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## **Anatomical regions of the abdomen**

Due to the size of the abdominopelvic cavity, it is separated into regions and quadrants. These divisions are listed below along with illustrations of them in Images 3 and 4. Take time to locate these in the images and be ready for recall in the lesson quiz. Left upper quadrant (LUQ) Right lower quadrant (LUQ) Engion- center-most region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region (belly button) Epigastric region- superior to the umbilical region (belly button) Epigastric region (belly region)-located lateral to the hypogastric region Left lumbar region- lateral to the umbilical region Left lumbar region- lateral to the epigastric region Right hypochondriac region Left lumbar region- lateral to the epigastric region Right lumbar region Right hypochondriac region Right lumbar region- lateral to the epigastric region Right lumbar region- lateral to the umbilical region Right lumbar region- lateral to the epigastric region Right lumbar region specific quadrants and regions each of the following organs of the body are found: stomach - epigastric region and RUQ/LUQ liver - right hypochondriac/epigastric region and region an the 9 abdominopelvic regions in this diagram? -If you were having pain in your LUQ, what organ might be the origin of the pain? -In what region is the bladder located? Depending on the context or clinical situation, there are two different ways that the abdomen can be divided: The "quick and dirty" way is to draw two lines, one down the midline and the other horizontal through the umbilicus. The result is four quadrant, left upper quadrant, right lower quadrant, right lower quadrant, right lower quadrant, and left lower quadrant, right lower q kidney, rt. colic (hepatic) flexure, sup. part of ascending colon, rt. half of transverse colon Left Upper Quadrant lt. lobe of liver, spleen, most of stomach, jejunum and proximal ileum, body and tail of pancreas, lt. suprarenal (adrenal) gland, lt. kidney, lt. colic (splenic) flexure, sup. part of descending colon, lt. half of transverse colon Right Lower Quadrant cecum, appendix, most of ileum, inf. part of ascending colon, rt. ovary, rt. uterine tube, rt. ureter, rt. spermatic cord The other way is to draw four lines. Two are horizontal, one at the lower rib margins and the other passing through the iliac tubercles. The other two are vertical, passing through the middle of each clavicle. The region, left lumbar region, left lumbar region, right inguinal region, hypogastric region, and the left inguinal region. Do not worry about knowing the exact contents of each specific region, although a general idea, along with some clinical information, is given in #7 below. (In Greek, chondros = cartilage, so hypochondriac = under cartilage, so hypochondriac = under cartilage. Epigastric is "upon the stomach", while hypogastric is "upon the stomach". In Latin, inguinalis = groin.) This illustration offers a different view of the ones above: Images from "Anatomy of the Human Body" by Henry Gray are provided by: The rectus sheath is formed by the interweaving of the aponeuroses of the external oblique, and transversus abdominis muscles. It encloses the rectus abdominis and pyramidalis muscles (only present 80% of the time - see below). It is divided into two parts, superior and inferior, by the arcuate line, which is halfway between the pubic crest and the umbilicus. The superior part of the sheath completely surrounds the rectus abdominal oblique and the internal abdominal oblique aponeuroses. The posterior layer (lamina) is composed of fibers from the transversus abdominial oblique aponeurosis and the internal abdominal oblique aponeurosis splits into two parts, one contributing to the anterior and the other contributing to the posterior layers of the sheath.) The inferior part is deficient posterior part is deficient posterior aspect of the rectus abdominis muscle, then, is the thin transversalis fascia. The fibers all meet in the middle and interweave at the linea alba. For more than you ever wanted to know about anatomical variation, the University of Iowa has a great site, an "Illustrated Encyclopedia of Human Anatomic Variation". Here is a quick and dirty link to the section on muscles of the abdominal wall, (including the pyramidalis). The anterior portion and the lateral portion of the abdominal wall are often considered together (anterolateral) because the muscles are functionally similar, and are functionally different than those of the posterior aspect. Lateral: from superficial fascia (Scarpa's fascia), membranous layer of superficial fasci tranversus abdominis muscle, transversalis fascia, extraperitoneum Anterior (supericial fascia, extraperitoneum Anterior layer of superficial fascia, extraperitoneum Anterior layer of superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate line): from superficial fascia, extraperitoneum Anterior (superior to arcuate li abdominis, posterior layer of internal abdominal oblique aponeurosis\*, transversus abdominis abd aponeurosis\*, internal abdominal oblique aponeurosis\*, transversus abdominis aponeurosis\*, rectus abdominal wall Spermatic cord/testes covering skin scrotum superficial fascia scrotum/ dartos fascia&muscle external abdominal oblique aponeurosis external spermatic fascia internal abdominal oblique muscle cremasteric f descriptions in both Woodburne&Burkel and Moore can be a bit confusing. Here is the basic gist (see also #5 below): Male: testes begin as retroperitoneal structures in the posterior abdominal wall. They are attached to the anterolateral abdominal wall by the gubernaculum. As the gubernaculum "pulls" the testes into the pelvis and developing inguinal canal, it is preceded by the processus vaginalis, derived from the peritoneum which lies anterior to the testes. The processus vaginalis "pushes" the muscle and fascia layers, which will eventually make up the canal and spermatic cord, into the scrotum. After the testes are in position in the scrotum, the gubernaculum persists as the scrotal ligament, while part of the processus vaginalis remains as a bursa-like sac called the tunica vaginalis testis. (Latin, scrautum = quiver (with arrows), vagina = sheath) Female: same as the male, up to a point. The gubernaculum is attached to the ovaries and the anterolateral abdominal wall. During development, though, it also attaches (in the middle) to the uterus. This attachment to the uterus prevents the ovaries from being pulled down. It also results in an adult derivative of the gubernaculum with two parts: the ovarien ligament and the round ligament and the inguinal canal. It should be noted that, at the time of birth, the inguinal canals run almost entirely posterior to anterior, with little medial deviation. With growth and development into an adult, they assume their oblique arrangement. These diagrams are from the Loyola University Chicago - Stritch SOM LUMEN website. See an animation of this process here. 6. Describe the anatomy of the inguinal canal. (W&B 433, M 193-198, N 242, 251,253, TG 5-10A, 5-11A) The inguinal canal can be thought of as a tunnel that travels from an "entrance", which is lateral and deep, to an "exit", which is medial and superficial. (As described below, during the development of the gonads there are structures that travel through the canal in this way.) It, like a tunnel, also has a roof, a floor, and two walls. Contents: spermatic cord (in males) or the round ligament of the uterus (in females) as well as blood vessels, lymphatic vessels, and the ilioinguinal nerve (which enters the canal from the side, rather than passing through the deep ring). Openings: deep (internal) inguinal ring: the entrance to the canal. The transversalis fascia pouches out, creating an opening through which structures can leave the abdominal oblique aponeurosis. Since the fibers split, anatomists get to give them different names. A lateral crus are formed. The lateral crus attaches to the pubic crest. (Latin, crus = resembling leg or legs) Defined by: roof: fibers of internal abdominal oblique and transversus abdominis muscles. floor: inguinal ligament throughout, with lacunar ligament added medially anterior wall: external abdominal oblique aponeurosis throughout, with internal abdominal oblique and transversus abdominal oblique and transversus abdominis aponeuroses, medially. Note: The inguinal region can be tricky to put together, what with all of these layers mixing and matching its remnants in your cadaver, then take another look at the books. It will come together. Also, beware - there are other places in the body where some tissue defines a "passage" or a "canal". You will see this type of thing again. Get used to thinking outside of the box! 7. Describe the anatomy of the various kinds of abdominal wall hernias (indirect and direct inguinal, umbilical, lumbar). (W&B 434-435, M 205-207, N 254, TG 5-11A, 5-11B, 5-11C) See the Clinical Terms in the Anatomy Tables for full descriptions. The most important distinction to make is between direct and indirect inguinal ring, often enter scrotum Direct: acquired, medial to inferior epigastric vessels, literally pierce the canal, seldom enter scrotum Also, give some thought to what coverings each would have. (Latin, hernia = rupture) 8. Identify the anatomical landmarks on the deep surface of the anterior abdominal wall and their relationships to the types of inguinal hernias. (W&B 435, N 245, 251, TG 5-07, 5-08, 5-09) The basic idea is that there are five folds (covering ligaments) and some spaces, or fossae, around and between them. While not extremely important clinically, they do provide another way to think about the possible locations of hernias. Furthermore, these structures are interesting from the viewpoint of development, i.e., what they used to be. Starting midaxillary on either side and going around to the midline, we have: structure: lateral inguinal fossa\* medial umbilical fold supravesicular fossa median umbilical fold contains: deep inguinal ring inferior epigastric vessels medial umbilical ligament median umbilical ligament clinical issue: indirect inguinal hernia direct inguinal hernia direct inguinal hernia direct inguinal hernia direct inguinal hernia fetal remnant: fetal umbilical artery urachus \* part of this fossa is the inguinal triangle Cultural enrichment: Check out these sections from the 1918 version of Gray's Anatomy of the Human Body! Some of the terms are (of course) out-of-date, but the illustrations are timeless. The Muscles and Fasciae of the Abdomen - The Abdomen and Pelvis - The Abdomen Questions of the Abdomen - Surface Markings of the and list the important structures and organs found there. (N 268, TG 5-01B, ascending colon, kidney umbilical: visceral pain often refers here left lumbar (flank): descending colon, kidney right inquinal: appendix hypogastric (pubic, suprapubic): bladder and rectum left inquinal lymph nodes, with afferent and efferent channels, below the plane of the inquinal ligament. What regions do they drain? (N 258, 528, TG 6-33, 6-34) They drain everything below the umbilicus including: lower abdominal wall buttocks penis & scrotum/labia majora (external genitalia) perineum superficial lymphatic plexus of the lower limbs 11. Distinguish between the fatty layer and the membranous layer of the subcutaneous tissue. (N 249, TG 5-02) The fatty layer is the superficial layer, also known as Camper's fascia, lies just below the umbilicus. 12. What is the extent of the membranous layer of the subcutaneous tissue? (N 249, 380, TG 5-02) This layer continues inferiorly as the superficial perineal fascia (Colles fascia) in the scrotum and labia majora, and also extends to the posterior border of the urogenital triangle (a line drawn between the two ischial tuberosities). It is attached to the iliac crest, the fascia lata of the thigh, and the public symphysis. The layer ends 1-2 cm into the thigh, below the inguinal region. 13. What are the characteristics of the subcutaneous tissue that continues into the scrotum and penis is entirely fat-free and contains smooth muscle to wrinkle the scrotum and elevate the testes, usually in response to actions like jumping into Lake Michigan in January, or even July. 14. Locate exemplary anterior and lateral cutaneous branches of one of the segmental nerves supply the abdominal wall? Do they run horizontally or follow the slope of the ribs? (N 257, 258, TG 5-02) See above for full description. Source: ventral primary rami of spinal nerves (T7-T11) and the subcostal nerves (T7-T111) and the subcostal nerves (T7-T111) and the subcostal nerves (T7-T111 (N 259, 263, TG 5-08A, 5-08A) The superficial inguinal ring is a passageway through the abdominal wall, formed by a gap in the external abdominal oblique muscle. It is located just superior and lateral to the pubic tubercle. Its components are as follows: Lateral crus: inferior margin of ring, blending with inguinal ligament towards its insertion. Medial crus: superior and medial boundary of superficial inguinal ring. Intercrural fibers: superolateral margin of superficial inguinal ring. Intercrural fibers: superolateral margin of superficial inguinal ring. 16. Consider the sources and extent of distribution of the ilioinguinal nerve. (N 257, 258, 497, 498, TG 5-02, 5-38) Source: L1 (Lumbar plexus) Terminal ends: Anterior scrotal/labial nerves Distribution: Distributes through the inguinal canal and superficial inguinal ring to the skin below the inguinal ligament and to the skin over the scrotum/labia majora. 17. What does the superficial inguinal ring transmit in the female? In the male? (TG 5-08A, 5-09A) Both: ilioinguinal nerve Female: round ligament of the uterus Male: spermatic cord, covered by cremaster muscle and fascia, and internal spermatic fascia 18. How do you differentiate the external abdominal oblique from the internal abdominal oblique originate on the lower ribs, running inferomedially towards the linea alba (like hands in your pockets). This is the same direction as the external intercostal muscles. The fibers of the internal abdominal oblique originate more laterally, on the iliac crest and thoracolumbar fascia, and run superomedially, like the internal abdominal oblique muscles? To where do they distribute? (N 267) TG 5-02, 5-38) Both nerves begin their journey between the internal abdominal oblique and transversus abdominal oblique abdominal abdominal wall. Think about their names to determine distribution. Iliohypogastric gets the hypogastric regions of the abdomen. Ilioinguinal goes through the superficial ring. 20. Where does the cremaster muscle lie in relation to the external spermatic fascia? (N 387, 388, TG 5-08, 5-10) In the male, the cremaster muscle lies just deep to the external spermatic fascia. It is the middle covering of the spermat in the "plane of separation", between the internal abdominal oblique muscle and the transversus abdominis muscle, that you are now attempting to open. How do the iliohypogastric and ilioinguinal nerves on the surface of the transversus abdominis muscle and consider their level, origin, areas of distribution, oblique orientation, and the manner in which they enter the rectus sheath. (N 257, 258, TG 4-08) See the discussion of anterior and lateral cutaneous nerves above. They are oblique because they roughly follow the oblique curves of the ribs. They penetrate the posterior lateral portion of the rectus sheath, passing behind the rectus abdominis, then they penetrate the rectus and inferior epigastric arteries. What are their sources? Do they anastomose? (N 190, 255, 262, TG 5-05) The superior epigastric artery comes from internal thoracic artery (the other branch of the internal thoracic is the musculophrenic artery). The inferior epigastric artery comes from external iliac artery (the other branch of the internal thoracic is the musculophrenic artery). The inferior epigastric artery (the other branch of the internal thoracic is the musculophrenic artery). The inferior epigastric artery comes from external iliac artery (the other branch of the internal thoracic is the musculophrenic artery). The inferior epigastric artery comes from external iliac artery (the other branch of the internal thoracic is the musculophrenic artery). The inferior epigastric artery (the other branch of the internal thoracic is the musculophrenic artery). The inferior epigastric artery (the other branch of the internal thoracic is the musculophrenic artery). The inferior epigastric artery (the other branch of the internal thoracic is the musculophrenic artery). arcuate line is a transverse line halfway between umbilicus and pubic symphysis. It is usually distinct, but occasionally it is a gradual transition. 25. What tissue is left on the posterior side of the rectus muscle caudal to this line? (N 252, TG 5-05, 5-07) Only the transversalis fascia, extraperitoneal connective tissue and peritoneum are left. 26. Note how each muscle layer contributes to the rectus sheath. What muscles contribute aponeurotic fibers to the posterior wall of the sheath at each level? (N 252, TG 5-05, 5-06, 5-06) see #4 and #5 above. 27. Review the descent of the gonads. (N 369A, 369B, 369C, 369D, animations) Briefly, the testes start out behind the peritoneum below the kidney, in the lumbar region. From there, they descend through extraperitoneal cannot the processus vaginalis. The gubernaculum (fibrous tissue band) helps to pull the testes down into the scrotum through the inguinal canal. In adult life, the gubernaculum will become the scrotal ligament. The female case is similar, but the uterus develops within the pelvic brim. The gubernaculum fuses to its side, interrupting the descent of the ovary just below the pelvic brim. The gubernaculum fuses to its side, interrupting the descent of the ovary just below the pelvic brim. The gubernaculum fuses to its side, interrupting the descent of the ovary just below the pelvic brim. of the uterus which passes from the uterus through the deep inguinal ring, the inguinal ring to the labia majora. Keep in mind that the descent of the testis involves an evagination of the abdominal wall and that this is where the inguinal canal starts (deep ring), this is also how the spermatic cord gets its layers from the layers of the abdominal wall. The peritoneum initially evaginates through the abdominal wall parallel to the round ligament (female) or spermatic cord (male) before birth. This normally closes but if it remains open it constitutes a congenital inguinal hernia. 28. What does the small genital branch of the genitofemoral nerve innervate? The small genital branch of the genitofemoral nerve innervates the cremaster muscle. It also anastomoses with the anterior scrotal/labial nerve (from the ilioinguinal in guinal cadaver. Netter 251 or TG 5-08, 5-09 shows it from the internal view. 30. What tissue forms the deep (internal) inguinal ring is formed by transversalis fascia above the midpoint of the inguinal ring; and how does it do so? The deep inguinal ring is formed by transversalis fascia above the midpoint of the inguinal ring. 354, TG 5-08, 5-09) In the male, the structures that make up the spermatic cord traverse the ring (actually, the cord is formed at the relationships of the medial inguinal fossa and lateral inguinal ring? (N 245, TG 5-07, 5-08, 5-09). Direct inguinal hernias start in the inguinal triangle, which is at the base of the medial inguinal fossa, between the medial and lateral umbilical folds. This triangle, since it is covered by weak fascia, allows direct hernias to pierce the anterior abdominal wall. Indirect inguinal hernias start at the base of the lateral inguinal fossa, lateral to the lateral umbilical fold. The deep inguinal ring, which transmits indirect hernias, is just lateral to the inferior epigastric vessels at the base of this fold. 33. Define the inguinal triangle. (N 251, TG 5-07) This is the weak area defined by the lateral border of rectus abdominis muscle, the inferior epigastric artery, and the inguinal ligament. 34. What is the relationship between direct and indirect inguinal hernias and the falx inguinal syou should know?) Direct inguinal hernias pass through the inguinal triangle (see #2, #10, and #11), which is an area of weak fascia. They almost never go into the scrotum. Both the superficial inguinal ring and the inherent weakness of abdominal wall lateral to the falx inguinals make this area susceptible to hernias. Indirect inguinal hernias start at deep inguinal ring, pass down inguinal canal, through superficial ring, and, in the male, usually descend into scrotum along with the spermatic cord. In the female they travel along the round ligament. 35. Define the inquinal canal, noting location, orientation, rings, walls, shape, and relationships. See above. 36. How are the coverings of the spermatic cord represented in the scrotum? (N 370, TG 5-10B, 6-31) From superficial to deep, the cord is covered by skin, tunica dartos muscle, external spermatic fascia, cremaster muscle, internal spermatic fascia, cremaster muscle, and internal spermatic fascia are the coverings of the spermatic cord proper, i.e., they wrap around it. 37. Compare the inguinal canal in male and female: (N 253, 360, TG 5-08A, 5-08B, 5 contents are different. 38. To what does the round ligament of the uterus on the lateral surface below the uterus of 369D) The scrotal ligament is the male remnant of the gubernaculum. It, however, does not run through the inguinal canal, since it pulled the testes through. 40. What is the scrotal ligament? (N 369) The remains of the embryonic gubernaculum, the fibrous tissue which helps to pull the testes into the scrotal cavity. It attaches the inferior end of the testis to the inner aspect of the scrotal sac.

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