with the vessels between the sclerotic and choroid coats nearly as far as the ciliary muscle: at this spot the nerves send offsets to the cornea, and pierce the fibres of the ciliary muscle to enter the iris, but their manner of ending is unknown. Offsets from the nerves supply the ciliary muscle. **Ciliary nerves** **end in iris and ciliary muscle.**

CHAMBER OF THE AQUEOUS HUMOUR (fig. 130). The space between the cornea in front and the lens behind, in which the iris is suspended, contains a clear fluid named the aqueous humour. In the fetus before the seventh month this interval is separated into two by the iris and the pupillary membrane, but in the adult it is only partly divided, for the two communicate through the pupil. The boundaries of the two chambers may be seen in the eye on which a vertical section has been made. **Space contains aqueous humour;** **is partly divided into two by the iris.**

The anterior chamber is the larger part of the space; it is limited in front by the cornea, and behind by the iris. **Anterior part.**

The posterior chamber is a narrow interval behind the circumference of the iris, which is bounded in front by the iris; behind by a piece of the membrane (suspensory ligament of the lens) on the front of the vitreous humour; and at the circumference by the ciliary processes. **Posterior; its boundaries.**

The aqueous humour is quite transparent, and consists nearly of pure water. A small quantity of chloride of sodium, with some extractive matter, is in solution in it. It has been supposed that this fluid is secreted by a special membrane lining the cavity, but evidence of the existence of such a layer is wanting: the fluid is formed by the vascular structures around. **Aqueous humour.**

THE NERVOUS TUNIC OR RETINA. This coat (tunica nervea) is in part continuous with the optic nerve, and is the most delicate of all the structures of the eyeball. On it the image of objects is produced by the rays of light being brought to a focus in the bottom of the eye. **Retina continuous with optic nerve.**

Dissection. The retina can be satisfactorily examined only on an eye that is obtained before forty-eight hours have expired since the death. To bring it into view on the eyeball on which **Dissection to see the retina.**

the choroid coat was dissected, the choroidal covering must be torn away carefully with two pair of forceps whilst the eye is immersed in water or spirit.

If an entire eye is used for the purpose, a thread may be passed through the cornea, and fastened to a pin fixed in wax; then on removing in a fluid the sclerotic and choroid coats, the retina will be laid bare.

The interior of the retina may be seen in the eye from which the cornea, the iris, and the corpus ciliare have been removed in front.

Situation in eyeball. The *retina* is the most internal of the three concentric strata in the globe of the eye, and is situate between the choroid coat and the transparent mass (vitreous humour) in the interior. It is moulded upon, and supported by the vitreous body; and its form is that of a segment of a sphere, but its aperture in front is very large.

Form and extent. Beginning behind at the optic nerve, this thin layer extends forwards to the ciliary processes (outer margin of the corpus ciliare), where it ends in a wavy border—the *ora serrata.* Where the retina ceases in front a thin layer of elongated nucleated cells, which are not nerve elements, is continued on as far as the tips of the ciliary processes.

Cells prolonged in front.

Colour; transparency and thickness. This nervous expansion is of a pinkish gray colour, and is semitransparent when fresh, so that an image can be seen on it at the bottom of the eye when the two external coats have been removed; but it soon loses this translucency, and is moreover rendered opaque by the action of water and other substances. Its thickness is greater at the posterior than the anterior part of the eyeball.

Outer surface is flocculent. On the outer surface are some fine shreds, fragments of a structure (Jacob's membrane) to be noticed presently, which float in the fluid in which the preparation may be placed; and in a fresh eye, on which the coats have been removed from behind, a continuous layer of this membrane may be detached with care.

On the inner surface are seen porus opticus, yellow spot, fovea centralis. On looking to the inside through the vitreous body, the surface is smooth; it is covered with folds in the preparation, but these are accidental, in consequence of the membrane having lost its proper support. At the spot where the optic nerve expands (porus opticus) is the central artery of the retina. In the interior of the human eye, in the axis of the ball, is a slightly elliptical yellow point, $\frac{1}{12}$th of an inch in diameter, which is named the *yellow spot* (limbus luteus of Sömmerring). Almost in the centre of that spot is a minute hollow, the *fovea centralis*, which appears black in consequence of the thinness of the wall allowing the dark pigment outside to be seen.

Layers in the retina. *Structure* (fig. 135). In the retina are three layers or strata of different materials, together with bloodvessels: viz., an inner (3), composed of nerve elements; an outer (Jacob's membrane), formed of peculiar bodies (1); and an intermediate or granular layer (2). Passing vertically through some layers of the retina are minute threads—fibres of Müller, together with a very fine areolar tissue in the two inner strata.

One of nerve substance

The *layer of nerve substance* (3) is made up of the same elements as the gray matter of the encephalon, viz., of a molecular matrix containing different-sized nerve cells, with nerve fibres instead of nerve tubes; these constituents have the following arrangement:—

has two strata;

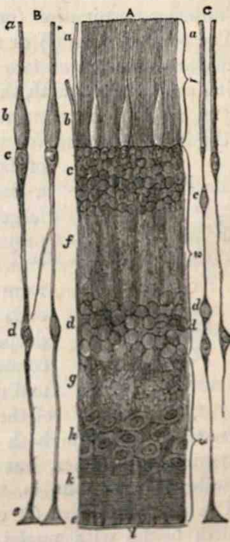
an inner of altered nerve fibres,

The tubules of the optic nerve (k), having become solid in texture and gray in colour from the absence of the white substance of Schwann, radiate in bundles from the end of the optic trunk, and communicate together to construct a thin web at the inner aspect of the nervous layer; this delicate network with lengthened meshes diminishes in strength as it is followed forwards.

and an outer of molecules, and nerve cells.

Outside the nerve fibres is a stratum of the molecular material (g), with large pale pyriform and roundish nucleated nerve cells (h) with offsets: this layer begins around the entrance of the optic nerve, and becomes thinner as it extends forwards. Around the optic nerve the cells are arranged in one layer, and over the yellow spot they are about six deep; but near the ora serrata they are scattered. Offsets of the cells, communicating with one another, join internally the nerve fibres, and are connected externally with the inner granular bodies (d).

Fig. 135.*



Blood-vessels in this layer.

In the nervous layer is a *plexus of bloodvessels*, which is derived from the central vessels of the retina contained in the optic

* Magnified vertical section, A, of the retina (Kölliker).—1. Columnar layer with rods, a, and cones, b. 2. Granular layer with outer bodies, c, and inner layer of granules, d, and intermediate non-granular part, f. 3. Nervous layer with h, nerve cells, and k, nerve fibres: outside the cells is a finely granular part, g, and inside the fibres a limiting membrane, e.

B. Cones of the outer layer, 1, connected with fibres (fibres of Müller), and passing through part of the retina.

C. Rods of the outer layer, 1, supposed to be united with fibres of Müller, like the cones.

nerve (p. 48). When the nerve becomes membraniform the artery divides into four or five branches; these pierce the stratum of fibres, and end in a network of capillaries amongst and outside the nerve cells, like the vessels in the gray substance of the encephalon. The larger branches of the artery keep clear of the axis of the eyeball, and only capillaries occupy the yellow spot.

At the yellow spot.

Artery in fetus.

In the fetus a branch of the artery is distributed to the back of the lens.

In animals a marginal vessel runs circularly round the ball at the anterior termination (ora serrata) of the retina.

Outer layer has special parts.

The *outer stratum* ([1]) or columnar layer of the retina (Jacob's membrane) consists of two different elements—rods and cones, which are arranged with their ends inwards and outwards.

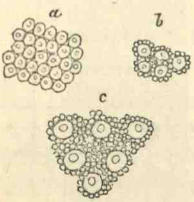
Rods.

The *rods* (C) are elongated solid particles, which are pointed at the inner end, and are the more numerous of the two kinds of bodies.

Cones.

The *cones* (B) are shaped like a flask with a long neck, and have the larger end turned inwards: they do not project so far out as the rods. When viewed on the outer surface, the cones form large isolated swellings amongst the ends of the rods (fig. 136, *c*), and at a deeper level. By their inner ends the cones are united with a pear-shaped cell and a Müllerian fibre, but the connections of the rods are doubtful.

Fig. 136.*



Characters.

In the fresh state both are clear and homogeneous, with a glistening appearance, but these characters are soon destroyed by water and other fluids.

Granular layers,

The *granular* layer ([2]) consists of innumerable rounded and ovalish bodies with nuclei, which are collected into two sets (*c*, *d*), with an intervening fine molecular material. In the outer layer there are in addition pear-shaped cells united with the cones, and elliptical clear bodies with three or four transverse bars on each (Henle).

with material between.

The intervening portion has a striated appearance, from the passage of the fibres of Müller through it.

Fibres of Müller.

The *fibres of Müller* (B, C) are extremely fine threads, which pass vertically through the substance of the retina, from the pyriform bodies connected with the cones, and as is supposed by Kölliker from the rods also, to the corpuscles in the inner nuclear layer (*d*).

* Microscopic appearance of the outer surface of the retina.—*a.* Over the yellow spot. *b.* Near the spot. *c.* Middle of the retina. The larger rings represent the cones, and the smaller ones the rods, seen endwise in all the figures.

The *limiting membrane* is a very delicate lining on the inner surface of the retina, which resembles the elastic layers of the cornea in its properties. The inner surface is smooth and in contact with the membrane of the vitreous body; and the outer is joined by bundles of areolar tissue which pass outwards between the nerve fibres. **Membrane lining retina.**

In the *yellow spot* the nerve cells of the inner layer form a continuous stratum which rests on the membrana limitans; whilst the nerve fibres and the molecular material extend only into the circumference. The granular layer and the fibres of Müller are absent over the central fossa. Only the cones of Jacob's membrane (fig. 136, *a*) are found in this spot. **Constituents of retina at yellow spot.**

The colour of the part is due to yellow pigment diffused through all the textures except Jacob's membrane. Water removes it readily. **Colour.**

Capillary vessels occupy the spot, whilst the larger branches pass around. **Vessels.**

Vitreous Body. A transparent mass fills the greater part of the space within the coats of the eyeball, which has been named vitreous body from its resemblance to glass; it consists of a clear aqueous fluid, contained in a translucent membrane, and has the consistence of jelly. **Vitreous body.**

Dissection. The vitreous body may be seen on the eye on which the retina was dissected, by taking away the retina, the ciliary ligament and processes, and the iris. **To obtain a view of it,**

To obtain a view of its anterior part with the lens in situation, an eyeball should be pinned upright on wax; the sclerotic and choroid coats should be cut through about a quarter of an inch behind the cornea; and on removing carefully the cornea, ciliary ligament and muscle, and ciliary processes, the vitreous body will be apparent. **and of its front.**

The *vitreous body* is globular in form, and fills four fifths of the ball of the eye, reaching forwards nearly to the iris. In front the vitreous body is slightly hollowed, and receives the lens with its capsule, to which it is closely united. The *fluid* of the vitreous body has nearly the same composition as the aqueous humour. Enveloping the whole is a thin membrane named hyaloid. **Part of the globe filled by it.** **Composition.**

The *hyaloid membrane* is the fine transparent covering of the vitreous body. It passes continuously over the surface of that mass; and in the fetus it is connected with fibres that penetrate the vitreous body. On the inner aspect are a few delicate nuclei. **Hyaloid membrane.** **Connections:**

At the fore part it is closely united with the membrane supporting the lens (fig. 130, [a]), and ends by joining the back of the capsule of the lens. At the bottom of the eyeball, opposite the optic nerve, the membrane is closely connected to the parts around. **in front** **and behind.**

How nourished. This membrane and the vitreous mass are extra-vascular, and receive their nutritive material from the vessels of the ciliary processes and retina.

Suspensory ligament. *Suspensory ligament of the lens* (Retzius). This is a transparent membranous structure (fig. 130, [5]), placed around the lens at Extent: the front of the hyaloid membrane, and between the anterior termination (ora serrata) of the retina and the lens capsule. After the ciliary processes of the choroid coat are detached from is marked by folds called ciliary processes. it, dark lines of pigment cover the surface; and when these are washed away plaits or folds, *ciliary processes,* come into view, which resemble the processes of the choroid coat, but are less prominent and longer, and do not quite reach the lens capsule internally. The two sets of folds are dovetailed together, the prominences of one membrane being received into hollows on Nature and use. the other; and thus the ligament gains a fixed point for supporting the lens. In this membrane are stiff longitudinal and elastic fibres.

Canal of Petit. *Canal of Petit.* Around the margin of the lens capsule is a small canal (fig. 130, [6]) about one tenth of an inch across, which Situation. has received the above name. It is situate between the suspensory ligament and the front of the hyaloid membrane—being an interval of separation between the two. Anterior part sacculated. When the canal has been opened and distended with air, it is sacculated at regular intervals, like the large intestine, in consequence of the inflation of the plaits of the anterior boundary. The margin of the capsule of the lens projects into the space.

Lens of the eyeball. CRYSTALLINE LENS AND ITS CAPSULE. The crystalline lens is situate behind the pupil of the eye (fig. 130, L), and acts in bringing to a focus on the retina the rays of light passing through that aperture.

Capsule of the lens. The *capsule* is a firm and very elastic transparent case, which is permeable to fluid, and closely surrounds the lens. It is Situation and connections. seated in a hollow on the front of the vitreous body. The anterior part projects towards the iris and the pupil; whilst the posterior is received in the vitreous body, to which it is inseparably united. The circumference of the case corresponds with the canal of Petit.

Its anterior part is firm and transparent, Its anterior surface (fig. 130, [7]) is free, and touches the iris near the pupil, but is separated from it by a slight space (posterior chamber) at the outer part; it gives attachment towards its circumference ($\frac{1}{16}$th of an inch) to the suspensory ligament.

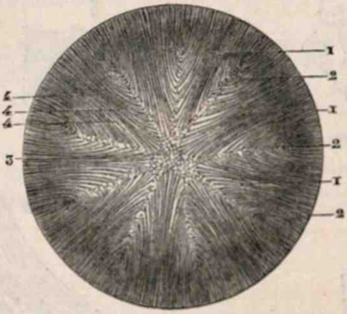
and very thick. The anterior part of the capsule is four or five times thicker than the posterior, as far outwards as to the attachment of the suspensory ligament, and supports itself after the removal of the lens; it is firm and quite transparent, being structureless, and remains clear for some time when immersed in spirit, acids, and boiling water, like the elastic layers of the cornea. The posterior part of the capsule ([8]) is thin and membranous, and decreases in thickness towards the centre: it is joined by the hyaloid membrane of the vitreous body. Posterior thin and fibrous.

In the adult human eye the capsule of the lens is not supplied with bloodvessels. But in the fetus a branch of the central artery of the retina passes through the vitreous body to supply it: and some offsets in front join the vessels of the membrane of the pupil and iris. Vessels to it.

Dissection. The lens will be obtained by cutting across the thin membranous capsule in which it is inclosed. Open capsule of lens.

The lens. When the lens is removed from its capsule, it is a solid and transparent doubly convex body; but the curves are unequal on the two surfaces, the posterior being greater than the anterior. Surfaces are curved unequally; Its margin is somewhat rounded. Its measurement from side to side is one third of an inch, and from before back about one fourth of an inch. dimensions: The density increases from the circumference to the centre; for whilst the superficial part may be rubbed off easily with the finger, the deeper portion is hard and firm, and is named the *nucleus*. density.

Fig. 137.*



On each surface are three lines diverging from the centre, and reaching towards the margin (fig. 137); they are the edges of planes or septa, and are so situate that those on one side are intermediate in position to those on the other. In the human eye they are not distinctly seen, because they bifurcate repeatedly as they extend outwards. Lines on the surfaces.

Covering the anterior surface of the lens, and connecting it A layer of cells joins

* Planes or septa at the pole of the lens, with the attached fibres.—1. Fibres reaching the centre of the lens between the planes. 2. Fibres joining the extremity of a plane or septum. 4. Fibres uniting with the plane between its extremities.

to the capsule.

with the capsule, is a layer of very transparent nucleated polygonal cells (fig. 138, *a*), which can be recognised only in a fresh eye. After a little time these cells absorb moisture from the aqueous humour, and breaking down form the fluid that has been called *aqua Morgagni* (Bowman); but naturally there is not any fluid between the lens and its capsule.

Lens is laminar.

Structure. After the lens has been hardened by spirit or boiling, it may be demonstrated to consist of a series of layers arranged

Fig. 138.*

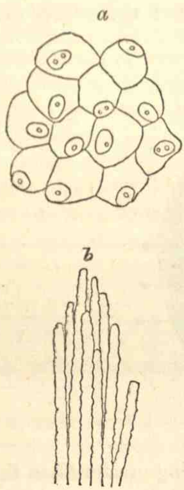
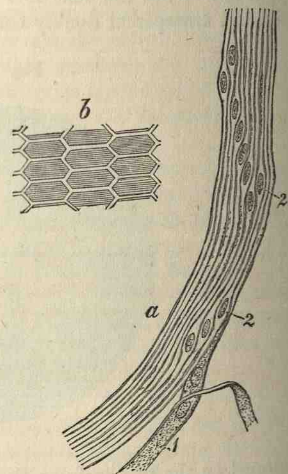


Fig. 139.†



one within another, like those in an onion. Under the microscope each layer may be seen to be constructed of minute parallel fibres. No bloodvessels are found in its texture. It consists mostly of albumen.

Form of the laminæ.

The *laminæ* of each surface have their apices in the centre, where the septa meet, and may be detached from one another at that spot, and turned outwards.

Fibres

The constituent *fibres* of the laminæ are about $\frac{1}{5000}$th of an inch in diameter, solid and rather flat, but most flattened at the margin of the lens; and the deeper fibres are narrowed and less

* Cells and fibres of the lens magnified (Bowman).—*a.* Cells uniting the body of the lens to the capsule. *b.* Lens-fibres with slightly wavy edges.

† Views of the lens fibres after Henle.—*a.* Surface fibres with their nuclei, in the equatorial region of the lens. *b.* Transverse section of the fibres of the surface of the lens, showing their union with others.

distinct. In the superficial fibres are contained granular nuclei (fig. 139, *a*).

The edges are slightly wavy (fig. 138, *b*); and each fibre touches six others (fig. 139, *b*), viz., two on each side, with one above, and another below: contiguous fibres are therefore dove-tailed together, and this interlocking is best seen in the lens of the codfish.

are wavy at the edge, and six-sided,

The extremities are soft and not well defined, and are connected to the partitions on opposite surfaces of the lens in this way:—those that are attached to the pole or the spot where the septa meet on the one aspect, are fixed to the extremity of a septum on the other aspect; and the rest of the fibres passing between two septa are connected at one end nearer to the pole, and at the other end farther from it, with the exception of the middle fibres which are at the same distance from the ends of the septa.

and attached to the septa by their ends.

Changes in the lens with age. Its form is nearly spherical in the fetus; but its convexity decreases with age, particularly on the anterior aspect, until the lens becomes flattened in the adult.

Changes in situation; form of lens,

In the fetus it is reddish in colour, is soft, and is not quite transparent; in mature age it is firm and clear; and in old age it becomes flatter on both surfaces, denser, and of a yellowish colour.

colour, and consistence.

CHAPTER XI.

DISSECTION OF THE EAR.

Constituents. THE organ of hearing is made up of many complex parts, which are lodged in, or are attached to the surface of the temporal bone.

Outline of the elements of the organ of hearing. The fundamental part in this organ, as in the eyeball, is an expansion of a special nerve over a membrane containing fluid. For its protection this structure is enclosed in bone; and it is surrounded by certain accessory bodies which collect, and convey to it the undulations of sound.

Arrangement into two sets. The several parts constituting the auditory apparatus may be arranged into those outside, and those within the substance of the temporal bone.

Outer set. The EXTERNAL SET (outer ear), which may be first examined, include the pinna or auricle, and the auditory canal: the former has been noticed at page 35, and the latter is described below.

Auditory canal. The AUDITORY CANAL (*meatus auditorius externus*) is the passage which leads from the pinna to a cavity in the temporal bone named the tympanum, and transmits inwards sounds.

How to obtain a view of it. *Dissection.* To obtain a view of this canal, a recent temporal bone is to be taken, to which the cartilaginous pinna remains attached. After the soft parts are removed, the squamous part of the bone in front of the Glaserian fissure is to be sawn off; and the fore part of the meatus, except the portion below that gives support to the thin membrana tympani, is to be cut away with a bone forceps.

Length. This *canal* is about one inch and a quarter in length, and is formed partly by bone, and partly by cartilage and membrane. Direction. It is directed forwards somewhat obliquely. Size and shape. In shape it is rather flattened from before backwards; and it is narrowest in the osseous part. The outer extremity is continuous with a hollow (concha) of the external ear, and the inner is closed by the membrana tympani.

Cartilaginous part The *cartilaginous* part is largest. It is about half an inch in length, and is formed chiefly by that portion of the pinna of the outer ear which is attached to the margin of the meatus; is deficient above. but at the upper and posterior aspect the cartilage is deficient, and the tube is closed by fibrous tissue. Two or three fissures (fissures of Santorini) are situate in the piece of cartilage.

Osseous part. The *osseous* part is about three quarters of an inch long in the adult, and is rather constricted about the middle, near which it may be bent, so as to slant outwards and inwards from that point. Outer end; Its outer extremity is dilated, and the posterior projects farther than the anterior wall; the greater part of the margin is rough, and gives attachment to the cartilage of the pinna. inner end. The inner end is less dilated, and is marked in the dry bone, except at the upper part, by a groove for the insertion of the membrane of the tympanum; it is so sloped that the anterior wall juts beyond the posterior by about two lines.

Condition in the fetus. In the fetus the osseous part of the meatus is absent. After birth it grows out of the osseous ring (tympanic bone) which supports the membrana tympani, and joins the rest of the temporal bone.

Lining membrane is derived from the skin. *Lining of the meatus.* A prolongation of the integument lines the auditory passage, and is continued over the membrane of the tympanum in the form of a thin pellicle. At the entrance of the meatus are a few hairs. Ceruminous glands. In the sub-cutaneous tissue of the cartilaginous part of the meatus lie some ceruminous glands of a yellow-brown colour, resembling in form and arrangement the sweat glands of the skin; these secrete the ear wax, and open on the surface by separate orifices: they are most abundant in that portion of the tube which is formed by fibrous tissue.

Vessels. *Vessels and nerves.* The meatus receives its *arteries* from the posterior auricular, the internal maxillary, and the temporal branch of the external carotid trunk. Nerves. Its *nerves* are derived from the auriculo-temporal branch of the fifth nerve, and enter the auditory passage between the bone and the cartilage (p. 97).

Internal set of auditory parts. INNER PARTS OF THE EAR. The internal constituents of the auditory apparatus are enclosed within the temporal bone, and consist of two large spaces, named tympanum and labyrinth, with their accessory parts.

Tympanum. The TYMPANUM, or drum of the ear, is a hollow interposed between the meatus auditorius and the deeper labyrinthic cavity. It communicates with the pharynx by a tube (Eustachian), through which the mucous membrane and the air have access to it; and it is traversed by a chain of small bones, with which special muscles and ligaments are connected. Numerous and minute vessels and nerves are contained in the space.

Dissection. The tympanic cavity is to be opened in a dried and a recent bone.

Open it in the dry bone, On the dry temporal bone, after removing most of the squamous portion by means of a vertical cut of the saw through the root of the zygoma and the Glaserian fissure, the tympanum will be brought into view by cutting away with the bone forceps the anterior part of the meatus auditorius, and the projecting bone above that forms the roof of the cavity.

and in the recent bone.

In the recent bone, in addition to the preparation already made of the meatus auditorius, only the roof of the tympanum should be taken away as far as may be necessary, and without doing injury to the membrana tympani, the chorda tympani nerve, and the chain of bones with its muscles.

Form and dimensions.

Form. The cavity of the tympanum has the form of a slice of a small cork about a quarter of an inch thick, the outer and inner boundaries being flattened and the circumference circular. Its size is greater from point to point of the circumference than across the space, or from without inwards; in the former direction it measures about half an inch, but in the latter not more than a quarter of an inch.

Inner wall is marked by promontory and its grooves.

The *inner boundary* is of greater extent than the outer, and on it the following objects are to be noticed. Occupying nearly the whole surface is the large projection of the *promontory* which becomes pointed posteriorly; it is marked by two or three minute grooves that lodge the nerves forming the anastomosis of Jacobson. Above and below the posterior or narrowed part of the promontory is a large aperture; and both lead into the labyrinthic spaces.

Fenestra ovalis.

The upper opening resembles in shape a segment of a circle, with the convexity placed upwards, and is named *fenestra ovalis:* towards the inner or vestibular cavity (part of the labyrinth) it has a sharp, prominent margin; and into it, in the recent state, the inner bone (stapes) of the osseous chain is fixed. The lower aperture, named *fenestra rotunda*, is rather irregular or triangular in shape, and leads into the cochlea: it is situate within a funnel-shaped hollow, somewhat oval in form on the surface. In the recent state it is closed by a thin membrane, the *secondary membrane* of the tympanum.

Fenestra rotunda.

On outer boundary, membrana tympani and Glasserian fissure.

The *outer boundary* of the cavity is formed by the membrana tympani, and by a small part of the surrounding bone. Above and in front of the membrane, is the *Glaserian* or glenoid fissure, which is occupied in the fresh condition by the long process of one of the small bones (malleus), and by a small muscle, the laxator tympani; and through which pass tympanic vessels. Crossing the membrane towards the upper part is the chorda tympani nerve, which issues through the Glaserian fissure.

Circumference;

The *circumference* of the tympanum is circular, and in some parts is rough and uneven on the surface. Around the edge of the cavity the student may observe the following points in its anatomy.

the roof; and floor.

The roof is wide and flattened, and consists of the thin osseous plate between the cranial and tympanic cavities. The floor is narrow, and is curved over the subjacent jugular fossa; in the dry bone it has more or less of an areolar or honeycomb condition, as well as some small apertures communicating with the fossa beneath.

At the posterior part of the circumference, towards the roof, is one large, together with other small apertures leading into the mastoid cells. Below those apertures, but near the inner wall and on a level with the narrowed part of the promontory, is a small conical projection named the *pyramid:* this is perforated by an aperture, and contains the stapedius muscle. A minute canal connects the hollow in this projection with the aqueduct of Fallopius. Attaching generally the pyramid to the above-mentioned part of the promontory, is a small round spiculum of bone. In a line with the pyramid, and arching upwards from it above the fenestra ovalis, is a bony ridge marking the situation of the aqueduct of Fallopius.

At back, opening of mastoid cells: pyramid: aqueduct of Fallopius.

The front of the tympanic cavity corresponds with the carotid canal, only a thin scale of bone intervening. In it are the apertures of two canals that lie on the outer side of the passage for the carotid artery :—the upper contains the tensor tympani muscle, and the lower is part of the Eustachian tube. Between the two canals is a thin osseous lamina, which is hollowed above and dilated at the inner end, and is named *processus cochleariformis.*

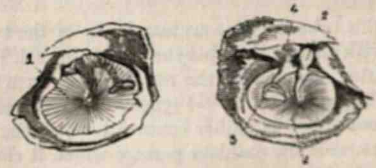
In front canals for tensor tympani and Eustachian tube.

Some parts that have been referred to above, viz. the membrana tympani, the Eustachian tube, and the secondary tympanic membrane, require separate notice.

The *membrana tympani* (fig. 140) is a thin translucent stratum between the meatus auditorius and the cavity of the tympanum.

Membrana tympani;

Fig. 140.*



It is oval in form, and is attached by its circumference to a groove at the inner end of the auditory passage ; but in the fetus it is fitted into a separate osseous ring, the tympanic bone. The membrane is placed very obliquely with respect to the meatus, so that it forms with the floor of that passage an angle

state in the adult and the fetus. Situation;

* Inner and outer views of the membrane and ossicles of the tympanum : the right-hand figure shows the inner surface,—1. Membrana tympani. 2. Malleus. 3. Stapes. 4. Incus bone.

of 45 degrees, and the outer surface is directed downwards. Towards the auditory canal the surface is concave; but in the tympanum it is convex, and attached to its upper half is the handle of the malleus ([2]), one of the tympanic ossicles.

surfaces.

It is formed of a cuticular, epithelial, and fibrous stratum.

Structure. This membrane is formed of three strata,—external, internal, and middle. The outer one is continuous with the integuments of the meatus auditorius; and the inner layer is derived from the mucous membrane of the tympanum. The middle stratum is formed of fibrous tissue, and is fixed to the groove in the bone as before said. From its centre, where it is connected with the handle of the malleus, fibres radiate towards the circumference; and near the margin, at the inner surface, lies a band of stronger circular fibres, which gradually ceases towards the middle.

Eustachian tube has

The *Eustachian tube* is the channel through which the tympanic cavity communicates with the fauces. It is about an inch and a half in length, and is directed downwards and inwards to the pharynx. Like the meatus auditorius, it is partly osseous and partly cartilaginous in texture.

an osseous part; situation and termination.

The *osseous* part is rather more than half an inch in length, and is narrowed at the middle. Its opening in the tympanum, and its situation with respect to the canal for the tensor tympani muscle have been alluded to; its course in the temporal bone is along the angle of union of the squamous and petrous portions, outside the canal of the carotid artery. Externally it ends in a dilated and somewhat oval opening, with the longest measurement in a vertical direction, and with an irregular margin which gives attachment to the special cartilage completing the canal.

Cartilaginous part.

The *cartilaginous* part of the tube is nearly an inch in length, and extends from the temporal bone to the interior of the pharynx (p. 133).

Use of the tube.

Through this tube the mucous membrane of the tympanum is continuous with that of the pharynx; and through it, by reason of its inclination downwards, the mucus passes from that cavity.

Membrane in fenestra rotunda.

The *secondary membrane of the tympanum* is placed within the fenestra rotunda, and is rather concave towards the tympanum, but convex towards the cochlear passage which it closes.

Construction of three layers.

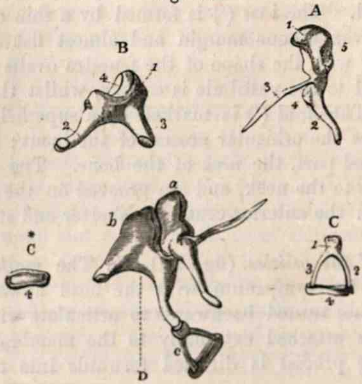
It is formed of three strata, like the membrane on the opposite side of the tympanum, viz. an external or mucous, derived from the lining of the tympanum; an internal or serous, continuous with that clothing the cochlea; and a central layer of fibrous tissue.

Ossicles of the tympanum are three.

Ossicles of the Tympanum. These are three in number, and are placed in a line across the tympanic cavity. The outer one is named malleus from its resemblance to a mallet; the next, incus, from its similitude to an anvil; and the last, stapes, from its likeness to a stirrup. For the examination of these little bones the student should be provided with some ossicles, besides those that are in position in the cavity.

The *malleus* (fig. 141, A) is the longest bone, and is twisted and bent. It is large at one end (head) and small and pointed at the other (handle); and it has two processes with a narrowed part or neck. The *head* or capitulum (1) is free in the cavity, is oval in shape, and is smooth except at the back, where there **Malleus has** **head,**

Fig. 141.*



is a depression (5) for articulation with the next bone. The *neck* is the slightly twisted part between the head and the processes. The *handle* or manubrium (2) decreases in size towards the tip, and is flattened from before backwards, except at the extremity where it is compressed from within outwards: to its outer margin the membrana tympani is connected. **neck,** **handle.**

The *processes* of the bone are two in number, long and short. The *short* one (4) springs from the root of the handle on the outer side, and is connected with the membrane of the tympanum. The *long* process—processus gracilis (3), is a flattened slender piece of bone, which is connected with the neck of the malleus at the anterior aspect, and extends into the Glaserian fissure: in the adult this process is joined with the surrounding bone, and cannot be separated from it. **Short and long process.**

The *incus* is a flattened bone (fig. 141, B), and consists of a **ncus,**

* Ossicles of the tympanum separate and united.—A. Malleus: 1. Head. 2. Handle. 3. Long process. 4. Short process. 5. Articular surface. B. Incus: 1. Head. 2. Long process. 3. Short process. 4. Articular surface. C. Stapes: 1. Head. 2. Posterior crus. 3. Anterior crus. 4. The base. C*. View of the end of the stapes. D. The three ossicles articulated together.

its body; body and two processes. The *body* is hollowed at the upper and anterior part (4) to articulate with the malleus. The two *processes* (long and short) extend from the side opposite to the articulation :—The shorter process (3) is somewhat conical, and is received into the large aperture of the mastoid cells: the long process (2) decreases towards the extremity, where it curves and ends in a rounded and convex point, the *orbicular* process.

processes; short and long.

Stapes; The *stapes* (fig. 141, C) has a base or wider part, and two sides or crura like a stirrup that are blended at the opposite end in a head. The *base* (4) is formed by a thin osseous plate, which is convex at one margin and almost flat at the other, corresponding with the shape of the fenestra ovalis: the surface that is turned to the vestibule is convex, whilst the opposite is excavated. The *head* (1) is marked by a superficial depression which receives the orbicular process of the incus; and below it is a constricted part, the *neck* of the bone. The *crura* extend from the base to the neck, and are grooved on the inner surface like the base: the anterior crus (3) is shorter and straighter than the other.

base; head; crura.

Position of the malleus, *Position of the ossicles* (fig. 141, D). The *malleus* is placed vertically in the tympanum, with the head upwards, and the articular surface turned backwards to articulate with the incus. Its handle is attached externally to the membrana tympani; and its long process is directed forwards into the Glaserian fissure.

of the incus, The *incus* is so placed that the long process is vertical, and the short one horizontal. Externally it is united with the malleus, and its processes are thus disposed :—the short one is received into the large aperture of the mastoid cells; and the long process descends, like the handle of the malleus, but rather posterior to it and nearer the inner wall of the cavity, to join inferiorly with the stapes.

and of the stapes. The *stirrup* bone has a horizontal position, with the crura directed forwards and backwards: its base is fixed over the fenestra ovalis, and its head is united with the long process of the incus.

The bones have two sets of ligaments; *Ligaments of the ossicles.* The small bones of the tympanic cavity are united into one chain by joints, and are further kept in position by ligaments that fix them to the surrounding wall.

either to join one to another by joints, *Joints of the bones.* The ossicles are connected together at the points where they touch by articulations corresponding with the joints of larger bones; for the osseous surfaces are covered with cartilage, are surrounded by a capsular ligament of fibrous tissue, and are lubricated by a synovial sac. One articulation of the nature above described exists between the heads of the malleus and incus, and a second between the extremity of the long process of the incus and the head of the stapes.

Union of the bones to the wall. The bones are kept in place by the reflection of the mucous membrane, and by special ligaments. From the head of the malleus a short suspensory band of fibres is directed upwards to the roof of the tympanum. Another ligamentous band passes backwards from the incus, near the end of its short process, to the posterior part of the containing cavity. And the base of the stapes is connected to the margin of the fenestra ovalis by fibres that constitute an orbicular ligament. or to fix them to the tympanic wall.

In the recent bone the thin mucous membrane closes the interval between the crura of the stapes, and is attached to the groove on their inner aspect. Membrane of stapes.

Muscles of the ossicles. Three muscles which possess transversely striated fibres are connected with the chain of bones; two of these are attached to the malleus, the other to the stapes. Three muscles to the ossicles.

The *tensor tympani* (internal muscle of the malleus) is contained in a special bony canal, which must be laid open to see it completely. It is the largest and most distinct of the muscles of the tympanum, and takes the shape of the containing tube. Tensor tympani lies in a bony canal. The muscle *arises* from the surface of its bony canal, also slightly in front from the cartilage of the Eustachian tube. Origin. Posteriorly it ends in a tendon which, contained in a sheath, is reflected over the end of the cochleariform process as over a pulley, and is *inserted* into the inner border of the handle of the malleus, near its base. Insertion into malleus.

Action. As the muscle draws inwards the handle of the malleus towards the inner wall of the tympanic cavity it makes more convex or tightens the membrane of the tympanum; and Use, on membrana tympani, as the long process of the incus moves inwards with the malleus the base of the stapes will be pressed into the fenestra ovalis, and an impulse will be made on the fluid in the labyrinth. and fluid of labyrinth. On the cessation of the contraction of the tensor, and the restoration of the bony chain to its state of rest by the laxator tympani, the stapes bone will be lifted from the fenestra.

Laxator tympani (external muscle of the malleus). Laxator tympani. It is connected externally with the spinous process of the sphenoid bone; Origin. and its tendon, passing through the Glaserian fissure, is attached to the neck of the malleus above the processus gracilis. Insertion.

Action. The muscle draws inwards and forwards the upper part of the malleus, and tilts outwards the lower part or handle, so as to relax the membrana tympani. Use on tympanic membrane.

The *stapedius* is lodged in the canal hollowed in the interior of the pyramid. Stapedius is in the pyramid Arising from the circumference of the tube, the muscle ends superiorly in a small tendon: this issues from the pyramid, and, encased in a sheath, is *inserted* into the neck of the stapes at the posterior part. attached to stapes.

Action. By directing the neck of the stapes backwards the Use.

muscle raises the fore part of the base out of, and depresses the hinder part towards the fenestra ovalis, diminishing the pressure on the fluid in the vestibule; and supposing it to contract simultaneously with the tensor, it would prevent the sudden jar of the stapes on that fluid.

Lining of tympanum. *Mucous membrane of the tympanum.* The mucous lining of the tympanic cavity adheres closely to the wall, and is continuous with that of the pharynx through the Eustachian tube.

Arrangement in cavity. It assists to form part of the membrana tympani, and of the secondary membrane in the fenestra rotunda, and is continued moreover into the mastoid cells through the apertures leading into them; it is reflected also over the chain of bones and the muscles, ligaments, and chorda tympani nerve. In the tympanum the membrane is thin and not very vascular, and secretes a watery fluid; but in the Eustachian tube it is thick and more vascular, is provided with numerous glands, and its epithelium is laminated and ciliated.

In Eustachian tube.

Epithelium. Its surface is covered with a ciliated *epithelium*, but the cilia are said (Kölliker) to be wanting on the membrana tympani.

Arteries are branches of carotid. BLOODVESSELS. The *arteries* of the tympanum are furnished from the following branches of the external carotid, viz., internal maxillary, posterior auricular, ascending pharyngeal; and some offsets come also from the internal carotid in the temporal bone.

Veins. The *veins* join the middle meningeal and pharyngeal branches.

From internal maxillary. The internal maxillary artery supplies a *tympanic branch* (inferior), which enters the cavity through the Glaserian fissure, and distributes a branch to the membrane of the tympanum.

Posterior auricular. The stylo-mastoid branch of the posterior auricular artery, entering the lower end of the aqueduct of Fallopius, gives twigs to the back of the cavity, and the mastoid cells. One of this set, *superior tympanic*, anastomoses with the tympanic branch of the internal maxillary artery, and forms a circle around the membrana tympani, from which offsets are directed inwards.

Inferior palatine. Other branches from the ascending pharyngeal, or from the inferior palatine artery, enter the fore part of the space along the Eustachian tube.

Nerves from several sources. NERVES. The lining membrane of the tympanum is supplied from the plexus (tympanic) between Jacobson's and the sympathetic nerve: but the muscles derive their nerves from other sources. Crossing the cavity is the chorda tympani branch of the facial nerve.

Dissection to prepare the nerves *Dissection.* The preparation of the tympanic plexus will require a separate fresh temporal bone, which has been softened in diluted hydrochloric acid, and in which the nerves have been hardened in spirit.

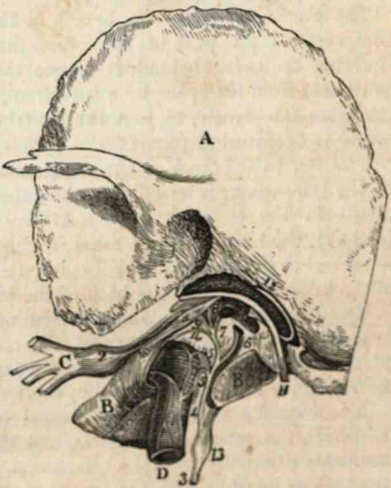
before entering, The origin of Jacobson's nerve from the glosso-pharyngeal is first to be sought close to the skull (p. 113); and the fine auricular branch of the pneumo-gastric is to be looked for at the same time.

Supposing the nerve to be found, the student should place the scalpel on the outer side of the Eustachian tube, and carry it backwards through the vaginal and styloid processes of the temporal bone, so as to take away the outer part of the tympanum, but without opening the lower end of the aqueduct of Fallopius, lest the facial nerve should be injured. After the tympanum has been laid open, Jacobson's nerve is to be followed in its canal; and the branches that lie in the grooves on the surface of the promontory are to be pursued—one of these arching forwards and two coursing upwards. and in the tympanic cavity.

The connections of the chorda tympani nerve can be seen on the preparation used for the muscles.

The *tympanic branch* of the glosso-pharyngeal nerve (nerve of Jacobson (fig. 142,[4]) enters a special aperture in the temporal bone, and is conducted by it to the inner wall of the tympanum. In this cavity the nerve supplies filaments to the lining membrane and the fenestra rotunda; and it terminates in the three undermentioned branches, which are contained in grooves on the promontory, and connect this nerve with others.* Tympanic nerve supplies membrane and other branches viz.:

Fig. 142.†



Branches. One branch ([5]) is arched forwards and downwards, and enters the carotid canal to communicate with the sympathetic on the artery (p. 122). One to the sympathetic.

* Instead of viewing these filaments as offsets of the nerve of Jacobson, it may be supposed that they are branches derived from the other nerves to which they are united. According to this view the *tympanic plexus* would be derived from many sources.

† A drawing of the tympanic nerve (Breschet).—C. Lower maxillary nerve. D. Internal carotid artery. *a.* Tensor tympani muscle. 1. Carotid plexus. 2. Otic ganglion. 3. Glosso-pharyngeal nerve. 4. Tympanic nerve. 5. Branches to carotid plexus. 6. Branch to fenestra rotunda. 7. Branch to fenestra ovalis. 8. Branch to join the large superficial petrosal

Another to petrosal nerve.

A second ([8]) is directed upwards to join the large superficial petrosal nerve in the hiatus Fallopii (p. 150).

And a third to otic ganglion:

And the third filament ([9]) has the following course to reach the otic ganglion :—It ascends towards the upper surface of the petrous part of the temporal bone, passing in front of the fenestra ovalis but beneath the canal for the tensor tympani muscle, and near the gangliform enlargement on the facial nerve, to which it is connected by filaments (p. 153).

this called small petrosal.

Beyond the union with the facial, the nerve is named *small superficial petrosal*, and is continued forwards external to the hiatus Fallopii, but without appearing on the surface of the temporal bone, until it issues from the skull to end in the otic ganglion (p. 154).

Nerves for the muscles.

Nerves to muscles. The tensor tympani muscle is supplied by a branch from the otic ganglion (fig. 142, [10]) : the stapedius receives an offset from the facial trunk ; and the laxator tympani from the chorda tympani nerve (?).

Chorda tympani crosses cavity.

The *chorda tympani* is a branch of the facial nerve, and is now seen in the part of its course through the tympanum. Entering the cavity behind, it crosses the membrana tympani, and issues from the space by a special aperture in or internal to the Glaserian fissure, to join the gustatory nerve. Its farther course is described at page 105.

Branch of vagus to the outer ear.

The *auricular branch* of the vagus nerve, though not a nerve of the tympanum, is an offset to the outer ear, and may be now traced in the softened bone. Arising in the jugular fossa (p. 117), the nerve enters a canal, which conducts it across the lower end of the aqueduct of Fallopius, and through the substance of the temporal bone to the back of the pinna of the ear.

Labyrinth formed of osseous and membranous parts.

THE LABYRINTH. The inner portion of the organ of hearing is so named from its complexness. It consists of dense osseous parts ; and of membranous sacs for the expansion of the auditory nerve, which are contained within the former.

Constituents of the osseous part.

The OSSEOUS LABYRINTH is formed of three parts, viz., the vestibule, the semicircular canals, and the cochlea : these communicate externally with the tympanum, and internally through the meatus internus with the cranial cavity.

Vestibule.

The VESTIBULE is the central cavity of the osseous labyrinth, and is placed behind the cochlea but in front of the semicircular canals.

Dissection to see it.

Dissection. This space may be seen on the dry bone that has been used for the preparation of the tympanum. The bone is to be sawn through vertically close to the inner wall of the

nerve. 9. Small superficial petrosal nerve. 10. Nerve to tensor tympani muscle. 11. Facial nerve. 12. Chorda tympani. 13. Petrous ganglion of glosso-pharyngeal. 14. Branch to the membrane lining the Eustachian tube.

tympanum, so as to lay bare this wall and the fenestra ovalis leading into the vestibule. In this section one of the semicircular canals (horizontal) may be laid open just above the fenestra ovalis. By enlarging the fenestra ovalis a very little in a direction upwards and forwards, the end of the superior semicircular canal and the vestibular space will appear.

Other views of the cavity may be obtained by sections of temporal bones in different directions, according to the skill and knowledge of the dissector.

Form and dimensions.

The *vestibular space* is somewhat oval in form (fig. 145), the extremities of the oval being placed forwards and backwards, and the under part or floor is more narrowed than the upper part or roof. It measures about $\frac{1}{5}$th of an inch in different directions, but it is narrowest from without inwards. The following objects are to be noted on the boundaries of the space.

Apertures before and behind.

In front, close to the outer wall, is a large aperture leading into the cochlea; and behind are five round openings of the three semicircular canals.

In outer wall.

The outer wall corresponds with the tympanic cavity, and in it is the aperture of the fenestra ovalis.

Crest on inner wall; fossa in front of it; and aqueduct behind.

On the inner wall, nearer the front than the back of the cavity, is a vertical ridge or *crista*. In front of the ridge is a small circular depression, *fovea hemispherica*, which presents anteriorly some minute apertures for nerves, and corresponds with the bottom of the meatus auditorius internus. Behind the crest of bone, near the common opening of two of the semicircular canals, is the small aperture of the aqueduct of the vestibule, which ends on the posterior surface of the petrous portion of the temporal bone.

Roof has a fossa.

On the roof is a slight transversely oval depression, *fovea semi-elliptica;* this is separated from the fovea hemispherica by a prolongation of the crista before mentioned on the inner wall.

Three canals;

The SEMICIRCULAR CANALS (fig. 145) are three osseous tubes, which are situate behind the vestibule, and are named from their form.

preparation of them.

Dissection. These small canals will be easily brought into view by the removal of the surrounding bone by means of a file or some cutting instrument. Two may be seen opening near the aperture made in the vestibule, and may be followed thence; but the third is altogether towards the posterior aspect of the petrous portion of the temporal bone.

Length. Termination by five openings. One end dilated.

The *canals* are unequal in length, but each forms more than half an ellipse. They communicate at each end with the vestibule, and the contiguous ends of two are blended together so as to give but five openings into that cavity. Each is marked by one dilated extremity which is called the *ampulla.* When a

Form and size.

tube is cut across it is not circular, but compressed laterally, and measures about $\frac{1}{20}$th of an inch, though in the ampulla the size is as large again.

They are named

From a difference in the direction of the tubes, they have been named superior, and posterior vertical, and horizontal.

superior vertical,

The *superior* vertical canal (4) crosses the upper border of the petrous part of the temporal bone, and forms a projection on the surface. Its extremities are more distant than in the other tubes: its outer end is marked by the ampulla (8), whilst the inner is joined with the following.

posterior vertical,

The *posterior* vertical tube (2) is directed backwards from its junction with the preceding towards the posterior surface of the temporal bone; the upper end is united with the superior vertical canal in a common tube (fig. 145, 7), and the lower end is free and dilated (10).

and horizontal

The *horizontal* canal (3) has separate apertures, and is the shortest of the three. Deeper in position than the superior vertical, it lies in the substance of the bone nearly on a level with the fenestra ovalis; its dilated end (9) is at the outer side close above that aperture.

Cochlea.

COCHLEA. This part of the osseous labyrinth has a position anterior to the vestibule, and has received its name from its resemblance to a spiral shell.

Dissection for it in dry

Dissection. To obtain a view of the cochlea in the dried bone it will be needful to cut or file away gradually, on the preparation before used for displaying the vestibule, the bone between the promontory of the tympanum and the meatus auditorius internus; or this section may be made on another piece of bone in which the semicircular canals are not laid bare. To dissect the same parts in the recent state, a softened bone should be used.

and recent bone.

Form and situation.

The *cochlea* is conical in form, and is placed almost horizontally in front of the vestibular space. The base of this body is turned to the meatus auditorius internus, and is perforated by small apertures; whilst the apex is directed to the upper and anterior part of the inner wall of the tympanum, opposite the canal for the tensor tympani muscle. Its length is about a quarter of an inch, and its width at the base is about the same. Resembling a shell in construction, the cochlea consists of a tube wound spirally round a central part or axis; but it differs from a shell by reason of the subdivision of the tube into two by a partition, and the greater thickness of the central part or axis.

Size.

Resembles a snail-shell in some respects.

Parts of the cochléa.

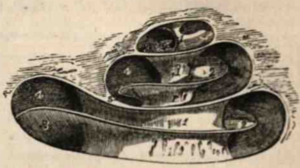
In the description of the cochlea, it will be necessary to notice separately the axis or centre, and the spiral tube with its partition and passages.

A central pillar or axis;

The *axis* or *modiolus* (columella) is the central stem which supports the windings of the spiral tube. Conical in shape, its size diminishes rapidly towards the last half turn of the spiral tube, where it is very thin though not porous. From that spot it is continued onwards to the tip of the cochlea, enlarging towards its extremity and forming a second cone: this last part is bent, and presents a free margin.*

is conical;

Fig. 143.†



and porous.

The axis is perforated by canals as far as the contracted part in the last half turn; these transmit vessels and nerves in the fresh state, and the central one is larger than the others.

Around it projects a piece of bone.

Winding around the axis is a thin osseous plate, the *lamina spiralis*, which projects a certain distance into the spiral tube, and constructs part of the septum.

A spiral tube closed at one end forms 2½ turns;

The *spiral tube* forms two turns and a half around the axis, and terminates above in a closed extremity named the *cupola*. When measured along the outer side, the tube is about one inch and a half long. Its diameter at the beginning is about one tenth of an inch, but it diminishes gradually to half that size towards the opposite end.

measurement: coils.

Of the coils that the tube makes, the first is much the largest; this projects at its commencement into the tympanum, and gives rise to the eminence of the promontory on the inner wall of that cavity. The second coil is included within the first. The last half turn bends sharply round, and presents a free semilunar margin (the edge of the axis) at one side.

Tube divided into two.

In the recent bone the tube is divided into two main passages (scalæ) by the septum. In the dry bone a remnant of this partition is seen in the form of a thin plate of bone, the lamina spiralis, projecting from the axis; and on the outer wall, opposite this ridge of bone, is a slight groove.

Septum bony and membranous.

Septum of the spiral tube. The partition dividing the tube of the cochlea into two large passages in the recent bone, consists of an osseous and a membranous portion (fig. 144).

Osseous part;

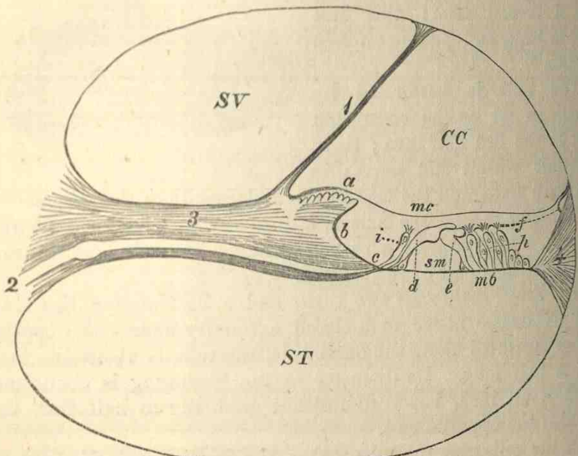
The *osseous* part ([2]), which is formed by the lamina spiralis, extends about half way across the tube. Inferiorly it begins in the vestibule, where it is wide, and is attached to the outer wall

* Some Anatomists apply the term *infundibulum* to the appearance which this bent part of the modiolus (? top of the cochlear tube) presents when it is looked at from the second turn of the cochlea. Others understand by the term the funnel-shaped space enclosed in the terminal half bend of the tube of the cochlea.

† The cochlea laid open to show the two turns and a half of the tube, with its scalæ (Arnold).—1. Axis or modiolus of the cochlea. 2. Osseous part (lamina spiralis) of the septum. 3. Scala tympani. 4. Scala vestibuli.

so as to shut out the fenestra rotunda from that cavity; and diminishing in size ends above in a free point, named the

Fig. 144.*



ends above in a point

over an aperture, through which the scalæ join.

hamulus, in the last half turn of the cochlea. Between the hamulus and the axis is a space which, in the recent state, is converted by the membranous part of the septum into a foramen (hiatus, helico-trema), and allows the intercommunication of the two chief passages of the cochlear tube.

Lamina spiralis.

The *lamina spiralis* is formed by two plates of bone, which enclose canals for vessels and nerves, and are separated from each other farthest at the modiolus.

differs on two surfaces;

The surface of the spiral lamina which is turned to the lower of the two cochlear passages (ST) is most pierced by apertures for vessels. The opposite surface is covered in the outer fifth of its extent by a structure resembling cartilage (*a*), which ends

* A diagram of a vertical section of the tube of the cochlea enlarged and modified from Henle. SV. Scala vestibuli. ST. Scala tympani. CC. Canal of the cochlea.

1. Membrane of Reissner. 2. Cochlear branch of the auditory nerve. 3. Lamina spiralis ossea. 4. Ligamentum spirale. Between 3 and 4 is the lamina spiralis membranacea.

a. Lamina denticulata. *b*. Sulcus spiralis. *c*. Tympani lip of the sulcus spiralis. *d*. Inner rods of Corti. *e*. Outer rods of Corti. *f*. Lamina reticularis. *i*. Cells of Claudius. *m b*. Membrana basilaris. *m c*. Membrane of Corti. *p*. Pedunculated cells of Corti, and fusiform cells of Deiters. *s m*. Space between the rods (scala media).

in wedge-shaped teeth near the margin of the bony plate, and has been named *denticulate lamina* (Bowman). denticulate structure.

Between the teeth and the underlying bone is a channel (*b*), lined by flat particles like epithelium (Bowman), which is called *sulcus spiralis:* its edges give attachment to membranes, and are named vestibular (*a*) and tympanic (*c*). Sulcus spiralis.

The *membranous* part (membrana basilaris, fig. 144, *m b*) reaches from the lower edge of the lamina spiralis to the groove in the outer wall of the cochlear tube. Its width varies. Near the base of the cochlea it forms half of the partition across the tube, but at the apex where the bony part is wanting, it constructs the septum altogether. Membranous part. Width and extent.

This membrane has an appearance like the elastic layers of the cornea. Close to the lamina spiralis it is homogeneous in texture, but farther out it possesses fine radiating lines, which cause it to split in shreds in the same direction. Is glassy looking, with transverse lines:

Near its outer attachment there is a gelatinous looking tissue (cochlearis muscle, Bowman; ligamentum spirale, Kölliker), which fixes it to the bone. Spiral ligament.

Two other thin membranes, prolonged to the outer wall from the osseous part of the partition, subdivide into three the upper of the two cochlear scalæ (fig. 144). One is called membrane of Reissner, and the other membrane of Corti. Subdivisions of the tube

The *membrane of Reissner* (memb. vestibularis ([1])), easily torn, is attached to the laminæ spiralis close to the denticulate lamina, and passes upwards and outwards to the part of the tube turned away from the axis of the cochlea: it is said to have a layer of epithelium on each side. It intervenes between the scala vestibuli (SV) and the canal of the cochlea (CC). by membrane of Reissner,

The *membrane of Corti* (membrana tectoria, fig. 144, *mc*) stretches horizontally across the tube of the cochlea near and parallel to the membrana basilaris. Internally it is attached to the upper lip of the sulcus spiralis and to the denticulate lamina; and externally to the wall of the cochlear tube. It is an elastic special, transversely fibred layer, which is thicker internally than externally. Between it and the membrana basilaris (*mb*) is a third narrow channel for the reception of the organ of Corti. and membrane of Corti.

Scalæ of the cochlea. The tube of the cochlea is divided by its septum into two passages or scalæ of equal size, of which one is the scala tympani (fig. 144, ST) and the other scala vestibuli (SV); but the latter is rendered much the smallest by two canals being cut off from it by membranes as before said. Scalæ of the cochlear tube.

The two larger scalæ are placed one above another, the scala vestibuli being nearest the apex of the cochlea, as they wind from base to apex of that body. Position. Extent.

Above they communicate through the aperture named helicotrema. Below they end differently, as the names express: the Join above, separate below.

scala vestibuli opens into the front of the vestibule; the scala tympani is shut out from the vestibular cavity by the septum cochleæ, and is closed below by the membrane of the fenestra rotunda.

They differ in extent, and size. Each has certain peculiarities; thus the vestibular scala extends to the apex of the cochlea; whilst the tympanic scala ([3]) is largest near the base. Connected with the last is the small *aqueduct of the cochlea*, which begins close to a ridge or crest near the lower end of the scala, and ceases at the lower border of the petrous portion of the temporal bone.

Opening in lower.

Small spaces of cochlea. *Smaller passages of the cochlea.* These are two in number, viz., canal of the cochlea (fig. 144, CC), and a central passage beneath it, which lodges the organ of Corti.

Duct of the cochlea, boundaries. The *canal* or *duct* of the *cochlea* (CC) is a narrow passage towards the outer part of the cochlear tube, which is separated from the scala vestibuli by the membrane of Reissner ([1]), and from the space containing the organ of Corti by the membrane of Corti (*mc*). Extent. It extends from apex to base of the cochlea like the larger scalæ, and contains a fluid (endolymph).

Closed above, joined by duct below. Above it is closed, and reaches into the cupola. Below it ends also in a closed point near the cavity of the vestibule; but near this it is joined by a very small tube (canalis reuniens, Hensen), which unites it with the cavity of the saccule in the vestibule.

Small central space, boundaries. The *central passage* is a narrow interval corresponding in depth with the sulcus spiralis, and is placed between the membrane of Corti (*mc*) and the membrana basilaris (*mb*). It contains the rods and cells constituting the organ of Corti.

Organ of Corti. The *organ of Corti* occupies the middle passage of the cochlear tube, and consists of rods and cells placed vertically on each side of a median space (*sm*).

Two rows of rods, position, and characters. The *rods* are firm peculiar bodies, which are arranged in two rows (fig. 144, *d* and *e*) over an intervening triangular space: they slant towards each other above, and are separated below like the rafters in a roof. Where they touch above they are flattened and directed out, the inner (*d*) overlapping the outer (*e*); and where they rest on the membrana basilaris each is provided with a nucleus-like body.

In the inner row they are most numerous; and in the outer they are narrow and rounded, and are bulged below.

Cells in organ of Corti. The *cells of the organ of Corti* are arranged vertically on the side of the rods; one end rests on the membrana basilaris, and the other directed upwards, is provided with stiff filaments or cilia.

Inner set. The inner set (cells of Claudius, (*i*)) stand in a single line between the sulcus spiralis and the inner row of rods.

Outer set: two kinds. The outer set (pedunculated cells of Corti, fig. 144, *p*) are set one before another three deep outside the external row of rods, and the filaments at the upper end project through apertures in the layer (f) above them. Cells of Corti,

Between the rows of the outer set of cells are interposed the spindle-shaped cells of Deiters, with their pointed ends directed up and down, like the others. and of Deiters.

In the cells in the organ of Corti the filaments of the branches of the auditory nerve in the cochlea are thought to terminate. Supposed use.

Membrana reticularis (f) (Kölliker). From the line of contact of the upper ends of the rods a very thin layer of flattened particles is continued over the outer half of the organ of Corti towards the wall of the cochlear tube. Where it lies over the cells of Corti it is said to have apertures, through which pass the filaments at the end of those cells. Its use is supposed to be to fix and keep in place the rods, and the cells of the outer half of the organ of Corti. Membrana reticularis.

An epithelial layer covers the floor of the middle passage of the cochlear tube outside the organ of Corti. Epithelium.

Lining membrane of the osseous labyrinth. A thin fibrous membrane lines the vestibule, the semicircular canals, and the scalæ of the cochlea, and is likewise continuous with fibrous processes in the aqueducts of the vestibule and cochlea.* On the outer wall of the vestibule it stretches over the fenestra ovalis; and in the scala tympani it assists in closing the fenestra rotunda opening into the tympanic cavity. Fibro-serous membrane lines the labyrinth;

Fig. 145.†

The outer surface of the membrane is adherent to the bone; but the inner is covered by a single layer of epithelium, with polygonal nucleated cells like that on serous membranes, and secretes a thin serous fluid, *liquor Cotunnii*, or *perilymph.* This fluid in the interior fills the two large scalæ of the cochlea, sur- has an epithelium and contains a fluid.

* This membrane is considered by M. Breschet to be originally part of the fibro-serous lining of the skull. He supposes that the membrane has been gradually enclosed by bone, until the connection between it and the parent structure has been obliterated, except by means of the processes in the aqueducts.—*Recherches Anatomiques et Physiologiques.*

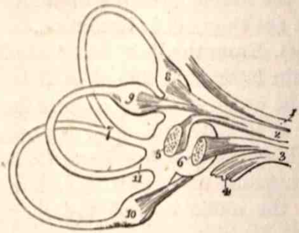
† View of the membranous labyrinth in its bony case (Breschet).—1. Cochlea. 2. Posterior vertical semicircular canal and its membranous tube, of which the ampulla is marked by 10. 3. Horizontal canal, with its contained tube: 9, marks its ampulla. 4. Superior vertical semicircular canal and tube: 8, indicating the ampulla. 5. Utricle or common sinus. 6. Saccule.

rounds the membranous labyrinth, and occupies for a short distance the aqueducts.

Two sacs float in fluid of labyrinth.

The MEMBRANOUS LABYRINTH (fig. 146) is constituted of sacs containing fluid, in which the auditory nerve is expanded. The sacs are two in number, viz., the utricle and the saccule, and have the general form of the surrounding bony parts; they are not found in the cochlea, but are confined to the vestibule and the semicircular canals. Surrounding them is the fluid of the perilymph.

Fig. 146.*



Dissection of them in a fresh bone.

Dissection. The delicate internal parts of the ear, with their vessels and nerves, cannot be dissected except on a temporal bone, which has been put in spirit, and afterwards softened in acid. The previous instructions for the dissection of the osseous labyrinth will guide the student to the situation of the membranous structures within it, but the surrounding softened material must be removed with great care.

A lens and a microscope will be needed for the complete examination of the sacs. For the display of the blood-vessels a minute injection will be necessary.

The utricle.

Situation

and form;

contains a fluid

and otolith.

The *utricle*, or the common sinus (fig. 146, [5]) is the larger of the two sacs, and is situate at the posterior and upper part of the vestibule, opposite the fovea semi-elliptica in the roof. It is transversely oval in form, and connected with it posteriorly are three looped tubes, which are prolonged into the semicircular canals. The sac and its offsets are filled with a clear fluid, like water, which is named *endolymph;* and in the wall of the sac is a small calcareous deposit (otolith) opposite the entrance of the nerve into it.

It sends tubes into the arched canals;

they are dilated

The prolongations into the semicircular canals are smaller than the osseous tubes, being only one third of their diameter; and the interval between the bone and the membrane is filled by the perilymph. In form they resemble the bony cases, for they are marked at one end by a dilatation corresponding with the

* Membranous labyrinth separated from the bone; and the primary branching of the nerve (Breschet).—1. Facial nerve. 2, 3. Vestibular branches; and 4, cochlear branch of the auditory nerve. 5. Utricle. 6. Saccule. 7. Common opening of the tubes of the two vertical semicircular canals. 8. Ampulla of the tube of the superior vertical; 9. Ampulla of the tube of the horizontal; and 10, ampulla of the tube of the posterior vertical semicircular canal: distributed to the last ampulla is the third branch of the auditory nerve. 11. Undilated end of the tube of the horizontal canal.

ampulla of the osseous tube; and, further, two are blended at one end, like the canals they occupy (fig. 146, [7]): they communicate with the utricle by five openings, and are filled with the endolymphic fluid of that sac. At each ampullary enlargement there is a transverse projection into the interior of the cavity, and at that spot a branch of the auditory nerve enters the wall.

at one end, and contain a fluid.

The *saccule* (fig. 146, [6]) is a smaller and a rounder cyst than the utricle, and is placed in front of it in the hollow of the fovea hemispherica. Like the larger sac it has a translucent wall, in which is an otolith opposite the entrance of the nerve; it is also filled by endolymph. It is supposed to be separate from the other. It is continuous below by a short and small duct (ductus reuniens) with the canal of the cochlea (p. 808).

Smaller sac is before the other, joins canal of cochlea.

Structure of the sacs. The wall of the sacs of the membranous labyrinth is translucent and firm; but it is more opaque where the vessels and nerves enter it. Three strata enter into the construction of the wall, together with bloodvessels and nerves.

Wall of the sac has three strata.

The outer covering is loose and flocculent, and easily detached, and contains irregular pigment cells with ramifying bloodvessels. The middle stratum is clear and tough, and seems like the hyaloid membrane of the eyeball: it exhibits however an appearance of fibrillation; and on the addition of acetic acid nuclear-looking bodies become visible. (Todd and Bowman.) And the inner one is formed by a layer of polygonal nucleated cells, which are easily separated from one another.

Outer. Middle. Inner.

The small calcareous masses, or the *otoliths*, consist of minute, elongated, and six sided particles of carbonate of lime, which are pointed at the ends, and are situate in the inner part of the wall of the utricle and saccule. Within the enlargement of each semicircular tube a calcareous material (otolith) is contained in the cells lining it. (Todd and Bowman.)

Otoliths are grains of lime.

BLOODVESSELS. The membranes of the labyrinthic cavity receive their blood from an artery that enters the internal auditory meatus with the nerve; but some offsets enter it behind from the posterior auricular.

Bloodvessels of the membrane.

The *internal auditory* artery arises from the basilar trunk within the skull (p. 192), and enters the internal meatus with the auditory nerve. In the bottom of that hollow it divides into two branches—one for the vestibule, the other for the cochlea.

Internal auditory artery

The *branch* to the *vestibule*, after piercing the wall of the cavity, subdivides into small branches, which ramify over the exterior of the sacs, and the tubes occupying the semicircular canals. The vessels end in a network of capillaries on the exterior as well as in the substance of the special layer, and this is most developed about the termination of the nerves.

has a branch to membranous sacs; termination;

and another to the cochlea.

The *branch* to the *cochlea* subdivides into twigs that enter the canals in the modiolus. Small offsets from these are directed outwards through canals in the lamina spiralis, and communicate together in loops near the margin of that osseous zone.

Mode of termination.

From this anastomosis vessels are supplied to the membrane lining the scalæ, and to the structure called cochlearis muscle; but the septum cochleæ prevents the communication of the vessels of those two passages.

Longitudinal vessel.

A longitudinal vessel is placed on that surface of the membranous part of the septum cochleæ which is turned to the scala tympani: and communicates here and there with the arterial loops before mentioned.

Vein to petrosal sinus.

The *vein*. One branch of vein is derived from the cochlea, and another from the membranous labyrinth: the two are united near the cochlea, and the trunk ends in the superior petrosal sinus in the base of the skull.

Auditory nerve

NERVE OF THE LABYRINTH. Only one special nerve, *auditory* (p. 198), is distributed to the labyrinth. Entering the internal auditory meatus, the nerve divides into two branches, like the artery, viz., an anterior for the cochlea, and a posterior for the membranous labyrinth. In the trunk and in both branches nerve cells are contained: in the nerve to the labyrinth they form a swelling, which was named *intumescentia ganglioformis* by Scarpa.

divides into two.

A cochlear branch,

The *cochlear branch* divides at the base of the modiolus into twigs that enter the apertures in the bone. Then they are directed outwards with the vessels in the canals in the lamina spiralis. As they enter the lamina spiralis they form a plexus with ganglion cells, and are continued onwards near the scala tympani, being still plexiform, as far as the edge of the lamina spiralis. At this spot they leave the bone, and are arranged in conical bundles, which enter apertures in the membrana basilaris, but their ending is unknown.

runs at first in the bone,

and then enters the membrane.

Supposed ending.

Deiters states that he has seen the axis cylinder of the nerve filaments enter the organ of Corti. And Kölliker supposes the ultimate filaments of the nerve to be connected with the spindle shaped cells in the organ of Corti.

Vestibular branch divides into three;

The *vestibular branch* ends in three nerves for the membranous labyrinth: these pierce the cribriform plate in the bottom of the meatus, and are thus distributed:—One appertains to the utricle, and to the enlargements on the tubes contained in the superior vertical and horizontal semicircular canals (fig. 146, [2]); a second ([3]) ends in the saccule; and the third belongs to the ampullary swelling on the tube in the posterior vertical semicircular canal ([10]).

Termination on the sacs,

On the *membranous sacs* the nerve divides, and its filaments separate, some fibrils passing through the otolith and others outside it. In the middle layer of the wall the ultimate filaments spread out, and meeting with the epithelium inside, are said to end in spindle-shaped nucleated corpuscles with fine terminal ends between the cells of epithelium. **probable ending;**

Schulze (F. E.) states that he has once seen a continuation of the nerve filament into hair-like processes on the inner surface of the sacs. **supposed ending.**

In the *ampullary enlargement* of the tubes of the semicircular canals the nerve enters the external or flattened side, where it forms a forked eminence (Steifensand), corresponding with the projection in the interior. The nerve divides at first into two chief parts, which are directed to the sides; but no filaments have been traced into the tube beyond those eminences. **In the tubes they form projections, and, branching, end inside.**

INDEX.

The letter (o) refers to the origin, (c) to the course, and (d) to the distribution of a nerve or vessel that is described in different pages.

THE END.

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