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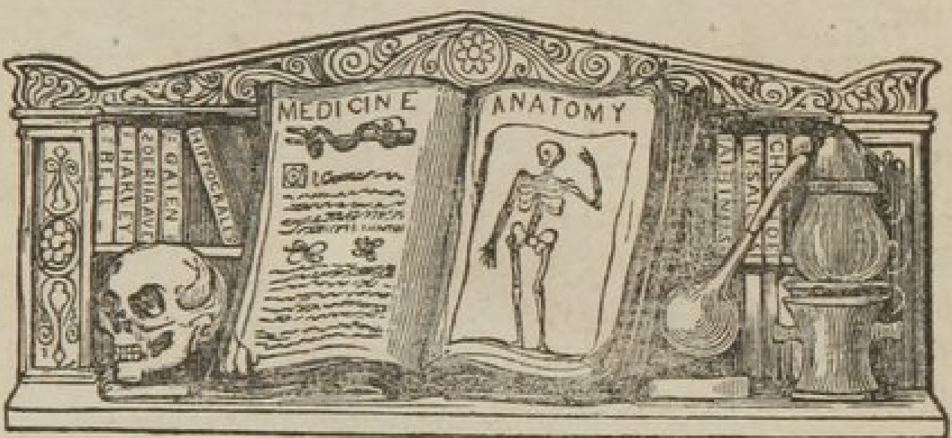

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H. Ludwig, Print.

PREFACE.

In undertaking to prepare an American edition of the Dublin Dissector, the editor has been principally actuated by a desire to aid the publishers in placing within the reach of the medical students of this country, a work which he has long considered the best manual of Practical Anatomy in our language. It was suggested by the publishers, that some additions might perhaps be made, which would enhance the value of the book, and it was left to the editor to decide what those additions should be: it should be distinctly understood, that the additions are merely compilations, principally from J. Cruveilhier, (Anatomie Descriptive, Paris 1834): Horner, (Treatise on Special and General Anatomy, Philadelphia 1836): Tiedemann; and Gross on Pathological Anatomy, (Boston 1839): and that nothing can be claimed on the score of originality, it having been intended to select those facts which are of the most practical importance, and yet not to introduce so much new matter as to diminish the convenience of the book as a dissecting room Manual.

The classification of the muscles has been introduced, because in the performance of his public duties the editor has found something of the same kind very useful in impressing upon the minds of students their number, situation, and functions; the only muscles omitted in the classification, are those of ordinary respiration, and those of the back, which are left as classed in the text, in which all are described in the order in which they are met with on dissection, which order has for that reason been left unchanged: the classification cannot be considered as original, and yet it would be difficult to give credit for it. It was deemed important to introduce the weights and measurements of the different internal organs, and to give the averages as nearly as possible, both in reference to their normal condition, and to those changes in size and density which result from a morbid state. It also seemed proper in such a work, to introduce all the principal varieties which are met with in the muscular, arterial, and venous systems, and a good deal of pains has been taken particularly with the chapter on the arteries: there likewise appeared to be a propriety in connecting with the description of each bone a table of the muscles arising from, and inserted into it, and in enumerating the fractures to which each is most commonly liable; also in referring in the chapter on Articulations to those luxations not enumerated by the author: in the Appendix a few additional directions are given on the subject of injections: in short, it has been the earnest endeavour of the editor to increase the value of the book to the practical student of anatomy. But few liberties have been taken with the text, and those principally where they were necessary to the continuity of sense in the text and the context; most of the additions are distinguished by a smaller type, and all of them except mere verbal alterations, are included in brackets []; in those cases where it seemed proper, reference has been made to anatomical preparations which are in the College Museum, or in private collections in this city.

It is needless to offer any apology for the manner in which the editorial part of the work has been executed, as its merits and demerits will be judged of by the proper tribunal: the editor will be repaid for his labour should those for whose benefit it has been undertaken find the book not less useful to them, with the additions, than it was without them, to himself when a student.

New York, 8th October, 1840.

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DUBLIN DISSECTOR.

CHAPTER I.

DISSECTION OF THE EXTERNAL PARTS OF THE FACE AND HEAD.

SECTION I.

EXTERNAL PARTS OF THE HEAD.

THE integuments covering the cranium are firm and dense, although when felt they give the sensation of being thin: the cuticle is delicate, but the cutis is very thick, and furnished with many sebaceous follicles; the subjacent cellular membrane contains granulated fat, and the bulbs of the hairs, which afterwards perforate the skin in an oblique direction. The cellular tissue is condensed, having somewhat a ligamentous structure, it adheres so intimately to the subjacent muscular and tendinous expansion, that the inexperienced student may find some difficulty in exposing the surface of the latter. Make an incision through the integuments along the median line, from the tuberosity of the occipital bone, as far forwards as the lower part of the forehead, from each extremity of this, make a transverse incision about three inches long; let the posterior one be parallel to the superior transverse ridge of the occipital bone, and the anterior one parallel, and about half an inch superior to the eyebrow; cautiously dissect off the integuments from the subjacent muscular and tendinous expansion, which is the occipito-frontalis. This muscle, like most of the superficial muscles of the face, is closely attached to the skin, which circumstance, added to the paleness and smallness of their fibres, renders their dissection somewhat difficult and tedious. Most of the superficial muscles of the head and face, during life, assist some of the organs of sense, and contribute to produce certain changes in the countenance, indicative of character or passion, and expressive of many diseases, tetanus, peritonitis, &c. In point of function, they may be considered as belonging to the class of mixed muscles, that is, they are in part voluntary and in part involuntary: with the exception of the aponeurosis of the occipito-frontalis, the tendon of the orbicularis palpebrarum, and that of the corrugator supercilii, there is no perfect tendinous structure in the other muscles of this class.

The superficial muscles of the head are divided into those of the cranium and face. Those of the cranium are the occipito-frontalis, and the three common muscles of the ear, to these some add the corrugatores superciliorum; these, however, I prefer placing among the muscles of the face.

[The following arrangement will give a comprehensive view of the muscles of the head and face, classed according to the part upon which they particularly act. There are six classes, including thirty-six pair of muscles, and two single muscles as follows:

FIRST CLASS, ONE MUSCLE.

Occipito Frontalis.—*Vide p.* 4.

This by its palpebral insertion becomes a muscle of the eye, and by its nasal process, a muscle of the nose; it acts upon the scalp, eyebrow, lid, and nose.

SECOND CLASS, ELEVEN MUSCLES.

These are the muscles of the ear, and are arranged in three groups, the first of three muscles moves the external ear, upon the head; the second of five muscles, moves the cartilages of the external ear, upon themselves: the third of three muscles moves the bones of the internal ear so as to render the membrana tympani, lax or tense.

First Group, three Muscles.

Superior Auris, or Attollens.—*Vide p.* 6.
Anterior Auris, or Attrahens, } *Vide p.* 7.
Posterior Auris, or Retrahens, }

Second Group, five Muscles.

Tragicus,
Anti Tragicus,
Helicis Major, } *Vide p.* 355.
Helicis Minor,
Transversalis Auris,

Third Group, three Muscles.

Stapedius,
Tensor Tympani, } *Vide p.* 355.
Laxator Tympani,

THIRD CLASS, ELEVEN MUSCLES,

Including the occipito-frontalis. These are the muscles of the eye, and are found in two groups, the one of five muscles, acting upon the appendages of the eye, the other of six muscles, acting upon the ball of the eye.

First Group, five Muscles.

Occipito-frontalis, its palpebral insertion,	*Vide p.* 14.
Corrugator Supercilii.	" " 16.
Levator Palpebræ Superioris,	" " 361.
Orbicularis Palpebrarum,	" " 8.
Tensor Tarsi,	" " 10.

These muscles are all exterior to the orbit except the Levator Palpebræ Superioris which is within.

Second Group, six Muscles, all within the orbit.

Superior Rectus, or Levator oculi,
Inferior Rectus, or Depressor oculi,
Internal Rectus, or Adductor oculi,
External Rectus, or Abductor oculi,
Obliquus Superior,
Obliquus Inferior,
} *Vide p.* 361.

FOURTH CLASS, FOUR MUSCLES.

These are the muscles which act upon the nose, and they are arranged in two groups, the one of two muscles proper to the nose; the other also of two muscles common to the nose and upper lip.

First Group, two Muscles, proper to the nose.

Pyramidalis Nasi, a process of the occipito-frontalis,
Compressor Nasi,
} *Vide p.* 10.

Second Group, two Muscles, common to the nose and upper lip.

Levator Labii Superioris alæque nasi,	*Vide p.* 11.
Depressor Labii Superioris alæque nasi,	" " 12.

FIFTH CLASS, TEN MUSCLES.

These are the muscles which act upon the different parts of the mouth and are arranged in four groups, the first group includes but one muscle, which surrounds the whole mouth; the second embraces two muscles, which act upon the upper lip (already enumerated, as common to it, and the nose) the third includes two muscles, which act upon the lower lip, and the fourth five muscles, which act upon the angle of the mouth.

First Group, one muscle—a single muscle.

Orbicularis Oris—*Vide p.* 13.

Second Group, two Muscles, common to the upper lip and nose.

Levator Labii Superioris alæque nasi,	*Vide p.* 11.
Depressor Labii Superioris alæque nasi,	" " 12.

Third Group, two muscles.

Levator Labii Inferioris,	*Vide p.* 13.
Depressor Labii Inferioris,	" " 12.

plain many of the *pathological* phænomena which are of ordinary occurrence in this region; thus, it is frequently the seat of encysted tumours, horny growths, &c., these appear to arise in the sebaceous follicles, the ducts of which have become obstructed from irritation or injury; a vitiated secretion then accumulates in the sac, which sometimes becomes circularly enlarged, and at others the contents slowly escaping from the ducts, and hardening, assume horny and various other appearances. The scalp is a common seat of erysipelas, both idiopathic and symptomatic. Injuries of it are of very frequent occurrence, and are more serious than those of the same extent in other situations. Incised wounds bleed more freely; punctured wounds are very frequently followed by high inflammatory symptoms, local and general, in consequence of matter being confined under the tense epicranial aponeurosis, which, in such cases, will require free division. The compact density of the cellular tissue explains the hard rim which surrounds the ecchymosis, the effect of injury, [and also explains the deceptive appearance of fracture and depression of the bone which is sometimes presented when the injury is in fact merely a contusion followed by the effusion of blood. As above stated the scalp is very abundantly supplied with blood which is derived principally from the frontal branches of the internal carotid, and the temporal, posterior auricular, and occipital branches of the external carotid; these anastomose very freely with each other, on the same side, and also very freely across the top of the head with the same branches of the opposite side, and hence the severe and extensive operation which is necessary for aneurism by anastomosis of the scalp, which operation consists in circumscribing the tumor, sometimes even after the common carotid artery of the affected side has been ligatured. For an extensive aneurism of this kind, both common carotid arteries were ligatured with perfect success, by Prof. Mussey, at that time of Dartmouth College. The scalp is also the seat of encephaloid disease and nævi materni.]

In the fœtus the scalp is very thin, and the aponeurosis is loosely attached to the cranium by reticular membrane; this, and not the subcutaneous cellular tissue is the seat of those large ecchymoses so commonly seen after parturition, and which in general are quickly removed by the absorbent system.

The common muscles of the ear are three in number, viz. superior, anterior, and posterior auris:

Superior Auris, or Attollens Aurem, is a small, thin, triangular muscle, situated on the temple, and above the ear, *arising* broad and tendinous from the cranial aponeurosis, where it covers the temporal fascia on the side of the cranium, just above the external ear; the fibres descend converging, become fleshy, and are *inserted* into the upper and interior part of the cartilage of the ear:—*use*, to raise the cartilage, and deepen the meatus of the ear, also to make tense the epicranial fascia. This muscle is between the skin and temporal fascia, its anterior edge is confounded with the following muscle.

ANTERIOR AURIS, or ATTRAHENS AUREM, is connected with the last, is of the same form, but smaller, and often indistinct; it *arises* from the posterior part of the zygomatic process, and from the cranial aponeurosis, passes backwards and downwards, and is *inserted* into the anterior part of the helix; *use*, to draw the external ear forwards and upwards. This muscle is superficial, and lies on the temporal fascia, vessels, and nerves, its lower edge is lost in the cellular tissue.

POSTERIOR AURIS, or RETRAHENS AUREM, often consists of two or three distinct fasiculi, it is the strongest of these auricular muscles; it has no connection to the epicranial fascia, but *arises* from the mastoid process above the sterno-mastoid muscle, passes forwards, and is *inserted* into the back part of the concha; *use*, to enlarge the meatus of the ear and direct it backwards. This muscle is covered only by the skin, it lies upon the temporal bone.

In addition to these muscles, which move the external ear, there are several small muscles attached to different parts of the cartilages, which serve to alter their form, and expand their cavities; these muscles, as also those in the tympanum, shall be described hereafter in the dissection of the organ of hearing.*

SECTION II.

DISSECTION OF THE EXTERNAL PARTS OF THE FACE.

The muscles of the *face* require careful dissection; they are delicate, and often very pale; they may be classed into the superficial and deep: the former into those of the eyelids, nose, lips, and mouth; the latter into those of the lower jaw and palate. Make an incision around the base of the orbit, through the skin, which is here very

*Previous to, or immediately after dissecting the muscles of the face, the student should examine the brain, the description of which organ will be found at the head of that of the nervous system.

fine, and closely adhering to the fibres of the orbicularis muscle; next make a perpendicular incision along the middle line of the nose, to the centre of the upper lip, continue this in a semicircular manner round the angle of the mouth to the middle of the lower lip, and thence to the chin, and lastly from the chin to the angle of the jaw; reflect the integuments cautiously from the eyelids and side of the face, as far back as the ear, avoiding the slender muscular fibres which adhere to the skin, and the vessels and nerves which will be exposed in this dissection.

The superficial muscles of the face may be considered as thirty-three in number, that is sixteen pair and one azygos, and are arranged as follows.

Three pair belong to the *palpebræ*, viz. orbicularis palpebrarum, tensor tarsi, and corrugator supercilii, (the levator palpebræ is deep seated in the orbit, and is arranged among the muscles of that region.)

Four pair belong to the *nose*, viz. pyramidalis nasi, levator labii superioris alæque nasi, compressor and depressor naris.

Three pair belong to the *upper lip*, viz. levator labii superioris, levator anguli oris, and depressor labii superioris.

Three pair belong to the *lower lip*, viz. depressor anguli oris, depressor labii inferioris, and levator labii inferioris.

Three pair belong to the *mouth*, viz. zygomaticus major, minor, and buccinator, and one azygos, the orbicularis oris; writers vary this arrangement, but no material difference exists.

Orbicularis Palpebrarum, broad and thin, somewhat oval, in some subjects very pale and indistinct, in others strong and well marked, it surrounds the base of the orbit, and occupies a great portion of the face; it *arises* by several fleshy fibres from the internal angular process of the os frontis, and from the upper edge of a small horizontal tendon, (which *tendon*, tendo oculi, or tendo palpebrarum, [or *internal Palpebral Ligament*,] which is nearly one half of an inch in length, is *inserted* internally into the upper end of the nasal process of the superior maxillary bone, thence it passes outwards and backwards to the internal commissure of the eyelids, where it forks into two slips which enclose the caruncula lachrymalis, and are then *inserted* each, into the tarsal cartilage, and the lachrymal duct;) the fleshy fibres then proceed in curves, upwards and outwards, along the upper edge of the orbit, the eyelid, and tarsal cartilage, as far as the temple and external commissure of the eyelids; thence the fibres curve in a similar manner along the inferior eyelid and edge of the orbit to the internal canthus, where the fibres are *inserted* into the nasal process of the superior maxilla, and into the inferior edge of the horizontal tendon.—*Use*, to close the eyelids, chiefly by depressing the superior, the levator muscle of which it directly opposes, it also serves to press the tears inwards towards the puncta lachrymalia; the superior and external fibres can depress the eyebrow, and thus oppose the occipito-frontalis and shade the eye; the inferior fibres can raise the cheek, raise and draw the lower eyelid inwards, and compress the lachrymal sac, which they cover. In sleep it is relaxed, and the eye is covered chiefly by the descent of the upper palpebra, its elevator being also relaxed: when awake its contraction covers the globe, not only by bringing down the upper, but also by elevating the lower eyelid, hence the "equator oculi," the line formed by the approximated tarsi, is lower during real than in feigned sleep; in the former, also, the cornea is seldom entirely covered, as it always is in the latter.

This muscle is covered by and adheres to the skin: superiorly it intermixes with the occipito-frontalis, and covers the corrugator supercilii, the frontal vessels and nerves, the tarsal cartilage and ligament, and the levator palpebræ superioris; inferiorly it intermixes with the muscles of the cheek and lips, and sometimes with the platysma myoides, and covers the malar bone, the inferior tarsus and its ligament, the origin of the levator anguli oris, levator labii superioris, and the infra orbital vessels and nerves. The external or *orbital* fibres of this muscle are strong and red, and run circularly round the base of the orbit; the middle or *palpebral* fibres are pale, thin, and scattered, and are contained in the eyelids; the internal or *ciliary* portion is a thick but pale fasciculus, situated under the ciliæ, at the edge of each eyelid. The palpebral and ciliary portions adhere more closely to the skin, and present an elliptical appearance, as the fibres from the upper and lower eyelid intersect each other at the outer canthus, and adhere to the ligament of the external commissure. The horizontal tendon of this muscle passes across the lachrymal sac a little above its centre, and a strong aponeurosis derived from its upper and lower edge, covers all the anterior surface of the sac, and adheres to the margins of the bony gutter, in which it is lodged, where it becomes continuous with the periosteum. This tendon can be seen or felt through the integuments during life, particularly when the muscle is in action, or when the eyelids are drawn towards the temple.

This muscle is of the mixed class: it sympathizes with the eye in a remarkable and most useful manner; it possesses great irritability, particularly in children; in purulent and strumous ophthalmia it is frequently spasmodically contracted, and totally prevents the eye being seen: this affection is somewhat analogous to the spasmodic constriction of the sphincter ani muscle.

In the operation of opening the lachrymal sac, the incision should commence immediately below this tendon so as to avoid injuring it, and be carried obliquely downwards and outwards, to the extent of about half an inch.

Separate the orbicularis from the occipito-frontalis over the internal half of the superciliary arch, the tensor tarsi and the corrugator supercilii muscles will be exposed.

Tensor Tarsi, *arises* tendinous from the posterior edge of the os unguis, where it joins the os planum, passes forwards between the conjunctiva and the expansion of the tendo oculi which covers the lachrymal sac, divides into two portions, which are *inserted* into the lachrymal ducts, along which the fibres extend, nearly as far as the puncta: *use*, to draw the puncta and eyelids into close contact with the eye, also to press the puncta towards the nose, to compress the lachrymal sac, and to force out the secretion from the follicles of the caruncula lachrymalis. This muscle is also named Horner's muscle from its discoverer, it will be better seen if the two tarsi be divided about their middle, and their inner portions turned towards the nose.

Corrugator Supercilii, *arises* fleshy and tendinous from the internal angular process of the os frontis, passes upwards and outwards, and is *inserted* into the middle of the eyebrow, mixing with the orbicularis and occipito-frontalis muscles: *use*, to depress and approximate the eyebrows, throwing the skin of the forehead into vertical wrinkles: this pair of muscles is voluntary but they cannot act separately; they directly oppose the occipito-frontalis and shade the eye. They are covered by the orbicularis and occipito-frontalis, and lie on the os frontis, and on the frontal nerve and vessels.

Pyramidalis Nasi, superficial, long, thin, often wanting, *arises* from the occipito-frontalis, descends close to its fellow, covering the nasal bones and sutures, becomes broad and aponeurotic, and is *inserted* into the compressor nasi muscle. *Use*, it raises the skin covering the ossa nasi.

Compressor Nasi, is thin and triangular, placed on the side of the nose, between the skin and the cartilage; it *arises* from the inner side of the canine fossa, in the superior maxilla; the fibres pass forwards, expanding over the ala nasi, and are *inserted* by a thin aponeurosis into the dorsum of the nose, joining some fibres from the opposite side: *use*, to press the ala toward the septum, or to draw it from it, so that it may alternately enlarge or diminish the anterior nares. The insertion of this muscle is connected with the occipito-frontalis, and its origin with the following muscle which partly covers it.

LEVATOR LABII SUPERIORIS ALÆQUE NASI, is long, thin, and triangular, placed on the side of the nose, between the orbit and the upper lip; it *arises* by two origins; first, from the upper extremity of the nasal process of the superior maxilla: second, broad, from the edge of the orbit, above the infra-orbital hole; the fibres descend and converge a little, and are *inserted* into the ala nasi, and into the upper lip and orbicularis oris muscle: its name denotes its *use*. The superior and orbital origins of this muscle are covered by the orbicularis palpebrarum, the inferior portion is superficial; the angular vein and artery separate its origins: the orbital head covers the infra-orbital nerve and vessels and the levator anguli and some of the orbicularis oris muscles.*

ZYGOMATICUS MINOR is very small, and sometimes wanting; it *arises* from the upper part of the malar bone, passes downwards and forwards, and is *inserted* into the upper lip near the commissure, uniting with the other muscles which are inserted there; *use*, to draw the angle of the mouth upwards and outwards, as in smiling; it lies superior, and parallel to the major, between which, and the levator labii, it is inserted.

[This muscle is sometimes wanting; sometimes double; sometimes a slip from the orbicularis palpebrarum; sometimes it stops short of the angle of the mouth.]

ZYGOMATICUS MAJOR, is long and narrow, and inferior to the last; *arises* tendinous and fleshy from the lower part of the malar bone, near the zygomatic suture: it descends obliquely forwards, and is *inserted* into the angle of the mouth.—*Use*, to draw the corner of the mouth upwards and backwards. The zygomatic muscles are partly concealed at their origin by the orbicularis palpebrarum; their insertion intermingles with the levator, depressor anguli, and orbicularis oris muscles; they lie on the malar bone, and cross the masseter and buccinator muscles, also the labial vein and artery, and they run superficial and superior to

* The external or orbital head of this muscle is described by most writers as a distinct muscle, and has been enumerated by me as such; it is called *Levator Labii Superioris*: as, however, it will be found on dissection to be inseparably connected with the levator labii alæque nasi, I prefer describing it as part of the outer head of that muscle; in like manner I have united the *depressor labii superioris* or *incisor*, and the *depressor naris*, which are by some described as distinct muscles; this note, therefore, may serve to explain to the student the different descriptions given of these muscles by different authors.

the duct of the parotid gland; they are imbedded in much soft adipose substance.

Levator Anguli Oris, (musculus caninus) is situated about the middle of the face, behind and a little external to the orbital portion of the levator labii superioris alæque nasi, or the levator labii of some; *arises* from the canine fossa in the superior maxillary bone immediately below the infra-orbital foramen, and above the alveolus of the first molar tooth; it descends obliquely forwards and outwards, and is *inserted* narrow into the commissure of the lips, and into the orbicularis oris; its name denotes its *use.* This muscle is covered by the orbicularis palpebrarum, levator labii superioris alæque nasi, zygomatic muscles, and by a quantity of soft adeps, also by the infra-orbital nerve and vessels, which ramify upon its surface, and separate it from the orbital portion of the levator labii alæque nasi: it lies on the superior maxilla, the buccinator muscle, and the mucous membrane of the mouth.

Depressor Labii Superioris Alæque Nasi, a small flat muscle, exposed by everting the upper lip, and raising the mucous membrane on the side of its frænum; it *arises* from the alveoli of the canine and incisor teeth of the superior maxilla, ascends obliquely forwards, and is *inserted* into the integuments of the upper lip, and into the fibro-cartilage of the septum and ala nasi; *use,* to press the lip against the anterior teeth, and even to draw it under these, also to depress the septum and ala nasi. It is covered by the levator labii, orbicularis oris, and mucous membrane, and it lies upon the bone.

Depressor Anguli, vel Triangularis Oris, flat and triangular, apex above, situated at the lower part of the face; *arises* broad and fleshy from the external oblique line on the outer side of the lower jaw, which extends from the anterior edge of the masseter muscle to the mental foramen; the fibres ascend converging, and are *inserted* narrow, into the commissure of the lips, where the fibres are continuous or mingled with the orbicularis, zygomatic, and levator anguli muscles: its name denotes its *use.* This muscle is covered by the skin, some of its fibres are continuous with those of the platysma myoides; it overlaps the buccinator and the following muscle. The facial artery bounds its external edge and separates it from the masseter.

Depressor Labii Inferioris, vel Quadratus Menti, broad and somewhat square, *arises* from the side and front of the lower maxilla, just above its basis, internal to the last, and continues as far forwards as the middle line; the fleshy fibres, intermixed with fat, ascend a little inwards, decussating with some of the opposite muscle, and are *inserted* into half of the lower lip, and into the orbicularis oris; its name denotes its *use.* This muscle is covered by the skin, and externally by the depressor anguli oris, it lies on the bone, the mental nerves and vessels, orbicularis oris muscle, and mucous membrane: by separating this from the last muscle, the mental nerve and vessels are exposed; the fibres are parallel, and many are continuous with those of the platysma; this muscle is difficult to dissect, its inner fibres being pale and intermixed with fat, it is not unlike the structure of the tongue: it conceals the following muscle.

Levator Labii Inferioris, vel Menti, is best exposed by turning down the ~~upper~~ lip, and raising the mucous membrane by the side of the frænum; *arises* from the alveoli of the incisor teeth of the lower maxilla, by the side of the symphysis; the fibres diverge as they descend obliquely forwards between the mucous membrane and the depressor labii inferioris; *inserted* into the integument of the chin; *use*, to elevate the chin and lower lip, this muscle is analogous to the depressor of the upper lip. It assists in forming the prominence of the chin.

Orbicularis Oris, surrounds the opening of the mouth; consists of two fleshy fasciculi, one for either lip, placed between the skin and mucous membrane, and constituting the chief thickness of the lip; these fasciculi decussate each other at the commissures, and intermix with all the muscles inserted there; *use*, to approximate the lips and regulate their motions in the acts of speaking and breathing, and to oppose the actions of the several muscles which are inserted into the commissures; it can also close the lips with different degrees of force, as in the processes of suction, mastication, and deglutition. This muscle has no bony attachment; its fibres are blended with fat, particularly on their cutaneous surface; internally they are more smooth and distinct: they adhere most closely to the skin, and throw it into numerous minute rugæ, when they contract.

Buccinator, is broad, thin, and somewhat square, situated between the two alveolar arches, it forms the inner side of the cheek, and the lateral boundary of the mouth, and lies close to the mucous membrane of the latter; *arises* posteriorly from the two last alveoli of the superior maxilla, as far back as the pterygoid process, from the external surface of the posterior alveoli of the lower maxilla, as far back as the coronoid process, and forms a strong aponeurosis, named the *intermaxillary ligament*, which extends from the extremity of the internal pterygoid plate to the root of the coronoid process, and which affords attachment to the superior constrictor of the pharynx posteriorly, and to the buccinator anteriorly. From these three origins the fibres pass horizontally forwards, converging a little, and are *inserted* into the commissure of the lips, where they intermix with those of the orbicularis, and of the other muscles at the angle of the mouth. *Use*, to press the cheek against the teeth, so as to bruise and push the food between them, and to diminish the cavity of the mouth, as in mastication and deglutition; it is also much engaged in the articulation of certain expressions, as well as in filling wind instruments; it can also retract the commissure of the lips. The buccinator is covered by a considerable quantity of fat, which separates it from the coronoid process of the lower maxilla, and from the insertion of the temporal muscle, this fat often extends in the form of large, soft, round masses beneath the masseter muscle; it is also covered by the zygomatic, the depressor anguli oris and platysma muscles, and by the facial vessels; several branches of the facial artery and vein, and of the seventh and fifth pairs of nerves, ramify on its surface; it lies on the mucous membrane, and on a number of small round mucous glands called buccal; it is perforated near its superior posterior third by the duct of the parotid gland, opposite the third superior molar tooth.

The deep muscles of the face, which are connected with the lower maxilla, and which are employed in the process of mastication, are the masseter, temporal, internal, and external pterygoid of each side: previous to dissecting these, the student should examine the situation and connexions of the parotid gland, the chief of the salivary glands. There are six *salivary glands*, three on each side, the parotid, submaxillary, and sublingual.

The salivary glands, together with the lachrymal, mammary, and pancreas, are commonly called conglomerate glands, in contradistinction to the absorbent, or lymphatic, or conglobate glands; this term, however, is by no means distinct or definite, for other glands, viz. the liver and kidney, are equally conglomerate, though not so obviously such. The general arrangement of the glandular system we propose, is into two orders, the Absorbent and Secreting; the *absorbent*, or *lymphatic*, or *conglobate*, will be noticed hereafter: the *secreting* order may be divided into two classes, viz. the simple and the complex; the *simple* are the numerous glands which are attached very generally to the mucous membranes; the *compound* secreting or conglomerate glands, are the lachrymal, salivary, mammary, pancreas, liver, kidney, prostate, and testis. There is no evidence for considering the pinæal, pituitory, thyroid, thymus, or supra-renal bodies, or the spleen and ovaries as true glands.

[Here, as in most of the systems of anatomy the term gland is applied to two classes of organs which differ essentially in their structure, their relations, and their functions, viz. the glands proper and the lymphatic ganglia. If we examine the works on general anatomy, we shall find that the glandular tissue is defined as consisting of an assemblage of secreting organs, more or less globular in form, and having an excretory duct lined with mucous membrane, which terminates directly or indirectly upon the surface of the body: this being the case, it is evident that in the present state of our knowledge, the lymphatic or absorbent bodies cannot be brought under the head of glands; it is therefore better to drop the term as applied to them, because it leads to error as to their functions, &c., and substitute the term ganglion, which is used by some writers. Accordingly, in revising this book the terms ganglion and ganglia are substituted for gland and glands, whenever used as referring to the lymphatic bodies. The glands proper, as stated above, may be divided into *simple* and *compound;* and the *compound* may be again divided into *conglobate* and *conglomerate:* by conglobate we mean glands composed of an assemblage of glandular particles united in mass by cellular tissue, and having a common and distinct sheath or covering, as the liver: by *conglomerate* we mean an assemblage of small conglobate glands, united together by cellular tissue, and connected by an indistinct covering of loose cellular substance, the whole organ presenting an uneven lobulated appearance, instead of being smooth, and the excretory ducts of each lobule terminating in a common duct, as the pancreas, &c.]

The salivary glands, including the lachrymal, the mammary, and the pancreas, all correspond in certain characters, in which, also, they differ from other secreting glands: they are all symmetrical, except the pancreas, which however, is attached to the digestive organs, the chief apparatus of organic life, but one in which no symmetry is observed: they are of a pale grey colour, with a slight reddish tint; the virgin mammary gland is almost white; they have no perfect capsule, except the mammary, and that, though perfect, is very thin and loose: their form and size are not accurately defined, two or more being sometimes connected; they are very irregular in these respects; their texture is loose, that is, they consist of grains which are but loosely connected by cellular tissue and vessels into small lobules, and these into larger lobes: the granules themselves are very firm and compact: they are all well supplied with nutrient vessels, the arteries ramify minutely before they enter them, which they do at all parts of their surface, and not at any particular fissures, as in the liver and kidney; the transit of the carotid and facial arteries through the parotid and submaxillary glands is not an exception to this statement: the veins in like manner escape at different parts, and enter the neighbouring vessels: their excretory ducts in some unite into one vessel, which proceeds to its destination, but in others, as in the lachrymal, mammary, and sublingual, they continue separate to the surface. In no case is there any perfect reservoir to delay or retain the secretion, as in the case of the liver and the gall bladder, the kidney and the vesica; the lachrymal sac cannot be considered as such: they are largely supplied with nerves, and, except the filaments of the sympathetic, which accompany the vessels, these are derived from the spinal and cerebral system; the pancreas is an exception to this rule: not only cellular tissue in abundance, but even adipose enter into their composition: they are in close connexion with the lymphatic or absorbent system, numerous lymphatic vessels pervade them, and lymphatic ganglia are in their close vicinity, and occasionally even imbedded in their substance. In many of these characters, the salivary glands form a remarkable contrast with the other complex secreting glands, which will more fully appear when the latter come under our notice. All the secreting glands, simple as well as compound, are subject to many diseases; these will be noticed in the account of the individual glands.

The Parotid Gland is the largest of these conglomerate glands, it derives its name from its proximity to the ear; it is exposed by dissecting off the integuments and some fibres of the platysma, also a dense fascia which covers and adheres to it; this fascia is continued from that of the neck, spreads over the gland, is closely connected to the cartilaginous part of the meatus auditorius, and sends numerous processes into the gland in every direction, serving to separate its lobules, and to conduct the different vessels through its substance. The parotid gland is not of any regular figure, by some it is considered pyramidal, the apex above, the base directed outwards and downwards; by others, (the upper end being more developed,) an irregular square; as such we shall consider it, and, of course, as presenting two surfaces, a superficial and a deep, and four margins, a superior, inferior, anterior, and posterior: it occupies, together with some other important parts, that deep excavation on the side of the face between the lower jaw and the auditory meatus, it also extends into the small region of the neck, named the posterior digastric space; it is bounded above by the zygoma, below by a line drawn from the angle of the jaw to the mastoid process, posteriorly by the meatus auditorius, the mastoid process, and sterno-mastoid muscle, and anteriorly by the masseter muscle, the posterior third of which it overlaps. The external surface is pale, flat, or slightly convex, in this respect, however, differing in different persons, as it also does in superficial extent; probably the absence of a regular capsule may in some measure account for this diversity; the anterior and inferior margins are the least defined, are irregular in their extent, in some they considerably exceed the ordinary bounds; the superior border is limited by the attachment of the fascia to the zygoma, and the posterior is resisted by the meatus of the ear, and by the sterno-mastoid muscle.

The connexions of the deep surface may be examined after the course of the excretory duct, and of the several vessels and nerves which pass through the gland, shall have been exposed. The *Parotid* or *Steno's duct arises* from its anterior superior border, and is formed by the union of numerous small vessels, which issue, each, from one of the granulations of the gland; it passes forwards over the masseter muscle about an inch below the zygoma, parallel to a line drawn from the tube of the ear to midway between the commissure of the lips and the root of the nose; it winds round the anterior edge of the masseter, beneath the zygomatic muscles and through a quantity of soft adeps, pierces the buccinator, and opens through the mucous membrane of the mouth by a very small hole opposite the second or third superior molar tooth, about half an inch from the junction of the cheek with the gum. Between the duct and the zygoma, a small, smooth, glandular mass is frequently found; it appears like a detached lobe of the parotid, it is named the *socia parotidis;* from the lower and anterior part of this process, a small duct proceeds, which after a short course unites with the duct of Steno; in some this duct opens distinctly into the mouth. The transverse artery of the face, and several branches of the facial nerve, accompany this vessel, and in general the artery is superior to it, while the nerves wind around it. This duct appears much larger than its calibre really is; it is formed of two coats, the external, white, fibrous, and dense, commences beyond the anterior edge of the gland, and ends at the buccinator muscle; and the internal, a fine, delicate, mucous membrane, is continuous with that lining the mouth: the canal is larger at the commencement and outside the buccinator than in the intervening space, or at the orifice in the mouth.

The parts which pass through this gland are the external carotid artery and several of its branches, with their accompanying veins, and branches of the inferior maxillary and cervical nerves, also the plexus of the portio dura, or facial nerve. The first or most superficial of these parts is the *ascendens colli nerve*, or the superficialis colli or auricularis, it enters the gland near its lower border, and is lost chiefly in communicating with the *portio dura;* this last-named nerve escapes from the cranium by the stylo-mastoid foramen, enters the gland at its posterior inferior part, passes forwards and upwards through it, and forms in its substance the remarkable plexus, *parotidœan*, or *pes anserina*, which crosses superficial to the external carotid artery, and then separates into its two great divisions, the superior and inferior; a small portion of the gland intervenes between it and the vessels. The branch of the inferior maxillary nerve, which traverses the gland is the *temporo-auricular*, which will be found between the neck of the lower jaw and the meatus auditorius, about half an inch above, but much deeper than the portio dura, with which it communicates, and for which it is sometimes mistaken.

The *external carotid artery* will be found to enter the lower border of the gland, near its deep surface; as it ascends it is crossed by the portio dura, and becomes much more superficial, its posterior auricular branch borders the lower and back part of the gland, the temporal ascends through it, the internal maxillary is deeply imbedded in it in its course forwards and inwards, the transverse facial artery also traverses it in a direction forwards, and it also gives off numerous branches to the granules of the gland and to the ear. The veins corresponding to these arteries also pass through this organ; the temporal and internal maxillary, by their confluence, which is superficial to the external carotid artery, and very rarely to the portio dura also, forms the *external jugular vein*, which descends through the gland, and becomes then superficial in the neck. Several lymphatic vessels and ganglia are connected with the parotid, particularly to its inferior border; generally one or two small ganglia may be found imbedded in its substance, in front of the meatus auditorius, just where its cartilage is deficient.

Now divide the parotid duct, raise off the gland from the masseter muscle, and from the ramus of the jaw, and observe its several deep-seated connexions.

The deep or posterior surface of the gland is very irregular, it covers the posterior third of the masseter, also the ramus of the jaw, behind which it sinks, and fills the deep excavation between this bone and the ear, envelops the styloid process of the temporal bone and the muscles which arise from it, and it touches the internal carotid artery, jugular vein, and the large nerves connected with these vessels; it also fills the posterior part of the glenoid cavity in the temporal bone, and adheres to the capsular ligament of the maxilla, inferiorly it is wedged in between the internal pterygoid, digastric, and styloid muscles.

The styloid process is in some cases so involved in it as to appear to divide the gland into a superficial and a deep lobe, the latter will then be deeper than this process and in close connexion with the great cervical nerves and vessels: a portion of the gland will also be found to accompany the internal maxillary artery between the ramus of the jaw and its internal lateral ligament; this touches the inferior maxillary nerve, and in many instances extends into the fatty space between the two pterygoid muscles, where it swells out to a considerable size, so as to appear like a distinct lobe connected to the body of the gland by a narrow neck.

The parotid gland is composed of numerous small granulations, united together by cellular tissue, by branches of blood-vessels and nerves, and by the small roots of its excretory duct. This gland is subject to several MORBID changes, viz. inflammation, or cynanche parotidæa, or parotitis, or mumps; abscess; hypertrophy, or scirrhus induration, which sometimes requires extirpation; scirrhus, ending in cancer; fistula, the effect of abscess or wound of the gland or duct; atrophy, or absorption, this latter condition is usually caused by tumors, lymphatic or encysted, these by degrees come to occupy the position of the gland and cause its absorption. Such tumors simulate the enlarged parotid, though essentially different, they admit of more easy extirpation as they are usually surrounded by a capsule, and are not traversed by the adjacent nerves and vessels.

[This gland is also the seat of encephaloid disease, of melanosis, and of fatty degeneration; salivary calculi also occur sometimes in its ducts: but the mumps is the disease to which it is most subject. This is an infectious disease, usually occuring but once, attacking young persons and on both sides, and not unfrequently presenting a metastasis in the male to the testicle, and in the female to the breast: several cases are reported of the successful extirpation of this organ, in this country, by Drs. Bush, McClellan and Parker.]

Next clean the masseter muscle and the temporal aponeurosis.

MASSETER: the greater part of this muscle is superficial, it is thick and strong, covers the ramus and angle of the jaw, and consists of *two portions*, one anterior, which is the larger, the other posterior, these decussate each other; the *anterior arises* chiefly tendinous from the superior maxilla where it joins the malar bone, also from the inferior edge of the latter, the fibres pass downwards and backwards and are *inserted* fleshy into the outer surface of the angle of the lower maxilla. The *posterior* or deep portion of the muscle *arises* chiefly fleshy from the edge of the malar bone and from the zygomatic arch, as far back as the glenoid cavity; the fibres descend, some vertically, others obliquely forwards, and are *inserted* chiefly tendinous, into the external side of the angle and ramus of the jaw, as high as the coronoid process; thus the two layers of this muscle are contrasted both in the direction of their fasciculi, as well as in the relative position of their tendinous and fleshy fibres. *Use*, if both portions of both muscles act together, they will elevate the lower jaw; if the anterior portions only of opposite sides act together, they can carry the jaw forwards and upwards; and if the posterior alone, they can move it backwards and upwards; if the superficial layer of one side act alone it can rotate the chin to the opposite side, and if the deep layer only act it can rotate it to its own side. Thus the masseter muscles of opposite sides, by the alternate action of their different portions, are powerful agents in mastication; they not only cause the division of the food by the direct elevation and pressure of the lower maxilla against the upper, but they can also triturate it, by the great lateral motion of the jaw which their different laminæ are capable of exercising alternately. The masseter is covered by the skin, some fibres of the platysma and orbicularis palpebrarum, a portion of the parotid gland, and its excretory duct, by the transverse facial vessels and nerves, and by the zygomatic muscles. It lies on the ramus of the jaw, and conceals the insertion of the temporal, and the origin of the buccinator, from which it is separated by a great quantity of fat; the superficial layer covers the deep one, except a small portion of the latter near the articulation of the maxilla; strong tendinous septa pass from the surface of this muscle through its substance, and adhere to the ramus of the bone beneath.

The masseter by its superficial layer may assist in dislocating the lower jaw, if it suddenly contract when the chin is much depressed. This muscle, like the temporal, appears to be much under the influence of the nervous system and extremely irritable, it is very seldom in a state of paralysis, even when the superficial muscles of the face are so; whereas in tetanus it is in a state of almost rigid contraction: in rigors also, or when exposed to much cold these muscles evince their sympathy with the general system, the will loses all control over them, they act irregularly, and produce the "chattering of the teeth."

TEMPORALIS, is concealed by the temporal aponeurosis, the zygoma, and the masseter, it fills the temporal fossa, is thin and broad above, thick and narrow below. The *aponeurosis* is very strong and tense, of a semicircular form, adhering by its superior convex border to the semicircular ridge on the side of the cranium, which extends from the external angular process of the frontal along the parietal as far back as the mastoid process of the temporal bone, and by its inferior straight margin to the upper edge of the zygoma, and to the superior posterior edge of the malar bone. This fascia is thin above, the muscle appears through it, inferiorly it is thick and opaque; it consists of two laminæ which are very distinct inferiorly, some fat being interposed; the fibres composing the external layer, run longitudinally, those of the internal, irregularly. The temporal aponeurosis confines the muscle in its place, and gives additional origin to its fibres. Separate the masseter from its superior attachment, divide with the saw the zygoma at either end, and elevate it together with the lower part of the temporal fascia; the temporal muscle will be thus exposed. It consists of two laminæ, the superficial is thin, but the deep layer is very thick; an aponeurosis or tendon is between these. It *arises* from all the side of the cranium beneath the semicircular ridge on the parietal bone, and from all the temporal fossa and fascia; the fibres therefore are attached internally to the parietal, frontal, and temporal bones, also to the sphenoid as low down as the crest at the root of its great wing, which crest separates the temporal from the zygomatic fossa; anteriorly to the malar bone, and externally to the inside of the temporal fascia, and to the zygomatic arch. The fleshy fibres all descend converging; the middle nearly vertical; the anterior with a little obliquity backwards; the posterior, which are very long, pass nearly horizontally forwards, over a smooth surface at the root of the zygoma, and the inferior fibres, which arise from the crest on the sphenoid bone, are very short, and pass transversely outwards.

Inserted by a strong tendon into the coronoid process of the inferior maxilla; it nearly surrounds that process, except on its outer side, and is continued along its fore-part as far as the last molar tooth. *Use*, to raise the lower jaw when the whole muscle acts; the anterior fibres may also advance the jaw, and the posterior long fibres can draw it backwards, while the inferior transverse fibres, which are nearly parallel to the external pterygoid muscle, may assist in its lateral and rotatory motions; this muscle, particularly its posterior portion, is the greatest security which the jaw possesses against dislocation, as it directly opposes the external pterygoid muscles which tend to advance the jaw, and to place its condyles on the zygomatic eminences. The temporal muscle is covered by the integuments, occipito-frontalis, superficial temporal vessels and nerves, temporal fascia, zygoma, masseter, orbicularis palpebrarum, and auricular muscles: it lies on the side of the cranium, and covers all the bones which compose the temporal fossa, also the deep temporal vessels, and part of the external pterygoid and buccinator muscles, from which it is separated by much fat.

Wounds of the temporal aponeurosis are often attended with serious effects, the severe pain and tension interfere with the action or extension of the muscle, the mouth can scarcely be opened, nor can mastication be performed without great difficulty; these symptoms simulate tetanus, from which, however, they may be distinguished by attention to the countenance and to the state of the muscles of the opposite side: suppuration beneath this fascia is both troublesome and dangerous; injury to it should be avoided in arteriotomy. In vital powers this muscle is analogous to the masseter, it is largely supplied with nerves from the same source. Remove the temporal, masseter, and buccinator muscles, also the zygomatic arch, saw or break off, low down, the coronoid process, dissect away some fat, and the pterygoid muscles will be exposed, the dissection of which may be still further facilitated by dividing the side of the lower jaw in front of the insertion of the masseter, as the angle and ramus of the jaw can then be moved backwards and forwards.

The pterygoid muscles are situated very deep behind the ramus of the lower jaw, they are two in number, internal and external, their names, however, only refer to their origins from the external pterygoid plate of the sphenoid bone, for neither are attached to the internal plate; that which is called external is nearer to the median line of the body, the internal is more superficial, and therefore first met with in dissection.

[This muscle is usually described as arising from the internal pterygoid plate of the sphenoid bone.]

Pterygoideus Internus is strong and thick, placed on the inner side of the ramus of the jaw, parallel and very similar to the superficial layer of the masseter muscle externally; it *arises* tendinous and fleshy from the inner side of the external pterygoid plate, and pterygoid process of the palate bone; it fills the greater part of tne pterygoid fossa, descends obliquely outwards and backwards, and is *inserted* tendinous and fleshy into the inner side of the angle of the jaw, and into the rough surface above it. *Use*, if the muscles of opposite sides act together, to draw forwards and to elevate the jaw, thus co-operating with the superficial layers of the masseter muscles; if alternately, they can rotate it, each moving the jaw laterally, so as to turn it to the opposite side. This muscle is larger than the external pterygoid, inferior and external to which it lies. Above, the tensor palati, superior constrictor, and below the submaxillary gland are in contact with its internal surface: the ramus of the jaw is external to it, and separated from it by the dental nerve, the internal maxillary artery and its primary branches, which are protected from the pressure of the muscle by the internal lateral ligament of the jaw: the lower extremity of this muscle is very superficial, lying between and in contact with the parotid and submaxillary glands: the upper extremity or origin is separated by the tendon of the tensor palati muscle from the internal pterygoid plate, it is concealed by, and lies deeper than that of the external pterygoid muscle.

PTERYGOIDEUS EXTERNUS is short and triangular, the base at the pterygoid process, the apex at the condyle, placed at the lower part of the temporal fossa, it *arises* broad and fleshy from the outer side of the external pterygoid plate, from the crest on the root of the great wing of the sphenoid, (which divides the temporal from the zygomatic fossa,) and from the back part of the tuberosity of the superior maxilla; the fibres pass outwards and backwards, horizontal, converging, and twisted, are *inserted* tendinous into the anterior and internal part of the neck of the lower jaw, into the interarticular cartilage and inferior synovial membrane. *Use*, when both muscles act, they draw forward the jaw, and at the same time the interarticular cartilages, which serve as moveable or temporary sockets to prevent the condyles slipping off the zygomatic eminences, when the chin is advanced, or the mouth much opened; if the muscle of one side only act, it will draw forward the condyle of that side, and turn the jaw to the opposite, and therefore when both muscles act alternately, they will become the principal agents in triturating or grinding the food. The external pterygoid muscle lies in a transverse direction beneath the base of the cranium, superior to the internal pterygoid, except at its origin; it is internal, and inferior to the temporal muscle, and is also concealed by the masseter and the ramus of the jaw; superiorly it is in contact with the sphenoid bone, posteriorly with the inferior maxillary nerve at its exit from the foramen ovale, while anteriorly and inferiorly it is in contact with much adipose matter, and with the principal branches of the maxillary artery and nerve. As the external and internal pterygoid muscles arise so near each other, and thence pass in different directions to their insertions, the external going transversely, and the internal descending, they leave between them a triangular space, which contains a quantity of fat, a small portion of the parotid gland, the internal maxillary artery and vein, and the dental and gustatory branches of the inferior maxillary nerve: as the internal maxillary artery is about to sink into the spheno-maxillary fossa, it sometimes passes between the origins of the external pterygoid muscle.

The condyles of the jaw enjoy a slight rotation forwards and downwards in the temporal articular cavities, they can also advance a little from the glenoid depressions, and descend so as to rest on the zygomatic tubercles. The lower jaw can be moved in five directions; depressed, elevated, carried forwards, backwards and rotated to either side. Depression, whereby the cavity of the mouth is opened, follows the simple relaxation of the elevator muscles, as when asleep in the erect posture, but a greater depression, as in yawning, is effected by the platisma, digastric and hyoidean muscles; in opening the mouth very wide, the upper jaw is also raised by the sterno-mastoid and digastric muscles. Elevation of the lower jaw is performed by the combined actions of the temporal, the masseter and the internal pterygoid muscles. The jaw is moved forwards by the internal pterygoid, the anterior fibres of the temporal, the superficial layer of the masseter, and above all, by the external pterygoid muscles, if these of one side only act at a time, the chin will not only be advanced, but turned to the opposite side. The jaw is carried backwards by the deep layer of the masseter, and particularly by the posterior portion of the temporal muscle. In the rotatory motions, such as occur in mastication, the chin is moved from one side to the other by those muscles which can advance and draw back the condyles acting in alternate succession on opposite sides; during these rotatory motions, the elevators are also in slight action, and thus the food is perfectly comminuted by the pressure of the latter, and by the friction of the former against the uneven surfaces of the molar teeth.

The external pterygoid muscles are the chief agents in producing dislocation of the jaw; when the mouth is widely opened, their spasmodic action may suddenly draw the condyles and interarticular cartilages of one or both sides forwards off the tubercles into the zygomatic fossæ.

SECTION III.

VESSELS AND NERVES OF THE FACE.

The arteries which are to be met with in the dissection of this region, are the facial and the terminating branches of the external carotid; the nerves are branches of the seventh and fifth pair. The *facial artery*, which is a branch or the external carotid, is seen winding round the side of the jaw, anterior to the masseter, and running in a contorted course towards the commissure of the lips, and thence ascending along the side of the nose, to the internal canthus of the eye; in this course it sends off numerous *muscular branches*, the *coronary arteries of the lips*, the *nasal*, and terminates in the *angular*, which communicates with the ophthalmic artery, at the inner side of the orbit. The facial artery and its divisions are accompanied by corresponding veins: the *facial vein* at the lower edge of the jaw generally, but not always, divides into two branches, one superficial joins the external jugular vein, the other passing deeper into the neck joins the internal jugular. *The external carotid artery*, which is seen ascending from the neck into the parotid gland, gives off numerous branches to its several lobules, and to the ear, and a little below the latter divides into the transversalis faciei, temporalis superficialis and maxillaris interna. *The transverse artery of the face* [is usually a branch of the temporal, and] crosses the masseter above, sometimes below the parotid duct, and divides into small muscular branches, some of which communicate with the facial and infra-orbital arteries. *The temporal artery* ascends behind the articulation of the maxilla, on the temporal aponeurosis, and soon divides into an anterior and posterior branch; the former is directed towards the forehead, supplies the integuments and muscles there, and communicates with the frontal branches of the ophthalmic artery; the posterior division of the temporal runs tortuously upwards, and backwards, divides into numerous branches, which supply the integuments and inosculate with the occipital and posterior auris arteries. *The internal maxillary artery* is the largest branch of the carotid; it bends in behind the neck of the lower jaw, between the bone and the internal lateral ligament, then runs tortuously between the pterygoid muscles upwards, forwards, and inwards, to the lower and back part of the orbit, where it sinks into the spheno-maxillary fossa; in this course it sends off the *middle artery of the dura mater*, the *inferior dental*, several *muscular branches* to the temporal, masseter, pterygoid, and buccinator muscles, and terminates by dividing into the *nasal*, *descending palatine*, and *infra-orbital arteries*. Veins accompany these different arteries, and in the parotid gland we find the temporal and internal maxillary veins forming, by their junction, a considerable vessel called the *external jugular vein*, which will be afterwards seen descending superficially in the neck. (For the particular description of the blood-vessels of the face, see the Anatomy of the Vascular System.)

The nerves which are met with in the dissection of the face are branches of the seventh and fifth pair; those of the seventh, or the portio dura, have in general a *transverse* direction from behind forwards, are remarkable for their plexiform arrangement, and have numerous communications with three branches of the fifth, which are distributed chiefly in a *vertical* direction along the anterior part of the face. The *portio dura* escapes from the temporal bone through the stylo-mastoid hole, turns forwards into the parotid gland, in which it divides into two large branches, which subdivide and join again by several filaments forming the plexus, named *pes anserinus*, or *parotidæan plexus*, from which several nerves proceed; some ascend obliquely forwards to the temple and forehead, others pass transversely to the muscles of the face, and several descend, some parallel, and others inferior to the side of the lower maxilla.

The fifth pair of nerves consists of three portions, viz. the ophthalmic, superior maxillary, and inferior maxillary; a branch of each of these divisions is met with in the dissection of the face. The *frontal* nerve, which is a branch of the ophthalmic, or first division of the fifth, is seen escaping from the orbit by the superciliary notch or foramen; it then ascends on the forehead, distributes its branches to the integuments and muscles, and communicates with the portio dura. The *infra orbital* nerve, which is a branch of the superior maxillary, or second division of the fifth, is observed passing out of the infra-orbital foramen, behind the levator labii superioris alæque nasi, and dividing into several branches; the most of these pass obliquely downwards, and communicate freely with branches of the seventh pair. Through the mental foramen the *mental nerve* escapes: this is a branch of the inferior maxillary, or third division of the fifth pair; most of its branches ascend to the muscles of the lower lip, and several communicate with the portio dura.—(For the more particular description of the nerves of the face, see the Anatomy of the Nervous System.)

The mouth, fauces, and palate, are the parts of the face next in order to be examined; but as these are connected and continuous with the pharynx, and as this organ cannot be seen until the muscles of the neck have been removed, the student had better postpone the dissection of the former until he has become acquainted with the anatomy of the latter; we shall therefore proceed next to the dissection of the neck.

CHAPTER II.

DISSECTION OF THE NECK.

SECTION I.

[The neck extends from the base of the cranium and lower jaw above, to the sternum clavicle and circumference of the first rib below; it is divided into an anterior and a posterior cervical region. These regions are divided from each other on the superficies of the neck, by the anterior edges of the trapezius muscles; in the thickness of the neck, they are divided by a plane, corresponding to the anterior surface of the cervical vertebræ, and thence reflected a little forward on either side, to the anterior edges of the same muscle. Of these two regions, the posterior is comparatively of little importance in a surgical point of view, it is occupied principally by muscles which act upon the head and neck, and by their appropriate vessels and nerves. On this region it is sometimes necessary to operate for the removal of new formations, such as tumors of various kinds; but mostly adipose.

The anterior cervical region, on the other hand, is of great surgical importance in reference to the occurrence of new formations, and also in reference to morbid conditions of organs naturally situated there. In the dissection of this region, we find that it has three coverings, that it is divided naturally into three triangles, which are again subdivided, and that it presents us with four groups of muscles which are considered as the muscles of the neck proper; besides those of the styloid process, of the tongue, of the pharynx, of the palate, and of the larynx, which constitute five more groups separate and distinct.

OF THE COVERINGS.

These are three in number. *First*, the *cutaneous* or *tegumentary* covering, which is thin, abundantly supplied with sebaceous follicles, and at its upper part, with follicles which secrete the hair or beard; the skin here is loosely attached beneath, it is extensible and retractile, allowing great freedom of motion. *Second*, the *musculo-fascial* covering, composed of the platysma myoides muscle, and the fascia superficialis; this covering is composed of three laminæ, the platysma myoides being placed between two laminæ of the superficial fascia.

Third, the *fascia profunda cervicalis*, which, according to the investigations of Godman, is divided into six processes, forming sheaths for different organs on the neck; and one of which descends down behind the sternum, into the thorax, to form the fibrous lamina of the pericardium.

Of the Sub-regions.

The anterior cervical region is divided into three triangles by the sterno-cleido-mastoid muscles. One of these is between the two mastoid muscles, and is therefore called the *inter-mastoid;* the other two are above the clavicles on either side and are the *supra-clavicular*. The *inter-mastoid* triangle is bounded on either side by the anterior edges of the mastoid muscles, inferiorly it terminates in an apex, at the sternum, and superiorly its base is formed by the inferior maxilla, the tube of the ear, and the anterior edge of the mastoid process. This triangle is divided into two spaces by the os-hyoides, and a transverse line drawn from it, to the edges of the mastoid muscles; the space above is the *supra-hyoideal* and that below is the *infra-hyoideal;* in the former we find the tongue and epiglottis, the upper part of the pharynx, the palate, the external carotid artery and most of its branches, the internal jugular vein, the sublingual, gustatory and other nerves: the sublingual, sub-maxillary and parotid glands besides numerous muscles; in the latter are situated the larynx and the trachea, the thyroid body, the œsophagus and lower part of the pharynx, the common carotid artery, internal jugular vein, and other vessels, the pneumo-gastric and other nerves. In the infra-hyoideal region there are two points at which the common caratid artery may be tied, these points are separated by the omo-hyoid muscle; the point above this muscle is the *omo-mastoid* angle, bounded externally by the anterior edge of the mastoid muscle, and internally by the superior edge of the omo-hyoid; in this angle the common carotid artery is situated internally, the internal jugular vein externally, and the pneumo-gastric nerve between the two and somewhat behind them, all being enclosed in a common sheath, over the fore part of which runs the descendens noni nerve; these organs are here superficial, being directly beneath the coverings of the neck; the space for tying the artery below the omo-hyoid muscle, is the *omo-tracheal* triangle, which is bounded superiorly, by the lower border of the omo-hyoid, externally by the anterior edge of the sterno-mastoid, and internally by the outer edges of the sterno-hyoid and sterno thyroid muscles; in this space we find the same organs as above and these holding the same relation to each other, they are however deeper seated, because in addition to the cervical coverings, they are overlapped by the sterno-mastoid and sterno thyroid muscles.

The supra-clavicular triangles of either side are bounded inferiorly by the clavicle, posteriorly or externally, by the anterior edge of the trapezius, and anteriorly by the external edge of the sterno-mastoid muscle. These triangles are each divided into two spaces by the inferior belly of the omo-hyoid muscle; the space above, which is very much the largest, is the *omo-trapezian;* that below is the *omo-clavicular;* in the former we find the cervical plexus, the upper part of the axillary plexus, arteries and veins, and in this space we sometimes find new morbid formations or enlarged lymphatic ganglia; in the latter are situated, frequently, the supra-scapular artery, the subclavian artery and vein, and the axillary plexus of nerves, also the termination of the external jugular vein; this is the space for tying the subclavian artery above the clavicle, it being here at a depth of an inch and a half to two inches, from the surface of the neck behind the clavicle; the artery is bounded inferiorly and somewhat anteriorly by the vein, and superiorly and externally by the axillary plexus of nerves.

MUSCLES OF THE NECK.

As already stated, there are four groups considered as the muscles of the neck proper, these groups include eighteen pairs of muscles, in the first, two; in the second, four; in the third, five; and in the fourth, seven: besides these there are the five other groups referred to, including twenty-one pairs of muscles, and two single muscles, viz. fifth, the styloid muscles, three; sixth, the proper muscular structure of the tongue, four; seventh, the muscles of the pharynx, three; eighth, the muscles of the palate four pairs and a single muscle; and ninth, the muscles of the larynx, seven pairs and a single muscle; so that upon the anterior region of the neck there are in fact thirty-nine pairs of muscles and two azygous muscles.

First Group, two pairs of Muscles.

Platysma Myoides,	*Vide p.* 32.
Sterno Cleido-Mastoideus,	" " 34.

This group extends from the thorax to the face and head, the first muscle is somewhat analagous to the sub-cutaneous muscle of certain inferior animals.

Second Group, four pairs of Muscles.

Sterno-Hyoideus, Sterno-Thyroideus,	*Vide p.* 36.
Thyreo-Hyoideus,	" " 60.
Omo-Hyoideus,	" " 37.

This group extends from the thorax to the os-hyoides, and is for the most part situated in the infra-hyoideal space, the muscles are muscles of deglutition.

Third Group, five pairs of Muscles.

Digastricus,	*Vide p.* 39.
Mylo-Hyoideus,	" " 41.
Genio-Hyoideus, Hyo-Glossus, Genio-Hyo-Glossus,	*Vide p.* 42.

This group extends between the os-hyoides, lower jaw, and tongue, one of its muscles also reaching the base of the cranium; it is situated in the supra-hyoideal space; the muscles depress the lower jaw, elevate the os-hyoides and move the tongue, they accordingly act in mastication, in articulation, and in deglutition, in which last operation, they are antagonists to the second group, the former raising the os-hyoides in the commencement of deglutition and the latter afterwards depressing it. These three groups are all anterior to the larynx trachea, œsophagus and pharynx, while the next and fourth group is behind those organs, lying directly upon the bodies and transverse processes, of the cervical vertebrae.

Fourth Group, seven pair of Muscles.

Longus Colli, Rectus Capitis Anticus Major, Rectus Capitis Anticus Minor, Rectus Capitis Lateralis,	*Vide p.* 64.
Scalenus Anticus, Scalenus Medius, Scalenus Posticus,	*Vide p.* 65.

Fifth Group, three pair of Muscles.

Stylo-Hyoideus,	*Vide p.* 43.
Stylo-Glossus, Stylo-Pharyngeus,	*Vide p.* 44.

These are the styloid muscles extending from the styloid process of the temporal bone, to the os hyoides, tongue, and pharynx, they are situated in the supra-hyoideal space, and are muscles of deglutition, being antagonists of the second group, and congeners of the third.

Sixth group, four pair of Muscles.

Lingualis,	*Vide p.* 43.
Superficial Lingual Muscle. Transverse Lingual Muscle, Vertical Lingual Muscle,	*Vide p.* 50.

These are the proper muscles of the tongue, being situated entirely in that organ, and forming a large part of its substance. They are of course in the supra-hyoideal region.

Seventh Group, three pair of Muscles.

Constrictor Pharyngis Inferior,	*Vide p.* 51.
Constrictor Pharyngis, Medius, Constrictor Pharyngis Superior,	*Vide p.* 52.

These muscles are situated on the back and sides of the pharynx, they are muscles of deglutition, and are partly above, partly below, the level of the os hyoides.

Eighth Group, four pair; and a single Muscle.

Levator Palati, Tensor Palati, or Circumflexus, Palato-Glossus, or Constrictor Isthmi Faucium, Palato-Pharyngeus, Motor, or Azygos Uvulæ, a single Muscle,	*Vide p.* 55.

These muscles are situated upon the soft palate, and are above the os hyoides, they act upon the velum, in such manner as to cut off the openings of the posterior nares, from the pharynx in deglutition, so as to prevent the food or liquids from being thrown up into the nares; or on the other hand, they cut off the mouth from the pharynx, so that fluids or gases, may be thrown up into the nostrils, and pass out through the anterior nares.

Ninth Group, seven pairs; and a single Muscle.

Crico-Thyroideus,	*Vide p.* 61.
Crico-Arytenoideus Posticus,	" " 62.
Crico-Arytenoideus Lateralis,	" " 61.
Thyreo-Arytenoideus,	" " 61.
Arytenoideus Obliquus,	*Vide p.* 62.
Arytenoideus Transversus, a single Muscle,	*Vide p.* 62.
Aryteno-Epiglottideus,	*Vide p.* 62.
Thyreo-Epiglottideus,	*Vide p.* 62.

These are the proper muscles of the larynx, they are below the os hyoides, and are situated partly externally, partly internally, in reference to the circumference of the thyroid cartilage; they act upon the cartilages of the larynx in such manner, as to enlarge or diminish the area of the rima glottidis, and relax or make tense the chordæ vocales, hence they are the muscles of the voice.]

DISSECTION OF THE MUSCLES.

Raise the shoulders of the subject by blocks placed beneath them, so as to make tense the muscles in this region; divide the integuments, which in this region are thin and delicate, near to, and in a line with the clavicle, also along the side of the jaw from the chin to the mastoid process: connect these incisions by another made in a perpendicular direction, in the middle line from the chin to the sternum; dissect off the integuments from before backwards, in an oblique direction, from the chin towards the clavicle; this should be done cautiously, to avoid injuring the platysma or fascia; in the child and in the female there is generally more subcutaneous fat than in the male subject. The platysma myoides will be now fully exposed, and the sterno-mastoid and hyoid muscles partially so; in the middle line of the neck a chain of projections may be observed, which can also be felt during life, viz. a little below, but at some distance behind the chin, is the body of the os hyoides; inferior to this is the angle of the thyroid cartilage; next is the cricoid below which the commencement of the trachea may be felt, on the forepart of which the soft swelling of the thyroid body can be discerned; and lastly, the continuation of the trachea descending into the chest. The muscles on the anterior part of the neck are very numerous, they are concerned in several functions and execute different motions; some act as the ordinary muscles of locomotion, others are occasionally engaged in deglutition, and in respiration, also in the exercise of voice and speech. They are symmetrical, or similar on each side of the middle line; they are twenty-one pair in number, and may be arranged for the convenience of dissection into three layers, a superficial, middle, and deep; the superficial consists of two pair, the platysma myoides and sterno-cleido mastoid; the middle may be divided into two orders, the inferior and superior; the inferior are three in number, viz. sterno-hyoid, thyreo-hyoid, and omo-hyoid; the superior are nine in number, viz. digastric, mylo-hyoid, genio-hyoid; three styloid muscles, hyo-glossus, genio-hyo-glossus, and lingualis muscles; the deep layer consists of seven pair, viz. longus colli, rectus capitis anticus, major and minor, rectus lateralis, and three scaleni; this arrangement excludes the muscles of the palate, pharnx, and larynx.

Platysma-myoides, or latissimus colli, is a thin and pale cutaneous muscle, in many subjects weak, and even indistinct, is situated on the forepart and side of the neck, extending from the thorax to the face; its figure is somewhat square, being a little longer than it is broad, and narrower in the centre than at either end; it *arises* by many fine fleshy fibres from the cellular membrane, covering the upper part of the deltoid and pectoral muscles, a few also adhere to the clavicle; the fibres ascend obliquely inwards, at first loosely, afterwards closely connected to each other, and form a broad thin muscle, covering the side of the neck, *inserted*, first, into the skin and cellular tissue on the chin, decussating there with fibres from the opposite side; second, into the fascia along the side of the lower jaw, a few only into the bone; some fibres may be traced high on the face, and seen to join the depressor anguli oris, the zygomatic and orbicularis palpebrarum muscles; and third, into the fascia, which covers the parotid, and which adheres to the meatus auditorius. *Use*, to depress the angle of the lips and the lower jaw, but if the mouth be closed it may elevate the integuments of the neck; it also serves to compress and support the several muscles, glands, and vessels in this region. The platysma is covered only by the skin [and anterior lamina of the superficial fascia;] it partly conceals the clavicle and the deltoid and pectoral muscles, the sterno-mastoid, hyoid, and thyroid muscles; also the digastric and stylo-hyoid, the sub-maxillary gland, the lower part of the parotid, the side of the jaw and some of the muscles of the face; also, in part, the *external jugular vein:* this vein commences in the parotid gland, descends obliquely outwards over the sterno-mastoid muscle, where it lies very superficial and then sinks behind the clavicle, and joins the subclavian vein or some of its branches. The upper portion of the external jugular vein is accompanied by a large nerve, which lies to its outer side, *superficialis colli*, a branch of the cervical plexus ascending to the parotid gland and external ear. This vein in its course down the neck receives several cutaneous veins, and frequently communicates with the internal jugular: it presents great varieties in its size and course, and is sometimes even wanting. Superficial veins may also in general be marked descending along the anterior part of the neck; they arise about the os hyoides and upper part of the thyroid body, and descend beneath some fibres of the platysma along the anterior edge of the mastoid muscle, and end in the internal or external jugular, or in the venæ innominatæ.

[*Variety.* This muscle is sometimes though rarely found thick and round, and inserted into the occiput instead of being distributed upon the face.]

The fibres of the platysma are closely connected to a layer of condensed cellular tissue, which in some subjects is very strong, and in some situations aponeurotic; this is the *superficial cervical fascia;* this fascia extends over the anterior and lateral parts of the neck; is continued down over the forepart of the thorax, where it becomes cellular and adipose; ascends to the jaw, to which it is attached; expands over the parotid gland and adheres to the cartilage of the ear; in this situation its strength is greatly increased: towards the lateral and posterior parts of the neck it becomes weak like cellular membrane. From the posterior or deep surface of this fascia a lamina of membrane is derived, which passes behind the sterno-mastoid muscle: this is *the deep cervical fascia*, whose connexions are important, and may be examined in this stage of the dissection. If the superficial lamina be divided along the median line of the sterno-mastoid muscle, this deep fascia will be seen to be continuous with or produced from the superficial, and to pass behind the anterior border to the posterior surface of that muscle, so that the latter may be considered as enclosed between these fasciæ: at the lower part of the neck it is strong, and adheres to the inter-clavicular ligament and posterior edge of the sternum and clavicles. Some loose fatty substance is here interposed between it and the superficial fascia: as the deep fascia extends upwards, it covers and adheres to the sheath of the cervical vessels, and arriving at the space between the trapezius and mastoid muscles, it becomes weak and cellular, inferiorly accompanying the great vessels beneath the clavicle, and superiorly lost on the branches of the cervical plexus of nerves; at the superior and lateral parts of the neck it sinks deep, behind the angle of the jaw, to which it adheres, and is connected to the styloid process of the temporal bone, and to the stylo-maxillary ligament; absorbent ganglia, the lower part of the parotid, and much cellular membrane here lie between these two fascæ. In this situation collections of matter often form, the result of cynanche parotidæa, or of inflammation of some of the lymphatic ganglia: such collections are productive of great inconvenience, causing such swelling and tension as to interfere with the motions of the jaw, and with the act of deglutition. The cervical fasciæ bind down the muscles and support the vessels and glands in this region; at the lower part of the neck they serve to protect the trachea and the upper part of the thorax from the pressure of the atmosphere during inspiration. Dissect off the platysma and superficial fascia, and examine the subjacent muscles, the second pair of the first order.

Sterno-Cleido Mastoideus, long and flat, placed at the anterior and lateral part of the neck, *arises* by a strong flat tendon with fleshy fibres posterior to it, from the upper and anterior part of the first bone of the sternum, also by short aponeurotic and fleshy fibres from the upper and anterior edge of the sternal third, sometimes half of the clavicle; a small triangular space separates these two origins, through which small vessels and some cellular membrane pass: this space corresponds to the sterno-clavicular articulation.

The sternal and longer portion of this muscle ascends obliquely backwards and outwards, and overlaps the clavicular, which ascends vertically; about the middle of the neck they are intimately joined, and are *inserted* by a thin, broad aponeurosis into the upper part of the mastoid process, and into the external third of the superior transverse ridge of the occipital bone. *Use*, the sternal portion can rotate the head so as to turn the face towards the opposite side: the clavicular can bend the head and neck to its own side, so as to approximate the ear and shoulder; and if the two portions of the muscle on each side act together, they will move the head downwards and forwards, but if the muscles on the back of the neck be in action, so as to fix the vertebræ and head, then these muscles, particularly the sternal portions, may assist in still further extending the neck, and carrying the head backwards, in consequence of their insertion being posterior to the centre of motion in the occipital condyles; this appears to be the case in tetanus: these muscles can also assist in laborious respiration, by raising and fixing the shoulders. This muscle is covered by the integuments, platysma, superficial fascia, external jugular vein, ascending branches of the cervical plexus of nerves, and by a small portion of the parotid gland; it conceals part of the sternum and clavicle, of the sterno-hyoid, sterno thyroid, omo-hyoid, and digastric muscles, also the lower part of the cervical vessels and several ganglia. The spinal accessory nerve perforates this muscle a little above its centre, and near its posterior surface; this nerve is a division of the eighth pair, it distributes small branches to the mastoid and trapezius muscles, and joins freely with the cervical plexus; the spinal accessory does not always perforate, but sometimes passes posterior to the mastoid muscle.

[*Varieties.* The fissure between the sternal, and clavicular origins is sometimes wanting, the two origins being continuous; sometimes there is an isolated fasiculus at its posterior margin; sometimes its inferior extremity descends as low as to the rectus abdominis or even to the end of the sternum.]

The student may remark that the two sterno-mastoid muscles bound a large triangular space situated on the fore-part of the neck, the apex at the sternum, the base at the jaw: this is divided by the mesial line into two lateral portions, which are named the anterior lateral triangles of the neck.

Between the mastoid and the trapezius muscle also, on each side, a large triangular space is enclosed, the base formed by the clavicle, the apex by the mastoid process; this space is called the posterior lateral triangle of the neck. Both these triangular regions may be observed to be subdivided into two by the omo-hyoid muscle, which crosses the neck obliquely from the shoulder to the os-hyoides. Thus on each side of the middle line four triangle spaces may be noticed, principally formed by the trapezius, sterno-mastoid, and omo-hyoid muscles; these triangles are distinguished by the terms—1. posterior inferior; 2. posterior superior; 3. anterior inferior; and 4. anterior superior.

The student should examine each of these regions, and consider the parts situated in them. These spaces can be ascertained during life, and therefore an accurate knowledge of the contents of each may be of practical importance. 1. The *posterior inferior triangle* is that small space behind the clavicular portion of the mastoid muscle, between the clavicle and posterior belly of the omo-hyoid muscle; in this space we find the subclavian artery, vein, and brachial plexus of nerves; it is here that the operation of tying the subclavian artery, in case of axillary aneurism, is recommended to be performed. 2. *The posterior superior triangle* is above the posterior belly of the omo-hyoid, and between the mastoid and trapezius muscles; it contains the cervical plexus of nerves, several lymphatic ganglia, and a great quantity of cellular membrane. 3. The *anterior inferior triangle* is above the sternal third of the clavicle between the median line and anterior belly of the omo-hyoid; this space contains the carotid artery, jugular vein, and accompanying nerves, also the lateral lobe of the thyroid body, all of which are covered by the sterno-mastoid, hyoid, and thyroid muscles. 4. The *anterior superior triangle* is between the sterno-mastoid and anterior belly of the omo-hyoid muscles; the apex is formed by the decussation of these muscles, and is opposite the cricoid cartilage; the base is, superiorly, marked by the digastric muscle and lingual nerve;—this space also contains the great vessels and nerves, which here, however, are only superficially covered, so that in this situation the operation of tying the carotid artery can be more easily effected. Divide the sterno-mastoid muscle about its centre, and reflect each portion towards its attachment; at the lower part of the neck, behind and between the sterno-mastoid muscles, are seen the following:

Sterno-Hyoideus is long, flat, and thin, *arises* within the thorax from the posterior surface of the first bone of the sternum, cartilage of the first rib, sternal end of the clavicle, and sterno-clavicular capsule; ascends obliquely inwards, approximating its fellow above, and is *inserted* into the lower border of the body of the os hyoides, internal to the omo-hyoid, [with which it is here closely connected for a short distance.] *Use*, to depress the os hyoides, pharynx and larynx. This muscle is covered by the sternum and clavicle, by the sterno-mastoid and integuments; it lies on the sterno thyroid, crico-thyroid, and thyreo-hyoid muscles, and on the thyroid body and its vessels; a tendinous line often intersects it about its centre.

[*Varieties.* This muscle sometimes is double, sometimes it arises from the middle of the clavicle, and at other times in common with the next muscle.]

Cut this muscle across, and reflect each portion towards its attachments, and we see the following pair of muscles:

Sterno-Thyroideus is broader and shorter than the last, *arises* from the posterior surface of the sternum and cartilage of the second rib, ascends obliquely outwards, [diverging from its fellow,] and is *inserted* into the oblique line on the ala of the thyroid cartilage. *Use*, to depress the larynx. This muscle is covered by the sterno-mastoid and hyoid muscles, and by the skin; it conceals the arteria and vena innominata, the carotid and subclavian vessels, and adjacent nerves, also the thyroid body, and the trachea; between it and the latter there is a considerable quantity of cellular membrane, which contains several veins (*inferior thyroid* v.) Several filaments of the descendens noni nerve are distributed to this and to the former muscle. It is between the sterno-thyroid muscles that the operation of tracheotomy is performed, while that of laryngotomy is between the sterno-hyoid muscles, and between the thyroid and cricoid cartilages.

[*Varieties.* This muscle is sometimes double, sometimes lost upon adjoining muscles, and sometimes connected to its fellow by transverse fibres.]

Omo-hyoideus is long, slender, and digastric, situated obliquely along the side and forepart of the neck, it *arises* broad and fleshy from the superior costa of the scapula behind its semilunar notch, from the ligament covering that notch, sometimes from the base of the coracoid process, and sometimes also from the acromial end of the clavicle; it ascends obliquely forwards a little above the clavicle, passes beneath the sterno-mastoid muscle, where it is generally tendinous, except in the very young subject; becoming again fleshy, it ascends nearly vertical along the outer side of the sterno-hyoid, and is *inserted* fleshy into the lower border of the os hyoides, at the junction of its body and cornu. *Use,* the muscle of one side cannot act independent of the other, both draw the os hyoides, pharynx, and larynx, downwards and backwards, and in deglutition serve to urge the food into the œsophagus. The origin of this muscle is concealed by the trapezius, it is anterior to the insertion of the levator anguli scapulæ, and between the serratus magnus and supra-spinatus muscles; the posterior belly is covered by the integuments and fascia, in some the clavicle overhangs it; it divides the great posterior lateral triangle of the neck into an inferior and superior part, as was before mentioned; this portion of the omo-hyoid can frequently be distinguished in the living neck. The tendon crosses the carotid artery and jugular vein, and is covered by the sterno-mastoid, which can thus move more easily on this structure. The anterior belly and insertion are covered by the integuments and fascia; this portion of the muscle divides the anterior lateral triangle of the neck into an inferior and superior part. The omo-hyoid crosses over the scaleni muscles, the brachial plexus, phrenic, pneumogastric and sympathetic nerves, the carotid artery, jugular vein, and superior thyroid vessels.

[*Varieties.* This muscle is sometimes double, and has one insertion into the side of the tongue. We have been informed of one subject, in which the muscle was entirely wanting on one side.]

Beneath the three last described muscles, and lying on the trachea and sides of the larynx, is a large, soft, red mass, of a crescentic shape, the concavity directed upwards; this is the *thyroid body;* it is in general larger and of a deeper colour in the child than in the adult or old [subject] and in the female than in the male; its size, however, varies considerably in different individuals, even of the same sex and age.

[Still its average weight may be set down as about one ounce in a state of health, in a diseased state it sometimes weighs as much as a pound and a half; its transverse measurement is three inches and a quarter; its vertical measurement a little over two inches.]

It consists of two large pyramidal portions, called *lateral lobes*, connected together by a narrow slip, *the middle lobe* or *isthmus;* the latter is thin and flat, and closely connected to the second, third, and fourth rings of the trachea; the lateral lobes are plump and convex, large below, pointed above, placed by the side of the trachea and larynx, and extending as high as the alæ of the thyroid cartilage; the left lateral lobe rests on the œsophagus, and both right and left overlap the carotid artery, inferior thyroid vessels, and recurrent nerve; they are covered by the sterno-mastoid, hyoid, thyroid, and omo-hyoid muscles, by the platysma and skin; they lie on the side of the trachea and larynx, on the crico-thyroid and inferior constrictor of the pharynx. The middle lobe is very irregular, it is sometimes deficient; in some cases it passes behind the œsophagus, or between this tube and the trachea a circumstance which might be productive of great inconvenience, and even danger, in the event of enlargement of this body occurring in one in whom this malformation existed. A narrow slip is often seen to ascend from the middle lobe as high as the os hyoides, [being generally placed a little to the left of the median line; following very nearly the course of this process, and frequently confounded with with it, is sometimes found a small muscle the *levator glandulæ thyroideæ*, it is attached below to the isthmus of the thyroid body, and above to the lower margin of the base of the os hyoides.] In the infant the lower part of the thyroid is connected to the thymus body. This organ has no perfect capsule, a fine cellular tissue only surrounds it; it is of a soft and spongy texture, the cells contain a yellow, serous, and sometimes an oily fluid, it appears composed of a number of granulations united by cellular tissue into lobules, the serous fluid is contained in the connecting cellular membrane, no excretory duct has been discovered, nor does there appear to be any communication between the lobes and lobules, except through the medium of the blood-vessels, which are of considerable size; four arteries, two from the carotid and two from the subclavian, are distributed to it, the former border its superior margin, the latter bend along its inferior and posterior portions; several veins issue from it, small superiorly, but very large and numerous below. This body has been by many considered as glandular, and named accordingly the thyroid gland, but there does not appear any evidence to support this opinion; it cannot belong to the secreting glands unless we admit that its veins (which are certainly very large) serve the additional office of excretory ducts, neither does it appear to have any peculiar connection with the lymphatic or absorbent system. Anatomical writers usually describe it in connexion with the larynx, but without any reason except from its contiguity to that organ. Although it is an opinion prevalent among many physiologists that the thyroid body is an organ for sanguification, yet it may be affirmed that its use is by no means fully ascertained.

The thyroid body is very subject to enlargement, which is sometimes partial, sometimes general, this affection is named *bronchocele* or *goitre*, and presents great varieties as to size, form, and consistence of the tumor, in some being firm and regular, in others very uneven, and soft or pulpy to the feel.

[Suppuration is sometimes the result of acute, but more often of chronic inflammation of the organ, and in some cases the accumulation of pus, is very great; five pounds of purulent matter having been found in one of these abcesses, which was eventually cured. This organ is also the seat of calcareous concretions, of cartilaginous and osseous formations, and of schirrus. One form of enlargement seems to depend upon a varicose condition of the vessels, and Dr. Mott, mentions that in a case upon which he operated, he found the thyroid arteries in their trunks, nearly as large as the end of his little finger. Enlargement of this body occurs in many of the inferior animals.]

Next dissect the muscles at the upper part of the neck.

Digastricus, placed at the lateral and anterior part of the neck, thick and fleshy at each extremity, round and tendinous in the centre, *arises* from a groove in the temporal bone, internal to the mastoid process, descends obliquely forwards and inwards, ends in a round tendon which perforates the stylo-hyoid muscle, and is connected to the cornu of the os hyoides by a dense fascia, sometimes by a tendinous ring like a pully; the tendon is then reflected upwards and forwards, and soon ends in the anterior fleshy belly, which continuing forwards and inwards, is *inserted* into a rough depression on the inner side of the base of the jaw, close to the symphysis. *Use*, to depress the lower jaw, and when the mouth is closed, to elevate the os hyoides, tongue and larynx; the posterior belly can also draw these backwards and upwards, and the anterior upwards and forwards, so that this muscle can exert great influence in deglutition; it can also draw the head backwards, if the chin be fixed.

[*Variety.* This muscle is often adherent by its anterior belly to its fellow of the opposite side.]

The digastric is covered posteriorly by the sterno-mastoid and splenius, and by a portion of the parotid, more anteriorly by a few fibres of the stylo-hyoideus and a small part of the submaxillary gland, by the cervical fascia, platysma and skin; it passes across the styloid muscles, the external and internal carotid, the labial and lingual arteries, the eighth, ninth, and sympathetic nerves; also the origin of the hyo-glossus and insertion of the mylo-hyoid. In the position in which the subject is placed during this dissection, the muscle forms the inferior or convex border of a semicircular space, the superior strait edge of which is marked by the side of the maxilla, and by a line continued from its angle to the mastoid process: this *digastric space* is divided by the stylo-maxillary ligament into a posterior and anterior part. The *posterior* smaller one contains the parotid gland, the carotid artery, and seventh pair of nerves; and deeper than these, the styloid process and origin of the styloid muscles, also the internal carotid artery, jugular vein, and eighth, ninth, and sympathetic nerves. The *anterior* digastric space contains the submaxillary gland, the facial and lingual arteries; the lingual and gustatory nerves, the several small muscles, which connect the tongue and os hyoides to the chin, also the sublingual gland, which cannot be seen in the present stage of dissection. The student should examine the connexions of the submaxillary gland before he dissects the muscles in this region.

The *submaxillary* is the second of the salivary glands, of an oval form and pale colour, surrounded by cellular membrane and several absorbent *ganglia* covered by the skin, platysma and fascia, bounded posteriorly by the digastric tendon, externally by the internal pterygoid muscle and stylo-maxillary ligament; anteriorly by the side of the maxilla, and internally by the anterior belly of the digastric; it rests on the mylo-hyoid, stylo-hyoid and hyo-glossus muscles; a small process of the gland accompanies its excretory duct, turns round the posterior edge of the mylo-hyoid, and lies between the upper surface of that muscle and the membrane of the mouth; this process frequently joins the sublingual gland. The facial artery and vein pass through a deep groove in this gland, [passing between the gland and base of the inferior *maxilla.*] The duct of this gland is called *Whartonian duct*, it *arises* by numerous fine radicles from the lobules of the gland, leaves it at its outer end, winds above the mylo-hyoid muscle, and runs forwards and inwards towards the frænum linguæ, by the side of which it *opens* into the mouth; the orifice can be distinctly seen in the mouth, in a prominent papilla, which appears when the anterior part of the tongue is raised: this duct is about two inches and a halt long, is thin and transparent, its coats are weaker, but its calibre is larger than in Steno's duct, the gustatory nerve accompanies it, at first superior but afterwards inferior to it: sometimes a second or accessory duct is met with.

The submaxillary gland is subject to the same *morbid* changes as those which have been alluded to in speaking of the parotid gland. Its removal in case of scirrhus is also spoken of by authors, and this operation has been described as having been frequently performed; most probably, however, many of these recorded accounts were rather cases of tumors which have pressed this gland aside, and have thus come to occupy its place. The Whartonian duct is not unfrequently obstructed near to, or closed at its termination in the mouth, the saliva then distends it into the form of a tumour of variable size, which is situated beneath the tongue, and causes more or less inconvenience to the latter; this disease is termed Ranula. Detach this gland from the mylo-hyoid, turn it outwards, leaving the duct and deep process to be further examined afterwards; separate the anterior belly of the digastric from the chin, and we see the following muscle.

Mylo-hyoideus, triangular, *arises* from the oblique line (the myloid ridge,) on the inner surface of the side of the maxilla, which line descends obliquely from beneath the last molar tooth towards the chin; the fibres descend obliquely inwards and backwards to the mesial line, and *are inserted* into the base of the os hyoides, and along with its fellow, into a middle tendinous line between that bone and the chin.

[This muscle forms the floor of the mouth.]

Use, to elevate the os hyoides and tongue, so as to press the latter against the palate. This muscle is covered by the submaxillary gland, and by the digastric; it lies on the hyo-glossus, stylo-glossus, and genio-hyoid muscles, and conceals the Whartonian duct, the lingual and gustatory nerves and sublingual gland.

[*Variety*. This muscle is sometimes lost in part upon the middle tendon of the digastric, or upon the sterno-hyoideus.]

Detach this muscle from the os hyoides and from its fellow; in the middle line we shall then see the following pair.

GENIO-HYOIDEUS, short and round, *arises* by a small tendon on the inner side of the chin, above the digastric, descends obliquely backwards, and is *inserted* broad and fleshy into the base of the os hyoides. *Use*, to draw the os hyoides upwards and forwards, to push the tongue against the incisor teeth, or protrude it from the mouth: this pair of muscles lie superior to the digastric and mylo-hyoid, and inferior to the genio-hyo-glossus.

[*Varieties.* This muscle is sometimes double on both sides, sometimes there is but one muscle.]

Reflect the genio and mylo-hyoid muscles towards the lower jaw, we thus expose superiorly the membrane of the mouth, with the sublingual gland attached to it, close to which is the gustatory nerve; inferior to this the Whartonian duct is seen, and nearer to the os hyoides is the lingual nerve, from which a plexus extends to the gustatory; the hyo and genio-hyo-glossi, and the three styloid muscles are also now exposed.

The *sublingual* is the third and smallest of the salivary glands, oblong, placed beneath the anterior and lateral part of the tongue, covered superiorly by the mucous membrane, to which it adheres, and resting inferiorly on the mylo-hyoid, is in contact internally with the genio-hyo-glossus, and is connected externally to the deep process of the submaxillary gland. This gland opens by several small ducts, some of which join the Whartonian canal, others perforate the mucous membrane of the mouth, between the tongue and inferior canine, and bicuspid teeth by small openings, which may be observed on a sort of crest or fold of the mucous membrane in this situation. The three salivary glands, though generally separated from each other, yet are in some cases so joined together as to resemble one irregular glandular mass, the parotid being united to the submaxillary behind the angle of the jaw, and the latter being connected to the sublingual around the mylo-hyoid muscle.

HYO-GLOSSUS is flat and thin, *arises* from the cornu and part of the body of the os hyoides, ascends a little outwards, *inserted* into the side of the tongue. *Use*, to render the dorsum of the tongue convex by depressing its side; it may also elevate the os hyoides and base of the tongue. This muscle is covered by the mylo-hyoid in part and by the sublingual gland and lingual nerve; it lies on the middle constrictor of the pharynx, the lingual artery, and the substance of the tongue.

GENIO-HYO-GLOSSUS is triangular, *arises* by a small tendon from an eminence inside the chin, beneath the frænum linguæ ; thence the fibres radiate, the superior ascend and turn forwards towards the tip of the tongue, the middle also ascend some inclining forwards, others backwards; the inferior and posterior pass backwards and downwards to the base of the os hyoides.—*Inserted* into the mesial line of the tongue from the apex to the base, and into the body or lesser cornu of the os hyoides. *Use*, the posterior fibres can draw the os hyoides towards the chin, and thus protrude the tongue from the mouth, the anterior can draw back the tongue, and bend its tip down towards the frænum, the middle portion can depress the middle of the tongue and make it concave from side to side ; it can also draw it forwards so as to enlarge the opening of the fauces. This muscle is therefore used in mastication and deglutition, also in the articulation of several letters. The several muscles last described cover this muscle externally, internally it is in contact with its fellow.

Lingualis is a fasciculus of fibres taking a longitudinal course on the inferior surface of the tongue from the base to the apex, and intermixing with the muscles on either side, so that it appears as being derived from these rather than a distinct muscle; the fibres are attached through their whole length, and are mixed with a soft fatty substance; anteriorly they are broader and more distinct; they are situated between the genio-hyo-glossus internally, and the hyo and stylo-glossus externally. *Use*, to shorten the tongue and bend the tip downwards and to one side. External to the muscles now described, we see the three styloid muscles.

Stylo-Hyoideus *arises* from the outer side of the styloid process near its base, descends obliquely forwards parallel to the posterior belly of the digastric, whose tendon generally perforates this muscle, *inserted* into the cornu and body of the os hyoides and into the fascia, which connects the digastric tendon to this bone. *Use*, to co-operate with the posterior part of the digastric, in raising and drawing back the os hyoides and tongue. This muscle is nearly superficial, but at first is covered by the parotid; the digastric lies to its external side and the external carotid artery to its internal: this vessel is posterior to the lower part of the muscle, but anterior to its origin; a ligament often accompanies the stylo-hyoid muscle, from the styloid process to the cornu of the os hyoides; it is named the stylo-hyoid ligament, and is sometimes ossified.

[*Variety*. This muscle is often double.]

Raise the digastric and stylo-hyoid, and we see the remaining styloid muscles.

STYLO-GLOSSUS *arises* tendinous and narrow from the inner side of the styloid process near its point, and from the stylo-maxillary ligament; descends obliquely forwards and inwards, and is *inserted* into the side of the tongue; its fibres overlap and unite with those of the hyo-glossus, and can be traced as far as the tip.—*Use*, to draw the tongue backwards, and to one side, and to raise the tip behind the upper incisor teeth. It is covered by the sub-maxillary and lingual glands, by the gustatory nerve and mucous membrane.

[*Variety.* This muscle has been found double on both sides.]

STYLO-PHARYNGEUS, long and narrow, *arises* from the back part of the root of the styloid process, descends inwards and backwards, passes between the superior and middle constrictors of the pharynx, with which it mixes; is *inserted* with these into the side of the pharynx, also into the cornu of the os hyoides and thyroid cartilage. *Use*, to elevate, dilate, and draw forwards the pharynx, so as to receive the food from the tongue. It is covered by the stylo-hyoid, middle constrictor and external carotid, and it lies on the superior constrictor, internal carotid, sympathetic and par vagum; the glosso-pharyngeal nerve winds round it.

SECTION II.

DISSECTION OF THE VESSELS AND NERVES OF THE NECK.

THE arteries which are met with in dissecting the neck are the carotid and subclavian of each side, and their several branches; the veins are the external and internal jugular and subclavian; the nerves are the gustatory branch of the fifth, the eighth, and the ninth pair, the sympathetic and the anterior branches of the eight cervical and first dorsal spinal nerves. The *right carotid artery* arises from the arteria innominata, behind the right sterno-clavicular articulation; the *left carotid* arises from the upper part of the arch of the aorta; in other respects these arteries are similar; both ascend by the side of the trachea and larynx, surrounded by a sheath of cellular membrane, on the forepart of which are seen the branches of the descendens noni nerve; behind the sheath lies the sympathetic, and within it are the jugular vein, lying to the outside of the artery, and the par vagum nerve, between, and rather behind both these vessels; opposite the os hyoides each carotid divides into two branches, viz. the internal and external; the *internal carotid artery* is the larger branch, lies deeper in the neck, and more external; it ascends along the forepart of the transverse processes of the vertebræ to the base of the cranium, enters this cavity, through the foramen caroticum in the temporal bone, and is distributed to the brain. The *external carotid artery* ascends towards the parotid gland, being crossed by the digastric and stylo-hyoid muscles, and by the lingual and portio dura nerves; in this course it gives off several branches, viz. the superior thyroid, lingual, labial or facial, auricular, occipital, pharyngeal, transverse facial, internal maxillary and temporal.

The *Subclavian arteries* are situated at the inferior and lateral part of the neck; the *right* arises from the arteria innominata, the *left* from the posterior part of the arch of the aorta; each subclavian artery passes upwards and outwards to the anterior scalenus, behind which it passes; it then turns downwards and outwards behind the clavicle, and over the first rib into the axilla; the difference in the origin causes an important difference in the situation and connexions of the right and left subclavian in the early part of their course; the right being shorter and nearly transverse, lies higher in the neck, and more superficial than the left, which arises deep in the thorax, out of which it ascends perpendicularly before it turns outwards to pass between the scaleni; after this point, these vessels are similar in every respect; each gives off the following branches, viz. arteria vertebralis, mammaria interna, axis thyroidea, cervicalis profunda, and intercostalis superior.

The external jugular vein has been already noticed; the *internal jugular vein* of each side commences at the termination of the lateral sinus in the foramen lacerum posterius, descends along the outer side, first, of the internal, and afterwards of the common carotid artery, and at the inferior part of the neck joins the *subclavian vein*, which returns the blood from the upper extremity, and accompanies the subclavian artery; the junction of each jugular and subclavian, which is posterior to the sternal end of each clavicle, forms the right and left venæ innominatæ; these veins enter the chest, and uniting, commence the superior vena cava, as will be seen in the dissection of the thorax.—(For the more particular description of the vessels of the neck, see the anatomy of the vascular system.)

The *gustatory nerve* is the principle branch of the inferior maxillary, or third division of the fifth pair; it is seen, on dividing the mylo-hyoid, taking an arched course parallel to the stylo-glossus muscle, from within the angle of the jaw towards the tip and side of the tongue; it accompanies the Whartonian duct, and rises above the sublingual gland, between it and the tongue; it gives branches to the submaxillary and sublingual glands, and terminates in fine filaments, which are lost in the papillæ beneath the mucous membrane, covering the sides and tip of the tongue. The chorda tympani joins it near the condyle, and parts from it opposite the angle of the lower maxilla; this delicate nerve then swells into a small ganglion, whose branches pass into the submaxillary gland. The *eighth pair of nerves* leave the cranium by the foramen lacerum posterius, anterior to the jugular vein; it immediately separates into its three portions, the internal or glosso-pharyngeal, the external or spinal accessory, and the middle or par vagum. The *glosso-pharyngeal* is connected to the stylo-pharyngeus muscle, its name denotes its destination; the arch which it forms, as it runs to the base of the tongue, is inferior to and deeper in the neck than the gustatory nerve. The *spinal accessory nerve* separates from the par vagum, and in general winds round behind the internal jugular vein, perforates the sterno-mastoid muscle, as was before mentioned, and distributes its branches to it and to the trapezius; several of these also communicate with the cervical plexus, and descend towards the acromion. The *par vagum* or *pneumogastric* descends along the neck, between, and rather behind the carotid artery and jugular vein, and enclosed in their sheath; it then passes through the thorax, and terminates on the stomach. The cervical portion only of this nerve is to be observed at present; from it arises several branches, viz. communicating branches to join the sympathetic and lingual; pharyngeal branches to the side of the pharynx; superior laryngeal nerve, which takes an arched course behind the great vessels to the thyroid cartilage, and is distributed to the upper part of the larynx; and small cardiac branches, which join similarly named branches of the sympathetic nerve. At the inferior part of the neck, on each side of the trachea, a large nerve, the *inferior laryngeal* or *recurrent nerve*, is seen; this is also a branch of the par vagum. On the *right* side, this nerve *arises* at the lower part of the neck, turns round the subclavian artery, and passing behind it and the carotid, pursues its course upwards and inwards behind the thyroid body to the lower and back part of the larynx; on the *left* side the recurrent nerve *arises* in the thorax, opposite the lower part of the arch of aorta, under which it passes, and then attaching itself to the forepart of the œsophagus, ascends to the larynx, to the muscles of which it is distributed like that of the opposite side. At the inferior part of the neck, the eighth pair of nerves enter the thorax; that of the right side passes anterior to the subclavian artery, crossing it at a right angle; that of the left side descends anterior but parallel to the left subclavian artery. The *ninth pair*, or *lingual nerve*, leaves the cranium by the anterior condyloid hole in the occipital bone, descends forwards and inwards, nearly parallel to the digastric muscle, and is distributed to the muscles of the tongue; the arch which the course of this nerve describes is parellel, but inferior to that of the gustatory. From the convexity of this arch a long branch arises, the *descendens noni;* this descends along the forepart of the sheath of the carotid artery, communicates with the second and third cervical nerves about the middle of the neck, and is distributed to the sterno-hyoid and thyroid muscles: in some cases this nerve descends within the sheath behind the vein. The *sympathetic nerve* may be found descending along the vertebræ posterior to the carotid artery: this nerve commences at the base of the cranium, in a long, oval, red swelling, the *superior cervical ganglion*, which extends as low as the third cervical vertebra; from this the nerve becoming very small, descends almost vertically, and in general opposite the fifth cervical vertebra, it forms a second swelling, called the *middle cervical ganglion;* from this, the small nervous chord continues its course down the neck, and opposite the seventh cervical vertebra, and the neck of the first rib, it expands into a large irregular swelling, the *inferior cervical ganglion*, from the lower part of which the nerve descends into the thorax. (For the particular description of the branches of the sympathetic, as well as of the cerebral nerves, met with in the dissection of the neck, *see the Anatomy of the Nervous System.*) On the side of the neck are seen numerous branches of the cervical spinal nerves; there are *eight pair of cervical nerves;* the first, or suboccipital, is very small; the eighth is very large; the first leaves the spinal canal between the occipital bone and the atlas; and the eighth between the last cervical and first dorsal vertebra: these cervical nerves all divide into a posterior and anterior branch, the former are distributed to the muscles and integuments, on the back of the neck; the anterior branches of the first, second, third, and fourth, communicate with each other, and give origin to several branches, which again unite with each other, and constitute *the cervical plexus;* this plexus is between the mastoid and trapezius muscles; it sends off several branches, which are entangled with much cellular membrane, and several absorbent ganglia: the anterior branches of the four inferior cervical nerves with that of the first dorsal, unite and form the *brachial plexus;* this is situated at the lateral and inferior part of the neck, and accompanies the subclavian artery beneath the clavicle into the axilla, in which region the plexus divides into several branches to supply the upper extremity and the muscles on the parietes of the thorax. In the inferior and lateral part of the neck, on each side, the *phrenic nerve* is also seen; this arises by several fine filaments, from the third, fourth, and fifth cervical nerves; the phrenic nerve descends obliquely inwards along the anterior scalenus muscle, enters the thorax between the subclavian vein and artery, and is distributed to the diaphragm. Previous to examining the deep muscles of the neck, the student should study the anatomy of the mouth, pharynx, and larynx.

SECTION III.

DISSECTION OF THE MOUTH, PHARYNX, AND LARYNX.

The cavity of the mouth may be exposed by dividing the commissure of the lips, and the cheek of one side, and removing a small portion of the side of the lower jaw; draw forward the tongue with a tenaculum, and cleanse the parts very well. The *mouth* is bounded anteriorly by the lips, superiorly by the hard and soft palate, laterally by the cheeks, inferiorly by the tongue, and mucous membrane reflected from it to the gums; posteriorly it communicates with the pharynx: this opening is named the *isthmus faucium;* it is bounded above by the velum and uvula, below by the tongue, on each side by the arches of the palate. The anterior part of the palate, or *hard palate,* is formed of the palate plates of the maxillary and palate bones, covered by mucous membrane and glands; the posterior part of the palate or *soft palate,* or *velum pendulum,* consists of a dense aponeurosis, and of several muscles and glands, enclosed in mucous membrane; the *cheeks* are formed of mucous membrane, covered by the buccinator and a quantity of fat; several small mucous glands lie between the membrane and this muscle, and towards the upper and back part on each side we perceive the small opening of Steno's duct. The mouth is lined throughout by mucous membrane, which is continuous with the cutis on the lips, and extends posteriorly through the pharynx, whence it ascends to line the nares, the Eustachian tube and tympanum on each side, and descends to line the œsophagus and larynx; as it is reflected from one surface to another, it forms folds or fræna, as between the lips and alveoli, and beneath the tongue; at the sides of the fauces, also, it forms two semilunar folds on each side, called the pillars or arches of the palate; these folds enclose muscular fibres, which we shall examine afterwards.

[The mucous membrane lining the mouth, tongue, pharynx and œsophagus, is furnished with a delicate cuticle or epithelium, which terminates at the œsophageal opening of the stomach; the existence of this membrane, is demonstrated by its occasional separation in shreds, in fevers. or from taking a quantity of hot fluid into the mouth, it is also shown by maceration.]

On looking into the mouth, either in the living or dead subject, the following objects strike the attention; inferiorly the tongue and teeth; laterally the cheeks; posteriorly the back part of the pharynx; superiorly the hard and soft palate, from the centre of the latter, the uvula, and from the sides, the pillars or arches descending to the tongue and pharynx; in the recess between these pillars on each side the tonsil or amygdala is also seen; lastly, if the tongue be drawn forward, the epiglottis comes into view.

The *tongue* is of a triangular shape: its base, thick and broad, is connected to the epiglottis and palate by mucous membrane, and to the os hyoides and inferior maxilla by muscles; the apex is thin and unattached; that portion between it and the base is named the body of the tongue; all the upper surface, the sides, and about one-third of its inferior surface, are covered by mucous membrane, which is very rough superiorly, from the number of papillæ that project through it; anteriorly, these papillæ are small, conical, and connected with the terminations of the nerves of taste; posteriorly they are large, round, fungiform, lenticular, and very irregular; these are small glands which open on the mucous surface; near the epiglottis these glandular papillæ are often observed to have a peculiar arrangement, like the letter v, the concavity turned forwards; behind the apex of this angle, a deep depression (foramen cœcum) is observable; this contains some mucous follicles; a superficial groove runs along the dorsum of the tongue, one more distinct exists along the inferior surface, so that this organ is divided by the mesial line, into two symmetrical portions; accordingly, in paralysis, one side only of this organ is frequently found affected.* The sub-

* In hemiplegia, when the muscles of one side of the face are paralysed, it has been remarked, that if the tongue be protruded, the apex will be directed towards the affected side; this phenomenon, which is only an apparent exception, depends on the action of the genio-hyo-glossus muscle of the healthy side, which will pull the base of the tongue on that side towards the chin, and must therefore turn the point to the opposite side.

Geo. J.,—

stance of the tongue is composed of adeps blended with numerous muscular fibres derived from the stylo, hyo, genio-hyo-glossi, and linguales muscles, and of many other fleshy fibres which do not properly belong to any of these [*viz.* the superficial transverse, and vertical lingual muscles:] two large arteries (lingual) and six considerable nerves (the gustatory, the lingual, and the glosso-pharyngeal, on each side) supply this organ. The tongue is not only the organ of taste, but by its great mobility it assists in speech, in suction and in deglutition. The fifth pair of nerves endów the tongue with sensation and with the sense of taste, the ninth with mobility, and the eighth supply its base with sensation, and connect the motions of this organ with those of the pharynx and stomach.

The tongue is subject to many *morbid* changes, viz. inflammation, acute or chronic, causing great and dangerous, and sometimes fatal enlargement; tumors of different kinds occur here, also ulceration, cancerous, syphilitic, apthous, &c.; portions of this organ can be removed with safety, either by ligature or excision.

[The tongue is sometimes the seat of congenital malformations; its tip is sometimes bifurcated, sometimes nipple shaped; the organ is sometimes entirely wanting, sometimes double. The frænum linguæ (a vertical fold of the mucous membrane, as it is reflected from the inferior surface of the tongue to the floor of the mouth,) is sometimes too long, antero-posteriorly, or too short vertically, constituting the *tongue tie*, which interferes with nursing in the infant, and with distinct articulation at a subsequent period: this is easily relieved, by dividing the frænum for a line or two. It has been supposed that in excising one lateral half of the tongue there would be serious hemorrhage, in consequence of a free anastomosis of the arteries of the two sides; that this free anastomosis does not exist, is proved by minute injection, most of the vessels, terminating at the middle septum of the tongue; it is also proved by the fact, that the lateral excision of the tongue, has been accomplished, without hemorrhage, by first tying the trunk of the lingual artery, just at the cornu of the os-hyoides.]

SECTION IV.

DISSECTION OF THE PHARYNX.

To obtain a view of the muscles of the pharynx and palate, the student may now make the following dissection: divide the trachea and œsophagus in the lower part of the neck; detach them from the vertebræ, to which they are loosely connected; draw forward these organs, together with the vessels and nerves on either side; place the saw flat on the bodies of the vertebræ; insinuate its edge between the styloid and mastoid processes on each side, and make a vertical section of the head: we have thus the face and anterior part of the cranium separated from the vertebral column; or, should it be desirable to preserve the cranium, we may separate the occipital bone from the atlas, and then remove from the subject the whole head, together with the organs we wish to examine; distend the pharynx with hair or tow, and remove some of the loose cellular tissue connected to it.

The *pharynx* is a large, muscular, and membranous bag, extending from the base of the cranium to the fourth or fifth cervical vertebra, where it ends in the œsophagus; it is placed behind the nose, mouth, and larynx; is somewhat of an oval form, the largest part being opposite the os hyoides, and the smaller extremity joining the œsophagus. The pharynx is attached superiorly and posteriorly to the cuneiform process, by an aponeurosis, which is very strong in the middle line, laterally by a thinner aponeurosis to the petrous bone, and anteriorly, by fleshy fibres to the internal pterygoid plate and hamular process, and to the posterior part of the mylo-hyoid ridge of the lower maxilla;—the pharynx is connected posteriorly to the vertebræ, and to the deep muscles of the neck, by loose reticular membrane; anteriorly it is attached by mucous membrane and muscular fibres to the cornua of the os hyoides and thyroid cartilage, and to the sides of the cricoid, behind which the pharynx abruptly contracts and ends in the œsophagus: on either side of the pharynx, and loosely connected to it, is the sheath of the carotid artery with its accompanying nerves. The muscular fibres which cover the back and sides of the pharynx, are named constrictor muscles; they are symmetrical, and are three in number on each side, they are named the superior, middle, and inferior; they overlap each other, the inferior being most superficial, the middle next, and the superior the deepest; the constrictor muscles of opposite sides have one common insertion into the *middle tendinous line*, or raphe on the back part of the pharynx, which line is very strong and distinct superiorly, being *inserted* into the cuneiform process, but inferiorly it is weak and often indistinct.

Constrictor Pharyngis Inferior is somewhat square, *arises* from the side of the cricoid cartilage, from the inferior cornu and posterior part of the ala of the thyroid cartilage, external to the crico-thyroid andthyreo-hyoid;

the superior fibres ascend obliquely, and overlap the middle constrictor; the inferior fibres run circularly and overlap the œsophagus; *inserted* along with that of the opposite side into the middle line on the back of the pharynx; its origin is covered by the sterno-thyroid muscle, and the thyroid body; this muscle lies on the mucous membrane, except its superior fibres, which are separated from it by the middle constrictor. The inferior laryngeal or recurrent nerve passes beneath its lower edge, and the superior laryngeal beneath its upper.

Constrictor Pharyngis Medius is of a triangular form, *arises* from the cornu and appendix of the os hyoides, also from the stylo-hyoid and posterior thyreo-hyoid ligaments; its fibres expand on the back of the pharynx, the superior ascend to the occipital bone, the middle run transversely, and the inferior descend beneath the lower constrictor, *inserted* into the mesial tendinous line or raphe, and into the cuneiform process. The lingual artery and hyo-glossus muscle are connected to the origin of this muscle, which part is separated from the inferior constrictor by the superior laryngeal nerve and cornu of the thyroid cartilage, and from the superior constrictor by the stylo-pharyngeus muscle and glosso-pharyngeal nerve; on dividing the edge of this muscle, the Stylo-pharyngeus appears; it *arises* from the root of the styloid process, descends to the side of the pharynx, where it expands between the superior and middle constrictors, and is *inserted* beneath the latter partly into the submucous tissue, and partly into the cornu of the thyroid cartilage. *Use*, to elevate, dilate, shorten, and draw forwards the pharynx, in order to receive the food from the tongue, it will also raise the larynx: divide the stylo-pharyngeus, and the superior constrictor will be exposed.

Constrictor Pharyngis Superior, surrounds the superior part of the pharynx, *arises* by a dense aponeurosis from the petrous bone, which soon becomes connected with the next origin, which is fleshy, from the lower part of the internal pterygoid plate and hamular process, also from the intermaxillary ligament, (*see page* 7,) which connects it to the buccinator muscle, from the posterior third of the mylo-hyoid ridge, and from the side of the base of the tongue; all the fibres take a semicircular course backwards and inwards, and are *inserted* into the cuneiform process and into the middle tendinous line on the back of the pharynx. The superior constrictor is covered by the styloid muscles and by the great vessels and nerves, and inferiorly by the middle constrictor, from which the stylo-pharyngeus and glosso-pharyngeal nerve separate it: between the attachment to the petrous bone and that to the occipital, the mucous membrane is uncovered by muscular fibres in a small semicircular space, named *sinus of Morgagni;* this is beneath the cuneiform process, on each side of the middle line, and corresponds to the Eustachian tubes; between the temporal and pterygoid attachments, the muscles of the velum lie, and between the pterygoid and maxillary origins the internal pterygoid muscle and the gustatory nerve are situated. *Use*, the constrictors diminish the capacity of the pharynx, and by the successive contractions of each, the food is forced into the œsophagus, the complex muscular structure of the pharynx may also assist in the modulation of the voice and in the production of certain sounds. Open the pharynx by a perpendicular incision through the middle tendinous line; on looking into the cavity it will be found divided by the velum into two portions, a superior and inferior; *seven openings* also may be remarked leading from it in different directions, viz. in the upper and nasal portion there are the two posterior nares, and on the side of each of these is the opening of the Eustachian tube; below the velum is the isthmus faucium, or posterior opening of the mouth; below and behind the tongue is the opening of the glottis; and lastly, the termination of the pharynx in the œsophagus. The *openings of the nares* are of an oval shape, their long diameter being vertical; the body of the sphenoid bone bounds them superiorly, the palate bones inferiorly, the internal pterygoid plates externally, and the vomer separates them from each other: through these openings the air generally passes during respiration. The *Eustachian tubes* open on each side of the posterior nares, behind the inferior spongy bone; they are circular, and look forwards and inwards towards the septum narium, are formed of thick cartilage, covered by mucous membrane; through these air is admitted from the nose into the tympanum, to support the membrana tympani on its inner side. The Eustachian tube must be again examined in the dissection of the organ of hearing.* Beneath the velum is the *isthmus faucium*, transversely oval, but capable of great change in figure and size, bounded above by the velum and uvula, below by the tongue, and on either side by the *pillars* or *arches* of the palate, and by the amygdalæ. The opening of the *glottis* or *superior* opening of the larynx, is at the lower and anterior part of the pharynx, behind the

* The student may practice the introduction of a probe into this tube: slightly curve a blunt probe, pass it along the floor of the nose to the posterior nares, then direct its extremity upwards, outwards, and backwards, that is, towards the ear, and it will enter this tube.

epiglottis, and rather beneath the tongue; it is of a triangular form, the base anteriorly, formed by the epiglottis; the sides are composed of folds of mucous membrane, termed aryteno-epiglottidean, and the apex, which is posteriorly, is formed by the appendices of the arytenoid cartilages. The glottis, which will again be considered in speaking of the larynx, is always open, except in the act of deglutition. The *œsophageal opening* is below and behind the glottis; it is always closed, except in deglutition. The student should next examine the velum pendulum palati, or palatum molle.

SECTION V.

DISSECTION OF THE PALATE AND ITS MUSCLES.

The *velum pendulum palati* is a soft moveable substance, attached superiorly and anteriorly to the hard palate on each side of the tongue and pharynx, and posteriorly and inferiorly it terminates in a thin edge, from the centre of which the uvula descends, thus giving a lunated appearance to the edge of the velum on each side; these crescentic edges are named the *half arches* of the palate.

[Being two in number on each side, between which the tonsils are placed; the space bounded anteriorly and posteriorly, by these half arches, or pillars, is the *fauces*, and the anterior opening into this space is called the *isthmus faucium*.]

The velum is situated obliquely, its fixed edge being superior and anterior to the loose, one surface looking forwards and downwards towards the mouth and tongue, the opposite surface looking upwards and backwards; during life this aspect can be altered by the action of muscles, which can either elevate, depress, or make tense the velum. Beneath the mucous membrane of the velum several small glands are situated, chiefly on the inferior surface. The *uvula* is a conical prolongation of the velum, enclosing small glands, loose cellular membrane, and some muscular fibres; in deglutition, the velum and uvula are raised so as to touch the back part of the pharynx, and thus they are of *use* in preventing the food ascending into the upper or nasal part of the cavity, from which it might regurgitate into the nares. The muscles of the velum or soft palate are five pair, the levator and tensor palati, the moto uvulæ, palato-glossus and palato-pharyngeus.

Levator-Palati, *arises* narrow from the petrous bone, in front of the foramen caroticum and behind the Eustachian tube, descends obliquely inwards and backwards, and is *inserted* broad into the velum near its centre; its name denotes its *use.* It is situated on the side of the posterior nares, its insertion intermixes with its fellow and with the other muscles of the palate.

Tensor-Palati vel circumflexus palati, *arises* fleshy from a depression at the root of the internal pterygoid plate, from the spinous process of the sphenoid, and from the forepart of the Eustachian tube, descends between the internal pterygoid plate and muscle, ends in a flat tendon, which turns round the hamular process inwards to the velum, it then expands, and *joins* that from the opposite side. *Use*, to make tense, the velum in a horizontal direction between the hamular processes.

Motor Uvulæ, *arises* from the posterior extremity or spine of the palate bones, descends close to its fellow, along the median line of the velum, and is *inserted* into the cellular tissue of the uvula. *Use*, to raise and shorten the uvula: this pair of muscles are so close that they appear but as one, hence they have sometimes received the name of *azygos uvulæ*.

Palato-Glossus vel constrictor isthmi faucium, or the anterior arch or pillar of the palate, *arises* from the inferior surface of the velum, descends forwards and outwards, enclosed in a fold of mucous membrane anterior to the tonsil. *Inserted* into the side of the tongue. *Use*, to elevate the tongue or to depress the velum; this pair of muscles may also close the fauces.

Palato-Pharyngeus, or posterior arch of the palate, *arises* broad from the inferior surface of the palate, arches downwards and backwards behind the tonsil, and is *inserted* into the side and back of the pharynx, and into the cornu of the thyroid cartilage, its fibres mixing with those of the stylo-pharyngeus. *Use*, to elevate the pharynx, like the stylo-pharyngei in the commencement of deglutition; but afterwards to depress the velum.

The *tonsil* or *amygdala*, though apparently a compact body, is formed of a congeries of mucous glands, of an irregular figure, somewhat oval, the larger extremity above, placed in a triangular recess between the pillars of the palate, above the side of the base of the tongue, covered internally by the mucous membrane, and externally by the superior constrictor of the pharynx; small holes are remarked on its surface; these lead into cells from which the mucus can be expressed.

[The tonsil is usually described, as being of the size of an almond;

it is from six to eight lines in length, from four to five in breadth, and three in thickness, and is of a reddish grey color.]

The amygdalæ are very vascular and secrete a viscid fluid, which being pressed out in the moment of deglutition by the contraction of the surrounding muscles, *serves* to lubricate the alimentary bolus in its passage. The internal carotid artery is posterior and somewhat external to it, the external carotid is also to its outer side, and the facial artery, just before it enters the submaxillary gland, is anterior to it; from these three vessels, this gland when of its healthy size, is separated by the superior constrictor, and by a considerable interval which is filled by cellular tissue, but when enlarged, as in the case of abscess, it comes into such close contact with these, particularly with the internal carotid, that there is some danger of wounding the latter in opening the abscess with the lancet.

The soft palate and its arches, the uvula and the tonsils, are liable to many *morbid* affections, viz. acute inflammation and all its consequences; syphilitic ulceration very commonly attacks these parts, particularly that surface, towards the mouth; polypi, also, are not unfrequently produced from the velum, and in general from its upper or nasal surface. When the uvula is the seat of inflammation, its pendulous extremity becomes so distended by serous infiltration, that its figure is totally changed, and it sometimes interferes so much with deglutition and respiration, or excites such irritation, as to require free scarification, or excision of its lower portion. The velum is sometimes found cleft at birth with or without the accompanying similar anormal state of the hard palate and upper lip.

The tonsil is very subject to acute inflammation (cynanche tonsillaris); in this affection it enlarges so much as to impede deglutition, induce deafness, and even in some cases to threaten suffocation. It is sometimes, also, the seat of chronic enlargement, to such a degree, as to require the operation of removal; it is also frequently affected with syphilitic ulceration.

[The tonsil is sometimes the seat of a calcareous concretion; the chronic cases of hard enlarged tonsils, are commonly spoken of as schirrus; it is not however of a cancerous nature. True cancer here is exceedingly rare. Gross has been unable to find a single case recorded, but one instance of the kind has come to our knowledge, and of that case the minutes are in the possession of Prof. Parker.]

The *œsophagus* appears as the continuation of the pharynx, it differs from it, however, in structure; the mucous membrane is paler, and thrown into longitudinal folds; the muscular fibres are arranged in two laminæ, the external are longitudinal, strong and red, attached superiorly and anteriorly to the cricoid cartilage, and below are lost on the stomach; the internal circular fibres are pale, and cease abrubtly at the cardiac orifice of the stomach.

[According to some anatomists, the circular fibres of the œsophagus do not terminate at this point, but are collected into two bands, one of which is situated at the left of the orifice of the stomach, and is thence distributed over its anterior and posterior faces, while the other is at the right of the orifice and is thence distributed over the anterior and posterior faces of the greater cul de sac, if so they must decussate each other, and form a sort of sphincter muscle, around the orifice.]

In the neck the œsophagus descends posterior to the trachea, and nearly in the middle line; it inclines a little to the left side below, so as to be uncovered by that tube; the left lobe of the thyroid gland, the recurrent nerve, and the inferior thyroid vessels, lie on it in this situation.

The *morbid* appearances met with in the pharynx and œsophagus are not very many; the mucous membrane of the former is liable to inflammation, (cynanche pharyngea,) and to ulceration from various causes; the submucous tissue is frequently the source of polypous growths, particularly at the upper part. The lining membrane of the œsophagus is seldom the seat of active inflammation, except as the consequence of some foreign body, or the contact of some acrid substance; it is not unfrequently the seat of stricture, caused in some cases by a contraction and thickening of its coats, in others by true scirrhus, ending in cancerous ulceration; tumours in the vicinity of this tube will also interrupt its functions, for example, bronchocele, enlarged bronchial ganglia, or aneurism of the descending aorta. The œsophogus is also sometimes affected with paralysis, and in hysterical patients it is very subject to nervous affections, which frequently bear a close resemblance to true stricture of this tube. The course and connexions of the œsophagus in the chest will be seen hereafter.*

[This organ is the seat of various congenital malformations; it may be double or entirely wanting, the pharynx ending in a blind cul-de-sac: it may terminate in a blind cul-de-sac just below the pharynx or near the œsophageal extremity of the stomach: it may end in the trachea, and it may be preternaturally dilated or contracted. Stricture usually occurs a short distance below the pharynx, and if treated early with bougies may be cured, it is sometimes spasmodic.]

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* The student should practice the passing of a probe or canula armed with a ligature, along the nares into the pharynx, and endeavour to enclose the uvula in the noose, thus imitating the operation of tying polypi when situated in the pharynx, on the velum, or in the posterior nares; he may also pass a flexible tube into

SECTION VI.

DISSECTION OF THE LARYNX.

The *larynx* is composed of several cartilages and muscles; it is placed at the anterior part of the neck, between the tongue and trachea, and in front of the pharynx and œsophagus, it is suspended by the muscle and ligaments from the *os hyoides*; this bone is connected to the chin by several muscles, and to the styloid process of the temporal bone on each side by the digastric and stylohyoid muscle and ligament; it consists of five parts, the middle portion, or *body*, is very rough and convex anteriorly and superiorly for the attachment of muscles, concave posteriorly and inferiorly where it covers the epiglottidean gland; from the body the *cornua* pass off, one to either side, giving attachment to muscles above and below, lined by mucous membrane, and serving to expand the pharynx and fauces; where each cornu joins the body, a small process, the *appendix*, ascends obliquely backwards, and gives attachment to the stylo-hyoid ligament and muscle. *Use*, to serve as a fixed point for the muscles of the tongue, pharynx and larynx.

Four cartilages enter into the formation of the skeleton of the larynx, the thyroid, cricoid and two arytenoid, and one fibro-cartilage, the epiglottis. The *thyroid cartilage* is placed at the anterior and lateral parts of the larynx; it presents, anteriorly, a prominence, named, in the male subject, the *pomum Adami*, laterally the *alæ*, each of which, in passing backwards, increases in depth, and presents an oblique ridge for the attachment of the sterno-thyroid, and thyreo-hyoid muscles; a hole is frequently observed in each ala near this ridge; posteriorly the alæ terminate round and thick, and from their upper and lower extremities send

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the pharynx, and thence direct it to the stomach or into the larynx; any practitioner may be suddenly called on to use the stomach pump, in case of poison having been swallowed, or to inflate the lungs in asphyxia: in the *first case*, when the tube has passed into the pharynx, from the mouth or nares, the tongue should be pressed back, so as to close the glottis, and the end of the instrument should be kept close to the vertebræ to avoid irritating or pressing on the epiglottis: in the *second case*, the tube should be passed through either naris into the pharynx, the forceps or the finger of the surgeon, introduced into the mouth, can then guide it downwards and forwards to the glottis; at this time, however, the tongue should be drawn forwards; thus the epiglottis will be raised and the glottis opened opposite the edge of the velum; the tube may then be urged into the larynx, and artificial respiration commenced. In conducting this process it is advisable to press the upper part of the trachea gently against the vertebræ, so as to fix the larynx and the tube, as well as to guard against the admission of air into the œsophagus, and the consequent inflation of the stomach.

off the processes called *cornua;* the *ascending cornua* are connected to those of the os hyoides by round ligaments, [the *lateral hyo-thyroid*] which are often cartilaginous, and sometimes even bony; the *inferior cornua* are shorter, and are attached by the lateral crico-thyroid ligaments to the sides of the cricoid cartilage; the anterior angle of the thyroid is connected superiorly to the body of the os hyoides by a thin membrane, *anterior hyo-thyroid ligament*, and inferiorly to the cricoid cartilage by a strong elastic ligament, *crico-thyroid.*—The *cricoid*, or annular cartilage, forms the lower part of the larynx, is narrow before, deep behind; the inferior edge or circumference is nearly horizontal; the superior is oblique, leading from above and from behind, downwards and forwards; on its posterior surface is a middle prominent ridge, on each side of which is a depression, filled by the posterior crico-arytenoid muscle; at the upper and back part on each side is a smooth articulating convex surface, on which each arytenoid cartilage moves.

[This is a diarthrodial articulation, having a small synovial membrane.]

The *arytenoid cartilages* are triangular, the base below moving on the cricoid, the apex above inclining a little backwards, and surmounted by a small process, the *appendix;* the internal, or opposed side of each cartilage is flat, the external is rough for the insertion of muscles, the posterior surface of each is concave, and covered by the arytenoid muscle; the anterior is sharp, and connected superiorly to the epiglottis by the aryteno-epiglottidean folds of mucous membrane, which folds form the sides of the glottis, and inferiorly to the angle of the thyroid by two ligaments on each side, called *thyreo-arytenoid*, or *chordæ vocales:* these *arise* from a sharp projection on the forepart of the base of each arytenoid, pass forward converging, and are *inserted* into the angle of the thyroid; the inferior is the stronger, it is tendinous and horizontal, the superior is membranous and semilunar; the narrow passage between these ligaments of opposite sides is called the *rima glottidis;* between the superior and inferior ligament of each side is a semilunar fossa called the *sinus* or *ventricle* of the *larynx.*

The *epiglottis*, or fibro-cartilage, is anterior to the glottis; it is somewhat of an oval form, connected inferiorly at its origin by a stalk-like process to the notch or angle of the thyroid cartilage; anteriorly by cellular membrane and by the epiglottidean gland to the os hyoides, also to the tongue by three folds of mucous membrane, the central one of which is called the *frænum epiglottidis*; posteriorly to the arytenoid cartilages by the folds of mucous membrane, which form the sides of the glottis. The epiglottis stands nearly vertical; it is a little curved forwards at its upper border and along its sides, so that its anterior surface is concave from above downwards, and convex transversely; and its posterior surface is concave from side to side, and convex from above downwards; it is very elastic, and never found ossified, a change which the cartilages of the larynx are prone to undergo. In deglutition the epiglottis is of much *use*; it covers the larynx, and so prevents any foreign substance entering it: during this act the tongue is turned backwards, and the larynx raised forwards; thus the glottis is closed, and the contents of the mouth pass over the epiglottis into the pharynx. The larynx is lined by mucous membrane, which passing from the tongue and pharynx, covers the epiglottis and arytenoid cartilages, forms their connecting folds, descends into the larynx, covers the chordæ vocales, lines the ventricles of the larynx, and is continued down through the trachea and the branches of that tube; it is but loosely connected to the cartilages above at the glottis, but more closely below; several mucous glands are connected to it, thus in the aryteno-epiglottidean fold of each side there are small glands called *arytenoid*, and in front of the epiglottis, behind the os hyoides, the *epiglottidean gland* is situated; this opens by small ducts on the posterior or laryngeal surface of the epiglottis. The openings of the larynx are two, the *superior* or the *glottis*, and the *inferior* or the *rima glottidis*. The opening of the glottis has been already noticed; it is immediately behind the tongue and epiglottis, and is of a triangular form, the base anteriorly. (See page 53.) The *rima glottidis* is three quarters of an inch below the glottis; it is like a slit, being very narrow from side to side, and of a triangular figure, the base posteriorly formed by the bases of the arytenoid, and by the upper and posterior edge of the cricoid; the apex is anteriorly in the angle of the thyroid cartilage, the chordæ vocales form the sides: below the rima glottidis the larynx enlarges within the cricoid cartilage, and is of a circular figure, and soon terminates in the trachea. The muscles of the larynx are symmetrical, they are found on the front, sides and back part; those on the forepart are the thyreo-hyoid, and the crico-thyroid; on each side are the thyreo and lateral crico-arytenoid, and posteriorly are the arytenoid and posterior crico-arytenoid.

Thyreo-hyoideus, broad and flat, *arises* from the upper edge of the oblique ridge on the ala of the thyroid cartilage, ascends a little outwards, and is *inserted* into the lower border of the cornu of the os hyoides. *Use*, to elevate and draw forwards the larynx beneath the tongue and epiglottis, and so cause the glottis to be closed in deglutition. This muscle is partly covered by the integuments and sterno and omo-hyoid; it appears like a continuation of the sterno-thyroid.

CRICO-THYROIDEUS, inferior to the former, short and triangular; *arises* narrow from the forepart of the cricoid cartilage, ascends obliquely outwards, and is *inserted* broad into the lower border of the thyroid. *Use*, to approximate these cartilages, and to depress and draw forward the thyroid, also to raise and draw backwards the cricoid cartilage, and thus make tense the chordæ vocales. The crico-thyroid ligament occupies the space between these muscles; they are covered by the sterno-hyoid. Raise the ala of the thyroid cartilage on one side, and the lateral muscles of the larynx will be exposed.

THYREO-ARYTENOIDEUS is flat and thin, *arises* from the posterior surface of the thyroid cartilage near its angle: the fibres pass backwards and outwards, expanding over the side of the rima glottidis, and are *inserted* into the anterior edge of the arytenoid cartilage. *Use*, to draw the cartilage forward and towards its fellow, thereby diminishing the capacity of the rima glottidis; these muscles can also produce various alterations in the form, position, and degree of tension of the chordæ vocales, which they cover, and they can compress the sinus or sacculus laryngis. The thyreo-arytenoid muscles are considered by some as the principal and most important agents in the production of voice, in consequence of their proximity to the vocal chords, and their capability of producing endless varieties in their condition, causing the vibration in their edges so to differ in intensity and duration, as to produce, from the air passing over them, (to a certain extent only,) corresponding varieties of sound or tone.

These muscles are covered by the alæ of the thyroid cartilage; they lie on the chordæ vocales, and on the intermediate sinus; superiorly, their fibres extend to an indefinite height in the mucous folds of the glottis, and inferiorly they are connected to the following muscles.

CRICO-ARYTENOIDEUS LATERALIS, *arises* from the upper edge of the side of the cricoid cartilage, where the latter is covered by the ala of the thyroid cartilage; ascends obliquely backwards, *inserted* into the base of the arytenoid. *Use*, to draw that cartilage forwards and outwards, and thus to relax the vocal chords, and enlarge the rima from side to side, but contract it from before backwards. Raise the mucous membrane on the back part of the larynx, to expose the muscles situated there.

Crico-arytenoideus Posticus, strong and flat, *arises* from the depression on the posterior surface of the cricoid; the fibres ascend obliquely outwards, *inserted* by a tendon into the outside of the base of the arytenoid cartilage. *Use*, to draw this cartilage backwards and outwards, so as to enlarge the rima in every direction, as in full inspiration. These muscles lie on the back of the cricoid cartilage, and are covered posteriorly by the pale mucous membrane descending into the œsophagus: these and the crico-thyroid muscles are the dilators of the rima glottidis.

Arytenoideus, fills the interval between the arytenoid cartilages, and is enclosed in a fold of mucuous membrane: it consists of *oblique* and *transverse* fibres; the former consist of two or three fasciculi, which pass from the apex of one cartilage to the base of the opposite; the transverse fibres are more numerous, and are attached to the posterior surface of each cartilage. *Use*, to approximate these cartilages, and close the sides of the rima: these, together with the thyreo and crico-ary tenoidei laterales are the contractors of the rima glottis. In the aryteno-epiglottidean folds, fleshy fibres are sometimes discernible, and have been described as distinct muscles, and named from their situation, *aryteno-epiglottidean* and *thyreo-epiglottidean* or the depressors of the epiglottis. In the human subject, however, these are never sufficiently well marked to merit the apellation of distinct muscles.

The arteries which supply the larynx are derived from the superior and inferior thyroid; the former is a branch of the external carotid, the latter of the subclavian. The laryngeal nerves are four in number, two on each side, the *superior* and *inferior;* both are derived from the par vagum or pneumo-gastric; the former arising from it near the base of the cranium, the latter, on the right side, comes off from this trunk at the lower part of the neck, and on the left side it arises from it in the thorax, below the arch of the aorta: the inferior laryngeal nerves are principally distributed to the muscles, and the superior to the membrane and glands of the larynx, but not exclusively so. The inferior supplies the posterior and lateral crico-arytenoid and the thyreo-arytenoid muscles; the superior sends a large branch to the arytenoid, and a small, but very long filament to the crico-thyroid muscle; several branches of this nerve are distributed to the epiglottis and to the mucous membrane at the glottis, which in this situation possesses great sensibility. From this view it would appear that the inferior laryngeal nerve supplies the dilating muscles of the larynx which are the principle agents in voice, while the superior supplies those which close the glottis, as also the lining membrane, which possesses very peculiar and very delicate sensibility. [For the anatomy of the trachea, see p. 93.]

The larynx and trachea are subject to many *morbid* changes of which the mucuous membrane is most commonly the seat; inflammation of that lining the larynx is named cynanche laryngea, or laryngitis, of that lining the trachea, cynanche trachealis, or croup; in the latter case an exudation of lymph, or a false membrane is usually formed in the trachea, in the former case, effusion of serum in the loose submucous tissue, or œdema of the glottis, is a frequent and often fatal effect; ulceration, the effect of inflammation, is not uncommon about the glottis: syphilis and phthisis also occasionally induce ulceration in this part, and even involve the epiglottis and the arytenoid cartilages.

[In ulceration of the cartilages, large pieces are sometimes thrown off, but these organs are more prone to ossification, particularly in advanced life: the thyriod and cricoid cartilages, are most commonly affected and it is said that no cases of ossification of the arytenoids, or epiglottis have been recorded. There is however in the college museum a specimen of very complete ossification, of the thyroid cricoid, and both arytenoid cartilages. Polypes are sometimes found within the larynx. The muscles of the larynx are also sometimes diseased, either being infiltrated with tuberculous matter, or else being in a state of atrophy, hence causing alterations in the voice: foreign bodies may from their size be arrested in the calibre of the larynx, or if small they may be lodged in its sinuses; the term bronchotomy as applied to operations upon the larynx or trachea, is manifestly improper, there being in fact no such operation as bronchotomy, which implies a section of the bronchial tubes, and they are beyond the reach of the surgeon.]

Foreign bodies impacted in the lower part of the pharynx, or when engaged in the larynx, or when fallen into the trachea, may cause such suspension of respiration as to call for the operation of bronchotomy; suspended animation, also, from any cause, or any tumour in the fauces which impedes respiration, may require the same means; this operation is two-fold, laryngotomy and tracheotomy; in the first the air tube is to be opened through the crico-thyroid ligament, in the second through the fourth, fifth, and sixth rings of the trachea.

SECTION VII.

DISSECTION OF THE DEEP MUSCLES OF THE NECK.

THESE muscles, which are seven in number on each side, form the third layer of the cervical muscles; they lie close to the vertebræ, and are exposed by removing the pharynx, larynx, cervical vessels and nerves.

LONGUS COLLI extends from the third dorsal vertebra to the atlas; it *arises* from the sides of the bodies of the three superior dorsal and four inferior cervical vertebræ, from the intervertebral ligaments, also from the head of the first rib, and from the anterior tubercles of the transverse processes of the four last cervical vertebræ; the fibres ascend obliquely inwards, adhering to each bone in their course, and are *inserted* into the forepart of the first, second, and third cervical vertebræ. *Use*, to bend the neck to one side, and rotate the atlas on the dentata; or, if both muscles act, to bend the neck directly forwards. This muscle appears to consist of an inferior and superior portion; the first arising from the bodies of the dorsal is inserted into those of the inferior cervical vertebræ; the second arising from the transverse processes of the third, fourth, and fifth cervical vertebræ, is inserted into the bodies of the first and second. These muscles, like most of those which adhere to the vertebræ, though long, yet consist of short fibres which pass from one bone to another, are generally intermixed with tendinous substance, and are irregular as to the number of the vertebræ to which they are attached.

RECTUS CAPITIS ANTICUS MAJOR, long and flat, *arises* by small tendons from the anterior tubercles of the transverse processes of the four last cervical vertebræ; they soon unite in a fleshy substance which ascends obliquely inwards, and is *inserted* broad into the cuneiform process of the occipital bone. *Use*, to bend forwards the neck and head. This muscle lies behind the carotid artery and sympathetic nerve, and between the longus colli and scaleni. Separate this muscle from its insertion, and we expose the following:

RECTUS CAPITIS ANTICUS MINOR, short and narrow, *arises* from the transverse process of the atlas, ascends inwards, and is *inserted* into the cuneiform process. *Use*, to bend the head forwards and to one side on the atlas: this muscle lies to the outer side, but is in part concealed by the last.

RECTUS CAPITIS LATERALIS, very short, *arises* from the transverse process of the atlas, ascends, and is *inserted* into the semilunar ridge or jugular process of the occipital bone, which extends from the condyle to the mastoid process. *Use*, with the last muscle it can bend the head forwards or incline it to one side. This muscle is external to that last described; it lies on the vertebral artery, and is covered by the jugular vein.

Scalenus Anticus, *arises* tendinous from the anterior tubercles of the transverse processes of the third, fourth, fifth, and sixth cervical vertebræ; the fibres descend obliquely forwards and outwards, form a flat muscle, which is *inserted* tendinous into the upper surface of the first rib, near its cartilage. *Use*, to bend the neck forwards and laterally, also to elevate and fix the rib as in inspiration. The phrenic nerve descends on the anterior surface of this muscle; the subclavian vein crosses its insertion; the omo-hyoid and sterno-mastoid lie anterior to it; the subclavian artery and brachial plexus are behind it, and the vertebral vessels separates it from the longus colli.

Scalenus Medius, *arises* from the posterior tubercles of the transverse processes of four or five inferior cervical vertebræ, by small tendinous fibres; these become fleshy, and descend obliquely outwards and backwards, and are *inserted* into the upper surface of the second rib behind the subclavian artery. *Use*, similar to the last. This muscle is covered by the brachial plexus, subclavian artery, and anterior scalenus.

Scalenus Posticus, *arises* from the posterior tubercles of two or three lower cervical vertebræ, descends behind the former, and is *inserted* into the upper edge of the second rib, between its tubercle and angle. *Use*, to elevate the second rib, to bend the neck to one side, and a little backwards. One or two branches of the brachial plexus sometimes separate this from the middle scalenus, at other times there is no distinction between them, excepting in their insertion: behind the posterior scalenus lie the transversalis and splenius colli, also the levator anguli scapulæ, which muscles cannot be examined at present.

[*Varieties.* The fasciculi of the scaleni muscles, are variable, and are more or less run together, so that the number described varies with different anatomists, from Chaussier, who describes but one, to Albinus who makes five.]

We shall next proceed to the dissection of the thorax.

CHAPTER III.

DISSECTION OF THE THORAX.

SECTION I.

OF THE MUSCLES ON THE ANTERIOR AND LATERAL PARTS OF THE THORAX.

Make one incision through the integuments along the clavicle, a second from the upper end of the sternum to the ensiform cartilage, and from this point carry a third towards the shoulder; reflect the integuments and subjacent cellular membrane from within and from below, upwards and outwards, and thus the great pectoral muscle will be exposed, the dissection of which will be facilitated if its fibres be made tense by separating the arm from the side.* Beneath the integuments in the female we find the *mammary gland;* this is a conglomerate gland, imbedded in fat, hemispherical, flat posteriorly, convex anteriorly, surrounded by a capsule of condensed cellular membrane, which is loosely connected to the pectoral muscle, and sends processes into the gland to support and connect its several lobules; these last are very soft and pale, almost white; from each of them small ducts arise, which uniting together form larger tubes; these converge towards the root of the nipple, where they expand into sinuses, from which smaller ducts proceed and open on its surface: the skin covering the breast is soft and delicate, and about the centre of it, is the conical projection called the *nipple,* near the point of which the lactiferous ducts open; the base is surrounded by an *areola* of a dark colour. This gland will be found to differ in structure in different subjects; in some the capsule is indistinct, and the lobules scattered, or more separate than usual; in some it has a redder appearance than in others, and it frequently feels unusually hard or rugged, although free from disease.

[This gland is of a light pink color; it is difficult to lay down any rule, as to its volume, for it is very small, up to the age of puberty, when it rapidly increases in development, and it reaches its maximum

* The student of some experience, instead of removing the skin from this region, according to the above directions, may rather practise the operation of extirpation of the breast, which can be easily accomplished by two semielliptical incisions, one below, and the other above the gland, through the integuments and nearly parallel to the fibres of the great pectoral muscle, from which the gland can be then easily detached, unless disease should have caused any very close adhesion.

during gestation and lactation, and again after the period of child bearing is past, it becomes atrophied, and even confounded with the surrounding cellular tissue; if separated entirely from the adjoining cellular and adipose tissue and placed upon a flat surface, it is found to be of a circular form having a diameter of from three to five inches, and a thickness of from ten to fifteen lines. It is said that the left mamma is usually somewhat larger than the right. These organs in connexion with their functions constitute the characteristic of one of the zoological classes of animals, the mammalia.

The organs exist in the male subject though not usually developed, except in some rare instances in which they have afforded an abundant secretion of milk.

On the surface of the areola, there are a number of small tubercles surrounding the nipple, which are particularly prominent in pregnant, and nursing females, it has been supposed that these bodies secreted an oleaginous substance, to protect the nipple, and guard it against excoriation, while nursing, but there are several circumstances which go to prove that they are of the same structure as the mamma, itself, and that they secrete milk. The mammæ are very abundantly supplied with blood, by the external thoracic, intercostal, and internal mammary arteries also with nerves from the intercostals and axillary plexus.]

The female breast is the seat of many morbid changes, viz. inflammation, and suppuration, either in the body of the gland, or in the cellular tissue around it or behind it, that is between it and the muscle—enlargement—atrophy—tumours of various kinds, adipose, hydatid, cartilaginous, scirrhus, cancerous, &c.; some indolent, chronic, and innoccuous, others more rapid in their progress, fungoid, and malignant.

[Hypertrophy of the breast, sometimes occurs in the male, and in the female it occasionally acquires an enormous magnitude; cases being recorded, in which it weighed fifteen, twenty, and even sixty four pounds. Encephaloid disease and calcareous formations, and neuralgia also occur; apoplexy of the breast is an affection peculiar to young girls, coming on just before the establishment of the menstrual secretion and disappearing soon after. Carcinoma sometimes occurs in the male breast; in male infants a few days old, the breasts sometimes become swelled, red, and painful, and by gentle pressure a fluid resembling milk is forced out. Additional nipples are not uncommon, and occasionally a supernumerary mamma exists, a case is recorded in which the additional organ occupied the left groin, and secreted milk freely.]

Pectoralis Major, flat and triangular, *arises* somewhat tendinous from the sternal half of the clavicle, from the anterior surface of the sternum, fleshy from the cartilages of the third, fourth, fifth, and sixth true ribs, and from an aponeurosis common to it and the external oblique muscle; the clavicular fibres descend, the sternal pass horizontally, and the costal ascend obliquely; all pass outwards in front of the axilla towards the humerus, into which they are *inserted* by a flat tendon into the anterior edge of the bicipital groove, and by an aponeurosis into the fascia of the arm; a line of cellular membrane separates the clavicular from the sternal portion; in some cases these appear as distinct muscles. *Use*, the clavicular portion can raise the arm and draw it forward, the sternal can press it to the side, particularly if assisted by the latissimus dorsi, and the costal portion can draw it downwards and forwards: the whole muscle will draw the arm forwards and inwards on the chest: if the arm have been rotated outwards, it can roll it inwards, and so pronate the hand; if the arms be fixed, and this pair of muscles act, they will draw the ribs upwards and outwards, and thus by enlarging the thorax assist in inspiration. This muscle is covered by the skin, platysma and mammary gland, and its insertion is partly concealed by the deltoid; it covers a portion of the sternum and of the true ribs, also the subclavian and lesser pectoral muscles, the coraco-clavicular ligament, the thoracic and axillary vessels and nerves. Between the clavicular portion of this muscle, and the anterior edge of the deltoid, is a space filled by cellular tissue, the cephalic vein and a small artery, [a branch of the thoracica acromial.] The tendinous fibres of the sternal portions of opposite sides decussate each other, and cover the sternum with a sort of aponeurosis; the insertion has a twisted appearance in front of the axilla, the sternal and costal portions being folded behind the clavicular, and *inserted* superior and posterior to it into the anterior edge of the bicipital groove, while the clavicular is united to the deltoid, and is *inserted* into the humerus along with that muscle; in some subjects a bursa may be found between these two insertions of the pectoral muscle. From the lower edge of the costal portion a fleshy slip sometimes descends and joins either the rectus or external oblique muscle of the abdomen; and in some a strong muscular band connects it to the inferior margin of the latissimus dorsi.

[*Other varieties.* Sometimes this muscle is attached by a fasciculus to the brachialis internus, sometimes a fasciculus comes off towards the axilla, is converted into a tendon, and finally inserted into the internal tuberosity of the os humeri; sometimes a fasciculus comes off from its tendon, crosses its insertion, and the bicipital groove of the os brachii, and is blended with the tendon of the supra spinatus.]

Make a perpendicular division of this muscle, reflect the edges, one towards the sternum, the other towards the shoulder; and the lesser pectoral and subclavian muscles come into view.

Pectoralis Minor, flat and triangular, *arises* from the external surface and upper edge of the third, fourth, and fifth ribs, sometimes from the second, external to their cartilages; the fibres ascend, obliquely outwards and backwards, and converging, end in a flat tendon, which is *inserted* into the inner and upper surface of the coracoid process, near its anterior extremity, being here connected with the coraco-brachialis and short-head of the biceps; a band of this tendon frequently passes over this process through the triangular ligament, and is connected to it, or to the tendon of the supra-spinatus, or to the capsular ligament of the shoulder. *Use*, to draw the shoulder forwards, downwards, and inwards, also to assist the great pectoral in elevating the ribs in inspiration. This muscle is covered by the great pectoral, and partly at its insertion by the margin of the deltoid muscle, a few of its inferior fibres are covered only by the skin; it lies anterior to the serratus magnus, axillary vessels and nerves.

[*Varieties.* A third pectoral muscle, sometimes lies below this, arising from the first and second ribs, and inserted into the coracoid process. Sometimes a fasciculus arises from the first rib and passing beneath the lesser pectoral is inserted into the capsular ligament of the shoulder joint; it is sometimes connected with the tendon of the coraco-brachial by a fleshy slip.]

Subclavius, small and round, *arises* by a flat tendon from the cartilage of the first rib, external to the rhomboid or costo-clavicular ligament, soon becomes fleshy, and ascending outwards and backwards, is *inserted* into the external half of the inferior surface of the clavicle, extending as far outwards as the space between the conoid and trapezoid ligaments. *Use*, to draw the clavicle and shoulder forwards and downwards, also to elevate the first rib in inspiration, if the shoulder and clavicle be raised and fixed. This muscle is covered by the clavicle and great pectoral; it lies anterior to the axillary vessels and nerves, which separate it from the first rib; it is covered by a thin but strong aponeurosis, which is attached to the cartilage of the rib, and to the clavicle and subclavian muscle, from which it passes downwards and outwards to the coracoid process, arching across the great vessels, and is then connected to that process, and to the tendon of the lesser pectoral; this fascia is called by some the *coraco-clavicular ligament*, by others the *costo-coracoid;* it is sometimes very strong, and from the manner in which it is extended over the vessels, it renders it difficult to feel the pulsation of the axillary artery below the clavicle.

[*Variety.* This muscle is sometimes double.]

Serratus Magnus, thin and broad, particularly anteriorly, placed behind the pectoral muscles and the axillary vessels, and between the scapula and the ribs, *arises* by eight or nine fleshy slips, from the eight or nine superior ribs; the fibres ascend obliquely backwards, and are *inserted* between the subscapular, the rhomboid and levator anguli muscles into the base of the scapula, but particularly into the superior and inferior angles. *Use*, to draw the scapula forwards, particularly the inferior angle, and thus, by rotating this bone on its axis, to raise the acromion process and the shoulder joint; when the upper extremity is fixed, this muscle can raise and draw outwards the ribs, so as to assist in inspiration.—The serratus magnus lies on the ribs and intercostal muscles; also on a portion of the serratus posticus; external to it are the axillary vessels, the scapula and subscapular muscle; the trapezius, latissimus dorsi and rhomboid muscles lie behind it, and the pectoral muscles are anterior to it; an abundance of loose cellular membrane connected to its surface allows it to glide on the ribs, and also facilitates the movements of the scapula upon it. The four superior digitations lie behind those of the lesser pectoral, and the four inferior, which are only covered by the skin, indigitate with the origins of the external oblique. If the clavicle be separated from the sternum, and the scapula pulled from the side, this muscle will then become tense, and in this state it appears to consist of three portions, which differ in structure and in form: the *superior* is a thick, short and strong fasciculus, somewhat square, passing from the two first ribs beneath the axillary vessels and brachial plexus, to the superior angle of the scapula; its flat surface is directed upwards, and lies on a plane anterior to the next or *middle division*, which is very thin, consisting of but few fleshy fibres, connected together by an aponeurosis. This portion is of a triangular form, the apex attached to the third and fourth ribs, the base to the basis of the scapula, not exactly to the bone, but to a strong tendinous cord, which extends along this line from the superior to the inferior angle. The third, or *inferior* division of the serratus is the strongest and most extensive; it is radiated or triangular: the apex thick and fleshy, attached to the inferior angle of the scapula; the base thin and expanded on the ribs. The serratus may be again examined when dissecting the muscle on the back of the trunk.

[*Variety*. This muscle has sometimes ten or eleven origins.]

Intercostales, are twenty-two in number on each side, eleven external and eleven internal;—the *external* commence at the transverse processes of the dorsal vertebræ, *arise* from the inferior edge of each rib, descend in fasciculi obliquely forwards, and are *inserted* into the external lip of the superior edge of the rib beneath, and terminate a little behind the costal extremity of the cartilages; an aponeurosis, the fibres of which run in the same direction, supply their place as far as the sternum. The *internal intercostal muscles* take an opposite direction, and decussate the former: they commence at the sternum, and are discontinued at the angles of the ribs; they *arise* from the inner lip of the lower edge of each cartilage and rib, the fibres, paler and shorter than those of the external, descend obliquely backwards, and are *inserted* into the inner lip of the superior edge of the cartilage and rib beneath. *Use*, both laminæ co-operate to raise the ribs, the first rib being fixed by the scaleni. The intercostal muscles, in elevating the ribs, also evert their lower edges, and twist them at their vertebral and sternal ends, and thus assist in inspiration by enlarging the chest transversely, and from before backwards. The internal layer lies on the pleura, and is separated from the external by the intercostal vessels and nerves; the external layer is connected to the pleura only in the space between the angles of the ribs and the vertebræ. At the posterior extremity of the external intercostal muscles there are the following twelve small muscles, which, however, may be seen more fully when the muscles of the back have been dissected.

Levatores Costarum, arise narrow and tendinous from the extremity of each dorsal transverse process, descend obliquely outwards, and are *inserted* broad into the upper edge of the rib beneath, between its tubercle and angle; their name denotes their *use.* They are parallel to, and frequently appear as a portion of the external intercostals; the first levator is short, and arises from the last cervical vertebra; the inferior increase in length and size.

Behind the sternum are a pair of small muscles, triangulares sterni, which cannot be seen until this bone is removed; we describe them now, although their dissection may be postponed until the cavity of the thorax has been opened.

Triangularis Sterni, or sterno-costalis, *arises* from the posterior surface and edge of the lower part of the sternum, and from the xiphoid cartilage; the fibres ascend obliquely outwards, the inferior pass transversely—*inserted* into the cartilages of the fourth, fifth, and sixth ribs. *Use*, to depress and draw backwards the cartilages of the ribs, so as to assist in expiration. These muscles lie on the pleuræ, pericardium, and diaphragm, are covered by the sternum, cartilages of the ribs, and mammary vessels. They antagonize the external intercostals, to whose fibres, however, they are parallel, but they arise from the more fixed, and are inserted into the more moveable part of the cartilage, and this also explains the cause of the external intercostals terminating at the ends of the ribs, and not continuing as far forwards as the sternum. The mechanism of respiration shall be further considered when the diaphram has been examined, (see dissection of it.) In connexion with the muscles of the thorax, the student should study the anatomy of the axilla.

SECTION II.

DISSECTION OF THE AXILLA.

The *Axilla* is a conical cavity, the apex superiorly at the coracoid process and clavicle, the base below, between the pectoralis major, and the latissimus dorsi muscles, and formed by the skin and a thick fascia; it is bounded anteriorly by the great and lesser pectoral muscles, internally by the serratus magnus and the ribs, externally by the scapula, subscapular muscle, and the upper part of the humerus, and posteriorly by the serratus, latissimus dorsi, and teres major muscles. This region contains several lymphatic ganglia, vessels and nerves, and a quantity of loose cellular and adipose tissue, which is continued from the neck beneath the clavicle, and often presents a watery reddish appearance. When the pectoral muscles have been divided, and some cellular membrane removed, the *axillary vein* first appears; at the upper part of the axilla, this vessel is internal and anterior to the artery; inferiorly it is directly over this vessel, and more closely connected to it than above; this vein receives the cephalic vein, and several branches from the parietes of the thorax, and from the shoulder. The *axillary artery* may be next seen, taking an oblique course downwards and outwards through this space, and giving off thoracic branches from its internal side; and from its external, the subscapular and circumflex arteries; behind the artery, at the upper part of the axilla, the *brachial plexus of nerves* is seen; as this descends it becomes more and more closely connected to it, and at the lower part of this cavity, the branches of the plexus have almost surrounded the artery. This plexus may be seen dividing into several branches; superiorly, it gives off the thoracic, supra, and subscapular; and lower down it divides into the external and internal cutaneous, the median, ulnar, radial, or spiral, and articular or circumflex. The general distribution of these branches will be noticed in the dissection of the upper extremity, and for their particular description, see Anatomy of the Nervous System. At the lower part of the axilla, the artery may be observed in general to lie between the two roots of the median nerve, with the external cutaneous to its outer or humeral side, and with the ulnar and internal cutaneous to its inner or thoracic side, while posterior to it are the musculo-spiral and articular nerves. The lymphatic ganglia are connected to the axillary vessels by the small branches which supply them: several lie posterior to the edge of the pectoral muscle; from these a chain continues up to the coracoid process, and are continued beneath the clavicle and the ganglia in the neck; several also lie on the subscapular muscle, and some are scattered indifferently through this space. Some of the conglobate ganglia of the axilla are very generally *diseased*, in cases of malignant affections of the breast, and must therefore be removed by the surgeon, at the time of extirpating the latter.

SECTION III.

DISSECTION OF THE CAVITY OF THE THORAX.

The thorax is situated at the upper and anterior part of the trunk; it contains the lungs, the organs of respiration; the heart, the chief agent in the circulation of the blood, also several nerves and vessels passing to and from the heart, and through the cavity; this region is bounded anteriorly by the sternum and costal cartilages, laterally by the ribs and intercostal muscles, posteriorly by the vertebræ and angles of the ribs, inferiorly by the diaphragm, superiorly by the several muscles connected to the clavicle, first rib and sternum, and by the different parts passing into or out of the cavity. The thorax, viewed externally, presents a very different form before and after the upper extremities are detached from it; in the former state it appears of great transverse width above, and narrow below; whereas in the latter condition, it is seen to be very contracted above and expanded below. The thorax may be compared to a section of a cone, the posterior fourth being removed, the three anterior parts retained and united to each other. The axis of the cavity is oblique from above downwards and forwards; the base of the thorax is also oblique from before, backwards and downwards, and the apex on the contrary is oblique from behind, forwards and downwards; hence the perpendicular diameter of the thorax is much greater posteriorly than it is behind the sternum. The apex of the thorax is somewhat truncated, and presents an oval opening, longer transversely than from before backwards; this, the *superior orifice of the thorax*, is bounded anteriorly by the upper edge of the sternum and interclavicular ligament, posteriorly by the last cervical and first dorsal vertebræ, and laterally by the first rib: the several important parts which pass through this opening shall be noticed afterwards. The inferior circumference of the thorax is five or six times more extensive than the superior; it is bounded by the xiphoid, the last true and all the false costal cartilages, and by the last dorsal and first lumbar vertebræ: its longer diameter is also transverse. Open the cavity by dividing the cartilages of the ribs on each side of the sternum, and raising the latter from below upwards; if we look under the sternum as we thus slowly raise it, we perceive that space called *anterior mediastinum* to be gradually developed, from the right and left pleuræ separating from each other as we tear the loose cellular membrane, which naturally connects the pleuræ and pericardium to the posterior surface of the bone: when the sternum is removed, this region is fully exposed; it is described as being of a triangular form, the base, the sternum; the sides, the pleuræ, converging behind, so as nearly to touch each other; the apex, the small portion of pericardium left uncovered by the pleuræ; naturally, however, all the parts within the thorax are so closely applied to the parietes, that no space or cavity of a defined form, like that assigned to the anterior mediastinum, can truly be said to exist.* The dissector,

* For the purpose of examining the morbid appearances after death, the cavities of the thorax and abdomen are generally opened at the same time; an incision, carried from the top of the sternum to the symphisis pubis, through the integuments, muscles, and peritoneum, will bring the latter cavity into view; next let the skin and muscles covering the front of the thorax be turned back, which will expose the cartilages connecting the ribs with the sternum; immediately at their point of connexion with the bone, these are to be cut; in doing this take care not to wound the viscera within.

In some old subjects, where the cartilages of the ribs are in some degree ossified, a saw must be employed: all the cartilages, except those of the first rib, being divided, the sternum may be raised like the lid of a box, and a very convenient hinge is made by cutting the articulation between the first and second pieces of the sternum on the inside, opposite the second rib; the figure of the thorax will thus be preserved, and a sufficient view be obtained of its contents.

however, may cause this space to appear more distinct by the following precaution: before you divide the cartilages, push your fingers from the abdomen behind the sternum, and break down the cellular connexions between it and the pleuræ, then cut the cartilages very near the sternum, and raise the latter; without this precaution before dividing the cartilages, the pleura, particularly the right, will be in almost every instance laid open, and so the appearance of the anterior mediastinum injured. This region in general inclines a little to the left side below, in consequence of the left pleura being more attached to the pericardium, which lies rather to the left of the middle line, whereas the right pleura is connected to the sternum in a vertical line: the anterior mediastinum is wider superiorly and inferiorly than in the centre, hence some compare it to the letter X, and describe it as consisting of two triangular spaces, their apices joined in the centre, the base of one towards the neck, and that of the other towards the diaphragm: the superior portion contains the origins of the sterno-hyoid and thyroid muscles, and the remains of the thymus body; inferiorly there is much loose cellular membrane, which leads from the neck to the abdominal muscles, also lymphatic ganglia, and close to the sternum are the mammary vessels, and the triangulares sterni muscles.

Next examine the organs on each side of the thorax; these are the lungs and their investing membranes the pleuræ; in almost all respects these organs are similar on the right and left side, and therefore either may be selected for examination; for this purpose lay open one side, suppose the right, of the thorax, by sawing through the ribs about their centre, and removing their anterior portion; the first rib may be left uninjured; thus the cavity of the right pleura will be opened, its glistening surface seen, with the lung lying collapsed. The *pleuræ* are serous membranes, their internal surface is smooth, polished and free; their external surface is connected by fine cellular membrane to the parietes of the thorax, and to the tissue of the lungs, over which they are reflected. That portion of each which invests the lungs is called *pleura pulmonalis*, and that which is connected to the parietes *pleura parietalis* or *costalis*; the latter portion of the membrane is much more dense and strong than the former; each pleura is a shut sac, and contains only the serous vapour it exhales; for although the lung appears within the cavity, it is yet really external to it or behind it; internally each pleura presents one continuous surface, which can be traced throughout its whole extent; thus we can perceive that the right pleura passes from the back of the sternum to form the side of the anterior mediastinum, and arriving at the forepart of the pericardium is continued along the side of that bag as far back as the root of the lung, whence it is reflected over the anterior surface of this organ, sinking into its fissures, and connecting all its lobules to each other; having thus invested the whole lung, it arrives at the posterior surface of its root, from which it is reflected to the back part of the pericardium, where it approaches the opposite pleura, to which it is connected by cellular membrane; thence it passes to the sides of the vertebræ, thus forming the side of the posterior mediastinum (to be examined presently;) the pleura then expands along the side of the spine, ascending as high as the transverse process of the sixth or seventh cervical vertebra, and descending to the diaphragm, the convex surface of which it covers; on this muscle also it is reflected from the lower edge of the root of the lung by a fold called *ligamentum latum pulmonis*, loose and triangular, the base towards the diaphragm, one side connected to the lung, and the opposite to the mediastinum; from the vertebræ, the pleura continues to pass outwards, lining the ribs and intercostal muscles, as far forwards as the side of the sternum, where the sac was opened, and the description commenced. The pleuræ are of a conical form, the apex of each is in the neck, covered by the anterior scalenus and subclavian artery, the base adheres to the diaphragm; the right pleura is shorter but broader than the left, which is long and narrow; the liver on the right side and the heart on the left cause these differences to exist; the apex of the right is often higher in the neck than that of the left. The two pleuræ have been compared to two bladders placed nearly parallel to each other, not having any communication, but touching each other along the mesial line; this juxta-position of the two pleuræ between the sternum and vertebræ forms a sort of partition between the right and left sides of the thorax; this partition is called mediastinum; it consists of course of two laminæ, right and left, connected anteriorly to the sternum, posteriorly to the spine; these laminæ are separated from each other in three situations, in order to enclose certain organs, so that the mediastinum is divided into—first, the anterior part, or anterior mediastinum, which has been already examined; second, into a middle part, or middle mediastinum, containing the heart and pericardium; and third, into a posterior mediastinum, which lies in front of the vertebræ, and which the student may next examine.

The *posterior mediastinum* extends in a vertical direction from the third to the tenth dorsal vertebra, behind the pericardium and roots of the lungs, and in front of the spine; to obtain a view of the parts contained in it, draw the right lung forward, and to the left side, and make a perpendicular division of the right pleura, between the root of the lung and the spine. This region is described as being of a triangular form, the base posteriorly, the pleuræ forming its sides, and the pericardium its apex; like the anterior mediastinum, however, it has naturally no exact figure, the pleuræ being folded round the organs which lie between them. In the posterior mediastinum we find the œsophagus and eighth pair of nerves, the thoracic duct, vena azygos, descending aorta, splanchnic nerves, several lymphatic ganglia, and a considerable quantity of fine, loose cellular membrane; the division of the trachea, also, is enclosed in this space, just at its commencement. The *œsophagus* is anterior to the other parts in the posterior mediastinum; this tube having passed behind the left division of the trachea, enters this space, and descends obliquely forwards behind the pericardium and before the aorta; above, it lies to the right side of this vessel, but below it is to the left; in the lower part of its course it is surrounded by branches of the eighth pair of nerves, and enlarging a little, it perforates the fleshy part of the diaphragm, opposite the ninth or tenth dorsal vertebra, and joins the stomach. The *eighth pair of nerves* having passed behind the roots of the lungs, attach themselves to the œsophagus, and form by their branches a plexus around it, (*the œsophageal plexus*); the left nerve then descends on the fore, and the right on the back part of this tube to the stomach. The *thoracic aorta* enters this region about the fourth or fifth dorsal vertebra, and descends along the left side of the spine; about the eleventh or twelfth dorsal vertebra it passes between the crura of the diaphragm into the abdomen; in this course the aorta furnishes the following branches: two or three bronchial arteries, which go to the lungs, as many œsophageal branches, and nine or ten pair of intercostal arteries, whose name implies their destination.

The *vena azygos* commences in the abdomen by a small branch from one of the superior lumbar veins, enters the thorax behind the right side of the posterior mediastinum, covered by the right pleura; and opposite the third or fourth dorsal vertebra it arches forwards over the root of the right lung, and opens into the superior vena cava, as that vessel is entering the pericardium.

The vena azygos in this course receives the bronchial, œsophageal, and intercostal veins; those of the left side often unite into one branch, which passing behind the aorta, joins opposite the sixth or seventh vertebra, the principal trunk on the right side. The *thoracic duct* also commences in the abdomen, on the second or third lumbar vertebra behind the aorta, in a sinus, called receptaculum chyli; contracting in size it enters the posterior mediastinum, along with, and to the right side of the aorta; it ascends between this vessel and the vena azygos, imbedded in fat, and opposite to the fifth or sixth dorsal vertebra it attaches itself to the back of the œsophagus, runs obliquely along it, behind the arch of the aorta, to the left side, and ascends in the neck behind the left carotid artery and jugular vein, as high as the sixth cervical vertebra; it then bends downwards and outwards, and enters the left subclavian, just before it joins the jugular vein. The coats of the thoracic duct are so fine and thin, that it is often difficult to see or trace this vessel. (For a more particular description of it, see the Anatomy of the Absorbent System.) The *splanchnic nerves arise* by four or five filaments from the dorsal ganglions of the sympathetic nerve; the first is from the fifth or sixth ganglion, the rest arise in succession below it; all unite and form the splanchnic nerves, which descend obliquely forwards on each side of the aorta, along with which they enter the abdomen, where each terminates in a large ganglion, termed *semilunar;* these two ganglions are joined together by numerous branches, which constitute the *cæliac*, or *solar plexus*, from which the greater number of the abdominal viscera are supplied with nerves. In the dissection of the posterior mediastinum, the sympathetic nerve is also seen on each side; it does not lie in this space, but descends external to it, between the pleuræ and the heads of the ribs; opposite each intercostal space it forms a ganglion, from which some branches pass to join the dorsal spinal nerves, others to form the great splanchnic; and at the lower part of the thorax, two or three filaments often unite to form a small nerve, called *lesser splanchnic*, which enters the abdomen behind or through the crura of the diaphragm, and joins the renal plexus of nerves. The sympathetic on each side enters the thorax close to the neck of the first rib, where it forms a large ganglion; it passes from this cavity by a very small filament, between the crus of the diaphragm and the psoas magnus, into the abdomen, where it again enlarges considerably.—(See the Anatomy of the Nervous System.) The division of the trachea, the last part of any importance connected with the posterior mediastinum, does not, strictly speaking, lie in this space, but like the heart and great vessels, it is in the middle mediastinum, or between the anterior and posterior; this tube can be more conveniently examined afterwards, when we are dissecting the parts which pass through the upper opening of the thorax. Next examine the lungs.

The *lungs* are situated at either side of the spine, and when distended with air, as they constantly are during life, they so exactly fill each side of the thorax that the pleuræ pulmonalis and costalis are always in such perfect apposition, that there never can be any intermediate cavity; they are of a conical figure, the apex, above, rises into the neck a little above the level of the first rib, and in general higher on the right than on the left side; the base, below, concave, rests on the diaphragm: the external surface convex, and divided into two or three parts by a deep fissure; the internal slightly concave, and attached near its centre by the root to the heart and great vessels; the posterior edge of each lung is thick, round and vertical; the anterior is thin, irregular, oblique and shorter than the posterior; that of the left side is in general notched opposite the apex of the heart. The right lung is broader but shorter than the left, the former consists most commonly of three lobes, the latter has only two. The *great fissure* of each lung descends obliquely forwards; it commences behind the apex, and ends in front of the base; it divides the substance of the lung, to a great depth into *two lobes;* one is anterior and superior, and the other posterior and inferior; the latter is somewhat larger; on the right side a *small fissure* leads from about the middle of the great one, forwards to the edge of the lung, and cuts off the *middle lobe* from the superior; this fissure does not penetrate to the same depth as the great one does; it is sometimes absent, and in some subjects it exists on the left as well as on the right side. The *root* of each lung is situated a little above the centre of the internal surface, and about two-thirds from the anterior edge; the phrenic nerve and a few filaments of the pneumogastric lie anterior to it, and the pulmonary plexus is posterior to it; the fold called ligamentum latum is below it; it consists of several vessels and nerves connected together by cellular tissue, and all enclosed between the laminæ of the pleura; dissect off this membrane from the forepart of the root, and we shall observe the two pulmonary veins inferior, but anterior to the pulmonary artery, which is immediately above and behind them; posterior and superior to the artery is the bronchial tube; a quantity of cellular tissue connects these vessels, and contains the bronchial arteries and veins, also several nerves, which are derived from the pulmonary plexus. In the root of the left lung the bronchial tube is rather inferior to the artery, but still posterior to it, as on the right side.

The lungs have a peculiar soft, emphysematous feel, and are so light as to float in water; their colour is grey, interspersed with spots of dark blue or blackish tint: the younger the subject the redder the lungs will be found; in the adult they are generally grey, and slightly streaked with dark lines; in the old they are usually mottled with blue or black spots, which exist, not merely on the surface, but through their substance. The lungs are composed of the ramifications of the pulmonary arteries and veins, of the bronchial arteries and veins, of the pulmonary nerves, of lymphatic vessels and ganglia, and of the ramifications of the bronchial tubes, which end in numerous air cells; these are collected at first in clusters, and joined by cellular membrane into the lobules: these last are again united into larger masses by the pleura, so as to form lobes; the *air-cells* are the terminations of the bronchial vessels; they are globular, are lined by mucous membrane, and covered by a fibrous, or, as some suppose, a muscular lamina; each bronchus divides into two branches, these again subdivide into two, and so on in binary order; these canals increase in number, and diminish in size; their final capillary branches end in small sacs or air-cells; these constitute the principal bulk of the lung: the larger bronchial tubes are composed of the same materials as the trachea, but in the smaller branches there is no cartilaginous structure. On their delicate parietes the fine capillaries of the pulmonary arteries and veins are spread, and here during life is effected that important change in the blood, from venous to arterial, which appears to be the great design of the function of respiration. The soft and yielding tissue of the lungs admits of the free entrance and rapid circulation of the air through their cells, all which become distended in the moment of inspiration; in this act the lungs are wholly passive, the air distending them in the exact proportion with which the parietes of the chest are expanded; in expiration, the contraction of the thorax expels a great portion of the air from the cells, and thus the lungs become diminished in capacity; in effecting this change, the elasticity, aided in all probability by the irritable or muscular energy of these organs, may assist the muscular and elastic power of the parietes of the chest. In expiration the air-cells are not wholly emptied; no power can completely discharge the air from lungs that have once breathed.—See Anatomy of the Diaphragm.

[There being no other organ of size, in the cavity of the thorax, besides the lungs and the heart, and the latter being on an average of the size of the fist of the individual, it is obvious that from an external examination of the thorax, we can draw a sufficiently correct inference as to the development of the lungs within; neither is it the absolute size of the thorax, that indicates the best development of lungs, but its size as compared with the rest of the body and particularly the expansion of its antero-posterior diameter; the volume of the right lung and its capacity are greater than that of the left, and this is in accordance with the fact, that the right bronchus is much larger than the left; may not the difference in the size and length of the two bronchii (the left being nearly twice as long as the right, and but about half its calibre) and the smaller capacity of the left lung, have some relation with the fact, that this organ is more affected by tubucular disease, than the right. It is estimated that the capacity of the lungs is such as to contain one hundred and forty-five cubic inches of air, and that by each act of expiration, thirty cubic inches are thrown off; we know of an individual who can displace one gallon of water by a single expiration, without great effort.

The specific gravity of the lungs after inspiration is less than that of water, but in the fœtus, and still born infants, it is greater than that of water, in which it sinks, a fact of much importance in legal medicine, and which in its practical application constitutes the *hydrostatic test;* the absolute weight of the lungs, also differs at different periods. In infants before respiration it is to the weight of the body, as one to sixty, after respiration, as one to thirty, owing probably to the increased determination of blood through the pulmonary vessels; in the adult subject of usual stature, it is said that the weight of the lungs, is about three pounds; in disease it is often very much changed. The apex of the lung rises above the level of the first rib, sometimes an inch, and even two inches, and it has been suggested that the compression of the lungs by the edge of the first rib may produce irritation, and that this may be the reason that tubercles, are generally first developed in the apices.]

The pleuræ and lungs are the seat of many *morbid* changes; the pleura, when inflamed, becomes thickened and vascular, and presents a deposit of lymph on the surface, which commonly causes an adhesion between the pleura costalis and pulmonalis to a very variable extent; when these adhesions are recent, they are soft and easily broken, but when of long standing they become strong and resisting: adhesions of different extent and length are very common appearances. Portions of the pleura costalis are found sometimes converted into bony plates, and apparently without having caused any inflammation or inconvenience. The cavity of each pleura is also the seat of effusion; if of water or serum, it is named hydrothorax, if of pus, empyema; the operation of paracentesis, or tapping, is frequently required in the latter case. The place usually selected for this operation, is about midway in the fifth intercostal space, just in front of the digitations of the serratus magnus muscle.

The lungs are often found in a state of inflammation, (pneumonia), this is denoted by increased density, weight, and colour, sometimes dark, sometimes very florid: the affected portion is often so heavy as to sink in water; the dark colour from the gravitation of blood to a depending part, must not be confounded with that arising from disease. Inflammation sometimes ends in abcess, which may open into the trachea or into the pleura, and so cause empyema. The lungs are very subject to tubercles, which present great variety in size, from a pin's head to that of a walnut; when small they are firm, when large they become soft, suppurate in the centre, and form abscesses or vomicæ, which often communicate with the bronchial tubes. Tubercles are often found in the upper part of the left lung, when the remainder of both organs is healthy. The lungs are also occasionally the seat of cancerous and fungoid tubercle and tumour. We shall next direct our attention to the pericardium and the heart.

The *pericardium* is a strong fibro-serous membrane, in the form of a conical bag, whose base is below and apex above; it is larger than the heart, which it encloses, together with a portion of the great vessels connected to it, and over whose surface its internal or serous layer is reflected: the external fibrous lamina is connected, inferiorly, to the central division of the cordiform tendon of the diaphragm, and to some of its fleshy portion between the central and the left divisions of that tendon; anteriorly to the pleuræ, and to the parts contained in the anterior mediastinum; posteriorly, to the œsophagus and to the other parts in the posterior mediastinum; superiorly, it is continued along the outer coat of the great vessels, while the serous layer is reflected on these towards the heart. On each side it is in a similar manner connected to the pulmonary vessels; the pleura and the phrenic nerve also are attached to it in this situation. The connexion between it and the tendon of the diaphragm, particularly towards its forepart, is very intimate; in the adult they are almost inseparable, not so, however, in the fœtus. Open this bag, and we shall see that it is lined throughout by a smooth serous membrane, which, if we trace to the superior part of the sac, we shall perceive to be reflected on the vena cava on the right side, on the aorta in the middle, and on the pulmonary artery on the left side; on these three vessels it descends towards the heart: there is a longer portion of the aorta covered by the serous membrane, than of the vena cava or pulmonary artery, which two are nearly equal in this respect. The serous layer is reflected on the superior cava, opposite the entrance of the vena azygos; as it descends along that vessel it nearly surrounds it, except a small portion of it posteriorly; from the vena cava it continues to the right auricle, which it covers anteriorly and on the right side; from this it passes on the right pulmonary veins, covers these partially, and is thence reflected to the fibrous layer; from the lower part of the right auricle it is continued partly round the inferior cava, and from it also it is reflected to the fibrous layer. On the aorta the serous layer descends at first on the forepart, afterwards on its sides and back part, so as to encircle it; near the heart it passes from it over the pulmonary artery, so as to connect these vessels to each other, leaving of course uncovered so much of each as are in apposition; along these vessels the serous membrane descends to the ventricles, and having covered all the anterior surface of the heart, it turns round its apex, covers the posterior surface, and ascending on it as high as the upper edge of the left auricle, it is thence reflected on the fibrous layer in front of the posterior mediastinum; from the left auricle also it extends to the left pulmonary veins, from which it is continued to the fibrous layer, and on this we can trace it in an uninterrupted course to that point, at which we commenced its description.

The pericardium, by its fibrous lamina, is of *use* in fixing the heart in its situation, and strengthening its parietes, so as to resist over distention; this tunic also, by its elasticity, may assist in the subsequent contraction of its cavities, while the serous layer being always lubricated by a fine fluid, facilitates the motion of the heart. When the pericardium is fully opened, the right auricle, the two cavæ, the appendix of the left auricle, the right or anterior ventricle, that small portion of the left which forms the apex of the heart, the aorta and pulmonary artery, also branches of the coronary vessels, ramifying on the anterior surface of the heart, all come into view.

The pericardum is liable to inflammation: this is not a very common *disease;* in this state it is crowded with minute vessels, carrying florid blood; it is also more pulpy and thicker than natural; extravasated coagulable lymph is found loosely connecting it to the heart; this sometimes has a reticulated or lace-like appearance, and portions of it float in the serous fluid, which exists in the cavity. In some cases large quantities of pus are formed, without any appearance of ulceration, but always accompanied with a thickened state, and a deposition of coagulable lymph on the internal surface of the membrane. The presence of a small quantity of fluid in the pericardium after death, is not to be set down as a morbid appearance, or confounded with the disease called hydrops pericardii, as in every healthy body a few drachms of fluid are found in the bag of the pericardium, arising from the condensation of the natural exhalation, which exists in all serous cavities, or the oozing out of the blood from the contraction of the heart after death.

[The pericardium is sometimes entirely absent, but this is rare: it sometimes appears to be wanting in consequence of a complete adhesion to the surface of the heart. This organ is partially converted into bone, and one instance is recorded in which this conversion was complete. Three forms of effusion may coexist with pericarditis, serum, pus, and blood, and the quantity is sometimes very great, thus cases are recorded, of eight pounds of serum, of four quarts of pus, and of one quart of blood, having been found. The false membrane of pericarditis varies in thickness from one line to nearly an inch; inflammation of the fibrous lamina of the pericardium, occurs sometimes by metastasis from other parts of the body.]

The *heart* is placed obliquely between the lungs, the base of it is superior, posterior to the right side, and near to the spine, while the apex points towards the costal end of the cartilage of the sixth rib on the left side, and during life can be felt pulsating a little above and below this rib; the heart is retained in situ by the pericardium, and by the great vessels; it is subject, however, to a slight change of position, according as that of the body is altered, as well as from the different states of inspiration and expiration. The heart consists of four cavities, two ventricles, and two auricles; these the student may examine in that order or course which the blood pursues in passing through this organ. Suppose the two venæ cavæ pour their blood into the right auricle, so as to distend it, the parietes of this cavity then contract, and empty its contents into the right ventricle; this next propels the blood into the pulmonary artery, the branches of which convey it through the lungs; from these organs it is returned by the four pulmonary veins, two on each side, into the left auricle; from this cavity it is forced into the left ventricle, which then propels it into the aorta, through whose branches it is conveyed to all parts of the body, whence it is again returned to the heart by the veins. The *superior vena cava* is seen descending obliquely forwards and inwards within the pericardium, and joining the upper and back part of the right auricle. Of the *inferior cava* but a short portion is seen within the pericardium; this vessel lies on a plane posterior to the superior cava, and passing obliquely upwards, backwards, and inwards, joins the lower and back part of the auricle. Between these two veins the *right auricle* is situated; it is somewhat square, its posterior part, between the two cavæ, is called the *sinus;* the anterior loose portion, the *auricular appendix* or *process;*

the right auricle is connected inferiorly to the right ventricle, and partly rests on the diaphragm; on the right side it is free, and on the left it is connected to the left auricle; lay open this cavity by a perpendicular incision from the superior down to within half an inch of the inferior cava, from the centre of this make a transverse cut towards the anterior part of the auricle, wash out the blood, and we may then observe at the back part of the sinus the *openings* of the *two cavæ*, and between these a slight projection, *tuberculum Loweri;* and in the auricular appendix the muscular fibres called *musculi pectinati.* We can also now perceive that the left or internal side of the auricle is formed by a thin sheet of membranous and muscular substance; this is the *septum auricularum;* on the inferior part of this we may observe a depression, the *fossa ovalis*, immediately above the inferior cava, and surrounded in part by a thick lip, named its *annulus;* at the upper and deeper part of this fossa we frequently find a small oblique passage leading into the left auricle, its obliquity, however, prevents any communication taking place during life; in the fœtus before birth this was a free opening, the *foramen ovale*, between the two auricles. Anterior to the opening of the inferior cava, we observe the semilunar fold of the lining membrane, the *Eustachian valve:* this valve is connected by its convex edge to the angle between the vein and auricle; its concave edge is loose, and looks backwards and to the right side; its superior cornu is connected to the anterior or the left limb of the fossa ovalis, and the inferior to the forepart of the vena cava; this cornu is sometimes continued round that vessel to the posterior limb of the fossa ovalis: in the adult and old this valve is often reticulated and imperfect; in the fœtus it is generally more perfect and large, hence it is considered by many as being of *use* at that period in directing the blood from the inferior cava at once into the left auricle through the foramen ovale, and preventing its mixing with that from the superior cava. To the left side of the Eustachian valve, between it and the ventricle, is the *orifice* of the *coronary vein*, which is also partly covered by a semilunar fold of membrane,[the *valve of Thebesius*] that secures this opening against the re-entrance of the blood during the contraction of the auricle; this valve also is often imperfect; on different parts of the auricle small orifices may be often seen, (*foramina Thebesii ;*) these are probably the extremities of small veins.

In the anterior part of the auricle we see the small circular opening of the appendix, inferior to which, and opposite the tuberculum Loweri, is the large orifice leading into the right ventricle; this, the right *auriculo-ventricular* opening, is circular and surrounded by a dense white line, which has been erroneously described as the right tendon of the heart. We may next examine the right ventricle: for this purpose open its cavity, by raising the anterior wall in the form of a flap from below, making one incision along its right side, and the other near the septum cordis. The *right ventricle* is triangular, its base is joined to the auricle, the apex is a little above the apex of the heart; the right is separated from the left ventricle by a thick muscular lamina (the *septum cordis*:) the parietes of this cavity are rendered very irregular internally by numerous muscular projections, the *carneæ columnæ*; *some* of these are attached throughout their whole length, *others* are fixed by their extremities, and loose in their centre, and a *third* species are fixed by one end to the fleshy substance of the heart, by the other to thin tendinous cords [*chordæ tendineæ*] which are attached to the auricular valves; the carneæ columnæ take various directions, and are all covered by the fine lining membrane of the heart. At the base of this cavity we observe the auricular and arterial openings, the latter is superior, anterior and to the left side of the former; from the margin of the auricular opening a fold of the lining membrane descends into the ventricle, the inferior loose edge of which divides into three portions, each ending in a very irregularly notched margin, to which the chordæ tendineæ are attached; these are the *tricuspid valves*, one division is anterior; the second is posterior, on the septum cordis, and the third, which is the largest, is to the left side, and separates the auricular from the arterial opening; many of the tendinous threads are connected to the dorsum, as well as to the edge of these folds, and cross each other as they run to the carneæ columnæ. The *use* of the tricuspid valves is to prevent the reflux of the blood from the ventricle into the auricle; as the former cavity is being distended, the blood separates the valves from the parietes of the ventricle, and thus becomes situated on their outer side; when the ventricle then contracts, it presses the blood against these folds, which are thus approximated to each other, and slightly raised against the opening so as to close it; the carneæ columnæ at the same time contracting make tense the chordæ tendineæ, and thus accomplish the two objects, 1st, of completely approximating the valves; and 2d, of preventing their being reversed or thrown up into the auricle. The orifice of the pulmonary artery is small, and situated at the highest point, and at the left extremity of the ventricle, the surface of which becomes smooth as it approaches it; this vessel is connected to the ventricle by the external and internal serous membranes of the heart, between which its fibrous coat is connected to the fleshy fibres of the ventricle by three roots, convex towards the heart, and marked internally each by a distinct white line; from this arterial opening three folds, the *semilunar valves*, extend into the vessel, the convex edge of each is fixed to the white line at each of the roots of the artery; the concave is loose, but thick, and contains in its centre a small tubercle, the *corpus Arantii* or *sesamoideum*. The *use* of these valves is to prevent the blood returning from the artery into the ventricle, for, as the former becomes distended, the blood flows along behind these valves, [into the *sinuses* of *vals-alva*,] separates them from the sides of the artery, and so approximates them to each other; and when the artery contracts, it presses the blood so strongly against these valves as nearly to intercept the opening, and cause the blood to flow onwards through the artery; the corpora Arantii are supposed to be of *use* in giving additional strength towards the centre of the opening, where the pressure will be greatest; the semilunar valves, both in the pulmonary artery and in the aorta, while they support the column of blood in these vessels, cannot wholly prevent its regurgitation to the heart. The *pulmonary artery* ascends obliquely backwards for about two inches and a half within the pericardium; and just as it escapes from this cavity it divides into the right and left branch; in this course it lies at first anterior to the aorta, and afterwards to the left side. The *right pulmonary artery* is the longer branch; it turns in a traverse direction to the right side, and passes through the arch of the aorta, and behind the superior cava, to the root of the right lung, and there divides into three branches. The *left pulmonary artery* is short, proceeds to the left side, and entering the root of the left lung anterior to the left bronchus, divides into two branches; from the division of the pulmonary artery a ligamentous cord extends backwards and downwards to the lower extremity of the arch of the aorta; this is the remains of the *ductus arteriosus*, which in the fœtus conveyed the blood from the pulmonary artery into the aorta, as it could not pass in any quantity through the condensed structure of the lungs; the recurrent, or inferior laryngeal nerve of the left side winds round this substance. In the lungs the pulmonary arteries divide into numerous branches, which spread minutely on the air-cells, on which they terminate in the *pulmonary veins*, which vessels thus arise by innumerable ramifications; these unite with each other, and form larger trunks, which arrive at the root of the lungs, two on each side, where they lie anterior and inferior to the pulmonary artery; these veins then pass inwards to join the left auricle, a cavity which may be next examined.

The *left auricle* is situated at the upper and back part of the heart, in front of the mediastinum; it may be exposed, either by raising the apex of the heart, or removing this organ from the body, and placing it on its anterior surface; it is somewhat square, smaller than the right, but its parietes are thicker and stronger; from its upper and left extremity its appendix, which is very small, passes forwards, and overlaps the origin of the pulmonary artery; lay open this cavity by a perpendicular incision along its middle line; internally we perceive it smooth, except in the appendix, where a few fleshy fasciculi appear, as in the right side; on the septum auricularum, a slight depression, not so distinct as that in the right auricle, marks the former situation of the foramen ovale; the four pulmonary veins are seen opening into the angles of this cavity, two on each side; those of the left open very near each other, and sometimes in common, beneath the opening of the appendix; at its inferior part we perceive the opening into the left ventricle, circular, smooth and marked by a white line, as in the right auriculo-ventricular opening, than which this of the left side is somewhat smaller. The *left ventricle* is conical; its apex forms the apex of the heart; flattened anteriorly, longer but smaller than the right ventricle, its parietes are much thicker, and to it the septum cordis appears to belong. Continue the incision that had been made in the left auricle downwards along the back of the left ventricle to its apex; the great thickness of its walls, and the roughness of its internal surface from the strong and projecting carneæ columnæ, may now be remarked; at the superior part of this cavity, we find the auricular and aortic openings; these lie very near each other, the arterial being immediately in front of the auricular: from the circumference of the latter there descends a fold of membrane, which divides into two portions, called the *mitral valves;* these are stronger, but in every other respect are similar to the tricuspid valves in the right ventricle; these also answer a similar office, that of preventing the blood returning from the left auricle. The aortic opening is situated at the upper and anterior part of the left ventricle, in front of the auricular, from which it is separated by the anterior or large division of the mitral valve; the ventricle is smooth in the vicinity of this opening. The anterior division of the mitral, and the left of the tricuspidal valves are supposed to be larger than the other portions, *for the purpose* of preventing any blood flowing from the auricle or ventricle into the aorta or pulmonary artery, until the ventricle is fully distended. The *aorta* arises from the left ventricle in the same manner as the pulmonary artery from the right; three *semilunar valves* also proceed from this orifice into the aorta, stronger, but similar in structure and in function to those in the pulmonary artery, the *corpora Arantii* in particular are larger and firmer in the aortic valves; external to each semilunar valve, the aorta is dilated into a small sinus; these three are named the *sinuses of Morgagni*, or lesser sinuses of the aorta. The aorta at its origin is covered by the pulmonary artery; it ascends obliquely forwards and to the right, as high as on a level with the cartilages of the second rib of each side; it then passes backwards, and to the left side; and lastly, descending as low as the fourth dorsal vertebra, it becomes closely attached to the spine; this portion of the aorta is called the *arch*, at the termination of which this vessel receives the name of thoracic or descending aorta, which descends through the posterior mediastinum, as was already stated; the *arch of the aorta* is divided into the ascending, the transverse, and the descending; the first is the longest portion, and in general is so much dilated at the upper part as to have received the name of the *great sinus;* this *ascending* portion is within the pericardium, covered at first by the pulmonary artery; it afterwards lies between this vessel and the vena cava; from the commencement of this, the two coronary arteries arise; the *middle* or *transverse* portion of the arch lies above the pericardium, and in front of the trachea; from it arise the innominata, left carotid, and left subclavian; the *descending* portion bends behind the root of the left lung, and is connected to the pulmonary artery by the remains of the ductus arteriosus; through the arch of the aorta, the right pulmonary artery, left bronchus and left recurrent nerve pass.

The heart is composed of three tunics; first. the reflected serious layer of the pericardium, externally; second, the serious membrane which lines the vascular system, internally, [the *endocardium;*] and thirdly, between these membranes a lamina of muscular substance: the serous membranes are stronger, but the muscular tunic weaker in the auricles than in the ventricles; the muscular fibres are arranged chiefly in a spiral direction, but they are so closely united that their course is not obvious, unless after long maceration; external to this tunic, in the adult or old, and on the right side principally, we generally find a quantity of adeps placed. The coats of the heart are supplied with blood from the two coronary arteries, the first branches of the aorta: the nerves of the heart are small and numerous, they are derived from the cervical ganglions of the sympathetic, and from the pneumogastric of each side.—(See Vascular and Nervous Systems.)

[The heart is of a florid red color, in the healthy adult; but becomes paler in advanced life; the internal muscular fibres, are usually redder than the external, the color however depends upon the state of the system. The size of the heart is about the same as that of the fist of the individual, varying however with disease; in persons of middle stature, or under, this organ is absolutely larger than in very tall people; the capacity of the auricles is greater than that of the ventricles and that of the right cavities, greater than that of the left. By comparing the results obtained by several of our best anatomists and pathologists, it is found that the average weight of the healthy adult heart, is from eight to eight and a half ounces; the weight of this organ compared with that of the body, is in inverse ratio to period after conception. Thus at the end of three months, it is as one, to fifty, at the full time, as one to one hundred and twenty. The average length of the heart from base to apex, is five and a half, to five and three quarter inches, of which about four inches belong to the ventricles. The average circumference, at the auriculo-ventricular groove, is from eight to nine inches, the breadth three and a half to four inches, and the thickness about two inches. The parietes of the several cavities differ in thickness, and those of each cavity vary at different points; it may be stated in general terms, that the average thickness of the right auricle is one line, of the left auricle one line and a half; of the right ventricle two lines and a half, and of the left ventricle, from six to seven lines; the average thickness of the ventricular septum, is five lines and a half, being however thicker at its centre, and that of the auricular septum is one line and a half. The circumference of the aorta, is about two inches and three quarters; of the pulmonary artery three inches, or a trifle more, of the left auriculo ventricular opening, four inches, and of the right four inches and a half.

In the fœtus and infant, the position of the heart is vertical instead of oblique, as afterwards. A portion of the heart is not overlapped by the lungs, this part is behind the sternum a little to the left of the median line, and here the heart may be examined by auscultation; by having the patient seated so as to lean forward, the heart will be more completely projected against the sternum, and hence the sound will be more distinct than if the patient is on his back, as then the heart falls somewhat towards the spine. The congenital malformations of this organ, are numerous, but as in its development it passes through various stages, similar to the normal development of the heart, in inferior animals, so these malformations, for the most part, appear to depend upon an arrest of development, in one or the other of these stages. Most of these malformations, are incompatible with the prolongation of life, yet occasionally we find that subjects laboring under them live for many years. The heart is rarely entirely wanting, when this is the case, there is also an absence of the brain. It is always a double organ, the two parts united together, but sometimes there are two hearts, for example, one case, where one organ was in the thorax the other in the abdomen; the heart sometimes inclines to the right side instead of the left, a case is known to us, in which two members of the same family are thus formed. This malposition is usually attended with a transposition of other organs. A remarkable specimen of transposition has been preserved in the Cincinnatti medical college, and another, in the medical department of Yale college, both within two years. The valves are sometimes deficient in number, sometimes incomplete, so as not to meet in the centre of the orifices to which they belong. Congenital varieties in the origins and terminations of the larger vessels, connected with the base of the heart are not uncommon.]

The heart is subject to many *diseases*, the morbid appearances of which will be soon detected by any person well acquainted with its natural structure. Carditis, or inflammation of its substance is rare, it is usually confined to some portion of the organ, and pus is found diffused amongst its fleshy fibres, or sometimes collected into a cyst. Ramollissement, in this case the heart is sometimes so soft that the finger can pass through it; the colour is brown or deep red if the change have been recent, if chronic, pale and yellowish; this affection sometimes ends in rupture. Induration, is usually confined to some portions of the heart which will be found so crisp as to grate under the knife. Hypertrophy, or enlargement of its cavities and thickening of its parietes; this change is most common in the left ventricle. Atrophy, or diminution of the organ; its fibres are pale, flabby, and intermingled with soft adeps; in this case the cavities are not diminished in size; this change is most frequent in the right ventricle. Tubercles are sometimes found in the parietes of the heart, and are very small. Sanguineous concretions, or coagula, incorrectly called polypi, are common in the right cavities, they are usually free from the colour of the blood, and are like a mass of fibrine; in dropsical subjects they often appear gelatinous and semi-transparent; when recent they have no adhesion, but if long formed they often adhere closely. The aortic and mitral valves are often found diseased, on the latter fleshy vegetations frequently grow, and calcareous matter is very commonly deposited both in these valves as well as in the semilunar folds at the aortic opening. The left auriculo-ventricular opening is occasionally so much contracted as to embarrass the circulation very considerably, this function is also occasionally suspended by a rupture of one of the mitral or semilunar valves: the valves at the right side of the heart are seldom found diseased. Malformation, or imperfect development, is not uncommon in this organ; thus the foramen ovale is sometimes open; also a communication between the ventricles, through their septum, occasionally exists. These conditions are usually attended with a bluish tint of the skin and other marks of imperfectly oxygenated blood.

[The heart is sometimes the seat of a fatty transformation, this is most common in old subjects; it is also the seat of cartilaginous and osseous transformations, but these are rare. Ossification is sometimes confined to a few of the muscular fibres, sometimes involves the whole paries of one cavity, and one case is recorded by Monro, in which the whole heart except the left auricle was converted into bone: from the cases reported it would seem that the ventricles are more subject to this change than the auricles; there are specimens of this affection in the college museum. Endocarditis is an inflammation of the lining membrane of the heart; it is apt to result in vegetations (probably fibrine,) which are most common at the aortic and mitral valves, but may occur in any of the cavities of the heart; this inflammation may also result in a cartilaginous thickening or ossification, which also generally occurs upon and around the aortic and mitral valves, those of the right side, being rarely thus affected; a pathological fact establishing the difference between the venous and arterial membranes, and proving that the right endocardium is similar to the lining membrane of the veins, and the left, to that of the arteries. There is a preparation in the college museum showing that aneurism of the valves may occur; in this specimen, one of the mitral valves is affected.]

The student may next examine what are the parts which pass through the *upper orifice of the thorax*.

Posterior to the deep cervical fascia, we perceive the sterno-hyoid and thyroid muscles first ascending through this opening: behind these is a quantity of cellular membrane, and the remains of the thymus body: next are the *right* and *left venæ innominatæ* the former descending perpendicularly, the latter obliquely across this opening; these two veins unite opposite the cartilage of the second rib of the right side, and form the superior vena cava, which soon enters the pericardium, and empties itself into the right auricle; behind these veins, the phrenic and par vagum enter the chest; the former is external and anterior to the latter, and both are anterior to the subclavian arteries. The *phrenic nerve*, accompanied by the internal mammary vessels, descends through the thorax, anterior to the root of the lungs, to the diaphragm, to which it is distributed; this nerve on the left side is longer, and lies somewhat posterior to that on the right side; *the eighth pair* entering the chest, between the subclavian vein and artery, passes backwards behind the root of the lung, on which it forms an extensive plexus, *pulmonary plexus;* it then enters the posterior mediastinum, and becomes attached to the œsophagus, which conducts it to the stomach. We next perceive the innominata, left carotid, and left subclavian arteries ascending out of this cavity; the innominata is most anterior, and the left subclavian the most posterior of the three. The *trachea* is next seen entering the thorax, behind these vessels, and inclining a little to the right side; this tube commences opposite the fifth or sixth cervical vertebra, descends at first in the middle line, but as it approaches the chest, it inclines to the right, the aorta pressing on its left side; in the neck it rests on the œsophagus, and lies between the great vessels; it is covered by the thyroid body and its veins, the sternal muscles, the arteria and left vena innominata: in the thorax, the trachea descends obliquely backwards, and opposite the third dorsal vertebra it divides into the right and left bronchial tubes; a number of dark lymphatic ganglia (the *bronchial ganglia*) lie in the angle of the division, and adhere closely to the branches. The trachea is composed of eighteen or twenty fibro-cartilages, connected together by an elastic substance, and lined by mucous membrane; each cartilage forms about three-fourths of a circle, the deficiency posteriorly being filled by a fibrous membrane, which also encloses the cartilages, and by some transverse muscular fibres and mucous glands; the *right bronchial tube* is the larger branch; it runs transversely into the root of the lung, and divides into three branches; the vena azygos bends over this vessel; the *left bronchial tube* is longer, and takes a course slightly curved downwards and to the left side, through the arch of the aorta to the root of the left lung, and then divides into two branches; the further subdivisions of these two tubes gradually lose the cartilaginous structure, divide into numerous fine membranous vessels, each of which terminates in a cluster of small cells; those in each single group communicate freely, but those of one lobule do not communicate with those in another, except through the medium of the air-tube, from which both are derived; on the delicate membrane composing these air vesicles, the pulmonary arteries and veins minutely ramify: the bronchi are composed of the same structures as the trachea, the cartilages, however, soon lose their annular form, and become irregular; in their minute subdivisions they no longer exist; the air serves to retain these as well as the cells in a permanently distended condition.

[The rings of the trachea, are not apt to ossify, still this takes place occasionally, even to such extent as to involve the whole ring. The bronchial tubes are also sometimes ossified. If a small foreign body passes down into the trachea, it may be, and generally is arrested at the befurcation; if not it passes by preference into the right bronchial tube, after which, though beyond the reach of the surgeon, it is sometimes thrown off by the efforts of nature, and the patient recovers. An interesting case of this kind is recorded in the Boston Medical and Surgical Journal, in which a nail passed into the trachea of a child; the operation of tracheotomy was performed, low down, but the nail had passed the bifurcation and was beyond reach; the patient recovered from the operation, but labored under severe symptoms for some time, when the nail was coughed up with a quantity of pus, and the child recovered. If the ear be placed over the two bronchial tubes different sounds will be detected.]

Behind the trachæa, the *œsophagus* is seen entering the thorax, lying close to the spine; at first a little to the left of the mesial line, afterwards to the right of that line, and as it descends through the posterior mediastinum, it again inclines to the left. On the left side of this tube, the thoracic duct is seen ascending from the thorax into the neck, between the left carotid and subclavian arteries. As the œsophagus enters the chest, we observe on either side of it the recurrent nerve; that of the left side passes out of this cavity, that of the right arises on a level with the opening: external to this nerve, on each side, we perceive the *sympathetic* entering the chest; it lies posterior to the phrenic and the vagus, but between both; this nerve having formed its inferior cervical ganglion, divides into several branches which descend into the thorax, a few pass anterior to the subclavian artery, the principal pass behind it; they all unite in its first thoracic ganglion, which is situated on the neck of the first rib; the sympathetic then descends along the side of the spine, passing over the heads of the ribs, and opposite each intercostal space forms a small triangular ganglion, from each of which two or three small branches proceed to join the dorsal spinal nerves, and from the five or six inferior the great and small splanchnic nerves arise; the sympathetic is so small, inferiorly, that it is often difficult to trace it; it escapes from the thorax into the abdomen, beneath the true ligamentum arcuatum. Posterior to the œsophagus, the longi colli muscles ascend through the upper opening of the thorax; on each side of these lie the superior intercostal artery, and the anterior branch of the first dorsal nerve, ascending to join the last cervical in the brachial plexus.

CHAPTER IV.

MUSCLES OF THE BACK.

SECTION I.

Place the subject on the forepart, raise the chest by blocks, let the head and arms hang; thus, the muscles in this region will be made tense: divide the integuments along the middle line, from the occiput to the sacrum; make a transverse incision from the last cervical vertebra to the acromion, and another from the last dorsal vertebra to the posterior part of the axilla; reflect the upper and lower flap of integument from the spine towards the side, and raise the middle portion from below upwards and outwards; thus the dissector can more easily expose the trapezius and latissimus dorsi muscles; the integuments in this region are dense, also the subjacent cellular tissue, which seldom contains much adeps; inferiorly it is often anasarcous; when all this is dissected from the posterior part of the trunk, we see exposed the trapezius superiorly, the latissimus dorsi inferiorly, and between these, in a small triangular space behind the base of the scapula, a part of the great rhomboid, also two or three tendons of the sacro-lumbalis, and a portion of the seventh, eighth, and ninth ribs, and of the corresponding intercostal muscles; along the middle line of the neck a strong ligament is observed, (ligamentum nuchæ), at the lower part of which is a strong aponeurosis of an oval form, (the cervical aponeurosis): also covering the lumbar region another still stronger is seen, (the lumbar fascia): to each of these the student should pay attention. The *ligamentum nuchæ* is *inserted* superiorly into the occipital protuberance, it descends in the median line, broad above, and sinking in deep, so as to form a septum between the muscles on the right and left sides, and is *inserted* inferiorly into the spinous processes of the three or four last cervical vertebræ, and into the cervical aponeurosis. *Use*, to support the head in flexion of the neck, and to give attachment to muscles. The *cervical aponeurosis* extends from the fifth cervical to the fifth dorsal vertebra, narrow at each extremity, and broad in the centre between the superior angles of the two scapulæ; the fibres are transverse, and continuous with the fibres of the trapezius on each side; it gives strength to these, and binds down the subjacent muscles.

The *lumbar fascia* is of great strength; it is also somewhat oval, attached by its inferior extremity to the spinous processes of the sacrum, and by its superior to those of the inferior dorsal vertebræ; on either side it is connected to the crest of the ilium, and to the abdominal muscles, particularly to the transversalis, also to the latissimus dorsi and serratus posticus inferior; its internal surface is attached along the median line to the spines of the lumbar vertebræ, and on either side to the traverse processes. In the course of the dissection of the lumbar muscles, this fascia will be found to consist of three laminæ, the first, or posterior, that which is seen at present, is attached to the spines of the lower dorsal and to those of all the lumbar vertebræ and sacrum, it gives attachment to the latissimus dorsi, serratus posticus inferior, obliquus internus, and transversalis abdominis muscles. The second or middle layer is attached to the transverse processes of the lumbar vertebræ, and lies posterior to the quadratus lumborum muscle; and the third or anterior layer is in front of the quadratus and psoas muscles, and is attached to the sides of the bodies of the lumbar vertebræ. This fascia gives great support to the loins, where the skeleton is comparatively weak; like the ligamentum nuchæ it supports the trunk in flexion, it also assists in maintaining it *in equilibrio* in lateral motion, and it also serves to give attachment to several muscles, which, again in their turn, serve to keep it in a state of tension.

The muscles of the back are many of them indistinct, and vary very much in different subjects both in their appearance and in their exact attachments to any certain number of vertebræ; the student is not to expect therefore to find each muscle in this region to correspond accurately with the description that is given, some being attached to a greater, others to a less number of processes than is stated. The muscles of the back are arranged in *four* successive layers, each nearly covering the other between the integuments and the bones; the muscles of the *first* layer are two in number, viz. the trapezius and the latissimus dorsi.

Trapezius, broad, triangular, the base along the spine, the apex at the shoulder, *arises* by a thin aponeurosis from the internal third of the superior transverse ridge of the occipital bone, from the ligamentum nuchæ, and from the spinous processes of the last cervical, and of all the dorsal vertebræ; the superior fibres descend obliquely outwards and forwards; the middle pass transversely, the inferior ascend obliquely forwards; all converge towards the shoulder, and are *inserted* into the posterior border of the external third of the clavicle, and of the acromion process, also into the upper edge of the spine of the scapula. *Use*, to raise and draw backwards the shoulder; the inferior fibres which end in a triangular shaped tendon, which glides over the triangular smooth surface at the commencement of the spine, may draw down the base of the scapula, and thus by rotating this bone will elevate the acromion process, and assist the remainder of the muscle in raising the shoulder; the trapezius may also incline the head backwards and to one side. This muscle is covered by the skin only, its origin in many points is continuous with that of its fellow; it covers the splenii, complexi, serratus superior, levator scapulæ and rhomboid muscles; its anterior fibres are parallel to the sterno-mastoid, in contact with it above, but separated below, by fat, vessels and nerves; in some subjects a band of fleshy fibres unites these muscles above the clavicle.

[*Variety*. The origins from the three or four lower dorsal vertebræ are sometimes wanting; also the lower part of the muscle, is sometimes separated from the rest by a large triangular space.]

Latissimus Dorsi is very broad, and also triangular; it covers the greater part of the lumbar and dorsal regions, and extends from these to the inner side of the arm; *arises* from the six inferior dorsal spines, and by the lumbar fascia from all the lumbar spines; also from the back of the sacrum, from the posterior third of the crest of the ilium, and by distinct fleshy slips from the three or four last ribs near their anterior extremity; the iliac and lumbar fibres ascend obliquely outwards; the dorsal, which are much weaker, pass transversely; and the costal are nearly vertical; all converge towards the inferior angle of the scapula, over which they glide, and from which they often derive an additional fasciculus of fleshy fibres; thence the muscle continues to ascend obliquely outwards over the teres major, and near the inside of the arm it twists beneath this muscle to its forepart, ends in a flat broad tendon, which is closely connected to that of the teres, and is *inserted* into the inner or posterior edge of the bicipital groove, anterior and superior to that tendon; a small bursa is usually found between these tendons in this situation. *Use*, to depress the shoulder and arm, to draw the arm backwards and inwards, to rotate the humerus inwards, so as turn the palm of the hand backwards, also to depress the ribs as in expiration; but if the upper extremity be raised and fixed, this muscle may elevate the ribs, and so assist in inspiration, as well as in raising the whole body, as in climbing.

The dorsal portion of the latissimus dorsi is covered by the trapezius; the remainder of this muscle is superficial, its origin is superior to the glutæus maximus, its anterior edge is connected to the abdominal muscles, the inferior fasciculi of the external oblique indigitate with its costal origins; it covers the serratus inferior, the lumbar muscles, and the angle of the scapula; its humeral end forms the posterior fold of the axilla; a fasciculus of fleshy fibres sometimes passes across the floor of this region, and connects the latissimus to the great pectoral muscle; between the angle of the scapula and the humerus this muscle has a twisted appearance, the lumbar and costal fibres being inserted into the upper part of the tendon, and the superior or dorsal portion into its inferior edge; the axillary vessels and nerves lie on this tendon at its insertion, and the bicipital groove is lined by aponeurotic fibres derived from it, and from the tendon of the great pectoral, which are thus united to each other, although previous to this they are separated by the brachial vessels and nerves, and by the coraco-brachialis and biceps muscles.

[*Another variety*, in this muscle is, that a fasciculus comes off from it, is connected to the coraco brachialis, and then inserted into the coracoid process of the scapula.]

Divide the trapezius and latissimus longitudinally between the spine and the scapula, reflect one portion towards the vertebræ, the other towards the side, and the second layer of the dorsal muscles will be exposed. (In dissecting off the latissimus take care not to injure the serratus inferior, which is very thin and adheres closely to it.)

The second layer of muscles consists of the rhomboid, levator anguli scapulæ, serratus inferior and superior, and the splenii; a considerable portion of each of these is now seen, although they partly conceal each other.

Rhomboideus is broad, thin and the most superficial of this layer; it is divided into a superior or minor portion, and an inferior or major; the *minor arises* from the lower part of the ligamentum nuchæ, and from the two last cervical spinous processes; the fibres run parallel outwards and a little downwards and are *inserted* into the base of the scapula, opposite to and above the spine. The *major arises* from the four or five superior dorsal spines; the fibres pass outwards and downwards, parallel to the former, and are *inserted* into the base of the scapula, extending from the spine to the inferior angle. *Use*, to draw the shoulder backwards and upwards; the inferior fibres also can, by pulling back the inferior angle, rotate the scapula so as to depress the acromion process, thereby assisting the levator anguli and the pectoralis minor muscles. The rhomboid muscles are covered by the trapezius and latissimus, a portion of the major between these muscles is covered only by the integuments, they conceal part of the serrati postici muscles.

Levator Anguli Scapulæ, long, and somewhat round, placed at the upper and posterior part of the side of the neck, *arises* by four or five tendons from the posterior tubercles, of the transverse processes of the four or five superior cervical vertebræ; these soon terminate in a fleshy belly, which descends obliquely outwards and backwards, and is *inserted* into the base of the scapula, between the spine and superior angle; its *use* is to elevate the whole scapula, if assisted by the trapezius, or to elevate the superior angle alone, and to rotate the scapula so as to depress the acromion, thus co-operating with the lesser pectoral muscle; it is covered by the trapezius; a small portion may be seen superiorly between this and the sterno-mastoid muscle: the tendinous origins have those of the splenius colli behind them, and of the scaleni and rectus capitis anticus major before them. Divide and reflect the rhomboid muscles; beneath these a quantity of loose cellular membrane is placed, between them and the serratus magnus, to the posterior view of which muscle the student should now attend; he may therefore again peruse the account given of that muscle, (see page 69.)

Serratus Posticus Superior, *arises* by a thin aponeurosis from the ligamentum nuchæ, and from two or three dorsal spines, forms a thin fleshy belly, which ends in three fleshy slips, which are *inserted* into the second, third, and fourth ribs external to their angles. *Use*, to expand the thorax by elevating the ribs and drawing them outwards. This muscle is covered by the trapezius and rhomboid; it lies on the splenius and the deep layer of muscles; an aponeurosis is continued from it to the inferior serratus.

Serratus Posticus Inferior, *arises* by a thin tendinous expansion, which is connected through the lumbar fascia to the two last dorsal and two upper lumbar spines; it forms a thin fleshy expansion, which divides into three or four fasciculi, which are *inserted* into the lower edges of the four inferior ribs anterior to their angles. *Use:* by depressing the ribs it assists the abdominal muscles in *expiration;* also, by fixing the lower ribs it increases the power of the diaphragm, and by aiding this muscle in enlarging the thorax it assists in *inspiration;* the two serrati also, by making tense the aponeurosis which connects them to each other, compress and support the deep muscles in this region. The serratus posticus lies under the middle of the latissimus dorsi, to whose tendon it adheres intimately, but can be separated from it by cautious dissection: its attachment to the ribs is behind those of the external oblique and latissimus dorsi muscles. Reflect from its origin the superior serratus, and we shall see the following muscle.

SPLENIUS, is long and flat, fleshy and tendinous, lying beneath the trapezius, and extending in an oblique direction from below, upwards, forwards and outwards; it is divided into two portions, the inferior, or splenius colli, and the superior or splenius capitis. The *splenius colli arises* from the spines of the third, fourth, fifth, and sixth dorsal, ascends obliquely outwards, and is *inserted* by distinct tendons into the transverse processes of the three or four superior cervical vertebræ behind the origins of the levator scapulæ. *Use*, to bend the neck backwards, and to one side. *Splenius capitis* is larger than the last, superior and internal to which it lies; it *arises* from the spinous processes of the two superior dorsal and three inferior cervical vertebræ, and from the ligamentum nuchæ; it ascends a little obliquely outwards, and becoming larger, is *inserted* into the back part of the mastoid process, overlapping the sterno-mastoid, and into the occipital bone, below the superior transverse ridge. *Use*, to bend back the head, and when one only acts to turn the head to that side; thus cooperating with the sterno-mastoid of the opposite side.

The splenii capitis muscles diverge superiorly, and the complexi which converge appear between them. Detach the splenii from the spinous processes, and divide the fascia lumborum, and the next layer of muscles will appear; this consists of the sacro-lumbalis, longissimus dorsi, and spinalis dorsi, cervicalis descendens, transversalis colli, trachelo-mastoideus and complexus.

SACRO-LUMBALIS, LONGISSIMUS DORSI, and SPINALIS DORSI, these three muscles are so closely connected inferiorly as to appear but one mass, and several fibres must be divided in order to separate them from each other; they fill the hollow between the angles of the ribs and the spinous processes, the sacro-lumbalis is external, the longissimus dorsi in the middle, and the spinalis dorsi is internal. *Sacro-lumbalis* is the largest of the three; it *arises* from the posterior third of the crest of the ilium, from the oblique and transverse processes of the sacrum, from the sacro-iliac ligaments, and from the transverse and oblique processes of the lumbar vertebræ; it ascends and divides into several long tendons, which are *inserted* into all the ribs near their angles. *Use*, to extend the spine, and bend it a little to one side, also to depress the ribs as in expiration. The *longissimus dorsi* lies internal to the last, and *arises* in common with it, from the posterior surface of the sacrum, and of the transverse and oblique processes of the lumbar vertebræ; ascending along the vertebral column, it is *inserted* internally by small tendons into all the dorsal vertebræ, and externally by fleshy and tendinous slips into all the ribs between their tubercles and angles. *Use*, to extend, bend to one side, and support the spinal column. When we separate the sacro-lumbalis from the longissimus dorsi and evert the former, we shall expose five or six small tendinous and fleshy fasciculi which *arise* from the superior edge of each rib, and ascending are *inserted* into the tendons of the sacro-lumbalis; these are called the *musculi accessorii;* they are very irregular in number, structure, and size. *Spinalis dorsi* lies between the longissimus dorsi and spine; it *arises* from the two superior lumbar and three inferior dorsal spines; it ascends close to the spinal column, and is *inserted* into the nine superior dorsal spines: its *use* is similar to the last. These three muscles are covered by the lumbar fascia, and by the two preceding layers. These lumbar muscles in old subjects will be often found soft, weak, and pale, and often blended with a soft fatty substance, so as sometimes to resemble a mass of adipocere.

CERVICALIS DESCENDENS, or more properly ASCENDENS, looks like a continuation of the sacro-lumbalis, internal to which it *arises* by four or five tendons from as many of the superior ribs between their tubercles and angles; these unite in a small fleshy belly, which ascends obliquely forwards and outwards, and is *inserted* by three or four tendons into the transverse processes of the 4th, 5th, and 6th cervical vertebræ, between the splenius colli and levator scapulæ. *Use*, to extend the neck, and incline or turn it to one side; it may also assist in inspiration by elevating the ribs.

TRANSVERSALIS COLLI, appears as a prolongation of the longissimus dorsi, internal to which it *arises* by small tendinous and fleshy slips from the transverse processes of five or six superior dorsal vertebræ; the fibres uniting ascend obliquely outwards and forwards, and are *inserted* by small tendons into the transverse processes of three or four inferior cervical vertebræ, between the cervicalis descendens and the trachelo-mastoideus; its *use* is nearly similar to that of the last described musole.

TRACHELO-MASTOIDEUS lies internal to the last, and external to the complexus; it *arises* by several tendinous bands from the transverse processes of three or four superior dorsal vertebræ, and from as many inferior cervical; ascending a little outward it is *inserted* into the inner and back part of the mastoid process, beneath the insertion of the splenius. *Use*, to assist in extending the neck, to bring the head backwards, and to incline and rotate it to one side. This muscle is covered by the splenius and transversalis, it lies upon the complexus, the obliqui capitis, and the digastric muscles.

COMPLEXUS *arises* from the transverse and oblique processes of three or four inferior cervical, and five or six superior dorsal vertebræ, internal to the transversalis and trachelo-mastoideus; it forms a very thick muscle intersected by many tendinous bands; it ascends a little inwards, and is *inserted* close to its fellow into the occipital bone, between the two transverse ridges. *Use*, to draw back the head, to fix and support it on the spine, also to rotate it, being, in this action, an antagonist to the splenius, and an auxillary to the sterno-mastoid of its own side. The complexus is concealed by the trapezius and splenius; its insertion, which is covered by the former only, can be felt and seen through the integuments; it lies on the semi-spinalis colli, the deep cervical artery, and the small oblique and recti muscles. Detach the complexus from the spine and reflect it towards the occiput, and evert towards the ribs the other muscles of this layer, we shall thus expose the fourth layer of the dorsal muscles, which consists of the spinalis or semi-spinalis colli, the semi-spinalis dorsi, multifidus spinæ, inter-spinales, inter-transversales, and immediately below the occupit, the recti, postici, major and minor, and obliqui capitis, superior and inferior.

SPINALIS, OR SEMI-SPINALIS COLLI, is one of the largest muscles in this region; it *arises* from the extremity of the transverse processes of five or six superior dorsal vertebræ, ascends obliquely inwards close to the spine, and is *inserted* by four heads into the spinous processes of the second, third, fourth, and fifth cervical vertebræ. *Use*, to extend the neck and incline it a little to its own side: this thick muscle fills up the space between the spinous and transverse processes of the cervical and dorsal vertebræ; it lies external to the semi-spinalis dorsi, is overlapped by the longissimus dorsi inferiorly, the complexus superiorly, and the serratus posticus superior, in the middle.

SEMI-SPINALIS DORSI is similar to the last muscle in form and attachment; indeed they appear as one long muscle, which has been thus rather unnecessarily divided into two, each named from the situation of its principal portion; it *arises* by five or six tendons from the transverse processes of the dorsal vertebræ, from the fifth to the eleventh; its fibres ascend obliquely inwards, and are *inserted* by five or six tendons into the spinous processes of two inferior cervical, and three or four superior dorsal vertebræ. *Use*, co-operates with the last described muscle, in extending the neck, supporting the trunk, and inclining the spine backwards, and to one side : it is situated close to the spine above, and internal to the last muscle; but below, it lies on the outer side of the spinalis dorsi.

Multifidus Spinæ is close to the vertebræ, between the spinous and transverse processes, and is covered by the two last described muscles; it consist of a series of small tendinous and fleshy fasciculi; the *first arises* from the spine of the dentatas, or second vertebræ, and descending obliquely outwards, is *inserted* into the transverse process of the third: thus the succeeding muscles are attached, running obliquely from vertebra to vertebra between their spinous and transverse processes; some fasciculi extend over two or three vertebræ; the *last arises* from the spine of the last lumbar vertebræ, and is *inserted* into the false transverse process of the sacrum. *Use*, to support the spinal column, extend it, and incline it to one side, also to rotate one bone upon the other, as far as their articulating surface will admit.

Inter-spinales are short muscles, consisting of longitudinal fibres; their name expresses their situation and attachment; between the cervical spines they are more distinct, and appear to be in pairs, right and left, as the spinous processes here are forked; some fibres in the neck deserve the name of *supra-spinous* muscles, as they pass over these processes, cover and adhere to several of them; in the back they are very indistinct, almost wanting, and in the loins they are much weaker than in the neck, chiefly consisting of ligamentous fibres, with a few muscular intermixed. *Use*, to support and extend the spine.

Inter-transversales consist of longitudinal fibres attached and situated, as their name implies; between the cervical vertebræ these muscles are more strong and distinct, and consist of two planes, an anterior and posterior; between the lumbar vertebræ they are less distinct; and still less so, indeed often wanting, between the dorsal. *Use*, to support the spine on either side, and to bend it laterally. External to these in the back, the levatores costarum muscles are seen, which have been already noticed in the description of the intercostals. Between the occiput and the first and second vertebræ, the following four pair of muscles are situated.

Rectus Capitis Posticus Major. Triangular; *arises* narrow from the spinous process of the second vertebra; ascends outwards, and is *inserted* broad into the inferior transverse ridge of the occipital bone. *Use*, to extend the head, or draw it backwards, also to rotate it and the atlas on the dentatas, co-operating with the splenius of the same side; this muscle is situated obliquely between the occiput and the second vertebra; it is covered by the complexus; its insertion is overlapped by that of the superior oblique.

Rectus Capitis Posticus Minor, also triangular, *arises* narrow from the posterior part of the atlas; passes upwards, outwards, and backwards, and is *inserted* broad into the occipital bone, behind the foramen magnum. *Use*, to assist the former in drawing back the head, and steadying it on the spine; this pair is partly covered by the last muscles; a portion of them, however, is seen between these: both the recti resemble the continuation of the inter-spinous muscles.

Obliquus Capitis Inferior, is the strongest of these small muscles; it *arises* inferior and external to the posterior rectus, and superior to the spinalis colli, from the spinous process of the second vertebra, ascends obliquely backwards and outwards, and is *inserted* into the extremity of the transverse process of the atlas. *Use*, to rotate the head and atlas on the second vertebra, co-operating with the splenius of the same side, and the sterno-mastoid of the opposite side: this muscle is covered by the complexus, trachelo-mastoideus, and trapezius.

Obliquus Capitis Superior, smaller than the last, above the insertion of which it arises, narrow, from the upper part of the transverse process of the atlas, ascends obliquely inwards, overlapping the rectus, and is *inserted* broad into the occipital bone, between its transverse ridges, just behind the mastoid process. *Use*, to bend the head to one side, and to draw it a little backwards; it cannot have any rotatory power, as there is no rotation between the occipital condyles and the atlas. In the dissection of the muscles of this region, but few vessels or nerves of size or note are met with; the arteries which supply these muscles are branches of the occipital and deep cervical superiorly; the posterior branches of the intercostals in the middle, and of the lumbar arteries below. The veins accompany the arteries and join the nearest venous trunks. The nerves are the small posterior branches of the cervical, dorsal, and lumbar spinal nerves.

CHAPTER V.

DISSECTION OF THE UPPER EXTREMITY.

The upper extremity is connected to the trunk by the sterno-clavicular ligaments, and by ten muscles, of which one is connected to the clavicle, (subclavius,) two to the humerus, (pectoralis major and latissimus dorsi,) and eight to the scapula—viz., trapezius, levator anguli scapulæ, omohyoid, rhomboid major and minor, serratus magnus, pectoralis minor, and latissimus dorsi; this last is also inserted into the humerus; all these muscles have been already examined; these the student may divide, then separate the extremity from the trunk, and place a block under the axilla; the dissection of the arm, however, may be performed while it remains connected to the body. The muscles of the upper extremity are classed into those of the shoulder and arm, fore arm and hand.

SECTION I.

[The muscles which act upon the superior extremity, are arranged with express view to the two great functions of the extremity, of which the one is to prepare and carry food to the mouth, the other to defend the body, and particularly the head and face from external violence, both of which actions are prompted by the innate feeling of self preservation; accordingly we find that those muscles which actually lie upon the extremity are so arranged, that all the extensor muscles are situated upon the outer and back part of the limb, while all the flexor muscles, are on the inner and forepart; which enables the extremity to be carried forward, inwards, and upwards, in a curvilinear direction so as to cover the face and thorax; this arrangement is very different from that of the inferior extremities, whose great function is progression and retrogression (see muscles of lower extremity.) The motions of the superior extremities are flexion, and extension, abduction, adduction, rotation, inwards and outwards, and circumduction; these motions are all performed by a rapid combination of actions, on the part of the flexor, and extensor muscles, except in the case of the revolution of the radius upon the ulna, for which purpose there are special and appropriate rotator muscles. The muscles which move the upper extremities, should be classed as nearly as may be according to their functions, and they may be examined in the five regions of the trunk, shoulder, arm, fore arm, and hand; this arrangement has reference to the part upon which the muscles chiefly lie, and it will be seen, that those in the region of the trunk, are not what are usually considered as muscles of the extremity; in the several regions the muscles are arranged in classes having reference to the particular part of the extremity upon which they act, and lastly, the classes are divided into groups, according to the particular and principal motion effected by their contraction as flexion, extension, &c.

In proceeding with the muscles which move the upper extremity, we first examine those on the region of the *trunk*, and we here find nine muscles on each side, all of which serve to connect the extremity with the trunk; these muscles are arranged in two classes, one of seven muscles, which act upon the shoulder, a second of two muscles, which act upon the os brachii.

FIRST CLASS, SEVEN MUSCLES.

Trapezius,	*Vide p.* 96.
Levator Angulii scapulæ,	" " 99.
Rhomboideus Minor, Rhomboideus Major,	*Vide p.* ~~93.~~ 98
Sarratus Magnus Anticus,	*Vide p.* 69.
Pectoralis Minor,	" " ~~63.~~ 68
Subclavius,	" " 69.

Of these muscles the subclavius acts upon the clavicle only, the trapezius upon the clavicle and scapula, and the other five upon the scapula only; their combined action is to cause the scapula to rotate in such manner as to keep its glenoid cavity in contact with the head of the os brachii, so as to guard against dislocations of the shoulder joint. The omo-hyoid muscle is attached to the scapula but cannot effect its motions.

SECOND CLASS, TWO MUSCLES.

Pectoralis Major,	*Vide p.* 67.
Latissimus Dorsi,	" " 97.

These muscles act upon the os brachii to depress it, and are antagonists to most of the muscles on the region of the shoulder. The muscles of these two classes are situated on the anterior, lateral and posterior aspect of the trunk.

The muscles on the region of the *shoulder* are six in number on each side, constituting a single class, and arranged in two groups.

ONE CLASS, SIX MUSCLES.

First Group, five Muscles.

Deltoid,	*Vide p.* 111.
Supra Spinatus, Infra Spinatus,	*Vide p.* 112.
Teres Minor, Subscapularis,	*Vide p.* 113.

These muscles all act upon the upper end of the os brachii, except the deltoid and for the most part raise and abduct the arm, being antagonists to the pectoralis major, latissimus dorsi, and teres major.

Second Group one Muscle.

Teres Major,	*Vide p.* 114.

This antagonises the last group, and is a congener of the great pectoral and latissimus dorsi, with which last it is inserted: they depress and adduct the arm. The muscles of these two groups are situated for the most part on the surfaces and borders of the scapula.

The muscles on the region of the *arm* are five in number on each side, arranged in two classes, the first, of one muscle acts upon the os brachii, the second of four acts upon the fore arm, and is arranged in two groups of two muscles each.

FIRST CLASS, ONE MUSCLE.

Coraco-Brachialis,	*Vide p.* 114.

This muscle lies upon the inner aspect of the arm which it raises, it is therefore a congener of the first group on the region of the shoulder.

SECOND CLASS, TWO GROUPS.

First Group, two Muscles.

Biceps Flexor Cubiti,	*Vide p.* 115.
Brachialis Anticus,	" " 116.

These muscles flex the fore arm upon the arm, the first can also act upon the arm.

Second Group, two Muscles.

Triceps Extensor Cubiti,	*Vide p.* 117.
Anconeus,	" " 129.

These muscles extend the fore arm upon the arm, and the first can also act upon the arm. The muscles of the first group are on the fore and inner part of the arm, those of the second upon the back and outer part. The muscles on the region of the *fore arm* are nineteen in number on each side, arranged in three classes, the first of four muscles, rotates the radius upon the ulna. The second of six muscles, flexes and extends the hand upon the fore arm; and the third of nine muscles, flexes and extends the fingers upon the hand, and can also move the hand upon the fore arm.

The first class has two groups of two muscles each, one for supination, the other for pronation. The second class has two groups of three muscles each, one for flexion the other for extension; the third class has two groups one of three muscles, which act upon the fingers generally, and is divided into two sets, another of six muscles, which act upon individual fingers, and is divided into three sets according to the fingers to which they are attached.

FIRST CLASS, TWO GROUPS.

First Group, two Muscles

Supinator Radii Longus,	*Vide p.* 127.
Supinator Radii Brevis,	" " 129.

Second Group, two Muscles.

Pronator Radii Teres,	*Vide p.* 122.
Pronator Radii Quadratus,	" " 126.

These four muscles are all on the anterior aspect of the fore arm, and are all inserted into the radius, the two first turn the dorsum of the hand to the ground, and the two last the palm.

SECOND CLASS, TWO GROUPS.

First Group, three Muscles.

Flexor Carpi Radialis,
Flexor Carpi Ulnaris,
Flexor Carpi Medius, or Palmaris Longus, } *Vide p.* 123.

Second Group, three Muscles.

Extensor Carpi Radialis Longus,
Extensor Carpi Radialis Brevis, } *Vide p.* 127.
Extensor Carpi Ulnaris, " " 128.

The first group is on the fore part, and the second on the posterior aspect of the fore arm.

THIRD CLASS, TWO GROUPS.

First Group, two sets.

First set, two Muscles.

Flexor Digitorum Sublimis Perforatus, *Vide p.* 124.
Flexor Digitorum Profundus Perforans, " " 125.

Second set, one Muscle.

Extensor Digitorum Communis, *Vide p.* 128.

These three are the common muscles of the fingers, the flexors are on the anterior, and the extensor on the posterior surface of the fore arm, hand, and fingers; their primary action is to flex or extend the fingers, their secondary action, to flex or extend the hand.

Second Group, three Sets.

First Set, four Muscles.

Flexor Longus Pollicis, *Vide p.* 126.
Extensor Ossis Metacarpi Pollicis,
Extensor Primi Internodii Pollicis,
Extensor Secundi Internodii Pollicis, } *Vide p.* 130.

These, as appears from their names, are all long muscles of the thumb; the first is on the anterior, the other three on the posterior and outer aspect of the fore arm; these three will also abduct the hand.

Second Set, one Muscle.

Extensor Indicis, or Indicator, *Vide p.* 131.

Third Set, one Muscle.

Extensor Minimi Digiti. *Vide p.* 129.

These two are on the posterior face of the fore arm, and can also assist in extending the hand.

The muscles on the region of the *hand* are twenty in number on each side, arranged in two classes, in the first class are the twelve common muscles of the hand, in two groups; in the second class are eight muscles belonging to individual fingers, and arranged in three groups.

FIRST CLASS, TWO GROUPS.

First Group, one Muscle.

Palmaris Brevis, *Vide p.* 121.

This is a superficial cutaneous muscle, it arches the palm.

Second Group, eleven Muscles.

Lumbricales, four, *Vide p.* 132.
Interossei, seven, " " 133.

These are deep seated muscles, the lumbricales and four of the interossei are to be seen from the palm of the hand, the other three interossei from the dorsum.

SECOND CLASS, THREE GROUPS.

First Group, four Muscles of the Thumb.

Abductor Pollicis, } *Vide p.* 131.
Opponens Pollicis, }
Flexor Pollicis Brevis, } " " 132.
Adductor Pollicis, }

Second Group, one Muscle of the Fore Finger.

Abductor Indicis, *Vide p.* ~~133~~. 139

Third Group, three Muscles of the Little Finger.

Abductor Minimi Digiti, }
Flexor Brevis Minimi Digiti, } *Vide p.* 133.
Adductor Minimi Digiti, }

If then, we review the muscles which act directly upon the superior extremity, we shall find that on the region of the trunk there are nine muscles, on the region of the shoulder, six, on the region of the arm, five, on the region of the fore arm, nineteen, and on the region of the hand twenty, in all fifty-nine muscles for each extremity, or one hundred and eighteen for both ; the same number will be found in the classification of the muscles acting upon the inferior extremities. Of the above number it will be seen that one hundred muscles are situated upon the superior extremities themselves.

It may be proper to state here, that the muscles are subject to certain morbid conditions of which one is preternatural contraction and rigidity ; this is more fully referred to in the chapter on the muscles of the lower extremities. Inflammation of the muscles is less common than of some other tissues, it may be either acute or chronic, it seldom runs into suppuration, mortification, or ulceration. The muscles are sometimes in a softened, sometimes an indurated, and occasionally even an ossified state ; this last affection is very rare, but a remarkable case is recorded in which most of the muscles of the extremities were converted into a solid mass of bone ; the muscles of the shoulder, loins, and calf, are most subject to this change. The muscles sometimes undergo a fibrous or a fatty transformation, they may also be hypertrophied or atrophied ; tubercular, melanotic, schirrous, and encephaloid, deposit are very rare. These organs are sometimes infested by parasitic animals; many of the muscles are subject to congenital varieties, and those for the most part have their type in the muscles of different inferior animals.]

DISSECTION OF THE MUSCLES OF THE SHOULDER AND ARM.

Dissect off the integuments from the shoulder and arm as low as the bend of the elbow; beneath the skin and adipose substance is the *brachial aponeurosis;* this is weak and imperfect in some situations as on the deltoid muscle; in others it is strong and well marked, and it increases in strength as it descends; it is connected posteriorly to the spine of the scapula, and to the infra-spinatus muscle; inferior to this it receives an addition of fibres from the insertion of the deltoid; internally it is in part continued along the vessels from the fascia of the axilla, and in part also from the tendons of the great pectoral and latissimus dorsi; it invests the whole arm, confining the muscles in their situation, and pressing them towards each other, particularly along the inner side of the arm, so as to overlap the *brachial* vessels and nerves: as it descends it adheres to the lateral ridges of the humerus, which lead to the condyles; these connexions are named *inter-muscular ligaments;* the *internal* is augmented by a prolongation of the coraco-brachialis tendon, and the *external* by fibres from the deltoid: the fascia of the fore arm we shall examine afterwards. Between the integuments and fascia of the arm we notice two cutaneous veins, the cephalic on the outer, and the basilic on the inner side; the *cephalic* will be found hereafter to commence about the thumb, and to ascend along the radial side of the fore arm, and having passed the elbow joint, it is now seen continuing its course up the arm, at first on the outer side of the biceps, and afterwards between the deltoid and great pectoral muscles to the clavicle, beneath which it sinks to join the axillary vein; the cephalic vein is unaccompanied by nerves in its course up the arm, but in the dissection of the fore arm the external cutaneous nerve will be seen closely connected with it. The *basilic vein* will be found to commence about the little finger, to ascend along the ulnar side of the fore arm, and to pass over the elbow joint; it is now seen continuing its course on the inner side of the biceps, between the skin and fascia, and about the middle of the arm it perforates the latter, to join one of the deep brachial veins; in some it continues superficial as high as the axilla, where it joins the axillary vein; the basilic vein in the arm is accompanied by the cutaneous nerves of Wrisberg, which having escaped from the intercostal branches of the second and third dorsal nerves, and passed across the axilla, are then distributed to the integuments on the inner side of the arm; inferiorly the internal cutaneous branch of the brachial plexus accompanies this vein, and continues with it along the fore arm; dissect off the fascia and cellular membrane from the muscles of the shoulder and arm. The muscles of the shoulder are six in number, viz. the deltoid, supra and infra-spinatus, teres minor and major, and sub-scapularis; those of the arm are four in number, viz. the biceps, coraco-brachialis, brachialis anticus and triceps;—first examine the muscles of the shoulder.

Deltoides, very thick and strong, triangular, *arises* tendinous from the lower edge of the spine of the scapula, and rather fleshy from the anterior edge of the acromion, and of the external third of the clavicle; the fibres converge and descend obliquely, the posterior forwards, the anterior backwards, and the middle at first outwards, and then vertically downwards; *inserted* tendinous into a rough surface, about two inches in extent, situated on the outer side of the humerus, and commencing just above its centre. *Use*, to abduct and raise the arm, the anterior fibres can also draw it forwards, the posterior backwards, and when the arm is by the side, these portions can rotate it inwards or outwards. This muscle can also move the scapula on the arm when the latter is fixed, as in the case of a fall upon the hand or elbow, or in lifting a very heavy weight; under these circumstances this muscle sometimes co-operates with the great pectoral and latissimus dorsi, to dislocate the head of the humerus into the axilla. The deltoid is covered only by the skin, and a few fibres of the platysma; its origin corresponds to the insertion of the trapezius, with which it is often connected by aponeurotic fibres; its insertion is surrounded by the origin of the brachialis anticus, and lies between the biceps and second head of the triceps; its posterior margin is thin, and sends off an aponeurosis to cover the infra-spinatus muscle; its anterior edge is separated from the great pectoral, by the cephalic vein, some cellular membrane, and a small artery. This muscle is fleshy on its external surface, coarse and rough, and composed of several distinct triangular fasciculi. Divide it transversely, and reflect each portion, and we shall then see that its structure is very complex, and that its internal surface is much more tendinous; a large *bursa* is also seen beneath it; this *bursa* extends under the acromion, and is expanded on the tendon of the supra-spinatus, and on the capsular ligament; it allows the deltoid muscle and the exterior of the shoulder joint to glide easily against each other; the deltoid also covers the coracoid process, the muscles which are attached to it, all the small muscles connected to the capsular ligament, the insertion of the great pectoral, and the circumflex vessels and nerves.

[*Variety.* A slip sometimes arises from the anterior edge of the scapula and joins the deltoid.]

SUPRA-SPINATUS, fills the fossa of that name, and *arises* from all that portion of the scapula above its spine, which is engaged in forming this fossa, also from a strong fascia which covers the muscle; the fibres pass forwards beneath the acromion process and triangular ligament, end in a tendon which glides over the neck of the scapula, (a bursa intervenes;) *inserted* into the upper and forepart of the great tuberosity of the humerus, into the most anterior of the three depressions which are marked on that surface. *Use*, to assist the deltoid in raising and abducting the arm, it also strengthens the capsular ligament, and draws it out of the angle, which is formed by the elevation of the arm, between the humerus and the glenoid cavity; it also presses the head of the humerus and glenoid cavity towards each other, prevents the head of the former from descending out of the latter, and thus it becomes the antagonist to the pectoral, deltoid, and those other long muscles, which have a tendency to dislocate the head of the bone into the axilla. This muscle is covered by the trapezius, much cellular membrane and fat and by a strong aponeurosis; its insertion is concealed by the deltoid, and the large bursa beneath that muscle, also by the acromion process and triangular ligament; the tendon is inseparably connected to the capsular ligament.

INFRA-SPINATUS, is inferior to the last, flat and triangular; *arises* fleshy from the inferior surface of the spine of the scapula, and from the dorsum of this bone, below this process, as low down as the posterior ridge on the inferior costa, but not from the rough surface on the inferior angle of the scapula; it also arises from the aponeurosis which covers it; the inferior fibres ascend obliquely forwards, the superior run horizontally; all converge, and are *inserted* by a strong tendon, which covers and adheres to the outer part of the capsular ligament, into the middle of the external or greater tuberosity of the humerus, below the supra-spinatus. *Use*, to assist the superior part of the deltoid in raising the arm, and drawing it backwards, also in rotating it outwards: when the arm has been raised, its lower fibres can depress it; it will also draw the capsular ligament out of the joint, and strengthen the articulation; it is covered by the trapezius and deltoid; but between these and the latissimus dorsi, a portion of it is superficial.

It lies on the bone, and the scapular vessels and nerves; a large bursa lies between its tendon and the neck of the scapula.

TERES MINOR, small and narrow, inseparably attached to the last muscle, along the lower edge of which it runs; it *arises* from a depression between the two ridges on the inferior costa of the scapula, extending from the neck of the bone to within an inch and a half of its inferior angle, from the fascia which covers it, and from ligamentous septa, which enclose it; the fibres ascend obliquely forwards and outwards, cover and adhere to the capsule, and are *inserted* below the infra-spinatus into the inferior depression on the great tuberosity of the humerus. *Use*, to co-operate with the last muscle. The origin of the teres minor is between and overlapped by the infra-spinatus and teres major muscles; its middle portion is superficial, and its insertion is covered by the deltoid; it lies on the scapula, sub-scapular vessels, capsular ligament, and long head of the triceps, which last separates it from the teres major.

SUB-SCAPULARIS, is situated on the inner side of the scapula, opposite to the three last described muscles, broad and triangular, the base behind, the apex before: it *arises* from all the surface and circumference of the sub-scapular fossa, the fibres run in thick fasciculi upwards and forwards, and all converge towards the neck of the scapula, over which they glide, beneath the coracoid process, and the muscles which are inserted into it; they end in a tendon which is intimately united to the capsular ligament, and *inserted* into the internal or small tubercle of the humerus; this muscle is covered by the scapula and the muscles of the shoulder; its inferior edge is in contact with the teres major; its internal surface, which forms part of the axilla, is connected to the serratus magnus, and to the axillary vessels and nerves, by loose cellular membrane: a large bursa, very often communicating with the joint, lies between its tendon and the neck of the scapula, beneath the coracoid process: another smaller bursa is sometimes situated lower down, between the tendon and the capsular ligament. *Use*, this, which is the strongest of these *capsular* muscles, strengthens the inner side of the articulation, and guards against dislocation when the elbow is suddenly drawn backwards and outwards. This muscle can depress and adduct the arm, draw it backwards, and rotate it inwards, so as to turn the palm of the hand backwards, thus it antagonizes the infra-spinatus and teres-minor muscles.

The deltoid and the four *capsular* muscles, which have been just described, are of great use to the shoulder articulation; the head of the humerus is so large, the glenoid cavity so superficial, and the capsular ligament so loose and long, that, but for these muscles, the bones could not remain in apposition; hence, in cases of paralysis of the muscles of this region, the joint becomes elongated and flattened, and a partial dislocation exists; in the dissecting-room also, if we divide all the muscles surrounding the capsule, and leave the latter uninjured, the bones will no longer be in contact; these muscles, therefore, serve to strengthen the capsule, to keep the head of the humerus pressed against the glenoid cavity, and thus to counteract that tendency to dislocate the head of the bone, which the larger muscles of the limb frequently have, in consequence of their insertion being at such a distance from the centre of the joint, added to the anatomical imperfections in the latter already alluded to; which imperfections, however, are much counterbalanced by the great mobility which the joint enjoys in consequence of this formation, by the numerous opposing muscles which serve to protect the articulation, and by the rotatory motion of which the scapula is allowed to partake.

Teres Major, long and flat, *arises* from a rough flat surface on the inferior angle of the scapula, below the infra-spinatus; it forms a thick fleshy belly, which ascends forwards and outwards to the inner side of the arm, and ends in a broad thin tendon, which is at first closely connected to the back of the tendon of the latissimus dorsi; but near the humerus, a small bursa intervenes, and is *inserted* into the inner or postérior edge of the bicipital groove, behind the tendon of the latissimus, and in general, but not always, extending lower down than it. *Use*, to rotate the humerus inwards, to adduct and draw it downwards and backwards; also to draw forward the inferior angle of the scapula; whereby it not only assists the capsular muscles in retaining these two bones in apposition, but it also keeps the glenoid cavity opposed to the head of the humerus. The origin of this muscle is superficial, the latissimus dorsi sometimes overlaps it; it is here connected to the infra spinatus and teres minor; from the latter the long head of the triceps afterwards separates it; it passes anterior to this muscle, and assists the latissimus dorsi in forming the posterior fold of the axilla.

The four muscles of the arm are the coraco-brachialis, biceps, and brachialis anticus in front, and the triceps behind.

Coraco-brachialis *arises* tendinous and fleshy from the point of the coracoid process, and from the tendon of the short head of the biceps; it descends obliquely forwards, and is *inserted*, chiefly tendinous, into the internal side of the humerus, about the middle, and into the ridge leading to the internal condyle, by an aponeurosis, which forms the internal inter-muscular ligament, which is joined to the fascia of the arm. *Use*, to adduct, raise, and draw forwards the arm; also to rotate it outwards. The origin of this muscle cannot be separated from the short head of the biceps, but as it descends, it lies behind, and to the inner side of that muscle; it is covered above by the deltoid and pectoral; a small portion of it below is superficial, and is seen between the biceps and triceps; its insertion is just below that of the teres major, and separates the brachialis anticus and posticus: the coraco-brachialis passes over the tendon of the subscapular, latissimus, and teres muscles; the brachial artery and median nerve, at first lie to its inner side, but pass superficial to its insertion; the belly of this muscle is generally, but not always, perforated by the external or musculo-cutaneous, or perforans Casserii nerve.

Biceps, is situated along the fore part of the humerus, and consists of two portions superiorly, the external or long, the internal or short; the *internal arises* tendinous from the coracoid process, between the coraco-brachialis and triangular ligament; it soon becomes fleshy, descends obliquely outwards, and a little above the middle of the humerus is united to the *external* or *long* head, which *arises* by a long tendon, from the upper part of the glenoid ligament of the scapula; this tendon passes outwards through the joint over the head of the humerus, within the capsular ligament, but external to the synovial membrane; it then descends into the groove, between the two tuberosities of this bone, in which groove it is bound down by tendinous fibres, continued from the capsular ligament, and from the adjacent tendons; the synovial membrane of the joint is reflected *on* this tendon at its origin, and is again reflected *from* it inferiorly on the parietes of the groove, between the tendons of the great pectoral, latissimus dorsi, and teres major muscles; thus, although the tendon passes through the cavity of the joint, it is, strictly speaking, external to the synovial membrane. A little below the middle of the humerus, these two portions of the biceps unite in a large fleshy belly, which, descending to within about an inch and a half of the elbow joint, ends in a flat tendon; this sends off a process called the semilunar fascia, to join the general aponeurosis of the fore arm, and then sinks below the joint into a triangular hollow between the supinator longus and pronator teres, and is *inserted* into the back part of the tubercle of the radius: a bursa intervenes between this tendon and the anterior part of the tubercle, which is covered by cartilage; the *semilunar fascia* which *arises* narrow from the forepart of this tendon, opposite the bend of the elbow, passes upwards and inwards, expanding towards the internal condyle, to which, and to the muscles proceeding from it, some of its fibres are attached: the remaining become continuous with the aponeurosis of the fore arm. *Use*, to flex the fore arm, and make tense its fascia; also to abduct and raise the arm. When the hand is prone, the first effect of the contraction of the biceps is to roll the radius outwards, and turn the hand supine; the long tendon of the biceps, by passing over the head of the humerus, prevents this bone being dislocated upwards and outwards, as otherwise might occur, in consequence of a fall, or of a sudden muscular contraction: the biceps may also assist the coraco-brachialis, in rotating the scapula on the humerus, so as to depress the point of the shoulder. The long head of the biceps is concealed by the deltoid, supraspinatus and capsular ligament; the short head by the great pectoral and deltoid: not unfrequently this muscle has another origin from the humerus below its head; in some a fasciculus unites it to the coraco-brachialis, and in others to the brachialis anticus muscle, which lies behind it.

[This muscle is very liable to varieties; sometimes its two parts remain separate as far as the elbow, in a few rare cases it has had five heads.]

The belly of the biceps is superficial, and lies on the brachialis anticus, so also is the tendon in its passage over the elbow joint; the brachial artery descends along its internal border, and somewhat overlapped by it, in the middle and lower part of the arm. This muscle or its tendon will serve as a guide in the living subject, in case we are required to tie this vessel, but superiorly the coraco-brachialis intervenes; the semilunar fascia is extended over the brachial artery and nerve, and affords them some, but not a constant protection, in performing venesection in the median basilic vein, which vein is superficial to this fascia, but parallel, and often so close to the artery as to expose the latter to some danger in that operation. In dislocation, and in other injuries of the shoulder joint, the long tendon of the biceps is sometimes ruptured.

Brachialis Anticus, or Externus, improperly called by some Internus, *arises* from the centre of the humerus by two fleshy slips, one on either side of the insertion of the deltoid, from the forepart of the bone down to the condyles, and on each side as far as the inter-muscular ligaments; the fibres descend converging, pass anterior to the elbow joint, adhere to the synovial membrane, and are *inserted* by a strong tendon into the coronoid process of the ulna, and into a rough surface on this bone beneath that process. *Use*, to flex the fore arm, and in doing so it draws the synovial membrane out of the angle of the joint; it also strengthens this articulation in its extended state, by pressing the ulna against the humerus, and supporting the joint in front; this muscle is covered by the biceps and by the brachial vessels and nerves; external to the biceps it is superficial; its external head is the longer, and lies between the deltoid and second head of the triceps; the internal separates the deltoid from the coraco-brachialis; the tendon passes deep into the hollow at the elbow, behind the tendon of the biceps, and is inserted on its internal side; a fleshy fasciculus often unites this muscle and the biceps about the middle of the arm.

[A fasciculus sometimes passes off to the supinator radii longus, and sometimes there is a second muscle but small,at the outer edge of the main muscle, having nearly the same attachments.]

Triceps Extensor Cubiti, covers the back of the humerus, and extends from the scapula to the olecranon; it consists superiorly of three portions, viz. the middle or long, the second or external, and the third or internal, or short head, or the brachialis internus or posticus.

The *long*, or *middle head*, *arises* by a flat short tendon about an inch broad, from the lower part of the neck of the scapula, and from the anterior portion of the inferior costa; it also adheres to the inferior part of the capsular ligament; it soon ends in a large fleshy belly which descends along the back part of the humerus, that surface which is towards the bone continues tendinous for some distance: about the superior third of the arm it joins the *second* or *external head*, which *arises* immediately below the insertion of the teres minor by a narrow tendinous and fleshy slip, from a ridge on the outer side of the humerus commencing below the great tuberosity, and leading down to the external condyle; it also arises from the bone behind this ridge, from the intermuscular ligament, and from the external condyle, by a tendon which passes upwards and inwards, and joins the remainder of the muscle; these inferior fibres are parallel to the anconæus; the *third*, or *short head*, or *brachialis internus*, or *posticus*, improperly called brachialis externus, *arises* narrow on the inside of the humerus, above its centre, commencing tendinous just below the insertion of the teres major, and continuing to arise from the ridge which leads to the internal condyle, and from the internal intermuscular ligament; these three portions of the triceps unite above the middle of the arm, and descending along its posterior part, end in a flat broad tendon which consists of two laminæ, a superficial and a deep; the former is continued over the flat triangular surface of the olecranon into the fascia on the back part of the fore arm, the latter, which is stronger but narrower, is *inserted* into the olecranon process. *Use*, to extend the fore arm on the arm, and by its long portion to carry the arm backwards, and in some cases to adduct it; it also draws up the synovial membrane from between the olecranon process and the humerus, and thus protects it from pressure in the extended state of the limb.

The long head gives support to the inferior part of the capsular ligament of the shoulder, and so tends to protect that joint against dislocation, in that situation where it would be most likely to occur. The sudden contraction of the triceps during life sometimes breaks off the olecranon process, and draws upwards the separated portion, of course the individual loses for some time the power of extending the fore arm; the fractured piece, however, is prevented being separated to any considerable distance by the aponeurosis of the triceps which covers the olecranon, and which joins the fascia of the fore arm, and also by the inferior fibres of this muscle, which being connected to the condyles, and having to ascend a little to the olecranon, tend to draw down its fractured portion. The first, or long head of the triceps, arises and descends between the two teres muscles; the second, or outer head commences below the teres minor; and the third, or the brachialis internus or posticus, below the teres major; the long and the second head are covered above by the deltoid, the remainder of them is superficial; the second lies external to the supinator longus and radial extensors of the carpus; the third or internal head is also superficial, and lies between the brachialis anticus and coraco-brachialis anteriorly, and the long portion of the triceps posteriorly; the ulnar nerve descends along this, and the radial or spiral separates it from the second or outer head; a small bursa lies between the tendon, and the point of the olecranon, a larger one between the skin and the aponeurosis which covers that process; this superficial bursa is peculiarly liable to inflammation, which is generally of an unhealthy character, in consequence of an injury, such as a fall upon the elbow producing a superficial lacerated wound. In the dissection of the muscles of the arm, we should notice the course of the brachial artery and of its principal branches, also the divisions of the axillary plexus of nerves: the cutaneous veins have been already noticed; the deep veins accompany the arteries, two to each.

The *brachial artery*, which is the continuation of the subclavian and axillary, descends obliquely outwards, along the inner side, first of the coraco-brachialis, and afterwards of the biceps; near the elbow it inclines forwards, and then sinks beneath the fascia of the biceps, and a little below the bend of the elbow it divides into the radial and ulnar arteries. In this course it is covered by the fascia and integuments, and overlapped a little by the biceps; it is surrounded by a sheath of cellular membrane, which also contains the two venæ comites; the internal cutaneous nerve lies superficial to it; the median or brachial is also superficial to it above, and rather to its outer side; about the middle of the arm, it crosses the artery, and inferiorly it is almost always to its ulnar or inner side. The ulnar nerve lies internal to the artery, and at some distance from it inferiorly; the radial or spiral nerve is posterior to it, and separates it above from the triceps. In this course the artery passes over the tendons of the latissimus and teres, a small part of the triceps, the coraco-brachialis, and the brachialis anticus. The brachial artery gives off several muscular branches from its external side; and from its internal the *superior profunda*, which accompanies the spiral nerve round the back of the humerus to its external side; the *inferior profunda* which descends along with the ulnar nerve towards the inner condyle, and the *anastomotica* magna, which runs towards the inner side of the elbow joint.—See Anatomy of the Vascular System.

The branches of the brachial plexus of nerves, which are met with in the dissection of the arm, are six in number: first, the *internal cutaneous*, which has been already noticed; second, the *external cutaneous*, or musculo cutaneous, or perforans Casserii, pierces the coraco-brachialis muscle, descends obliquely outwards between the biceps and brachialis anticus, to which it sends several filaments, and at the anterior edge of the supinator longus it becomes cutaneous, descending along with the cephalic vein and its branches; third, the *median* or brachial nerve accompanies the brachial artery to the bend of the elbow, and sinks beneath the muscles of the fore arm, in the dissection of which the remainder of its course will be exposed: fourth, the *ulnar* nerve descends along the inner portion of the triceps, or the brachialis internus, runs behind the inner condyle, and is then distributed to the muscles of the fore arm and hand; fifth, the *musculo-spiral*, or radial nerve, descends between the second and third head of the triceps, and winds round the back part of the humerus, supplying the triceps in its course; it next runs spirally forwards to the forepart of the bone, between the supinator longus and brachialis anticus; it then descends over the forepart of the elbow joint to the muscles of the fore arm, where we shall trace it afterwards; sixth, the *circumflex*, or articular nerve, accompanied by the posterior circumflex artery, passes out of the axilla between the long head of the triceps and the neck of the humerus, winds round the latter beneath the deltoid muscle, to which its branches are distributed.—See Anatomy of Nervous System.

SECTION II.

DISSECTION OF THE FORE ARM AND HAND.

Remove the integuments from the front and back of the fore arm and hand, and the investing fascia will be exposed, together with the sub-cutaneous nerves and veins: the latter may be noticed first. The *basilic* vein is seen to arise by small branches from the sides of the little finger, one of which is named *salvatella;* it then ascends along the ulnar side of the fore arm, receiving in this course small branches from the front and back of the arm, and passing anterior to the internal condyle, it is joined by the median basilic; it then ascends along the inner side of the arm, passes beneath the fascia, and joins one of the deep brachial veins; sometimes it continues in a superficial course to the axilla, and joins the axillary vein. The *cephalic vein* commences by several small branches about the thumb and back of the hand; it ascends along the radial side of the fore arm, passes over the bend of the elbow, is joined by the median cephalic, and then ascends along the outside of the arm to the clavicle. The *median vein* arises by small branches from the forepart of the wrist, it ascends along the fore arm between the cephalic and basilic veins, and near the elbow divides into two or three branches: first, the *median basilic*, which ascends obliquely over the fascia of the biceps to join the basilic; second, the *median cephalic*, which passes obliquely upwards and outwards, and joins the cephalic vein; the third branch of the median, when present, sinks deep, and joins one of the deep veins. The internal cutaneous nerve and its branches accompany the basilic vein, some passing anterior, others posterior to it; the external cutaneous, or musculo-cutaneous, in general lies behind the cephalic vein at the bend of the elbow, its branches afterwards twine around that vessel. The relation between the cutaneous nerves and veins is liable to great variety.

The fascia of the fore arm is very strong, particularly on the posterior part; it consists of tendinous fibres, which run in every direction, connected on either side to the condyles, and to the muscles which are attached to these; it receives an addition from the biceps before, and from the triceps behind; as it descends, it invests the limb so closely as to give it a certain form; it sends septa between the different muscles, which give attachment to several fibres, and it adheres very closely to the olecranon and to the ulna its whole length; inferiorly it is connected to the annular ligaments of the carpus. The *annular ligaments* of the wrist appear formed in part by this fascia, strengthened by proper transverse fibres; the *posterior* is attached to the styloid process of the ulna internally, and to that of the radius externally; it binds down the extensor tendons. The *anterior annular* ligament is much stronger; it is attached to the unciform and pisiform bones internally, to the scaphoid and trapezium externally; its upper edge is connected to the fascia of the fore arm, its lower to that of hand: this ligament, together with the carpus, forms a canal or ring for the passage of the flexor tendons. The integuments of the hand are thin posteriorly, and cover several cutaneous veins; anteriorly they are dense, and the subjacent cellular tissue granulated and firm; on the back of the hand a very thin aponeurosis exists, but anteriorly, there is a remarkable, strong fascia, the *palmar fascia:* this is of a triangular form, commences narrow at the annular ligament, from which, and from the tendon of the palmaris longus, it *arises;* it then expands over the palm of the hand, and near the fingers divides into four fasciculi, each of which is forked and *inserted* into either side of each of the sheaths of the flexor tendons, and into the capsular ligaments of the first phalanges; transverse bands pass across these diverging fasciculi, and several fibres penetrate between the tendons, and join the metacarpal bones and the interosseous muscles; a thin aponeurosis, derived from the outer edge of the palmar fascia, covers the muscles of the thumb, and a similar one, those of the little finger. Attached to the palmar fascia is the following small cutaneous muscle.

Palmaris Brevis, *arises* from the annular ligament and from the inner edge of the palmar fascia; the fibres pass transversely inwards, and are *inserted* by scattered fibres into the integuments on the inner side of the palm of the hand. *Use*, to deepen the hollow of the palm of the hand by drawing the integuments towards the thumb. We have no analogous muscle to this in the foot. We may now dissect off the fascia of the hand and fore arm, to expose the muscles; in some situations it is difficult and unnecessary to separate this from the muscular fibres; beneath the palmar fascia we expose the superficial palmar arch of vessels and nerves passing across the flexor tendons and the lumbricales muscles.

The muscles of the fore arm are so very numerous, that it will be found convenient to class them according to their situation and their use. One set of these muscles is employed in bending the fore arm, wrist and fingers; these are the *flexors:* a second, nearly allied to these, have the power of pronating the hand, that is, of rolling the radius across the ulna, so as to make the palm of the hand look downwards; these are the *pronators:* a third set, the *extensors*, can extend the fore arm, hand, and fingers; and a fourth, allied to these, the *supinators*, can turn the hand supine: that is, place the radius and ulna on the same plane, and make the palm of the hand look upwards. The pronators and flexors arise chiefly from the internal condyle, and from the inner or ulnar side of the fore arm; each of these divisions may be arranged into a superficial and deep layer.

The pronators and flexors arising from the inner side of the fore arm, are eight in number: five in the superficial layer, three in the deep; the five *superficial* are, the pronator teres, flexor carpi radialis, palmaris longus, flexor digitorum sublimis, and flexor carpi ulnaris: the three *deep* muscles are the flexor digitorum profundus, flexor pollicis longus, and pronator quadratus. In the following description of these muscles, the hand is supposed to be turned forwards, the radius externally, and the ulna internally. The muscles, which arise from the internal condyle of the humerus, are covered by the fascia of the biceps; they cannot be separated from each other above, but have a common tendinous origin from the condyle, the fascia, and its septa, also from the ulna.

Pronator Radii Teres, *arises* tendinous and fleshy from the anterior part of the internal condyle, from the fascia of the fore arm and its intermuscular septa; also by a small tendon from the coronoid process of the ulna; the median nerve separates these origins; the fibres pass obliquely outwards over the radius, and are *inserted*, chiefly tendinous, into the outer and back part of the radius, about its centre. *Use*, to pronate the hand, by rolling the radius forwards and inwards over the ulna; it is also a flexor of the fore arm: this is the most external of the muscles, arising from the inner condyle; it is superficial, except at its insertion, which is covered by the supinator longus, and by the radial vessels; it lies inferior to the supinator brevis: this muscle forms the internal boundary of the triangular hollow at the bend of the elbow, which contains the tendon of the biceps, the brachial nerve and vessels.

[*Variety.* This muscle is sometimes double.]

FLEXOR CARPI RADIALIS, *arises* narrow and tendinous from the inner condyle, and fleshy from the intermuscular septa; it forms a thick belly, which lies very superficial, and ends in a prominent flat tendon; this descends obliquely outwards, passes beneath the annular ligament, and is *inserted* into the base of the metacarpal bone of the index finger. *Use*, to bend the hand, and assist in pronating it; this muscle is overlapped above by the pronator teres, and covered below by the annular ligament and by the muscles of the thumb, so that its insertion cannot be seen until the palm of the hand has been dissected; it arises and descends at first between the pronator teres and palmaris longus, afterwards between this latter and the supinator longus, from which it is separated by the radial nerve and vessels: the radial edge of this tendon may serve as a guide, in cutting down on the radial artery in the living subject.

PALMARIS LONGUS *arises* by a slender tendon from the inner condyle, and from the fascia of the fore arm; forms a short belly, which ends in a flat tendon; *inserted* near the root of the thumb into the annular ligament and palmar aponeurosis. *Use*, to bend the hand and make tense the palmar fascia; it descends between the flexor carpi radialis and ulnaris, and lies on the flexor sublimis: it is sometimes wanting.

[Sometimes its fleshy part is in the middle, and at other times its belly extends almost to the wrist.]

FLEXOR CARPI ULNARIS, *arises* tendinous from the internal condyle, tendinous and fleshy from the inner side of the olecranon process; the ulnar nerve and posterior ulnar recurrent arteries separate these origins; it also arises by a tendinous expansion from the inner edge of the ulna nearly its whole length, and from the fascia of the fore arm, the fibres pass obliquely forwards to a tendon which descends in front of the ulna, and which overlaps the ulnar nerve and vessels, and is *inserted* into the pisiform bone, and by a few ligamentous fibres into the base of the fifth metacarpal bone; this insertion is also connected to the muscles of the little finger. *Use*, to flex the hand, and adduct it, particularly when assisted by the extensor carpi ulnaris: adduction of the hand is not so limited as abduction, in consequence of the ulna being shorter below than the radius.

This muscle is superficial, and lies internal and rather posterior to the preceding muscles; it descends between the flexor sublimis and extensor carpi ulnaris, and lies upon the flexor profundus; the tendon passes over the annular ligament, and is connected to it by a tendinous slip, which also passes over the ulnar artery and nerve.

FLEXOR DIGITORUM SUBLIMIS PERFORATUS, *arises* tendinous and fleshy from the internal condyle and internal lateral ligament; tendinous from the coronoid process, and fleshy from the radius below its tubercle, internal to the pronator teres, and between the supinator brevis and flexor pollicis longus: it forms a large muscle, which ends in four tendons; these descend, two anterior, for the middle and ring finger; and two posterior, for the index and little finger; they all pass beneath the annular ligament, and proceed along the palm of the hand, superficial to the deep flexor tendons, and beneath the palmar fascia: and at the first phalanx of each finger, or opposite the head of each metacarpal bone, each of these tendons becomes enclosed in a strong sheath, with one of the deep flexors; this sheath is continued to the anterior extremity of the second phalanx. Near the end of the first phalanx, each of the superficial flexor tendons is split for the passage of the tendon of the deep flexor, which is continued on to the last or ungual phalanx; while the divisions of each of the superficial tendons become somewhat twisted, that is, their inner or opposed edges are everted or folded out beneath the deep flexor, so as to lie nearer to the bone, and are *inserted* into the anterior part of the second phalanx. *Use*, to flex the second joint of each finger on the hand, the hand on the fore arm, and the latter on the arm. The origin of this muscle is partly concealed by the three first described muscles, which arise from the internal condyle, and to which it is connected by the intermuscular septa; inferiorly a portion of it is superficial between the flexor carpi ulnaris and palmaris longus. The tendons of this muscle are enveloped in a large bursa behind the annular ligament; this *carpal bursa* is connected anteriorly to the annular ligament, posteriorly to the carpus, is expanded around the superficial and deep flexor tendons, the median nerve, and the tendon of the flexor pollicis longus, and ends above and below in a *cul de sac*, each end of which extends beyond the edges of the annular ligament.

[This bursa is the seat of that affection called ganglion, in which the bursa forms a sort of hour glass tumour, one globe projecting into the palm of the hand, the other on the fore part of the wrist and the middle being constricted by the annular ligament; on opening this tumour it may be found filled with serum, either thin and watery, or very albuminous; or with a substance resembling rice water; or in more rare cases with a great number of small and distinct bodies like grains of barley. In the only case of this kind which we have met with, there was very little fluid, and none of the ordinary fluctuation, but an albuminous crepitus or grating sound, such as is sometimes heard in inflammation around joints after contusions: the rationale of cure in all these cases, is to effect an obliteration of the sac, by adhesive inflammation.]

In the palm of the hand the tendons of the flexor sublimis are covered by the integuments, palmar fascia, and the superficial palmar arch of vessels and nerves; along the fingers each tendon is enclosed in a strong fibrous sheath, which is continued to the end of the second phalanx of each finger; this sheath, together with the anterior surface of the phalanges, forms a complete canal or tube, which, half fibrous and half osseous, is lined by a synovial membrane, which forms a *cul de sac* at either extremity; being reflected over the tendons it encloses, and forming several folds or fræna to connect these tendons to this canal: this sheath is weak, opposite each articulation, but is very strong on the phalanges; its anterior extremity is continuous with the insertion of the deep flexor tendon.

[*Varieties.* The tendon to the little finger is sometimes wanting, and supplied by the flexor profundus; the portion of the muscle going to the fore finger, is sometimes so distinct, as to appear like a separate muscle.]

Divide the flexor sublimis and carpi radialis, and the three deep muscles will be partially exposed,—namely, the flexor digitorum profundus, flexor pollicis longus, and nearly concealed by these, the pronator quadratus.

Flexor Digitorum Profundus Perforans, *arises* fleshy from three superior fourths of the anterior surface of the ulna, and from the internal half of the interosseous ligament; it sometimes receives a small slip from the radius below its tubercle; it forms a thick muscle which descends along the middle and ulnar side of the fore arm, and ends in four flat tendons; these pass beneath the annular ligament, enter the ligamentous sheaths on the fingers, pass through the slits in the superficial flexor tendons, and are *inserted* into the last phalanx of each finger. *Use*, to bend the last phalanx and to co-operate with the superficial flexor muscle in bending the other phalanges and the wrist; this muscle is covered by those of the superficial layer, which have been described; the ulnar vessels, the median and ulnar nerves also descend along it; and it covers the ulna, the interosseous ligament and vessels, the pronator quadratus and the carpus, and on each finger its tendon is superficial to that of the flexor sublimis.

[*Variety.* There is sometimes a fasciculus uniting the tendon going to the fore finger, with the flexor longus pollicis.]

FLEXOR POLLICIS LONGUS, *arises* from the forepart of the radius, commencing narrow just below its tubercle, and from the interosseous membrane, to within about two inches of the carpus, it also very frequently arises by a long and narrow tendinous and fleshy slip from the coronoid process; this at first looks like a distinct muscle; all the fibres descend obliquely forwards to a tendon, which passes beneath the annular ligament, and then runs outwards between the two portions of the short flexor, and the two sesamoid tubercles at the extremity of the metacarpal bone; it next enters a strong ligamentous sheath, and is confined by it as far as the last phalanx of the thumb, into the middle of which it is *inserted.* *Use,* to flex and adduct the different joints of the thumb upon the hand, and the latter upon the fore arm. This muscle is covered by the flexor sublimis and radialis, and by the radial vessels, and inferiorly by the annular ligament, it descends along the radial side of the flexor profundus.

PRONATOR QUADRATUS, is exposed by separating the flexor pollicis and profundus; it is a small square muscle situated just above the carpus, and *arises* tendinous and fleshy from the inferior fifth of the anterior surface of the ulna; the fibres pass transversely outwards, descend a little, and are *inserted* into the anterior part of the inferior fourth of the radius. *Use,* to roll the radius over the ulna, and so to pronate the hand: this muscle is covered by the tendons of the preceding, and by the ulnar and radial vessels, and it lies on the interosseous ligament, the radius and the ulna.

[*Variety.* This muscle is sometimes, though rarely, wanting.]

The muscles which are situated on the outer and back part of the fore arm are supinators and extensors, and are also arranged into two layers, a superficial and deep; the superficial consists of seven, namely, supinator radii longus, extensor carpi radialis longus, and brevis, extensor digitorum communis, extensor minimi digiti, extensor carpi ulnaris and anconæus; these muscles arise more distinctly than those on the internal side of the arm: some of them however, particularly those on the back part, are closely connected to each other, arising in common from the external condyle of the humerus, from the posterior surface of the radius and ulna, the intermuscular ligaments and the fascia, which is partly derived from the tendon of the triceps.

Supinator Radii Longus, forms the prominence along the outer and anterior part of the fore arm, *arises* tendinous and fleshy from the external ridge of the humerus, commencing a little below the deltoid and continuing to within about two inches of the outer condyle; it also arises from the intermuscular ligament, which separates it from the second or outer head of the triceps, between which and the brachialis anticus this muscle is situated. The supinator longus descends along the outer and anterior part of the elbow, and about the middle of the fore arm ends in a flat tendon, which descends along the radius, and is *inserted* into a rough surface on the outside of that bone, near its styloid process. *Use*, to roll the radius backwards, so as to make the hand look supine; it can also bend the elbow joint. This muscle is superficial; it passes over the extensor carpi radialis longus above, the tendon of the pronator teres in the middle, and the radius inferiorly; its tendon descends at first between the pronator teres and extensor radialis longus, afterwards between the latter and that of the flexor carpi radialis; at its insertion it is crossed by the extensor tendons of the thumb. This muscle and its tendon overlap the radial nerve and vessels; its ulnar edge, therefore, will serve as a guide to the latter, in case we are required, during life, to expose them, in order to tie a ligature around the radial artery.

Extensor Carpi Radialis Longus, *arises* tendinous and fleshy from the ridge on the external side of the humerus, between the supinator longus and the external condyle; it forms a thick short belly which passes over the outside of the joint, ends in a flat tendon, which descends along the outer and back part of the radius, runs through a groove on its lower extremity, and passing over the wrist joint, is *inserted* into the back part of the carpal end of the metacarpal bone of the index finger, nearly opposite to that of the flexor carpi radialis. *Use*, it extends the wrist, bends the hand backwards, and abducts it a little; it may also assist in bending the elbow joint; its belly is covered by the last described muscle, but projects behind it; the tendon descends behind that of the supinator longus, and passes beneath the extensors of the thumb and the annular ligament; it covers the supinator brevis and the following muscle.

[*Varieties.* This muscle is also sometimes inserted into the third metacarpal bone by a distinct slip; sometimes this muscle and the next, are so blended, as to appear common.]

Extensor Carpi Radialis Brevis, *arises* tendinous and fleshy from the inferior and posterior part of the external condyle, and from the external lateral ligament, forms a thick belly, which descends along the back part of the radius, ends in a flat tendon, which runs through the same groove as the tendon of the last muscle, internal to which it lies; passes also beneath the annular ligament, and is *inserted* into the carpal extremity of the third metacarpal bone, or that of the middle finger. *Use*, similar to that of the last; it is covered superiorly by the last described muscle, and by the supinator longus, and below by the tendons of the extensor muscles of the thumb, and by that of the last muscle, and by the skin; it covers the supinator brevis and the insertion of the pronator teres.

Extensor Digitorum Communis, is situated more towards the back part of the fore arm than the last described muscles; it *arises* in common with the last, and with the extensor minimi digiti from the external condyle, the fascia, and its intermuscular processes, also from the ulna; it descends along the back of the fore arm, and about the middle of the latter ends in four tendons, which pass under the annular ligament in a groove in the radius, extend along the back of the hand, expanding as they approach the four fingers, into all the phalanges of which they are *inserted* by a tendinous expansion. *Use*, to extend all the joints of the fingers, also the carpus; this muscle arises between the extensor carpi radialis brevis and extensor minimi digiti; it descends superficially between these, and over the supinator brevis and extensors of the thumb; on the back of the hand the tendons are connected to each other by cross slips; that which goes to the ring finger is the largest; all the tendons, as they approach the base of the first phalanx, become thick but narrow; afterwards they enlarge and are joined by the tendons of the lumbricales and interossei; at the articulation of the first and second phalanx each divides into three bands; the middle one is inserted into the posterior surface of the second phalanx; the lateral pass along the sides of this articulation; they afterwards converge and unite in a flat tendon, which is inserted into the base of the last or third phalanx. The back part of all the fingers is covered, as far as the last phalanx, by a tendinous expansion, derived from these tendons, and from those of the lumbricales and interossei muscles.

[*Variety.* This muscle sometimes sends a double tendon to the little finger.]

Extensor Carpi Ulnaris is very superficial, *arises* tendinous and fleshy between the extensor minimi digiti and anconæus, from the external condyle, fascia and intermuscular septa; descends obliquely inwards, between the flexor ulnaris and extensor minimi digiti, towards the ulna, and receives an addition from it; it ends in a strong tendon, which runs through a groove on the back of the ulna, beneath the annular ligament, and is *inserted* into the carpal end of the fifth metacarpal bone. *Use*, to extend the hand and bend it backwards: also to adduct it, that is, flex it laterally towards the ulna.

[*Variety.* Sometimes the tendon of this muscle is united to the extensor muscle of the little finger.]

Anconæus, small, triangular, and placed at the outer side of the olecranon, beneath the skin; *arises* narrow and fleshy from the posterior and inferior part of the external condyle and lateral ligament, forms a thick triangular mass, which adheres to the synovial membrane and descends obliquely inwards, to be *inserted* into the external surface of the olecranon, and about the superior fifth of the posterior surface of the ulna. *Use*, to extend the fore arm on the arm, and to raise the synovial membrane out of the articulation; this muscle is partly covered by the tendon and aponeurosis of the triceps; the remainder of it is superficial; it is situated between the olecranon and the extensor carpi ulnaris; it often appears as a continuation of the triceps; it covers a portion of the elbow joint and of the supinator brevis.

Extensor Minimi Digiti, *vel* Auricularis, *arises* in common with the extensor communis, and descends between it and the extensor carpi ulnaris; it forms a small fleshy belly, which descends very obliquely inwards, and ends in a slender tendon; this passes through a separate groove in the radius, and also through a distinct division of the annular ligament, in which situation it is frequently found divided into two, which continue in contact, and afterwards unite; this tendon becomes attached to the fourth tendon of the extensor communis, and is *inserted* along with it into the posterior part of the phalanges of the little finger. *Use*, to assist the extensor communis, and to extend and abduct the little finger independent of the others.

The deep muscles in this situation are five in number, they will be exposed by removing the superficial layer; they consist of the supinator radii brevis, three extensors of the thumb, and the indicator.

Supinator Radii Brevis, short and flat, surrounds the upper part of the radius, *arises* from the external condyle, external lateral and coronary ligaments, and from a ridge on the outer side of the ulna, which commences below its lesser sigmoid cavity; the fibres adhere to the capsular ligament, and descend obliquely outwards and forwards round the upper part of the radius, and are *inserted* into the upper third of the external and anterior surface of this bone, from above its tubercle down to the insertion of the pronator teres. *Use*, to turn the radius outwards, so as to make the hand look supine; it can also assist in extending the fore arm. This muscle nearly surrounds the upper part of the radius, it is covered by the supinator longus, the radial extensors of the carpus, and the extensor digitorum communis externally; by the anconæus and extensor ulnaris posteriorly; and anteriorly by the radial nerve and vessels, and by the brachialis and biceps; it partly surrounds the humeral and ulnar articulations of the radius; its anterior edge is notched above for the insertion of the biceps, and is overlapped by the pronator teres below.

[*Variety.* This muscle is sometimes double.]

Extensor Ossis Metacarpi Pollicis, or Abductor Pollicis Longus, *arises* fleshy from the middle of the posterior part of the ulna, below the anconæus, also from the interosseous ligament and posterior surface of the radius below the supinator brevis; it descends outwards and forwards, and ends in a tendon, which passes through a groove on the outside of the lower end of the radius, runs by the side of the carpus, and is *inserted* in general by two tendons, one into the os trapezium, and the other into the upper and back part of the metacarpal bone of the thumb. *Use*, to extend the first joint of the thumb, and separate it from the fingers; it also extends the wrist, and abducts the hand; it can also assist in supination. The origin of this muscle is concealed by the extensor communis and carpi ulnaris; the tendon is superficial and passes over the tendons of the radial extensors of the carpus, also over the radial vessels.

[*Variety.* This muscle is sometimes double.]

Extensor Primi Internodii Pollicis, or Extensor Minor, *arises* from the back part of the ulna, below its middle, and from the interosseous ligament and radius; it descends along the ulnar side of the last muscle; its tendon passes through the same groove in the radius, is bound down by the same portion of the annular ligament, and is *inserted* into the posterior part of the first phalanx; a small slip is often continued on to the second phalanx. *Use*, to extend the second joint of the thumb, and to assist the last described muscle; its connexions are also similar.

[*Varieties.* This muscle is sometimes an appendage of the last, and sometimes confounded with the next muscle.]

Extensor Secundi Internodii Pollicis, or Extensor

Major, *arises* from the posterior surface of the ulna above its centre, and from the interosseous membrane; its belly overlaps the two former muscles, its tendon passes along a distinct groove in the radius, runs over the outer side of the wrist, the metacarpal bone and first phalanx of the thumb, and is *inserted* into the posterior part of the second or last phalanx. *Use*, to extend the last phalanx of the thumb upon the first, and to assist the former muscles in extending and supinating the hand. The tendon of this muscle is separated from the two former, on the outer and back part of the wrist, by a considerable interval, in which we perceive the tendons of the radial extensors of the carpus, and the radial artery; the relations of this muscle in other respects are nearly similar to those of the other extensors of the thumb.

Extensor Indicis, or Indicator, *arises* from the middle of the posterior surface of the ulna and interosseous membrane; its tendon passes under the annular ligament along with those of the common extensor, is attached to the radial side of that tendon which belongs to the fore finger, and is *inserted* along with it into its second and third phalanges. *Use*, it assists the common extensor, or produces the extension of the fore finger alone, as in pointing. This muscle is concealed by the extensor communis and ulnaris, lies to the ulnar side of the extensor pollicis major, and its tendon passes under those of the common extensor, to which it is sometimes connected by a tendinous slip.

[*Varieties.* This muscle sometimes has two bellies, sometimes it is double, and the second muscle goes to the middle finger.]

Next dissect the muscles of the hand; first, those in the palm, which consist, externally, of the muscles of the thumb; internally, of those of the little finger, and in the middle of the lumbricales superficially, and the anterior interosssei, deep seated.

The short muscles of the thumb are five in number, viz. the abductor, opponens, flexor brevis, adductor pollicis, and abductor indicis.

Abductor Pollicis, *arises* broad and thin from the anterior part of the annular ligament, os naviculare and trapezium, *inserted* into the outside of the base of the first phalanx, and by an expansion into the back of both phalanges; its name implies its *use*, to separate the thumb from the fingers; it lies superficial, and is most external of these small muscles, which form the ball of the thumb.

Opponens Pollicis, or Flexor Ossis Metacarpi, *arises* from the annular ligament and os naviculare; *inserted* into the anterior extremity of the metacarpal bone of the thumb.

Use, to approximate the thumb to the fingers; it is internal to and partly overlapped by the last muscle; it lies on a part of the annular ligament, and of the following muscle, from which it is separated with difficulty.

FLEXOR POLLICIS BREVIS, consists of two portions, between which is the tendon of the flexor longus; one head, the *external* or *anterior*, *arises* from the inside of the annular ligament, and from the trapezium and scaphoid bones, passes outwards, and is *inserted* into the external sesamoid bone or cartilage and base of the first phalanx of the thumb; the second, or *internal* or *posterior*, *arises* from the os magnum, and the base of the metacarpal bone of the middle finger; it also passes outwards, distinct from the other at first, but afterwards united to it, and is *inserted* into the internal sesamoid bone, and base of the first phalanx. *Use*, to flex the first phalanx and metacarpal bone on the carpus; this muscle is concealed by the two former, and by the first lumbricalis; it covers the two first interossei muscles, and the tendon of the flexor carpi radialis; its outer edge is connected to the opponens pollicis, and the internal to the adductor.

ADDUCTOR POLLICIS, triangular and broad, *arises* fleshy from three-fourths of the anterior surface of the third metacarpal bone, or that of the middle finger, the fibres pass outwards over the second metacarpal bone, and converging are *inserted* into the inner side of the root of the first phalanx of the thumb, along with part of the last muscle; its name denotes its *use*. This muscle at its origin is covered anteriorly by the deep flexor tendons and by the lumbricales; its insertion is covered by the following muscle, which may be best seen from behind.

ABDUCTOR INDICIS, is also triangular, is situated between the thumb and index finger, and is best seen on the posterior aspect of the hand. *Arises* tendinous and fleshy from the metacarpal bone of the fore finger, and from one-half of that of the thumb; its fibres extend obliquely inwards and forwards, end in a tendon which passes by the outer side of the first joint of the fore finger, and is *inserted* into the outer side of the base of its first phalanx. *Use*, to separate the fore finger from the others, or to adduct the thumb. This muscle is superficial posteriorly; anteriorly it is covered by that last described; the radial artery passes between its two heads or origins: this muscle is similar to, and may be regarded as one of the posterior interossei; like these also, its insertion joins that of the common extensor tendon. In the middle of the palm of the hand are seen *four* small muscles.

LUMBRICALES, are four in number; they *arise* from the outer or radial side of the tendons of the flexor profundus, near the carpus, a little beyond the annular ligament; they each form a small fleshy belly, which ends in a tendon; this runs along the radial side of the finger, joins the tendon of the corresponding interosseous muscle, and is *inserted* about the middle of the first phalanx into the tendinous expansion which covers the back part of each finger. *Use*, to assist in bending the first joint of the finger; they cannot do so unless the flexors are tense; they can also adduct and abduct the fingers, and when the common extensor muscle is in action, they may assist in extending them; these small muscles are covered by the superficial flexor tendons, palmar vessels and nerves: the first is the largest, the fourth the smallest; the two middle run nearly parallel, but the internal and external diverge: the tendons of the lumbricales frequently divide into two portions; one of these will be *inserted* into the first phalanx, the other into the posterior tendinous expansion.

Variety. One of these muscles is sometimes wanting: sometimes one or more is double, and then the accessory is sent to the ulnar side of the adjoining finger.]

On the inner side of the palm of the hand are the short muscles of the little finger, which are three in number.

Abductor Minimi Digiti, *arises* fleshy from the annular ligament and from the pisiform bone; its fibres run along the ulnar side of the metacarpal bone, and are *inserted* tendinous into the ulnar side of the first phalanx; its name implies its *use;* it is superficial; a few fibres of the palmaris only cover it; its origin is partly continous with the insertion of the flexor carpi ulnaris.

Flexor Brevis Minimi Digiti, *arises* from the annular ligament and unciform bone, *inserted* by a round tendon into the base of the first phalanx of the little finger. *Use*, to flex and adduct the little finger; it lies to the radial side of the last muscle, along with which it is inserted.

[*Variety*. This muscle is sometimes wanting.]

Adductor, or Opponens Minimi Digiti, *arises* along with, but internal to the last, and overlapped by it, and is *inserted* into all the metacarpal bone of this finger: its name denotes its *use.*

When all the flexor and extensor tendons have been removed, we observe the intervals between the metacarpal bones to be filled by muscular fibres, which are called the interosseous muscles; they are divided into two planes, a posterior and an anterior. The Interossei Antici, or Interni or Palmares, are four in number; they *arise* from the sides of the metacarpal bones, and are *inserted* into the first phalanges, and into the tendinous expansion which covers the dorsum of each finger: the first or prior, or externus indicis, *arises* from the radial side of the second metacarpal bone, and is *inserted* into the external side of the first phalanx of the fore finger. *Use*, to adduct the fore finger; the second or posterior, or internus, or adductor indicis, *arises* from the ulnar side of the second metacarpal bone, and is *inserted* into the inner side of the first phalanx of the fore finger; third or prior, or externus or adductor annularis, *arises* from the radial side of the fourth metacarpal bone, and is *inserted* into the external side of the first phalanx of the ring finger. *Use*, to draw the ring finger towards the thumb; the fourth, or interosseous minimi digiti, *arises* from the radial side of the fifth metacarpal bone, and is *inserted* into the outside of the first phalanx of the little finger. *Use*, to draw the little finger towards the thumb.

The Posterior or Dorsal Interossei, are seen on the back part of the hand; they are longer than the anterior; they each *arise* by two sets of fibres from the opposed sides of two metacarpal bones, and are *inserted* into the base of the first phalanx of each finger, and into the posterior tendinous expansion; the first, or prior, or externus medii, *arises* from the second and third metacarpal bones, fills the space between these two, and is *inserted* into the outer side of the base of the first phalanx of the middle finger. *Use*, to draw the middle finger towards the thumb; the second or internus medii is situated between the metacarpal bones of the middle and ring finger, and is *inserted* into the inner side of the first phalanx of the middle finger. *Use*, to draw the middle towards the ring finger; the third, or externus annularis, is between the fourth and fifth metacarpal bones; and is *inserted* into the inner side of the ring finger. *Use*, to draw the ring finger inwards. All these muscles can also extend the fingers. Some consider the dorsal interossei as four in number, making the *abductor indicis* the first of this class.

In the dissection of the fore arm and hand we meet with the branches of the brachial artery, with their accompanying veins; also branches of the brachial plexus of nerves: the cutaneous veins have been already noticed. The brachial artery, when it arrives at the bend of the elbow, divides into its radial and ulnar branches. The *radial artery* descends from the elbow obliquely outwards, to the styloid process of the radius, passes over the outer side of the carpus, and then between the metacarpal bones of the thumb, and of the fore finger, where it divides into three branches, radialis indicis, magna pollicis, and palmaris profunda: the radial artery at first lies between the pronator teres and supinator longus; afterwards between the supinator and flexor carpi radialis: it then winds round the carpus, over the external lateral ligament, and beneath the extensor tendons of the thumb; in the fore arm it is only overlapped above by the supinator longus; in the rest of its course it is superficial; it is accompanied by two veins, and by the radial branch of the musculo-spiral nerve, which lies to its outer side. The radial artery gives off, first, the recurrent branch, which ascends in front of the external condyle, to supply the muscles attached there, and to inosculate with the superior profunda; second, in its course down the fore arm, several muscular branches: third, near the wrist, the superficialis volæ, which passes to the small muscles of the thumb, and communicates with the superficial palmar artery; fourth and fifth, branches to the fore and back part of the carpus: and between the thumb and index finger it divides into its three last branches; the magna pollicis subdivides, and supplies the sides of the thumb; the radialis indicis, in like manner, supplies the fore finger; and the palmaris profunda passes beneath all the flexor tendons across the four metacarpal bones, forms the deep palmar arch, and then joins a branch from the ulnar artery. The *ulnar artery* is larger than the radial: it descends obliquely inwards, beneath the superficial flexors and pronators, and lies on the flexor profundus; it passes over the annular ligament into the palm of the hand, and there divides into a superficial and deep branch; this vessel is covered above by several muscles, inferiorly it is superficial, and lies between the tendon of the flexor sublimis and flexor carpi ulnaris; it is attended by its two veins, and in the inferior two-thirds of the fore arm by the ulnar nerve, which always lies to its ulnar side; near the wrist this nerve is somewhat behind the artery. The ulnar artery sends off, first and second, its recurrent branches, the anterior, small, ascends in front of the internal condyle, the posterior, large, passes behind that condyle and joins the inferior profunda; third, the interosseous artery, which passing backwards, divides into its posterior and anterior branch; the posterior passes through the upper part of the interosseous space, and ascends in the substance of the anconæus [by its recurrent branch, after which it descends upon the back of the fore arm, as far as the wrist;] the anterior interosseous descends between and beneath the flexor profundus and flexor pollicis as far as the pronator quadratus, where it terminates; fourth, muscular branches; fifth and sixth, branches, to the back and front of the carpus; and in the palm of the hand it terminates in the deep and superficial branch; the former sinks between the muscles of the little finger, to join the deep palmar arch; the superficial runs across the flexor tendons, forming the superficial arch, from the convex side of which, the long digital arteries arise; these supply the three inner fingers. (See Vascular System.)

In addition to the cutaneous nerves already noticed, we find the median, ulnar and musculo-spiral descending in the fore arm; the *median nerve* passes between the heads of the pronator teres, and descends beneath the flexor sublimis, giving off the anterior interosseous nerve, and branches to the muscles of the fore arm; it passes beneath the annular ligament, appears superficial in the palm of the hand near the thumb, and sends off digital branches, which accompany the digital arteries to all the fingers, except the little and the ulnar side of the ring finger. The *ulnar nerve* winds round behind the internal condyle, between the heads of the flexor carpi ulnaris, and descends along the internal side of the ulnar artery to the hand, where it terminates, by dividing into a small superficial and a large deep branch. The *musculo-spiral* or *radial nerve* is seen beneath the supinator longus, descending along the outer side of the radial artery, and supplying the adjacent muscles; near the elbow it gives off the posterior interosseous nerve, and a little below the middle of the fore-arm it passes beneath the tendon of the supinator, and becomes cutaneous, being distributed to the integuments of the thumb and back of the hand. (See Anatomy of the Nervous System.)

CHAPTER VI.

DISSECTION OF THE ABDOMEN.

SECTION I.

OF THE MUSCLES ON THE ANTERIOR AND LATERAL PARTS OF THE ABDOMEN.

Divide the integuments from the sternum to the pelvis, from the crest of the ilium on each side to the umbilicus, also from this point upwards and outwards on each side over the cartilages of the ninth and tenth ribs, as high as midway between the axilla and the border of the thorax; dissect off the flaps; the subcutaneous cellular membrane will be found dense and strong, so as to have received the name of superficial fascia; this may be removed along with the integuments from the superior and lateral parts of the abdomen, but inferiorly and anteriorly it may be suffered to remain for further examination, a knowledge of its structure and connexions being of practical importance in the disease of hernia. The *superficial fascia* is continued from the surface of the thorax, over the abdominal muscles; weak and thin above, it increases in density as it descends; from the abdomen it extends on either side over Poupart's ligament to the thigh, which it invests, and in the centre over the organs of generation: in the male a process of it passes round the spermatic cord on each side, descends into the scrotum, and is continuous with the fascia of the perinæum, and from the linea alba a thick portion runs to the dorsum of the penis, invests this organ, and serves as a suspensory ligament to it. In the female it is loaded with fat in this situation, and descends into the labia. As this fascia passes over Poupart's ligament, it is connected to it, through the medium of a thin transparent but strong membrane, which ascends from the fascia lata of the thigh, and is soon lost on the abdominal muscles; to this the superficial fascia is attached, so as to give the latter the appearance of adhering to Poupart's ligament, although it really is not so. This structure is sometimes called Scarpa's fascia, as that writer has described it under the name of the "Aponeurosis of the fascia lata," it is very unequally developed in different subjects; some of the inguinal ganglia separate this from the superficial fascia, so also does a femoral hernia, in its ascent on the surface of the abdomen. About an inch below this ligament, in the groin, the superficial adheres intimately to the fascia lata; in this situation the former is very thick and laminated, forming capsules for the inguinal lymphatic ganglia, and is connected to the fascia lata, by vessels and nerves which perforate the latter in their course to and from these ganglia, the superficial fascia and integuments; the fascia lata here also is very weak, and rather cellular, so that the superficial and deep fasciæ are continuous or identified in this situation; soon afterwards, however, they become distinct. The superficial fascia is thinner along the sides than it is on the forepart of the abdomen: its cutaneous surface is cellular, and closely connected to the integuments, particularly in the median line; its posterior surface is more compact and smooth; several blood-vessels ramify between the skin and this membrane; three set on each side, viz. the external circumflex ilii, external epigastric, and external pudic arteries; these all arise in the groin, from the fermoral artery, or from some of its branches, and ascend over Poupart's ligament: the first ramifies towards the anterior spinous process of the ilium; the second, which is the largest of the three, ascends towards the umbilicus; and, the third passes transversely towards the pubis; these several arteries supply the integuments, and inosculate with the deep seated vessels of the same name; they are each accompanied by one or two veins, which are often found remarkably tortuous. The superficial fascia supports and connects the fleshy and tendinous fasciculi of the abdominal muscles; it also possesses a good deal of elasticity, which assists these muscles in the contraction of the parietes of the abdomen. Remove the integuments and fascia from the surface of the abdominal muscles, and continue the dissection as far back as within two or three inches of the spine. In dissecting the external oblique muscle at its upper and anterior part, care must be taken not to raise its aponeurosis, which is so thin, as it passes over the anterior part of the thorax, that it may be mistaken for condensed cellular membrane. In order to expose the external oblique muscle, make its fibres tense by putting a block under the loins, and dissect in a line nearly parallel to its fibres; to clean the posterior portion, the subject should be turned a little to the opposite side. The abdominal muscles consist of five pair, viz. obliqui externi, and interni, transversales, recti, and pyramidales.

[These muscles are found in three layers, in the first one pair, in the second three pair, and in the third one pair.

FIRST LAYER, ONE PAIR.

Obliquus Externus, or Descendens.

SECOND LAYER, THREE PAIR.

Obliquus Internus, or Ascendens.
Rectus Abdominis.
Pyramidalis.

THIRD LAYER, ONE PAIR.

Transversalis Abdominis.]

OBLIQUUS EXTERNUS, OR DESCENDENS, broad, thin, and somewhat square, extends over the anterior and lateral parts of the abdomen, fleshy above and behind, tendinous before and below; it *arises* by eight or nine triangular fleshy slips, sometimes there are only seven, from the lower edges and external surface of the eight or nine inferior ribs, at a little distance from their cartilages; the five superior indigitate with corresponding portions of the serratus magnus; and the three inferior with those of the latissimus dorsi, by which they are a little overlapped. The superior fibres are thin, aponeurotic, and weak, and pass horizontally inwards; a tendinous and fleshy slip often connects this portion to the great pectoral muscle: the middle are the longest, and descend obliquely forwards and inwards; the posterior are strong and fleshy, and descend almost vertically: the superior and middle fibres end in a broad tendon, which commences at a little distance external to the linea semilunaris; this tendon is continued over the forepart of the abdomen, covers the rectus muscle, and is so broad inferiorly, as when taken with its fellow to extend from one spine of the ilium to that of the opposite side; it is very strong inferiorly, but so very thin above, where it covers the thoracic portion of the rectus, that the inexperienced dissector often removes it along with the integuments. The external oblique is *inserted* tendinous into the ensiform cartilage, linea alba, pubis, Poupart's ligament, which is formed by this tendon, and into the anterior superior spinous process of the ilium, also tendinous and fleshy into the outer edge of the two anterior thirds of the crest of the ilium. *Use*, to depress the ribs, and compress the abdominal viscera, so as to assist in expiration, and in the evacuation of the urine and fæces. When both muscles act, they can bend the trunk forwards; if one only act, it will bend it to that side, and it may also rotate it to the opposite side. This muscle is covered by the skin and superficial fascia, its posterior border is sometimes overlapped by the latissimus dorsi; in some cases, however, these muscles do not meet, and a small part of the internal oblique is seen in the triangular space between them.

[*Variety*. This muscle may be defective at different points, thus giving a tendency to the formation of ventral herniæ.]

On the dissected tendons of this pair of muscles, we may remark the following particulars; the linea alba and umbilicus, lineæ semilunares, lineæ transversæ, the external abdominal or inguinal rings, and Poupart's ligament on each side. The *linea alba* is a dense ligamentous cord, extending from the ensiform cartilage to the upper part of the symphisis pubis; it is formed by the intimate union, or by the crossing of the tendinous fibres of the two oblique and transverse muscles of opposite sides; its greatest breadth is at the umbilicus, from this to the pubis it decreases; its superior portion is much broader than its inferior: the integuments are more closely connected to this line, than they are at either side; hence the more fat the subject, the more indented will the skin appear along it. About the centre of the linea alba is the *umbilicus;* this, in the fœtus, was a foramen, through which were transmitted the umbilical vein from the mother, and the umbilical arteries and the urachus from the child; before the teguments were removed, this spot appeared depressed, particularly if the subject have been very fat; it now projects, and seems formed of dense, cicatrized cellular tissue, surrounded by, and connected to the adjacent tendinous fibres. Umbilical hernia occurs in the infant through this opening, but in the adult in its immediate vicinity.

The linea alba may be regarded as the continuation of the sternum, it serves as a fixed point for the oblique and transverse muscles on either side, also as a ligament to connect the thorax to the pelvis, and to support the former when bending the trunk backwards, so as to resist or prevent too forcible extension of the spine. In the inferior part of this line the following operations may be performed: puncturing the bladder in retention of urine: paracentesis, or tapping of the abdomen, in ascites; and the high operation for lithotomy.

The inferior fourth or fifth part of the linea alba is sometimes deficient, as also a portion of the muscles on each side; so that the urinary bladder is superficial, and constantly exposed: in such cases the anterior part of this viscus also is usually wanting, and therefore its cavity and the orifices of the ureters can be perceived during life.

The *linea semilunaris* extends from the tuberosity of the pubis on each side upwards and outwards, about four inches from the linea alba, towards the cartilages of the eighth and ninth ribs; it appears white, and somewhat depressed, and is formed by the tendon of the internal oblique, dividing at the edge of the rectus into two layers, to enclose this muscle in a sort of sheath. In the living subject this line may be traced by taking the point midway between the umbilicus and the anterior superior spinous process of the ilium, and from it drawing one line towards the tuberosity or spine of the pubis, and another towards the cartilage of the ninth rib. The operation of tapping ovarian dropsy, should always be performed here: and this situation is also selected by some as the best for performing paracentesis in case of ascites. In this last mentioned disease, however, this line is not exactly midway between the umbilicus and spine of the ilium, but half an inch nearer the latter.

The *lineæ transversæ* are three or four on each side, they cross the rectus muscle from the linea alba to the linea semilunaris; they are tendinous intersections of that muscle, particularly of its anterior part, which adhere so intimately to its sheath, as to give to the latter this indented appearance. They are much better marked in some than in others; during life they are very distinct, when the abdominal muscles are in strong action. These lines will be again noticed in the dissection of the rectus. Between the linea alba and semilunaris on each side many small holes are often to be observed in the tendon of the external oblique: these are only for the transmission of small vessels and nerves: they are generally of a square form, and are much larger and more numerous in some than in others. External and superior to the pubis on each side we may always remark the opening called the *external inguinal*, or *abdominal ring*, transmitting in the male subject the spermatic vessels and cremaster muscle, and in the female the round ligament of the uterus. This opening is of a triangular form, the base at the pubis, the apex is superior and external; the sides are called the pillars of the ring, one of which is superior, internal, and anterior; the other, or Poupart's ligament, is inferior, external, and posterior; the first, or superior pillar, is broad, and inserted into the symphysis and into the opposite pubis; some fibres are continuous with the fascia lata of the opposite thigh; this pillar decussates with that of the opposite side, on the forepart of the pubis, and both send fibres to the dorsum of the penis; the inferior pillar is the internal or pubic portion of Poupart's ligament; the apex of this opening is rounded by a series of fibres, which serve to connect the pillars to each other. These fibres arise from Poupart's ligament at a little distance from the spine of the ilium, pass in curved lines upwards and inwards across the upper part of the ring, and are lost on the surface of the tendon; they serve, by preventing the separation of the sides of the ring, to protect this part of the abdomen against a protrusion of its contents. These fibres are in some cases so closely connected, as to merit the name of a fascia (the *intercolumnal fascia*); this, in old cases of hernia, has been found of great strength, and prolonged for some distance on the hernial sac, and intimately connected with the cremaster muscle (fascia spermatica); it is this fascia, or these intercolumnal bands, that obscure this opening in many cases, and deprive it of that defined figure usually mentioned by writers, or delineated in plates. The tendon of the external oblique is alone concerned in the formation of the external abdominal ring, there being no corresponding deficiency in the internal oblique or transverse muscles; the spermatic cord, or round ligament, must therefore take an oblique course to arrive at this opening; this will be seen in the next stage of the dissection.

Poupart's or *Fallopius' ligament*, or the *crural arch*, is the inferior thickened edge of the tendon of the external oblique; it is very strong, and when the lower extremity is extended, and the foot and toes everted, it appears very tense; if we consider it as a distinct ligament, it may be described as having an attachment to, or as *arising* from the anterior superior spinous process of the ilium, and thence descending obliquely forwards and inwards to the pubis, into which it is *inserted* by two attachments, one anteriorly into the tuberosity or spine; the other posteriorly into the linea innominata of the pubis, or the commencement of the linea ilio-pectinea: the first or iliac end of Poupart's ligament is broad and continuous above with the tendon of the oblique, and below with the fascia lata; the anterior portion of the pubal end, or the *second* insertion, is distinct and round, and can be felt through the skin; it lies behind the cord, and is connected to that portion of the fascia lata which covers the adductor muscles; the posterior pubal attachment, or the *third* insertion, also called *Gimbernaut's ligament*, is broad and thin, and lies superior, posterior and external to the former; it may be seen by raising the cord out of the external ring, and everting Poupart's ligament a little; it is of a triangular form, the apex is anterior towards the tuberosity or spine of the pubis; the base is external and posterior, somewhat crescentic, looking towards the femoral vessels; to it some fibres from the outer or iliac part of the fascia lata are attached, so as to elongate it in this direction; this third insertion of Poupart's ligament forms the internal boundary of the femoral ring, and is therefore concerned in the anatomy of femoral hernia, as will be seen hereafter. Poupart's ligament owes much of its strength to its connexion with the fascia lata of the thigh, as may be seen at present, also to its attachment to the fasciæ transversalis and iliaca, which will be exposed in a future stage of the dissection. Poupart's ligament is of *use* in strengthening the inferior part of the abdomen, and affording a fixed point of attachment to the deeper muscles and to the different aponeuroses; it also protects the great femoral vessels and nerves in their passage from the abdomen to the thigh, and its third insertion partly fills up the internal portion of the crural arch. From this third insertion, and from the pubis, a band of fibres may be observed to pass upwards and inwards behind the superior pillar of the ring towards the linea alba; these assume in general, a triangular shape, and have received the name of the *triangular ligament or fascia;* the base is inferiorly at the linea ileo-pectinea; the apex is superior and internal towards the linea alba, and is continuous with the external oblique tendon of the opposite side: this fascia serves to protect the abdomen in this region. Raise the external oblique, by dissecting off its serrated origins from the ribs, detach also its insertion from the crest of the ilium, and from the internal oblique muscle, cleaning, at the same time, the surface of the latter, throw the external oblique towards the opposite side, separating it as far forwards as its connexions will permit, that is, about half an inch internal to the linea semilunaris; divide its tendon transversely from the spine of the ilium, towards the lower third of the rectus, about an inch above the external ring, thus preserving Poupart's ligament and the external ring for further examination, in relation to the anatomy of hernia. When the external oblique is raised, we see the inferior ribs, the inferior intercostal muscles, the internal oblique, and the cremaster.

Obliquus Internus, or Ascendens, is also situated at the anterior and lateral part of the abdomen, broader before than behind, and more fleshy below than above; it *arises* tendinous, but soon becomes fleshy, from the fascia lumborum, from all the crest of the ilium, and from the two external thirds of the grooved or abdominal surface of Poupart's ligament, the fibres diverge in a radiated manner; those from the lumbar fascia and posterior part of the ilium ascend obliquely forwards; those from the anterior part of the ilium pass transversely, and those from Poupart's ligament descend obliquely inwards; the fibres continue fleshy further forward than those of the external oblique; at the linea semilunaris they end in a flat tendon, which, at the edge of the rectus, divides into two layers, to enclose this muscle; the anterior is united to the tendon of the external oblique, the posterior and thinner layer is joined to the tendon of the transversalis; about midway between the umbilicus and the pubis, the tendon of the internal oblique does not divide, but the whole passes in front of the rectus, along with the tendon of the transversalis, to which it is closely connected; a little above the pubis these two tendons are inseparably joined, and are called the *conjoined tendons*. The internal oblique is *inserted*, tendinous and fleshy, into the cartilages of the six inferior ribs, tendinous into the ensiform cartilage, and into the whole length of the linea alba; the conjoined tendons are *inserted* into the symphisis and upper edge of the pubis, and passing external to the rectus are also inserted into the linea innominata, where they are connected with Gimbernaut's ligament, and inseparably joined to the fascia transversalis; these conjoined tendons lie posterior to the spermatic cord and to the triangular ligament, and afford much security to that part of the abdomen behind the external abdominal ring. *Use* of the internal oblique muscle, to assist the external oblique in expiration, and in compressing the abdominal viscera, also in bending the trunk forwards, or to one side; it can also rotate the trunk, but in doing so, it co-operates with the external oblique of the opposite side, with which it forms a sort of digastric muscle; this muscle is covered by the external oblique and latissimus dorsi; it lies on the transversalis muscle; some small vessels ramify between them: a small portion of the internal oblique is sometimes superficial, between the external oblique and latissimus dorsi, and above the posterior part of the ilium.

[*Variety.* This muscle also, is sometimes deficient at some parts.]

Along the inferior border of this muscle we observe the following:

Cremaster, consists of a fasciculus of pale fleshy fibres, which *arise* from the internal surface of the external third of Poupart's ligament, and from the lower edge of the last described muscle; a few fibres also sometimes proceed from the lower edge of the transversalis muscle; it frequently too has a tendinous attachment to the pubis, behind the external abdominal ring; the fibres all pass downwards and forwards around the spermatic cord, but chiefly along its outer side, many of them in the form of arches reversed or concave upwards; they are *inserted* into the tunica vaginalis; a few fibres are lost in the scrotum. *Use*, to support, compress, and raise the testicle and its vessels; the origin of this muscle is covered by the tendon of the external oblique, and lies on the fascia transversalis; a small but long nerve, a branch from one of the lumbar nerves, runs between its fibres; the lower part of the muscle is superficial and very pale; in cases of old hernia, the fibres of the cremaster are found greatly increased in thickness and are often of a yellow colour; and in that form of the disease called the oblique, or common inguinal hernia this muscle always forms one of the coverings of the sac. The cremaster is absent in the female. This muscle is probably formed incidentally, the testis, in its descent to the scrotum, carrying before it the lower border of the internal oblique; hence too the arched direction of some of its fasciculi. Raise off the internal oblique from the transversalis muscle; commence above the anterior part of the crest of the ilium, where the muscles are separated by cellular membrane, and some branches of the circumflex-ilii vessels, make one incision from the ilium towards the cartilage of the ninth rib, and another from the ilium, towards the lower third of the linea semilunaris;

carefully dissect off the posterior part of the muscle, towards the spine, and the anterior towards the rectus; this portion can be separated from the transversalis, a little beyond the linea semilunaris.

TRANSVERSALIS, somewhat square, broader anteriorly than posteriorly, *arises* tendinous from the fascia lumborum and the posterior part of the crest of the ilium, fleshy from the remaining anterior part of the crest, and from the iliac third of Poupart's ligament; it also arises tendinous from the two last ribs, and by fleshy slips from the inner side of the five succeeding; these indigitate with the origins of the diaphragm; all the fibres pass transversely forwards, except the most inferior, which are curved a little downwards; they all end in a flat tendon, which, near the linea semilunaris, joins the posterior lamina of the internal oblique, and is *inserted* along with it into the whole length of the linea alba, into the upper edge of the pubis, and into the linea innominata; this tendon passes behind the rectus superiorly; but inferiorly, that is, about midway between the umbilicus and the pubis, the conjoined tendons pass anterior to this muscle, and are *inserted* in the manner before mentioned. The transversalis abdominis is covered by the internal and external oblique; it lies on the fascia transversalis and on the peritonæum. *Use*, to compress the abdominal viscera, and assist in expiration; this muscle is tendinous before and behind, fleshy in the middle, also above and below, contrary to the two oblique muscles; the posterior tendon is described by some, not improperly, as dividing into three layers, which are in fact the three sheets or leaves of the lumbar fascia; the posterior, very strong, is continuous with the fascia lumborum; the middle, thinner and weaker, is attached to the transverse processes of the lumbar vertebræ; and is separated from the former by the lumbar muscles; and the anterior lamina, which is the weakest, is expanded over the quadratus lumborum, and the inferior part of the diaphragm, and is connected to the sides of the bodies of the lumbar vertebræ. The inferior edge of the transversalis is in some degree confounded with that of the internal oblique; particularly at their origin from Poupart's ligament; it seldom, however, descends as low as that muscle, and it crosses the spermatic cord, or round ligament, just as either of these is about to enter the abdomen: the conjoined tendons also often admit of separation inferiorly near the external ring, when the tendon of the transversalis muscle may be traced very distinctly behind the cord, intimately united to the transversalis fascia. Replace the oblique muscles, divide their tendons all along the side of the linea alba, and dissect them off the rectus towards the linea semilunaris; this anterior part of the sheath adheres so closely to the lineæ transversæ, that it is difficult to separate it from them.

Rectus, long and flat, broader above than below, *arises* by a flat tendon, which is sometimes double, from the upper and anterior part of the pubis, ascends parallel to its fellow, becomes broad and thin above the umbilicus, and is *inserted* into the anterior part of the thorax by three fasciculi, the internal one of which is fixed to the ensiform cartilage and costo-xiphoid ligament; the middle, longer, and thinner, to the cartilage of the sixth rib; and the external, still broader and thinner, to the cartilage of the fifth rib. *Use*, to bend the chest towards the pelvis, or to raise the latter towards the chest, also to compress the abdomen. The rectus is covered superiorly by the great pectoral, in the middle by the tendon of the external, and the anterior layer of that of the internal oblique muscle, and inferiorly by the external oblique and the conjoined tendons of the internal oblique and transversalis, also by the pyramidalis. These muscles are much nearer to each other below than above; they are each enclosed in a distinct sheath, which consists, anteriorly, of the tendon of the external oblique and the anterior lamina of the internal oblique, posteriorly of the posterior layer of the internal oblique, and the tendon of the transversalis. This sheath commences at the edge of the thorax, and terminates midway between the umbilicus and the pubis; below which, all the tendons pass anterior to this muscle. If this part of the rectus be divided, the deficiency in the back of the sheath will be obvious, as it generally terminates abruptly by a lunated edge; in some cases, however, it ends gradually: the epigastric vessels ascend within this sheath, on the posterior surface of the muscle. The sheath of the rectus serves to confine this muscle in its proper place, and to prevent it, when contracted, from injuring the abdominal viscera immediately behind it; it also strengthens the parietes of the abdomen, and prevents the more frequent occurrence of hernia; the deficiency in the back part of the sheath below, may permit the abdominal muscles to exert more direct influence on the urinary bladder when distended. The rectus is intersected by three or four irregular, or zigzag, transverse, tendinous lines; one of these is always to be found opposite the umbilicus, a second midway between this and the xiphoid cartilage, opposite to which a third is always placed; if a fourth exist, it will be found below the umbilicus: these intersections are not complete; they are generally deficient on the back part of the muscle; the anterior part of the sheath adheres intimately to each of them, some fleshy fibres pass over one line and are inserted into those above and below, hence the posterior fasciculi are longer than the anterior; by means of these lines the rectus is a sort of polygastric muscle, and is enabled to act in distinct or separate portions, so as to compress different parts of the abdomen in succession, each section having a distinct nerve.

[*Varieties.* This muscle is attached to the eighth rib, when that bone reaches the sternum, as is sometimes the case; it also sometimes ascends as high as the fourth rib, in other cases as high as the neck, in front of the pectoralis major.]

Anterior to the origin of the rectus is the following small muscle:

PYRAMIDALIS, is sometimes absent, it *arises* broad and fleshy from the pubis, ascends obliquely inwards, and is *inserted* narrow and tendinous into the linea alba, midway between the umbilicus and pubis. *Use*, it assists the rectus, and makes tense the linea alba; it is covered by the tendon of the external oblique, by the triangular ligament and the conjoined tendons: it appears in some cases to be enclosed in a splitting of the latter.

[*Varieties.* This muscle is often wanting, sometimes there are two, three, and even four on a side.]

Dissect off the transversalis muscle in a direction from the ilium towards the linea semilunaris, and the *fascia transversalis* will be exposed covering the peritonæum; this fascia is connected to the internal lip of the ilium and to the whole length of Poupart's ligament, as far as the third insertion or Gimbernaut's ligament, from which it is continued behind the rectus to that of the opposite side; from these attachments, the fascia transversalis ascends between the peritonæum and the transversalis muscle, as high as the diaphragm, and as far back as the psoas magnus; it is very strong and tense inferiorly for about an inch above Poupart's ligament, but superiorly it is little more than condensed cellular membrane: this fascia serves to support the peritonæum, particularly at the inferior part of the abdomen, where the internal oblique and transversalis muscles are deficient; the spermatic cord or the round ligament always perforates this fascia about three quarters of an inch above Poupart's ligament, and about an inch and a half from the tuberosity of the pubis; this perforation is called the *internal abdominal ring*, and is situated about midway between the spine of the ilium and the symphisis pubis; it is not a distinct opening, for the edges are prolonged along the cord, and lost in its cellular covering. The interval between the internal and external abdominal rings is traversed by the spermatic cord, and is named the *inguinal* or *spermatic canal*, to the anatomy of which the student should particularly attend, as the disease of *inguinal hernia* is situated here, in the treatment of which a correct knowledge of this region will be required. The *spermatic* or *inguinal canal* commences at the internal ring, and leads obliquely downwards, forwards, and inwards to the external ring, where it terminates; this passage is bounded anteriorly by the skin and fasciæ, the tendon of the external oblique, and by the inferior fleshy margin of the internal oblique and transverse muscles, posteriorly by the transversalis fascia and by the conjoined tendons of the two last named muscles, inferiorly by Poupart's ligament and its third insertion, superiorly this space is closed by the apposition of its opposite sides; in the male the spermatic cord and cremaster muscle, and in the female the round ligament of the womb passes through this canal, the obliquity or valve-like structure of which serves to protect the abdomen against a protrusion of its contents. Inguinal hernia occurs more frequently in the male than in the female sex, in consequence of the spermatic cord and the inguinal rings in man being larger than the ligamentum teres or these openings in the female: there are two species of this disease, oblique and direct. *Oblique inguinal hernia* is the more common form; in this case, the peritonæum or hernial sac, with its contents, protrude through the internal ring along the anterior part of the spermatic vessels, carrying before it the surrounding cellular tissue and a prolongation of the fascia transversalis from the edges of the opening; this covering of the hernial sac is called the *fascia propria* of inguinal hernia, and by some the fascia infundibuliforme. When the tumour has arrived at the lower edge of the transversalis and internal oblique it insinuates itself between the cremaster muscle and the vessels of the cord, along which it descends to the external ring, where it is in general delayed for some time; the form of this opening and the inter-columnar fascia preventing its free passage through it; as the sac, however, descends towards the scrotum these inter-columnar fibres become closely united to the cremaster, and are gradually elongated on the surface of the tumour.

If the sac of an oblique inguinal hernia which has passed the external ring be carefully dissected, it will be found covered by the following parts; beneath the integuments the superficial fascia, in general much thickened and divisible into several laminæ, will be seen to surround the tumour; on dissecting off this, the fibres of the cremaster, in general also thickened, will be observed spread on the forepart and sides of the sac, the inter-columnar bands from the external oblique tendon will be found closely connected to this muscle, and both will form a sort of capsule for the sac, suspending it towards the abdomen; if this covering be divided, the fascia propria will appear closely investing the tumour, and so adhering to it as to be separated with difficulty from it; this covering can often be divided into several layers, it presents, however, great difference in different cases; beneath this, the hernial sac or the peritonæum will be found, which also in cases of old hernia will be considerably thickened; on opening the hernial sac, its contents, either omentum or intestine, will be seen. The student should next attend to the situation of the epigastric vessels and their relation to the parts concerned in oblique inguinal hernia; these vessels are placed behind the fascia transversalis between it and the peritonæum, and in general can be discerned through the fascia; if not, a little dissection will render them apparent; two veins usually accompany the artery, one on either side; sometimes there is but one epigastric vein, and that is on the pubal or inner side of the artery; the *epigastric artery* arises from the external iliac near Poupart's ligament; it first descends a little forwards and inwards, then ascends toward the rectus muscle, immediately behind the fascia transversalis, and very near to the inner or pubal side of the internal abdominal ring; in oblique inguinal hernia the neck of the sac is nearly in contact with the epigastric vessels, which thus bound it on its internal side, hence the rule of practice, in performing the operation for the relief of strangulated oblique inguinal hernia, when the stricture is seated in the neck of the sac, is, to direct the edge of the knife or bistoury upwards and outwards. *Direct* or *ventro-inguinal hernia* protrudes directly through the external ring without descending along the spermatic channel: the occurrence of this disease is in a great degree guarded against by the fascia transversalis, and by the conjoined tendons which lie immediately behind the external ring: the edge of the rectus, the triangular ligament, and the spermatic cord may be also all enumerated as additional protections to this part of the abdomen: in this species of hernia the sac will be found covered only by the integuments, superficial fascia, and some tendinous and aponeurotic bands it may have carried before it; it is not covered by the cremaster, and in general it descends along the inner and anterior side of the cord, that is, the cord will be found external and inferior or posterior to it, but in some few cases the cord has been found passing across the neck of the sac, that is, anterior to it; the sac is never, however, found between the cremaster muscle and the spermatic vessels. The epigastric vessels lie to the iliac or outer side of the neck of the sac; in dividing the latter, therefore, in case this operation be required during life, the edge of the knife should be directed upwards and inwards. When the disease of oblique inguinal hernia has continued for a considerable length of time, the spermatic canal will be found altered in many respects from its natural condition; it will have become dilated and shortened, and the abdominal rings expanded and approximated so as to render it difficult to distinguish the oblique from the direct inguinal hernia. This is the condition of the inguinal canal in the infant; on account of the narrow pelvis, the canal is then short, the rings are more nearly opposed, and of course, if the same exciting causes were present, hernia would be more frequent in its occurrence.

In connexion with inguinal hernia, the student may next study the anatomy of the groin in reference to *crural hernia*, or he may postpone this dissection until the contents of the abdomen have been examined and removed; we shall, however, here subjoin the description of the parts concerned in this disease: remove the teguments from the anterior part of the upper third of the thigh, the superficial fascia will be seen descending over Poupart's ligament to invest the lower extremity; in the groin this fascia is very thick, and may be divided into several layers, which are separated by lymphatic ganglia and the superficial inguinal vessels; this fascia may be easily raised from the fascia lata on the outer and inner sides of the thigh, but in the middle of the groin and about an inch below Poupart's ligament, these fasciæ are almost inseparably joined; when the superficial fascia shall have been dissected off the forepart of the thigh, we shall see several lymphatic ganglia, the saphena vein and some small blood vessels lying on the fascia.

The form and boundaries of the *inguinal region* also may then be more distinctly seen; the term *crural* is sometimes applied to this space, and that of inguinal to the smaller region above Poupart's ligament; I prefer naming the latter spermatic, and the former inguinal or superior crural. The inguinal region is triangular, the base is Poupart's ligament; the apex is, inferiorly, formed by the meeting of the sartorius and adductor muscles, at the lower part of the upper third of the thigh; the external side is very prominent, and consists of the sartorius, iliacus, rectus and other muscles, all covered by the fascia lata; the internal or pubic side is flat and on a plane posterior to the iliac; it is formed by the pectinæus and adductor muscles, also covered by the fascia lata. The *inguinal lymphatic ganglia* are irregular in number, and size, they are in general about twelve in number, and may be divided into a superficial and a deep set; the former are the more numerous, and may be arranged from their situation into the superior and inferior; the superior are small, four or five in number, lie parallel to Poupart's ligament, some above, others below it; the inferior are two or three in number, larger than the former, and placed perpendicularly or parallel to the saphena vein; in general one lies behind this vessel; the *deep inguinal ganglia* are beneath the fascia lata, are three or four in number, and are closely connected to the sheath of the femoral vessels, chiefly to its inner side; in general one occupies the femoral ring. The *saphena vein* is the principal cutaneous vein of the lower extremity; it will be seen in a future dissection to arise from the dorsum and inner side of the foot, and to ascend in front of the inner ankle along the inner side of the leg, and passing behind the inner condyle of the femur it continues to ascend along the inner and anterior part of the thigh to within about an inch and a half or two inches of Poupart's ligament, when it begins to pass through an opening in the fascia lata, (the saphenic opening,) it then joins the femoral vein about an inch or an inch and a half below the crural arch. The *saphenic opening* in the fascia lata will be very distinctly seen if the vein be divided on the thigh and raised towards Poupart's ligament, it presents a well-marked semilunar edge, the concavity looking upwards; the edge, though apparently sharp, yet if carefully examined will be found reflected backwards on the sheath of the femoral vessels; remove the inguinal ganglia, clean the surface of the fascia lata, to the connexions of which in this region the student should next attend. The fascia lata may be observed to be united to the spine of the ilium, to the whole length of Poupart's ligament, also to the linea innominata and spine of the pubis; it covers the muscles on either side of the groin, and the vessels in the middle; for the purpose of more particular examination, this fascia may be divided into three portions, the internal or pubic or pectineal portion, the external or iliac, and the middle or cribriform; the *internal* or *pubic portion* covers the pectinæus, gracilis, and adductor muscles, and is inserted internally into the ramus of the ischium and pubis; superiorly into the linea innominata or ilio-pectinea, anterior to Gimbernaut's ligament; externally it passes behind the sheath of the femoral vessels, and at the edge of the psoas tendon divides into two laminæ, one passes beneath that tendon, and is attached to the capsular ligament of the hip-joint; the other passes over that tendon and is continued into the deep surface of the fascia iliaca. The *middle* portion of the fascia lata is very thin, and has been termed the *cribriform fascia;* this extends from the saphena vein to Poupart's ligament, and is connected on either side to the pubic and iliac portions of the fascia lata. The cribriform fascia covers the femoral vessels, and is perforated by the lymphatic vessels passing to the iliac ganglia; this portion of the fascia lata is more closely connected than any other to the superficial fascia: indeed in structure it resembles the superficial more than the fascia lata, nor are its fibres directly continued from those of the fascia lata; some have, therefore, considered the cribriform fascia as a deep lamina of the superficial fascia; in many cases, however, it has an aponeurotic structure, and appears to be clearly derived from the iliac portion, and inserted into the pubic portion of the fascia lata; it presents much variety in this respect. The *external* or *iliac portion* of the fascia lata is very dense and strong, it is continued from the external surface of the thigh, and is intimately attached superiorly to the spine of the ilium, and to Poupart's ligament; and uniting with the cribriform fascia, is continued in front of the femoral vessels, along with the inferior fibres of Poupart's ligament, and is inserted along with these into the linea innominata, thus assisting to form the external part or the base of Gimbernaut's ligament. If the cribriform fascia be removed along with the superficial fascia, then the iliac portion of the fascia lata will present the appearance of a *crescentic* or *falciform process*, extending across the femoral vessels, the concavity of which process will look downwards and inwards: the inferior cornu joins the external cornu of the saphenic opening, and the superior cornu is inserted along with the posterior fibres of Poupart's ligament, or Gimbernaut's ligament, into the linea innominata, on the internal border of the crural ring; although this crescentic process appears to present a defined edge, yet if the latter be examined closely it will be found reflected backwards on the sheath of the vessels and on the muscles, in the same manner as the apparent edge at the lower part of the saphenic opening.

Next direct your attention to the internal surface of the crural arch, and to the connexion between it and the deep fasciæ of the abdomen, viz. the transversalis and iliaca; divide the fascia transversalis from the spine of the ilium towards the rectus muscle; dissect it carefully down from the peritonæum, then push up this membrane, together with the cæcum or sigmoid flexure of the colon, out of the iliac fossa, to which they are connected by very loose cellular membrane; we thus obtain a view of the internal surface of Poupart's ligament, and of the parts which pass beneath it, and which naturally fill the space or cavity of the crural arch: first, observe the fascia transversalis attached to the inner lip of the ilium and to Poupart's ligament from the spine of that bone, as far as the pubis, into the linea innominata of which it is inserted; here also it is inseparably joined to the conjoined tendons of the internal oblique and transverse muscles; as this fascia is passing anterior to the iliac or femoral vessels, a portion of it extends beneath Poupart's ligament, in front of these vessels, so as to form the *anterior part of their sheath;* this process of the fascia transversalis soon becomes thin and indistinct, and is lost in the cribriform part of the fascia lata. The *fascia iliaca* is a tolerably strong aponeurosis; it covers the iliac and psoas muscles, passes behind the iliac vessels, and adheres to the upper margin of the pelvis; externally it is connected to the inner edge of the ilium, and inferiorly it is attached to Poupart's ligament, and to the fascia transversalis, from the spine of the ilium as far inwards as the iliac artery; here it presents a semilunar edge, separates from Poupart's ligament, and from the fascia transversalis, passes behind the femoral vessels, forms the *posterior part of the sheath*, adheres to the pubis, and to the capsule of the hip joint, and is connected to and continuous with the pubic or pectinæal portion of the fascia lata. The fasciæ transversalis and iliaca may be compared to a funnel, containing in the superior wide portion the peritonæum and its contents, and enclosing in the inferior narrow part, or pipe, the femoral vessels, and one or two lymphatic ganglia; of this funnel the fascia transversalis forms the anterior, and the fascia iliaca the posterior wall; these fasciæ may now be seen to be perfectly continuous with each other, between the vessels and the spine of the ilium, different names only being applied to differant portions of one extensive aponeurosis; as the iliac and transverse fasciæ are continued one into the other, external to the iliac artery, a white line may be observed; this is the circumflex ilii artery enclosed in a sort of canal between these fasciæ and Poupart's ligament, to which these aponeuroses are united.

The student should next consider how the space, commonly called the crural arch, is naturally filled; that portion of it between the spine of the ilium and the iliac or femoral artery is occupied by the psoas and iliac muscles; imbedded between these muscles is the anterior crural nerve; on the pubic side of these muscles is the femoral artery, next to which is the femoral vein, and at a little distance to the pubal side of this vessel is Gimbernaut's ligament, which closes the internal part of this space; thus, almost all the crural arch is filled, except a small portion between the femoral vein and the third insertion of Poupart's ligament; this space is the *femoral or crural ring;* this is somewhat of a triangular form, the base, externally, is the femoral vein, the apex internally is Gimbernaut's ligament; it is bounded anteriorly by Poupart's ligament, and by the superior fibres or cornu of the falciform process of the fascia lata, and posteriorly by the pubis, covered by the pectinæal muscle, and by the pectinæal portion of the fascia lata; the spermatic cord or the ligamentum teres lies on the anterior boundary of this opening. Gimbernaut's ligament prevents femoral hernia occurring internal to this space, which is the only part in the crural arch where a hernia can descend, and even here this accident is in a great degree guarded against, as a lymphatic ganglia generally occupies this situation, and a layer of condensed cellular membrane extends across the opening; this must be carried down before the hernial sac, so as to form a covering for it, and hence it has been named the *fascia propria;* this fascia, though often weak and indistinct in the natural and healthy state, becomes very thick and strong in cases of old femoral hernia: the fascia propria may be described as arising thin and delicate from the fascia iliaca on the external side of the iliac vessels; passing over these vessels it descends internally into the pelvis; inferiorly it is continued along these vessels to Poupart's ligament, covers the femoral ring, and then ascending is lost on the inner surface of the fascia transversalis. Crural hernia cannot occur external to the ring, as there the femoral vessels fill up the space, and strong partitions pass from the fascia transversalis to the fascia iliaca on the inner side of the vein, and between it and the artery; these septa prevent the distention of the sheath; the fascia propria also rounds off the angle between the fascia transversalis and the forepart of the vessels, and prevents a hernia occurring in front of the artery or vein; external to these vessels the crural arch is completely closed by the close connexion between the fasciæ transversalis and iliaca and Poupart's ligament, in front of the psoas and iliac muscles. *Femoral hernia* then can occur only at the femoral or crural ring; this disease is more frequent in the female than in the male, the crural arch and ring being larger in the former than in the latter; femoral hernia descends through a sort of canal which commences at the crural ring, and ends at the saphenic opening in the fascia lata, through which the sac protrudes; the hernial sac in descending carries before it the fascia propria, descends in the sheath of the vessels along the inner side of the vein, and may remain in this situation for a considerable time; as the tumour increases in size it bursts through the sheath, and either tears or dilates some opening in the cribriform fascia, and then turns forwards into the groin; if the tumour increase still further, it is found to turn upwards over Poupart's ligament, and to rest on the lower part of the tendon of the external oblique; the form of the crural ring, the course of the superficial epigastric vessels, and the close connexion between the superficial and cribriform fasciæ account for its ascending in this manner. If we dissect off the integuments from a femoral hernia of long standing, we shall find beneath them the superficial fascia so increased in thickness and vascularity as to present a compact and almost fleshy-like appearance; when this shall have been divided, the tumour can be brought down off the abdomen into the groin, and will be found covered by a dense and smooth capsule, which often presents a glossy appearance; this is the fascia propria; in dissecting off this, it will in general be found to consist of several laminæ, which sometimes separate so easily and appear so distinct as to lead an inexperienced operator to suppose that the hernial sac itself is exposed. These then are the coverings of the sac, which is thus placed external or superficial to the fascia lata: the neck of the sac, however, it is to be recollected, lies deep within the sheath of the vessels, and is, therefore, covered by the fascia transversalis, and by the superior cornu of the falciform process of the fascia lata. Let the student now review the dissection that has been made; let him move the thigh in different directions, and he will remark that, when it is rotated inwards, Poupart's and Gimbernaut's ligaments, as well as the fascia lata feel relaxed, and that the crural ring will feel larger or more dilatable; let him also observe the relation of the femoral vein, the epigastric vessels and the spermatic cord or round ligament to this opening; pass up the finger from the groin into the crural ring, and suppose that the stricture on femoral hernia was seated here, and that this opening required to be dilated, he will now perceive that this may be done with most safety by directing the edge of the bistoury forwards and a little inwards, so as to divide the external edge or base of Gimbernaut's ligament, which edge is composed of the insertion of the superior cornu of the falciform process of the fascia lata; the stricture on femoral hernia may, however, be seated lower down than in the neck of the sac; it may be situated in that opening of the cribriform fascia through which the hernial sac has protruded; in such a case, the stricture may be divided by directing the edge of the knife directly inwards along the surface of the pectinæus muscle

The following measurements of the parts engaged in, or referred to in the foregoing account of the anatomy of the inguinal and femoral herniæ have been extracted from Cooper's valuable work on Hernia, and have been sanctioned by several other writers on the same subject: I have tested these very frequently, and though I can bear testimony to their general accuracy, I must observe, I have found deviations to have occurred so frequently, and in cases where there was no *a priori* reason to expect such, that I do not consider these numbers as facts of much value, or of any material practical importance.

	Male.	Female.
From the symp. pubis to the ant. sup. spinous process of the ilium, - - - - - - - - -	$5\frac{3}{4}$ in.	6 in.
to the tuberosity of pubis, - -	$1\frac{1}{3}$	$1\frac{1}{4}$
to the inner margin of ext. abdominal ring, - - - -	$0\frac{7}{8}$	1
to the inner edge of internal abdom. ring, - - - - - - -	3	3
to the middle of iliac artery,	$3\frac{1}{4}$	$3\frac{1}{4}$
to the middle of iliac vein, -	$2\frac{7}{8}$	$2\frac{3}{4}$
to the origin of epigastric artery, - - - - - - - - -	3	$3\frac{1}{4}$
to the epig. art. on the inner edge of ext. abdom. ring, -	$2\frac{3}{4}$	$2\frac{5}{8}$
to the middle of lunated edge of fascia lata, - - - - -	$3\frac{3}{4}$	$2\frac{3}{4}$
to the middle of crural ring, -	$2\frac{1}{4}$	$2\frac{1}{4}$
From ant. edge of crural arch to saphena major vein, - - - - -	1	$1\frac{1}{4}$
From symp. pubis to centre of orifice of femoral hernial sac, - -	2	$2\frac{1}{4}$
From centre of orifice of do. to external iliac artery, - - - - - -	1	$1\frac{1}{4}$
to centre of ext. iliac vein, - - - - - - -	$0\frac{1}{2}$	$0\frac{3}{4}$
to origin of epigastric artery, - - - - -	$0\frac{3}{4}$	1
to inner edge of int. abdominal ring, - - -	1	$1\frac{1}{4}$
From tuberosity of pubis to centre of orifice of fem. hernial sac, .	1	$1\frac{1}{4}$

(*Anat. and Surg. Treatment of Abdom. Hernia, by* Sir A. COOPER, Bart., *2nd. edit. by* C. A. Keys.)

SECTION II.

DISSECTION OF THE VISCERA OF THE ABDOMEN.

THE abdomen is the largest cavity in the body; it is of an oval form; its capacity, and in some degree its figure, differ at different ages and in different subjects; it is bounded superiorly by the diaphragm, anteriorly and laterally by the abdominal muscles, inferiorly by the true and false pelvis, and posteriorly by the lumbar vertebræ, the crura of the diaphragm, and the psoæ and quadrati lumborum muscles. Although the expression "cavity of the abdomen" is in common use, it is not correct, for during life there is no cavity, as the diaphragm and abdominal muscles by their alternate action keep up such a constant and uniform pressure on the viscera, that these and the parietes are always in perfect contact. The abdomen contains the peritonæum and the organs of digestion; the kidneys, renal capsules and ureters; also the thoracic duct, the sympathetic nerves, the aorta, vena cava, and the numerous branches of these vessels. The abdomen is generally divided by writers into nine, but by some into twelve regions; by drawing two transverse lines, one between the extremities of the cartilages of the ninth ribs, and the other between the anterior superior spinous processes of the ossa ilii, we may define three regions; the *epigastric* above, the *umbilical* in the middle, and the *hypogastric* below; and then by drawing a vertical line on each side from the extremity of the ninth rib to the anterior superior spinous process of the ilium, we shall subdivide each of these regions into three parts: the three divisions of the epigastric region are the *epigastrium*, or scrobiculus cordis in the centre, and the *right* and *left hypochondriac regions* on either side: the epigastrium is immediately below the ensiform cartilage, and the hypochondriac regions are covered by the false ribs; the lateral portions of the *umbilical* division are the *lumbar regions;* the middle of the hypogastric region is the *hypogastrium*, and the lateral portions are the *iliac regions;* the lower part of the hypogastrium is called by some the *pubic region*, and the lower part of each iliac division is called *inguinal region*, or more properly *spermatic*, (the term inguinal being commonly applied to the upper and anterior part of the thigh,) and contains the iliac vessels, and in the male the spermatic cord, and in the female the round ligament of the uterus.

The viscera, which constantly or occasionally occupy the regions of the abdomen will be seen when the peritonæal cavity has been opened, and with these the student should make himself familiar, as this knowledge may be of practical importance in cases of wounds penetrating this cavity, or in making an examination during life to detect any suspected organic disease. Dissect the abdominal muscles off the peritonæum; these can be easily separated laterally and inferiorly; but anteriorly, particularly near the umbilicus, it will be found very difficult to detach the sheath of the rectus from this membrane. The external surface of the peritonæum, which is thus exposed, appears rough and cellular, from its connexion to the superincumbent muscles; three ligamentous cords are seen extending along it anteriorly and inferiorly, from the summit and sides of the urinary bladder towards the umbilicus; the central one of these is the remains of the urachus, and that on each side is the obliterated umbilical or hypogastric artery; anteriorly and superiorly we perceive another ligamentous substance, ascending from the umbilicus obliquely backwards, and to the right side; this is the remains of the umbilical vein; it is at first placed between the peritonæum and the muscles, but it soon sinks deep towards the liver, carrying around it a fold of peritonæum, named the suspensory ligament of the liver, which will be seen when the peritonæum is opened; the epigastric vessels also may be observed ascending from each inguinal region, and branches of the internal mammary arteries descending on the surface of this membrane. Next open the peritonæum by an incision from the ensiform cartilage to the umbilicus, and from this point carry another on each side obliquely downwards, to the spine of the ilium: on throwing down the inferior flap thus formed, we remark on its internal surface the projections of the three ligamentous cords which were before noticed as ascending from the bladder to the umbilicus; we may also remark how the external of these cords, or the obliterated umbilical artery on each side, throws the lower part of the peritonæum into pouches, two on each side, the *external* and *internal inguinal pouches* or *fossæ*; the former lies between the ilium and the obliterated hypogastric vessels, the latter between this cord and the fundus of the bladder. The external pouch is large and very concave internally, and appears to protrude towards the inguinal canal: the existence of this pouch may conduce to the production of oblique inguinal as well as of femoral hernia: the internal pouch lies behind the external ring, and becomes protruded in direct or ventro-inguinal hernia. When the peritonæum has been fully opened, we perceive its inner surface smooth and polished like all serous membranes, and filling its cavity we see the numerous digestive organs; these, though apparently within this bag, are really behind it, and only protrude the posterior side of this large sac into the cavity; nothing is contained within the peritonæum but the serous fluid, which is constantly exhaled, for the purpose of lubricating its opposite sides. We also obtain a partial view of the following organs, which in general occupy the same situation during life as we perceive them now to hold. Filling the right hypochondrium is the liver, with the fundus of the gall bladder projecting a little below it. In the epigastric region we see a portion of the liver also, resting on the stomach, and below it we see the pylorus and the commencement of the duodenum;

in the left hyponchondrium lie the spleen and great extremity of the stomach; in the right and left lumbar regions we find the colon, ascending through the former, and descending through the latter, behind which is each kidney; the duodenum also partly occupies the right lumbar region; through the proper umbilical region the transverse colon runs, not fixed, however, in any particular part of it, and from this intestine we perceive the great omentum descending towards the lower part of the abdomen, presenting, however, very different appearances in different subjects: in some being expanded over the small intestines, so as nearly to conceal them; in others being coiled up into a narrow fold, and often concealed in some recess between the surrounding viscera: the convolutions of the jejunum and ileum intestines occupy the lower part of the umbilical, and extend indifferently into the hypogastric, and iliac regions; the cæcum or caput coli is fixed in the right, and the sigmoid flexure of the colon in the left iliac fossa; the rectum and other pelvic viscera occupy the hypogastric regions, but will of course change their own situation as well as that of the small intestines, according as they are contracted or distended. The student may next examine the anatomy of the *peritonæum;* this is the largest serous sac or membrane in the body; it lines the abdominal muscles, and covers almost all the abdominal viscera; that portion which adheres to the parietes is called the *parietal*, and that covering the viscera the *visceral layer*. The peritonæum is a shut sac, and therefore, when opened presents one continued surface, which may be traced throughout the whole extent without any interruption; it covers the viscera in such a manner that they lie external or posterior to it; the familiar example of the double night-cap on the head has been, not unaptly, adduced, to explain how the viscera may be covered by the peritonæum, and yet really lie beneath it or behind it. Let us now trace this membrane through its entire extent, commencing at the umbilicus; from the transverse incision that was made into it in this situation, we may perceive it to ascend on the internal surface of the transverse and recti muscles, as high as the margin of the thorax; then bending back, it adheres to the inferior surface of the diaphragm, and continues very far back on this muscle, particularly in the left hypochondrium; from the diaphragm it is reflected on the spleen on the left side, on the stomach in the centre, and on the liver on the right side; it is also reflected on this last named viscus by a distinct fold, the falciform or suspensory ligament, from the umbilicus, and from the abdominal muscles on the right side of the linea alba; as the peritonæum is reflected from the diaphragm on each side of these organs in the epigastric and hypochondriac regions, it forms folds, which to a certain extent serve as ligaments; these will be noticed more particularly in the examination of the individual viscera.

Having covered the organs in the upper division of the abdomen, it is continued downwards in the following manner: having invested both surfaces of the liver as far as its transverse fissure; it is conducted along and around the vessels of this gland towards the lesser curvature of the stomach; this fold, which thus surrounds the hepatic vessels, is called the lesser or the gastro-hepatic omentum; it is also sometimes named the capsule of Glisson; at the lesser arch of the stomach the two laminæ of this process separate to enclose the stomach, the posterior layer giving a serous covering to the back part of this organ, and in like manner the anterior layer covering its anterior surface, on which it is continuous with that portion of peritonæum which has descended from the diaphragm, and with that which is also continued from the spleen to the stomach. The peritonænm having thus enclosed the stomach and its vessels between the two layers of the lesser omentum, we next observe that these laminæ having passed the great curvature of the stomach touch each other, and being joined by the peritonæum from the lower end of the spleen, descend under the name of the gastro-colic or the great omentum, to the lower part of the abdomen: in general it descends lower on the left side than on the right; it then turns on itself, and ascends obliquely backwards to the arch of the colon, along the convex edge of which its laminæ separate to enclose this intestine and its vessels; along the concave edge of the colon these laminæ again unite, and increasing in density form that process which is called the transverse meso-colon, which passes backwards to the spine: opposite the duodenum this process separates into an ascending and descending layer; the inferior division of the duodenum lies between these; the ascending layer proceeds in front of the lower and middle divisions of the duodenum, up to the back part of the right lobe of the liver, where it becomes continuous with the peritonæal tunic of that viscus and with the posterior layer of the lesser omentum which is descending along the back part of the hepatic vessels. The descending layer of the transverse meso-colon expands into each lumbar region, in which it attaches the lumbar portions of the colon by a duplicature called the right and left lumbar meso-colon; in the centre the inferior layer of the transverse meso-colon adheres to the vertebral column, and to the great vessels which lie upon it, and is thence reflected forwards and downwards, over the small intestines and their vessels, and returns around these to the spine, thus forming a very important and remarkably folded or plaited process named the mesentery. From the inferior surface of the mesentery the peritonæum extends into either iliac region, and descends into the pelvis in the middle; it serves to connect the cæcum in the right, and the sigmoid curve of the colon in the left iliac fossa; in the pelvis the peritonæum descends around the rectum, forming the process named the meso-rectum; opposite the lower third of the sacrum, it is reflected to the lower and back part of the bladder, and in the female to the upper and back part of the vagina, from which it ascends on the uterus, and forms on each side of this organ the broad ligament which supports the Fallopian tube and the ovary; the peritonæum is then reflected from the fore part of the uterus to the back of the bladder, ascends, both in the male and female, along the posterior surface and sides of this viscus to its superior fundus, from which, and from the iliac fossæ, it is continued to the abdominal muscles; forms the inguinal pouches, and may then be traced on the inner surface of the recti and transverse muscles up to the umbilicus, where the sac was opened. The different folds which the peritonæum forms in this course are termed processes, the principal of which, in addition to the ligaments of the several organs, which shall be noticed in the description of the latter, are the lesser omentum, the great omentum, the splenic omentum, the colic omentum, the appendices epiploicæ, the transverse, and the right and left lumbar meso-colons, the mesentery, meso-cæcum and meso-rectum.

The *lesser* or *gastro-hepatic omentum* consists of two laminæ, which extend from the transverse fissure of the liver to the lesser curvature of the stomach and to the upper part of the duodenum; it contains between its layers the vessels of the liver, viz. the hepatic artery to the left side, the ductus choledochus to the right, and the vena portæ behind and between both; at its connexion to the stomach, it encloses the coronary vessels of this organ; the lesser omentum lies anterior to the foramen of Winslow; this omentum seldom contains much fat.

The *great* or *gastro-colic omentum* also consists of two laminæ, which descend from the lower end of the spleen, and from the anterior and posterior surface of the stomach; between these laminæ are several long and tortuous vessels, descending from the vessels of the stomach, and some adipose substance, the quantity of which varies very much in different subjects; the great omentum descends in front of the large and small intestines to the lower part of the abdomen, in general lower on the left than on the right side; (this explains the reason why the omentum is more frequently found in a hernial sac on the left than on the right side;) it then turns upwards and backwards until it reaches the transverse arch of the colon; that portion of omentum, therefore, which is inferior to the colon, consists of four laminæ, two descending and two ascending; these, in the young subject, can be separated from each other, and a distinct cavity can be seen between them; this is part of the cavity or bag of the omentum which communicates with the general cavity of the peritonæum by the opening of Winslow, and which will be more particularly described presently; at the arch of the colon the two ascending laminæ of the great omentum separate to enclose this intestine, and again uniting, form the commencement of the following process.

The *transverse meso-colon* extends from the concave border of the arch of the colon backwards to the spine; this process is very strong and dense, it encloses the vessels of the colon and forms a sort of division or partition in the abdomen between the epigastric and umbilical regions; when the transverse meso-colon has arrived at the spine, its two laminæ separate, one descends, the other ascends; the descending layer is very strong, expands laterally into the right and left lumbar regions, in each of which it is reflected either partially or perfectly around the ascending and descending colon, and thus forms a short fold or process very irregular in different subjects, termed the *right* and *left lumbar meso-colons;* the inferior or descending layer of the transverse meso-colon is continued obliquely downwards in the middle line to form the mesentery, a process which we shall trace when we have pursued the superior or ascending layer of the meso-colon to its termination. This lamina is thin and delicate; it ascends in front of the inferior and middle portions of the duodenum, and of the pancreas; it also covers the aorta and vena cava, and continues along this latter vessel to the liver, on the Spigelian lobe of which it expands, and on it and on the right lobe, behind the foramen of Winslow, it becomes continuous with the peritonæum, which has been reflected on the back part of the liver from the diaphragm. As this ascending layer proceeds in front of the pancreas, it is continuous on each side with the posterior layer of the lesser omentum which covers the back part of the stomach. The ascending layer may be best seen and traced by dividing the great omentum a little below the stomach, and raising this organ towards the thorax; we shall thus lay open the cavity of the omentum, and shall be able to trace the parieties of this bag through their whole extent.

The *cavity of the omentum* extends from the transverse fissure of the liver superiorly, to the lower border of the great omentum inferiorly; it is bounded anteriorly by the lesser omentum, the stomach, and the anterior or descending portion of the great omentum; inferiorly it is formed by the great omentum turning on itself; and posteriorly it is bounded by the ascending portion of the great omentum, by the colon, by the transverse meso-colon, and by the superior or ascending layer of this process, which terminates at the liver. The cavity of the omentum communicates with the general peritonæal cavity through the foramen of Winslow; this opening is situated in the lower part of the right hypochondriac region just above the right lumbar; it is somewhat oval, bounded anteriorly by the lesser omentum and by the hepatic vessels, posteriorly by the termination of the ascending layer of the meso-colon which invests the vena cava, superiorly by the lobulus caudatus of the liver, and inferiorly by the superior portion of the duodenum; if the membrane composing the omenta be perfect, and if air be forced through this opening, it will descend behind the stomach, and will inflate the omental cavity; the great omentum, however, in general is so cribriform that this experiment cannot be performed; the principal use of this cavity is most probably to afford a serous surface or cavity for the stomach to move or to distend into posteriorly during the progress of digestion.

The *splenic omentum* extends from the fissure in the spleen to the great end of the stomach, and is continuous inferiorly with the great omentum; the splenic vessels and the vasa brevia are contained between the laminæ of this process.

The *colic omentum* is a fold of peritonæum which descends from the upper part of the right or ascending colon; it generally lies posterior to the great omentum; it is composed of two laminæ, between which are contained blood-vessels and adipose substance.

The *appendices epiploicæ* are attached all along the large intestine; but principally to the transverse arch of the colon; they are small prolongations of the peritonæum, filled with a soft fatty substance; they are never found attached to the small intestine; they vary very much in different subjects in number and size; their use is not ascertained.

The *mesentery* is the largest and most remarkable process of the peritonæum; it is continuous with the descending layer of the meso-colon, and extends from the left side of the second lumbar vertebra obliquely downwards to the right iliac fossa; this is the root of the mesentery; from this it expands very much, and is folded round the jejunum and ileum intestines, and then returns again to the spine or to the inferior surface of the root; the laminæ of the mesentery can be easily separated; between them we find the mesenteric arteries, veins and nerves, also numerous absorbent vessels and ganglia; the mesentery serves to support the convolutious of the small intestines and the numerous vessels passing to and from these.

The *meso-cæcum* is a fold of peritonæum which attaches the cæcum to the right iliac fossa; this process, however, is frequently imperfect; the posterior portion of this intestine being sometimes deprived of a serous coat, and connected to the iliac muscle by cellular membrane.

The *meso-rectum* is a short fold of peritonæum which connects the superior portion of the rectum to the upper and anterior part of the sacrum; it encloses the hæmorrhoidal vessels and nerves.

The viscera of the abdomen are the digestive and urinary organs; the former we shall examine first; they may be divided into the membranous and glandular. The membranous viscera are the stomach and intestinal tube; the latter is divided into the small and large intestine; the small intestine is subdivided into the duodenum, jejunum, and ileum; the large intestine into the cæcum, colon, and rectum. The glandular viscera are the liver, spleen, and pancreas. We shall consider the membranous viscera first, and commence with the description of the *stomach*, which is the most important part of the digestive apparatus, the principal change in the food being accomplished in this organ.

The *stomach* is placed between the œsophagus and the duodenum, and communicates with both; it is situated in the left hypochondriac and epigastric regions, and a small portion of it extends into the right hypochondrium; from the left side it passes across the epigastric region, obliquely downwards and forwards, and near its right or pyloric extremity it bends a little upwards and backwards. The stomach is connected to the diaphragm by the œsophagus and by the peritonæum; to the spleen by the splenic omentum; to the liver by the lesser omentum, and to the arch of the colon by the great omentum. If the stomach be moderately distended with air or fluid, its form and connexions can be better understood; it will then appear somewhat of a conical figure, the base to the left side, the apex to the right, the intermediate part being somewhat curved; it will present two extremities, the left and right;

two orifices, the cardiac and pyloric [or œsophageal and duodenal ;] two surfaces, an anterior or superior, a posterior or inferior ; and two curvatures or edges, the lesser or concave, the greater or convex. The *left* or *splenic extremity* is very large, swells into the left hypochondrium beneath the ribs, so as nearly to conceal the spleen ; the right or *pyloric extremity* is much smaller, is cylindrical and slightly convoluted like an intestine ; it lies anterior and inferior to the left or splenic end, and extends to the fundus of the gall bladder or to the edge of the lobulus quadratus of the liver ; it sometimes descends into the umbilical region. The *cardiac orifice* is the highest point of the stomach ; it is situated between the left or great end and the lesser curvature, about three inches distant from the former ; it is surrounded by vessels and nerves.

The *pyloric orifice* is between the stomach and the duodenum ; it lies to the right side of the spine ; it is, in general, in contact with the liver and gall-bladder, and anterior to the pancreas ; it lies inferior, anterior, and to the right side of the cardiac orifice ; it has a peculiar firm, hard feel. The *anterior surface* looks upwards aud forwards, and is in contact with the diaphragm, the ribs and the left lobe of the liver. The *posterior surface* looks backwards and downwards, and rests on the meso-colon. The lesser, or *concave edge* of the stomach, looks backwards and upwards towards the spine and lobulus Spigelii of the liver ; this edge, near the pylorus, is convex, the great edge being concave opposite to this ; the lesser omentum is attached to it, and the coronary vessels run along it. The *great* or *convex edge* looks forwards and downwards towards the colon ; to it the great omentum and the epiploic vessels are attached : in the empty or contracted state of the stomach, these edges are thin and directed almost vertically, but when the stomach is distended, they become enlarged and round, and continuous with the surfaces.

The stomach is composed of *three tunics*, a serous, a muscular, and a mucous ; these are connected to each other by two laminæ of cellular membrane ; the *serous* or *peritonæal coat* is derived, as was before explained, from the laminæ of the lesser omentum, separating at the lesser curvature, expanding over its surfaces, and uniting along the convex edge, to form the great omentum : the serous coat is loosely united to the edges, but almost inseparably so to the middle of each surface and to the pyloric extremity ; a layer of very fine cellular tissue connects this to the following tunic, the *muscular ;* this consists of fibres, which run in three different directions ; the first or superficial are longitudinal ; they are continued from the œsophagus, and are very strong along the curvatures, particularly on the lesser; the middle layer of fibres run circularly; they commence at the left extremity, or *cul de sac*, and are arranged in nearly parallel rings; they are very strong about the centre, where they often cause a constricted appearance around the stomach, as if dividing it into two portions; the circular fibres again increase in thickness as they approach the pylorus: these fibres do not form perfect circles; the extremities of each fasciculus turn obliquely to one side; the third set of fibres take a very irregular or oblique direction; they are most distinct on the great end, or *cul de sac*, and appear as a continuation of the circular fibres of the œsophagus. Beneath the muscular tunic is the second lamina of cellular tissue, which contains the minute divisions of the nerves and vessels of the stomach, and has been, by some, called the nervous coat of the stomach. The *internal*, or *mucous* or *villous* coat is very soft, and of a pale red or rose colour, sometimes interspersed with such very vascular patches as might lead the inexperienced to mistake them for the effects of inflammation: in order to examine this tunic of the stomach, this organ should be removed from the subject, everted and washed. This membrane will be found covered with a viscid fluid, and thrown into numerous rugæ, and will appear very different from that lining the œsophagus; at the pylorus it forms a circular fold, [the *phylosie valve*] which is thin and floating; external to this is a circular fasciculus of muscular fibres, which have a peculiar dense feel: this fold of mucous membrane narrows the opening into the duodenum, and when assisted by the surrounding muscular fibres, can perfectly intercept the passage from the stomach into the intestine; in the cellular tunic, external to this membrane, particularly along the curvatures, are many small mucous glands, which open on the mucous surface; these are the *glandulæ Brunneri:* the mucous coat of the stomach secretes the fluid called the gastric juice, which is generally believed to have the remarkable properties of being powerfully solvent and anti-putrescent. In the stomach the food undergoes the first important change in digestion, being here converted into a soft homogeneous pulpy mass, called chyme.

[Cases have been recorded of double and even triple stomachs, in the human subject; but this appearance is deceptive, and is merely the result of a contraction of the organ at one or more points of its circumference, dividing it into separate compartments. The, volume of the organ differs very much in different individuals, and in the same individual under different circumstances. The average capacity of the adult stomach in a medium state of distension is probably from two to three pints; this capacity however may be doubled, or tripled by distension: as compared with the inferior animals, the human stomach is smaller than that of the herbivorous, and greater than that of the carnivorous animals, which is one of the arguments in favor of the opinion that man is omnivorous. The lower part of the stomach sometimes presents a remarkably sacculated appearance without evidence of disease.]

The *duodenum* is the next portion of the alimentary canal; this is the first and shortest division of the small intestines; it extends from the pylorus to the root of the mesentery, where the jejunum commences; it lies partly in the right hypochondriac, and partly in the right lumbar and in the umbilical regions; it takes a semicircular course around the head of the pancreas: this course may be divided into three parts; the first, or superior transverse; the second, or perpendicular, and the third or inferior transverse. The *superior transverse portion* ascends from the pylorus obliquely backwards and to the right side, beneath the edge of the liver, so as to touch the gall-bladder; here the intestine makes a sudden turn, (the superior angle,) and the *middle* or *perpendicular portion* of it commences; this descends in front of the right kidney, as low as the third lumbar vertebra, where it makes a second turn (the inferior angle) from which the *inferior transverse portion* extends obliquely upwards, and to the left side, and at the first lumbar vertebra ends in the jejunum. The duodenum differs from the remainder of the small intestine, in being fixed in its situation, and being only partially covered by the peritonæum, and being of much larger calibre, particularly near the inferior angle; its muscular coat is very strong, and the valvulæ conniventes very numerous and large. The superior transverse portion is more contracted than any other part of it; it is covered on both surfaces by the peritonæum like the stomach, and is, therefore, more moveable than the rest of the intestine. The perpendicular portion is concealed by the omentum, and by the colon, and is covered by the ascending layer of the mesocolon; this portion lies on the right kidney, and on the vena cava, and has no peritonæum posterior to it; it is, therefore, fixed, and is dilatable; the biliary and pancreatic ducts perforate the inner side of this division of the duodenum; these pass through its coats very obliquely, and open into the intestine, sometimes distinctly, and at other times conjointly, on a small papilla, opposite the inferior angle. The inferior transverse part of the duodenum passes across the aorta and the right renal vessels; like the middle portion, it is only partially covered by the peritonæum, being placed between the layers of the meso-colon; its lower border may be seen without dissection, projecting through the inferior layer of the meso-colon; the superior mesenteric vessels pass in front of the termination of this part of the duodenum, and appear to compress it against the aorta, so as to retard the passage of its contents into the jejunum. In the duodenum, the chyme is mixed with the biliary and pancreatic fluids, and a separation takes place between the chyle and the excrementitious part of the food.

The *jejunum* and *ileum intestines* are covered by the omentum: if we raise this process and the arch of the colon, and place them on the edge of the thorax, the convolutions of these intestines will be seen in the umbilical, hypogastric, and iliac regions; convex anteriorly, concave posteriorly, and attached to the mesentery; the jejunum commences in the left lumbar, and the ileum ends in the right iliac region. There is no exact division between these two intestines; the upper two-fifths are named the jejunum, and are placed higher in the abdomen than the ileum, which is the name given to the three remaining fifths. The jejunum is redder, feels thicker, and is larger than the ileum, which is pale and thin: these differences are striking when we compare the commencement of the jejunum with the terminating portion of the ileum; in the intermediate space, however, they are gradually lost; they depend on the greater vascularity and number of valvulæ conniventes in the jejunum than in the ileum.

The *large intestine* forms about one-fifth of the intestinal canal, and is subdivided into the cæcum, colon, and rectum; the large intestine differs from the small not merely in size, but in having a peculiar cellular and sacculated appearance, particularly when distended; small processes also (the appendices epiploicæ) are attached along its whole course: three strong muscular bands, running in a longitudinal direction, may also be observed, chiefly in the cæcum and colon, they appear to pucker the large intestine, so as to give it the cellular structure before mentioned: these bands, in addition to a muscular property, possess some elasticity also; in some animals indeed they are decidedly elastic. The large intestines are paler than the small, and much thinner, having but few valvulæ conniventes.

The *cæcum*, or *caput coli*, is situated in the right iliac fossa, in which region it is fixed by the peritonæum, which in general covers it only anteriorly and laterally, while cellular membrane connects it posteriorly to the iliac and psoas muscles; in some, however, the peritonæum covers this pouch all round, and connects it to the iliac fossa loosely by a process named the meso-cæcum; it is always covered anteriorly by the abdominal muscles, and sometimes by the convolutions of the ileum; it lies beneath the right kidney, and is continuous with the ileum and the colon. The cæcum is somewhat triangular, the apex below, the base above at the colon, on its external surface are three irregular protuberances, one anteriorly, and two posteriorly; from its lower and posterior part a small tortuous process named *appendix vermiformis*, about the size of a goose quill, hangs into the pelvis; it is attached to and communicates with the cæcum just below the ileum; a sort of mesentery connects it in its situation: its use is not ascertained.

[The position of the appendix is by no means invariable; it sometimes lies behind the cæcum, extending up towards the liver, or else projecting beyond the cæcum on its right side; in other cases it lies behind the termination of the ileum, or even in front of it. Intestinal worms have been found in it and it is sometimes ulcerated.]

The ileum joins the left or inner side of the cæcum at a very acute angle; it appears to perforate the latter, the peritonæum and external muscular fibres of the ileum being continued into the corresponding parietes of the cæcum, while the circular fibres and mucous coat of the ileum protrude into the cæcum to form valves, as may be seen by opening the latter in a perpendicular direction, on the opposite, that is, on the right side, and washing out its contents; we then perceive the opening of the ileum, narrow, like a transverse slit, looking obliquely downwards and outwards, towards the right os ilii, and protected by two semilunar folds of mucous membrane, which enclose a few muscular fibres. The inferior fold, or *ileo-cæcal valve*, is the larger, is placed somewhat vertical, and secures the ileum against any matter re-entering it from the cæcum; the superior fold, or *ileo-colic valve* is smaller, and placed rather horizontal; it secures the ileum against regurgitation from the colon; these semilunar folds are united to each other at their extremities, (*commissures*,) and from each commissure a prominent fold is continued round on the inner side of the cæcum; these folds are called the fræna or *retinacula* of these valves, in consequence of which, and of the commissures, the distention of the cæcum closes the ileo-cæcal foramen; the cæcum is provided with the same longitudinal bands as the colon; it has no valvulæ conniventes. The *colon* extends from the cæcum to the rectum; it is divided into four portions, the right or ascending, the middle or transverse arch, the left or descending, and the sigmoid flexure; there is, however, no mark of distinction whatever as to structure between these different divisions.

The *ascending colon* extends from the cæcum to the inferior surface of the right lobe of the liver, which it marks with a superficial depression; this portion of the colon is concave anteriorly, and covered by the peritonæum and by the abdominal muscles; it lies on the right kidney; the duodenum is connected to it internally; the superior extremity is generally tinged with bile from being in contact with the gall bladder.

The *transverse arch of the colon* extends tortuously from the right hypochondrium, across the inferior part of the epigastric or the umbilical region into the left hypochondrium; it is covered by the abdominal muscles, and lies anterior to the small intestines: on the right side it is connected to the liver, in the middle to the stomach and to the great omentum; and its left extremity, which is superior and posterior to the right, is attached to the spleen by peritonæum; the appendices epiploicæ are very numerous on this part of the colon.

The *left* or *descending colon* extends from the spleen to the iliac region, is longer than the right, and is connected to the kidney and psoas by peritonæum and cellular membrane.

The *sigmoid flexure* is connected so loosely in the iliac fossa, that a great portion of it often lies in the pelvis: this part of the colon is partially covered by the small intestines, and connected to the psoas and iliac muscles, to the ureter and spermatic vessels.

The *rectum* extends from the sigmoid flexure of the colon to the anus; it commences opposite the left ilio-sacral articulation, and descends obliquely towards the middle line as far as the lower end of the sacrum: it then bends forwards towards the perinæum, and lastly turning downwards, it ends at the anus. The rectum is connected posteriorly to the sacrum and coccyx by the meso-rectum superiorly, and by vessels and nerves inferiorly; anteriorly the rectum is connected to the peritonæum above, and below, in the male subject, to the inferior fundus of the bladder, the vesiculæ seminales, and the prostate gland: in the female to the uterus and the vagina: along the sides of the rectum is a considerable quantity of cellular tissue, and several vessels, particularly tortuous veins; inferiorly the levatores ani muscles cover the sides of this intestine, and its lower extremity is surrounded by the orbicular and cutaneous sphincters. The rectum is separated from the bladder in the male, and from the uterus in the female by the *cul de sac* of the peritonæum, which may or may not contain some of the small intestine according to the state of the pelvic viscera; the rectum, therefore, is only partially covered by the peritonæum; in the superior third this membrane covers the intestine all around, forming the meso-rectum behind it; in the middle third it is only connected to the fore part, and somewhat to its sides; and to its inferior third it is wholly un-attached. The rectum is also sacculated like the colon, but the cells present a different arrangement in consequence of the peculiar disposition of the lining membrane; it is found in general much dilated about an inch above the anus.

In order to examine the *structure* of the intestinal canal, let the student remove the following portions of intestine, including each part between ligatures, having first distended them with air; a portion of duodenum, of jejunum near its commencement, of ileum near its termination, of the arch of the colon, and of the upper part of the rectum;—first, the duodenum possesses three coats connected to each other by cellular membrane; the peritonæal or serous, the muscular and the mucous; the first has been already mentioned as giving but a partial covering to this intestine; the muscular coat of the duodenum is formed of strong red fibres, which take a circular direction; there are very few longitudinal fibres to be observed along it, except on the superior transverse portion: lay open a part of this intestine, and the internal mucous coat will be found, like that of the stomach, thrown into soft folds which lie nearly parallel to each other in a circular direction; these are named valvulæ conniventes. Second, the jejunum and ileum also possess three tunics and intermediate cellular tissue; the serous or peritonæal coat almost perfectly surrounds them except the small triangular space along the concave side where the vessels and nerves divide, and which space admits of the more easy distention of the intestine; the muscular coat is not so strong as on the duodenum, but more evidently consists of two sets of fibres; the longitudinal are the most superficial, they are very pale and indistinct, except along the anterior or convex side of the intestine; the circular fibres lie beneath these; they are more distinct but also very pale: no fibre passes perfectly round the tube. The mucous coat is paler than in the stomach, and is thrown into numerous folds, particularly in the jejunum; these folds are smaller and less numerous in the ileum; the muscular coat in the latter intestine also is paler and weaker than in the former. The folds of mucous membrane, called valvulæ conniventes, are larger in the jejunum than in the duodenum or ileum; in the first they will be found to be a quarter of an inch deep in some situations; in others, however, much less; they form arches which encircle about three-fourths of the intestine, and end, some in a point, others are forked or pass off obliquely into adjacent folds: these valves are of use in delaying the food in its passage along the canal, thus affording to the absorbents a better opportunity to imbibe all the nutritious matter of the chyle it may contain; in proportion also as the intestine become distended, these valves become more tense, and project into the canal, so as to separate the food into smaller portions, and thus expose the entire mass to the action of the absorbents: on each of these valves are a number of small conical projections called *villi:* when these are examined through a magnifying glass, small pores are observable; these are the mouths of the lacteal or absorbent vessels. Very small mucous glands are attached to the external surface of the mucous membrane of the intestine throughout its whole length; larger glands may be noticed in different situations, some scattered singly, others collected into clusters; the former, or the *glandulæ solitariæ or Brunneri*, are most distinct in the duodenum; the latter, or the *glandulæ aggregatæ* or *Peyeri*, are most obvious in the ileum, particularly near its termination. Third, the large intestine, in some situations, as has been already observed, is but partially covered by peritonæum; this membrane is more loosely connected to the transverse arch of the colon than it is to the small intestine, and is un-attached along two triangular spaces, one along the concave border between the laminæ of the mesocolon, the other along the convex, between the layers of the great omentum; this circumstance favours the distention of the colon. The muscular coat of the large intestine also consists of longitudinal and circular fibres; the former, however, are collected into three fasciculi, all of which commence at the vermiform process, and pass along the cæcum and colon to the rectum: on this intestine the fibres separate, increase in thickness and number, and form a more perfect tunic; near the anus these fibres are confounded with those of the levator ani muscle of each side. The internal or mucous coat of the large intestine is pale, and forms but few and imperfect folds; in the rectum it becomes more vascular and villous, and presents several longitudinal folds, as also three or four very remarkable, in a horizonal direction, these are so disposed, being at intervals and on opposite sides, as to convert the canal into a sort of spiral passage. As the food is propelled along the intestinal canal, the chyle is absorbed by the numerous lacteal vessels to which it becomes exposed; it is also mixed with a quantity of fluid (*succus intestinalis*) secreted by the mucous glands, and by the vessels of the mucous membrane; in the large intestine the food first presents the fæculent properties, and in its passage along this part of the canal, the absorbent vessels continue to take up any chyle that may have escaped the preceding, as well as the watery parts of the food.

The *peritonæum* and abdominal viscera present many *morbid* appearances. *Peritonitis* or inflammation of the peritonæum is denoted by an increased and a reddish vascularity of the membranes, a number of small red vessels can be distinctly seen; it loses its transparency, and becomes somewhat thick and pulpy; the parietal and visceral layers are sometimes found agglutinated by coagulable lymph which also cements the several intestinal convolutions, but sometimes the cavity is filled with serous, or sero-purulent fluid, with shreds of lymph: peritonitis more frequently ends in some such effusion than in the adhesive process, the contrary is more frequent in pleuritis; peritonitis also sometimes exhibits gangrenous patches, but if it have been chronic, adhesive bands and false membranes are very apparent. In *ascites* or dropsy of this membrane, the tissue of the latter appears sound, sometimes remarkably clear or pearly; in this disease, some of the viscera, particularly the liver, are usually found in an anormal state.

The *omentum* is sometimes the seat of general induration, or of particular tumours, adipose, sarcomatous and fungoid. The *stomach* may be the seat of an acute inflammation, or *gastritis*, the coats appear more thick and vascular than usual, and blood is sometimes seen effused between its tunics. *Ulcers* are frequently found in the stomach, of an oval or circular form, with thin and firm edges: independent of disease, the stomach not unfrequently presents considerable red patches on its mucous surface; the coats are also sometimes nearly destroyed in some places, presenting a soft and ragged appearance; this is caused by the gastric fluid digesting or dissolving the coats of the stomach after death. Both the cardiac and pyloric ends of the stomach are the frequent seat of *cancer;* this principally involves the mucous and muscular tissues, on the former, large fungoid masses are thrown out which more or less constrict or obstruct the orifices of the organ, and impair its functions.

The *intestinal tube* is subject to numerous diseases, in most of which the effects of inflammation are more or less visible: inflammation or *enteritis* is denoted by increased vascularity of the mucous surface and thickening of the tunics, in some cases the peritonæum is also engaged; the colour of the intestine is a deep or dark red; acute inflammation sometimes ends in gangrene and effusion, sometimes in ulceration. The whole of the intestinal surface may be the seat of ulceration; in the small intestines, the ulcers are generally small, and are often found in the situation of the mucous glands; in the large intestines the ulceration is usually in larger patches, and in cases of dysentery is often very extensive. The intestinal tunics are occasionally the seat of malignant tubercle, which may obstruct the course of the contents of the tube; of all parts of the intestinal canal the rectum is most frequently the seat of scirrhus and its consequences.

[The gastro-enteric mucous membrane, is of much importance in its pathology, and it is therefore necessary to understand fully its physiological state, as to thickness, consistence and color; the two former as a general rule are in direct ratio, but differ much in different situations. The color also varies much in a state of health, as well as in disease. The entire thickness of the intestinal walls, is less in the lower part of the jejunum, the ileum, and the colon, than in the stomach, duodenum, upper part of the ileum and rectum. The thickness of the mucous membrane is greatest in the duodenum, and next in some parts of the stomach and rectum; in the small intestines its thickness gradually diminishes, from the duodenum to the ileum, in the lower part of which it becomes very thin. In the large intestine, the mucous membrane is thin from its commencement until we reach the middle of the transverse portion of the arch, from which point it increases in thickness as far as the sigmoid flexure, where it is again thin, and lastly in the rectum, it is again nearly as thick as in the duodenum. The mucous coat of the stomach about the œsophagus, and in the great cul de sac, is thin, soft, and can only be separated in shreds, whereas towards the right side, and the pyloric extremity, it is from two to three times as thick, more resisting, and can be separated for a much greater extent: the gastro enteric mucous coat has no epithelium, this ending above at the termination of the œsophagus, and being again found below, near the verge of the anus. As already stated it is a general rule, that the consistence of this membrane is in direct ratio to its thickness; this however is not true of the duodenum, where it is thickest, yet its tenacity is so slight that it can only be raised in fragments. The consistence is greater near the pyloric than the œsophageal portion of the stomach; in the lower part of the jejunum and the ileum its consistence is greater than in the duodenum, while in the large intestine it is again less. The consistence throughout is greater in the adult, than in the fœtus. The color of this membrane varies at different periods of life, and appears to be deep, in proportion to the activity of the arterial development and circulation; accordingly in the fœtus and child, it is of a deep rose color, in the adult it is much whiter, and in the old subject it is of a greyish, or ash color; again the color differs with the state of the system, being deeper in those in strong health, and of the sanguine temperament, than in others in whom the reverse obtains.

The color also is affected by the process of digestion, by which it is changed from a pale pink or almost white, to a deep red almost vermilion hue, the intensity however depending upon the stimulating quality of the food used; this change of color seems to affect the stomach, duodenum, and upper part of the jejunum, while the other portions of the canal are but little altered. The color of the gastro-enteric mucous membrane, depends also upon the kind of death. In those who have died of long continued diseases, it is apt to be of a pale blanched appearance; in persons who die suddenly and from violence, as hanging, drowning &c., it is found of a deep red color. Lastly the color is affected by different substances taken into the stomach, as infusion of logwood, spirits of lavender, nitrate of silver &c., the two former cause a deep red color, the latter a greyish or slate color.

There is also a post mortem redness, of the membrane, depending, upon the accumulation of blood at the more dependent parts. All these facts are of importance in legal medicine. The submucous cellular tissue is so distinct and developed, that it deserves to be considered as a proper tunic, the third coat of the stomach and intestines; it gives great strength and resistance to the organs, and serves as a skeleton for the attachment of the muscular fibres; this coat is very distinct in the purely carnivorous animals, the vessels ramify upon this tunic, before being distributed to the mucous membrane, and the muciparous glands are imbedded in it, although they open upon the surface of the lining membrane. These follicles are more fully developed in children than in adults, and in preparing them may be rendered more distinct by the application of warm vinegar. The single follicles are larger in the duodenum, than in the stomach, in the rest of the small intestines, they are also larger, than in the stomach, but smaller than in the duodenum, or large intestines. The glandulæ agminatæ of Peyer, or *elliptical plates* as they are called from their form, are almost confined to the lower half of the ileum, and vary in number from eighteen to twenty-five; they also vary in size, being from half an inch, and even a fourth, to two inches in length, and from two or three to ten lines in breadth, they are always found along the convex edge of the intestine opposite the attachment of the mesentery, and are entirely wanting in the large intestine. These organs are supposed to be physiologically different from the solitary follicles, because they present certain pathological differences. The plates are found enlarged, prominent, and even ulcerated in phthisis, typhus fever, and scarlatina maligna. The intestines may communicate with the cavity of the peritoneum, either by perforation or laceration, the former of which is the result of ulceration of the coats, the latter of external violence, and may occur without any external marks upon the abdomen: the parts most liable to laceration, are the jejunum and upper part of the ileum. Any of the viscera of the abdomen may be involved in a hernial tumour, but most commonly the omentum, or the lower part of the small intestine is protruded. The small and large intestines are both the seat of intussusception, but the ileum is most liable to it; its extent varies from an inch or two to even three feet, and sometimes the invaginated portion sloughs off and is discharged. There is one form of this affection, which appears to occur in articulo mortis, presenting no signs of inflammation; there may be from one to twelve of these displacements in the same subject, and it may occur in either direction. Earthy concretions, are sometimes found in the alimentary canal, of the human subject as well as of inferior animals; they vary in size from that of a pea to that of an orange, and one case is recorded in which the body weighed four pounds; the number also varies, there being generally but two or three, but sometimes ten or fifteen, they usually exhibit a central nucleus. In the college museum there are two specimens from the inferior animals, (presented by Dr. Sabine of this city, who has a very choice private collection of Morbid Anatomy and Natural History,) one of which taken from the stomach of a horse has for its nucleus, what appears to be a bit of corn cob, its diameter is about four inches, it is formed of concentric laminæ, looks like marble and receives a high polish. The hair balls found in the stomach of the ox, appear to be formed by an accumulation of hair coated over with numerous layers of concrete mucus, which form a complete capsule.

In post mortem examinations of the abdomen, some portion of the intestine, is often seen very much contracted, so as almost to obliterate its cavity and yet no evidences of disease are present, this occurs in coils of the small intestine but more often in the large, in the following order as to frequency, the left part of the transverse portion of the arch of the colon, the descending portion, the sigmoid flexure, and the upper part of the rectum. This condition appears to depend upon the close contraction of the muscular fibres upon the empty intestine. Hemorrhoids, prolapsus ani, fissura ani, and fistula in ano, are all diseases occuring in the lower part of the rectum, and about the anus. Intestinal worms, of different kinds, may be found in the alimentary tube, at almost any point between the mouth and the anus. The existence of worms in the cavity of the peritonæum without perforation or laceration, was demonstrated to me a year since, in the post mortem examination of a horse, which died of acute pleuritis. These worms were found principally on the peritonæal covering of the liver, but were moving freely in the cavity; there were from ten to fifteen of them varying in length from two and a half or three, to six inches, and from one to two lines in diameter. There was no evidence of disease about the peritonæum; I am not aware that any thing of this kind has been seen in the human subject. Anomalies not unfrequently occur, in the development of the alimentary canal, and many of them are analogous, to the natural conformation of inferior animals. The large intestines are sometimes entirely wanting, the ileum ending in a blind cul de sac; sometimes the rectum only is wanting, at others, the anus is simply imperforate. The rectum sometimes terminates in the bladder, in the vagina or in the urethra; in a case of the latter kind which occured in a male child, the subject lived one year, and then died from inflammation arising from neglect of the parts. The vermiform appendix is sometimes entirely wanting, and not unfrequently the small intestines present processes or blind canals, from one to three or four inches in length.]

The glandular viscera of the abdomen which are subservient to digestion are the liver, spleen, and pancreas.

The *liver* is the largest secreting gland in the body; it fills the right hypochondrium, extends though the anterior part of the epigastric region into the left hypochondrium as far as the cardiac orifice of the stomach, beyond which, however, it frequently extends, even to the spleen; it is situated below the diaphragm, and above the right kidney, the stomach, duodenum, and lesser omentum; it is supported in this situation by several folds of peritonæum, termed ligaments of the liver, viz. the falciform, round, right, left and coronary; these connect it to the diaphragm and abdominal muscles, and the lesser omentum attaches it to the stomach and duodenum.

The *suspensory* or *falciform ligament* is a fold of peritonæum attached anteriorly by its convex border to the linea alba, to the rectus muscle of the right side, and to the diaphragm; it passes obliquely backwards and to the right side, and is attached by its posterior or concave edge to the upper or convex surface of the liver, on which its laminæ separate, and expand over each side of this organ; enclosed in the inferior edge of this fold is the obliterated umbilical vein, which substance in the adult is named the *ligamentum teres:* this which is enumerated as the second ligament of the liver, ascends from the umbilicus, obliquely backwards, and to the right side, and is inserted into a notch in the thin or anterior edge of the liver, which notch is the commencement of the umbilical or horizontal fissure of the liver. The *right* and *left lateral* ligaments are triangular folds, connecting the right and left lobes of the liver to the diaphragm: the left lateral ligament lies anterior to the cardiac orifice of the stomach; the right lateral ligament is directly above the right kidney. The *coronary ligament* is situated at the upper extremity of the falciform process, and consists of two laminæ of peritonæum, which separate from each other, and connect the superior thick edge of the liver to the diaphragm; between the laminæ of this process the liver is deprived of a serous covering, and is in contact with the diaphragm; this space lies anterior to the inferior vena cava. The liver is of an irregular form; it is longer transversely than from before backwards; its posterior edge is very thick, and in contact with the diaphragm; its anterior edge is thin, convex, and on a level with the edge of the right hypochondrium, and with the lower part of the epigastric region; two notches may be observed in this edge; one below the falciform ligament, into which the round ligament or obliterated umbilical vein enters, the other corresponds to the gall bladder.

[The size and weight of the liver are very much affected by disease, and by the state of its own circulation, which also affects its color. In a state of health its average weight is from three and a quarter, to four and a quarter pounds: the transverse diameter is from ten to twelve inches, the antero-posterior from six to seven, and the thickness at the centre and posterior edge from two and a half to three and a half. The color of the organ varies with the amount of blood in it, thus in the fœtus the organ is very vascular and of a florid red, in the adult it is of a reddish brown color, with blue or black spots, on the anterior margin and inferior surface; in persons who have been hung, it is said to be of a deep pink, or even purple, and in simple congestion it is of a florid red. The volume of the organ varies with its own circulation, thus it is very large if there be an obstruction to the return of the blood to the heart. It is also proportionably very much greater in the fœtus and new born infant, than in the child or adult; thus it is said that in the fœtus of three weeks, the weight of the liver is equal to half that of the whole body, at the full term to one eighteenth, and in the adult, to one thirty-sixth.]

The superior or anterior surface is smooth and convex, and divided by the suspensory ligament into a right and left portion, and is contiguous to the diaphragm. The inferior surface is very irregular, marked by several projections and depressions; the former are called *lobes*, and are five in number, viz. first, the *great* or *right lobe;* second, the *left*, separated from the former by the horizontal fissure; third, the *Spigelian* or *middle lobe;* this is situated behind the lesser omentum, and above and behind the transverse fissure, and between the œsophagus and the cava; it is connected to the right lobe by two roots; one is thin and placed vertically between the fissure for the vena cava and that for the ductus venosus; the other is thick and placed transversely, and is called *lobulus caudatus*, or the fourth lobe of the liver; the lobulus caudatus is immediately behind the transverse fissure, and extends from the Spigelian, along the right lobe between the depressions marked by the colon and right kidney. Fifth, the *lobulus quadratus* or *anonymus*, is at the anterior part of the right lobe, in front of the transverse fissure, and between the gall bladder and horizontal fissure.

The principal depressions or fissures on the inferior surface of the liver are the following: first the *transverse fissure* which is situated between the lobulus quadratus and caudatus, and extends from the horizontal fissure transversely to the right; the vessels and nerves of the liver enter the gland in this fissure; second the *horizontal fissure* extends from the notch in the anterior edge of the liver, backwards and upwards between the right and left lobes; the anterior part of this fissure contains the obliterated umbilical vein, the posterior part the obliterated ductus venosus; third, the *fissure for the vena cava* is between the lobulus Spigelii and the right lobe; this, at the anterior part of the horizontal fissure, is frequently like a foramen in the liver, being surrounded by the substance of the gland: fourth, *the depression for the gall bladder* is on the inferior surface of the right lobe, and to the right side of the lobulus quadratus; the substance of the liver is sometimes deficient over this bag; fifth and sixth, *superficial depressions* on the under surface of the right lobe; the anterior corresponds to the *colon*, the posterior to the *right kidney* and its capsule; these depressions are indistinctly marked in some subjects; they are separated from each other by the extremity of the lobulus caudatus; seventh, a superficial depression on the under surface of the left lobe, corresponding to the anterior surface of the stomach; eighth, a broad notch in the posterior edge of the liver, corresponding to the spine and to the right crus of the diaphragm; the venæ cavæ hepaticæ leave the liver in this situation. The liver is of a peculiar brown colour, interspersed with yellow; in some subjects it is much darker than in others: in the very young it is red and soft, and in the old it is generally pale and yellow, and often hard and brittle; it has two coats, a serous and fibrous; the serous or peritonæal tunic covers the whole surface of the liver, except in those situations where the vessels, either pervious or obliterated, are situated, and between the laminæ of the corronary ligament, also in the depression in which the gall bladder is lodged. The second, or fibrous coat, is the immediate capsule to the gland; it is thin, little more than condensed cellular membrane; it is most distinct and strong where the serous coat is deficient; it covers the whole surface of the liver, and adheres to it by innumerable shreds or processes, which pass into its substance; it also accompanies the three vessels of the liver which enter or leave the transverse fissure, and forms a capsule or sheath around their ramifications throughout the entire organ; this sheath receives the name of the *capsule of Glisson;* it surrounds the vessels very loosely, and also encloses loose cellular tissue; hence it is, that if these vessels be divided by a perpendicular incision through the liver, they will be found to collapse and recede; whereas, if the venæ cavæ hepaticæ, which run from the thin towards the thick edge of the liver, be divided by a transverse incision through the liver, they will not recede or collapse, but remain perfectly open, in consequence of the absence of this sheath, and of their close adhesion to the substance of the gland. The structure of the liver consists of numerous small granulations of a brown and yellow colour, connected together by the branches of the hepatic arteries, veins, and ducts; these grains are called *acini* of the liver, in each of them a branch of the hepatic artery and vena portarum terminate, and out of each proceed a branch of the hepatic veins and ducts. Through the liver, therefore, *four* sets of vessels ramify, in addition to numerous lymphatics, viz. the branches of the hepatic arteries, venæ portarum, hepatic ducts and hepatic veins: the venæ portarum are supposed to be the vessels from which the bile is secreted; the hepatic arteries nourish the substance of the liver; the hepatic ducts carry the bile from this organ, and the venæ cavæ hepaticæ return the blood which has circulated through the liver, to the inferior vena cava, just as this vessel is passing through the diaphragm. The *venæ cavæ hepaticæ*, three or four in number, are seen escaping from the liver at the superior thick edge, behind the coronary ligament, and immediately joining the inferior or ascending vena cava. The three other vessels of the liver may be seen between the layers of the lesser omentum, the artery lying to the left side, the biliary duct to the right, the vena portarum behind and between both; the artery and vein descend obliquely inwards towards the spine, behind the pancreas. The *hepatic artery* is a branch of the cœliac axis, and the vena portarum commences in front of the last dorsal vertebra, and behind the pancreas, from the confluence of the splenic and mesenteric veins The *right* and *left hepatic ducts*, on clearing the transverse fissure, unite and form the *hepatic duct*, which descends for about one inch and a half along the right side of the lesser omentum, and is then joined by the cystic duct, from the gall bladder: the union of these forms the *ductus communis choledochus;* this vessel, about three inches long, descends vertically behind the pylorus, the upper part of the duodenum and the pancreas, and is imbedded in the substance of the latter, about the middle of the internal or concave side of the middle division of the duodenum, this duct perforates the coats of this intestine in a very oblique direction, and opens on a small papilla internally, opposite the lower angle of the duodenum: as the ductus choledochus is about to perforate the duodenum, it is in general joined by the duct from the pancreas.

No viscus in the abdomen *presents* such frequent and varied *morbid* appearances as the liver; acute inflammation, or hepatitis is but rarely met in the dead body; it is denoted by a deep red or purple colour, a firm, heavy feel, and in the opinion of some, by an increase of size; the investing capsule is easily detached, and the parenchyma appears very granular and vascular: inflammation may end in suppuration, which, in general, is collected into a very large abscess, the contents of which may have been discharged into the colon, the stomach, or some of the intestimes; abscess of the liver also sometimes points externally, and in some rare cases, opens into the cavity of the pleura, or into some of the bronchial tubes. The liver is the seat of different sorts of tubercles, viz. small and diffused, large and circumscribed, scrofulous, scirrhous, fungoid, hydatid, melanotic, &c.: hydatid cysts containing several small hydatids are not uncommon in this organ.

[The liver is also liable to hypertrophy and atrophy, which are usually connected, with either an indurated or a softened state of the organ; it is also the seat of a fatty degeneration, and occasionally the worm called liver fluke is found in it, but much more frequently in inferior animals; it is also the seat of scirrhosis, in which disease it presents a tuberculated or nutmeg like appearance; cartilaginous and osseous depositions are also found.]

The *gall bladder* is situated in the right hypochondrium in a depression on the inferior surface of the right lobe of the liver: this membranous sac is of a pyriform figure; the large extremity or fundus being directed forwards and downwards; in some persons it projects below the liver against the abdominal muscles; it is generally contiguous to the pylorus and to the colon; the smaller extremity or neck of the gall bladder is directed upwards, backwards, and inwards, is a little convoluted, and ends in the *cystic duct*, which is about an inch and a half long: this duct bends downwards and inwards, and joins the hepatic duct at an acute angle, the union of which forms, as was before mentioned, the ductus choledochus. The gall bladder is closely united to the liver by the peritonæum, which passes over it; also by cellular membrane and small blood-vessels; it is composed of a partial serous and a perfect cellular coat, and is lined by a mucous membrane; the latter has a peculiar honey-comb-like appearance, and in the duct is disposed in a spiral lamina; there is no appearance of a muscular coat. This viscus serves as a reservoir for the bile, when this fluid is not required in the intestinal canal. The bile is secreted in the liver, and flows down the hepatic duct, and if not required in the duodenum, or if obstructed in the ductus choledochus, it passes into the cystic duct to the gall bladder, where it resides a longer or shorter time, during which period its watery part is absorbed; at the end of some time, when the bile is required to assist in digestion, it is forced out of the gall bladder, and then flows again along the same cystic duct to the ductus choledochus, and so to the duodenum. The bile is not secreted in the gall bladder, nor can it possibly enter or leave this viscus by any other channel than through the cystic duct.

The *morbid* appearances observed in the gall bladder are, great distention, in consequence of obstructed ductus choledochus, or almost total obliteration of its cavity in consequence of obstructed cystic duct. This viscus also frequently contains biliary calculi; when there is but one calculus it is usually large and of an oval form, and either fills the cavity, or partly obstructs the duct; there are frequently several calculi present, in this case they present every variety of form and size, as also several smooth sides and angles, the probable effect of rubbing against each other.

The *spleen* is situated in the left hypochondrium, between the stomach and ribs, beneath the diaphragm, and above the kidney and the colon; it is in contact with and connected to the diaphragm by the peritonæum, also to the stomach and pancreas by vessels and by the peritonæum. The spleen is somewhat oval; convex towards the ribs, and concave towards the stomach; on the latter surface there are several holes, and about the centre of it a depression or fissure for the entrance and exit of blood vessels; all this surface, however, is not concave, the part anterior to the vessels only being so, while the part posterior to them is convex; the colour of the spleen is somewhat purple or livid; it is covered by peritonæum, and beneath this by a fibrous capsule, which invests its entire surface, and also passes into its substance along with the blood-vessels, and assists in forming the cells of which this organ is composed: these cells are found to contain a quantity of blood, partly coagulated; also a number of small grains, which may be separated by maceration, but the nature of which is not well understood; the spleen has no excretory duct. The exact use or function of this viscus is not yet ascertained; sometimes two or more small bodies, of the same colour and structure as the spleen, are found in its vicinity, between the laminæ of the omentum.

[The color of the spleen varies from a pale grey to a dark brown, or deep blue, it is influenced by disease, age, and the kind of death. In the recent subject it is of a light blueish shade, which soon changes to a deep purple, especially on exposure to the air. Its weight is variable even in a state of health, rarely exceeding eight ounces, it is sometimes as much as fourteen, and then again as low as two. It also varies much in volume, in the majority of cases however, its length is from four and a half to five inches, its width from two and a half to three, and its thickness one and a half; its volume is proportionably greater in man than in other animals, and in the adult, than in the fœtus, its volume seems also to depend upon its own circulation in connection with the process of digestion. Supernumerary spleens sometimes exist, but there are rarely more than one or two of them; still cases are reported in which there have been seven, ten, and even twenty; they are found in the omentum gastro-splenicum, and are about the size of a nutmeg, many animals have more than one spleen.]

The spleen is not often found *diseased;* the greatest possible variety as to size and consistence is observed, without any morbid change; in some cases it is so soft as to break under the slightest pressure: its coats are subject to thickening and induration, cartilaginous and even bony tubercles or patches are very common occurrences in its fibrous capsule.

The *pancreas* lies behind the stomach, and may be exposed by dividing the great omentum below the stomach, and raising the latter organ towards the thorax. This conglomerate gland is of great length, about seven inches long, and about an inch and a half broad.

[And its medium thickness is six lines, it is however thicker at its right than its left extremity. Its volume is proportionably greater in the fœtus and child than in the adult. Its color varies with age, in children, it is of a rosy tint, in adults lighter, and in old age of a pale yellowish hue.]

It extends from the lower part of the left hypochondriac and epigastric regions, obliquely downwards and forwards into the umbilical region, where it is surrounded by the duodenum; it is covered by the stomach and the ascending layer of the meso-colon; it lies anterior to the left crus of the diaphragm, the vena portarum, and the aorta, and overlaps the concave border of the duodenum, to which it adheres very closely. The splenic or left extremity (its *tail*) is small, compared with the right, which is broad and flat, and is named the *head;* the anterior surface looks a little upwards, the inferior edge being raised forwards by the superior mesenteric artery and vein, which pass behind it; a groove may be remarked on the posterior and upper part of the pancreas; this contains the splenic artery and vein. The *pancreatic duct* may be seen by scraping off a little of the posterior surface of the gland about its centre. This duct is remarkably white and thin; it commences in the small extremity of the gland, and extends to the large end, receiving in its course numerous branches on each side; it usually joins the ductus choledochus; it sometimes, however, opens into the duodenum distinctly; attached to the head of the pancreas there is sometimes a glandular mass of the same structure as the pancreas, and opening by a small vessel into the pancreatic duct; this is named the *lesser pancreas.* The pancreatic fluid is supposed to be of use in diluting the bile, and rendering it and the contents of the duodenum more miscible with each other. The structure of the pancreas is similar to that of the salivary glands, and is thence called by some, the abdominal salivary gland

The pancreas is not often found in a *morbid* state, induration of its structure and calculi in its duct may be occasionally noticed.

OF THE VESSELS AND NERVES OF THE ABDOMEN.

THE abdominal aorta gives off three large branches to supply the organs of digestion, viz. the cœliac axis, the superior mesenteric and inferior mesenteric arteries. The *cœliac axis* may be seen by tearing through the lesser omentum above the lesser curvature of the stomach, to arise from the forepart of the aorta, at the upper edge of the pancreas; it is about half an inch long, and divides into three branches, viz. the gastric, hepatic, and splenic; the *gastric* artery and its branches run between the laminæ of the lesser omentum, along the concave edge of the stomach, and supply both surfaces of this organ. The *hepatic artery* accompanies the vena portarum and the biliary duct to the transverse fissure of the liver, first sending off a small branch to the pylorus (pylorica superior,) next a large branch (gastro-duodenalis,) which descends behind the pylorus and subdivides into two branches, the pancreatico-duodenalis and gastro-epiploica dextra; the former supplies the pancreas and duodenum; the latter runs along the convex edge of the stomach, between the layers of the great omentum; the hepatic artery then divides into the right and left hepatic arteries, which supply the right and left lobes of the liver; the right hepatic is the larger, and gives off a small branch, arteria cystica, to the gall bladder. The *splenic artery* is the longest and largest branch of the cœliac axis; it passes along the upper and posterior part of the pancreas, to which it gives many branches; near the spleen it sends off the gastro-epiploica sinistra, which runs along the convex edge of the stomach, between the layers of the great omentum; the splenic artery then divides into five or six branches, which enter the foramina in the concave surface of the spleen: from these splenic branches five or six small arteries, the vasa brevia, pass to the left or great end of the stomach. The *superior mesenteric artery* arises about half an inch below the cœliac axis, behind the pancreas; it descends in front of the duodenum, enters the mesentery, and bends obliquely towards the right iliac fossa; from its left or convex side it sends off sixteen or eighteen branches, which supply the jejunum and the ileum, and from its concave or right side arise three branches, the ileo-colica, colica dextra, and media; these arteries supply the corresponding portions of the colon, and inosculate with each other. The *inferior mesenteric artery* arises a little above the division of the aorta into the iliac vessels; it descends into the left side, and divides into three branches. First, the colica sinistra, which supplies the left lumbar colon, and inosculates with the colica-media; second, the sigmoid artery, which supplies the sigmoid flexure of the colon; and third, the superior hæmorrhoidal, which is distributed to the rectum.—These arteries are accompanied by corresponding veins, which all unite to form the vena portarum; the *inferior mesenteric vein* accompanies the artery of that name to the aorta, and there joins the *superior mesenteric vein*, which is a very considerable vessel; this common trunk then ascends behind the pancreas, and is joined by a very large vein from the spleen; the confluence of the splenic and mesenteric veins forms the commencement of the *vena portarum;* this vessel ascends obliquely to the right side, surrounded by nerves and cellular membrane, and enclosed in the lesser omentum; near the transverse fissure it becomes dilated (the sinus of the vena portarum) and then divides into the right and left branches; the former is the larger, the latter the longer of the two; each branches out through the liver, surrounded by the capsule of Glisson, and runs in a transverse direction: injection shows their minute branches to communicate in the acini with the pori biliarii, or with the commencements of the hepatic ducts.

The nerves which supply the digestive organs are the eighth pair, and the splanchnic branches, from the sympathetic: the *eighth pair* descend along the œsophagus, and are distributed almost wholly to the stomach; some few branches pass along the lesser omentum to the liver. The *splanchnic nerves* are two in number, a right and left; they are each formed by filaments from the dorsal ganglions of the sympathetic nerve, in the thorax; they enter the abdomen either along with the aorta, or perforate the crura of the diaphragm on either side of that vessel; in the abdomen each nerve soon ends in a large ganglion, the *semilunar ganglion*, from which numerous branches pass across the aorta, around the cœliac axis, and communicating with each other, form the nervous plexus, named *solar* or *cœliac plexus*, from which a fasciculus of nerves extends along each of the branches of the cœliac artery to supply the viscera in the epigastric region: thus a few accompany the gastric artery, and communicate with the eighth pair on the stomach; several surround the hepatic artery, and by it are conducted to the liver; in like manner others also pass to the spleen. From the lower part of the solar plexus several large branches descend and become attached to the superior and inferior mesenteric arteries, form plexuses around these vessels, and receive additional branches from the lumbar or abdominal ganglions of the sympathetic; these nerves then twine around the mesenteric arteries and their branches, and are thus conducted to the intestines, in the internal tunic of which they terminate. (See Anatomy of the Nervous System.) The student may now remove the abdominal viscera. Tie the lower extremity of the œsophagus and the upper end of the rectum, each with two ligatures, and divide these tubes between them; dissect out the vena cava from the liver, cut across the hepatic vessels, the cœliac axis, the superior and inferior mesenteric arteries; and then separate the liver, spleen, pancreas, and alimentary canal, from their connexions to the parietes of the abdomen; next clean the surface of the abdominal aorta and vena cava, the right and left kidney, and the renal capsules. The *abdominal aorta* may be now seen to pass into the abdomen, between the crura of the diaphragm, opposite the last dorsal vertebra; it then descends obliquely to the left side of the median line, and divides on the body of the fourth lumbar vertebra into the right and left iliac arteries. The abdominal aorta sends off the following branches: first, the two phrenic arteries; second, the cœliac axis; third, the superior mesenteric artery; fourth, the two renal arteries; fifth, the spermatic arteries; sixth, the inferior mesenteric artery; also four or five pair of lumbar arteries from its posterior part; and lastly, from the angle of its division the middle sacral artery descends. The *right* and *left iliac arteries* descend obliquely outwards and backwards; that of the right side is the longer of the two; opposite each ilio-sacral articulation each common iliac artery divides into the internal and external iliac. The *external* proceeds along the inner side of the psoas magnus, and passing beneath Poupart's ligament, becomes the femoral artery; just above this ligament it sends off two branches, the epigastric and the circumflex ilii. The *internal iliac artery* descends into the pelvis, and gives off several branches, which shall be noticed afterwards in the dissection of that cavity. The veins in the abdomen correspond to the arteries; each *external iliac vein* ascends along the inner side of the artery of the same name, and near the sacrum is joined by the *internal iliac vein*, which ascends from the pelvis; the union of these on each side form the *common iliac veins;* each of these ascends behind its accompanying artery, and opposite the right side of the fourth or fifth lumbar vertebra these veins unite and form the inferior or ascending vena cava; the left common iliac vein is longer than the right, and passes behind the right iliac artery. The *vena cava* ascends along the right side of the aorta, and receives the spermatic, renal, and lumbar veins; it lies, inferiorly, on the right psoas muscle, and on the right crus of the diaphragm; superiorly, it inclines forwards and to the right side, and enters the fissure in the liver; here it receives the venæ cavæ hepaticæ; it then passes through the opening in the tendon of the diaphragm, and arrives at the right auricle of the heart. On each side of the abdominal aorta the *sympathetic nerves* may be seen; they pass from the thorax into the abdomen, beneath the true ligamentum arcuatum, and then descend between the crus of the diaphragm and the psoas magnus on each side; in this course they form three or four oval ganglions. At the last lumbar vertebra these nerves pass outwards and backwards, and then descend into the pelvis.

The commencement of the *vena azygos* may be observed on the right side of the aorta; it is formed by the first or second lumbar veins, which communicate with the renal and inferior lumbar veins, and sometimes with the inferior vena cava. The vena azygos enters the thorax between the aorta and the right crus of the diaphragm, and then ascends along the posterior mediastinum. The *thoracic duct* also may be seen to commence in the abdomen by the union of several absorbent vessels on the body of the third lumbar vertebra; this vessel being larger here than it is above, has received the name of *receptaculum chyli;* this, however, does not always exist. The thoracic duct is covered at first by the aorta, it then ascends obliquely to the right side, and enters the thorax between the aorta and vena azygos. Let the student next examine the urinary organs; these consist—first of the kidneys, which secrete the urine; second, of the ureters, which convey this fluid to, third, the urinary bladder, which retains it for a longer or shorter time, and fourth the urethra, which discharges it externally.

DISSECTION OF THE KIDNEYS AND URETERS.

Each *kidney* is situated in the posterior part of each lumbar region, behind the peritonæum, between the last rib and the crest of the ilium; and corresponds to the two last dorsal and two first lumbar vertebræ; the right kidney is often a little lower than the left, particularly if the liver be larger than usual; they are each imbedded in a quantity of soft adipose substance, and lie on the diaphragm, psoas, and quadratus lumborum muscles; the right kidney is also sometimes in contact with the iliacus internus muscle: the ascending colon and duodenum lie anterior to the right, and the descending colon to the left kidney; the right is in contact with the liver above, and with the cæcum below; and the left with the spleen above, and the sigmoid flexure of the colon below. The anterior surface of each is convex, the posterior is flat; in the young subject the surfaces are very uneven, the kidneys at that age being lobulated. The external border of each is smooth and convex, and directed outwards and backwards; the concave edge is of much less extent, looks forwards and inwards, and contains the arteries, veins, and excretory duct; the veins are usually, but by no means constantly, anterior; the arteries, five or six in number, are behind these; and the ureter is posterior and inferior to both. The superior end of each kidney is larger and nearer to the spine than the inferior. The kidney is partially covered by peritonæum, to which it is but loosely connected; it has also a capsule of cellular and adipose substance, and a strong smooth fibrous tunic, which adheres closely to its substance, preserves its form, and is continued into its interior, along the vessels, as far as the calyces of the kidney.

[The usual weight of these organs is from three to five ounces, their length from three and a half to five inches, their width two, to three, and their thickness a little over an inch; their color is a reddish brown. One of these organs, is sometimes wanting, in which case the one is large. Sometimes there is a third kidney, in which case two are on one side, or else the supernumerary lies in front of the spine, or in the pelvis. Sometimes one kidney is in its usual situation the other in front of the spine: sometimes the two are united across the spine, and both have been found in the true pelvis. In the fœtus and until the third year after birth, the kidneys are distinctly lobulated, as in inferior animals; between the third and tenth year, this appearance is obliterated, but becomes again very apparent, in certain cases of disease.]

Remove one kidney from the subject, and divide it by a perpendicular incision from the convex to the concave edge, the gland will then be found to consist of two distinct substances, the external or vascular, the internal or membranous; the external, vascular, or *cortical substance*, forms a covering for the kidney about two lines thick, and sends longer prolongations into the body of the gland, between the tubular fasciculi. The cortical substance is of a dark brown red colour, particularly along its internal margin, it can be separated into numerous small grains; when injected it seems wholly composed of arteries and veins. Internal to this is the *tubular substance*, which consists of fine vessels of a pale colour, and very dense structure; these are arranged in conical fasciculi, about eight or ten in number; the base of each is directed towards the circumference, the apex towards the concave edge of the kidney: the apices of these cones are named *papillæ*; each papilla is perforated by several small holes, through which the urine may be observed to flow when the tubular cones are compressed. The papillæ are surrounded by membranous sacs called *calyces;* each calyx contains one or two papillæ, and they are five or six in number; they are dense and white, composed externally of the fibrous coat of the kidney, and internally of a fine mucous membrane, which is continued from the ureter along the pelvis of the kidney, lines all the calyces, and is reflected in the form of a very fine membrane over each papilla, and most probably is continued into the tubuli uriniferi. The calyces in each extremity, as also those in the centre, unite into three small tubes, which being of a funnel shape, are called *infundibula;* these have but a short course, and soon terminate in the pelvis of the kidney. The *pelvis* is a membranous reservoir formed by the union of the calyces or the infundibula, of a flattened oval figure, placed behind the blood-vessels of the kidney, and terminating in the ureter, which it resembles in structure. Each kidney receives a very large artery (the renal or emulgent) from the aorta: this divides into six or eight branches, which enter the notch in the gland, subdivide into numerous fine vessels, which proceed between the tubular portions to the cortex, in which they terminate in minute branches, some of which are continuous with corresponding veins, others with the commencements of the tubular fasciculi; these last separate the urine from the blood, and pour it into the tubuli uriniferi, which convey it to the papillæ, through the small pores of which it gradually flows into the calyces, and from these into the pelvis, and so into the ureter. The *ureter* is the excretory duct of the kidney, and extends from it to the urinary bladder; each ureter is about eighteen inches long, and about the size of a goose quill; its coats, are very pale, and always appear collapsed. These vessels take an oblique course downwards and inwards to the pelvis; each then inclines a little forwards, continuing still to run downwards and inwards to the inferior and posterior part of the bladder, passes obliquely between the muscular and mucous coats of this viscus, and perforates the latter at the posterior angle of the trigone. Each ureter passes anterior to the psoas magnus, and to the iliac vessels, is covered by the peritonæum, and crossed by the spermatic vessels, and near its termination in the male subject by the vas deferens; and in the female by the Fallopian tubes, and broad ligaments of the uterus. In the male each ureter attaches itself to the bladder at the posterior extremity of each vesicula seminalis, and now much diminished in size, it runs obliquely for the extent of an inch between the tunics of the bladder, and opens internally (as will be seen hereafter in the dissection of the pelvic viscera) about an inch and a half from the commencement of the urethra, and about the same distance from its fellow. In the female the pelvic portion of each ureter is longer than the male; they also lie at a greater distance from each other, and perforate the bladder nearer to its neck than in the male subject. The ureter is composed externally of a fibrous coat, and internally of a pale mucous membrane; it is surrounded by cellular tissue, and in some situations is partially covered by peritonæum, muscular fibres ascend from the bladder and can be traced for some inches along its parietes. The ureters are larger at their commencement, and smaller at their termination; the intermediate portion of each is nearly of one uniform diameter.

[The ureters are sometimes wanting, sometimes terminate in a cul de sac: if the bladder is wanting they may empty into the urethra, vagina, or rectum; sometimes there are two for one kidney, they may be almost obliterated or very much dilated, as is sometimes the result of an obstruction of the urethra.]

Attached to the upper extremity of each kidney is a small gland-like substance, named *renal capsule*, or *supra-renal*, or *atrabiliary body*; of a crescentric shape, the base attached to the kidney by cellular membrane and by small blood-vessels; these organs lie on the diaphragm, and on the semilunar ganglion of each side, and are covered, that on the right side by the vena cava and duodenum, and on the left by the spleen and pancreas; a vein also runs along their anterior surface. In the interior of each renal capsule we find a small triangular cavity filled with a brownish fluid; the walls of this cavity are very rough, no excretory duct can be found leading from it. The exact use of these bodies is not ascertained. The renal capsules in the adult are thin, and of a brownish yellow colour; in the fœtus they are very large and vascular, nearly equal to the kidney in size, and contain a quantity of reddish fluid.

The kidneys occasionally present the following *morbid* appearances: inflammation or nephritis is denoted by increased redness, vascularity, and induration, and sometimes attended with purulent infiltration; when the ureter is engaged it is also found thicker and redder than natural, with purulent matter on its inner surface. Inflammation also sometimes ends in a well defined abscess in the kidney. These glands are frequently the seat of scrofulous abscess in which the pus is white and curdy. Calculi are very common in the kidney, sometimes they are small and found in the tubular portion, but generally they are large, and fill up more or less of the pelvis of the ureter, not unfrequently extending by a stalk a short distance along that tube, and presenting a branched appearance at the opposite extremity corresponding to the infundibula. When the calculus is large and obstructs the flow of urine, the membranous portions of the gland become dilated, and should the stone be impacted lower down in the ureter, this tube will also become greatly dilated above the seat of the obstruction; in such cases the interior of the kidney will become more and more compressed and absorbed, and in time nothing will remain but the thickened capsule with a thin layer of vascular and glandular matter, containing several cells which communicate freely; sometimes the whole of the sac will be found in a state of suppuration. Hydatids are common formations in the kidney, they are found on its surface and beneath its capsule, they are generally scattered, each in its distinct cell. The kidneys present great variety as to form, size, colour, and consistence without any known corresponding difference in function. In diabetes they have been found large, vascular, soft, and easily torn; in purpura with hematuria the lining membrane has appeared turgid, and petechiæ have been distinctly seen beneath it. The kidneys have been the seat of cancer, fungoid diseases, and of melanosis.

[The kidney may be either indurated or softened, hypertrophied or atrophied as the result of inflammation; it may undergo the cartilaginous or fatty degeneration; and it may be converted almost entirely into bone, of which there is an admirable specimen, in the college museum. A parasitic worm is sometimes found in the human kidney, often in that of inferior animals.]

The bladder and urethra are the next divisions of the urinary organs to be examined; these, however, being pelvic viscera, we shall postpone the consideration of them for the present, as the student should next examine the deep muscles of the abdomen, viz. the diaphragm, the quadratus lumborum, psoas parvus, psoas magnus, and iliacus internus of each side.

DISSECTION OF THE DEEP MUSCLES OF THE ABDOMEN.

Diaphragm is exposed by dissecting off the peritonæum; it separates the abdomen from the thorax, being concave towards the former cavity, convex towards the latter; it may be divided into two portions, a superior transverse broad portion (the true diaphragm) and the inferior lesser portion, or the appendices or crura of the diaphragm. The *superior true diaphragm* is broad, thin, and nearly circular; it *arises* by distinct fleshy fasciculi, from the posterior surface of the xiphoid cartilage, and from the internal surface of the cartilages of the last true, and of all the false ribs; these fasciculi indigitate with those of the transversalis muscle; between the extremity of the last rib and the side of the spine, it arises from the upper part of a strong aponeurosis, which covers the quadratus lumborum muscle; this is the anterior lamina of the tendon of the transversalis; the upper edge of this fascia being very tense, particularly when the twelfth rib is everted, and appearing to be extended as a distinct ligament between this bone and the first lumbar vertebra, has received the name of the *ligamentum arcuatum;* it is not a distinct ligament; it may, however, be named the *external* or *false* ligamentum arcuatum, to distinguish it from a true and distinct ligament, which extends from the transverse process of the first to the body of the second lumbar vertebra; this may be named the *true* or *internal* ligamentum arcuatum; its concavity looks downwards, and extends across the upper extremity of the psoas magnus and the sympathetic nerve; from the convex edge of this ligament the diaphragm next arises; from this extensive origin the fibres pass in different directions, all converging like radii from the circumference towards the centre of a circle; the anterior backwards and upwards to the edge of the cordiform tendon, the middle upwards and inwards, and then a little downwards, to the lateral borders of the central tendon, and the posterior fibres pass forwards and upwards to the posterior edge of the tendon; the anterior fibres are the shortest, the lateral are the longest and the most arched, particularly those on the right side, the convexity of which is on a level with the fourth rib; the convexity of those on the left side is on a level with the fifth or sixth rib. The *central tendon* of the diaphragm is of great transverse breadth, and is divided into three portions, an anterior, right and left; the first is the largest, the last is the smallest; in regard to their relative size these divisions of the tendon are uncertain; the posterior border of the tendon is notched for the insertion of the crura or appendices of the diaphragm; the fibres of this tendon generally run in rays from behind, forwards and outwards; they are crossed and interlaced, however, by several bands, which have an irregular direction; this tendon is much stronger and larger in proportion in the old than in the young, [and is on a level with the inferior extremity of the second bone of the sternum.] Behind and below this tendon are the two *crura* or *appendices* of the diaphragm; the *right crus* is longer and thicker than the left, and *arises* by tendinous bands from the forepart of the bodies of the four first lumbar vertebræ. The *left* is smaller, and on a plane posterior to the right; it *arises* from the sides of the two or three first lumbar vertebræ; the fibres of each crus ascend obliquely forwards, are connected to each other by a semilunar tendinous band extended across the aorta; they then become fleshy, and a small fasciculus is sent from each crus to join the opposite; these *decussating fasciculi* separate the œsophageal from the aortic opening in the diaphragm; of these fasciculi, that from the right crus is always the larger, and that from the left is generally, but not always, anterior. Each crus then ascends, and is *inserted* into the posterior border of the cordiform tendon.

The right crus of the diaphragm is covered by the vena cava, renal capsule, semilunar ganglion, and by the liver; the left crus by the aorta, left renal capsule, semilunar ganglion, spleen and stomach. To the thoracic surface of this muscle the pleuræ are attached laterally, and the pericardium and the boundaries of the mediastinal regions along the middle. Three large openings are observed in the diaphragm; one for the aorta, one for the vena cava, and one for the œsophagus. The aortic opening is rather a tendinous passage, behind and between the crura of the diaphragm; it opens into the abdomen opposite the last dorsal vertebra, and nearly in the mesial line; the thoracic duct and vena azygos ascend through it, along the right side of the aorta; the splanchnic nerves, particularly the left, sometimes pass through this opening; but in general these nerves perforate the crura at a little distance from the aorta. The opening for the œsophagus and eighth pair of nerves is superior and anterior to that for the aorta, and is a little to the left of it; it is of an oval figure; its parietes are fleshy, and are formed by the decussating fasciculi from the crura; the union or crossing of these separate the œsophageal from the aortic opening. The opening for the vena cava is situated at the back part of the right division of the tendon, anterior to the insertion of the right crus; this foramen is perfectly tendinous; it is somewhat quadrilateral, and appears larger than the vein; the edges are attached to the vessel, and prolonged upon its coats; the anterior margin being continued on the abdominal portion, and the posterior margin on the thoracic portion of the vein. Posterior to the ensiform cartilage there is a small triangular space on each side, where the diaphragm is deficient, and through which the peritonæum is connected to the pleura and pericardium; through this space also the cellular membrane in the mediastinum is continuous with that between the abdominal muscles. *Use*, it is the principal muscle in inspiration; by its action it enlarges the thorax in the perpendicular direction, for the contraction of the crura draws down the cordiform tendon, and fixes it; and then, when the fibres of the superior diaphragm contract, they descend, and instead of being convex towards the chest they became nearly straight, so as to present a plane surface to the abdomen, looking downwards and forwards. As the fleshy fibres are longest at the sides, it is here the greatest descent in the muscle occurs, consequently the thorax is most enlarged on each side beneath the lungs. When the diaphragm relaxes, its elasticity and the connexion of the pleuræ and pericardium to its superior surface, cause it to re-ascend, so as to present a concave surface to the abdomen, and to diminish the capacity of the thorax. The diaphragm also assists in coughing, laughing, speaking; also in the expulsion of urine and fæces, and in the various exertions of the body.

The student may now re-consider the different muscles which assist, and which oppose the diaphragm in *respiration;* by this term we mean the act of taking into the lungs a certain quantity of air, and the subsequent expulsion of it from these organs; the former is termed inspiration, the latter expiration. *Inspiration* requires greater muscular efforts than expiration, which is chiefly effected by the relaxation of the muscles of inspiration, and by the elasticity of the parietes of the thorax. Inspiration may be performed with two different degrees of force: the first, in which there is little muscular effort, is called ordinary inspiration; the second, in which there is great exertion, is called full inspiration. In the first, the diaphragm and the intercostal muscles are employed, but chiefly the former; and in the second, several additional muscles assist, viz. the sterno-mastoidei, the scaleni, the subclavian, the serrati postici, and the levatores costarum; also when the superior extremities shall have been fixed, the pectoral, serrati magni, and latissimi dorsi muscles exert considerable power, in elevating the ribs and drawing them outwards, so as to enlarge the chest transversely, and from before backwards.

Expiration also may be performed in the same different degrees of intensity; in the first or ordinary degree, the elasticity and slight contraction of the abdominal muscles press the viscera against the diaphragm, which is already receding in consequence of its own relaxation, and the elasticity of the parts attached to its thoracic surface; when expiration is performed in the second or forced degree, the elasticity of the ribs and of their cartilages opposes the intercostal muscles: the triangulares sterni also depress the cartilages, and the abdominal muscles and levatores ani, by increasing their contracting force, push the abdominal viscera against the diaphragm, and draw down the ribs; the serrati postici inferiores and quadrati lumborum muscles assist, also the latissimi dorsi muscles, by acting towards the ilium; and should the last rib be fixed, it is possible for the intercostal muscles to depress the superior ribs, and so to become muscles of expiration.

QUADRATUS LUMBORUM, is a thick, flat muscle, between the anterior and middle layers of the transversalis abdominis tendon, posterior to the psoas, the kidney, and the diaphragm; and anterior to the sacro-lumbalis; it *arises* tendinous from the posterior fourth of the spine of the ilium, and from the ilio-lumbar ligament; the fibres ascend obliquely inwards, and are *inserted* into the extremity of the transverse processes of the four first lumbar vertebræ, and of the last dorsal; also into the internal surface of the posterior half of the last rib. *Use;* to bend the spine to one side, to depress the last rib, thus assisting in expiration; when both muscles act, they support the spinal column in the perpendicular direction.

PSOAS PARVUS is situated between the psoas magnus and the vertebræ, it *arises* fleshy from the side of the last dorsal and first lumbar vertebra, ends in a long flat tendon, which descends on the inner side of the psoas magnus, and is *inserted* broad and thin into the linea ilio-pectinæa, or brim of the pelvis, also into the fascia iliaca and fascia lata, behind the femoral vessels.—*Use;* it assists in bending the body forwards, or in raising the pelvis; it also makes tense the crural arch, in consequence of its attachment to the fascia lata. This muscle is often wanting; when present, it is situated internal and anterior to the psoas magnus, and is partly concealed by the diaphragm, the renal vessels, the peritonæum and at its insertion by the external iliac vein and artery.

PSOAS MAGNUS, long, round, and thick in the centre, small at its extremities, fleshy at its superior, tendinous at its inferior: it extends along the sides of the lumbar vertebræ, of the brim of the pelvis, and the anterior and inner part of the thigh; it *arises* fleshy from the side of the body of the two last dorsal, and from the bodies and transverse processes of all the lumbar vertebræ, also from the intervertebral ligaments; the fibres all descend, at first vertically, afterwards obliquely outwards, along the brim of the pelvis, and beneath Poupart's ligament; the muscle then becomes tendinous, and descends obliquely inwards and backwards, and is *inserted* tendinous into the back part of the lesser trochanter, also fleshy into a ridge below that process. *Use;* to flex the thigh on the pelvis, or the body on the thigh; it also rotates the thigh outwards; in standing it supports the spine, and prevents it bending backwards, and in walking it is particularly engaged; it then raises, and throws forwards and outwards the lower extremity. This muscle is situated between the psoas parvus and the quadratus lumborum above, and between the former muscle and the iliacus below; and in the groin, between the sartorius and the pectinæus; its insertion is between the vastus internus and the pectinæus; it is covered in the lumbar region by the diaphragm, the kidney, and its vessels; also on the right side by the vena cava, and on the left by the aorta; in the middle or pelvic division of its course it lies between the external iliac vessels and the iliac muscle, and the anterior crural nerve; in its lower or inguinal division it is partly covered by the femoral artery and nerve, and by some of their branches, also by the inguinal ganglia, and by a considerable quantity of cellular membrane. The psoas lies anterior to the transverse processes of the lumbar vertebræ, to the quadratus lumborum, the lumbar nerves, the inner edge of the iliacus internus, and the capsular ligament of the hip; the lumbar nerves or the lumbar plexus in general run through the psoas, perforating its posterior portion; a large bursa separates its tendon from the pubis and from the capsular ligament; this bursa sometimes communicates with the synovial membrane of the hip joint. A smaller bursa lies between the point of the lesser trochanter and this tendon. The tendon of the psoas is formed in the outer or iliac side of the muscle, and receives the insertion of the fibres of the iliacus internus.

[*Varieties.* This muscle sometimes also arises by fasciculi which ascend from the first, second, and third bones of the sacrum; sometimes there is a distinct fasciculus bordering on the pelvis, which joins the tendon of the principal muscle near the trochanter, and occasionally this muscle, and the iliacus internus are distinct from their origins to their insertions.]

Iliacus Internus, flat, or concave, radiated or triangular, *arises* fleshy from the transverse process of the last lumbar vertebra, from the inner margin of three anterior fourths of the crest of the ilium, from the two anterior spinous processes, and from the intervening notch, from the brim of the acetabulum, and from the capsular ligament, also from the iliac fossa, and from the strong aponeurosis, the iliac fascia, which covers it. The iliac fascia is attached to the crest of the ilium, to Poupart's ligament, as far inwards as the iliac artery, behind which it passes and becomes continuous with the pubic portion of the fascia lata; the fibres of this muscle all descend obliquely inwards, join the outer side of the tendon of the psoas magnus, and are *inserted* along with it, or rather into it; the inferior fibres, fleshy, are also inserted into the anterior and inner surface of the femur, below the lesser trochanter. *Use;* to assist the psoas in flexing the thigh, and in rotating it outwards; it also adducts it; it protects the fore part of the capsular ligament, and in flexion of the thigh draws it out of the angle between the neck of the femur and the edge of the acetabulum.

This muscle fills up the concavity of the iliac fossa; on the right side it is covered by the cæcum, on the left by the colon; in the groin this muscle is partly covered by the sartorius, and it lies on the rectus and on the capsular ligament. We may next proceed to the dissection of the perinæum and the viscera of the pelvis.

SECTION IV.

DISSECTION OF THE PERINÆUM IN THE MALE.

[The muscles to be examined in this region are fourteen in number, so arranged as to form two single muscles, and six pairs as follows.

SINGLE.

1. Sphincter Ani,	*Vide p.* 198.
2. Sphincter Internus or Orbicularis,	

PAIRING.

3. Erectores or Compressores Penis,	" " 200.
4. Acceleratores Urinæ or Ejaculatores Seminis,	
5. Transversales Perinæi,	" " 201.
6. Levatores Ani,	*Vide p.* 203.
7. Compressores Urethræ,	" " 204.
8. Coccygei,	" " 208.

Place the subject on the back, bend the thighs and knees upon the trunk, and secure them in the same position as if you were about to perform the lateral operation of lithotomy; the dissection will be fasciliated if the pelvis be raised by a block placed beneath it; moderately distend the lower end of the rectum with sponge or curled hair; introduce a staff or catheter into the urethra and bladder; secure the penis to it by a ligature, and raise up the scrotum. The *perinæum* extends from the os coccygis behind, to the arch of the pubis before; is bounded on each side by the rami of the pubis and ischium, by the tuber ischii, and by the great sacro-sciatic ligament, which extends from that process to the side of the sacrum and coccyx; the glutæus maximus overhangs this ligament; the tuberosity and ramus of the ichium can be felt through the integuments, also (unless the subject be very fat) the ramus of the pubis leading obliquely upwards on each side to the symphysis: the integuments of the perinæum and scrotum are generally of a dark brownish colour in the adult, and of a reddish hue in the child; very thin around the anus, and covering the scrotum, but dense in the intermediate space: along the mesial line, a prominent hard ridge is observable, the *raphe* of the perinæum; this line commences in front of the anus, and extends along the perinæum, scrotum and penis, as far as the prepuce of the latter. Dissect off the integuments from this region, and we expose posteriorly a cutaneous muscle (the sphincter ani) surrounding the anus, and anteriorly a stong fascia covering the muscles of the perinæum, the crura penis, and the corpus spongiosum urethræ.

Sphincter Ani is flat, thin, oval, pale, and open in the middle; it *arises* from a ligamentous substance, which extends from the os coccygis to the rectum; the fibres descend obliquely forwards, expanding on either side nearly as far outwards as the tuberosity of the ischium; at the posterior part of the anus this muscle divides into two fasciculi; which pass, one at each side of this opening, and unite at its anterior part, thus encircling this orifice; *inserted* into the raphe in the integuments, and into the superficial fascia; a fasciculus of it also perforates the latter, and is inserted into the common central point of the perinæum; a point which will be more fully seen when the fascia shall have been raised; *Use;* to close the anus; it may also draw downwards the bulb of the urethra; this muscle is almost constantly in a state of contraction, and, like all the sphincter muscles, belongs to the class of mixed muscles. One of its surfaces looks downwards, and is superficial, the other looks upwards, and is connected to the levatores ani muscles; one edge is internal, the other external. It is superficial; its lateral extent is much greater in some subjects than in others; a few of its external fibres are divided in the first incision in the lateral operation of lithotomy;—beneath and internal to this muscle we may expose the following, with very little dissection.

Sphincter Internus *vel* Orbicularis, consists of a thick, but pale fasciculus of muscular fibres, which encircles the lower extremity of the rectum, having no attachment to the coccyx behind, and but a slight one to the central point before: it is in close contact with the mucous membrane of the intestine; its *use* is similar to that of the last described muscle. Its surfaces are internal and external, its edges superior and inferior. Anterior to, and on each side of the anus, we find beneath the integuments a condensed cellular texture, covering the other muscles in the perinæum; this is the *superficial fascia;* it is continued from the inner side of one thigh across the perinæum to the opposite, adhering to the rami of the ischium and pubis on each side, by tendinous fibres; this fascia is very dense about the middle of the perinæum; posteriorly, on either side of the anus, it is loaded with soft, large-grained, adipose substance: anteriorly it extends over the scrotum, and becomes thin and fine, like reticular membrane, and continuous with the superficial fascia from the abdomen.

This fascia covers the vessels, and all the muscles of the perinæum, except the two sphincters of the anus. Separate this fascia from one side of the perinæum, and reflect it towards the opposite; its density and close connexion to the lateral boundaries of this region will then become obvious; a number of veins and nerves, and a quantity of fat also will be observed; when the latter is dissected away, those muscles of the perinæum, which are attached to the penis and urethra, will appear, covered, however, by a fine but dense aponeurosis, which may be next dissected off; these muscles are six in number, three on each side, viz. the erector penis, transversalis perinæi, and accelerator urinæ.* If the perinæum be divided by a transverse line drawn from one tuberosity of the ischium to the other, into an anterior and posterior part, we shall find that the anterior triangular space, or the *urethral* region, contains in the male subject the six muscles just named, also the crura penis and the corpus spongiosum urethræ: the posterior triangular division, or the *anal region*, contains the lower extremity of the rectum, surrounded by the cutaneous and deep sphincters, also on each side of this intestine a considerable quantity of fat, filling up the space between the side of the rectum and the obturator internus muscle and fascia; this, the *ischio-rectal space*, is bounded superiorly, that is, separated from the pelvis by the levator ani muscle, and inferiorly is closed by the fascia and integuments; the fat is from two to three inches in depth; when this mass is dissected out of the space which it fills, the levator ani muscle, covered by the ischio-rectal layer of the pelvic fascia, [or the deep perinæal fascia] will be seen extended from the internal surface of the pelvis to either side of the rectum, and to the coccyx, so as to form a partition be-

* A knowledge of these fasciæ will explain the resistance which this structure presents to collections of urine or of pus from coming to the surface.

tween the pelvis and the perinæum.—First examine the muscles in the anterior part of the perinæum; the erector or compressor penis is most external, and lies on the crus penis; the accelerator urinæ extends along the middle of the perinæum, attached to its fellow along the raphe, and covering the urethra; the transversalis perinæi connects the posterior extremities of these muscles. Immediately in front of the rectum, in the middle line, and behind, but connected to the bulb of the urethra, is a small, white, tendinous spot, composed of condensed cellular tendinous and muscular substance; into this many of the perinæal muscles are inserted; it is, therefore, called the *central point* of the perinæum, or the *common point* of insertion to the muscles of the perinæum.

Erector, or Compressor Penis, long and flat, narrow at each extremity, broader in the middle, *arises* tendinous and fleshy from the inner surface of the tuber ischii, and from the insertion of the great or inferior sacro-sciatic ligament, the fibres proceed forwards, upwards, and inwards, adhering to the edges of the rami of the pubis and ischium, and covering the crus penis. The fleshy fibres terminate in a tendinous expansion, which inclines forwards, upwards, and outwards, and is *inserted* into the fibrous membrane of the corpus cavernosum or crus penis. *Use;* to draw down the penis; it also contributes to the erection or distention of this organ by propelling the blood into it, and by the compression of the veins against the bone preventing the free return of this fluid through these vessels: it is the most external of the muscles in this situation, it covers and adheres to the crus penis.

Accelerator Urinæ, or Ejaculator Seminis, is in the middle of the perinæum, extends from the front of the rectum to the back part of the scrotum, and is attached to its fellow along the mesial line; it *arises* first, by tendinous fibres from the triangular or inter-osseous ligament, internal to the erector penis; secondly, by a broad tendon, which is common to the opposite muscle, and which lies above the urethra, between it and the pubis; thirdly, more anteriorly by a tendinous expansion from the side of the corpus cavernosum penis. The posterior and middle fibres descend inwards; the anterior fibres, which are longer, descend obliquely backwards and inwards; all the fibres are *inserted* along with those of the opposite muscle into the middle tendinous line or raphe of the perinæum, which extends from the common central point to the back of the scrotum.—*Use;* to expel the last drops of urine and semen, also to distend the corpus spongiosum urethræ by propelling the blood into its cells. The posterior origin of this muscle is overlapped by the erector penis, and by the perinæal vessels and nerves; some of its fibres extend in some cases outwards, as far as the ramus of the ischium, and arise from the bone; the origin of the middle fibres lies above the urethra, and that of the anterior is external to the crus penis. The anterior fibres of this pair of muscles, by converging towards the middle line, resemble the letter Y. The acceleratores urinæ muscles fill up the middle of the perinæum, cover the bulb, and encircle the urethra anterior to it. Separate these muscles from each other along the mesial line, and detach one of them from the corpus spongiosum urethræ; then by examining its deep surface, its origin, particularly that which lies above the urethra, anterior to the bulb, will be more distinctly seen.

Transversalis Perinæi, is thin and weak, often indistinct, and sometimes wanting; it *arises* from the inside of the tuberosity of the ischium, above the erector penis muscle, the fibres pass transversely inwards and a little downwards, and are *inserted* into the central point of the perinæum, behind the accelerator urinæ muscle. *Use*, to fix the central point, and support the anus; it may also dilate the bulb. This muscle is covered by the sphincter ani, and by the superficial fascia, a small artery (transversalis perinæi) runs along its anterior edge; it lies on the levator ani, is connected to it by cellular membrane, and in some cases is intimately joined to it. In some subjects a second muscle may be observed taking a transverse course (the *transversalis alter;*) this *arises* from the ramus of the ischium, proceeds obliquely forwards and inwards, and is *inserted* into the accelerator urinæ. The transverse perinæi muscles are very irregular in size in different persons, in some being found very distinct and strong, in others a few pale and scattered fibres only point out their course and situation: the dissector is frequently obliged to cut off a few fasciculi from the levatores ani muscles, to make even an appearance according with the description given in books. Between the three last described muscles on each side, we may remark a triangular space, which is bounded externally by the crus penis and the erector penis muscle, internally by the urethra and accelerator urinæ; the base is posteriorly, and is formed by the transversalis perinæi muscle. This space contains a quantity of fat, also the perinæal artery, veins, and nerves, branches of the pudic vessels and nerves; into this space, on the left side of the perinæum, the operator must sink his knife in the lateral operation of lithotomy, in order to lay bare the groove in the staff. In this incision the transversalis muscle and artery of the perinæum must be divided. Next dissect off the erector penis from the crus penis, also the acceleratores urinæ muscles from the bulb and corpus spongiosum urethræ; detach the transverse muscle from its attachments, and remove the vessels and cellular membrane out of the triangular space just now described; then press the bulb of the urethra to one side, from the crus penis, and between these two bodies we may observe a strong ligamentous substance, the fibres passing in different directions; this is the *triangular ligament of the urethra* or the *inter-osseous ligament of the perinæum.* The apex of this ligament is above, and is weak and cellular, being lost in front of the symphysis pubis, on the dorsal vessels of the penis; the sides are connected to the rami of the pubis and ischium; its base is directed towards the rectum, being connected in the middle line to the central point of the perinæum, on each side of which it is thin and weak, and gradually lost on the surface of the levator ani. Through this ligament the urethra passes about an inch below the inferior edge of the symphysis pubis, and as this canal passes through it, the ligament sends a lamina on it in each direction, one anteriorly on the bulb, the other posteriorly on the membranous portion of the urethra and prostate gland; the former is called the anterior, the latter the posterior layer of the triangular ligament, and they are separated from each other by Cowper's glands and the artery of the bulb. The *anterior layer of the triangular ligament* is expanded on the bulb, and gives to it the peculiar glistening appearance it now presents; it also retains it in its situation, and prevents it being detached, as will appear if you endeavour to draw it out of its place. The *posterior layer* is continued backwards around the membranous part of the urethra to the prostate gland, the capsule for which it forms, and then becomes continuous superiorly and laterally with the reflections of the pelvic fascia on the neck of the bladder. Divide a few fibres of the anterior layer of this ligament, and by a little dissection you will expose on each side of the bulb a small glandular body, *Cowper's* or the *anti-prostatic glands;* these are two in number, about the size of a small pea, situated at each side of, and behind the bulb, below the membranous part of the urethra, between the layers of the triangular ligament, and closely connected to the artery of the bulb; they are covered anteriorly by the acceleratores urinæ muscles, and by the anterior layer of the triangular ligament; from each a small delicate duct, about an inch in length, passes forwards, and opens obliquely into the lower and lateral part of the urethra, at a little distance anterior to the bulb. Dissect away all the cellular membrane at the side of the rectum, between it and the tuber ischii; you will thus expose the greater portion of the levator ani muscle; press the rectum to the opposite side, and you will then observe how this muscle, posteriorly, and the triangular ligament, anteriorly, close the inferior opening of the pelvis, and separate this cavity from the perinæum. Divide the triangular ligament on one side from the rami of the pubis and ischium, and draw it over towards the bulb of the urethra, which, together with the rectum, press or fasten with a tenaculum, towards the opposite tuberosity of the ischium. In separating this ligament from the bone, the pudic artery and its terminating branches will be seen; we thus also expose more fully the levator ani muscle.

Levator Ani, flat, thin, and broad, situated at the inferior part of the pelvis, broader above at its origin than below at its insertion; *arises* fleshy from the posterior part of the symphysis pubis below the true ligaments of the bladder; thin and tendinous from the obturator fascia, and from the ilium above the thyroid hole; thick, tendinous, and fleshy from the inner surface of the ischium, and from its spinous process; the fibres descend obliquely inwards, by the side of the neck of the bladder and rectum; the anterior passing more backwards than the others, while the posterior are more transverse or horizontal, *inserted*, the anterior or pubic fibres into the central point of the perinæum, and into the forepart of the rectum, uniting with the fibres from the opposite side. These anterior fibres descend along the side of the prostate gland and the membranous part of the urethra; the middle fibres into the side of the rectum, passing internal to the sphincters, and united to the outer surface of the longitudinal fibres of the intestine; the posterior fibres into the back part of the rectum, and into a tendinous raphe, extending from it to the os coccygis, in which raphe the muscles from the opposite sides unite, also into the two last bones of the coccyx. *Use*, to raise the rectum when this intestine has been protruded by the efforts of the abdominal muscles to expel its contents; it also assists in closing this intestine, it compresses the vesiculæ seminales and prostate gland; the anterior portion supports the perinæum by raising the common central point, and may also compress and close, like a sphincter, the membranous portion of the urethra; the levatores ani complete the inferior boundary of the pelvis and abdomen, and are opposed to the diaphragm in respiration, being muscles of expiration. The two levatores ani muscles resemble a funnel, with two openings in it inferiorly: the concavity directed towards the pelvis, the convexity to the perinæum; through the anterior aperture the urethra passes, through the posterior the rectum. On the perinæal surface of this muscle are placed the muscles, the triangular ligament, and the adipose substance of which we have spoken; its pelvic surface is covered by the peritonæum and by the pelvic fascia, which cannot be seen in the present dissection, but which shall be noticed presently.

At the anterior edge of each levator ani muscle fleshy fibres may be observed to surround the membranous part of the urethra very closely. These fibres, particularly at their insertion, will in general be found so united to the levatores ani, that they may be considered as portions of these muscles; they have, however, been described differently by different anatomists, no doubt in consequence of the different appearance they present in different subjects, and from the different mode in which the dissection has been conducted; Mr. Wilson describes them as follows:

COMPRESSORES URETHRÆ; each *arises* by a tendon from the inside of the symphysis pubis, about one-eighth of an inch above the lower edge of the arch, and at nearly the same distance beneath the anterior ligaments of the bladder, to which, and to the tendon of the opposite muscle, it is connected by loose cellular membrane; the tendon is at first round, but becomes flat as it descends, and is parallel to and in contact with its fellow; it then ends in fleshy fibres, which increase in breadth, and which approaching the upper surface of the membranous portion of the urethra, separate from those of the opposite muscle, descend along the side of the membranous portion of the urethra, and folding beneath it, again approach the muscle of the opposite side, and are *inserted* with it into a narrow tendinous line, which becomes lost in the common central point of the perinæum. *Use*, to compress, contract, close, and elevate the membranous portion of the urethra; these fibres encircle the narrowest part of the urethra, that portion which is just behind the bulb, and may, by their contraction during life, form such an impediment to the passage of an instrument into the bladder, as may lead the surgeon to suspect the presence of a stricture, when in reality no alteration of structure exists. The origin of these muscles is occasionally distinguished from the levatores ani, by some small veins which pass from the side of the neck of the bladder to join the trunk of the dorsal veins of the penis, but their insertion is confounded with these muscles in perinæo behind the bulb.*

Let the student next replace the triangular ligament, &c.,

* Mr. Guthrie states, that they *arise* from two tendinous lines, one on the upper, the other on the lower surface of the urethra, thence the fleshy fibres pass transversely outwards, and are *inserted* into the upper part of the ramus of the ischium.

and then re-consider the several parts before him, in reference to the operation of lithotomy: he has already examined the triangular space between the erector penis and accelerator urinæ muscles, into which the knife of the operator is to sink in order to reach the groove in the staff; this space has been fully opened, and the staff can be plainly felt or seen passing above the bulb through the membranous part of the urethra into the bladder: behind and below the bulb is the rectum; and close to the rami of the pubis and ischium are the internal pudic vessels: the large artery from the pudic, called the deep transverse artery, or the artery of the bulb, may also be observed passing in the substance of the triangular ligament, about an inch below the symphysis pubis. Hence then, in order to lay bare the staff without injury to the more important parts which surround it, we should endeavour to open the urethra as near to the base of the triangular ligament as possible, as we shall thus be most likely to avoid the artery of the bulb. Suppose the knife of the operator to be lodged in the groove of the staff, and then to be pushed along it into the bladder, the student will perceive that at that moment the posterior layer of the triangular ligament, the anterior fibres of the levator ani, and the left lateral lobe of the prostate gland, must be divided, and from this view he may also learn that the rectum will be protected from injury if the staff be well raised into the arch of the pubes, its groove turned a little to the left side, and the wrist of the operator depressed, so as to elevate the point of the knife, and thus direct it on into the bladder; as to withdrawing the knife the student may now learn in what direction this can be done with safety and effect, and what parts require to be divided; it is to be withdrawn slowly and steadily in a direction backwards and outwards, nearly parallel to the line of the cutaneous incision, the edge so lateralized as to avoid cutting the rectum posteriorly, or the pudic artery externally; in this part of the operation the middle fibres of the levator ani must be divided, also the adipose substance on its perinæal surface. The student may now withdraw the staff from the bladder, and pass it again and again along the urethra into that cavity; he will soon perceive how apt the point of the instrument is to descend into the sinus of the bulb, and the necessity of depressing the handle of the staff, in order to raise the point into the membranous part of the urethra.

[This is owing to the fact, that the membranous portion of the urethra does not terminate at the end and bottom of the bulb, but some lines above and before this, hence when the point of the staff is lodged in the bulb, it should be withdrawn a few lines, to disentangle it from any fold of the mucous membrane, and then by depressing the handle of the instrument, the point will be raised up to the opening through the triangular ligament.]

At the same time he should observe, that the latter is about an inch below the arch of the pubes, and that, therefore, the point of the instrument is not to be too much elevated, otherwise it may lacerate the upper part of the urethra, and injure some large veins that may be found in this situation. The student may now also examine what occupies the space between the urethra and the pubes; immediately above that canal is the upper portion of the triangular ligament, attached to the crura penis; behind and above this are one or two large veins from the dorsum of the penis, these enter the pelvis along the upper surface of the prostate gland; above these is a smooth dense ligament, the *pubic ligament*, which is attached to the lower edge of the symphysis pubis, and rounds off the angle between the opposite rami.

Posterior to the levator ani, and overlapped by the glutæus maximus, is the following small muscle:

Coccygeus, triangular, at the inferior and posterior part of the pelvis, behind and above the levator ani, *arises* narrow from the inner surface of the spine of the ischium, the fibres expand along the inner or lesser sacro-sciatic ligament, and are *inserted*, fleshy and tendinous, into the extremity of the sacrum and side of the coccyx: *Use*, to support the os coccygis and to assist in closing the inferior and posterior part of the pelvis; this muscle is between the levator ani and the glutæus maximus; it is more distinctly seen within the pelvis.

Next let the student divide the central point of the perinæum, separate the rectum from the bulb, and draw the former a little downwards from the bladder and prostate gland: he will thus expose the inferior or posterior surface of the neck of the bladder, the flat posterior surface of the prostate gland, also the vesiculæ seminales, the terminations of the vasa deferentia, and the commencement of the urethra, but the most important part to direct the attention to, is a small triangular space or portion of the bladder, just above and behind the prostate gland, which is bounded on either side by the vasa deferentia and vesiculæ seminales, posteriorly by the *cul de sac* of the peritonæum, and anteriorly by the prostate gland which forms the apex of this triangle; within this space the muscular coat of the bladder is in contact with the rectum, and from the cavity of the latter the former organ may be perforated during life without injuring any important part; this space is about three inches and a half, or four inches from the anus, and is selected by some surgeons as the best situation for tapping the bladder in case of retention of urine, when a catheter cannot be passed through the urethra. The student may now proceed to examine the pelvic viscera; for this purpose, separate the left crus penis from the bone, also the left border of the triangular ligament, (if not already done,) and detach the levator ani muscle of the left side from the bone; with the hand separate the cellular and aponeurotic bands which lie superior to this muscle; then divide the symphysis pubis, or saw the left os pubis about half an inch external to the symphysis, divide the left ilio-sacral articulation, cut through the psoas muscle and iliac vessels, and then remove the os innominatum and lower extremity of the left side; the pelvic viscera will remain in the concavity of the sacrum and of the opposite os innominatum. These viscera will be rendered more distinct by a little dissection, first, moderately inflating the bladder through the ureter, a ligature having been tied around the penis, the rectum also may be moderately distended with curled hair or a sponge, and attached to the spine by a ligature.

The *pelvic portion* of the *peritonæum* should be first attended to; this membrane may be now seen to descend along the sides and fore part of the rectum to within about three or four inches of the anus, whence it is reflected on the lower and back part of the bladder: the line of this reflection is, in the recumbent position of the subject, opposite the lower margin of the third piece of the sacrum; in the erect posture it will be found on a level with the junction of the sacrum and coccyx; the peritonæum is reflected on the bladder between the middle of the vesiculæ seminales, it then ascends on the back part and sides of this organ to its superior fundus, whence it is continued to the abdominal muscles; below the line of its reflection on the bladder, or below the *cul de sac*, we may again take notice of the triangular space on the inferior fundus of the bladder, before alluded to, as the situation in which that viscus can be punctured from the rectum, in case of retention of urine. The reflections of the peritonæum from each side of the rectum to the back part of the bladder, are called the posterior ligaments, and the folds which this membrane forms, one on each side between the bladder and the iliac fossa, are named the lateral ligaments of the bladder; these shall be more particularly noticed presently. Remark the curved course of the rectum, its dilatation near the anus, also the connexion of the peritonæum to its upper and middle thirds, and observe that the lower third of this intestine is completely below and unattached to this membrane. Next study the connexions of the unirary bladder.

Vescica Urinaria, when contracted, is situated in the anterior and inferior part of the pelvis behind and below the pubes; when distended it occupies more or less of the hypogastric region; when contracted, it appears of a flattened triangular form, the base towards the rectum, the apex behind the lower edge of the symphysis pubis; when distended, it presents an oval figure, the larger end towards the rectum, the smaller and anterior end towards the recti abdominis muscles, between the pubes and the peritonæum; the axis of the bladder is a line directed through its cavity from one extremity to the other; the posterior end of this line, if prolonged would touch the extremity of the coccyx, and if continued anteriorly it would reach the linea alba, midway between the pubes and the umbilicus. In the very young subject, the bladder is of a pyriform figure, and is principally lodged in the hypogastric region.

[The form and situation of the bladder vary very much, according to age, sex, and distention. In the fœtus and infant the bladder is nearly cylindrical in form, and almost entirely in the cavity of the abdomen, the cavity of the pelvis proper at that time, being so small, as not to contain it, particularly after the secretion of urine commences. In the adult male the form of the organ is ovoidal, the longest diameter being vertical to the plane of the superior strait of the pelvis. In the adult female, who has borne children, the bladder is more spheroidal in form, is more capacious than in the male, and its longest diameter is transverse. This difference appears to be owing to the pressure exerted upon the bladder, by the gravid uterus. We find also, that the position of the bladder is changed during utero-gestation, particularly in the advanced stage, when this organ, is somewhat raised and projected forward over the pubis, and the urethra is drawn up behind, and nearly parallel to the symphisis pubis. On this account, if necessary to draw off the urine, the point of the catheter being introduced into the orifice of the urethra, the handle must be depressed between the thighs, nearly to the fissure of the nates. If the bladder of the adult be but partially distended with urine, it will remain within the cavity of the pelvis proper, but when fully distended, the superior fundus, rises up above the brim of the pelvis, into the abdomen, and in some cases, of over distention, it has ascended above the umbilicus. The capacity of the bladder, in the adult will average about one pint, but there is a great difference in individuals in this respect, the capacity being greater in those who are in the habit of retaining their urine for a length of time, than in others, and this is thought by Cruveilhier, to be one cause of the greater capacity in the female; they, from the habits of society, being more often obliged to retain the urine, for a long time. Again the capacity of the bladder varies with certain morbid conditions, the organ in some cases, being so contracted as scarcely to contain an ounce of fluid, while in others, it is so dilated as to hold several pints.

According to the anatomist above named, the bladder is proportionably larger, before than after birth.]

The bladder is connected to the parietes and to the viscera of the pelvis by folds of the peritonæum, and by the reflections of the pelvic fascia. The folds of the peritonæum are termed false ligaments, and are five in number, viz. two posterior, two lateral, and one superior: the true ligaments are reflections of the pelvic fascia, and are four in number, two anterior and two lateral. We shall first consider the *false ligaments*, or the folds of the peritonæum, which serve to connect the bladder to the pelvic viscera. The *posterior ligaments* of the bladder are two in number, one on each side; they lead from the fore part of the rectum to the back part of the bladder; each is of a semilunar form, its concavity looking forwards and upwards; in this fold are contained the ureter posteriorly, and the obliterated hypogastric artery anteriorly; between the posterior ligaments the cul de sac of the peritonæum descends. This membrane will be also found thrown into one or two semilunar folds on the posterior surface of the bladder, provided this viscus be in a state of contraction; these disappear, however, when it becomes distended: hence it may be inferred, that these folds are designed to admit of the more easy distention of this organ. The *lateral ligaments* extend, one on each side, from the lateral regions of the bladder to the iliac fossæ; each contains in its duplicature the vas deferens in the male subject, and the ligamentum teres of the uterus in the female. The *superior ligament* extends from the summit of the bladder to the recti muscles; this portion of the peritonæum is partially reflected over the remains of the urachus and of the hypogastric vessels. Detach the peritonæum from the right iliac fossa, and gently draw the bladder and rectum from the pelvis, we shall then observe that the neck and sides of the former are retained in their situation by the reflection of a strong fascia (the pelvic fascia) from the parietes of the pelvis upon this viscus; these reflections are the *true ligaments* of the bladder. The *pelvic fascia* may be considered as a continuation of the iliac fascia; it descends from behind the iliac vessels and from the brim of the pelvis, to which it adheres, and lines the parietes of the cavity as low down as the upper edge, or the origin of the levator ani muscle; here the pelvic fascia divides into two laminæ, between which this muscle is enclosed: the external lamina is named the obturator fascia, [or deep perineal fascia] the internal the vesical fascia. The *obturator fascia* descends between the obturator internus and levator ani muscles, adhering very closely to the former, and sends off the ischio-rectal layer of fascia which covers the perinæal aspect of the levator ani muscle; the obturator fascia is then inserted inferiorly into the great sciatic ligament, into the tuber ischii, and into the rami of the ischium and pubis, where it is continuous with the triangular ligament of the urethra, which ligament thus appears to be the continuation of the obturator fascia, from one side of the pelvis to the other. The *vesical fascia* covers and adheres to the internal surface of the levator ani, lying between it and the peritonæum; this fascia descends anteriorly to the lower edge of the symphysis pubis, and laterally to a level with a line carried from this point round to the spine of the ischium; from the pubes it is reflected on the upper surface of the prostate gland, and on the neck of the bladder, forming the anterior true ligaments of this organ; laterally it is reflected from the pelvis on the side of the prostate, and on the lower part of the side of the bladder, just above the outer edge of each vesicula seminalis, and thus it forms the true lateral ligaments of the bladder; posteriorly the vesical fascia becomes thin and cellular, is attached to the side of the rectum, and lost on the nerves and vessels passing into and out of the pelvis. The vesical fascia thus forms a pouch on each side of the bladder, which assists in closing the pelvis; it also fixes the pelvic viscera, supports the peritonæum, and resists the pressure of the abdominal muscles and diaphragm. This fascia is perforated by several blood-vessels.

The *anterior ligaments* of the bladder are two in number; they *arise*, each, from the lower margin of the pubis by the side of the symphysis; pass backwards and upwards on the upper surface of the prostate gland, and expand on the anterior part of the bladder; many of their fibres may be seen to become continuous with the muscular fibres of the bladder, their inferior or convex surface is united to the posterior layer of the triangular ligament. A depression exists between these two ligaments, along which the dorsal veins of the penis pass from beneath the arch of the pubes to the side of the bladder in their course to the internal iliac veins, in which they terminate; the pelvic fascia, however, is not deficient between these ligaments, but is continued from one to the other, so as to line this depression and cover the superior surface of these veins. The *true lateral ligaments* of the bladder are, one on each side; each is continuous with the anterior ligament, and is formed by the reflection of the pelvic fascia from the inner surface of the levator ani to the side of the prostate gland and of the bladder.

The superior and anterior extremity of the bladder is sometimes named the *superior fundus;* the posterior extremity, which presses against the rectum, the *inferior fundus;* the intervening portion is called the *body*, and that part which is connected to the pubes the *cervix;* the latter is surrounded by the prostate gland, very little, however, of this gland being above it, a little dissection can separate the base of this gland from this part of the bladder, which it overlaps, the cervix is thus made more distinct, and it then presents somewhat a conical figure; in the adult it lies nearly horizontal, below and behind the pubes; in the child it is more vertical. If the bladder be moderately distended it will be found to present six regions, on each of which some important object may be noticed. 1st, The *superior region*, is in contact posteriorly with the convolutions of the small intestines, and anteriorly with the recti abdominis muscles; to it are attached the urachus and obliterated umbilical arteries; posterior to these this region is covered by peritonæum, whereas anterior to them this membrane is deficient. If the bladder be much distended, this region is sometimes found to incline to the left side. 2nd, and 3rd; The *lateral regions*, are contiguous to the sides of the pelvis, to the vesical fascia, and to the levatores ani muscles; descending obliquely backwards along this region on each side, we find the vas deferens crossing over the obliterated umbilical artery above, and over the ureter below, thus passing internal to both, or nearer to the mesial line; the peritonæum adheres to so much of each lateral region of the bladder as lies posterior to the vas deferens while that portion anterior to it is deficient of this serous covering. 4th, The *anterior region* is behind the recti muscles, the pubes, the pubic ligament, and the triangular ligament of the urethra; all this region wants the peritonæal covering; towards its inferior part we observe the anterior ligaments of the bladder, between them the dorsal veins of the penis, and below them the neck of the bladder surrounded by the prostate gland. 5, The *posterior region* is contiguous to the rectum in the male, to the uterus in the female, and in either sex occasionally to the convolutions of the small intestines; all this region is covered by peritonæum. 6th, The *inferior region*, in the female, lies on the ureters and on the vagina; in the male, on the vesiculæ seminales, the intervening cul de sac of peritonæum, the rectum and the prostate gland; the superior and posterior part of this region is covered by the peritonæum; but anterior to the line of the reflection of this membrane, from the bladder to the rectum, is the triangular portion of this region, in which the peritonæum is deficient, and which has been already attended to, as the situation in which the operation of tapping the bladder from the rectum may be performed.

The coats of the bladder are four, viz. 1st, the serous, or peritoneal; 2nd, the muscular; 3rd, the cellular; 4th, the mucous; the *serous* is but a partial coat, it covers all the posterior surface, the posterior part of the upper and lower fundus; also the posterior part of each side. All the anterior region, the fore part of the sides, and of the upper and lower regions, are therefore uncovered by peritoneum; when the bladder is distended there is more of this organ in proportion covered by this membrane than in its contracted state. The peritonæal covering of the bladder is very dense, it may be easily dissected off the following. 2nd, The *muscular* coat consists of fibres which are stronger and redder than the muscular fibres on any of the hollow viscera; they take different directions; those of the superficial layer run chiefly in a longitudinal direction, are connected anteriorly and inferiorly to the anterior ligaments of the bladder, and superiorly to the urachus, posteriorly and inferiorly to the base of the prostate gland; these fibres are stronger on the anterior and posterior surfaces than on the sides of the bladder: on the latter regions they run obliquely and are fewer in number. The anterior fibres, from having a fixed attachment, are called by some the *detrusor urinæ* muscle: the deep fibres mostly take a circular direction, are weak superiorly, but strong near the cervix, where they are supposed by some to act as a sphincter muscle; these circular fibres which have received this name, may be more distinctly seen by everting the bladder, and dissecting off the mucous membrane near the orifice of the urethra on each side of the uvula. At the anterior part of the inferior region there is a compact layer of white dense fibrous substance, into which the muscular, particularly the longitudinal, fibres of the bladder are inserted, but which itself does not appear to be very muscular except near the cervix; this structure will be found to correspond with a particular region, which will be noticed presently in the interior of the bladder, and which is called the trigone, or the velum. In addition to the longitudinal and circular fibres, a deeper, but only a partial lamina of fibres can be seen having a reticular arrangement. Beneath the muscular is the 3rd, or the *cellular coat;* it invests the whole organ, is very elastic, and seldom contains any adipose substance. Open the bladder by a perpendicular incision through its anterior part; and the 4th, or the *mucous coat*, will be observed; this is pale, and thrown into many folds, particularly if the bladder had been empty, for this membrane has no contractile power; through it the muscular fibres project, presenting a reticulated appearance, and very frequently the mucous membrane forms pouches, or small sacks, between these: inferiorly is seen the orifice of the urethra; is is somewhat of a crescentric figure, a very small tubercle (the uvula) projecting into it from below: posterior to this the mucous membrane presents a smooth and dense appearance throughout a small triangular space called the *velum* or *trigone;* at the posterior angles of this space the orifice of each ureter may be observed, the line extending between these forms the base of this triangle; this line is somewhat semilunar, and contains strong muscular fibres; the sides of the trigone are defined by lines drawn from each ureter to the uvula; each is from an inch to an inch and a half in length; beneath the membrane covering each of these lines, pale muscular fibres may in general be found; these have been named by Mr. Bell, the *muscles of the ureters*, who describes each as *arising* from the vesical extremity of the ureter, and thence descending obliquely forwards and inwards, to be *inserted* by a tendon common to its fellow into the uvula. The *use* which he assigns to them is, to restrain the termination of the ureters, and preserve the obliquity of the passage of these tubes through the coats of the bladder while it is being contracted; for, says he, without this provision, the urine would be sent retrograde into the ureters, instead of forward into the urethra. These lines, however, seldom present this structure so distinctly as has been described, and how far their supposed use is correctly ascribed to them is very questionable. The *uvula* of the bladder is a small eminence at the apex of the trigone, much better marked in some than in others; it is merely a thickening and peculiar organization of the sub-mucous tissue; it is nearly opposite, but a little anterior to the third or middle lobe of the prostate gland. The trigone is the most sensible and vascular part of the bladder; posterior to the trigone the bladder is frequently, particularly in old subjects, dilated into a sort of pouch. In the female the trigone is smaller, but broader in proportion than in the male, and the uvula is less distinct.

[There is one fact in reference to the bladder, as often found on post mortem examination, which should be borne in mind, this is a remarkable contraction of the bladder, from having been empty before death, the cavity being scarcely large enough to hold a couple of ounces of fluid, and the muscular coat appearing very thick and distinct, and the whole organ is almost concealed under the arch of the pubis. This is to be particularly distinguished from the contraction which depends upon a morbid condition, in which case there will be other evidences of disease.]

The bladder is occasionally found in a *diseased* state, inflammation of it (cystitis) may be general or confined to one particular part; the portion which is most frequently so affected is that near the neck, and commonly arises from the presence of a rough stone; from the naturally pale appearance of the mucous membrane in the dead body, any crowding of vessels containing arterial blood which takes place in inflammation makes this state of parts easy of detection; and this is the case in chronic inflammation or catarrh of the bladder: if the inflammation be violent, the muscular coat may become engaged, and abscesses and ulcers are not unfrequently the consequence; they sometimes proceed so far as to destroy a portion of the bladder, and form communications between it and the neighbouring viscera; with the rectum in the male, and vagina in the female; they have also been known to open into the cavity of the abdomen, producing peritonitis and death from extravasation of urine; abscesses about the neck of the bladder are generally found as a consequence of the operation of lithotomy or of fatal retention of urine, or diseased prostate gland.

[Inflammation of the bladder is sometimes caused, from the urine being retained too long. Inflammation may terminate in resolution suppuration, or gangrene, which last is very rare. We sometimes find a softening of the mucous membrane, sometimes also hypertrophy of the tunics, but more particularly of the muscular coat, and this generally arises from some obstruction about the neck of the bladder or in the urethra, which prevents the ready discharge of the urine.]

Calculi are not uncommonly formed in the bladder: their formation is confined to no particular period of life; they are found in very young children and in persons of middle and advanced age; they are very seldom met with in females, as the size of the urethra in that sex allows them to be discharged before they become large, probably also the tendency to their formation is not so strong in females. The stones which are found in the bladder are either originally formed in the kidneys, and pass through the ureters into the bladder, or they are at first formed in the bladder itself. Calculi lie either loosely in the cavity of the bladder, or are confined to some fixed situation from particular circumstances; when they are of a small size, they are sometimes lodged in pouches, formed by the protrusion of the mucous coat of the bladder, between the fasciculi of its muscular fibres. Urinary calculi have sometimes a smooth, uniform surface, but more frequently the surface is granulated and rough.

The urethra is the next division of the urinary organs to be examined; as this canal, however, in the male, is the common passage for the urine and seminal fluid, or as it is a part both of the urinary and generative organs, we shall postpone the description of it until we have considered the latter.

DISSECTION OF THE ORGANS OF GENERATION IN THE MALE.

The organs of generation in the male are the testicles and their appendices, the vesiculæ seminales; the prostate and anti-prostatic glands, (the latter have been already examined;) the penis, and the urethra. We shall describe these organs in the following order: 1st, the testes, with their coverings; 2nd, the vasa deferentia; 3rd, the vesiculæ seminales; 4th, the prostate gland; 5th, the penis, and 6th, the urethra.

1st. THE *Testes;* these two glands are, in the very young fœtus, contained in the abdomen beneath each kidney; a short time, however, previous to birth, they descend into that situation which they are found to occupy in the adult, and are surrounded by several tunics, viz. the scrotum, dartos, superficial fascia, tunica communis, tunica vaginalis, and tunica albuginea.

The *Scrotum* is a process of common integument continued from the inner side of each thigh, and from the perinæum and penis; it is generally of a dark brown colour, thinly covered with hair, and very rugged, being thrown into numerous rugæ, it is so thin that the small sub-cutaneous veins and sebaceous follicles can be seen through it, these latter secrete the peculiar perspirable matter of this region, the prominent hard ridge or raphe is continued from the perinæum along its middle line as far as the penis. The *Dartos* is the cellular tissue immediately subjacent to the skin, it usually presents a reddish appearance, a number of small vessels being distributed through it; its texture is very loose, and is readily distended in emphysema or in anasarca; it never contains any fat; it is somewhat more dense in the mesial line than at either side. The dartos is connected to the rami of the pubis and ischium of each side, and to the raphe in the middle, thence it ascends a short way between the testes to the urethra, and thus assists the superficial fascia in forming the *septum scroti.* The dartos manifests during life a degree of contractility above that which the cellular tissue enjoys in any other situation; it has therefore been considered by some as a cutaneous muscle; this idea is most probably incorrect, although it certainly possesses the power of corrugating the skin, distinct from that rolling motion of the testicle produced by the cremaster muscle; posteriorly the dartos frequently appears to derive a few muscular fibres from the sphincter ani.

[Meckel suggested, that the Dartos was the transition between muscle and cellular tissue. Cruveilhier looks upon it, as being the same tissue with the external coat of the vagina, with the external coat of the veins, and the substance of the nipple. By some anatomists the Dartos has been considered an expansion of the gubernaculum testis, and not to exist in the scrotum, until after the descent of the testicle; but on the other hand it has been found in the scrotum of the fœtus, before the descent of the testicle, and in the case of an adult, in whom the testicle had not passed down through the ring, Cruveilhier satisfied himself of the co-existence of the gubernaculum and the dartos, independently of each other.]

Beneath the dartos is the *superficial fascia* of the scrotum, this is continued from that of the abdomen around each spermatic cord, testicle, and epididymis; it is thin, loose and reticular, and becomes continuous with the fascia of the perinæum: as this fascia envelopes the cord and testis on each side, it, assisted by the dartos, forms the *septum scroti*, and so retains each testicle at its own side. The *tunica communis* is composed of the expanded fibres of the cremaster muscle and of fine connecting cellular membrane; this tunic surrounds the cord and testis: the fibres of the cremaster are expanded chiefly on the forepart and sides of the testis. The *tunica vaginalis* was originally, that is, in fœtal life, a process of the peritonæum, having been prolonged along the cord and around the testicle as the latter was descending from the abdomen to the scrotum; at this early age, the tunica vaginalis in the scrotum communicated with the general cavity of the peritonæum by a sort of canal which led along the forepart of the cord from the abdomen to the scrotum: this canal, however, about the period of birth was closed by the adhesive process, and ever afterwards the cavity of the tunica vaginalis is quite distinct from that of the peritonæum.* The tunica vaginalis, therefore, is a serous membrane, a shut sac, suspending, and partly enclosing the testicle, and also reflected over its anterior part and sides: that portion of it which suspends the gland, and which lines the scrotum, may be named the tunica vaginalis *scroti;* while the reflected portion which covers the sides and forepart of the testicle is the tunica vaginalis *testis*. This membrane is so loosely connected to the scrotum that it can be detached from it with little force; it is thence reflected on the sides and forepart of the epididymis and testis, it also ascends a short

* When this canal is not thus closed, a hernia usually occurs, which is named "congenital inguinal hernia."

distance on the forepart of the cord; the posterior part of the epididymis is altogether uncovered by it: as it is continued from the epididymis to the testicle it passes in between these organs, particularly on their outer side, so as to form a sort of pouch between them. Both the testicle and epididymis are in reality behind this serous membrane, and nothing is contained within its cavity except the serous fluid, which lubricates its opposed surfaces, and which facilitates that gliding motion which the testicle undergoes in the scrotum.

[The cavity of the tunica vaginalis will receive from one to two ounces of fluid without distention, but when distended, as in hydrocele, it sometimes contains even quarts.]

When the anterior part of the tunica vaginalis is divided, we see its internal surface smooth and polished, and shining through its reflected layer which covers the testis, we can discern the next tunic of this gland, *tunica albuginea:* this is a dense fibrous membrane; it forms the proper capsule of the gland, adheres to it, preserves its peculiar form, and sends several processes or septa into the testicle, which will be seen when the body of the latter shall have been opened; it has no connexion to the epididymis: it is difficult to dissect off the reflected layer of the serous membrane, or the tunica vaginalis testis from the tunica albuginea, they are so intimately united; through the latter several blood vessels can be distinctly seen; indeed the albuginea can easily be separated into two laminæ, the external strong and fibrous, the internal soft and vascular, formed by the ramifications of the spermatic artery. Each *testicle* is of an oval form, flattened on each side, also a little on the back part beneath the epididymis; it is suspended rather obliquely, the superior extremity being directed forwards and outwards, the inferior backwards and inwards.

[The testicles are not suspended at the same level, that of the left being lower down than that of the right side, for two reasons, says Sir A. Cooper, the one to allow of the disposition of the penis to one side of the median line, the other to allow of the one testicle gliding upon and above the other, in the close adduction and crossing of the thighs. It is said that there is usually a difference in the size of the testicles, but if any, it must be but slight as some anatomists give the difference in favor of the left, and others in favor of the right. In some cases as stated there is but one testicle, while in others there are more than two. Those cases reported as belonging to the former class, are almost always cases, in which one of the testicles has not descended into the scrotum. Cruveilhier however dissected a subject in which he found but one testicle. It does not appear to be satisfactorily proved, that there are ever more than two of the organs; the apparent instances, have been in consequence of the presence of tumours of some kind. I have seen two of these cases, in which the individuals supposed that they had three testicles, but on examination, the third body proved to be morbid, in one case it was a small hydatid. The situation of the testicles, in fœtal life, is very different from that in which they are usually found after birth. At the middle of the third month of utero-gestation, the cavity of the abdomen, communicates on either side, with the cavities of the scrotum or sacculi testium, by short oblique canals, which at this period correspond to what in the subsequent development of the parts, constitute the abdominal rings and inguinal canal. At this period the peritonæum lining the abdomen, is continued down into the sacculi, forming small pouches. The testicle itself is in the cavity of the abdomen, on the psoas muscle below the inferior extremity of the kidney; and is posterior to the peritonæum like all the abdominal viscera, that membrane however, is reflected over the sides, and fore part of the testis, from the lower end of which proceeds a small ligament, the gubernaculum testis which terminates at the upper and inner part of the scrotum, being also behind the peritonæum. At this time the spermatic vessels are quite short, and descend a little obliquely to the posterior border of the testicle, while the vas deferens passes obliquely over the iliac vessels, into the pelvis. This original position of the testis and its subsequent descent, explain the remarkable length of the spermatic vessels in the adult.

Being thus placed the testicle gradually descends towards the scrotum, as is said by some, from the contraction of the gubernaculum, until usually in the course of the seventh or eighth month, of utero-gestation it is lodged in the sacculus testis; having fairly reached this cavity the passage from the abdomen contracts and becomes completely obliterated, so that there is no longer any communication between the several cavities, and the serous membrane of the passage is converted into cellular tissue, which is sometimes the seat of hydrocele of the cord. The closure of the passage after the descent of the testicle, does not always take place, and then a portion of intestine may descend with the testicle, constituting congenital hernia, or fluid may pass down into the sacculus, which is called congenital hydrocele. The testicle while in the cavity of the abdomen has a proper and complete fibrous covering, the tunica albuginea; after it gets into the sacculus, the peritonæum which invested it in the abdomen, becomes the tunica vaginalis testis, while the original serous lining of the scrotum, is the tunica vaginalis scroti, and the two together, constitute the tunica vaginalis communis, exterior and posterior to the cavity of which is the testicle, and within which cavity, true hydrocele and hematocele take place. Both testicles do not always descend, one is sometimes retained in the abdomen or becomes entangled in the passage, and may in after life be confounded with concealed inguinal hernia.

Weight and Measurements of the Testicle. These differ much in different individuals; on the average they are from twenty-two to twenty-four lines in length, from twelve to eighteen lines broad, and from seven to eight lines thick. Their average weight is about six drachms, the epididymis ranging from two to three scruples; Sir A. Cooper gives the weight of the testicle as high as one ounce. The color of the organ is a greyish white depending upon the color of its tunics.]

Bent like an arch, along the posterior surface of each testicle, is the *epididymis*, long and narrow, large above, (globus major,) narrow in the middle, (body,) and again enlarged below, (globus minor,) attached to the testicle above by vessels, and in the rest of its extent by the reflected layer of the tunica vaginalis, closely on the internal, but very loosely on the external or femoral side; from its inferior extremity the vas deferens proceeds, and thence ascends along its internal side. Divide the tunica albuginea anteriorly, and we observe the testicle to be composed of a soft greyish or yellowish pulpy substance, which, when opened out a little, and floated in water, is found to consist of numerous fine tortuous shreds or vessels of delicate texture, loosely connected to each other; some are of considerable length, and with a little care may be drawn out of the gland to the extent of two or three feet; they are placed in packets or fasciculi, which are separated from each other by fibrous bands or septa, which are derived from the tunica albuginea, and which may now be seen to pass in considerable numbers through the gland towards the back part, where they join the *corpus Highmorianum;* this name is applied to a long fold or process of the tunica albuginea, which projects into the back part of the gland; it consists of two laminæ, between which the vessels and nerves of the testicle are enclosed; this process is broader above than below, is perforated in the former situation by the excretory ducts of the testicle; to its anterior border and sides are attached the sepimenta or processes of the tunica albuginea before mentioned. This process is also more properly denominated the "mediastinum testis" as it plainly consists of two laminæ, and contains in the interspace the excretory portion of the gland. From the several collections of small tubes, which are disposed between these bands or septa, about twelve or twenty larger vessels may be seen to proceed in parallel lines towards the back part of the gland; these are the *tubuli recti;* they enter the mediastinum, and if one lamina of this process be raised off they will be seen entangled with each other, and with the vessels and nerves of the gland; this structure receives the name of *Rete Testis*, it is placed near the posterior part of the gland, between the laminæ of the mediastinum or the corpus Highmorianum; from the upper part of this tissue five or six tortuous vessels ascend obliquely backwards, pierce the tunica albuginea, and arrive at the head of the epididymis; here they increase in size, and become coiled or convoluted; these are the *vasa* *deferentia* or *coni vasculosi;* they all terminate in the head or globus major of the epididymis, and unite into one small duct (the vas deferens), which is twisted and coiled over and over again in a most extraordinary and peculiar manner. The body and globus minor of the epididymis are solely composed of this convoluted vessel, which by care may be unravelled to a great extent: the convolutions of this tube, of which the epididymis thus consists, are connected to each other by fine cellular tissue and by the reflected tunica vaginalis; the epididymis has no fibrous capsule like the testis; from its lower extremity the *vas deferens* at length escapes, and increasing in size and density, this duct bends upwards along the inner side of the epididymis, and a little above the head of the latter it becomes connected to the spermatic vessels and cremaster muscle; with these it continues its course obliquely upwards and outwards along the inguinal channel, and through the internal abdominal ring: it here separates from the spermatic vessels, the latter ascending towards the spine, while the vas deferens passes backwards, inwards, and downwards, enclosed in the lateral fold of peritonæum, which conducts it to the bladder, along the side and inferior fundus of which it runs internal to the vesicula seminalis, and converging to its fellow: at the base of the prostate gland each vas deferens joins the duct of the corresponding vesicula, and the union of these forms the *ductus ejaculatorius communis* which runs through the prostate obliquely forwards and inwards, and opens into the prostatic portion of the urethra on the side of the verumontanum, [anteriorly, being from eight to ten lines in length.] While the vas deferens is contained in the spermatic cord, it lies posterior to the spermatic arteries and veins, and to the cremaster muscle; as it passes through the internal ring it hooks round the outer side of the epigastric artery, being separated from it by the spermatic artery alone; the vas deferens next passes over the psoas and iliac muscles, the external iliac artery and vein; it then bends over the obliterated hypogastric artery and descends internal to it; and in the same manner it next crosses over the ureter, so as to lie at first anterior to that tube, or between it and the bladder, and then to descend along its internal side; the vas deferens then runs between the bladder and rectum, near to its fellow, and internal to the vesicula seminalis, as far as the prostate gland, which it perforates in the direction before mentioned. This vessel has a peculiar hard wiry feel like whip-cord: its calibre is small; its coats are two in number, an internal mucous, and an external, very thick, firm, and white like cartilage. Between the vesiculæ each vas deferens is flattened, enlarged, and often covuluted; when it enters the prostate it again contracts, and its firm external tunic ceases. In some a second duct will be found to leave the testis and to run for some distance parallel to the vas deferens, which in some cases it will join, while in others it will be found to end in a *cul de sac*. The *spermatic cord* extends from the epididymis to the internal abdominal ring; it consists of the vas deferens, spermatic artery, veins, nerves, and lymphatics; this fasciculus of vessels is covered by loose cellular membrane, and by the cremaster muscle: beneath the latter the vessels of the cord will be found joined together by a fine but tolerably dense membrane, named the *tunica vaginalis of the cord;* this membrane is the remains of that portion of peritonæum which in the fœtus accompanied the spermatic vessels of the scrotum, and which after birth lost its serous characters, and became converted into condensed cellular membrane; this covering is strengthened by that prolongation of the fascia transversalis which is continued from the internal abdominal ring along the spermatic vessels. The spermatic artery arises from the abdominal aorta below the renal artery, and not unfrequently from the latter; it descends along the psoas muscle [over the ureter,] passes through the internal abdominal ring on the outer side of the epigastric artery; it then enters the spermatic cord, and is conducted to the back part of the testicle; it divides into several branches which enter the rete testis; these subdivide minutely as they proceed into the substance of the testicle, in which they terminate in the commencement of the tubuli seminiferi and of the spermatic veins. The last named vessels leave the rete testis, twine around the arteries, and then ascend in the spermatic cord; a little above the testicle these vessels become very tortuous, and form a plexus, which is named the Corpus Pampiniforme: the spermatic veins then accompany the spermatic artery through the inguinal canal and along the psoas muscle towards the spine: the spermatic vein on the right side generally ends in the inferior cava near the entrance of the right renal vein; the spermatic vein on the left side frequently ends in the left renal vein.

[The left spermatic vein, most commonly ends in the left renal vein and this will explain the fact, that varicocele most commonly occurs on the left side. The left spermatic vein terminates in the left renal vein, nearly at a right angle, while the latter terminates in the abdominal vena cava, also at nearly a right angle, hence the return of the blood from the left testicle must necessarily be retarded, having to describe these two angles, while the blood from the right testicle will readily flow into the vena cava into which the right spermatic vein empties very obliquely. The spermatic veins in varicocele, are sometimes so much distended, as entirely to destroy the usefulness of the valves and then if the cord be divided below the external abdominal ring, a direct hemorrhage from the vena cava will ensue. I have seen a case of this kind in a man twenty-seven years of age, who was castrated on account of a varicocele of twenty years standing, in which the hemorrhage from above was profuse, the dilated veins being nearly as large, as the end of the little finger. Besides the true spermatic artery, there are two other arteries connected with the cord, the deferential, and the cremasteric.

The deferential artery, is a branch of the vesicle, one of the branches of the internal iliac, it comes off in the pelvis, and applies itself to the vas deferens, which it follows up over the brim of the pelvis, and the external iliac vessels; at the out side of the epigastric it passes through the internal ring into the inguinal canal, and thence passes down to the testicle still following the vas deferens. The cremasteric artery is a branch of the epigastric, and is so called, from being distributed principally in connexion with the cremaster muscle. I have found the deferential artery on both sides, quite as large as the spermatic.]

The nerves of the testicle are derived chiefly from the spermatic plexus, which is formed by the union of branches from the lumbar ganglions of the sympathetic, with filaments from the splanchnic nerves and from the renal plexus; the cremaster muscle is also supplied by branches from the lumbar plexus of spinal nerves, hence this muscle is, to a certain extent, voluntary.

The *Vesiculæ seminales* are two in number; they are situated on the inferior surface of the bladder behind and above the prostate gland, on the outer side of the vasa deferentia, and anterior to the rectum.

[These organs are in fact, placed in a kind of fissure formed by the apposition of two cylindroidal bodies, the rectum and the bladder, and are imbedded in a mass of dense cellular tissue traversed by veins, so that they are not brought into view until this substance is dissected away. In these veins, I have several times found the phlebolites or vein stones.]

Each is of an oval figure.

[In length they are from two inches to two and a half, in breadth, half an inch, and in thickness two to four lines; their color is a greyish white depending upon the external tunic, their volume is greater in the middle aged than in the young or old subject, they are sometimes very small, and in some cases one is wanting.]

The superior and posterior extremity is round, and in contact with the ureter; the anterior extremity is narrow, connected to the prostate gland, and ends in a small duct, [a line and a half in length] which joins the vas deferens; the union of these forming the common seminal or ejaculatory duct, which latter passes obliquely forwards and inwards through the prostate gland, and opens into the urethra by the side of the verumontanum,

[Anteriorly, being from eight to ten lines in length, and running parallel with its fellow under the urethra.]

Although the vesiculæ look like a congeries of cells, yet by dissection they may be unravelled, so as to appear as one continued tube convoluted or coiled very much, the different coils communicating with each other.

[When the vesicles are thus unravelled, their length is from four to eight inches. Cruveilhier has seen one a foot in length.]

These organs are covered by a dense fascia, which is continued from that covering the prostate gland. Each vesicula consists of two tunics, viz. mucous membrane internally, and peculiar grey substance externally, somewhat similar to, but softer than the outer coat of the vas deferens. The vas deferens communicates more freely with the corresponding vesicula than the latter does with the urethra, hence air or fluid injected into the vas deferens will generally distend the vesicula seminalis of the same side before it escapes into the urethra. These organs are generally believed to contribute some additional secretion to the seminal fluid, rather than to serve as reservoirs for the latter; their exact use, however, is not well known; they are wanting in many animals.

The *Prostate gland* is situated at the anterior and inferior part of the pelvis, behind the triangular ligament, and in front of the rectum, to which it is connected by cellular membrane; it surrounds the neck of the bladder, and is attached by the anterior ligaments of this organ to the lower edge of the symphysis pubis, from which it is about three-fourths of an inch distant. The prostate gland is somewhat heart-shaped, or triangular; it is also compared to a chestnut; the base or larger extremity is posterior, and connected to the vesiculæ seminales; the apex is anterior, and extends to within a short distance of the triangular ligament; the neck of the bladder, and about an inch of the urethra run through its substance, but a small portion of it lies superior to the neck of the bladder and urethra; this part is convex, and is covered by the dorsal veins of the penis, and by the anterior ligaments of the bladder; the inferior or posterior surface of the gland is almost flat, a slight groove is generally observable on it, extending along the mesial line; this surface is attached to the forepart of the rectum, and may be felt distinctly either in the living or in the dead subject by the finger introduced into the intestine about two inches and a half above the anus; the sides of the gland are smooth and round, and are covered by a strong fascia, by several veins, and by the levatores ani muscles. In the base or posterior end is a notch for the entrance of the common ejaculatory ducts; this notch, together with the groove on the posterior surface, and the passage of the urethra above this, have caused this gland to be described as consisting of two lateral portions, called the *right and left lateral lobes*; these are connected to each other posteriorly by a small transverse process, called the *middle lobe;* this may be seen by detaching the vesiculæ seminales, and vasa deferentia from the bladder, and leaving them suspended by their common ducts, the middle lobe of the prostate will then be seen to pass from one lateral lobe to the other, and to be closely connected to the mucous membrane of the bladder.

[The prostate gland weighs about five drachms, its length is from eighteen to twenty-one lines, its breadth from fifteen to eighteen lines, and its thickness from nine to twelve lines.]

It has also a firm resisting feel, is of a greyish colour, and appears to possess a very compact structure; this, however, is chiefly owing to the strong fascia which invests it, and which forms its capsule: the capsule has been already described as being partly derived from the posterior layer of the triangular ligament, which expands on the sides and inferior surface of the gland, and partly from the reflection of the pelvic fascia from the pubes called the anterior ligaments of the bladder. Next continue the incision which was made in the forepart of the bladder, through the upper part of the prostate, so as to lay open the urethra, we shall perceive how this gland surrounds the canal, also the greater thickness of its lateral portions. The prostate gland consists of several follicles or acini closely connected to each other, and covered externally by the capsule, and internally by the mucous membrane; these follicles open by several small ducts, ten or twelve, on the lower surface of the urethra, on either side of the verumontanum; some small ducts also open on the upper surface of the canal.

[This organ is divided in the lateral and bilateral operations for stone, and is easily torn after being once cut into.]

The *Penis* is covered by the common integuments, and by the superficial fascia; the skin is thin and loose, it is continued from that of the abdomen and scrotum around this organ, and extends some way beyond it in the form of a loose fold, the *prepuce;* from the extremity of this process the skin is reflected inwards as far as the corona glandis, where it becomes very thin; it is thence continued over the glans penis to the orifice of the urethra, where it is continuous with the lining membrane of the urethra; inferior to this opening it forms a fold, the frænum preputii; the prepuce, therefore, is only a fold of the common integument, the sides of which are connected together by very loose reticular tissue; this fold is expanded when the prepuce is drawn back, or when the penis becomes distended; the inner side of the prepuce is of more delicate texture than the external, and that portion of it which is continued over the glans is still more delicate than either. Beneath the skin, around the corona glandis, are a number of small sebaceous glands, glandulæ odoriferæ, or Tysoni,

[Which secrete a white oleaginous substance the smegma preputii, which accumulates from want of cleanliness and becoming acrid, causes excoriations, which may be mistaken for syphilitic sores. The prepuce is sometimes too short and instead of covering the glans penis is contracted around the neck of the organ behind the corona glandis, this is called paraphymosis; on the other hand it sometimes covers the glans but cannot be drawn back so as to expose it, and this is phimosis, for which circumcision is performed. It is said that those who have the prepuce long are more apt to contract the venereal disease than those in whom it is shorter.]

The superficial fascia which covers the penis is continued from that of the abdomen, and extends around the penis as far as the corona glandis; it is thick and strong posteriorly, where it is reflected from the linea alba on the penis, so as to form the superficial suspensory ligament of the latter; anteriorly it is loose and delicate. Beneath these coverings the penis is found to consist of two long cylindrical bodies, termed the crura or corpora cavernosa penis; each of these is composed of a strong, elastic, tendinous and fibrous substance [which is called the theca,] forming a sort of tube, which is filled with a soft cellular or *erectile tissue*, through which a large artery, and many small tortuous veins, run from one end to the other. Each crus penis commences narrow in front of the tuber ischii, and adheres to the rami of the ischium and pubis, as far forwards as the symphysis; anterior to this the crura become inseparably united, and continue so as far as the corona glandis; here each crus ends in an obtuse point, over which the glans penis, which is the expanded extremity of the corpus spongiosum urethræ, is folded; the two crura are attached to the symphysis pubis by the *true suspensory ligament*, which is very strong, and of a triangular figure; it arises from the symphysis, and is inserted into each crus; it consists of two laminæ, between which the dorsal vessels and nerves of the penis pass. The crura penis are separated from each other by an imperfect tendinous septum, composed of parallel fibres, with such intervals between them that the cavity of one crus communicates with, and can be injected from that of the other; this septum is named *pectiniforme*. The crura penis are somewhat conical, the apex of each being attached to the ischium and pubis, the base supporting the glans; they are round externally, flattened towards each other; a wide and deep groove exists between them inferiorly, which contains the urethra, and a more superficial one superiorly, in which the dorsal vessels and nerves of the penis run.—The erection of the penis during life is caused by a greater quantity of blood than usually circulates through this organ being propelled by an increased action of the arteries into the small vessels of the corpora cavornosa penis, this increased action being induced by a peculiar excitement of the nervous energy: anatomists are not agreed as to the exact structure of the corpora cavernosa, or as to the proximate cause of their erection during life, or how the blood is circumstanced during that condition; some consider that the arteries pour their blood into the cells of the cellular tissue which surrounds them, so as to cause their distention, and that from these the blood is slowly and gradually absorbed by the veins; others conceive that the arteries directly communicate with the veins, and that these latter vessels are tortuous and coiled to such a degree as to form plexuses which serve to retard the course and delay the return of the blood, and so cause the distention and consequent erection of the whole organ.*

The *Urethra* extends from the neck of the bladder to the extremity of the penis [and averages about eight inches in length, its diameter varying at different points;] it is lined by a fine mucous membrane, which is continuous posteriorly with the mucous membrane of the bladder, and anteriorly with the thin integument, which is reflected from the inside of the prepuce, over the glans penis, as far as, and even within, the orifice of the urethra. Tnis membrane is covered at first by the prostate gland, and this portion of

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* In a paper in the Dublin Hospital Reports, vol. v., Dr Houston ascribes the erection of the penis, in a great degree, to the mechanical obstruction of the blood in the vena magna dorsalis penis, caused by the action of a pair of muscles, named the "compressores venæ dorsalis penis;" these muscles are very distinct in the dog and in other animals, and Dr. H. describes analogous fibres in the human subject; he states that they *arise* from the rami of the pubis. above the origin of the erectores penis and of the crura, thence the fibres ascend forwards, forming on each side a thin, fleshy, and tendinous stratum, which is *inserted* in common in the mesial line above the vena dorsalis; these may, perhaps, be regarded as portions of the erectores penis which instead of being inserted into the crura mount over them, in order to compress the vena dorsalis. The developement of these fibres, however, in man appears so irregular, weak, and imperfect, that I cannot concur in ascribing so much influence as appears to be justly attributed, by comparative anatomists, to this more perfect structure in some of the lower animals.

the canal is called the *prostatic portion* of the urethra; the next succeeding portion is covered by the compressores urethræ muscles, by the triangular ligament, and by a peculiar reddish or spongy-looking cellular tissue, which contains several small blood-vessels, chiefly veins; this part of the urethra is called the *membranous portion;* the remainder of the canal is covered by a cellular and vascular substance of a dark red or purple colour, named the corpus spongiosum urethræ, which commences in the bulb, and ends in the glans penis; this portion of the urethra is named the *spongy portion.* The first, or the prostatic portion of the urethra is within the pelvis; it is about an inch and a quarter, or an inch and a half in length; in the erect position of the body its direction is downwards and forwards; it is nearer to the upper than to the lower surface of the gland.

[The membranous portion is from six to ten lines long. Cruveilhier states that it differs in length at its two edges, being superiorly an inch in length, and inferiorly but six lines, owing to the projection backwards of the bulb. This portion of the urethra, is the more common seat of stricture, which sometimes leads to the formation of fistula in perineo. There may be a temporary obstruction here to the passage of the catheter, from a spasmodic contraction of the compressor urethræ muscle, which is to be overcome, by gentle but steady pressure. The same thing may occur in that part of the urethræ covered by the accelerator urinæ muscle.]

It is described in general as being concave towards the pubes: it is, however, but very slightly so, it runs nearly horizontal, about three quarters of an inch below the symphysis pubes. The spongy portion commences in the bulb in front of the triangular ligament, extends to the extremity of the canal, and ends in the glans penis.

[Its length will depend upon that of the penis, but allowing two to two and a quarter inches for the prostatic and membranous portions, this part will average from five and three quarters to six inches.]

This part of the canal is surrounded by a vascular and cellular texture, named the corpus spongiosum urethræ, which has some resemblance to the corpora cavernosa penis. The corpus spongiosum urethræ consists of a number of fine cells, which communicate with each other; through these an artery from each side (a branch from the internal pudic) extends; these vessels send off numerous branches, which pour their blood into the surrounding cells, from which the veins afterwards absorb it; the bulb and the glans penis are expansions of this cellular texture, the former on the inferior, the latter on the superior part and sides.

This spongy substance is invested by a fine, but strong and semi-transparent aponeurosis, very different from that which covers the corpora cavernosa. The corpus spongiosum surrounds the urethra, but is thicker inferiorly and laterally than superiorly; there is no direct communication between the corpus spongiosum urethræ and the corpora cavernosa penis, the one can, therefore, be distended with air or injection without the other, or both may be injected with different coloured fluids. In order to inject the crura penis, make a small opening in each crus near its attachment to the ischium, insert a pipe into one of these, and force warm water through it; this will soon escape through the opening in the opposite crus, carrying along with it the blood which was contained in the cells, then secure with a ligature the opposite crus, and inject some coloured fluid. To prepare the corpus spongiosum urethræ, make a small opening in the substance of the bulb, next open the dorsal vein of the penis, in it secure a small pipe; water injected through this will escape at the opening in the bulb: when all the blood shall have been thus washed out, the latter opening may be secured, and some coloured fluid injected along the dorsal vein.

If, however, a fine injection be forced from the pudic, or from the internal iliac artery, it may be made to distend the corpora cavernosa penis, and the corpus spongiosum urethræ at one and the same time. The student may now detach the crura penis and the neck of the bladder from the pubes, and remove these organs, together with the urethra from the subject; continue an incision from the anterior part of the bladder through the upper part of the prostate gland, and of the urethra to its extremity; the mucous lining of the urethra will be thus exposed, the difference in the diameter and other peculiarities in different parts of it may now also be observed. 1st. The prostatic portion is somewhat contracted at either extremity, and dilated in the centre, particularly on the lower surface, and at either side of the middle line; these enlargements are called the *prostatic sinuses;* they are separated from each other by a prominent fold of the lining membrane, extending from the uvula of the bladder along the mesial line of the urethra, as far as the bulb; this fold is named *verumontanum*, or caput gallinaginis; in the centre of it is a very large lacuna, (*sinus pocularis*,) the orifice of which is directed forwards; on either side of this pouch, and in general external to it, is the opening of the common ejaculatory duct, external to which, and in the prostatic sinus on each side, are the several small orifices of the ducts of the prostate gland. 2d, The membranous portion is shorter, and of a smaller calibre than the prostatic; it is cylindrical, its anterior extremity is the narrowest portion of the canal. 3d, The spongy portion of the urethra is much dilated at first, particularly inferiorly (*sinus of the bulb;*) anterior to this the small ducts of the anti-prostatic glands open. The canal of the urethra contracts a little beyond the bulb, and continues of nearly the same diameter until it arrives opposite the scrotum; it is there slightly contracted for a short distance: about an inch posterior to the external orifice of the urethra the canal is dilated in the transverse direction; this dilatation is called *fossa navicularis;* lastly, the orifice of the urethra is contracted into a narrow vertical slit. Several small lacunæ open on the surface of the mucous membrane of the urethra, between the bulb and the anterior extremity, [about sixty-five according to Loder;] the orifices of these, in a healthy condition of the membrane, are very small; they are all directed forwards: if bristles be introduced into some of these ducts they will be found in many cases to extend backwards for near an inch in the submucous tissue; these lacunæ secrete a thin mucous fluid, which is expelled by the urine in its passage along the urethra; in chronic diseases of the urethra these ducts not unfrequently become so much enlarged as to admit the end of a small bougie, and so lead to the formation of a false passage: the largest lacunæ are on the upper surface of the urethra; one in particular, near the fossa navicularis, is named the *lacuna magna.**

[If a section of the pelvis be made by dividing it at the symphysis pubis, and one of the sacro-iliac symphyses, leaving the rectum, bladder &c. in situ, it will be seen that the urethra in its natural position presents two curves, one behind the triangular ligament, which is somewhat concave above, and the other, before the triangular ligament, which presents its convex aspect upwards and forwards; if then the penis be carried up towards the abdomen, the second curve will be entirely obliterated, and the whole urethra will present a single sweep, the concavity of which looks upwards, hence the curved catheter is more commonly used; but the straight instrument may be readily

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* During the dissection of the pelvic viscera, perinæum, &c. the student should frequently practise the introduction of a catheter into the bladder, which is to be done in the following manner: the subject lying on its back with the legs drawn up, the penis should be held, by placing the thumb and index-finger on each side of the corona glandis, by which means the orifice of the urethra will not be compressed; the penis is then to be drawn upwards, and the catheter, being previously oiled, is next to be introduced in a line with the linea alba into the urethra, directly downwards as far as the bulb; the concavity of the instrument being towards the abdomen. The catheter having reached the bulb, its handle is to be depressed by bringing it forwards between the thighs, and in proportion as this is done, the point is elevated, and the catheter glides into the bladder; in this latter part of the operation, the penis must be allowed to sink down, for if it be kept extended on the instrument, the membranous part of the urethra would be drawn towards the pubes, by which means the introduction of the instrument would be rendered difficult.

introduced by drawing firmly upon the penis, at an angle of forty-five degrees.]

The testicle is the seat of many *morbid* appearances, both in its tunics and in its substance; hydrocele is very common, this is a dropsy in the serous cavity of the tunica vaginalis; this latter membrane may be inflamed, and the adhesive process may obliterate its cavity. The tunica albuginea is sometimes the seat of a firm fungus which protrudes through the other coverings to the surface. The testicle and epididymis may be the seat of acute inflammation, as in hernia humoralis the effect of gonorrhœa, also of chronic inflammation with indolent enlargement, or sarcocele. The testis is also the frequent seat of strumous inflammation and suppuration, of fungoid disease in which there is great enlargement, total change of structure and conversion into cerebriform matter; of true scirrhus and cancer, of hydatid tumours, &c.: these glands are also sometimes atrophied. The spermatic cord is sometimes the seat of encysted hydrocele, of varicocele, particularly on the left side, as also of different tumours.

[Another disease in the vaginal cavity is hematocle, or an accumulation of blood, or of blood and serum. Sometimes the inner surface of the tunic is much roughened by the deposition of fibrine. In recent hydroceles, the tunica vaginalis is transparent, but in old cases it is thick and opaque, and sometimes is partially converted into cartilage or even bone. In the radical treatment of hydrocele the great object is to bring about adhesive inflammation, and obliteration of the sac. We sometimes find tubercles in the testicle, either in its substance, or on its surface or in the epididymis, they rarely occur in both testicles at the same time. Hydrocele of the cord sometimes occurs from the passage between the abdomen and scrotum, not being completely obliterated at all points.]

The prostate gland is seldom found *diseased*, except in old men; it is rarely inflamed, an abscess however has been met with (unaccompanied by any thickening) in its substance, arising from common inflammation. *Scirrhus.* The most common disease of the prostate gland is scirrhus; the gland in its natural state is known to be about the size of a chestnut, but when it is affected with scirrhus, it is often enlarged to the size of the fist. The common appearances observed in scirrhus in other parts of the body, can be plainly seen in this gland; when cut into, it appears to consist of a very solid, whitish, or brown substance, with membranous septa, running through it in various directions. According to the degree of enlargement that takes place, the urine is passed through the bladder with greater or less difficulty, as well as an instrument for drawing it off. *Calculi* have been found lodged in the ducts of the prostate gland; they are usually small granules of a dark colour, and give it a mottled appearance when cut into.

[Tubercles are occasionally found in the prostate. When this organ is enlarged it presents an obstacle to the discharge of urine and even to the passage of the catheter; it sometimes is necessary to introduce the finger two inches and a half into the rectum under the prostate, so as to lift up the point of the instrument over the obstruction, which is more commonly on the under side of the urethra. In these cases of enlarged prostate the bladder becomes very much contracted, and the muscular coat very thick and distinct. This enlargement sometimes occurs in young men from acute inflammation of a gonorrheal character.]

The vesiculæ seminales are seldom found *diseased;* in cases of scrofulous testicle they have been found similarly affected and filled with cheesy fluid. The urethra is the frequent seat of inflammation, which when recent produces suppuration without ulceration, and if long continued, causes a thickening of the submucous tissue, and thus renders the canal narrow and irregular, and so commences the foundation of stricture.

[The most common seat of this affection is the membranous part of the urethra, the next most common seat, is about four, or four and a half inches from its orifice, and next just behind the glans penis. The urethra is sometimes malformed; it may open upon the upper or under surface of the penis, epispadias and hypospadias; it may terminate in the perineum, or above the pubes. All of these malformations do not necessarily imply impotence, sometimes the rectum terminates in the urethra of the male, and I have known a case of this kind in which the child lived a year and then died of inflammation, caused by the arrest of an apple seed near the orifice of the urethra.]

The coverings of the penis are the frequent seat of ulceration, also those of the glans penis; the latter in old persons is very often attacked with warty cancerous ulceration.

CHAPTER VII.

SECTION I.

DISSECTION OF THE FEMALE ORGANS OF GENERATION.

The generative organs in the female are more distinct from the urinary than in the male subject; they may be divided into the external and internal; the *external parts* are the mons veneris, vulva, labia, clitoris, nymphæ, vagina, and perinæum.

The *mons veneris* is an eminence placed on the upper and anterior part of the pubes; it consists of a quantity of adipose substance beneath the integuments, which in the adult are covered with hair. The *vulva* is the fissure which extends from the mons veneris to within an inch of the anus. The anterior *perinæum* is the small space in front of the anus, the posterior *perinæum* is between the anus and the os coccygis. The *labia externa* or *majora*, are the thick folds of integument which extend one on each side of the vulva, and are united inferiorly in a crescentic edge, called the commissure or fourchette. The *clitoris* is below the superior angle or commissure of the labia: it is a small red projection immediately beneath the symphysis pubis and above the vagina; it is attached by two crura to the rami of the pubes; these unite and form the body of the clitoris, on the anterior extremity of which is a round red swelling called the glans clitoridis; this is covered by a thin loose fold of integument or mucous membrane called the prepuce. The clitoris is composed internally of a spongy cellular texture, not very unlike the corpus spongiosum urethræ in the male subject. The *nymphæ*, or labia minora, descend one on each side of the vagina, from the prepuce of the clitoris, and are gradually lost about the centre of the vulva.

About half an inch below and a little behind the clitoris and between the nymphæ, is the round orifice of the *meatus urinarius;* this opening is surrounded by a projecting fold of mucous membrane, on the sides of which are the orifices of small mucous glands analogous to Cowper's glands in the male. The meatus is from an inch and a half to two inches in length; it leads backwards and upwards along the upper surface of the vagina, and is slightly curved beneath the symphysis pubis, to which, as also to the crura of the clitoris, it is attached by the triangular ligament.

[There are two rules given for the introduction of the catheter in the female; one is to feel for the clitoris and then to carry the finger down about three quarters of an inch until it rests upon a tubercular elevation, on which the orifice of the urethra will be found: the other rule is to carry the finger directly to the lower edge of the symphysis pubis; just below which is the tubercle above referred to: this last is the better rule, as by it we avoid as far as possible the handling of the parts; if the uterus be very much enlarged from disease, or pregnancy, the situation of the bladder and urethra will be changed, so that the latter will lie behind the symphysis and nearly parallel to it, in which case after the point of the catheter is introduced into the orifice of the urethra, the handle must be depressed far back between the thighs of the patient.]

The *vagina* is directly below the urethra: in the child it is partially closed in front by a crescentic fold of membrane, termed the *hymen:* in the adult several reddish eminences [the carunculæ myrtiformes] surround this opening; the course and connexions of this canal will be better seen when the pelvis shall have been divided for the purpose of examining the internal organs of generation. Dissect off the integuments and fascia from the perinæum and labia, and the following muscles may be seen: the *sphincter ani, levatores ani,* and *coccygæi;* these are similar to the muscles of the same name in the male perinæum, also the *transversales perinæi:* the *erectores clitoridis* are analogous to the compressores penis; and the *sphincter vaginæ* corresponds to the accelatores urinæ; it extends from the clitoris superiorly around each side of the vagina to the central point of the perinæum in front of the anus.

To examine the internal organs of generation make a lateral section of the pelvis in the same manner as was directed in the dissection of the male pelvis. The peritonæum may be first examined; this will be seen to descend along the fore part of the rectum, to within three or four inches of the anus; it is thence reflected forwards on the posterior part of the vagina, the superior third of which it covers; from the vagina it ascends on the posterior surface and sides of the uterus; continues round the superior fundus of this organ to its anterior part, on which it descends as low as the commencement of the vagina, it is thence reflected to the bladder, and is continued over this organ, as in the male subject, to the abdominal muscles; thus, in the female pelvis, the peritonæum forms one cul de sac between the rectum and vagina, and another between the uterus and bladder. From each side of the uterus a broad fold of peritonæum is extended transversely towards each iliac fossa; these folds are the *broad ligaments* of the uterus; enclosed between the laminæ of each of these are the *Fallopian tube, the round ligament* of the uterus, and the *ovarium* with its ligament and vessels. Dissect off the peritonæum from one side of the rectum and vagina, and the pelvic viscera will be more distinctly seen.

The *rectum* takes the same course as in the male only somewhat more curved, it lies behind the uterus and vagina, to the latter it is united by a close vascular plexus. The *vagina* is seen to surround the neck of the uterus, and thence to descend obliquely downwards and forwards for about six or seven inches between the rectum, the bladder, and urethra ; closely connected to the latter, and but loosely to the rectum.

[The length of the vagina in a healthy state, varies very much in different individuals ; it has been seen but one inch and a half long ; it varies also in the same individual under different circumstances, being about six inches long in the virgin, and about four in the woman who has borne children ; its apparent length also varies at different periods of utero-gestation, owing to the different positions of the uterus ; its capacity also varies very much, being much greater in those who have borne children than in those who have not ; its capacity however is always greatest at its upper part, where it receives the mouth of the uterus. Its great extensibility is proved during parturition.]

The vagina is lined by a vascular mucous membrane, which is transversely rugose, and is covered externally by a dense fibrous tissue and by numerous vessels, particularly veins, which form a plexus (retiform) or spongy body, which is situated beneath the sphincter vaginæ muscle; the vagina is also partially covered by peritonæum on its posterior surface. Between the bladder and vagina the *ureter* may be observed ; its course is longer and more curved in the female pelvis than in the male.

The *Uterus* is situated between the bladder and rectum, and connected to both by peritonæum ; the broad ligament which is a fold of peritonæum, and the round ligament which is a fasciculus of blood-vessels and nerves bound together by dense cellular tissue, connect each side of this organ to the pelvis, and to the inguinal regions. The uterus is somewhat pyriform or triangular, the larger end or fundus being superiorly and posteriorly, the smaller end or cervix inferiorly and anteriorly ; the intermediate portion is named the body ; the vagina surrounds the cervix uteri, and ascends higher posteriorly than anteriorly ; at the lower extremity of the cervix is a small transverse slit, termed the *os uteri* or *os tincæ*.

[It is bounded by the lips of the uterus of which the anterior is the thickest, and is continuous with the anterior wall of the vagina, while the posterior is thinner and longer, and is attached by its base to the posterior wall of the vagina, hence it projects into the latter organ, which forms behind it a large cul de sac. The uterus varies much in size in childhood, youth, and adult life ; it is larger and firmer in those who have borne children than in those who have not. It is from twelve to fourteen lines long at birth, and but an inch and a half long, at ten years of age, so that it is almost stationary, until the age of puberty at which period it is suddenly and rapidly developed, and fitted for its future functions. In the adult female the average size of the organ is as follows ; length two and a half to three inches; breadth at the fallopian tubes an inch and a half, at the neck six to twelve lines ; thickness ten to twelve lines ; medium thickness of the parieties of the body five lines, of the neck four, thickness of the lips three to four lines; heighth of fundus above the fallopian tubes a quarter of an inch. The weight of the organ averages at puberty from six to ten drachms; in the adult from one and a half to two ounces, and at the full term of utero-gestation from one and a half to three pounds. The cavity of the body of the uterus is an equilateral triangle flattened antero-posteriorly, with its sides convex internally, its diameter is about ten lines at its greatest, and much less at the angles; the cavity of the neck is about an inch long with a diameter of three or four lines, it is somewhat cylindrical in form, but wider at its centre than its extremities; the sides being concave towards each other. The situation of the uterus varies very much with the period of life and of utero-gestation, in the fœtus and infant it is in the cavity of the abdomen.]

The uterus consists of a dense fibrous substance, perforated by a great many vessels, covered externally by peritonæum, and lined throughout by mucous membrane, which is continued from the vagina throughout the entire organ, and thence into the Fallopian tubes, along which it extends to their fimbriated extremity, where it becomes continuous with the peritonæum on each side, thus presenting a singular example of the continuity of a mucous and serous membrane with each other: the mucous membrane of the uterus is often of a very dark colour, and is marked by several lines. The cavity of the uterus is very small, and somewhat triangular, being larger in the superior fundus than elsewhere.

The *Fallopian tubes* are from four to five inches in length; they extend from the fundus uteri upwards and outwards at first, and then a little downwards and backwards; each terminates in a soft fringed extremity, called *Corpus fimbriatum*, which communicates with the cavity of the peritonæum and which overhangs the ovary; these canals are narrow where they join the uterus, but each increases in size near the corpus fimbriatum.—The *ovaria* are two small, white, flattened, oval bodies, one at each side, enclosed in the posterior fold of the broad ligament, and behind the Fallopian tube; their surface is often irregular and as it were cicatrized.—Each ovary is connected to the side of the uterus by the broad ligament of the latter, also by a round fibrous cord, the proper ligament of the ovary; this is about two inches long, and is enclosed between the laminæ of the broad ligament of the uterus. Each ovary is covered by the peritonæum, which adheres very closely to it; beneath this is a strong white fibrous capsule, within which a number of small vesicles will be found connected together by cellular membrane and vessels.

[The ovaries vary in size with age, and they are proportionably large in the fœtus and child; their average size in eight females, between the ages of seventeen and twenty-three was found to be, length seventeen lines, breadth nine lines, thickness four lines and a half, and weight one drachm and a quarter: they are heavier in those who have borne children than in others. The ovaries of women who have had children present upon their surfaces, cicatrices which correspond to certain bodies internally, which are called the *corpora lutea* and which are supposed to be the debris of impregnated ova. The female organs of generation present many anomalies of conformation. The uterus and vagina are sometimes a solid mass having no cavity, the uterus is sometimes entirely wanting either with or without a corresponding deficiency of the tubes and ovaries, generally however the latter is the case: the uterus is sometimes divided by a longitudinal septum into two cavities, which open separately into the same vagina or each has its own vagina: the uterus may present two horns or cornua as in many of the inferior animals: it may also be absolutely double, the two organs opening into a common vagina, each into its own vagina, or one into the vagina and the other into the rectum: the mouth of the uterus is sometimes completely obliterated, of this I have a specimen from a female between fifty and sixty years of age; perhaps the cases of superfœtation, may be explained by referring to some of the anomalies above mentioned. One ovary is sometimes wanting, the other being larger than usual; the fallopian tubes may be imperforate. The vagina is sometimes solid, sometimes imperforate, from the presence of the hymen or an anomalous septum, it is sometimes double, sometimes it communicates with the bladder, and at other times with the rectum.]

The female organs of generation are the seat of many *morbid* changes. Not to notice the various ulcerations to which the *external parts* are liable, we occasionally find here also polypi, adipose and sarcomatous tumours in the labia, enlargement of the clitoris, &c.

The uterus may be found inflamed, (matritis), this occurs soon after parturition, the adjacent peritonæum is also generally affected; the uterus itself exhibits the same appearances as the inflammation of the substance of other parts; the inflammation is found to creep along the Fallopian tubes and ovaries. It often advances to suppuration, and pus is generally found in the large veins of the womb. When the peritonæum is inflamed, it has been remarked, that the extravasated fluid and coagulable lymph are found in a greater proportion to the degree of inflammation, than in common peritonitis. *Polypus.* Polypi are very frequently found in the uterus; they may grow at any period of life, but they are rarely met with in the young. By a polypus is meant a diseased mass, which adheres to the cavity of the uterus, by a sort of a neck or narrower portion. Polypus is of two different kinds; the most common kind is hard, and consists of a substance divided by thick membranous septa; this sort of polypus varies very much in its size, some not being larger than a walnut, and others being larger than a child's head. Another sort of polypus forms in the uterus, which consists of an irregular bloody substance, with tattered processes hanging from it; when cut into it appears to be a spongy mass, holding large cells. The most common part to which polypi adhere, is the fundus uteri, and sometimes they are found attached to the os tincæ. Hard fibrous tumours also not unfrequently exist in the parietes of the uterus.—The uterus is also frequently the seat of cancer, which usually commences near the os tincæ. The uterus also is subject to partial displacement, viz. prolapsus, inversio, and retroversio.

The membrane covering, or the substance of the *ovary*, are very rarely found inflamed, except when they are included in general peritonitis; when the inflammation proceeds from the uterus, it sometimes goes on to the formation of pus in the ovary. *Dropsy.* The most common disease in the ovary is dropsy, the whole snbstance of the ovarium is sometimes converted into a capsule containing fluid. When the ovaria have become dropsical, their natural structure has disappeared, and they are found converted into cells, communicating with one another by considerable openings, and very much enlarged: the ovaria are sometimes converted into a series of cysts, which have no communication with each other; these cysts have been confounded with hydatids, to which they bear some resemblance; they are however very different; they have much firmer and less pulpy coats than hydatids, they contain a different kind of fluid, and they are differently connected among themselves. Hydatids either lie unconnected, or one large one encloses a number of small ones; while ovarian cysts adhere to each other by broad surfaces, and do not enclose each other. The ovaria are sometimes found converted into cysts, holding large masses of fat, hair, and some teeth; these substances appear to be generated by the internal membrane of the cyst; the hairs are most of them loose in the fatty substance, but many of them adhere to the inside of the capsule; the teeth, which are not always perfect, are sometimes attached to the cyst, and at others, to an irregular mass of bone.

CHAPTER VIII.

DISSECTION OF THE INFERIOR EXTREMITIES.

Each inferior extremity is connected to the trunk by the strong ligaments of the hip joint, and by several muscles which pass from the pelvis to the thigh and leg. This dissection may be performed while the pelvis remains attached to the spine, or the former may be separated from the lumbar vertebræ, and divided into two.

[The muscles of the inferior extremity are very differently arranged from those of the superior. The great locomotive functions of the inferior extremities are progression, and retrogression, accordingly we find that the flexor and extensor muscles, are on opposite sides of the limb, and that they change their relative position in each subregion of the extremity; while in the superior extremity the flexor muscles are all on the same aspect of the limb, and so too with the extensors. Besides flexion and extension, the motions of these extremities, include rotation inwards and outwards, adduction and abduction, which movements are effected either by special and appropriate muscles, or by certain of the flexors and extensors: of the former fact, we have an illustration, in the rotator muscles of the thigh; of the latter in the tibiales anticus and posticus; the former flexes the foot upon the leg, the latter extends it, yet both together, turn the foot inwards and upwards. As in the case of the upper, so in the lower extremities, the muscles should be classed as nearly as possible according to their functions, and we find that they may be examined in the four regions of the hip, the thigh, the leg, and the foot; this arrangement has reference to the part of the extremity, upon which the muscle chiefly lies; again in the several regions the muscles are arranged in classes having reference to the particular part of the limb on which they act, and lastly the classes are divided into groups, according to the particular and principal motion effected by their contraction as flexion extension, &c. In proceeding with the muscles which act upon the inferior extremity, we examine first the region of the hip, in which we find but one class of muscles, all acting upon the thigh, these are twelve in number, on each side, arranged in three groups, the flexors three, the extensors three, and the rotators six, as follows.

First Group, Flexors.

The psoas parvus is inserted here rather as a matter of expediency, than propriety, not because it is a flexor of the thigh but from its position, and because it is in some respects a congener of the psoas magnus.

1. Psoas Parvus, } *Vide p.* 195.
2. Psoas Magnus, }
3. Iliacus Internus, *Vide p.* 196.

Second Group, Extensors.

1. Gluteus Maximus,	*Vide p.* 254.
2. Gluteus Medius,	" " 255.
3. Gluteus Minimus,	" " 256.

Third Group, Rotators.

1. Pyriformis,	*Vide p.* 256.
2. Obturator Internus,	" " 257.
3. Obturator Externus, 4. Gemellus Superior, 5. Gemellus Inferior,	*Vide p.* 259.
6. Quadratus Femoris,	*Vide p.* 258.

Of these groups the first is situated anteriorly, for the most part in the abdomen; the second and third are posteriorly, on and about the dorsum of the ilium, and are found in three layers, in the first the gluteus maximus, in the second the gluteus medius, and in the third the gluteus minimus, anteriorly and superiorly, and the six rotators posteriorly and inferiorly. The muscles on the region of the thigh are fifteen in number, on each side, and are arranged in two classes, one acting upon the leg, the other upon the thigh; in the first class there are three groups, the superficial group of three muscles, the flexors four, and the extensors also four; in the second class there is but one group, of four muscles, the adductors.

FIRST CLASS.

First Group.

Three superficial muscles at the outer, fore, and inner part of the thigh.

1. Tensor vaginæ femoris, an abductor and rotator of the thigh, and which acts upon the outside of the leg, through the fascia lata.	*Vide p.* 245.
2. Sartorius, a flexor of the leg, and adductor of the whole limb.	*Vide p.* 246.
3. Gracilis, a flexor of the leg and adductor.	*Vide p.* 249.

Second Group.

Four extensors of the leg, situated on the anterior aspect of the thigh.

1. Rectus Femoris, which also flexes the thigh upon the pelvis.	*Vide p.* 247.
2. Vastus Externus,	*Vide p.* 247.
3. Vastus Internus,	" " 248.
4. Crureus or Cruralis, beneath which at the lower part of the thigh, is sometimes found the Subcrureus.	*Vide p.* 248.

Third Group.

Four flexor muscles of the leg, situated on the posterior aspect of the thigh.

1. Biceps Flexor Cruris,	*Vide p.* 261.
2. Semi-Membranosus,	" " 262.
3. Semi-Tendinosus,	" " 261.
4. Poplitæus,	" " 273.

SECOND CLASS, ONE GROUP.

Four adductor muscles situated at the inner, back, and fore part of the thigh, and most of which also assist in flexion of the thigh upon the pelvis.

1. Pectineus,	*Vide p.* 249.
2. Adductor Longus,	" " 250.
3. Adductor Brevis,	" " 250.
4. Adductor Magnus,	" " 251.

The muscles on the region of the leg are twelve in number on each side, and are arranged in two classes: the first class acts upon the foot as a whole, and consists of three groups, one group posteriorly which extends the foot upon the leg, a second group along the fibula, and a third group along the tibia, in which two groups some of the muscles are flexors, and some extensors of the foot upon the leg. The second class consists of two groups which act primarily upon the toes, and if their action be continued, secondarily upon the foot.

FIRST CLASS.

First Group.

Three extensor muscles of the foot, situated on the posterior aspect of the leg. The two first by their fleshy bellies forming the calf of the leg, and lower down joining to form the tendo achillis.

1. Gastrocnemius,	*Vide p.* 271
2. Soleus,	*Vide p.* 272.
3. Plantaris	

Second Group.

Three muscles situated along the fore, back, and outer part of the fibula, of which the first and second extend the foot, and abduct it, also causing its external edge to look upwards, while the third flexes the foot, but is in other respects a congener of the other two.

1. Peroneus Longus,	*Vide p.* 269
2. Peroneus Brevis,	" " 269.
3. Peroneus Tertius,	" " 268.

Third Group.

Two muscles situated along the tibia, one anterior and the other posterior to the interosseous ligament; the first flexes the foot, the second extends it, but both together adduct it, and cause the internal edge to look upwards.

1. Tibialis Anticus,	*Vide p.* 267.
2. Tibialis Posticus,	" " 274.

SECOND CLASS, TWO GROUPS.

First Group.

Two extensors of the toes, and flexors of the foot, situated anteriorly.

1. Extensor Digitorum Longus,	*Vide p.* 267.
2. Extensor Pollicis Proprius,	" " 268.

Second Group.

Two flexors of the toes and extensors of the foot, situated posteriorly.

1. Flexor Longus Digitorum Perforans, *Vide p.* 273.
2. Flexor Pollicis Longus, " " 275.

In connexion with the different varieties of club foot or talipes, we find a shortening of the tendons of these muscles on the region of the leg, the particular tendons affected, depending upon the particular direction of the deformity. At first sight it would appear, as if certain muscles would be concerned in the production of talipes varus, the most common form, and certain other muscles, in the production of talipes valgus; for example—in the first case, the tibial muscles and the flexors of the toes; in the second case, the two peroneals, long and short, &c.: but experience goes to prove that in the operation for club foot, it is rarely necessary to divide any thing except the tendo achillis, after which the shortening and rigidity of the other tendons may be overcome; by the proper application and continuance of the machine and the shoe. Out of one hundred and eighty cases of club foot, Dr. Detmold found it necessary to divide the tendo achillis alone, in one hundred and sixty-three, in the other seventeen cases, it was necessary to divide the tendo achillis *and* other tendons.

On the region of the foot on either side we find twenty muscles, which all act upon the phalangeal bones, except the transversalis pedis, which acts rather upon the phalangeal extremities of the metatarsal bones. These muscles are arranged in two classes, the one acting upon the toes generally, the other upon individual toes. In the first class are two groups, chiefly common extensors, and flexors of the toes: in the second class also are two groups, the proper muscles of the great toe, and the proper muscles of the little toe.

FIRST CLASS.

First Group.

One muscle only, situated on the superior or dorsal surface of the foot.

1. Extensor Brevis Digitorum Pedis, *Vide p.* 268.

Second Group.

This group consists of fourteen muscles, situated on the plantar surface of the foot, for the most part. Some of them however, are between the metatarsal bones, and may be seen both on the plantar and dorsal surfaces of the foot, viz. the seven interossei. Some of these muscles are single, while others are manifold, viz. the four lumbricales and seven interossei.

1. Flexor Brevis Digitorum Pedis Perforatus, *Vide p.* 276.
2. Flexor Digitorum Pedis Accessorius, } *Vide p.* 277.
3. to 6. The Four Lumbricales, }

7. Transversalis Pedis, which is somewhat analogous to the palmaris brevis of the hand, except that the latter arches the hand at the carpus, while the former arches the foot at the phalangeal extremity of the metatarsus. } *Vide p.* 278.

8 to 14. The seven Interossei, of which four are seen on the dorsal surface of the foot, three on the plantar surface, and of these last, the third or most external, is the adductor of the little toe. All seven of these muscles are adductors and abductors of the four lesser toes. } *Vide p.* 279.

SECOND CLASS.

First Group.

Three muscles at the under surface and inner edge of the foot which act upon the great toe only.

1. Abductor Pollicis Pedis, *Vide p.* 276.
2. Flexor Brevis Pollicis Pedis, } *Vide p.* 278.
3. Adductor Pollicis Pedis, }

Second Group.

Two muscles at the under surface and outer edge of the foot, which act upon the little toe only

1. Flexor Brevis Minimi Digiti, *Vide p.* 278.
2. Abductor Minimi Digiti, to which may be added the third inferior interosseous muscle under the name of, } *Vide p.* 276.
3 Adductor Minimi Digiti. " " 280.

We find then on taking a review of all the muscles, which operate directly on the inferior extremity, that there are on the region of the hip anteriorly and posteriorly twelve muscles; on the region of the thigh, fifteen, without the subcruralis; on the region of the leg twelve; and on the region of the foot twenty; in all fifty-nine muscles for each extremity, or one hundred and eighteen for both. We find too that though each muscle exercises what may be considered its chief and leading motion, still its action is modified by its own course, by its combination with other muscles, and by its own extent, as for example we find that when a muscle arises in one region, and passes over a second to be inserted into a third, it will act upon both regions, but produce a different and opposite motion in the two; as in the case of the rectus femoris, which arises from the pelvis, passes over the whole length of the thigh, and is finally inserted into the leg, through the patella and its ligament. The leading action of this muscle is to extend the leg upon the thigh, but having done that it can then flex the thigh upon the pelvis. So too with many other muscles of the extremities.]

SECTION I.

DISSECTION OF THE MUSCLES OF THE THIGH.

Place the extended limb on the back part, raise the integuments from the anterior and lateral parts of the thigh, and from the upper part of the leg; several cutaneous nerves, veins, and lymphatic vessels are met with in this dissection; the nerves are branches of the lumbar plexus, and of the anterior crural nerve; they pierce the fascia lata near Poupart's ligament, and descend chiefly along the anterior and outer side of the thigh. The cutaneous veins are branches of the internal saphena vein; this vessel will be found, in dissecting the leg and foot, to commence at the inner side of the latter, and to ascend along the internal part of the leg and knee to the inner and forepart of the thigh, along which it continues its course towards the groin; and about an inch and a half or two inches below Poupart's ligament it pierces the fascia lata, and joins the femoral vein. In this course the saphena vein receives several cutaneous branches, and, in general, just before it ends in the femoral it is joined by one or two large veins from the outer and forepart of the thigh, and by some smaller branches from the abdominal parietes; some cutaneous branches from the anterior crural and lumbar nerves accompany this vein in its course along the thigh. Beneath the integuments the thigh is invested by the superficial fascia, which is prolonged around it from the parietes of the abdomen; in the groin this fascia is thick and laminated, and closely connected to the fascia lata, particularly to its cribriform portion; but inferiorly and posteriorly it is thin and loose, and differs but little from the ordinary sub-cutaneous cellular tissue. This fascia may be easily detached from the fascia lata of the thigh, except in the groin; in attempting to raise it in this region we expose the superficial inguinal ganglia; these are eight or ten in number: five or six of them are placed parallel to Poupart's ligament, some above, others below it; two or three are situated lower down in the groin than these, near the termination of the saphena vein; these last ganglia lie on the fascia lata; they are larger than the former, and are parallel to the saphena vein. Through these conglobate inguinal ganglia the superficial absorbents of the lower extremities pass; also those from the external parts of generation. Beneath the fascia lata, and close to the femoral vessels, are the deep-seated inguinal ganglia; they are small, and only three or four in number; the deep-seated absorbents of the limb pass through these. The integuments and superficial fascia having been removed, the *fascia lata* may be next examined. This aponeurosis surrounds the thigh; it is very strong and tendinous externally, but so thin and weak internally, that without caution it is apt to be removed along with the integuments; it is attached superiorly and externally to the crest of the ilium;

posteriorly to the sacrum and coccyx: on the glutæus maximus it is very weak and thin, but at the anterior border of this muscle it becomes very strong, receiving an addition of fibres, both from the tendon of that muscle, and from the tensor vaginæ femoris; anteriorly the fascia lata is attached to Poupart's ligament, and internally to the rami of the ischium and pubis; as this aponeurosis extends down the thigh, it confines the different muscles in their situation, so as to preserve the figure of the limb; several processes also pass in from its internal surface to form septa and sheaths for some muscles, and to bind down others in their place; to many of these processes the muscles adhere, so that when in action they serve to make the fascia more tense and resisting; these processes also serve to increase the surface of origin or attachment of several muscles. Along the posterior part of the thigh the fascia lata is connected to the whole length of the linea aspera, also to the insertion of the glutæus maximus, and to the origin of the short head of the biceps; inferiorly it adheres to the condyles of the femur, surrounds the knee-joint, and receives an addition of fibres from the different tendons in this region; below the knee it is continued over the heads of the tibia and fibula into the fascia of the leg. Numerous foramina are observable in the fascia lata, particularly at the upper and anterior part of the thigh; they transmit cutaneous nerves and vessels: the most remarkable of these holes is that for the saphena vein; it is situated about an inch and a half or two inches below Poupart's ligament, and may be most distinctly seen by dividing the vein on the forepart of the thigh, and raising it towards the abdomen; this opening is semilunar, the concavity directed upwards; from its apparently sharp edge the fascia is reflected backwards, and is lost on the sheath of the femoral vessels. That part of the fascia which is internal to this opening is named the pubic portion of the fascia lata; it covers the pectinæus muscle, adheres to the spine and linea innominata of the pubis, extends behind the femoral vessels, and is continuous with the fascia iliaca; that part of the fascia lata external to the saphenic opening is called the iliac portion; it covers the sartorious, tensor vaginæ, rectus, and iliacus internus muscles, and is continued obliquely in front of the femoral vessels, in the form of a *crescentic* or *falciform process*, the concavity of which is directed downwards and inwards; the convexity is towards the ilium, and attached to Poupart's ligament; the lower cornu of this crescentic process is continuous with the outer cornu of the saphenic opening, and the upper cornu extends in front of the femoral vessels to their inner side, and is inserted along with the third insertion of Poupart's ligament, or Gimbernaut's ligament, into the linea innominata, or ilio pectinæa. Between the margin of the falciform process and the pubic part of the fascia lata is a thin membrane, perforated by numerous vessels, this is termed the *cribriform fascia*, it is connected on either side to the iliac and pubic portions of the fascia lata, and extends from the saphena vein to Poupart's ligament, in front of the femoral vessels; it adheres to the anterior part of the sheath of the latter, or to the fascia transversalis; when this cribriform fascia is removed, the falciform process is made more distinct.—(See Description of Crural Hernia, page 150.) The fascia lata, in some situations, particularly along the outer side of the limb, is seen to consist of two laminæ of fibres; the external take a circular, the internal a longitudinal direction; these two laminæ are very distinctly separated at the upper and outer part of the thigh by the insertion of the tensor vaginæ femoris; the deep layer, which in this situation is very strong, is attached to the capsular ligament of the hip joint, and to the external head of the rectus muscle.—Raise the fascia lata from the anterior and lateral parts of the thigh, several muscles will come into view, the femoral vessels also in the groin will be partially exposed, they are still somewhat concealed by a quantity of adipose substance, and by a few deep-seated lymphatic ganglia; when these are removed, we always find the vein internal to the artery, and about an inch and a half from the spine of the pubis; immediately external to the vein is the artery resting on the psoas, and about a quarter of an inch external to the artery is the anterior crural nerve, imbedded between the psoas and iliacus, and covered by the fascia iliaca, it does not, therefore, lie in the sheath of the vessels. Clean the several muscles which now partially appear on the forepart of the thigh; external to the vessels, the sartorius and tensor vaginæ are first seen; internal to the vessels are the pectinæus, gracilis, and the three adductors, and immediately covering the anterior and lateral parts of the femur are the rectus, cruræus, vastus internus, and externus.

MUSCLES ON THE FOREPART AND SIDES OF THE THIGH.

These are eleven in number.

1. Tensor vaginæ femoris, at the upper and outer part of the thigh, narrow above, broad and thin below, *arises* tendinous and fleshy from the external part of the anterior superior spinous process of the ilium; it forms a fleshy belly, which descends obliquely backwards, and is *inserted*, broad and thin, into a duplicature of the fascia lata on the

outside of the thigh, about three inches below the great trochanter; *use*, to make tense the fascia, to rotate the thigh inwards; also, to assist in flexing and abducting it. The origin of this muscle is between the sartorius and glutæus medius: between these muscles it descends, covered by the fascia lata; its insertion is anterior to that of the glutæus maximus muscle.

2. Sartorius is the longest muscle in the body, thin and flat like a ribband, broader in the middle than at the extremities, situated obliquely along the anterior and inner side of the thigh, *arises* by short tendinous fibres from the anterior superior spine of the ilium, and from the notch below that process, it soon becomes broad and fleshy, extends obliquely across the thigh to its inner side, and descending perpendicularly to the knee passes behind the condyle of the femur; it then turns forwards and outwards towards the inner side of the upper end of the tibia, into which it is *inserted* below the tubercle, by a long flat tendon, the anterior edge of which is attached to the fascia lata covering the knee-joint, and the posterior edge sends off an aponeurosis to the fascia of the leg. *Use*, to flex the leg upon the thigh, also the latter on the pelvis; to adduct the thigh and leg obliquely, so as to cross the lower extremities; when the thigh and leg are extended, it assists in raising and advancing forwards the whole limb, also in turning the knee outwards; in standing, it also supports the pelvis and prevents it bending backwards on the thigh. This muscle through its whole extent is covered only by the fascia lata and the integuments, its superior extremity lies between the tensor vaginæ and the iliacus internus muscles; its inferior extremity expands into a strong aponeurosis, which covers and adheres to the tendons of the semitendinosus and gracilis muscles, anterior and superficial to both of which it is inserted; in its course along the thigh it first passes over the psoas, iliacus, and rectus muscles, next over the vastus internus and adductor muscles and the femoral vessels, from which it is separated by a strong aponeurosis; inferiorly it passes over the internal lateral ligament of the knee, between the tendons of the adductor magnus and the gracilis. The superior third of this muscle extends in an oblique direction from the ilium downwards and inwards, forms the external boundary of the inguinal region, and lies to the outer side of the femoral vessels; the middle third is more vertical in its course, and is here about two inches broad, and completely covers the femoral vessels, also a part of the adductor, and vastus internus muscles.

[*Varieties.* Meckel saw one subject in which this muscle was wanting. In the negro, it is sometimes found unusually broad, and sometimes it presents a middle tendon.]

3. Rectus Femoris, long and flat, rather round in the centre, placed vertically on the forepart of the thigh, *arises* by two tendons, one short, strong, anterior and internal, from the anterior inferior spinous process of the ilium, the other longer, broader, and more curved from the superior and external border of the acetabulum, and from the capsular ligament; these tendons soon uniting form a strong fleshy belly, which descends almost vertically, with a slight inclination inwards; this muscle has a peculiar penniform appearance, it is also tendinous anteriorly in the upper half, so that the sartorius can glide over it, and tendinous posteriorly in the lower half, whereby it can move on the surface of the cruræus. This muscle ends in a flat tendon, which is *inserted* along with the vasti and cruræus into the upper edge of the patella, a few fibres pass anterior to this bone, and are continued into the ligamentum patellæ, which descends obliquely outwards to the tubercle of the tibia. *Use*, to extend the leg on the thigh, and to flex the thigh on the pelvis; it also supports and draws forwards the pelvis on the thigh, and strengthens the capsular ligament of the hip joint. The anterior tendinous origin of this muscle is covered by the sartorius, tensor vaginæ, and iliacus internus muscles, the posterior by the glutæus medius and minimus muscles; the remainder of the muscle is only covered by the integuments and fascia; superiorly this muscle lies on the capsular ligament of the hip joint and the external circumflex vessels; in the rest of its course on the cruræus and vasti muscles, to which it is united below, so that some describe these four as one muscle, under the name of *quadriceps extensor cruris*. Beneath the rectus we find this large mass of muscular substance, covering the front and sides of the femur; it may be divided superiorly into three portions, but inferiorly these are inseparably united; the external portion is named vastus externus, the internal, vastus internus, and the middle, cruræus.

4. Vastus Externus, much larger than the other portions, and larger above than below, *arises* tendinous and fleshy from the root and anterior part of the great trochanter, anterior to the tendon of the glutæus maximus, from the outer edge of the linea aspera, its whole length, and from the oblique ridge which leads to the external condyle, anterior to the short head of the biceps; from all the external surface of the bone, and from the fascia lata, the fibres descend obliquely forwards; the superior are very long, the inferior are shorter and more transverse, *inserted* into the

external surface of the tendon of the rectus, also into the side of the patella, and by an aponeurosis, which adheres to the synovial membrane of the knee-joint, into the head of the tibia. *Use*, to extend the knee, also to rotate the leg outwards; this muscle is partly concealed by the rectus; its external surface is tendinous above and fleshy below, its internal is fleshy above and tendinous below.

5, Vastus Internus, smaller and shorter than the last, *arises* on the anterior part of the femur, from the inter-trochanteric line; from the inner edge of the linea aspera, its whole length, also from the inner side of the femur, the fibres descend obliquely forwards, and are *inserted* into the inner edge of the tendon of the rectus, also into the patella, and by an aponeurosis, which covers the inner side of the synovial membrane of the knee, into the head of the tibia. *Use*, to extend the knee and turn the leg a little inwards. The vastus internus is partly concealed by the rectus and sartorius, its origin lies anterior to the insertion of the psoas, pectinæus, and adductor muscles, and overlaps the cruræus, so as to be in contact with the vastus externus; its internal surface is tendinous above and fleshy below; an aponeurosis from the two vasti covers the patella and its ligament, also the sides of the joint; this aponeurosis is inserted into the head of the tibia, it serves to support the patella in its situation, and to protect the sides of the articulation like a capsular ligament; a small bursa is situated over the patella, between this aponeurosis and the skin; the insertion of the vastus externus into the patella overlaps that of the vastus internus, and both overlap the cruræus, from which the vastus externus can be more easily separated above, but the vastus internus below.

6. Cruræus, shorter than either of the vasti, between which it lies, larger and more tendinous below than above, *arises* fleshy from the anterior and external part of the femur, commencing at the inter-trochanteric line, and extending along three-fourths of the bone, as far outwards as the linea aspera; it does not adhere to the inner side of the femur, there being a portion of the latter, nearly an inch in breadth and extending almost the whole length of the bone, to which no muscular fibre adheres; the cruræus descends close to the femur to its inferior third, the fibres then incline forwards, become tendinous posteriorly, and are separated from the bone by a large bursa, and by a considerable quantity of fat; *inserted* into the upper and outer edge of the patella, also into the synovial membrane of the knee behind the vasti, particularly the external, to which it is here intimately united. *Use* to assist the vasti and the rectus in extending the leg. This muscle is cover-

ed by the rectus and the vasti, from the latter it can only be separated superiorly by tearing a few muscular fibres, and tracing some large nerves and vessels that pass between them. The large bursa, which is situated behind the lower part of this muscle, is attached to and frequently communicates with the synovial membrane of the joint; a few muscular fibres are generally attached to this membrane, and have been described as a distinct muscle, the SUB-CRURAL OR CAPSULAR, this *arises* from the anterior surface of the femur, about its inferior fourth, passes forwards and downwards, and is *inserted* into the synovial membrane. *Use*, to raise the synovial membrane in extension of the leg, so as to prevent its being contused by the patella.

7. GRACILIS, flat, long, and thin, broad and fleshy above, round and tendinous below, situated at the inner side of the thigh, immediately beneath the iuteguments and fascia; *arises* by a thin short tendon from the lower half of the symphysis, and from the inner edge of the descending ramus of the pubis; it soon becomes fleshy, and descends vertically, one edge directed forwards, the other backwards, and its surfaces looking one inwards, the other outwards; about the inferior fifth of the thigh it ends in a round tendon which passes behind the inner condyle, and then turns forwards along with the tendon of the sartorius, behind and beneath which it lies; *inserted* into the superior part of the internal surface of the tibia, uniting with the sartorius and semi-tendinosus, but superficial to the latter. *Use*, to adduct the leg and thigh, to bend the knee, and turn the leg and foot inwards. The origin of the gracilis is between the triceps and the crus penis; its whole course is superficial, except near the knee, where it is covered by the sartorius; its insertion is inferior to that of the sartorius, and superior to that of the semi-tendinosus; the saphena vein and nerve are situated between its tendon and that of the sartorius at the inner side of the knee, but these are separated from each other by a fascia, which attaches these tendons together, the vein lying superficial: from the tendon of the gracilis an aponeurosis is sent off to the fascia of the leg.

8. PECTINÆUS, flat, triangular, broad above, situated at the superior, anterior, and internal part of the thigh; *arises* fleshy from the linea innominata and the concave surface below it on the horizontal ramus of the pubis, between the spine of that bone and the ilio-pectinæal eminence; it forms a flat fleshy belly, which descends obliquely outwards and backwards, and is *inserted* by a flat tendon into the rough ridge which leads from the lesser trochanter to the linea aspera. *Use*, to adduct and flex the thigh, also,

to rotate it outwards; it may also serve to strengthen the capsular ligament of the hip joint internally, and in adduction of the limb to draw the capsule inwards from between the neck of the femur and the acetabulum. The pectinæus lies between the psoas magnus and the adductor longus; the latter overlaps it; it is covered superiorly by the fascia lata, and inferiorly by the femoral vessels; it covers the obturator nerve and vessels, the external obturator muscle, and the adductor brevis; it also adheres to the capsular ligament of the hip joint.

[*Variety.* A fissure sometimes divides this muscle into two, of which the lower part is the smallest.]

TRICEPS ADDUCTOR FEMORIS consists of three portions, which pass in distinct laminæ from the pelvis to the thigh.

9. ADDUCTOR LONGUS, flat and triangular, broad below, is situated at the upper and internal part of the thigh, superficial to the other adductors and to the pectinæus; it *arises* by a short, small, but strong tendon from the anterior surface of the pubis, between its spine and the symphysis; this ends in a broad fleshy belly, which descends obliquely backwards and outwards, and is *inserted* by a broad thin tendon into the middle third of the linea aspera, between the adductor magnus and the vastus internus, to both of which it is closely united. The origin of this muscle lies between the pectinæus and the gracilis, and above the adductor brevis; its insertion is behind the vastus internus, and in front of the adductor magnus; this adductor is covered by the integuments and fascia superiorly, and by the sartorius and the femoral vessels inferiorly; it lies anterior to the two following muscles.

[*Varieties.* This muscle is sometimes divided into two, by a fissure, and sometimes its insertion extends lower down than above described, by its tendon running into that of the adductor magnus.]

10. ADDUCTOR BREVIS, short, flat, and triangular, is situated posterior to the adductor longus and pectinæus, and internal to the psoas; *arises* flat and tendinous from the anterior inferior surface of the pubis, between the gracilis muscle, the symphysis pubis, and the thyroid hole; it soon ends in a fleshy belly, which passes outwards, backwards, and a little downwards, *inserted* by tendinous slips into the superior third of the internal root of the linea aspera, extending for about three inches below the lesser trochanter. The origin of this muscle is external to the gracilis, and concealed by the adductor longus and the pectinæus; as it descends it is covered by these muscles, except a small portion near its insertion, which appears between them; this portion is posterior to the femoral and profunda vessels;

its insertion is anterior to that of the adductor magnus; in the tendon of this adductor one or two large openings frequently exist for the passage of some of the perforating arteries.

[*Variety.* This muscle also is sometimes divided into two by a fissure, which according to Meckel, is analogous to the same muscle in the ape. The same is also true of the next muscle.]

11. ADDUCTOR MAGNUS, the longest and largest of the adductors. triangular, the base attached to the femur, the apex to the pelvis; *arises* chiefly fleshy from the anterior surface of the descending ramus of the pubis, external to the gracilis, also from the ramus of the ischium, and tendinous from the external border of the tuberosity of the latter; the fibres pass outwards with different degrees of obliquity; those which arise from the pubis ascend obliquely outwards, those from the ramus of the ischium pass outwards and downwards, and those from the tuber ischii more directly downwards; *inserted* fleshy into the rough ridge which leads from the great trochanter to the linea aspera, tendinous and fleshy into the linea aspera, and by a long round tendon into the internal condyle of the femur. The superior edge of this muscle has a twisted appearance, it is nearly parallel to the quadratus femoris; several branches of the internal circumflex vessels pass between these muscles, and in rotation of the leg inwards the lesser trochanter projects between them; the middle portion which is inserted into the linea aspera, is internal to the insertion of the glutæus maximus, and to the origin of the short head of the biceps. This part of the muscle is perforated by several branches of the perforating arteries; at the lower part of the linea aspera this muscle appears to separate into two portions, one of which is inserted into the linea aspera, between the vastus internus and the short head of the biceps; the other is continued into the long tendon which is inserted into the inner condyle. The adductor magnus is covered internally by the gracilis, and anteriorly by the long and short adductors, the pectinæus, part of the sartorius, and the femoral vessels; posterior to it are the sciatic nerve, and the hamstring muscles; the tendinous insertion of the lower part of this muscle is intimately connected to the vastus internus: about the inferior fourth of the thigh there is a large oblique opening between these two muscles, through which the femoral vessels pass into the poplitæal space, *Use*, the three adductors, in addition to adducting the limb, can rotate it outwards; they also serve to steady and support the pelvis on the thigh; the long and short adductors can also flex the

thigh on the pelvis, and the adductor magnus can extend it, when it has been flexed.

In dissecting the preceding muscles, we observe the following vessels and nerves.

The *Femoral Artery* passes from under Poupart's ligament about midway between the symphysis pubis and the spine of the ilium; it thence descends obliquely inwards and backwards, and about the lower part of the middle third of the thigh it perforates the tendon of the adductor magnus, enters the poplitæal space, and then receives the name of poplitæal artery. In the upper third of the thigh, or in the inguinal region, the artery is covered only by the skin, superficial fascia, some lymphatic ganglia, and the fascia lata; in the middle third of the thigh it receives the additional covering of the sartorius, and beneath this of a very strong tendinous aponeurosis, which passes from the tendons of the adductor longus and magnus over the artery and vein, and joins the tendon of the vastus internus; in this part of the thigh the artery is enclosed in a perfect tendinous sheath, consisting anteriorly of the aponeurosis just mentioned, posteriorly and internally of the tendons of the adductors, and externally of the vastus internus: at the lower end of the sheath the artery passes into the ham through a large oval opening which is bounded superiorly by the adductor longus and magnus, externally by the vastus internus, internally by the adductor magnus, and inferiorly by the united tendons of the adductor magnus and vastus internus. The femoral artery in this course first passes over a few fibres of the psoas, next over the pectinæus and adductor brevis, the adductor longus, and a small portion of the magnus.

The femoral artery, immediately below Poupart's ligament, gives off, 1st, some cutaneous branches; 2nd, small arteries to the inguinal ganglia; 3rd, about two inches below Poupart's ligament, a very large branch, the profunda: 4th, several muscular branches to the sartorius and vastus internus; and 5th, just before it enters the ham the anastomotica magna, which is distributed to the muscles and integuments at the inner side of the knee. The *profunda* is the largest branch of the femoral; it descends behind that vessel and to its inner side, and gives several branches to the muscles of the thigh, namely, the external and internal circumflex, and the three or four perforating arteries. (See Anatomy of the Vascular System.) The *femoral vein* takes the same course as the artery; in the groin it always lies to its internal or pubic side, but as it descends it becomes posterior to it. In dissecting the muscles on the fore part of the thigh, numerous branches of the *anterior crural nerve* are met with; this nerve in the groin is separated into several branches, many of these become cutaneous, others pass to the muscles on the fore part of the thigh, and two or three accompany the femoral artery; one of these, the *nervus saphenus*, enters its tendinous sheath, and descending along the fore part of the artery, as far as the opening in the tendon of the triceps, then leaves that vessel, descends between the tendons of the sartorius and gracilis muscles to the inner side of the knee; it there becomes cutaneous, and attaching itself to the saphena vein, it accompanies this vessel along the inner side of the leg to the internal ankle.—(See Anatomy of the Nervous System.)

SECTION II.

DISSECTION OF THE POSTERIOR PART OF THE THIGH.

PLACE the detached extremity on its fore part, with a block beneath the hip joint, so as to flex the latter slightly, and thus extend the muscles in this region. Raise the integuments from the posterior surface of the limb, from the crest of the ilium to the calf of the leg; the cutaneous nerves which are met with in this dissection are branches from the lumbar nerves, from the sacral plexus, and from the sciatic nerve. The cutaneous veins pass in different directions, some turn round the inner side of the limb to the saphena vein, others penetrate between the muscles, and join the deep veins which accompany the muscular or the perforating arteries, and others descend to the popliteal space, and join the popliteal or the lesser saphena vein. The fascia lata over the glutæus maximus is weak, but anterior to that muscle, that is, covering the glutæus medius, it is very strong and adheres to the surface of this muscle, and to the crest of the ilium above it; on the posterior part of the thigh, the fascia is not so dense as on the outer or anterior part; inferiorly, over the popliteal region, or the ham, it is much stronger than above; from the thigh it is continued over the muscles of the leg, in which situation it may be examined afterwards: the fascia and integuments being removed, the muscles should be cleanly dissected; these may be divided into the muscles of the hip and of the thigh.

DISSECTION OF THE MUSCLES OF THE HIP.

These are nine in number, viz. the three glutæi, the pyriformis, the gemini, the two obturator, and the quadrator femoris.

1. Glutæus Maximus covers the greater part of the pelvis, also the upper part of the thigh; it is somewhat square, one edge being the origin and attached to the sacrum, the opposite edge or the insertion to the femur, and to the fascia lata, the other edges are directed one upwards and forwards, the other downwards and backwards. The inferior edge is thick and round, and covered by a great quantity of fat; this forms the *fold of the nates.* It is difficult to clean the surface of the glutæus maximus, its fasciculi are so coarse and rough, this may be facilitated by dissecting parallel to the fibres, that is, in a line drawn from the sacrum towards the great trochanter. This muscle *arises* by fleshy and short aponeurotic fibres, from the posterior fifth of the crest of the ilium, from the rough surface between the crest and the superior semicircular ridge on this bone, from the posterior sacro-iliac ligaments and lumbar fascia, from the tubercles on the posterior surface of the sacrum, the side of the coccyx, and from the great sciatic ligaments, which last it covers: the fibres are collected into distinct fasciculi, which descend obliquely outwards and forwards, nearly parallel to each other, converging a little towards the thigh; the lower fibres are the longest, they all form a strong and dense mass, particularly below, and end in a flat and thick tendon, whose external surface is rough and coarse, but the internal smooth, and lined by a bursa which separates it from and allows it to glide over the great trochanter, this tendon is *inserted* into a rough ridge which leads from the trochanter to the linea aspera, also into the upper third of that line, and by a tendinous expansion into the fascia lata, covering the vastus externus muscle. *Use*, to extend the thigh, also to abduct and rotate it outwards, to support and extend the pelvis and the trunk on the lower extremity, also to make tense the fascia lumborum and the fascia lata. The glutæus maximus is covered by the integuments, by a considerable depth of fat, and by a thin fascia; as the latter approaches the upper edge of the muscle, it becomes more strong and adherent, and is thence extended over the anterior part of the glutæus medius, to which it adheres very closely, and is then inserted into the crest and anterior spine of the ilium. The glutæus maximus covers the tuber ischii and all the muscles on the posterior part of the pelvis, except the anterior portion of the glutæus medius, which is covered by the

fascia just now mentioned; its insertion into the linea aspera is above the short head of the biceps, and between the vastus externus and adductor magnus; a very large bursa lines its tendon, and is expanded over the trochanter and a portion of the vastus externus; it is very thin, it usually contains much synovial fluid, and it is frequently intersected by tendinous bands; a smaller bursa is often situated below it, between the tendons of the glutæus maximus and vastus externus.

Divide this muscle by a perpendicular incision, and separate the edges; several muscles, vessels, &c. may be noticed, having the following relation to each other; commencing above, we see the glutæus medius muscle, beneath this, the pyriformis, and between these, the glutæal vessels and the superior glutæal nerve; below the pyriform muscle we remark the great sciatic and some smaller nerves, also the sciatic and pudic vessels, all escaping from the pelvis by the lower part of the sciatic notch; next in order are the gemelli muscles surrounding the tendon of the obturator internus, below these is the quadratus femoris, parallel to the superior fibres of the abductor magnus; the great sciatic ligament, the tuber ischii, and the superior attachment of the hamstring muscles are seen in this dissection, also several small arteries and veins, and a considerable quantity of loose watery cellular tissue, which surrounds the sciatic nerve in its course, through the depression between the trochanter and tuber ischii.

2. Glutæus Medius, triangular, flat, thinner than the last described muscle, is exposed by dividing the glutæus maximus and dissecting off the strong fascia which extends from its anterior edge to the crest of the ilium, *arises* by fleshy and aponeurotic fibres from the deep surface of this fascia, from the three anterior fourths of the outer edge of the crest of the ilium, from the superior semicircular line or ridge which leads from the anterior spinous process of the ilium to the upper part of the sciatic notch, and from the surface of the ilium, above and below that ridge; the fibres descend in different directions, the middle perpendicularly, the anterior, which are very short, and the posterior, which are long, obliquely; they all converge into a strong and broad tendon, which is *inserted* into the upper and outer part of the great trochanter, and is attached anteriorly to the tendon of the glutæus minimus. *Use*, to abduct the thigh; its posterior fibres can extend and rotate it outwards, its anterior fibres can flex and rotate it inwards; it also serves to maintain the pelvis in equilibrio on the femur, as when standing on one leg. This muscle is covered in part by the glutæus maximus; the anterior and larger portion is

covered only by the integuments and fascia lata; it lies on the glutæus minimus, its posterior edge is parallel to the pyriform muscle, and separated from it by the glutæal vessels and nerves; the anterior edge is nearly parallel to and behind the tensor vaginæ muscle, is united to it above, but separated from it below by a quantity of fat, and by several branches of the external circumflex vessels and nerves.

3. Glutæus Minimus, is exposed by detaching from its origin the glutæus medius; small, semicircular, more tendinous than the last, it *arises* from the inferior semicircular ridge on the dorsum of the ilium, and from the rough surface between it and the edge of the acetabulum; the fibres converge as they descend, and end in a strong round twisted tendon, which is *inserted* into the upper and anterior part of the great trochanter, first passing over a small bursa. *Use*, similar to the last, it also strengthens the ilio-femoral articulation, and as it adheres to the capsular ligament, it can draw this out of the joint in abduction of the thigh. This muscle is covered by the glutæus medius, and a little overlapped by the tendon of the pyriformis, it covers the capsular ligament and the external tendon of the rectus.

4. Pyriformis, is of a flattened triangular form, the base at the sacrum within the pelvis, the apex at the trochanter; situated partly within the pelvis, partly behind the hip joint, nearly parallel to the posterior border of the glutæus minimus; it *arises* within the pelvis by three tendinous and fleshy fasciculi, from the anterior or concave surface of the second, third, and fourth divisions of the sacrum; it also receives a few fibres from the anterior surface of the great sciatic ligament, and from the upper and back part of the ilium; the fibres form a thick fleshy belly, which passing through the great sciatic notch, descends obliquely outwards and a little forwards, and is *inserted* by a round tendon into the upper part of the digital fossa, at the root of the great trochanter above the tendons of the gemelli, and obturator muscles, to which it is connected. *Use*, to abduct the thigh, to extend and rotate it outwards, it can also act on the capsular ligament in the same manner as the glutæus minimus. Within the pelvis this muscle lies on the sacrum and is covered by the hypogastric vessels, the sciatic plexus of nerves, and the rectum; the sciatic nerve often perforates it, near its lower margin; on the dorsum of the pelvis this muscle is covered by the glutæus maximus, and is parallel to, but not covered by the glutæus medius; it adheres to the capsular ligament, and is superior to the gemelli, from which it is separated by the sciatic nerve and vessels; this muscle divides the sciatic notch into two parts, through the superior pass the glutæal vessels and nerves,

through the inferior the sciatic and pudic vessels, the sciatic nerve and several smaller branches of the sacral plexus of nerves. To expose the following five small rotator muscles of the hip joint, draw to either side the great sciatic nerve, and remove the surrounding loose cellular tissue.

[*Variety.* This muscle is sometimes divided by the great sciatic nerve as it passes out of the pelvis. So far as I have observed, this occurs most commonly, when there is also an anomaly of the nerve itself, which consists in its high bifurcation, one trunk coming out in the usual situation, beneath the pyriform muscle, and the other, perforating the muscle.]

5, 6, Gemelli, two small muscles behind the ilio-femoral articulation between the ischium and the trochanter, the superior *arises* narrow and fleshy from the spine of the ischium: the fibres pass outwards above the tendon of the obturator internus, and are *inserted* with it into the upper part of the digital fossa of the great trochanter. Inferior *arises* also fleshy, from the upper part of the tuber ischii, and from the great sciatic ligament, the fibres run parallel to the former, and are also *inserted* into the digital fossa. *Use*, to rotate the thigh outwards, also to abduct it, to strengthen the capsular ligament and to confine the obturator tendon in its situation. These muscles are concealed by the glutæus maximus and the sciatic nerve; they are placed between the pyriformis and the quadratus femoris muscles: they form a sort of sheath around the tendon of the obturator internus, and adhere to its edges; they appear as portions of this muscle added to it as it escapes from the pelvis: the inferior is the larger of the two: the superior is inserted between the pyriformis and the obturator internus, and the inferior between the tendons of the obturator internus and externus: they both adhere to the capsular ligament.

[*Varieties.* These muscles are both wanting in some subjects; in others one only, the superior, is wanting, which is said to be analogous with the ape.]

7. Obturator Internus, is situated partly within the pelvis and partly behind the ilio-femoral articulation; somewhat triangular, the base within the pelvis, the apex at the great trochanter, *arises* by aponeurotic and fleshy fibres within the pelvis from the superior or pelvic surface of the obturator or thyroid ligament, and from all the circumference of the foramen of that name, except at the upper part where the obturator nerve and vessels pass through: beneath these a ligamentous arch is extended, and from this some fibres of this muscle proceed; it also arises from the pubis internally, and from the ischium inferiorly, and

from a thin but strong fascia of the same name, which covers this muscle and separates it from the levator ani muscle; the fibres descend obliquely outwards and backwards, converging towards the lesser sciatic notch, which is between the spine and the tuberosity of the ischium; the fibres here end in a flat tendon, which turning outwards. winds round the cartilaginous pully-like surface which the ischium here presents; a loose bursa, and one, in general, containing a quantity of synovia, is here interposed between this tendon and the bone; the tendon now runs outwards on the dorsum of the pelvis, between the gemelli muscles, and is *inserted* into the digital fossa of the great trochanter. *Use*, to abduct and rotate the thigh outwards; it may also act on the capsular ligament. This muscle within the pelvis is covered by the peritonæum, the pelvic fascia, levator ani muscle, and by a strong aponeurosis, termed the obturator fascia, which serves to give origin to some fibres both of the obturator muscle and of the levator ani, between which it is interposed; the *obturator fascia* is the external layer of the pelvic fascia; it adheres superiorly to the ilium and pubis, and is inserted inferiorly into the great sciatic ligament, into the tuberosity and ramus of the ischium, also into the ramus of the pubis, it here becomes continuous with the triangular ligament of the urethra; this fascia is closely connected to the obturator internus muscle, except inferiorly where the internal pudic nerve and vessels intervene. As the obturator tendon is passing through the sciatic notch, its deep surface is divided into four or five distinct tendons, which are lined by the synovial membrane, and connected to each other like so many plaits or folds; the pudic vessels lie external to this tendon in this situation; the continuation of the tendon to its insertion has the same relations as the gemelli muscles.

8. Quadratus Femoris, *arises* by fleshy and aponeurotic fibres from the external surface of the tuber ischii, anterior to the tendon of the semi-membranosus, the fibres pass transversely outwards, and are *inserted* tendinous and fleshy into the inferior and posterior part of the great trochanter, and into the posterior intertrochanteric line. *Use*, to adduct and rotate the thigh outwards: this muscle is covered by the glutæus maximus and sciatic nerve; its origin is also concealed by the hamstring muscles; it is parallel to and between the gemelli and the adductor magnus; its lower border is overlapped by the latter; it covers the obturator externus, the lesser trochanter, and the insertion of the psoas and iliacus. Divide this muscle, and a little dissection will expose the following, particularly if the gracilis, adductor, and pectinæus muscles have been previously removed.

[*Varieties.* This muscle is sometimes wanting. Very rarely it is found to consist of a large number of fasciculi, it is more prone than many muscles, to a fatty transformation.]

9. OBTURATOR EXTERNUS, situated at the superior, posterior, and internal part of the thigh, somewhat triangular or pyramidal, the base towards the pubis, the apex at the trochanter, *arises* fleshy from the inferior surface of the thyroid or obturator ligament, and from the surrounding surface of the pubis and ischium, the fibres descend obliquely outwards and backwards behind the neck of the femur, in a sort of notch or groove between the tuber ischii and the edge of the acetabulum; here they end in a strong tendon, which ascends a little behind the neck of the femur, then runs directly outwards along the inferior gemellus, and adhering to the capsular ligament, is *inserted* into the lower part of the digital fossa. *Use*, to adduct the thigh, and to rotate it outwards; it also supports and strengthens the inferior and posterior part of the ilio-femoral articulation, particularly in abduction of the thigh. This muscle is placed in a very deep situation, being covered, anteriorly, by the adductor brevis and pectinæus, also by the obturator nerve and vessels, internally by the adductor muscles, externally by the joint, and posteriorly by the quadratus femoris and glutæus maximus.

The several small muscles just described, in addition to their individual actions, effect the common purpose of strengthening the ilio-femoral articulation. The capsular ligament of this joint is covered anteriorly by the rectus, psoas, and iliacus; internally by the pectinæus and obturator externus; externally by the tendon of the rectus, the glutæus minimus and medius, posteriorly by the pyriform, gemelli, obturator tendons quadratus femoris, and glutæus maximus, and inferiorly by the tendon of the obturator externus. Many of these muscles, like the small capsular muscles of the shoulder joint, guard against dislocation in the different motions of the limb, and also serve to protect the capsular ligament by drawing it out of the angle which is formed between the acetabulum and the neck of the femur in the rotatory motion of the limb.

In dissecting the foregoing muscles, several vessels and nerves must have been remarked; the former are derived from the hypogastric or internal iliac vessels; the latter from the sacral plexus of nerves; the arteries are the glutæal, sciatic, and pudic. The *glutæal* artery escapes through the upper part of the sciatic notch, above the pyriform muscle, and immediately divides into several branches; these are distributed to the three glutæi muscles. The *sciatic artery* passes out of the pelvis through the lower part of the great sciatic notch, below the pyriformis; its principal branches descend between the tuber ischii and the great trochanter, and are lost in the surrounding muscles. The *pudic artery* escapes from the pelvis along with the last described vessel; it soon, however, re-enters the cavity through the lesser sciatic notch, and pursues its course forwards and inwards towards the perinæum and pubis, lying at first on the internal surface of the obturator internus, and afterwards on the rami of the ischium and pubis, its branches are distributed to the external organs of generation, and to the muscles in the perinæum. (See Anatomy of the Vascular System.) Each of these arteries have their corresponding veins, which take a similar course, and terminate in the internal iliac vein. The nerves which are found in this situation are the superior and inferior glutæal, the posterior cutaneous, the pudic, the great and lesser sciatic; these are all branches of the sacral plexus. The *superior glutæal nerve* accompanies the glutæal artery, and is distributed principally to the glutæus medius and minimus muscles. The *inferior glutæal nerve* escapes below the pyriform muscle, and is distributed principally to the glutæus maximus. The *inferior* or *lesser sciatic nerve* accompanies the last through the sciatic notch, descends obliquely inwards round the tuber ischii, and is distributed to the surrounding muscles and integuments. The *posterior cutaneous nerve* also passes through the lower part of the great sciatic notch, descends beneath the glutæus maximus, and then becoming cutaneous, divides into several long branches, which may be traced along the posterior surface of the thigh, even to the leg, where in general they will be found to communicate with the posterior cutaneous nerves of that region. The *pudic nerves* take the same course as the pudic artery, and terminate in corresponding branches. The *great sciatic* or *posterior crural nerve*, is the largest nerve in the body; it passes out of the pelvis below, but often through the pyriform muscle, descends behind the hip joint in the fossa between the trochanter and tuber ischii, covered by the glutæus maximus, and passing over the gemelli, obturator, and quadratus muscles; its course along the back of the thigh, and its branches, shall be considered after the dissection of the following muscles.

DISSECTION OF THE MUSCLES ON THE BACK PART OF THE THIGH.

The fascia in this situation has been already noticed; the muscles are only three in number, and are commonly called hamstring muscles; the semi-tendinosus and semi-membranosus form the inner, the biceps the outer hamstring.

Biceps Flexor Cruris, consists of a long and short head; the long head *arises* from the outer and back part of the tuber ischii in common with the semi-tendinosus, this descends obliquely outwards, and soon ends in a thick fleshy belly; about the inferior third of the thigh it joins, at an acute angle, the short head, which *arises* fleshy from the linea aspera, between the vastus externus and the adductors, commencing below the insertion of the glutæus maximus, and continuing to within two inches of the external condyle; here the muscle ends in a strong tendon, which descends at first behind the knee, then turns forwards and outwards towards the head of the fibula, into which it is *inserted;* the tendon is here divided in general by the external lateral ligament into two fasciculi, the superficial of which, in addition to its attachment to the head of the fibula, is also inserted into the fascia of the leg; and the deep fasciculus which is also inserted into the fibula, sends some fibres to the head of the tibia. *Use*, to flex the knee-joint, also, by its long head, to extend the thigh and rotate the whole limb outwards; the long head can also fix the pelvis, and prevent it and the trunk from bending forwards on the head of the femur. The superior fifth of this muscle is concealed by the glutæus maximus, the remainder is covered by the integuments and fascia, and descends between the vastus externus and semi-tendinosus, forming the outer hamstring; the long head passes over the semi-membranosus, the sciatic nerve, and the triceps muscles; it also conceals the short head: inferiorly the biceps passes over the external articular vessels and the external head of the gastrocnemius muscle, and forms the outer hamstring.

[*Varieties.* The short head is sometimes wanting which is analogous to some of the inferior animals; sometimes there is a slender third head from the tuber ischii, or the long head, which runs down the leg into the tendo achillis; this is analogous to other mammalia.]

2. Semi-tendinosus, large, flat, and fleshy above, round and tendinous below, *arises* by fleshy fibres from the tuberosity of the ischium in common with the long head of the biceps, also from the inner or anterior edge of the tendon of the latter for about three inches; it descends obliquely inwards, and about four inches above the knee it ends in a long round tendon, which passing behind the head of the tibia, is then reflected forwards between the tendon of the semi-membranosus and the internal head of the gastrocnemius, and is *inserted* into the anterior angle of the tibia below its tubercle, inferior and posterior to the

tendons of the gracilis and sartorius, to which it is connected: from the convex edge of the tendon an aponeurosis is given off, which joins the fascia of the leg. *Use*, to flex the knee and rotate the leg inwards, to extend the thigh, to support the pelvis, and prevent the trunk falling forwards. This muscle is covered superiorly by the glutæus maximus; the rest of its course is superficial, a transverse line usually intersects it about its centre.

[*Variety*. This muscle is sometimes divided into three parts, by two transverse tendinous lines.]

3. Semi-membranosus, beneath the semi-tendinosus, flat and aponeurotic superiorly, thick and fleshy in the middle, round and tendinous below; *arises* by a flat tendon from the upper and outer part of the tuber ischii; this descends obliquely inwards, ends in a fleshy belly, which retains this muscular structure lower down than either of the former muscles, a little above the knee it ends in a round tendon, which passes behind the internal condyle, and divides into three processes, one of which passes outwards, another downwards, and a third forwards; the first is a broad aponeurosis, which ascends obliquely outwards, beneath the heads of the gastrocnemius muscle over the back part of the knee-joint, and is *inserted* into the external condyle of the femur; this aponeurosis has been termed the *posterior ligament* of the knee-joint, or the *ligament of Winslow;* the second is a strong and broad fascia, which descends over the poplitæus muscle, and is *inserted* into the posterior part of the heads of the tibia and fibula, and is also continuous with the fascia of the leg; the third process appears the continuation of the tendon, it turns forwards beneath the internal lateral ligament, round the head of the tibia, into which it is *inserted*. *Use*, to extend the thigh on the pelvis, and to support the latter on the thigh, to flex the knee and to rotate the leg inwards; it also strengthens the back part of the knee, and can draw the synovial membrane out of the angle of the joint. This muscle, at its origin, lies external to the other hamstring muscles; it is covered at first by the semi-tendinosus, biceps, and glutæus maximus, inferiorly it is superficial; above, is passes over the quadratus femoris and adductor magnus muscles; below it overlaps the popliteal vessels, and the internal head of the gastrocnemius, from which last it is separated by a bursa; the sciatic nerve is on its outer, the gracilis on its inner side.

[This muscle together with the last forms the inner hamstring.]

The arteries which are met with in the dissection of these muscles are branches of the sciatic, circumflex, perforating, and articular, the numerous ramifications of these vessels are distributed to the hamstring and adductor muscles, and are accompanied by their corresponding veins; the principal nerve in this situation is the *great sciatic;* from the back part of the hip joint this large nerve descends along the back of the thigh to the upper part of the popliteal space, where it divides into the peronæal and posterior tibial nerves; in this course it is covered at first by the glutæus maximus, afterwards by the biceps and semi-tendinosus, and inferiorly by the integuments and fascia; having passed over the quadratus femoris and the other small muscles at the back of the hip joint, it next lies on the adductor magnus, and inferiorly on a quantity of adipose substance. The sciatic nerve gives off several cutaneous and muscular filaments, in addition to its two terminating branches, the peronæal and the posterior tibial; the *peronæal nerve* takes the course of the biceps tendon towards the head of the fibula, where it divides into several branches which are distributed to the integuments and muscles on the outer and forepart of the leg, as will be described in the dissection of that region. The *posterior tibial nerve* accompanies the popliteal vessels through the space of that name, which space the students should next examine.

The *popliteal space* is situated behind the knee-joint, extending upwards for about one-fourth of the thigh, and downwards for about one-sixth of the leg; it is somewhat oval, is bounded internally by the inner hamstring, and the internal head of the gastrocnemius; externally by the biceps, external head of the gastrocnemius, and the plantaris; it is covered by the integuments and by a strong fascia, which, derived from the fascia lata, is strengthened by adhering to the condyles of the femur, and to the adjoining tendons; this fascia serves to approximate the sides of this region, and thus to give to it a considerable depth. The popliteal space is bounded before by the flat surface of the femur, by the back part of the joint covered by the ligament of Winslow, by the head of the tibia, and by the poplitæus muscle; in this region are contained the terminating branches of the sciatic nerve, the popliteal artery and vein with their branches; also some lymphatic ganglia and much adipose substance. The nerves are superficial and external to the vessels, that is, nearer to the biceps; the vessels are close to the bone, and near to the semimembranosus muscle, the vein being superficial and a little to the outer side of the artery; two or three lymphatic ganglia are connected to the latter; and a quantity of fat, which is of a peculiar soft consistence, intervenes between the nerve and vessels. The course of the peronæal nerve has been already noticed; the *posterior tibial nerve* descends nearly vertically between the hamstring muscles and the heads of the gastrocnemius, and then runs beneath the solæus, and over the poplitæus; above it lies to the outer side of, and at some distance from, the artery, but below it is in close contact with it, and to its tibial or inner side, it then accompanies the posterior tibial vessels down the leg, and along the inner side of the heel, to the sole of the foot, in which course it shall be examined afterwards; in the ham this nerve sends off muscular branches, also the *posterior* or *external saphenus nerve*, which accompanies the posterior saphena vein along the back of the leg, towards the outer ankle, behind which it passes to the external and superior part of the foot, where it is distributed; this nerve is by some called "communicans tibialis." The *popliteal artery* descends obliquely outwards through this space, and at the lower edge of the poplitæus muscle divides into the anterior and posterior tibial arteries; in this course it sends off many muscular and five articular branches, the latter supply the ends of the bones, and the synovial membrane of the knee-joint. The *popliteal vein* accompanies the artery, lying superficial and somewhat external to it; it receives branches which correspond to those of the artery; and it is joined inferiorly by the lesser or posterior saphena vein. Next proceed to the dissection of the leg.

SECTION III.

DISSECTION OF THE LEG.

Remove the integuments of the leg and foot; on the plantar surface of the latter they are always remarkably hard and thick, even in the fœtus, particularly beneath the heel and the first and last joints of the toes; in these situations also the subcutaneous fat has a peculiar granulated structure, being intersected by tendinous bands, which pass from the skin to the plantar fascia. Beneath the integuments of the leg we find two cutaneous veins, the internal and external saphena; the *internal saphena* is large and regular, and has numerous branches; it commences by small veins from the upper surface of the toes, and from the dorsum of the foot; these run towards the inner malleolus and unite in one large vessel, which ascends along the inner side of the leg, receiving in its course numerous branches from the integuments; it then passes behind the inner condyle of the femur, and ascending along the inner and anterior part of the thigh, it terminates in the femoral vein about an inch and a half below Poupart's ligament; on the thigh this vein is accompanied by small nerves, which are derived from the lumbar plexus and from the anterior crural; along the leg the saphenus nerve, a branch of the anterior crural, is attached to it, and winds round it. The *posterior* or *external saphena vein* commences behind the external ankle from the junction of several small veins from the integuments of the heel and sole of the foot; it ascends along the surface of the gastrocnemius muscle, accompanied by the communicans tibialis nerve; at the ham this vein in general joins the popliteal vein, but sometimes it here turns inwards and joins the internal saphena vein, with which it always communicates in its course along the leg. Several cutaneous nerves are distributed to the leg, namely, the internal saphenus, from the posterior tibial, and several cutaneous branches from the peronæal and anterior tibial nerves perforate the fascia of the leg on its outer and anterior part, and are distributed to the integuments of the leg and foot.

The *fascia* of the leg is derived partly from that of the thigh; it also receives additional fibres from the tendons around the knee-joint, namely, the rectus and vasti anteriorly; the vastus externus and biceps externally; the sartorius, gracilis, and inner hamstring internally; the fascia adheres to the head of the tibia and fibula, to the spine of the tibia, near its whole length, to the annular ligaments of the ankle joint, and to the malleoli; it can scarcely be said to exist on the anterior surface of the tibia, which is only covered by the skin and periosteum. The fascia of the leg is stronger superiorly than inferiorly; near the ankle it again increases in strength from its connexion to the malleoli and to the annular ligaments; these are two in number, the anterior and internal. The *anterior annular ligament* is a little above the joint; it is somewhat square, and stronger externally than internally; in the latter situation it is attached to the malleolar process of the tibia, and to the os naviculare; in the former to the external malleolus, and to the upper part of the os calcis; it consists of two layers, which, by separating and re-uniting, from three rings or sheaths for the tibialis anticus, and the two extensor tendons; the anterior tibial vessels and nerves also pass beneath it. The *internal annular ligament* is broader than the anterior; it is attached to the internal malleolus, and to the os calcis; it forms a sort of arch over the groove or canal in which the three flexor tendons, and the plantar nerves and vessels run. The fascia of the leg is thin posteriorly; near the heel it is indistinct: on either side it is connected to the sheaths of the tendons that pass round the malleoli; and on each side of the tendo Achillis it sends in a lamina to join the fascia which covers the deep muscles of the leg. The fascia serves to confine the muscles in their situation, and to give origin to many of their fibres; this last effect is further accomplished by intermuscular bands or septa, which pass in from the fascia, between the extensor and peronæi muscles, and are attached to the tibia and fibula and interosseous ligament. From the anterior annular ligament, a thin fascia is extended over the dorsum of the foot; that covering the sole of the foot, *the plantar fascia*, is remarkably strong; it *arises* from the extremity of the os calcis, narrow but thick and strong; it passes forwards, expands and divides into three parts, which lie on different planes, and which, by sending in two processes, serve to separate the plantar muscles into three orders, the internal, middle, and external; the lateral portions of this fascia are attachad to the sides of the tarsus and metatarsus; the internal portion is the weakest: the middle division is the strongest, and on a plane inferior to the internal; as this middle portion expands beneath the plantar muscles, it is strengthened by transverse fibres, and near the base of the toes it divides into five fasciculi, these diverge, and opposite the head of each metatarsal bone, they each sub-divide into two fasciculi; these pass along the sides of the metatarso-phalangeal articulations, and are *inserted* into the lateral ligaments of these joints, and into the sheaths of the flexor tendons; between these fasciculi the tendons pass, also the digital vessels and nerves of each toe: the plantar fascia possesses the same strength as ligamentous structure; *use*, it serves to retain the arched form of the foot, and to protect the plantar muscles, vessels, and nerves, from pressure; it also gives attachment to several muscular fibres. The muscles of the leg may be divided into those on the anterior, external, and posterior part.

DISSECTION OF THE MUSCLES ON THE ANTERIOR AND EXTERNAL PART OF THE LEG.

The muscles on the forepart of the leg are four in number, viz. the tibialis anticus, extensor pollicis, extensor communis, and peronæus tertius; the muscles on the outer side of the leg are the peronæus longus and brevis; almost all these muscles are connected to each other superiorly, so that they cannot be perfectly separated from each other; they all adhere to and partly arise from the fascia of the leg, therefore, when exposed, they present a rough surface superiorly.

1. Tibialis Anticus, is next the tibia, somewhat triangular, large and fleshy above, tendinous below, *arises* tendinous and fleshy from the outer part of the two superior thirds of the tibia, from the head of the fibula, from the inner half of the inter-osseous ligament, from the fascia of the leg, and from the intermuscular septa; the fibres descend obliquely inwards, end in a strong and flat tendon which crosses from the outer to the forepart of the tibia, runs through a distinct ring in the annular ligament, near the internal malleolus, passes forwards and inwards above the astragalus and naviculare, increases in breadth, and is *inserted* into the inner side of the great or internal cuneiform bone, also, by a tendinous slip into the base of the first metatarsal bone or that of the great toe. *Use*, to flex the ankle, to adduct the foot, and to raise its inner edge from the ground; to turn the toes inwards, also to support the leg when standing, and prevent it bending backwards. This muscle is superficial through its whole length; the tendon, at its insertion, is partly concealed by the abductor and flexor pollicis brevis; superiorly this muscle is external to the tibia; inferiorly it is anterior to it: the extensor communis, and extensor pollicis, the anterior tibial vessels and nerves are to its outer or fibular side, a small bursa separates its tendon from the upper part of the internal cuneiform bone; another bursa in general surrounds it, as it is passing over the synovial membrane of the ankle joint.

2. Extensor Digitorum Longus, *arises* tendinous and fleshy from the external part of the head of the tibia, from the head of the fibula, and from about three-fourths of this bone, from part of the inter-osseous ligament, from the fascia of the leg, and its intermuscular septa; the fibres descend obliquely inwards; a liitle below the middle of the leg they end in three flat tendons, which pass under the annular ligament through a ring common to these and to the peronæus tertius, and extend forwards over the dorsum of the foot, the internal of the three tendons here divides into two; the four tendons now extend along the dorsum of each of the four external toes,—the great toe does not receive any,—and are *inserted* into the last phalanx of each. *Use*, to extend the toes and flex the ankle. This muscle is superficial; superiorly, it lies between the tibialis anticus and peronæus longus, and is connected to both; in the middle of the leg it is between the extensor pollicis and peronæus brevis: along each of the toes these tendons sub-divide at the joints between the first and second pha-

langes, into fasciculi, which pass over the sides of these articulations as the extensor tendons do on the fingers; on the dorsum of the toes also they form a sort of aponeurosis as on the fingers, the tendons of the lumbricales and inter-ossei as also the tendons of the extensor brevis assisting in its formation.

3. Extensor Pollicis Proprius, *arises* tendinous and fleshy from the inner edge of the middle third of the fibula, and from the inter-osseous ligament nearly as low down as the ankle; a few fibres also proceed from the lower part of the tibia; the fibres descend obliquely forwards to a tendon, which passes beneath the annular ligament, then runs forwards over the astragalus, naviculare, and cuneiforme internum; the tendon next passes over the first metatarsal bone, and is *inserted* by two tendinous fasciculi, one into the base of the first phalanx, and the other into the base of the second or last phalanx of the great toe. *Use*, to extend the great toe and flex the ankle; it may also adduct the foot, and rotate it inwards. The upper and middle portions of this muscle are overlapped and concealed by the tibialis anticus and extensor communis, between which muscles it is situated; its tendon is superficial; the anterior tibial nerve and vessels separate it from the tibialis anticus above, and from the extensor communis below; it lies on the fibula and inter-osseous ligament above: inferiorly it crosses over the tibial vessels, the synovial membrane of the ankle joint, and the bones of the tarsus.

4. Peronæus Tertius, or anticus, appears to be a portion of the extensor communis, and in some cases cannot be separated from it; it *arises* from the anterior surface of the lower half of the fibula; the fibres pass forwards to a tendon which descends along with that of the extensor communis beneath the annular ligament; it then passes forwards and outwards, and is *inserted* broad and thin into the base of the fifth metatarsal bone, and it frequently sends a band of fibres to join the fourth tendon of the extensor communis. *Use*, to extend the little toe, to flex the ankle, to abduct the foot and raise its outer edge. This muscle is sometimes wanting, an additional tendon from the extensor communis will then supply its place; it is superficial; on the foot it conceals the extensor brevis, which may be next examined.

Extensor Digitorum Brevis, is the only muscle situated on the upper surface of the foot, it *arises* tendinous and fleshy from the upper and anterior part of the os calcis, anterior to the groove for the peronæus longus, also from the cuboid bone, the astragalus, and the annular ligament; it forms a flat fleshy belly, which passes forwards and inwards, ends in four flat tendons, of which the two internal are the strongest; the little toe does not receive any; these tendons are *inserted* thus: the first or most internal, into the base of the first phalanx of the great toe; the three other tendons join the outer edge of the corresponding tendons of the extensor digitorum longus, and assist in forming the aponeurosis which covers the dorsum of each toe. *Use*, to extend the toes and rotate the anterior part of the foot outwards. This muscle is partly concealed by the tendons of the long extensor and peronæus tertius; it projects, however, behind and between them; the tendons cross the metatarsal bones and the inter-ossei muscles, beneath and in a contrary direction to the long extensor tendons. There is no analogous muscle to this on the dorsum of the hand.

[*Varieties.* The inner part is sometimes distinct from the rest, and sometimes the muscle presents four distinct bellies, as in birds. A tendon is sometimes sent to the little toe.]

The muscles on the outer part of the leg are the two peronæi.

1. PERONÆUS LONGUS, *arises* tendinous and fleshy around the head of the fibula and from the adjacent surface of the tibia, from the upper half of the external angle of the fibula, from the fascia and inter-muscular septa, the fibres descend obliquely backwards and outwards, end in a strong, flat tendon, which passes behind the external malleolus, through a groove in the lower end of the fibula, in which it is bound down by a strong aponeurosis, lined by a synovial membrane; it then passes forwards, downwards, and inwards, through a similar groove in the os calcis and cuboid; it next passes across the sole of the foot, above the plantar muscles, obliquely inwards and forwards towards the metatarsal bone of the great toe, into the outer side of which, and of the adjacent sesamoid bone, it is *inserted;* also, into the internal cuneiform, and into the base of the second metatarsal bone. *Use*, to extend the ankle joint, turn the foot outwards, and raise its outer edge, also to press the great toe against the ground as in walking; in the leg this muscle is superficial, and is situated between the extensor communis anteriorly and the solæus and flexor pollicis posteriorly; in the sole of the foot it is above all the muscles there, and cannot be seen until these are removed.

2. PERONÆUS BREVIS, *arises* fleshy from the outer and back part of the lower half of the fibula, and from the inter-muscular septa; the fibres descend obliquely, end in a tendon which passes behind the external malleolus in the same

groove as the peronæus longus; it then passes forwards through a distinct groove in the os calcis above the peronæus longus, and is *inserted* into the base of the metatarsal bone of the little toe, and into the os cuboides. *Use*, similar to the last. This muscle *arises* between the extensor longus and peronæus longus, and descends between the peronæus tertius and the flexor pollicis longus, and partly concealed by the peronæus longus; it continues fleshy lower down than it, and projects on either side of its tendon; it is separated from the peronæus tertius by the external malleolus; in the groove in the latter it is beneath the long peronæal tendon, that is nearer to the bone, but on the os calcis it is superior to it; an aponeurosis sometimes unites its insertion to that of the extensor tendon of the little toe.

[*Variety.* This muscle is sometimes double.]

In the dissection of the foregoing muscles we meet with the anterior tibial vessels and their branches; also the peronæal nerve and its divisions. The *anterior tibial artery* is a branch of the popliteal; it passes forwards between the solæus and poplitæus, perforates the inter-osseous space, surrounded by some fibres of the tibialis posticus; it then descends obliquely inwards and forwards as far as the cleft between the first and second metatarsal bones; in its course down the leg it is placed at first between the tibialis anticus and extensor communis, in the middle of the leg between the former and the extensor pollicis, and inferiorly between the tendon of the latter and that of the extensor communis; above it lies on the inter-osseous membrane, below it passes over the tibia, the synovial membrane of the ankle joint, the astragalus, navicular, and cuneiform bones, and beneath the annular ligament and the internal tendon of the extensor digitorum brevis; in the leg the anterior tibial artery sends off, first, the recurrent branch, which ascends on the outer and fore part of the head of the tibia, and meets the external articular arteries; second, in its course along the leg, several muscular branches; third, near the ankle, the two malleolar branches, of these, the external is the larger, and inosculates with a small artery (the anterior peronæal) which perforates the inter-osseous ligament about two inches above the ankle joint; on the tarsus, the anterior tibial artery sends off the tarsal and metatarsal branches, which pass obliquely outwards, and supply the inter-ossei muscles, the bones and joints of the tarsus and metatarsus; between the two first metatarsal bones the anterior tibial divides into the superior and inferior branch; the former supplies the integuments of the great toe; the latter passes deep towards the sole of the foot, and joins the external plantar artery; the anterior tibial artery is accompanied by two veins, which end in the popliteal vein. The *peronæal nerve* winds around the head of the fibula, perforates the peronæus longus, and divides into several branches; some of these supply the peronæal muscles, others the integuments on the outer and fore part of the leg and foot; and the continuation of the peronæal nerve passes obliquely forwards and downwards, and accompanies the anterior tibial artery, lying in general superficial, and to its fibular side.

DISSECTION OF THE MUSCLES ON THE BACK OF THE LEG.

THESE muscles are seven in number, and may be divided into a superficial and a deep layer; the former consists of three, the gastrocnemius, solæus, and plantaris; the latter of four, the tibialis posticus, flexor pollicis longus, flexor digitorum communis, and poplitæus. The cutaneous nerves and veins, and the fascia, have been already noticed.

[*Variety.* The tendinous connection with the flexor communis is often wanting.]

1. GASTROCNEMIUS, large and thick, tendinous below, fleshy and aponeurotic above, and divided into two heads, both of which are somewhat oval, convex behind, flat before; the internal longer and larger than the external; *arises* from the upper and back part of the internal condyle of the femur, and fleshy from the oblique ridge above it; the external head *arises* in the same manner, from above the external condyle, but is not so long or large; the fibres of each descend converging, and form two fleshy bellies, which unite a little below the knee in a middle tendinous line; about the middle of the leg the muscle ends in a broad and flat tendon, which gradually unites with that of the solæus, and both form that strong tendon which is commonly called the *tendo Achillis*, and which is *inserted*, into the lower and back part of the os calcis. *Use*, to extend the ankle joint, and thus, by raising the heel from the ground, to throw the weight of the whole body forwards on the toes as in progression; to flex the knee joint, also to secure the articulation against displacement, by preventing the condyles of the femur slipping backwards off those of the tibia. This large muscle is superficial, a small portion of its internal head is overlapped by the semi-membranosus; its deep surface is more aponeurotic than its superficial; the lower angle of the popliteal space separates its two heads; in this angle the popliteal vessels, the posterior tibial nerve, and the plantaris muscle are contained; a

bursa is placed between each head of this muscle and the condyle of the femur, which it covers; the external head conceals the tendon of the poplitæus; the internal covers the deep processes of the semi-membranosus tendon and an intervening bursa, also the insertion of the poplitæus; the gastrocnemius covers the greater part of the solæus, therefore, to examine the latter, detach the heads of the gastrocnemius from the condyles, and separate this muscle from the solæus to within two or three inches of the heel; the plantaris muscle is now also exposed.

[This muscle is said to be the one most frequently affected with fatty transformation. I have a specimen in which, one lateral half of the muscle was entirely changed, while the other half appeared quite natural. The soleus also is often affected at the same time.]

2. Plantaris, *arises* fleshy from the back part of the femur above the external condyle, and from the posterior ligament of the knee; it is connected to the external head of the gastrocnemius, and forms a small pyramidal fleshy belly, which descends obliquely inwards, crosses the popliteal vessels, and ends in a flat tendon (the longest in the body) which descends between the gastrocnemius and solæus; and when the tendons of these muscles are about to unite, that of the plantaris becomes superficial, it then descends along the inner side of the tendo Achillis to the heel, and is *inserted* into the posterior part of the os calcis, a little anterior to the tendo Achillis: it has also some connexion to the plantar fascia. *Use*, to extend the foot, and turn it inwards, also to make tense the fascia, and to flex the knee; its origin is partly concealed by the external head of the gastrocnemius; its tendon also is at first covered by this muscle, but inferiorly it is superficial. This muscle is sometimes wanting.

3. Solæus, of an oval flattened figure, consists superiorly of two heads, which are not so distinct from each other as those of the gastrocnemius; the external is longer and larger than the internal, and *arises* from the back part of the head and from the superior third of the fibula, behind the peronæus longus: the internal head *arises* from the middle third of the tibia, commencing below the oblique insertion of the poplitæus; the two heads are connected by a strong tendinous arch, beneath which pass the posterior tibial nerve and vessels; all the fibres descend and form a large oval belly, which continues fleshy lower than the gastrocnemius; a tendon is formed first on its superficial surface, which is gradually united to that of the gastrocnemius to form the tendo Achillis; this strong tendon is broad and thin above, narrow in the middle, and round and thick below, it is composed of strong vertical fibres

which descend behind the os calcis, over a bursa, covering a cartilaginous impression on that bone, and it is *inserted* into a rough surface below that. *Use*, to assist the gastrocnemius in extending the ankle; this muscle is almost entirely concealed by the gastrocnemius; a little below the middle of the leg, however, it projects on each side of the tendon of the latter, and forms the lower calf of the leg; it covers the deep seated muscles, vessels, and nerves.

Detach the solæus from its origin, and the strong deep fascia of the leg is exposed; this fascia is partly derived from the semi-membranosus and poplitæus, and partly from the more superficial fascia of the leg; it adheres to the tibia and fibula, to the solæus, and to the deep muscles; inferiorly this fascia is strong, and is connected to the sheaths of the tendons that pass behind the malleoli, and to the internal annular ligament of the ankle; dissect off this fascia and clean the four following muscles.

4. Poplitæus, situated obliquely at the upper and back part of the leg, behind the knee, and above the other muscles in this region, flat and triangular, *arises* by a round tendon from a depression on the external surface of the outer condyle, below the origin of the external lateral ligament, descends obliquely inwards and backwards, above the head of the fibula, and along the external semi-lunar cartilage, to which it is connected by the synovial membrane of the knee, and by a few tendinous fibres; becomes broad and fleshy, and is *inserted* into a flat triangular surface, which occupies the superior fifth of the posterior surface of the tibia. *Use*, to bend the knee, and when bent, to twist the foot and toes inwards; it may also assist when the limb is extended in rotating the knee outwards: it supports the external semi-lunar cartilage, and moves it slightly, so as to adapt its situation to the external condyle of the femur, in the rotatory motions of the joint; the poplitæus is covered by the two heads of the gastrocnemius and plantaris, also by the external lateral ligament, the popliteal nerve and vessels; it is superior to the inner head of the solæus, and passes over the tibio-fibular articulation and the back part of the tibia; it is nearly parallel to the upper part of the plantaris; the tendon is nearly surrounded by the synovial membrane of the knee, it lies however external to the cavity of the joint.

5. Flexor Digitorum Perforans, longus, or communis, broader in the centre than at either end, *arises* fleshy from the posterior flat surface of the tibia, commencing below the poplitæus, and extending to within two or three inches of the ankle, also from the fascia and inter-muscular septa; the fibres descend obliquely inwards to a tendon which

passes behind the internal malleolus, in a groove in the tibia which is lubricated by a bursa, and in which it is confined along with the tendon of the tibialis posticus by the internal annular ligament, separated, however, from that tendon by a ligamentous septum; each tendon also has a distinct synovial sac: this tendon then turns forwards and a little outwards into the sole of the foot, still confined in a bony groove, first in the astragalus, and then in the os calcis; in the sole of the foot it lies beneath the tendon of the flexor pollicis, and is connected to it by a tendinous slip; about the centre of this region it expands and receives the insertion of the accessory muscle, it then divides into four tendons, which pass to the four outer toes, and opposite the first phalanx, each tendon enters a strong fibrous sheath which is lined by synovial membrane; this sheath continues as far as the extremity of the second phalanx, and contains also the corresponding tendon of the flexor digitorum brevis; opposite the base of the second phalanx, each of the last named tendons is slit for the transmission of the long flexor tendon, which continues to run forwards to be *inserted* into the last phalanx of each of the four lesser toes. *Use*, to flex the toes and the metatarsus, to extend the ankle, and to steady the leg on the foot as when standing. This muscle in the leg is covered by the superficial muscles, the deep fascia, and the tibial vessels; it overlaps the tibialis posticus, and is on the inner or tibial side of the flexor pollicis; a little above the inner ankle, the tendon of the tibialis posticus crosses above that of the flexor communis, that is, becomes nearer to the tibia; in the sole of the foot its direction is horizontal, it is there superior to the flexor brevis, inferior to the transversalis pedis and peronæus longus tendon; the lumbricales muscles arise from its tendons.

6. Tibialis Posticus, larger above than below, *arises* from the posterior and internal part of the fibula, from the upper part of the tibia and from almost the entire length of the inter-osseous ligament; the fibres descend and end in a strong tendon which passes along with that of the last muscle behind the internal ankle, crosses above that tendon and then proceeds obliquely forwards and inwards, and is *inserted* into a tuberosity on the inferior and internal part of the os naviculare and into the internal cuneiform bone; it also sends some fibres to the cuboid and to the second and third metatarsal bones; a small bony or cartilaginous tubercle is often found in this tendon, near to its insertion, beneath the head of the astragalus; it also glides over a small bursa in this situation. *Use*, to extend the ankle and to raise the inner edge of the foot from the ground;

the upper end of this muscle is notched by the anterior tibial vessels, a few of its fibres accompany these vessels through the inter-osseous space and are attached to the anterior surface of the ligament; in its course down the leg it is covered by the solæus and overlapped by the flexor communis and flexor pollicis, it covers the tibia, fibula and inter-osseous ligament; it passes beneath the head of the astragalus and supports that strong fibro-cartilage, which extends from the os calcis to the os naviculare, beneath the head of the astragalus, which substance supports a great portion of the weight of the body in standing or in progression.

7. Flexor Pollicis Longus, *arises* from the two inferior thirds of the fibula by fleshy fibres which descend obliquely inwards to a tendon which passes behind the internal malleolus through a groove first in the tibia and next in the astragalus; entering the sole of the foot this tendon crosses above the flexor communis and is connected to it by a tendinous slip, it then proceeds forwards and inwards, between the two portions of the flexor pollicis brevis, enters a tendinous sheath, and is *inserted* into the last phalanx of the great toe. *Use*, to flex this toe, to extend the ankle and adduct the foot; this muscle lies to the fibular side of the tibialis posticus, between it and the peronæi muscles; as it passes behind the internal ankle it is about half an inch behind the tendons of the tibialis posticus and the flexor communis, and is separated from these by the posterior tibial nerve and vessels.

SECTION V.

DISSECTION OF THE MUSCLES OF THE FOOT.

There is but one muscle on the dorsum or on the upper surface of the foot, the extensor digitorum brevis, which has been already examined, as being a sort of appendix to, or continuation of the long extensors of the toes which arise from the bones of the leg. The integuments and fascia in the sole of the foot have been already noticed; the muscles here are very numerous, they may be divided into four laminæ, these are tolerably distinct about the middle of this region, but at either side this arrangement is rather artificial; the two inter-muscular processes of the plantar fascia also divide these muscles into three compartments, an internal, a middle, and an external. The muscles of the first, or superficial layer, are the abductor pollicis, flexor digitorum brevis, and abductor minimi digiti: in the second layer are the long flexor tendons, the accessory muscle, and the lumbricales: the third layer consists of the flexor pollicis brevis, adductor pollicis, transversalis pedis, and flexor minimi digiti; in the fourth layer, are the inter-ossei muscles, and the tendon of the peronæus longus.

Abductor Pollicis, *arises* tendinous and fleshy from the lower and inner part of the os calcis, from the internal annular ligament, the plantar aponeurosis, and internal inter-muscular septum; the fibres pass forwards and inwards, and are *inserted* tendinous into the internal sesamoid bone, and into the internal side of the base of the first phalanx of the great toe. *Use*, to separate the great toe from the others; this muscle is by some writers called the adductor pollicis, its action being then referred to the mesial line of the body; it is the most internal of the plantar muscles, and is superficial, the fascia covering it is very thin.

Flexor Digitorium Brevis Perforatus, *arises* from the inferior and rather from the internal part of the os calcis, from the internal annular ligament, the plantar aponeurosis, and inter-muscular septa; it forms a fleshy mass, which passing forwards divides about the middle of the foot into four delicate tendons, which accompany the flexor longus communis into the tendinous and synovial sheaths, beneath the phalanges of the four outer toes; each tendon is slit opposite the base of the second phalanx, and having transmitted the long flexor tendon, this short tendon is then folded out on the inferior surface of the second phalanx, and is *inserted* into it, above the long flexor tendon. *Use*, to assist the long flexor, to strengthen the plantar fascia, and to preserve the arch of the foot; this muscle is immediately above the strong central portion of the plantar fascia, from which a considerable portion of it arises, therefore it always presents a rough surface, when dissected; it is beneath the long flexor tendons, the accessory muscle, and the lumbricales; it is joined to the abductor pollicis posteriorly, but anteriorly is separated from it by the tendon of the flexor pollicis longus: the fourth or the external of its tendons, or that for the little toe, is sometimes wanting.

Abductor Minimi Digiti, is situated along the outer edge of the foot, *arises* tendinous and fleshy from the outer side of the os calcis, and from a strong ligament which extends from this to the fifth metatarsal bone, also from the base of the latter, from the plantar fascia and its external inter-muscular septum; *inserted* tendinous into the outer side of the base of the first phalanx of the little toe, and into the adjoining surface of the metatarsal bone. *Use*, to separate the little toe from the others, and to flex it; this muscle is also superficial, the fascia covering it is very strong, it is the most external of the muscles in this region.

Detach this first layer of muscles from their posterior attachments, and throw them forwards towards the toes; the tendons of the flexor pollicis and communis are now exposed, also the accessory muscle and the lumbricales; all these constitute the second layer of the plantar muscles, which is partially concealed by the first.

The tendon of the flexor longus digitorum communis is seen passing from the inner side of the os calcis to the middle of the plantar region, where it divides into its four tendons, which have been already described as entering the sheaths on the inferior surface of the four outer toes, passing through the slits in the tendons of the flexor brevis, and then inserted into the last phalanx of each toe. The tendon of the flexor pollicis longus is now also seen passing above the former, to which it is united by a tendinous fasciculus, and then proceeding forwards to its insertion in the base of the great toe.

Musculus Accessorius, or flexor digitorum accessorius, *arises* fleshy and tendinous, from the inferior and internal part of the os calcis, forms a flat and somewhat square fleshy belly, which proceeding forwards, is *inserted* into the upper and outer part of the tendon of the flexor digitorum longus, just before it divides. *Use*, to assist the long flexor, and to counteract its obliquity by pulling it directly towards the heel; this muscle lies above the flexor digitorum brevis. There is no analogous muscle to this in the hand, as there the flexor tendons pass directly over the centre of the carpus.

Lumbricales are four small muscles which arise tendinous and fleshy from the tendons of the flexor digitorum longus; there is none for the great toe; the first or the internal one is the largest; these four muscles proceed forwards along the internal edge of the long flexor tendons, each ends in a thin aponeurosis, which is *inserted* into the internal side of the first phalanx of the four lesser toes, and joins the tendinous expansion of the extensor tendons on the dorsum of the toes. *Use*, to adduct and to assist in flexing the four toes, they may also extend their second and last phalanges. These muscles are covered in the sole of the foot by the superficial layer; their tendinous insertions are superficial, and are best seen on the dorsum of the toes. These are analogous to the four lumbricales in the hand, where they arise also from the deep or perforating flexors, and run along the radial side of each tendon, or that next the thumb, so in the foot they run along that side which corresponds to the great toe; hence, although they are described as running along the outer sides of the flexor tendons in the hand, and along the inner in the foot, yet still they are perfectly analogous, supposing the hand in the prone position, or the foot in the supine. Detach this second layer of muscles and throw it also forwards towards the toes.

The third layer of the plantar muscles consists of the flexor pollicis brevis, adductor pollicis, transversalis pedis, and flexor minimi digiti.

Flexor Pollicis Brevis, narrow posteriorly, broad and notched anteriorly; *arises* by a strong tendon from the lower and anterior part of the os calcis, also from the external cuneiform bone, it forms a fleshy belly which is inseparably connected to the abductor and adductor pollicis, and passes forwards and inwards, and divides into two short tendons; these are *inserted* into the sesamoid bones beneath the first phalanx of the great toe. *Use*, to flex the first joint of the great toe, also to approximate this toe to the others. This muscle forms a sort of sheath for the tendon of the flexor pollicis longus, and is analogous to the short flexor on the thumb.

Adductor Pollicis, is situated external to the last muscle, or more in the centre of the foot; it is also inseparably attached to it; it arises tendinous and fleshy from the strong calcaneo-cuboid ligament, and from the base of the second and third metatarsal bones, it passes forwards and inwards, and is *inserted* along with the external portion of the last muscle into the external sesamoid bone. *Use*, to draw the great toe outwards towards the other toes, also to flex it, so as to bring the great toe beneath the other toes. By some this muscle is named the abductor pollicis, its action being then referred to the mesial line.

Transversalis Pedis, *arises* by distinct fleshy slips from the anterior extremities of the four external metatarsal bones; the fibres pass inwards and forwards, converging to the external sesamoid bone of the great toe, into which they are *inserted* along with the last described muscle. *Use*, to approximate the toes, and to contract the transverse arch of the foot; there is no analogous muscle in the hand; behind this muscle, and nearly parallel to it, the strong calcaneo-cuboid ligament is observed, also the tendon of the tibialis posticus dividing into several slips, which are inserted into the adjacent bones and ligaments.

Flexor Brevis Minimi Digiti, *arises* tendinous and fleshy from the cuboid and fifth metatarsal bone, and from the sheath of the peronæus longus tendon; it passes forwards and outwards, and is *inserted* into the inner side of the base of the first phalanx of the little toe. *Use*, to flex and adduct this toe. This muscle is connected to the abductor minimi digiti; it fills up the concavity of the fifth metatarsal bone. Detach these four muscles in this layer from the tarsus, and the fourth layer will come into view, namely, the tendon of the peronæus longus and the interossei muscles; the former crosses the foot obliquely forwards and inwards from a deep groove in the cuboid, beneath the cuneiform and metatarsal bones, to be *inserted* into the internal cuneiform, and into the base of the first and second metatarsal bones; in this course this strong round tendon is enclosed in a tendinous sheath, which is lined by synovial membrane, and is attached to the several projections of the adjoining bones. *Use*, to serve as a strong transverse ligament in strengthening the tarsus and metatarsus in that direction; this course and connexion of the tendon explain the action of the personæus longus muscle, namely, to extend the ankle joint, to elevate the external side of the foot, to depress its internal side, and to turn the point of the foot outwards.

Interossei Muscles are seven in number; three are seen in the sole of the foot, and four on the dorsum; they fill up the interstices between the metatarsal bones: the three inferior are named *interossei interni* or *inferiores;* they *arise* tendinous and fleshy from between the metatarsal bones of the four external toes, and are *inserted* tendinous into the inner side of the base of the first phalanx of the three lesser toes. *Use*, to adduct the toes.

The *first* of the inferior interossei is situated between the second and third metatarsal bones, it *arises* chiefly from the inner side of the latter, and is *inserted* into the inner side of the first phalanx of the third or middle toe; this may be named the *adductor medii digiti;* the *second* is between the third and fourth metatarsal bones; *arises* chiefly from the inner side of the latter, aud is *inserted* into the inner side of the first phalanx of the fourth toe, and may be named *adductor quarti digiti;* the *third* is between the fourth and fifth metatarsal bones, *arises* from the latter, and is *inserted* into the inner side of the little toe, and may be named the *adductor minimi digiti.*

The *interossei externi* or *superiores* are four in number, are larger than the last, and are seen on the dorsum or convex surface of the foot; they are bicipital muscles; the *first* is between the first and second metatarsal bones, and may be named the *adductor digiti secundi;* it *arises* from the internal side of the second metatarsal bone, and by a distinct fasciculus from the outer side of the first; these two origins are separated by the deep branch of the anterior tibial artery; the fibres end in a tendon which is *inserted* on the inner side of the base of the first phalanx of the second toe; it also joins the corresponding extensor tendon. *Use*, to approximate the second to the great toe.

Abductor Digiti Secundi is placed between the second and third metatarsal bones; *arises* from their opposite surfaces, but chiefly from that of the former; the fibres end in a tendon which is *inserted* into the outer side of the first phalanx of the second toe. *Use*, to separate the second from the great toe.

Abductor Digiti Medii is placed between the third and fourth metatarsal bones, and *arises* from their opposite surfaces, but chiefly from that of the third; the fibres end in a tendon which is *inserted* into the outer side of the first phalanx of the third or middle toe. *Use*, to separate the third toe from the first and second.

Abductor Digiti Quarti is situated between the fourth and fifth metatarsal bones; it *arises* from their opposite surfaces, and is *inserted* into the outer side of the first phalanx of the fourth toe. *Use*, to separate the fourth toe from the three internal.

All the interossei muscles serve to strengthen the metatarsus, to press the metatarsal bones together; they also serve to flex the first joint of the four outer toes, and may assist in extending their last phalanges; these muscles can exert no influence on the great toe; there is only one muscle between the two first metatarsal bones; between the others there are two, therefore there are four superior or dorsal interossei muscles, but three inferior; the latter are situated more in the concavity of each metatarsal bone than between these bones; the superior are stronger and more tendinous than the inferior; and are only partially covered by the long and short extensor tendons.

In dissecting the muscles on the back of the leg, and those in the sole of the foot, we meet the posterior tibial vessels and nerve, and their principal branches. The posterior *tibial artery* is the larger branch of the popliteal; it descends obliquely inwards beneath the deep fascia and the superficial muscles, and over the tibialis posticus and flexor communis, to the fossa between the heel and inner ankle, it here ends in the two plantar arteries; in this course it gives off many muscular branches, also the *peronæal artery;* the latter arises from the tibial, about an inch below the poplitæus; it descends obliquely outwards along the back part of the fibula beneath the flexor pollicis longus; behind and a little above the outer ankle, it divides into the anterior and posterior peronæal arteries; the former perforates the interosseous space and joins the external malleolar artery; the latter descends between the external ankle and the heel, and is distributed to the ligaments and adipose substance in that region.

The two plantar branches of the posterior tibial artery are distributed to the muscles and integuments of the foot and toes; the *internal plantar* is the smaller of the two, it supplies the muscles along the inner side of the tarsus; the *external plantar*, the larger branch, runs across the foot obliquely outwards, towards the fifth metatarsal bone, between the first and second layers of the plantar muscles; from the little toe it next runs obliquely forwards and inwards, towards the first metatarsal bone, above the second layer of the plantar muscles, and between the first and second metatarsal bones it joins the deep branch of the anterior tibial artery, and thus forms the great plantar arch of arteries, from the convexity of which proceed the digital arteries, to supply the toes, (see Anatomy of the Vascular System.) The posterior tibial artery and its several branches are accompanied by corresponding veins, all of which end in the popliteal vein. The *posterior tibial nerve* is the principal branch of the sciatic, it accompanies the posterior tibial artery, at first lying to its tibial, afterwards to its fibular side; in this course it sends off several small branches to the deep and superficial muscles of the leg, and between the heel and ankle it divides into the two plantar nerves, which take the course of the corresponding arteries. In this internal malleolar region, when the integuments, fascia and internal annular ligament are removed, we find the three tendons and the posterior tibial nerves and vessels to have the following relation to each other, the tibialis posticus and flexor communis tendons are bound close to the ankle, about half an inch behind these is the posterior tibial artery accompanied by two veins, the nerve is a little nearer to the heel, and the tendon of the flexor pollicis lies about half an inch nearer to the latter.

PART II.

CHAPTER I.

ANATOMY OF THE NERVOUS SYSTEM.

THIS SYSTEM MAY BE DIVIDED INTO FOUR PRINCIPAL PARTS, THE BRAIN, THE SPINAL CORD, THE NERVES AND THE GANGLIONS.

SECTION I.

DISSECTION OF THE BRAIN.

THE brain is subdivided into three portions, cerebrum, cerebellum, and medulla oblongata; these are, however, so intimately connected, that it is difficult to mark the exact limits of each.

Divide the scalp from one ear across the vertex to the other; reflect one flap over the face, the other over the back of the neck; make a circular cut with the saw through the cranium on a level with the cartilage of the ear on each side, anteriorly about an inch above the superciliary arches, and posteriorly a little below the tubercle of the os occipitis. It is only necessary to saw through the outer table of the bones, the elevator, or a few smart strokes with the claw of the hammer will then suffice to crack the internal table; (indeed the cranium may be opened by the hammer alone, this plan however injures the bones so much as to leave them of little use to the student.) The calvarium being now forcibly torn away, the dura mater is exposed; the latter, in some subjects, adheres so closely to the bone as to be torn along with it; this accident will injure the brain, and may be avoided by introducing the handle of the knife or any blunt instrument between the membrane and the bone as you gradually raise off the latter. If the student can procure two subjects it will facilitate his study to examine the brain of both at the same time; in one dissect the parts *in situ*, and from the other remove the brain in the following manner: commencing anteriorly, gently raise it from the base of the skull, divide each nerve and vessel in succession from before backwards close to the bone, dislocate the pituitary gland from the sella turcica, and cut through the tentorium; next divide the spinal cord as low down in the neck as you can pass the knife through the foramen magnum; then place the brain, its base upwards, in a shallow basin; thus the different surfaces and structures of the brain, as also the several processes and sinuses of the dura mater, can be examined in continuation with each other.

The MEMBRANES covering the brain are three, the dura mater, arachnoid membrane, and pia mater; the first may be termed the *fibrous*, the second the *serous*, and the third the *vascular* coat; these tunics also extend through the spinal canal and cover the spinal cord.

The *dura mater* is a fibro-serous membrane, of very considerable strength and of a whitish colour, sometimes it has a bluish tint; the external surface adheres intimately to the bones; it now presents a rough surface and several red spots, particularly in the course of the sutures; these are owing to the ruptured vessels which passed from the dura mater to the bone, the former being the internal periosteum to the latter; in the young subject the connexion between the two is so close and vascular, that it is very difficult to separate them in the recent state, and when this is effected numerous bloody dots are observable on each; this membrane is more intimately attached to the bones at the base of the cranium than in any other situation, it there sends small processes through the several foramina, some of these accompany the vessels and nerves, and are gradually lost on them, others become continuous with the periosteum; the most remarkable of these processes, next to that which is continued along the spinal canal, is one which passes through the foramen lacerum orbitale, and joins the periosteum in the orbit, and another which surrounds the optic nerve and is united to the sclerotic coat of the eye. Several small arteries ramify on this membrane, between it and the bones of the cranium, anteriorly these are derived from the ophthalmic and internal carotid vessels; the middle artery of the dura mater is the largest, this is a branch of the internal maxillary, it enters the base of the cranium through the spinous hole in the sphenoid bone, passes forwards and upwards above the temporal and sphenoid bones, then ascends obliquely backwards on the inner surface of the parietal bone, the anterior and inferior angle of which it grooves very deeply; posteriorly the dura mater receives several small arteries, viz. branches from the occipital, pharyngeal and vertebral arteries; these vessels of the dura mater also supply the superincumbent bones with blood. Cut through this membrane parallel to the edge of the cranium, raise it from each side of the brain towards the vertex, leaving a small portion of it in the mesial line both before and behind undivided; the internal surface is now seen to be smooth and polished, and moistened with a fine serous exhalation; this surface is the reflected or the parietal layer of the arachnoid membrane, (to be examined presently,) it adheres so closely to the dura mater that it is difficult to separate them for any extent, unless previously macerated.

From the internal surface of the dura mater folds or processes extend into the cranium, which divide this cavity into several compartments and support and separate different portions of the brain; these processes are the falx cerebri tentorium cerebelli and falx cerebelli. The *falx cerebri* is exposed by gently separating one hemisphere of the brain from the other; it commences narrow at the crista galli and the middle ridge of the ethmoid bone, thence it ascends in the median line, and passing backwards, ends by being continued into the tentorium; the convex edge of this process corresponds to the middle ridge or groove of the os frontis, to the sagittal edge of the two parietal bones, and to the perpendicular ridge of the occipital; the great longitudinal sinus is enclosed between the layers of this process, the whole extent of this edge; the concave or inferior border of the falx corresponds to the middle line of the corpus callosum, from which it is but a very short distance; the inferior or lesser longitudinal sinus is enclosed in this edge; the falx divides the cavity of the cranium in the median line, it separates the hemispheres of the cerebrum, and in different positions of the body supports the weight of each; in old subjects it is often cribriform, and in some it is partly converted into bone.

[I have a specimen of ossification of the falx cerebri taken from a subject, that died of apoplexy.]

The *tentorium cerebelli* extends in somewhat a horizontal direction across the posterior part of the cranium; it may be seen by gently raising the back part of either hemisphere of the brain; the convex edge of this fold is attached to the transverse ridge of the occipital bone, to the inferior angle of the parietal bones, to the superior angle of the petrous bones, and to the posterior clinoid processes of the sphenoid; over this last attachment, the concave edge of the tentorium glides and is *inserted* into the anterior clinoid processes; the tentorium is raised and held in a state of tension along the median line by the falx, its inferior surface is concave; anteriorly it presents a large oval opening, which is on a plane anterior to the foramen magnum, this is filled by the superior vermiform process of the cerebellum, the crura cerebri, and the pons varolii; along the convex edge of the tentorium, between its layers, are two sinuses on each side, the great lateral and the superior petrous; in the median line also is another called the straight sinus, which extends along the base of the falx; the tentorium serves to support the weight of the cerebrum off the cerebellum.

The *falx cerebelli* is seen when the brain is removed; it is a small but thick process of little importance, the base is superiorly attached to the tentorium, the apex inferiorly, at the foramen magnum; its convex edge adheres to the occipital spine, and contains between its layers the occipital sinuses; its concave edge separates the hemispheres of the cerebellum; this process serves to retain the tentorium and falx cerebri in a state of tension. Attached to the lesser wing of the sphenoid bone, on each side, is a slight fold of dura mater, termed the *sphenoidal fold;* these serve to increase the surface of the anterior fossæ of the base of the cranium, and correspond to the fissures of Sylvius at the base of the brain. The *uses* of the dura mater are, first, to serve as a periosteum; second, to cover the brain; third, by its processes to separate and support the different parts of this organ; fourth, to form sheaths for several of the nerves as they leave the cranium; and fifth, to form the sinuses which may be next examined.

The *sinuses* correspond to the veins, or in fact they are veins enclosed between the laminæ of the dura mater, which thus retain them in their situation, and enable them to resist distention; the principal sinuses are sixteen in number, viz. the superior and inferior longitudinal, the straight, the right and left lateral, the superior and inferior petrous, the right and left cavernous, the circular, the transverse, the occipital, and the torcular Herophili. The *superior longitudinal sinus* commences at the crista galli, either in a small cul de sac, or by a small vein from the nose; it extends upwards and backwards along the median line, increasing in size, and opposite the tubercle of the os occipitis it divides into the right and left lateral sinuses, the right branch being in general the larger; with the scissors lay open this sinus through its whole length; it appears somewhat triangular, lined by a smooth fine membrane, which is continuous with that lining the venous system; in general it is usually dilated near the vertex; small white fibrous bands cross it in many places; these have an imperfect resemblance to the valves of veins; and may serve to resist distention of the sinus: they have been named *cordæ Willisii;* about the middle of this sinus there are in general a number of small whitish bodies, sometimes lying singly, but more frequently in clusters, near the openings of some of the veins in the sinus, these are termed *glandulæ Pacchioni;* their size, number, and appearance, differ considerably in different subjects; in the very young there are few, if any; in the old, they are most numerous, and often so very large, as to cause considerable depressions in the frontal and parietal bones; they are found in three situations, in the cavity of the sinus, external to the dura mater, or internal to it; the first are termed the glandulæ mediæ, the second, the externæ, and the third the internæ; their use or structure is unknown, most probably they are by no means allied to the glandular system. The longitudinal sinus, like all the other sinuses, consists of two tunics, the internal or the venous membrane, and the external or fibrous coat derived from the dura mater; this membrane is described as dividing into two layers on either side of the cavity; one continues to adhere to the bone, and the other laminæ descend on either side of the sinus, and unite in the falx; the base of the triangular cavity thus formed is towards the bone, the apex towards the falx; in addition to many small veins, from the bones and from the dura mater, this sinus receives near the vertex eight or ten large veins from the upper surface of each hemisphere of the brain, these run obliquely forwards between the coats of the sinus, some for an inch, others for less, before they open into the cavity, and just as they are terminating, they turn slightly, so that their mouths look inwards, or towards those of the opposite side; all the veins which enter the sinus do not take the oblique course now described, and which is most probably designed to impede the reflux of the blood from the sinus into the cerebral veins. The *inferior longitudinal sinus* is not always present, it resembles a small vein enclosed in the lower edge of the falx near its base, it receives small veins from the corpus callosum, and ends in the following; the *straight sinus*, is situated in the median line, enclosed between the laminæ of the base of the falx and above the tentorium, it receives the blood from the lateral ventricles returned by the two venæ Galeni; this sinus proceeds backwards, and downwards and ends in the confluence of the two lateral and longitudinal sinuses; it presents internally the same fibrous appearance as the great longitudinal sinus. The *lateral* are the largest sinuses, of somewhat an elliptical figure, each proceeds at first horizontally outwards and forwards, enclosed between the laminæ of the tentorium, in a groove in the occipital bone, and in the inferior angle of the parietal; it then descends inwards along the mastoid portion of the temporal bone, and again indenting the occipital, it turns forwards, and passing through the foramen lacerum posterius, ends in the internal jugular vein.

[It occasionally happens that both lateral sinuses, do not follow the course here described, but that one of them descends along the falx-cerebelli, nearly to the foramen magnum, of the os occipitis, and then diverges so as to reach the foramen lacerum posterius, being situated upon the occipital bone through its entire course. I have a specimen of this kind on the right side, and Meckel states that this anomaly is generally found on the right side.]

Each lateral sinus receives several small veins from the posterior lobes of the cerebrum and from the cerebellum; these enter the sinus from without inwards, contrary to the current in the sinus; through these sinuses all the blood is returned from the cranium to the general system; there are seldom any transverse bands or glandulæ Pacchioni in these sinuses. The following sinuses are situated on the base of the cranium. The *cavernous sinus* on each side extends from the anterior clinoid process to the point of the petrous bone along the side of the body of the sphenoid; the dura mater in this region divides into two layers, one very thin adheres to the irregular bony surface which bounds this cavity, the other much more dense is reflected over this space, and contains between its laminæ the third and fourth nerve, and the first part of the fifth: the ophthalmic vein which has passed through the foramen lacerum orbitale superius, opens into the fore part of this sinus, and the two petrosal sinuses lead from it posteriorly to the lateral sinus; this sinus is intersected by tendinous bands, and presents rather a cellular or spongy appearance like the corpus cavernosum penis; the internal carotid artery and the sixth or abducens nerve pass through the cavity of this sinus, also several small branches from the sympathetic; the venous membrane, however, is reflected around each, so as to separate them from the blood; the cavernous sinuses communicate through the following; the *circular sinus* consists of two small veins, which lead from one cavernous sinus to the other, the anterior is beneath the optic commissure, and before the pituitary glands; the posterior is behind and rather below that body. The *petrosal sinuses* are four in number, two on each side, the superior and inferior; they each lead from the cavernous sinuses backwards, the former along the upper edge of the petrous bone, to the lateral sinuses opposite the inferior angle of the parietal bone; the inferior petrous sinus leads downwards and backwards, over the suture between the petrous and occipital bones, and ends in the lateral sinus near its termination. The *transverse sinus* leads from one inferior petrosal sinus to the other, across the cuneiform process of the occipital bone. The *occipital sinuses* are two small canals contained in the falx cerebelli; they receive veins from the cerebellum, and sometimes from the vertebral canal, and open into the torcular Herophili; these sinuses sometimes extend along each side of the foramen magnum, and communicate with the lateral sinuses; the occipital sinuses are often wanting. The *torcular Herophili* is a sort of common reservoir in which several sinuses end; it is situated opposite the tuberosity of the occipital bone, and enclosed between the layers of the falx and tentorium; it is somewhat oval, and presents six openings, viz. the lateral sinus on each side, the longitudinal sinus above, the straight sinus before, and the occipital sinuses below.

The second covering of the brain is a serous membrane, the *arachnoid*, so fine and delicate that in some situations it is difficult to demonstrate it; between the convolutions of the brain it can be raised from the pia mater, which sinks into the fissures between these; and a little air forced between these membranes will separate them for some distance, and will raise the arachnoid membrane in a vesicular form; on the base of the brain, and in the spinal canal, it is stronger, and can be distinctly detached from the subjacent membrane. The arachnoid membrane covers the whole surface of the brain, and is thence reflected to the dura mater, which it lines throughout, except at the sella turcica, where the pituitary gland intervenes between these membranes; from the surface of the brain it is reflected on the dura mater in several situations, viz. superiorly, as the veins enter the longitudinal sinus, this membrane accompanies them from the brain to the sinus, it is then reflected to the inner surface of the dura mater: inferiorly, also, it surrounds the nerves in their course from the brain to the foramina, through which they pass, and is then reflected on the dura mater, the latter membrane being really perforated and continued for a short distance around each nerve, whereas the arachnoid membrane forms a cul de sac at the exit of each; thus the arachnoid membrane, like all serous membranes, forms a shut sac, one side or layer of it (the parietal) adhering to the dura mater; the other (the visceral) covering the brain and extending from one eminence to another, without penetrating between them; it is smooth, polished and transparent, without any distinct vessels; it exhales and again absorbs a fine serous halitus which allows the opposed surfaces to move against each other without friction; this membrane is also continued into the cavities or ventricles of the brain, and gives to them a smooth lining. To see this process of the arachnoid membrane, separate gently the posterior lobes of the cerebrum, divide the falx, and at the anterior edge of the tentorium the two venæ Galeni will be seen entering the straight sinus; these veins are surrounded by the serous membrane; press these gently to one side, and underneath them a small round hole or canal may be observed, leading forwards below these veins, and above the pineal gland, and opening into the back part of the third ventricle; this canal is lined by the arachnoid membrane, which is continued from that on the surface of the brain, and expands within the ventricles, so as to cover all the inequalities observed within them; this *arachnoid canal*, or the *canal of Bichat*, will be noticed again in the examination of the ventricles. The third tunic of the brain is the *vascular coat*, or the *pia mater*, of a very soft and delicate structure, loaded with numerous fine vessels; it adheres to the whole surface of the brain, and following every involution of its surface, it is intimately united with its substance by numerous shreds and vessels, which admit of being drawn out like fine threads; on the convolutions of the brain it is inseparably connected to the arachnoid membrane, but in most other situations, particularly at the base of the brain, they are but loosely united to each other. The pia mater is also prolonged into the lateral ventricles, through an extensive fissure, which will be seen in the dissection of the brain between the fornix and the corpus callosum above, and the tubercula quadrigemina and pons Varolii below; this fissure descends obliquely forwards on each side into the inferior cornu of each lateral ventricle between the optic thalamus and the hippocampus major; through these lateral prolongations of this fissure, a process of the pia mater enters, termed the choroid plexus, and through the central or transverse portion of it, another process, termed the choroid membrane or velum interpositum; these processes are covered by the arachnoid membrane, and are all connected together, as will be seen in the dissection of the ventricles; this great fissure in the brain is closed every where by the arachnoid membrane on the surface of the brain except at the foramen of Bichat. The use of the pia mater is to form an exact capsule for the brain, also an extensive surface, on which the vessels divide minutely, and are probably arranged in some peculiar manner, previous to their penetrating the substance of the brain.

There are two modes of dissecting the brain; first, by removing it in successive slices from above downwards; and, secondly, from below upwards; the first plan is best adapted for studying the relative anatomy of the different parts of the brain, or for examining this organ pathologically; the second for unravelling its structure; the student should practise both, and first, that from above downwards.

DISSECTION OF THE CEREBRUM.

[The great volume of the cerebrum seems to be characteristic of man; there are certain inferior animals, in which the whole encephalic mass is proportionably greater than in the human race; but this is not true of the cerebrum as considered by itself, it being proportionably greater in man than in other animals. This would certainly seem to favor the phrenological philosophy, which locates the moral and intellectual faculties in the cerebrum, and the animal propensities in the cerebellum. In the horse and the ox the weight of the cerebrum does not exceed half that of the human subject. The volume of the cerebrum is independent of stature, and of sex, although it was formerly thought to be smaller in the female than the male. Again its volume is proportionably greater in the fœtus and infant than in the adult, and in old age it not unfrequently is atrophied to a certain extent. The weight of the cerebrum is from two to three pounds, averaging about two and a half, the cerebellum being equal to from a seventh, to a twelfth of the cerebrum. The antero-posterior measurement of the cerebrum is about six inches, its greatest breadth which is behind, five inches, and its vertical diameter from four to five inches. It is said that the volume of the entire encephalo-rachidian mass, as compared with that of the nerves connected with it, is greater in man, than in any inferior animal.]

THE CEREBRUM is the largest part of the brain, of an oval figure, the larger end posteriorly, a little flattened on the sides, convex above, and divided into two equal portions, the right and left hemispheres, by a deep fissure which extends along the median line; this fissure is continued before and behind through the entire depth of the cerebrum, but in the middle it is bounded below by the corpus callosum; it contains the falx cerebri and the arteries of the corpus callosum; each hemisphere is convex superiorly and externally, and flat internally, or towards the falx, ininferiorly very irregular and uneven; the surface of each hemisphere is every where marked by a number of eminences termed the convolutions of the brain; these are of various size and shape, and are somewhat convoluted like the intestines; their round edges are separated by fissures which are closed by the arachnoid membrane; these fissures are nearly an inch deep; they take different directions, serpentine, longitudinal, and oblique; if a section of the cerebrum be made, these fissures will be found to be only involutions of the cineritious substance covering the brain; each fissure, therefore, is only a continuation of the surface, and is covered throughout by the pia mater.

The cerebrum, on its inferior surface, is also divided into the two hemispheres by the great median fissure at each extremity, and in the centre by a depression containing several substances; each hemisphere inferiorly is divided into three lobes, the anterior, small, triangular, flat, or a little concave, rests on the roof of the orbit, presents a deep groove which lodges the olfactory nerve; the middle lobe is prominent, round, and deep, fills up the middle fossa in the base of the cranium, and is separated from the anterior lobe by a deep fissure, (*fissura Sylvii,*) which ascends obliquely outwards and backwards; this fissure corresponds to the sphenoidal fold of the dura mater, and to the lesser wing of the sphenoid bone; the brain above it is perforated by a number of small holes for the entrance of vessels (*pars perforee externe;*) this fissure contains the middle artery of the brain, and one origin of the olfactory nerve.

The *posterior* lobe rests on the tentorium, and is separated from the middle only by a slight excavation; between the hemispheres we observe, immediately behind the anterior extremity of the median fissure, the lower end of the corpus callosum; posterior to this, and connected to it is the commissure of the optic nerves; behind this is a soft grey substance, the *tuber cinereum;* this is connected anteriorly to these nerves, and posteriorly to two small white bodies termed the *corpora mamillaria* or *albicantia:* these are about the size of small peas, situated behind the tuber cinereum, and attached by it to each other; they are grey internally, although white externally, the anterior pillars of the fornix terminate in these. From the centre of the tuber cinereum a thin conical tube of a reddish colour descends, the *infundibulum;* this passes behind and rather beneath the commissure of the optic nerves; it terminates on the surface of the pituitary gland; it is surrounded by arachnoid membrane; it is not pervious inferiorly; above it communicates with the third ventricle. The *pituitary* body is placed in the sella Turcica between the dura mater and arachnoid membrane; transversely oval, composed anteriorly of a yellowish substance, which is notched before, and convex behind like a kidney, and posteriorly of a whitish semi-fluid or pulpy substance. Behind the corpora albicantia, we next observe a small triangular depression, closed above by a thin plate which forms the posterior part of the floor of the third ventricle; this is the *middle perforated plate* *of the brain;* on either side of this is the crus cerebri, connecting the cerebrum to the pons Varolii, which last is situated in the median line behind the last described substances; behind the pons is the posterior extremity of the corpus callosum, and between these eminences is the great transverse fissure which transmits the pia mater into the ventricles, and which also contains the arachnoid canal and the pineal gland; behind this we observe, lastly, the posterior extremity of the median fissure separating the posterior lobes of the cerebrum.

Cut off the upper part of one hemisphere nearly on a level with the corpus callosum, the appearance now presented is termed the *centrum minus ovale*, a mass of white substance surrounded by the irregularly undulating line of grey substance; a small cavity or fissure may now also be observed between the corpus callosum and the lower and internal margin of each hemisphere: next slice off both hemispheres on a level with the corpus callosum, and the *centrum magnum ovale* is presented, that is, a line of grey substance surrounding the central mass of white substance. The *grey* or *cortical* or *cineritious* substance of the brain is soft and pulpy, and more vascular than the white; on the surface of the cerebrum it is about the eighth of an inch in thickness; in other situations it is placed in considerable masses, and covered by the white substance; the shade of its colour differs in different parts of the brain, and in different subjects: in the child it is reddish, in the old it is grey or ashy. It consists of a number of very minute globules, connected together by the pia mater and vessels. The *white* or *medullary substance* is more firm, and when fresh, has some elasticity, and in many parts appears distinctly fibrous; its divided surface appears dotted with red spots; these are the divided vessels, they vary in number and in size in different subjects: in a very fresh brain, when a section has been made of this white substance, it will, by its elasticity, force the blood to exude out for some little time in small drops from the divided vessels. The *corpus callosum* is now seen in the median line of the cerebrum, but nearer the frontal than the occipital bone, between three or four inches long, convex, white, marked by two or three raised longitudinal lines close and nearly parallel to each other, (*the raphe,*) from these several transverse lines [*lineæ transversæ*] pass to either side; its posterior end broad, round, and a little concave, is bent downwards, and is continuous on either side with the fornix and the hippocampi; its anterior end is also round, and bent downwards and backwards, is continued on each side into the anterior lobes, and in the middle it joins the tuber cinereum and the optic commissure ; the corpus callosum connects the white fibrous substance of the hemispheres, and is therefore properly called the great commissure of the cerebrum ; it covers the lateral ventricles, the septum lucidum, and the fornix. Divide this substance at a little distance from either side of the raphe, the lateral ventricles will be opened, press the middle portion of the corpus callosum to one side, and the septum lucidum may be seen descending in the median line from it to the upper surface of the fornix. The *septum lucidum* separates the two lateral ventricles, and is triangular, the apex behind, the base before, the upper edge connected to the corpus callosum ; the lower edge to the fornix posteriorly, and anteriorly to the inferior curved portion of the corpus callosum ; it consists of four laminæ, two on each side, grey externally, white internally ; between the white laminæ a small cavity exists termed the *fifth ventricle.* This cavity is naturally closed, but when the corpus callosum is divided transversely, and the anterior portion raised forwards, the laminæ of the septum separate, and this cavity becomes distinct ; it is larger in the child, but it is very irregular in size, and even in existence, in different subjects ; the septum lucidum appears to be formed by a lamina descending from each side of the raphe of the corpus callosum to the fornix, some grey matter superadded. Divide transversely the septum lucidum and corpus callosum, raise forwards the anterior portion of the latter, and backwards its posterior part ; it will now be seen that this substance is united to the fornix posteriorly, but is nearly an inch above it anteriorly ; the septum lucidum is generally so soft that in this stage of the dissection it will have nearly broke down into the surrounding fluid.

The *lateral ventricles* extend from the middle of the brain into the anterior and posterior lobes, also to the inferior part of the middle lobe, hence they are named *tricorne ;* the *anterior cornu* of each passes forwards and outwards, they are about an inch distant from each other ; the middle portion, or *the body* of each, passes horizontally backwards, they are separated from each other by the septum lucidum ; near the posterior part of the corpus callosum the posterior and inferior cornua pass off in different directions ; the *posterior cornu* proceeds into the posterior lobe at first outwards, afterwards it turns inwards in a curved direction, the concavity towards the median line ; the *inferior cornu* descends obliquely forwards and outwards into the middle lobe, and is then also curved a little inwards ; it terminates behind the fissure of Sylvius and beneath the anterior cornu. The anterior cornu is bounded superiorly and laterally by the corpus callosum, and inferiorly by the large extremity of the corpus striatum; the middle, or body of each, is bounded superiorly and externally by the corpus callosum; internally by the septum lucidum, and inferiorly by the posterior extremity of the corpus striatum, the tænia semicircularis, the optic thalamus, the choroid plexus, and the fornix. The posterior cornu is bounded superiorly and laterally by the medullary substance, and inferiorly by the hippocampus minor. The inferior cornu is bounded superiorly by the optic thalamus, externally by medullary substance; internally it is deficient of cerebral substance, and is closed by the arachnoid membrane; inferiorly by the hippocampus major and corpus fimbriatum or tænia hippocampi.

The several bodies, observed in the different regions of these cavities, must next be examined individually; and first, *corpora striata*. These pyriform bodies have their larger ends directed forwards and inwards; their posterior small and pointed extremities pass backwards and outwards; smooth and unattached superiorly and internally, on all other sides they are continuous with the white substance, vascular, soft, and cineritious on their surface; they will be found, when cut into, to consist of alternate laminæ of grey and white substance; the latter may be traced from the crura cerebri through these bodies to the upper and anterior part of the cerebrum, hence the corpora striata are named by some the anterior or superior ganglions of the cerebrum. The *tænia semi-circularis*, is a narrow, semitransparent band, whitish, fibrous, placed in the groove between the optic thalamus and corpus striatum; it arises narrow from a tubercle on the back part of the optic thalamus, (corpus geniculatum externum,) passes forwards and inwards, becomes broader, and joins the descending pillar of the fornix; the anterior portion has a resemblance to the cornea, and has been named *lamina cornea:* several veins from the corpus striatum pass beneath the tænia to join the venæ Galeni. The *choroid plexus* is a fold of thin vascular membrane derived from the pia mater; it enters the inferior cornu between the optic thalamus and the tænia hippocampi; loose and floating it ascends obliquely backwards over the hippocampus major, then turns forwards between the thalamus and the fornix, beneath which it is connected to the choroid membrane, and ends by uniting with its fellow in the foramen commune anterius; each choroid plexus is covered by the arachnoid membrane; they receive a number of veins from the parietes of the ventricles, particularly from the corpora striata; these veins join the venæ Galeni, which will be noticed presently; very frequently small vesicles, hydatids, and even small hard tumours may be found in these membranes.

The *fornix*, white, fibrous, triangular, is situated horizontally, beneath the corpus callosum and septum lucidum, attached to the former posteriorly, to the latter anteriorly it lies on the velum interpositum and choroid plexuses, the base, posteriorly, *arises* by two flat bands, (the *posterior pillars* or *crura*,) one from either side, by three roots, from the hippocampus major and minor, and from the tænia hippocampi; these crura pass forwards and inwards, and unite (the *body* of the *fornix*;) this bends forwards and downwards, over the foramen commune anterius, and divides into two short, round, white cords, (the *anterior pillars* of the *fornix*,(these descend behind the anterior commissure, and end in the corpora mamillaria, which are connected to the grey substance of the tuber cinereum; the inferior surface of the fornix which rests on the velum is marked posteriorly by several fine oblique lines (*lyra* or *corpus psalloides*.) Although the septum lucidum is a partition between the lateral ventricles, yet these cavities communicate together, as also with the third or middle ventricle, through an opening termed *foramen commune anterius*; this is situated in the median line at the anterior part of the body of each ventricle, it is bounded superiorly and anteriorly by the fornix, posteriorly by the two choroid plexuses and velum, laterally it leads from one lateral ventricle to the other, and inferiorly it opens into the third. The optic thalami cannot be fully examined at present. In the posterior cornu of each ventricle is a small eminence, the *hippocampus minor*, large anteriorly, small and pointed behind, white on the surface, grey internally. In the inferior cornu we see the *hippocampus major*, a large white substance, convex externally, concave internally, smooth and white on the surface, grey within, extending all along the floor of the cavity, and ending in a tuberculated expansion, the *pes hippocampi;* along its internal or concave edge, and connected to it, is a narrow white band, the *tænia hippocampi* or *corpus fimbriatum*, the concave edge of which is loose; this substance is directly continuous with the posterior pillar of the fornix; beneath the tænia hippocampi, a narrow cineritious line may be observed, shorter than the tænia, its edge is serrated; this is the *corpus denticulatum*. Divide the fornix about its centre, draw forwards its anterior portion, and the foramen commune anterius will be seen; throw the posterior portion backwards, and the *choroid membrane* or the *velum interpositum* will be exposed; this is of a triangular form, beneath the fornix, and above the arachnoid canal, the optic thalami, the pineal gland, and the third ventricle; the choroid plexuses are united to it laterally and in front, the *venæ Galeni* extend along its median line; these veins receive the blood from each plexus, and from the different eminences in the ventricles, they pass backwards, and end in the straight sinus, they sometimes first unite into one trunk; the velum is formed of pia mater, which is continued from the surface of the brain through the great transverse fissure, which is beneath the corpus callosum and the fornix, and above the tubercula quadrigemina and the pineal gland; it is also covered by the arachnoid membrane, which is of extreme delicacy; raise this membrane from before backwards, first dividing the small veins which run into it, the optic thalami will be now exposed, and posterior to these the pineal gland, and the superior surface of the tubercula quadrigemina; the anterior extremity of the arachnoid canal also is seen; this orifice is beneath the veins of Galen and above the gland; it is in general surrounded by small granulations; remove the velum. The *pineal gland* is situated above the tubercula quadrigemina, behind and between the thalami, about the size of a pea, cineritious, heart-shaped, the base anteriorly containing, in general, some small sandy particles (the *acervulus*,) the posterior part is soft and pulpy, (the *conarium*) is surrounded by a very vascular membrane derived from the velum; unconnected to the brain in every situation, except anteriorly, whence a small transverse medullary band proceeds, which divides into two long delicate processes, (*pedunculi*,) these pass forwards on the inner surface of the optic thalami, and join the descending pillars of the fornix, at the foramen commune anterius. The *optic thalami*, two firm bodies white on their surface, grey within, placed behind and between the corpora striata, smooth superiorly where they enter into the lateral ventricles, touching each other internally, where they are soft and grey; this connexion is termed the *commissura mollis*, it is a broad, soft, and cineritious union between the internal surfaces of the thalami, and anterior to their centre, this must be broken through before the third ventricle can be seen; a sort of fissure separates the thalami; this fissure anteriorly leads to the foramen commune anterius, and posteriorly to the *foramen commune posterius*, this last hole is behind the soft commissure, and between the peduncles of the pineal gland, it is, however, so closed by the velum and the fornix, that no communication can occur through it between the third and the two lateral ventricles, as through the anterior common opening; the optic thalami externally and anteriorly are continuous with the corpora stiata and the medullary substance of the hemispheres; inferiorly they present two tubercles; (*corpus geniculatum internum* and *externum;*) their anterior extremity is in the foramen commune anterius, their posterior is in contact with the corpus fimbriatum; the upper surface of each is in the body of the lateral ventricle, the inferior surface is in the inferior cornu; through the substance of the thalami some portious of the crura cerebri pass in their course to the convolutions of the hemispheres, hence they are named by some the inferior ganglions of the brain. Separate the optic thalami, and the third or middle ventricle will be opened. The *third ventricle* is a narrow cavity placed in the median line, bounded on each side by the optic thalami, above by the velum and the fornix, below by the locus perforatus and tuber cinereum, before by the descending pillars of the fornix and the anterior commissure, behind by the posterior commissure and pineal gland, its pedunculi and the tubercula quadrigemina. The foramen commune anterius opens into the upper and anterior part of this cavity; the infundibulum leads from the lower and anterior part downwards and forwards, between the pillars of the fornix and below the anterior commissure, to the pituitary gland; this canal is large above, but it is generally impervious below. From the posterior part of the third ventricle a small canal leads backwards and downwards, above and behind the pons Varolii, and below the tubercula quadrigemina, this is the *aqueduct of Sylvius* or the *iter ad quartum ventriculum.* The *anterior commissure* is a distinct round cord, extending from one hemisphere to the other, immediately before the anterior pillars of the fornix, bent like an arch, convex anteriorly, unattached in its central portion, but on each side it is imbedded in the corpus striatum, through which it descends obliquely backwards and outwards, and then terminates in rays near the fissure of Sylvius, and the inferior cornu of the lateral ventricle; it is enclosed in a delicate sheath of pia mater, like a nerve. The *posterior commissure* is shorter and smaller than the anterior, but white, round, and fibrous like it; it extends transversely behind the third ventricle, above the aqueduct of Sylvius, below the pedunculi of the pineal gland to which it is connected, and anterior to the tubercula quadrigemina; its extremities are connected, to the optic thalami. The *tubercula quadrigemina* are below and behind this commissure and the pineal gland, they are all connected by their bases, on an oblique plane, and separated from each other near their points by two superficial grooves, a transverse and a vertical; the two superior and anterior are called the *nates*, the two inferior and posterior the *testes*, white on their surface, grey internally;

they lie above and behind the aqueduct of Sylvius, which alone separates them from the pons Varolii; the nates are connected to the optic thalami, and the testes to the cerebellum, by two thin white plates, which descend obliquely backwards and outwards, and end in the substance of the cerebellum; these are the *processus a cerebello ad testes;* they diverge towards the cerebellum, and are continuous externally and inferiorly with a thick, round, white chord, the crus cerebelli; between these two processes there is a thin lamina extended named the *valve* of *Vieussens*, or of the *fourth ventricle*, cineritious and very soft, triangular, the apex between the testes, the base attached to the cerebellum, and the sides to the two processes just described; this valve forms the roof of the fourth ventricle, it is overlapped by the superior vermiform process. Pass a probe along the aqueduct of Sylvius, divide the valve of Vieussens, and the cavity of the *fourth ventricle* will be exposed; this is directed obliquely downwards and backwards, between the cerebrum, cerebellum, and medulla oblongata; it is bounded anteriorly by the pons Varolii, in the median line of which is a narrow fissure, the *calamus scriptorius*, from each side of which a few white lines pass off to join the auditory nerve; laterally by the processes from the testes and by the crura cerebelli; superiorly by the valve of Vieussens; posteriorly by the cerebellum, and inferiorly by the reflection of the arachnoid membrane, and of the pia mater from the inferior surface of the cerebellum to the back of the spinal cord; the pia mater is here peculiarly dense, and it sends a small process into the lower part of this cavity, (the choroid plexus of the fourth ventricle,) which is loaded with tortuous vessels, and frequently presents a small number of reddish granular bodies.

Raise either hemisphere of the cerebrum; from its inferior surface, just below the corpus striatum and the optic thalamus, a thick, white fasciculus may be observed descending obliquely backwards and inwards; this is the *crus cerebri;* fibrous and white on the surface, each crus internally contains cineritious substance of a very dark colour (*locus niger;*) the crura cerebri converge as they descend, and end in the upper extremity of the pons Varolii; the third ventricle is between them, and the tractus opticus of each side surrounds them. The crura cerebri and the following substance can be better examined when the brain is removed from the subject, and the base placed uppermost. The *pons Varolii* or cerebral protuberance is somewhat square, it is placed obliquely on the cuneiform process, between the cerebrum and cerebellum; the fourth ventricle, the aqueduct of Sylvius and the tubercula quadrigemina, are on its superior and posterior surface; its inferior and anterior surface rests on the bone, and is grooved longitudinally by the basilar artery; its superior extremity receives the crura cerebri, which it surrounds like a ring, hence it is sometimes called the annular protuberance; the crura cerebelli are attached to its sides, and the medulla oblongata to its lower extremity, from which it is distinguished by a deep groove: the pons is of a more firm structure than any part of the brain, its surface is white and fibrous; the superficial layer of fibres on its inferior surface runs transversely from one crus cerebelli to the other, hence the pons has been named the commissure of the cerebellum; beneath this lamina of transverse fibres a quantity of cineritious substance exists, through which white fibrous substance may be seen to ascend obliquely outwards, in the direction of the crura cerebri. The pons Varolii is described by some authors as a portion of the medulla oblongata; it is, however, so connected with it as well as with the cerebrum and cerebellum, that it may be considered as equally common to all.

DISSECTION OF THE CEREBELLUM.

[The average weight of the cerebellum is six ounces, its transverse diameter averages from three and a half to four inches, its antero-posterior diameter from two, to two and a half inches, and its vertical diameter also from two, to two and a half inches. These measurements being made at its broadest, longest, and thickest parts. The average proportion of the cerebellum to the cerebrum, is as one to seven. The volume of the cerebellum, is greater in man than in all other animals. According to Gall and Cuvier, it is proportionably greater in woman, than in man, while it is proportionably less in the child, than in the adult. It is also said by Gall to be in proportion to the generative function, this however, Cruveilhier considers mere hypothesis, because certain species of animals remarkable for their venereal ardor have the cerebellum very small, and because the invertebrated animals have no cerebellum. The cerebellum is continuous, on the one hand, superiorly with the cerebrum through the processus a cerebello ad testes; on the other hand, with the medulla oblongata through the corpora restiformia, or processus a cerebello ad medullam oblongatam. Again a continuity between the two hemispheres of the cerebellum, is established by transverse fibres, in the annular protuberance. In four cases Cruveilhier has seen atrophy of the right hemisphere of the cerebrum, and of the left hemisphere of the cerebellum conjoined. The cerebellum does not become distinct until after the medulla spinalis, and the medulla oblongata, and in the earliest months of utero-gestation passes through stages of development, which resemble the cerebellum of fish and of reptiles]

Remove the posterior lobes of the cerebrum, divide the tentorium, and the cerebellum will be exposed; transversely oval, raised in the centre, divided into *right* and *left hemispheres* by a deep groove posteriorly and inferiorly, which receives the falx cerebelli, and by a broad notch anteriorly which is behind the fourth ventricle; the upper surface of each hemisphere is nearly flat, and is marked by a great number of narrow lines which run semicircularly, convex posteriorly; these are fissures into which the pia mater descends, the arachnoid membrane passing over them; these fissures are analogous to those in the cerebrum; they are involutions of the grey substance, the superficial extent of which is thus considerably augmented: the same appearance is also observable inferiorly; the lines, however, are not so numerous or regular as above; some lines pass in very deep into the cerebellum, and divide it into lobes, others are only superficial: and divide it into lobules; the inferior surface of each hemisphere is very convex, and fills the inferior occipital fossæ. Along the circumference of each hemisphere a deep fissure extends, at the bottom of which a white cord is observed; this is the *crus cerebelli*, which ascends obliquely forwards and inwards to join the pons Varolii; this great fissure separates the superior from the inferior surface. The central portion of the cerebellum is narrow, and raised superiorly into a small conical process, the *superior vermiform process*, this overlaps the valve of Vieussens, the tubercula quadrigemina, and the processus a cerebello ad testes; inferiorly there is a deep depression, which contains, anteriorly, the commencement of the spinal cord, and posteriorly a large process, the *inferior vermiform* which is marked by numerous transverse lines or fissures, which divide it into several laminæ or lobules. Divide either hemisphere parallel to, and about an inch from the median line, a thick mass of white substance is seen in the centre, branching out into fine fibres, which extend into the lobes, and again subdivide into fine filaments, which pass to every lamina or lobule on the surface, and are there covered by a thin layer of grey substance; [this arrangement is called the arbor vitæ,] nearly in the centre of this white mass, which is continuous superiorly with the processus ad testem, and inferiorly with the crus cerebelli, is a small oval mass of grey substance, its edges convoluted or serrated; this is the *corpus dentatum* or *rhomboideum;* the white substance which is continued from the medulla oblongata to the crus cerebelli, appears to run through this, and thus to be increased in quantity: hence it is named by some the ganglion of the cerebellum.

DISSECTION OF THE MEDULLA OBLONGATA.

[The medulla oblongata is situated so as to extend from the upper margin of the first cervical vertebra, to the middle of the basilar fossa of the occiput. Its extent superiorly and anteriorly, is defined by the annular protuberance, not so posteriorly. Inferiorly it gradually diminishes in circumference, and is continuous with the medulla spinalis, it is however, limited here artificially, and is said to be from an inch, to one inch and a quarter in length; this however will depend somewhat upon the position of the head, its breadth is eight or nine lines at its base and its thickness six lines.]

The medulla oblongata is that conical portion of white substance which extends from the lower margin of the pons Varolii to the spinal cord, about an inch in length, large above, narrow below, where it passes through the foramen magnum, divided by longitudinal lines into six oval eminences placed parallel to each other; the median line anteriorly separates the two corpora pyramidalia; next to each of these is a slight groove, external to which is the corpus olivare, behind which is a groove and another eminence, the corpus restiforme or the posterior pyramid.

The *corpora pyramidalia* are about an inch long.

[They extend the whole length of the medulla oblongata, being a line and a half in breadth below, but gradually increasing until they acquire a breadth of three lines above.]

And they arise gradually from the fore part of the spinal cord above the atlas, ascend parallel to each other, increase in size, enter the pons, and they may be traced through this substance for some extent; the median fissure, which extends along the spinal cord, separates them; near the pons this fissure enlarges into a small hole (foramen cæcum.) Dissect off the pia mater from these eminences, endeavour to separate them from each other, and about three quarters of an inch below the pons five or six white bands may be observed ascending obliquely from one corpus pyramidale to the other, the fasciculi of opposite sides perfectly indigitating with each other; these are the *decussating fibres* of the pyramids.

The *corpora olivaria* are oval, large in the centre, white on the surface, and containing within a *corpus fimbriatum* of grey substance; they are separated by a superficial groove from the former eminences; their upper extremity is continued into the pons Varolii.

[From which they may be traced into the thalami nervorum opticorum. They are but six or seven lines long, and two and a half lines broad, and are elevated about a line. Internally they are separated from the pyramids, by a slight fissure, in which are the roots of the hypoglossal nerve, and externally there is a deep fissure, between these, and the corpora restiformia. The corpora olivaria are almost peculiar to man, they are found in other mammalia, but are small and do not exist in birds, reptiles, and fish.]

The *corpora restiformia* are rather larger than the last, behind which they are placed; they are separated from each other by a fissure which is continued from the calamus scriptorius along the posterior median line of the spinal cord; the restiform bodies are continued superiorly into the crura cerebelli, hence they are sometimes named the processus a medulla spinali ad cerebellum: they are also partly continued into the crura cerebri.

[They are continuous with the posterior fissure of the medulla spinalis, and on the upper surface of the medulla oblongata, is a remarkable excavation, between the corpora restiformia, the calamus scriptorius which is marked by medullary striæ, which give origin to the auditory nerve, and some of which Meckel, supposes to be connected with the trifacial and pneumo-gastric nerves.]

ORIGIN OF THE CEREBRAL NERVES.

There are nine pair of cerebral nerves; their connexion to the brain is named their origin; they are distinguished by the terms first, second, third, &c., &c.; in every respect, those of the opposite side are symmetrical.

The FIRST PAIR, or OLFACTORY, are situated beneath the anterior lobes of the brain; each *arises* by three filaments, the *external*, very long and white, from the fissure of Sylvius, below the corpus striatum; the *internal*, also white, from the grey substance at the extremity of the corpus callosum; the *middle* is cineritious, and *arises* from one of the posterior convolutions of the anterior lobe; the three filaments soon unite and form a triangular swelling, from which the nerve proceeds forwards and inwards for about two inches, in a groove in the anterior lobe, in which it is confined by the arachnoid membrane and protected from pressure; it then ends in a soft oval bulb which is placed over the cribriform plate of the ethmoid bone; from this several fine filaments descend through the foramina in this bone, and are distributed to the mucous membrane in the nose. The olfactory differ from the other cerebral nerves in figure, course, and structure; prismatic or triangular, the apex is imbedded in the cerebrum; they converge as they leave the cranium; they consist of several striæ, some white, others grey, all very soft; they are not surrounded by arachnoid membrane, but lie above it; they have no distinct sheath, and each ends in a soft grey swelling from which the ultimate filaments proceed, and which leave the cranium by a number of foramina.

The SECOND PAIR, or OPTIC, are large, soft, and flat posteriorly, round and inclosed in a dense neurilema anteriorly; each *arises* by two bands, one from the nates, the other from the testis; these pass outwards beneath the optic thalamus, the first joins the corpus geniculatum externum; the second the corpus geniculatum internum; these roots then unite in a soft flat band, which turns forwards in a semicircular course (*tractus opticus*) around the crus cerebri, to which it has a slight attachment, and from which it receives a few fibres: the optic nerves then converge, and unite before the sella turcica, in the *optic commissure;* in this flat, white, square substance, which is connected to and receives additional fibres from the tuber cinereum, the two nerves are so confounded that the direction of each is indistinct, and it is uncertain whether they decussate in whole or in part; from the commissure each nerve passes forwards and outwards on the inner side of the carotid and above the ophthalmic artery, through the optic foramen, into the orbit; it is then surrounded by a process of dura mater, and proceeding to the back part of the eye, it perforates the sclerotic and choroid coats of this organ, and terminates in the retina.

The THIRD, or MOTORES OCULORUM, are smaller than the optic; each *arises* from the inner side of the crus cerebri, close to the pons, behind the floor of the third ventricle, and between the posterior artery of the cerebrum, and the anterior artery of the cerebellum; this round nerve passes forwards and outwards external to the cavernous sinus, through the foramen lacerum orbitale, and is distributed to five of the seven muscles contained in the orbit.

The FOURTH, or TROCHLEATORES, or PATHETICI, are the smallest of the cerebral nerves; each *arises* by two or three delicate filaments from the valve of Vieussens and from the processus a cerebello ad testem; it takes a long course forwards and outwards between the cerebrum and cerebellum, enters a small canal between the layers of the tentorium behind the posterior clinoid process, and continues its course along the outer side of the cavernous sinus through the foramen lacerum orbitale to the superior oblique muscle.

The FIFTH, or TRIFACIAL, or TRIGEMINI, are the largest of the cerebral nerves; each consists of nearly one hundred fine filaments, but loosely connected to each other, and very easily detached from the brain: *arises* by two fasciculi, one, large and posterior, from the angle between the pons Varolii and the crus cerebelli, the other, small and anterior, from the corpus pyramidale in the substance of the pons; these pass together forwards and outwards over the point of the petrous bone in a sort of canal formed of dura mater, and lined by arachnoid membrane, which last is reflected on the nerve, so as to form a cul de sac around it; in the middle fossa of the base of the cranium it expands into a large grey swelling, (the *triangular*, *semilunar*, or *Casserian ganglion*;) this ganglion is concave posteriorly; convex anteriorly and externally; the dura mater covers and adheres intimately to its plexiform surface; three large branches proceed from it, the *ophthalmic*, the *superior* and *inferior maxillary*; the first passes into the orbit through the foramen lacerum; the second leaves the cranium by the foramen rotundum, and the third by the foramen ovale. If the ganglion be raised from the bone, a small fasciculus of fibres may be observed to pass from the trunk of the fifth pair, without entering into the ganglion, to the inferior maxillary nerve; this fasciculus can be traced into the anterior root of the fifth, or through the pons Varolii into the corpus pyramidale.—When this nerve is detached from the brain, a small nipple-like tubercle is seen on the latter at the point of separation. The fifth pair of nerves resemble the spinal nerves, in *arising* by two roots, and in having a ganglion placed on the posterior, to which the anterior is only connected.

The SIXTH, or ABDUCENTES, are of a middle size between the third and fourth; each *arises* from the outer side of the corpus pyramidale, a little below the pons, it passes forwards and outwards, pierces the dura mater behind the body of the sphenoid bone, traverses the cavernous sinus on the outer side of the carotid artery, and is there joined by two or three small filaments from the superior cervical ganglion of the sympathetic nerve, it then enters the orbit through the foramen lacerum, and is distributed to the external rectus muscle; the basilar artery is between the sixth pair of nerves.

The SEVENTH PAIR consists of two portions, the PORTIO DURA, or the FACIAL nerve, and the PORTIO MOLLIS, or the AUDITORY nerve. The *facial* nerve is the anterior and smaller of the two, it *arises* from the lower edge of the side of the pons below the crus cerebelli, and behind and above the corpus olivare.

The *auditory* nerve, or portio mollis, is the posterior and the larger, it *arises* by three or four striæ from the side of the calamus scriptorius and from a small mass of grey substance on the back of the corpus restiforme; these are at first separated by the restiforme, but soon unite into one soft white cord, which passes forwards and outwards and joins the portio dura; the two nerves then pass outwards, the mollis being larger than the dura, which is contained in a groove in the former, and a small blood vessel runs between them; they both enter the meatus auditorius internus, where they soon separate; the facial nerve runs along the aqueduct of Fallopius, which canal opens inferiorly at the stylo-mastoid foramen; this nerve then turns forwards, and is distributed to the side of the face; the auditory nerve descends obliquely forwards, and is distributed to the cochlea and semicircular canals.

The EIGHTH PAIR, or PAR VAGUM, consists of three portions, the GLOSSO-PHARYNGEAL the smallest, the PNEUMO-GASTRIC the largest, and the SPINAL ACCESSORY, which is of a medium size.

The *glosso-pharyngeal arises* by four or five delicate filaments between the corpus olivare and restiforme; these unite into one small nerve.

The *pneumo-gastric*, or the vagus, *arises* by ten or twelve filaments below the last, but in the same groove; these also unite into one nerve, which, with the glosso-pharyngeal, passes forwards and outwards to the foramen lacerum posterius or jugulare, where they are joined by the third portion.

The *spinal accessory nerve arises* from the side of the medulla spinalis by several delicate roots or fibres, which commence a little above the middle of the cervical portion of this organ.

[Sometimes these roots commence as far down as opposite the seventh cervical nerve; there are also three or four filaments from the medulla oblongata.]

This nerve ascends behind the ligamentum denticulatum, and very near the posterior roots of the spinal nerves; it frequently receives filaments from the roots of these nerves: having passed through the foramen magnum it joins the other divisions of the eighth pair, the inferior artery of the cerebellum having previously passed between them. The eighth pair of nerves passes through the jugular foramen anterior to the vein and immediately separates into its three portions, the particular course of each of which shall be considered afterwards. The spinal accessory is distributed to the muscles on the side of the neck; the glosso-pharyngeal to the pharynx and the tongue, and the pneumo-gastric to the lungs and stomach.

The NINTH or LINGUAL nerve *arises* by six or eight fine filaments between the corpus olivare and pyramidale, and behind the vertebral artery; these unite and pass through the lingual or anterior condyloid hole in the occipital bone. The ninth pair of nerves are distributed to some of the inferior muscles of the neck, also to those of the tongue.

Nerves are either *simple* or *compound;* by simple is meant a nerve possessed of but one property; by compound, a nerve possessed of two properties. The properties with which nerves are endowed, so far as we are positively informed, are two, viz. *sensation* and *volition;* nerves endowed with the former are called *sensitive nerves*, the latter are the *voluntary nerves* or *nerves of motion*. Of the nine pair of cerebral nerves some are simple, some compound, the simple are the first, second, third, fourth, sixth, and ninth; the first and second are simple nerves of sense; the third, fourth, sixth and ninth, are simple nerves of motion. The fifth, seventh, and most probably the eighth, are all compound nerves, thus the ganglionic portions of the fifth are sensitive, while the non-ganglionic are motor; the portio mollis of the seventh is sensitive, but the portio dura is motor. The peculiar position of the origin of the eighth from the side of the medulla oblongata and spinal cord would imply that it partook of the double properties of these organs, that is, of their anterior and posterior surface, and that it was a compound nerve, and accordingly, in experiments on living and on recently killed animals, irritation applied to the divisions of the eighth pair, has in the former state of the animal produced pain, and in the latter muscular contraction.

[The cranial or cerebral nerves, are so called because they pass out of the foramina, of the cranium, and not as the name would imply because they all arise from the cerebrum, for we have just seen that many of them arise from the medulla oblongata, and in one case even from the medulla spinalis low down. The nine pair of nerves, above described are named by Willis and others indifferently, according to to their origin, from before backwards, numerically, or according to their distribution and uses. There is however a defect in the above arrangement, for we find that the seventh pair as described, includes two nerves entirely distinct in their distribution and uses: again the eighth pair comprehends three distinct nerves, accordingly Sœmmering modified the nomenclature as follows.

First pair,	Olfactory nerves.
Second pair,	Optic nerves.
Third pair,	Motores Communes Oculorum.
Fourth pair,	Trochleatores, or Pathetici
Fifth pair,	Trigemini, or Trifacial.
Sixth pair,	Abducentes, or Motores Externi.
Seventh pair	Portio Dura, or Facial nerve.
Eighth pair,	Portio Mollis, or Auditory nerve.
Ninth pair,	Glosso-Pharyngeal.
Tenth pair,	Par Vagum, or Pneumo Gastric.
Eleventh pair,	Spinal Accessory.
Twelfth pair,	Sublingual, or Hypoglossal.

This appears to be much the best arrangement, except that the spinal accessory nerve should be considered as the twelfth pair, in consequence of its arising low down from the medulla oblongata, and medulla spinalis.

In accordance with the present state of our knowledge of the development of the nervous system, as regards priority, we ought to examine the cranial nerves from behind forwards, instead of from before backwards, and in this more philosophic point of view the spinal accessory, would be the first pair. The present more common mode of examining them is, however, the most convenient.]

Before the student dissects the cerebral nerves to their termination, he may examine the spinal marrow, and also dissect the brain from below upwards.

CHAPTER II

DISSECTION OF THE MEDULLA SPINALIS.

THE spinal marrow is contained or rather suspended in a cavity or canal much larger than itself, and which is bounded by the bodies and processes of the vertebræ and by their connecting ligaments; this organ, like the brain, is surrounded by three membranes, which are continuous with those in the cranium. Place the subject on the fore part, remove the soft parts covering the spine, and with the saw divide the crura of the spinous processes of all the vertebræ close to their articulating processes, then with the elevator raise the posterior arch of the spinal canal; a quantity of loose reddish cellular tissue, and the numerous vertebral venous sinuses, intervene between the bones and the dura mater, which membrane is loosely connected to them, and cannot therefore serve the office of periosteum as in the cranium; it is more closely attached to the ligaments and bones anteriorly, than laterally or posteriorly.

The *dura mater* of the spinal canal is termed the theca vertebralis; it is continued from the cranium through the foramen magnum, down the spinal canal as far as the third lumbar vertebra, where it divides into several processes, which are continued on the sacral nerves; throughout this extent it regularly sends off a tubular process along each of the spinal nerves; its external surface is smooth and polished. With the scissors divide this membrane along its whole length; its internal surface will be found lined by the reflected layer of the arachnoid or serous membrane.

The *arachnoid* or the *serous membrane* in this region has a corresponding appearance to that in the cranium; it is, however, rather stronger, and more loosely connected to the pia mater, so that air or any fine fluid may be impelled between them; a quantity of serous fluid is also naturally interposed, so that this, unlike other serous membranes, must possess two exhalant and absorbent surfaces. From the sides of the spinal marrow it is regularly reflected along each of the nerves of the dura mater; these several reflections or folds, when examined in succession, are found to be continuous with each other, and assist in forming the following substance, the *ligamentum denticulatum;* this is a narrow membranous and ligamentous band extending along each side of the whole spinal cord; its superior extremity is attached to the dura mater at the foramen magnum; its internal edge is straight, and is connected to the pia mater along the side of the spinal cord in the space between the anterior and posterior roots of the spinal nerves; its external edge is serrated and attached by several pointed processes to the inner surface of the dura mater, near the foramina for the passage of the nerves; each of these processes lies between the anterior and posterior fasciculi of the nerves; its inferior extremity is inserted into the ligamentous substance on the body of the fourth or fifth lumbar vertebra. The ligamentum denticulatum serves to separate the roots of the spinal nerves, also to connect or fix the spinal cord laterally, and so guard against concussion or displacement of the cord.

The *pia mater* in the spinal canal is more dense than in the cranium, it adheres so closely to the spinal cord as to appear to compress it, which is evident when the cord is cut across; it is not so uniformly vascular as it is on the brain, very large and tortuous vessels however extend along its whole length.

The MEDULLA SPINALIS extends from the foramen magnum, where it is continuous with the medulla oblongata as far as the second lumbar vertebra, where it ends in a lash of nerves called *cauda equina;* this organ is almost cylindrical; its transverse diameter exceeds the antero-posterior; a deep narrow fissure extends along the median line posteriorly, and a broad superficial groove anteriorly; at first the medulla spinalis is rather contracted or smaller than the medulla oblongata; but from the fourth or fifth cervical to the first dorsal vertebra it is larger than in any other situation; it then contracts through the upper and middle dorsal regions, and again swells out about the tenth dorsal vertebra into an oval bulbous expansion which terminates at the second lumbar vertebra in a point, from which the remains of the ligamenta dentata extend; this lower extremity of the spinal cord is sometimes round, sometimes bifid. The two enlargements of the spinal cord correspond to the origins of the largest nerves, viz. those to supply the upper and the lower extremity. The medulla spinalis appears to consist of two symmetrical portions united at the bottom of the two fissures by transverse bands or commissures,

[Which are three in number, anterior, posterior and middle. Besides these commissures, there is a distinct decussation of the anterior columns, for the space of four or five lines near the occipital foramen, a fact of much pathological value.]

If either side be divided by a transverse section, it will be found to consist of grey and white substance, the latter placed externally, the former internally, and of a lunated appearance, the concavity looking outwards; some grey substance is also placed transversely, and connects the convexities of these lateral masses. The younger the subject the more distinct is the cineritious substance in the spinal cord. The medullary substance on each side appears to be arranged in three columns, separated by superficial grooves; from these the spinal nerves proceed, and it has been ascertained by Majendie and Bell, that the posterior roots of these nerves are endowed with sensation only, and that the anterior are connected with voluntary motion; Bell also intimates, but without sufficient proof, that the middle, or those which arise from the sides of the cord, preside over the function of respiration.

[There is a remarkable difference in the relative situation of the medulla spinalis, as placed in the vertebrated and invertebrated animals. In the former it is superior, or posterior to the alimentary canal, in the latter it is inferior. In length the medulla spinalis measures from fifteen to twenty inches, according to the stature of the individual; its breadth, where most contracted is about one inch, and at its widest parts one inch and a half. Its length also depends somewhat upon the position of the subject, for it is elongated during the flexion of the spine, and retracts again during extension; this variation is estimated by Cruveilhier, at from twelve to fifteen lines. Neither does the medulla fill the whole circumference of the canal, but there is a space between the arachnoid tunic, and the dura mater filled by the cerebro-spinal fluid, this arrangement protects the medulla from compression, during the varied movements of the spine. The medulla spinalis is usually described, as ending opposite the first or second lumbar vertebra, but it sometimes descends as low as the third, and has been seen, to end opposite the eleventh dorsal vertebra. Thus we find that its length is not proportioned to that of the spinal canal; in the earlier months of fœtal life, the medulla extends down to the sacrum. In vertebrated animals the volume of the medulla spinalis as compared with the size of the animal, is in direct ratio with its vital activity, hence it is small in fish and reptiles, large in birds and mammalia. According to Sœmmering, its volume in man, relatively to the encephalon, is smaller than in other animals, but in proportion to the size of his body, man has a larger medulla than any other animal except birds.

Chaussier says that the volume of the medulla, is equal to from a nineteenth to a twenty-fifth part of that of the cerebrum, in the adult, but that in the new born infant it is but one fortieth. The volume of the spinal marrow at particular points, is in proportion to the size and number of the nerves connected with it, and the energy of function, in those organs, to which these nerves are distributed; and the function of sensation is connected with nerves of greater size than those connected with muscular contraction. We find that the cervical enlargement of the spinal marrow, is greater than the lumbar, for two reasons, the one because the superior extremity possesses a greater extent and variety of motion than the inferior, and the other, because these same extremities are the organs of touch.]

In addition to the spinal accessory nerves, which may be now seen to arise from each side of the medulla spinalis in the upper half of the neck by twelve or fourteen small filaments, and to ascend behind the ligamenta denticulata, the spinal cord gives origin to at least thirty pair.

ORIGIN OF THE SPINAL NERVES.

The spinal nerves are symmetrical; there are thirty pair, (some anatomists enumerate thirty-one or thirty-two,) which are divided into eight cervical, twelve dorsal, five lumbar, and five sacral; all these nerves arise and terminate nearly in a similar manner; each spinal nerve is at first composed of two roots, an anterior and posterior, each of which consists of several filaments, which *arise* from the anterior and posterior surface of the spinal cord on either side of the median fissures; these filaments unite into fasciculi; those composing the posterior root are larger than those in the anterior, (excepting in the case of the first or sub-occipital, whose anterior is equal or even larger than the posterior;) these two fasciculi or roots are separated from each other by the side of the spinal cord, and by the ligamentum dentatum; they can converge and proceed obliquely outwards and downwards to the dura mater, which they perforate distinctly by two small openings, which, however, are so close, as to appear but one; each fasciculus receives a sheath from the dura mater, they then pass through the inter-vertebral foramen, and in this situation a small oval ganglion is formed upon the posterior root of each, to the surface of this ganglion the anterior root is only connected; immediately on the outer side of this ganglion the two roots unite and form a single cord; this is the proper spinal nerve; after a short course outwards, this divides into two branches, a posterior and an anterior; the former is almost universally the smaller, except in the case of the second cervical, and is distributed to the muscles and integuments posterior to the vertebral column; the anterior branches of the spinal nerves are much larger; they enter into several plexuses, and supply the muscles anterior to the spinal column, as also the extremities. The superior cervical nerves take nearly a transverse course from their origin to the inter-vertebral foramina; the succeeding nerves are more oblique, and the lumbar and sacral take a longitudinal course, and form their ganglions and subsequent divisions within the spinal canal.

All the spinal nerves are compound nerves, but their roots are simple, the anterior being motor, and the posterior sensitive.

The course and distribution of the spinal nerves shall be examined individually afterwards, the student may next dissect the brain from below.

DISSECTION OF THE BRAIN FROM BELOW.

The brain, medulla oblongata, and the upper part of the spinal cord should be carefully removed from the subject; the brain, with the base uppermost, should then be placed in a shallow basin; the cerebellum and medulla oblongata will now fall a little backwards, and all the parts of the base of the brain will be exposed. Raise the pia mater from the forepart and sides of the medulla oblongata; the several eminences on this organ may be traced upwards to the cerebrum, or to the cerebellum: to follow these, the dissector should rather scrape the surrounding substance with the handle or with the back of the knife, then cut it with the edge. In the description of the brain already given, certain differences between the cineritious and the white substances have been stated; it is necessary to recollect that the former is soft, vascular, and pulpy, and that the latter is fibrous; it is an opinion entertained by many, particularly Gall and Spurzheim, that the grey is the origin or matrix of the white substance, or that the former is a secreting organ, and the latter consists of fine conducting vessels or filaments: the direction of the fibres in some situations is very distinct; some pass from below upwards and outwards; these are termed *diverging fibres*, others pass from the surface or circumference downwards and inwards, these are the *converging or uniting fibres:* first proceed to trace these two orders of fibres in the cerebellum.

STRUCTURE OF THE CEREBELLUM.

Trace the restiform body upwards into the crus cerebelli; divide this substance vertically, and the former may be seen continued into the mass of grey substance in the crus known by the name of corpus dentatum, or the ganglion of the cerebellum; from the inner edge of this a narrow white fasciculus may be traced inwards towards the median line; it there unites with a similar process from the opposite side, and both divide into several fine bands, which diverge and form the vermiform process, (or the primary portion of the cerebellum;) the peripheral extremities of these fibres are covered by cineritious substance, and present, when cut vertically, an arborescent appearance; the remainder, or the principal portion of the restiform body, passes upwards and outwards through the corpus dentatum, and then divides into several processes or stalks which diverge through each hemisphere and sub-divide into finer branches, each of which is covered by the grey substance on the surface; a vertical section of either hemisphere presents also that arborescent appearance known by the name of arbor vitæ. The converging fibres of the cerebellum are inferior and superior; the latter are very delicate and rather indistinct in their course; they consist of several fibres which issue from the vermiform process and unite in one broad lamina which is thin in the centre, (the valve of Vieussens,) and thick at each side (processus a cerebello ad testem;) thus these superior converging fibres form the superior or lesser commissure of the cerebellum, they also connect the cerebellum to the quadrigeminal bodies. The inferior converging fibres are more distinct, they proceed from the cineritious substance in either hemisphere forwards and inwards, and form the principal portion of each crus cerebelli; they then pass transversely across the pons Varolii and unite with those from the opposite side; thus the superficial lamina or the transverse fibres of the pons form the great or inferior commissure between the hemispheres of the cerebellum.

STRUCTURE OF THE CEREBRUM.

Remove the pia mater from the anterior pyramids of the medulla oblongata, and separate these from each other, the decussating fibres will be seen; through these the pyramid on one side may be said to arise from the spinal cord of the opposite side; as the pyramids approach the pons they are somewhat contracted; on entering this substance they separate into fasciculi, which intermix with cineritious substance; they are considerably increased in size and number in passing through the pons, and they then form the anterior and external two-thirds of the crura cerebri. The olivary body and a few fibres from the restiform of each side also ascend through the pons behind the fasciculi of the pyramids; these also increase in size in passing through the pons, and then enter the crura cerebri, the posterior and internal part of which they form. Each crus cerebri contains a mass of cineritious substance of a peculiarly dark colour, in passing through which the white fibres appear increased in quantity. The posterior and internal fasciculi of each crus ascend and pass into those masses of grey substance called the optic thalami, and the corpora striata; in passing through these their fibres are increased in number, and thence extend in a radiated manner into the posterior and superior convolutions of each hemisphere, where they are covered by a layer of grey substance. The anterior and external portion of each crus, which is in continuation with the corpus pyramidale, in like manner ascends and expands into fasciculi, which may be traced into the inferior, anterior, and external convolutions of each hemisphere. The uneven surface known by the name of convolutions appears to depend on the unequal length of these diverging fibres; if they were all of equal extent the surface of the cerebrum would be smooth, but as some fall short of others, and all are covered by the grey substance, an uneven or convoluted surface is the result. From this grey substance which covers the surface of each convolution, the converging or descending fibres are described as arising, and thence passing towards the mesial line to unite with those from the opposite side; the corpus callosum and the anterior and posterior commissures are supposed to be thus formed; in addition to these transverse processes there are several other parts which may serve as media of communication between different parts in each hemisphere of the brain, viz. the fornix, the tænia semicircularis, the pineal gland, and its pedunculi, the infundibulum, the septum lucidum, &c. &c.

VESSELS OF THE BRAIN.

The brain is supplied with blood by the two vertebral, and the two internal carotid arteries. The *vertebral arteries* are the first branches of the subclavian arteries, they ascend through the series of foramina in the transverse processes of the cervical vertebræ, and passing through the foramen magnum into the cranium, they proceed obliquely forwards and inwards, and end in a common trunk called the *basilar* artery; each vertebral first sends off two long and delicate branches, one on the anterior, the other on the posterior surface of the spinal cord, these extend the whole length of this organ, supplying it with blood, and sending out small branches along the several spinal nerves.

[Of these two arteries, the latter, the posterior vertebral, continue the whole length of the spinal cord parellel to each other, but the former, the anterior vertebral arteries, soon after their origin unite and form a single trunk, which descends along the anterior middle fissure of the cord.]

Next to these branches each vertebral gives off the inferior artery of the cerebellum; this turns backwards between the pneumogastric and spinal accessory nerves, and is distributed to the inferior surface of the cerebellum. The *basilar* artery ascends along the median groove in the pons, and at its superior edge divides into four branches, two for each side, viz. the superior cerebellar artery and the posterior cerebral; these are distributed as their names imply: the posterior cerebral artery of each side is joined by the posterior branch of each internal carotid; this communication completes the circle of Willis. Each *internal carotid artery* winds obliquely forwards, upwards, and inwards, through the tortuous canal in the temporal bone, and through the cavernous sinus; beneath the anterior clinoid process it perforates the dura mater, and rises perpendicularly to the base of the brain between the second and third nerves, and then divides into three branches, the anterior, middle, and posterior; before it thus divides it gives off, first, small branches to the cavernous sinus and to the dura mater, and next the ophthalmic artery which enters the orbit through the optic hole, and is distributed to the eye and its appendages. The anterior branch of the carotid is also named the anterior cerebral artery, or the artery of the corpus callosum: this passes forwards and inwards, and is joined to the corresponding artery of the opposite side by a short branch, (the anterior communicating artery,) it then ascends and runs along the upper surface of the corpus callosum, distributing its branches to the inner surface of each hemisphere; the middle branch [the middle cerebral artery] of the carotid is very large, it passes upwards and outwards deep in the fissure of Sylvius, and is distributed to the anterior and middle lobes of the cerebrum; the posterior branch of the carotid is named the posterior communicating artery; it is small, passes backwards, and joins the posterior cerebral artery; this forms the side of the circle of Willis.—(See Anatomy of Vascular System.) The vessels of the brain are accompanied by numerous fine filaments of the sympathetic nerve, these pass into its substance and supply its intimate structure.

The veins of the brain join the sinuses which have been already described; the principal veins are on the superior surface of the brain, whereas the large arteries are below.

The brain and its membranes exhibit many *morbid* appearances. The *dura-mater* is sometimes found in a state of inflammation; to an inexperienced eye this appearance is difficult of detection, as in this condition, very few vessels more appear carrying florid blood, than in the natural state; in injuries from external violence, where inflammation follows, suppuration often occurs, and the pus is found sometimes on its external surface, between it and the bone, in other cases the matter is internal, and then the arachnoid coat, lining the dura mater, is found covered with pus. *Scrofulous and fungoid* or *fibrous tumours* growing from the dura mater, producing absorption of the bone, or pressure on the brain, are occasionally found: also a deposition of bony laminæ in some part of the dura mater, more particularly in the falciform process or near the superior longitudinal sinus.

The arachnoid membrane is sometimes inflamed.—*Arachnitis*, when chronic, presents an opaque or in some instances a thickened state of the membrane, which gives it a tolerably firm consistence; serous fluid, sometimes of a gelatinous nature, and creamy appearance, is found between it and the pia mater; and although these appearances are said to depend on inflammation, still no vessels holding red blood are found ramifying on its surface, the redness which is sometimes present, being owing to the vessels of the pia mater appearing through it. Adhesions between the parietal and visceral laminæ of this membrane seldom occur, as in other serous cavities: in acute arachnitis, pus, or sero-purulent fluid, or serum with lymphy flakes and of a sanguineous colour is often effused.

Hydrocephalus is a disease of this membrane of frequent occurrence, it consists of an effusion of clear serous fluid, it may be acute or chronic, and the fluid, which may amount to a few ounces or to as many pounds, may be collected either within the ventricles, (hydrocephalus internus,) or it may be on the surface of the brain, (hydrocephalus externus;) in the latter the brain will be found compressed towards the base of the cranium, in the former, which is the more common form, the hemispheres will be found expanded; in both the cranium will be enlarged, and in young persons the sagittal and coronal sutures will be expanded, and the fluid, in passing from one lateral ventricle to the other, raises up the fornix, expands the foramen commune anterius, and so passes into the third and thence into the fourth ventricle. In hydrocephalus, scrofulous disease is frequently to be found at the base of the brain, as also small tubercles on the pleura and peritonæum. We often find fluid also between the arachnoid coat and the pia mater; sometimes effused in small patches between these two membranes, and at others over a large extent; when this anasarcous-like effusion takes place, the vessels of the pia mater are found more distended with blood than usual, and the arachnoid membrane is thick and opaque; in most cases where this effusion takes place, water is also secreted in the lateral ventricles, and in the sheath of the vertebral canal.

There is some difficulty experienced in distinguishing inflammation of the *pia mater* on account of the great number of small vessels which naturally ramify on it; however, in the inflamed state they become much more numerous, and by their anastomoses, make a beautiful reticulated appearance, not however, causing such a general redness as may be observed in the inflammation of some other membranes; and when the inflammation runs high, pus is formed, which is effused on the whole upper surface of the brain. A common morbid appearance found in the pia mater is the formation of small cysts, containing water, which are generally called hydatids; these are found more usually on the choroid plexus, and in the velum interpositum. *Inflammation* of *the substance* of the brain is occasionally observed arising from external injury; the redness, which is generally slight, is confined to one particular part; in this state, when cut into, the colour appears to arise from a great many small vessels which are filled with red blood; the inflamed part is softer and more yielding than natural, giving rise to an appearance which has been lately described by French writers, and called "ramollissement;" when the inflammation proceeds further, abscesses holding pus are formed, which, if of a large size, break down the substance of the brain, and present a very jagged appearance on their internal surface. *Apoplexy*, or an effusion of blood or serum either on the surface or in the substance of the brain, is also to be met with, and occasionally into some of the ventricles; the blood found in those situations is almost always black and coagulated, the substance of the brain is torn; when the person survives the attack, and recovers the energy of the organ, the blood becomes absorbed in part, a regular cyst or cell encloses the remainder, and in some cases no trace remains of the original disease, except some condensed or cicatrized appearance. *Deposition* of *caseous* and even of *earthy matter* in the arteries of the brain may also be looked for; this appearance is by no means rare, particularly in old subjects; arising from this state of the arteries, aneurisms of the internal carotids are described by some authors, but they are not of common cccurrence.

CHAPTER III.

DISSECTION OF THE NERVES.

THE course and ultimate distribution of most of the nerves have been already mentioned in the description of the muscles and of the several regions of the body; in the present chapter they shall be considered in a systematic manner, commencing with the cerebral nerves, the origins of which have been already described.

SECTION I.

DISSECTION OF THE CEREBRAL NERVES.

1. OLFACTORY nerves; from the bulb, which each of these nerves forms at the side of the crista galli, several branches descend into the nose, through the foramina, in the cribriform plate; they may be divided into the internal, middle, and external. The *internal branches*, about ten in number, descend in grooves along the septum, subdivide into many filaments which form a plexus with each other in the mucous membrane; some of these can be traced nearly to the floor of the nose. The *middle branches* are distributed to the mucous membrane lining the roof of each nostril. The *external branches* descend along the grooves on the turbinated bones, dividing and communicating frequently with each other, so as to form numerous plexuses, which are lost in the pituitary membrane. All the branches of the olfactory nerves are very soft in the cranium, but in passing through the ethmoid bone they each receive a sheath from the dura mater, which is ultimately lost in the external layer of the mucous membrane.—(See the Anatomy of the Nose.)

II. Optic Nerves; each optic nerve on passing through the optic foramen, becomes surrounded by a strong sheath, derived from the dura mater; the four recti muscles next surround it, from the fleshy portions of which it is separated by a considerable quantity of soft fat, in which several nerves and vessels are lodged; from the optic foramen this nerve proceeds forwards and a little inwards, so as to be slightly curved, the convexity outwards; at the back part of the eye it is very much constricted; it then pierces the sclerotic and choroid membranes and terminates in the retina.—(See Anatomy of the Eye.) The ophthalmic artery accompanies this nerve, in the optic foramen it lies beneath it, it afterwards twines around it to its internal side.

[This artery gives off the central artery of the retina, which perforates the sheath of the nerve, and gets into the substance of the nerve, with which it passes to the ball of the eye to be variously distributed.]

In addition to the dura mater, this nerve possesses a very dense neurilema which sends in numerous processes to form small canals or tubes in which the nervous substance is contained, so that this nerve is not composed like other nerves, of several filaments placed parallel to each other; if the white substance be removed by maceration in an alkali, its cellular structure will become obvious.

At the side of the body of the sphenoid bone, the following four nerves of the orbit lie according to their numerical order, viz. most superiorly the third pair, then the fourth, next the ophthalmic branch of the fifth pair, and most inferiorly the sixth or abducens nerve; they are here closely united to each other, forming what may be termed the *orbital plexus*, until they arrive at the anterior clinoid process, where they separate, and as they are entering the foramen lacerum orbitale they lie thus; most superior is the fourth, then the frontal branch of the ophthalmic, next the superior division of the third, external to which, and near to the outer wall of the orbit, is the lachrymal nerve of the ophthalmic, after these the nasal nerve, below which is the inferior division of the third, and lastly, lying inferior to them all, holding the same relation to them as at the cavernous sinus, is the sixth nerve; to this last the ascending branches of the superior cervical ganglion of the sympathetic nerve are intimately connected, and several filaments from these can be traced into the orbital plexus.

To expose these four nerves the orbit should be opened, which is to be done by dividing the orbital plate of the os frontis by two cuts with the saw, these should unite in the optic foramen; the internal is to be carried forward to the superciliary arch about half an inch external to the internal angular process; the external incision is to be carried deeply through the malar bone; a slight blow with the hammer will then throw fowards the roof of the orbit, and the bone will separate easily from the periosteum.

III. The THIRD PAIR, or motores oculorum, in passing through the foramen lacerum orbitale, divide into two branches, a superior and inferior; the *superior*, or the *smaller*, passes between the heads of the external rectus muscle and over the optic and nasal nerves, and divides into two branches, the smaller and shorter one of which supplies the superior rectus, the other the levator palpebræ muscle. The *inferior* or the *larger branch* passes below and to the outside of the optic nerve, and divides into three branches, an internal, middle, and external; the *internal* is the largest, it passes obliquely downwards, forwards, and inwards, beneath the optic nerve, and getting to its internal side is distributed to the internal rectus, the *middle* to the inferior rectus; and the *external*, which is the longest, passes downwards and forwards on the surface of the inferior rectus, between it and the globe of the eye, (it gives no filaments to this muscle,) and is lost in the inferior oblique muscle; this last branch gives off from its root a small short filament to the ophthalmic ganglion. All the branches of the third pair are distributed to the ocular surfaces of the five muscles they supply.

IV. The TROCHLEATOR, or fourth nerve, having entered the orbit by the foramen lacerum, ascends obliquely forwards and inwards above the levator palpebræ and the superior rectus, and is distributed by four or five fine branches to the upper or orbital surface of the superior oblique muscle: as this delicate nerve is passing along the outer side of the cavernous sinus, it lies between the third pair and the ophthalmic branch of the fifth, below the former and above the latter and the sixth; as it enters the orbit it mounts above the third and fifth, a fine filament usually connects it to the latter, it is then the highest nerve in the orbit, both it and the frontal being immediately beneath the periosteum; previous to entering the oblique muscle its size is somewhat increased.

V. THE TRIGEMINI, or the fifth pair, having formed the semilunar or Casserian ganglion, divides into three, the ophthalmic, the superior and inferior maxillary nerves.

The OPHTHALMIC NERVE passes along the outer side of the cavernous sinus below the third and fourth, and above the sixth; in this situation it receives some filaments from the sympathetic nerve; as it approaches the foramen lacerum orbitale, it divides into three branches, the lachrymal, frontal, and nasal, which are situated with respect to the other nerves as above described.

The *lachrymal nerve*, the smallest and most external of the three, passes forwards and outwards to the lachrymal gland above the external rectus muscle, and beneath the periosteum, but gives no branches to this muscle; it is surrounded by fat and accompanied by the lachrymal artery; it sends off, in this course, two small branches, one through the spheno-maxillary fissure to communicate with the superior maxillary nerve, and the other through the malar bone, to communicate with the facial nerve; near the gland the lachrymal nerve enlarges and sends four or five branches to its inferior surface, and it then terminates in several fine soft filaments on the conjunctiva, lining the superior palpebra and cellular membrane between the gland and malar bone.

The *frontal nerve* enters the orbit, between the superior rectus and the periosteum, along with the fourth but inferior and external to it; it passes forwards in a kind of groove on the upper surface of the levator palpebræ muscle; and near the superciliary arch it divides into two branches, an internal and external; the *internal* or *supra-trochleator* nerve, the smaller branch, runs forwards and inwards above the trochlea of the superior oblique muscle, and is distributed to the corrugator supercilii, orbicularis palpebrarum, and occipito-frontalis muscles, also to the integuments of the forehead and superior eyelid; it communicates with the infra-trochleator branch of the nasal nerve, and sends one or two small filaments into the frontal sinus. The *external* branch, or the *supra-orbital* or *proper frontal* nerve, appears as the continuation of the original trunk, both in size and in direction, it passes through the superciliary notch or foramen, ascends on the forehead divides into two branches which subdivide into numerous filaments, these chiefly ascend in the muscles and integuments of the scalp, many of them take a very long course, and communicate with the portio dura, with the occipital nerves, and with those from the opposite side. Neither the frontal nor lachrymal nerve gives any motor filaments to the muscles in the orbit.

The *nasal nerve* separates from the frontal behind the orbit, enters this cavity beneath that branch, and between the two heads of the external rectus, it then runs obliquely forwards and inwards above the optic nerve and below the superior rectus muscle, and continues its course along the inner side of the orbit below the superior oblique muscle, and here divides into two branches, the external or the infra-trochleator nerve, and the internal or the nasal; the nasal nerve, previous to its entrance into the orbit, is joined by a filament from the sympathetic nerve; on the outer side of the optic, and just as it enters this cavity, it gives off a delicate branch about an inch in length, which runs along the outer side of the optic nerve to the lenticular ganglion; as the nasal nerve passes over the optic it gives off two ciliary nerves. The *infra-trochleator* nerve runs forwards beneath the pulley of the oblique muscle, and divides into several filaments which communicate with the supra-trochleator nerve, and are distributed to the lachrymal passages, and to the integuments and muscles on the side and dorsum of the nose. The *internal* branch or the *proper nasal* passes through the anterior of the internal orbital holes into the cranium, crosses the cribriform plate, and descends by the side of the crista galli into the nasal fossæ where it divides into posterior and anterior filaments; the former are distributed to the septum, the latter descend behind the nasal bones, and are lost in the integuments at the tip of the nose. The sixth pair of nerves should be next dissected, as it is distributed along with the preceding nerves in the orbit.

Sixth or Abducens Nerve, after traversing the cavernous sinus (where it is joined by branches from the sympathetic nerve) on the outer side of the carotid artery, enters the orbit through the lower part of the foramen lacerum between the origins of the external rectus, beneath the other orbital nerves and above the ophthalmic vein; it then passes forwards and outwards, and is distributed to the ocular surface of the external rectus muscle. All the motor nerves in the orbit are distributed to the same surface of their respective muscles, except the fourth, which spreads its branches on the orbital surface of the superior oblique muscle.

The student should next examine the *lenticular* or *ophthalmic ganglion;* this small body is situated near the back part of the orbit between the optic nerve and the external rectus muscle; it is of a reddish colour and surrounded by soft fat; its posterior superior angle receives the filament before mentioned from the nasal branch of the ophthalmic, and its posterior inferior angle receives the twig from the inferior oblique branch of the third pair; these two nerves are described by some as forming this ganglion; from the anterior angles of this ganglion two fasciculi of fine nerves proceed, termed the *ciliary*, the inferior fasciculus is larger than the superior. The ciliary nerves are about twenty in number, eight or ten in the inferior fasciculus, about six in the superior, and three or four internally, which arise from the nasal nerve; the ciliary nerves twine along the surface of the optic nerve, accompanied by the ciliary arteries, and pierce the back part of the sclerotic coat, they then become flat, and proceed forwards in parallel grooves on the inner surface of that membrane, with very little connexion to the choroid coat; at the anterior part of the eye they meet the ciliary ligament, in this substance most of these nerves are lost, hence some consider this as a ganglion; on each side, however, one or two branches may be traced through this into the iris, in which they divide into numerous filaments of extreme minuteness.

The several nerves of the orbit have different offices to discharge; no less than *seven nerves* are engaged in the optic apparatus, viz. the second, third, fourth, sixth, and portions of the fifth, seventh, and sympathetic; the respective office of each of these is probably as follows:—the second is a sentient nerve, the seat of vision; the third, fourth, aud sixth supply the orbital muscles with their voluntary or motor power; branches of the seventh also impart the same to the sphincter oculi or orbicularis palpebrarum; the ophthalmic portion of the fifth endows with sensation all the parts within the orbit, also the interior of the eye, the surface of the globe, the palpebræ, the lachrymal apparatus, the teguments of the forehead, &c. &c. The filaments of the sympathetic nerve serve to connect more closely the component parts of the orbital plexus with each other, and with the system at large, they also probably serve some useful purpose in reference to the ophthalmic ganglion, to which they are connected through the nasal nerve, the sympathetic being directly connected to or engaged in most of the principal ganglions in the body. The lenticular or ophthalmic ganglion also is interesting as to its connexions, as it in this respect resembles the ganglions on the spinal nerves; thus, it has two roots, the third pair supplies the motor, while the nasal filament of the fifth which also carries the sympathetic connexion, imparts the sensitive quality; the distribution also of the branches of this ganglion is in accordance with its component elements, inasmuch as they are distributed to one of the most delicately sensible, and one of the most active structures in the whole range of the animal economy, namely the iris, the muscular nature of which too may be inferred from the very circumstance of this peculiar nervous supply.

The student should next proceed to examine the superior and inferior maxillary nerves, the remaining divisions of the fifth pair. Remove the outer wall of the orbit with the saw or hammer, make a vertical section of the nose and face, and separate the globe of the eye and its muscles from their attachments; below the cavity of the orbit the superior maxillary nerve may be seen.

The SUPERIOR MAXILLARY NERVE passes from the middle of the Casserian ganglion forwards through the foramen rotundum into the pterygo-maxillary fossa; it here sends off several branches, and then passing through the spheno-maxillary fissure it continues its course forwards along the infra-orbital canal to the cheek, where it terminates in the infra-orbital nerves; in the pterygo-maxillary fossa it first sends down two small branches along the back part of the superior maxillary bone; these, after a short course, unite in a small triangular reddish substance called the *spheno-palatine ganglion*, or the *ganglion of Meckel;* this ganglion is imbedded in fat, surrounded by the branches of the internal maxillary artery, and is situated on the external side of the nasal plate of the palate bone, which separates it from the cavity of the nose, behind the tuberosity of the superior maxillary bone, and in front of the pterygoid processes. Three sets of branches proceed from this ganglion, an inferior, internal, and posterior. First the *inferior* or the *palatine nerves* descend in the bony canal of that name, send some small twigs through this canal to the spongy bones, and near the palate separate into three filaments, an anterior, middle, and posterior; the anterior passes forwards in a groove within the alveoli and above the mucous membrane, supplying the latter and sending small branches into the bone to the teeth: the middle and posterior filaments of the palatine nerve are distributed to the amygdalæ, the soft palate, and the uvula. The *internal* branch, or the *spheno-palatine* nerve is very short, passes through the spheno-palatine hole into the upper and back part of the nose, and divides into five or six branches; the most of these pass immediately into the mucous membrane, covering the superior and middle spongy bones, one branch called the *naso-palatine nerve*, or *nerve of Cotunnius*, passes beneath the sphenoidal sinus, and descends obliquely forwards along the septum nasi as far as the foramen incisivum, where it communicates with the anterior palatine branches, and where some anatomists describe a small ganglion (*naso-palatine*) to exist; this, however, in the human subject, can seldom be distinguished from the surrounding fat and vessels. The third or the posterior branch of Meckel's ganglion is the *Vidian nerve;* this passes backwards through the Vidian canal above the internal pterygoid plate, and sends some small filaments into the sphenoidal sinus; it then perforates the cartilaginous substance that closes the foramen lacerum anterius, enters the cranium, and divides into two branches, an inferior and superior; the inferior or carotid branch enters the cavernous sinus, and joins the plexus formed in this sinus around the artery by the ascending branches of the superior cervical ganglion of the sympathetic; the superior branch runs backwards and outwards beneath the dura mater and Casserian ganglion in a groove on the petrous bone, enters the hiatus Fallopii in this bone, and becomes attached to the portio dura nerve, which it accompanies as far as the back part of the tympanum; the Vidian nerve then leaves the portio dura, receives the name of *corda tympani*, and enters the typanum a little below the pyramid; it now proceeds forwards between the long leg of the incus and the handle of the malleus, to the latter it is firmly connected; it then escapes by the hole in the glenoid fissure along with the tendon of the laxator tympani muscle; it next runs downwards, inwards, and forwards, joins the gustatory nerve, and continues attached to it as far as the submaxillary gland; it now leaves the gustatory nerve and unites with some filaments from it in the *submaxillary ganglion*, which is situated near the posterior edge of the submaxillary gland, and from which a number of filaments proceed; these form a plexus which supplies this gland. As this Vidian or recurrent nerve takes this singularly intricate course, it goes under different denominations, and serves to maintain several interesting communications; for example, it connects the cervical ganglions of the sympathetic nerve with the spheno-palatine, also the latter with the submaxillary ganglion, it also joins the superior and inferior maxillary nerves to one another and both to the portio dura; the nervous supply to the muscles of the palate also is thus connected to the portio dura, the great muscular nerve of the face, &c.

The superior maxillary nerve immediately after, and sometimes previous to giving off the two descending branches which join the spheno-palatine ganglion, sends off the *orbital branch*, this ascends through the spheno-maxillary fissure and divides into two branches, the malar and temporal; the *malar* communicates with the lachrymal nerve, passes through a small canal in the malar bone, and is distributed to the integuments and muscles covering the malar bone; the *temporal* branch also passes through the malar bone into the temporal fossa, pierces the temporal fascia, becomes cutaneous, and joining some branches of the facial nerve, it accompanies the temporal artery, and is lost in the integuments of the temple and head. The superior maxillary nerve next gives off the *posterior dental nerves;* these are two or three branches which wind round the tuberosity of the maxillary bone, enter small foramina, which lead to the posterior alveoli in this bone, and supply the molar teeth; some branches also supply the gums and the buccinator muscle. As the *infra-orbital nerve*, which is the last branch of the superior maxillary, proceeds along the floor of the orbit, it sends off some small filaments to the fat and muscles in this region, also the *anterior-dental;* this descends along the fore part of the antrum, to the lining membrane of which it gives some fine filaments and is then lost in several branches which supply the canine and incisor teeth: the infra-orbital nerve then escapes through the foramen of the same name, beneath the orbicularis palpebrarum and levator labii superioris alæque nasi muscles; it here divides into several branches which are distributed to the face, some of these ascend to the palpebræ, others pass outwards to the cheek, and the largest branches descend to the ala nasi and to the upper lip; these different branches have frequent communications on the side of the face with the portio dura, on the nose with the nasal nerves, and on the buccinator muscle they form a plexus with each other and with the buccal and facial nerves.

The Inferior Maxillary Nerve; this, which is the third and largest branch of the fifth pair, immediately passes from the ganglion through the foramen ovale into the zygomatic fossa behind the external pterygoid muscle, where it divides into two large branches, a superior or external, and an inferior or internal. The inferior maxillary nerve consists of two portions, one is plexiform and sensitive, and proceeds from the Casserian ganglion, the other is concealed by this, and consists of white parallel fibres which do not pass through the ganglion; this is the motor portion of this nerve; in the zygomatic fossa this small deep portion winds round the other, becomes anterior to it, and both unite inseparably; the nerve then divides into two branches, superior and inferior. The *superior* or *external* retains the motor portion of the trunk, and immediately subdivides into four set of branches, viz. the deep temporal, masseteric, buccal, and pterygoid; the *inferior* or *internal* division of the nerve is the larger, and subdivides into the auricular, inferior dental, and gustatory nerves, which are probably all nerves of sensation. First, the *deep temporal nerves* are two in number, an anterior and posterior, they ascend between the temporal bone and muscle, and are lost in the latter; some small branches escape through the temporal fascia and communicate with the cutaneous temporal nerves. Second, the *Buccal nerve* arises in general in common with one of the last, it passes forwards and downwards between the pterygoid muscles, to the external of which, and to the temporal, it sends some branches, it then passes between the coronoid process and the buccinator muscle, and on the latter it divides into several long branches which form a plexus on this muscle with branches of the facial and infra-orbital nerves. Third, the *masseteric* branch descends obliquely backwards and outwards through the sigmoid notch of the inferior maxilla, between the temporal muscle and the neck of the lower jaw, close to the latter, to which also it sends some filaments; it is lost in the substance of the masseter muscle. Fourth, the *pterygoid branches* are two or three delicate branches, which descend to the pterygoid muscles. Thus the muscular portion of the trunk of the inferior maxillary nerve can be traced into those muscular branches, which supply the five great muscles of mastication on each side.

The inferior division of this nerve divides into three branches, viz. the auricular, dental, and lingual or gustatory nerves; first, the *auricular* or *temporo-auricular* branch; this passes backwards and outwards behind the neck of the lower jaw, and before the meatus auditorius; it here communicates with the facial nerve, and sends small filaments to the meatus and to the cartilages of the ear, also to the articulation of the lower jaw; it then ascends through the parotid gland over the zygoma and divides into an anterior and posterior branch which follow the divisions of the temporal artery, communicate with the facial nerve, and are lost in the integuments on the anterior and lateral parts of the head. Second, the *inferior dental nerve* separates from the gustatory, and is connected to it by a small twig, it then descends external to it, at first between the two pterygoid muscles, then between the lower jaw and the internal pterygoid; it is here separated from the latter by the internal lateral ligament; about the middle of the internal surface of the ramus of the jaw it sends off a small filament, the *mylo-hyoid nerve*, this descends obliquely forwards, confined in a groove in the bone by an expansion from the internal lateral ligament; near the chin it divides into small branches from the mylo-hyoid, genio-hyoid, and digastric muscles, the adjacent cellular tissue and lymphatic glands. The dental nerve then enters the canal in the lower jaw, which extends from the dental foramen obliquely forwards beneath the teeth as far as the chin; in this course, this nerve, which is accompanied by the dental vessels, supplies each of the molar and canine teeth with soft delicate twigs, and at the mental foramen it divides into two branches, one continues its course within the bone beneath the incisor teeth, the other is the *mental nerve;* this escapes by the mental foramen, bends upwards, and divides in a radiated manner into several branches which pass to the muscles, mucous membrane, and integuments of the lower lip, and communicate with the facial nerve. Third, the *lingual* or *gustatory nerve* is smaller than the dental, to which it is connected by a short branch which encloses a space through which the internal maxillary artery passes; beyond this branch of communication, the corda tympani (which has been before traced from Meckel's ganglion) joins the gustatory nerve at an acute angle; the latter is increased in size at this spot; the gustatory nerve is here situated between the external pterygoid and the muscles of the palate and pharynx; it then descends obliquely forwards between the internal pterygoid and the ramus of the lower jaw; it next turns forwards above the sub-maxillary gland and the mylo-hyoid muscle, and lies on the mylo-hyoidean attachment of the superior constrictor of the pharynx, and on the mucous membrane of the mouth and the stylo-glossus muscle, and accompanies the Whartonian duct; it then ascends above the sublingual gland, and becomes attached to the lateral and anterior parts of the tongue. In this arched course the gustatory nerve gives off, first, one or two small filaments to the internal pterygoid muscle; second, several to the tonsils, to the muscles of the palate, to the upper part of the pharynx, and to the mucous membrane of the gums; third, the corda tympani, and some accompanying filaments to form a plexus which supplies the sub-maxillary gland; fourth, a few branches which descend along the hyo-glossus muscle to communicate with the ninth or the lingual nerve; fifth, a fasciculus of nerves to the sublingual gland, and to the surrounding mucous membrane; lastly, at the tongue, it divides into several branches, some pass deep into the tissue of this organ, others long, fine and soft, rise towards its surface, and are lost in the mucous membrane and in the small conical papillæ near its tip.

The SIXTH PAIR of nerves have been described at page 321.

VII. FACIAL NERVE OR PORTIO DURA of the seventh pair; as this nerve is passing along the aqueduct of Fallopius in the temporal bone it receives superiorly the Vidian nerve; at the back part of the tympanum it sends off that nerve again, which then receives the name of corda tympani, here it also sends off small twigs to the tensor tympani and stapedius muscles; as it escapes by the stylo-mastoid foramen it gives off three branches, the posterior auricular, stylo-hyoid, and sub-mastoid; the first, or the *posterior auricular*, bends upwards and backwards behind the cartilage of the ear, to which it sends several long branches, others also pass backwards to the integuments covering the mastoid process and occipital bone; the second, or the *stylo-hyoid* nerve is distributed to the digastric and styloid muscles, and anastomoses with the sympathetic and glosso-pharyngeal nerves; the third, or the *sub-mastoid branch* perforates the posterior belly of the digastric, supplies it with several filaments, and then communicates with the glosso-pharyngeal nerve around the jugular vein close to the base of the cranium; other filaments descend and join the laryngeal branches of the pneumo-gastric nerve. The facial nerve then turns forwards across the external carotid artery and through the parotid gland; in this substance it divides into two large branches, the superior or larger is called temporo-facial; the inferior, which is smaller, the cervico-facial; these two branches take different directions, but are still connected together by cross branches which interlace with each other in a plexiform manner; this plexus is named *parotidean plexus,* or *pes anserinus.* The *temporo-facial nerve* ascends obliquely forwards across the neck of the lower jaw; it first communicates with the auricular branch of the inferior maxillary nerve, and then divides into three fasciculi, the temporal, malar, and buccal; these nerves take that course which their name implies; they are all remarkable for the plexiform arrangement of their branches, and for their frequent communications with each other, and with the three divisions of the fifth pair, which are distributed to the face. The *cervico-facial nerve* descends obliquely forwards through the parotid gland towards the angle of the jaw, where it is only covered by the skin and platysma; this nerve also divides into many branches, which may be arranged in three fasciculi, the maxillary, the sub-maxillary, and the cervical; the first, or the *maxillary,* cross the ramus of the jaw and the masseter muscle, and communicate in the muscles of the lower lip with the mental nerve, and with the superior division of the seventh; the second, or *sub-maxillary,* course along the base of the jaw, sending filaments to the integuments and superficial muscles, these also communicate at the chin with the mental nerve; the third, or *cervical* branches, are very long and numerous; they are distributed to the platysma and to the superficial muscles of the neck, and communicate with several filaments of the cervical plexus. The portio dura nerve has been ingeniously but erroneously supposed by Mr. Bell to be the nerve that excites the muscles of the face in particular conditions of respiration and in the expression of passion, &c., hence he has named it the respiratory nerve of the face; others more correctly consider the portio dura as the exclusive motor nerve of all the superficial muscles of the face.

VII. The Auditory Nerve or Portio Mollis of the seventh pair; this simple nerve separates from the portio dura at the bottom of the meatus auditorius internus, and then divides into two branches, an anterior and posterior; the anterior passes forwards to the cochlea, penetrates through many small openings, and is distributed to the membrane covering its spiral lamina, and to that lining the canal on its axis: the posterior branch passes outwards, forms a grey swelling, from which proceed several filaments to supply the membrane lining the vestibule and semi-circular canals.—(See Anatomy of the Ear.)

VIII. Glosso-pharyngeal Nerve, the first and highest branch of the eighth pair; this small and most probably a compound nerve, passes though the foramen lacerum posterius by a distinct canal, it then passes downwards and forwards anterior and internal to the jugular vein and internal carotid artery, and behind the stylo-pharyngeus muscle; it then winds round this muscle to its forepart, and descends obliquely inwards between it and the stylo-glossus to the posterior and lateral parts of the tongue; in this course this nerve forms an arch nearly parallel to that which the gustatory and lingual nerves describe; the glosso-pharyngeal is smaller than either of these nerves; it is situated between them, but deeper than either; and has very little if any, communication with them. As this nerve leaves the cranium it sends one or two small twigs into the temporal bone, these communicate with the carotid plexus in the cavernous sinus; it is next attached to the facial, pneumo-gastric and sympathetic nerves by small filaments, which are connected together by loose reddish cellular membrane, and entangled with several small vessels. This nerve next gives off some branches to the pharyngeal plexus, some of these descend along the neck, and unite with the sympathetic and cardiac nerves, others ascend to the amygdala, and assist in forming the tonsillitic plexus; as it approaches the pharynx, this nerve gives several branches to the stylo-pharyngeus and hyo-glossus muscles, also the superior and middle constrictors of the pharynx; several filaments pass between these to the mucous membrane of the pharynx and fauces, also to the folds or arches of the palate, and to the epiglottis; the remaining branches of the glosso-pharyngeal nerve are distributed to the muscular substance, large papillæ, and mucous membrane at the root of the tongue; the lingual branches are considered sentient, the muscular or pharyngeal both sentient and motor.

Pneumo-gastric nerve, or nervus vagus; this large compound nerve passes through the foramen lacerum in a fibrous canal in common with the spinal accessory, but distinct from the last described nerve, and anterior to the jugular vein; it then communicates with the spinal accessory, glosso-pharyngeal, lingual, facial, sympathetic and first and second cervical nerves; to all these it is closely connected, and the nerve here has the compact appearance, and sometimes the greyish tint of a ganglion; at first it is placed anterior to the vein and to the lingual nerve; it soon, however, passes behind both and opposite the atlas, the vein separates it from the glosso-pharyngeal nerve which lies anterior to that vessel; the vagus then descends along the forepart of the neck enclosed in the sheath of the carotid artery and jugular vein: in this sheath it is placed between these vessels, rather behind and more closely connected to the vein; on the right side this nerve enters the thorax between the subclavian vein and artery, crossing the latter at right angles; on the left side it is also anterior but nearly parallel to the subclavian artery, a little below which it crosses obliquely the back part of the arch of the aorta; in the thorax these nerves descend at first obliquely backwards behind the roots of the lungs, and enter the posterior mediastinum, they then descend along the œsophagus through the diaphragm, and end on the stomach. The branches of each may be divided into cervical, thoracic, and abdominal; the cervical branches are, the pharyngeal, superior laryngeal, cardiac and recurrent or inferior laryngeal. First, the *pharyngeal nerve* arises from the vagus near the base of the cranium, and soon receives a twig from the spinal accessory; it descends obliquely inwards behind the carotid artery to the side of the pharynx, divides into several branches, which communicate with those from the glosso-pharyngeal, superior laryngeal, and sympathetic; all these branches form the *pharyngeal plexus;* this plexus extends along the side of the middle and upper constrictors, and sends numerous filaments to each of these muscles, and to the mucous membrane of the pharynx and fauces. Second, the *superior laryngeal nerve* arises a little below the last; it runs in an arched manner downwards and forwards behind the internal carotid artery, and below the superior cervical ganglion, with which it communicates, as also with the lingual nerve; it sends several filaments to the pharyngeal plexus, and then divides into two branches, external and internal; the external is distributed to the sterno and hyo-thyroid, and to the other superficial muscles, also to the thyroid body and to the cartilages of the larynx; the internal perforates the thyreo-hyoid membrane and divides into numerous branches, many of these go to the anterior surface of the epiglottis, to the glands and mucous membrane connected with it, also to the arytenoid glands and muscles; one long filament descends obliquely forwards along the side of the larynx, beneath the thyroid cartilage, and supplies the crico-thyroid muscle. As the vagus descends it gives off fine filaments to the carotid artery, some of which unite with the sympathetic and with the cervical nerves; a little above the arteria innominata the right vagus gives off, third, *cardiac branches*, these, two or three in number, join the cardiac nerves from the sympathetic; the nerve of the left side does not send off so many or such large branches as that on the right side; on the left side they accompany the carotid artery to the arch of the aorta, expand over it, and join the cardiac plexus. Fourth, the *inferior laryngeal nerve*, or *recurrent;* that on the right side curves round the subclavian artery, ascends obliquely inwards behind the carotid and inferior thyroid artery, along the side of the trachea to the larynx; at its origin it gives off some cardiac filaments, afterwards some branches to the forepart of the trachea and the thyroid gland; it then supplies the lower part of the pharynx, and ends in the posterior and lateral crico-arytenoid and in the thyreo-arytenoid muscles, also in the mucous membrane of the larynx on which it communicates with the superior laryngeal nerve. The recurrent nerve on the left side is much longer, it curves round the arch of the aorta behind the ligamentous remains of the ductus arteriosus; it gives off several cardiac and pulmonary branches, and then ascends along the œsophagus and terminates in a similar manner to that on the right side. The pneumo-gastric nerves in their course through the thorax, pass behind the roots of the lungs, close to the bronchi, where they present an open plexiform appearance, and send off the pulmonary and œsophageal nerves. The *pulmonary branches* arise from each vagus a little above the root of each lung; a few of these branches pass to the forepart of the bronchial tubes, and form there a small plexus termed the *anterior pulmonary plexus;* this plexus communicates with the phrenic nerve, and sends its fine filaments along the pulmonary vessels to the lungs and pericardium; the greater number of these pulmonic branches pass behind the bronchial tubes to the posterior pulmonic plexus; near the root of the lung each vagus increases in size, its fibres divide, sub-divide, and re-unite in an areolar or plexiform manner, forming the *posterior pulmonic plexus;* this plexus is very large, lymphatic ganglia and vessels are entangled in it, and several branches from the sympathetic join it; its numerous filaments accompany the bronchial tubes closely through the substance of the lungs. Below the root of each lung the fibres of each vagus again approximate, and these nerves now become attached to the œsophagus, along which they descend to the stomach, the left on its anterior, the right (which entered the chest on a plane anterior to the left) on its posterior surface ; they frequently communicate with each other so as to encircle the œsophagus with a sort of plexus, which is named the *œsophageal plexus*, or *plexus gulæ*. On the stomach the right vagus, which is the largest, passes behind the cardiac orifice, to which it sends several small branches which unite with some from the left or anterior nerve; these form the cardiac plexus which encircles this part of the stomach; it then sends many long filaments to the muscular and mucous coats of the stomach, these communicate with the solar plexus, also with the splenic, hepatic and renal. The left or anterior vagus spreads its branches along the anterior surface of the stomach and the lesser curvature; several of these pass along the lesser omentum to the liver.

The Nervus Accessorius, or the third branch of the eighth pair; this nerve, in passing through the foramen lacerum, is closely connected to the vagus; below the base of the cranium it communicates with the eighth, ninth, and sympathetic nerves, passes behind the internal jugular vein, perforates the upper third of the sterno-mastoid muscle, to which it sends some filaments, it then communicates freely with the cervical plexus, is increased in size, and supplies the trapezius, &c. This is supposed to be a compound nerve.

IX. The Lingual Nerve, or the ninth, is a simple nerve, on escaping from the condyloid foramen it communicates with the eighth, the sympathetic, and the nervous arch or loop of the atlas; it is at first posterior to the vessels and nerves in this situation, it then descends along their outer side, soon turns forwards, and becomes superficial to them; it then takes the arched course of the digastric muscle across the neck, parallel but superficial to the lingual artery, and arriving at the side of the base of the tongue above the os hyoides, it passes above the mylo-hyoid muscle and lies on the middle constrictor and on the hyo-glossus, at the anterior edge of which it divides into several filaments; some of these plunge into the lingualis and genio-glossus muscles, others continue on to the point of the tongue, communicating with each other and supplying the muscular substance of this organ. As the lingual nerve is bending across the neck below the digastric tendon, it sends off a considerable branch, the *descendens colli*, or *noni;* this nerve frequently receives a filament from the pneumogastric; it descends along the forepart of the sheath of the carotid artery; about the middle of the neck it is joined by the internal descending branches of the cervical plexus, with which it forms a small triangular plexus, the branches of which pass to the omo and sterno-hyoid and thyroid muscles; on the latter some filaments descend into the chest. Near the os hyoides the lingual nerve sends some filaments to the constrictors of the pharynx and to the stylo-pharyngeus, also one to the thyreo-hyoid muscle; on the surface of the hyo-glossus it gives off several branches to the surrounding muscles, some also to communicate with the gustatory branch of the fifth pair; the lingual nerve then terminates chiefly in the genio-hyo-glossus muscle, and in the general muscular structure of the tongue, which organ it supplies with motor power.

SECTION II.

DISSECTION OF THE SPINAL NERVES.

There are eight cervical nerves, the first passes out above the atlas, and is named the sub-occipital, the eighth passes out above the first dorsal vertebra. All these nerves immediately outside the inter-vertebral foramina, divide into a posterior and an anterior branch; the posterior of each is smaller than the anterior, with the exception of the second cervical nerve, whose posterior branch is very considerable, as it not only supplies the adjacent muscles, but also accompanies the occipital artery and its ramifications in the scalp; the posterior branches of the other cervical nerves are small, they all communicate with each other, and are distributed to the integuments and muscles on the back part of the neck. The anterior branch of the first or the *sub-occipital* passes forwards above the transverse process of the atlas, and supplies the adjoining small recti muscles, then descends before the atlas, and unites with the anterior division of the second cervical, so as to encircle the transverse process of that bone with a nervous loop; in this course the sub-occipital is united by branches to the eighth and ninth, and to the superior ganglion of the sympathetic nerve; with the latter nerve the anterior branches of all the spinal nerves regularly communicate. The anterior branch of the second having received that from the first, descends and joins the anterior division of the third, this in like manner is connected to the fourth; these anastomoses between the anterior branches of the four superior cervical nerves constitute the cervical plexus; the anterior branches of the four inferior cervical are much larger than those of the superior; they are united in like manner to each other, and to the anterior branch of the first dorsal, and constitute the brachial plexus; these two plexuses and their branches the student may next dissect.

The CERVICAL PLEXUS is formed by the anterior branches of the four superior cervical nerves, which join each other in arches, from the convexities of which, branches arise that again join in a similar manner; a quantity of cellular membrane is entangled in the areolæ between these; this plexus is situated on the side of the neck, on a level with the second, third, and fourth vertebræ, between the sterno-mastoid and trapezius muscles; it sends off several branches which may be classed into ascending and descending; the former consist of superficial and deep, the latter of internal and external; the ascending superficial branches are two or three in number, they ascend obliquely forwards over the sterno-mastoid muscle, supply the platysma and integuments over the parotid gland, also on the ear and on the side and back part of the head, and communicate freely with the portio dura of the seventh pair of nerves; one of these is much larger than the others, is named *superficialis* or *ascendens colli*, it may be traced chiefly from the third cervical, and is lost near the ear and in the parotid gland; this nerve accompanies the external jugular vein. The deep ascending branches of the plexus are small nerves which supply the sterno-mastoid, digastric, splenius and adjacent muscles, and communicate with the neighbouring nerves. The descending branches are internal and external, the internal are two, a superficial and a deep; the superficial internal descending branch joins the descendens noni, and assists it in supplying the superficial muscles on the forepart of the neck. The deep internal descending branch is the *phrenic nerve:* this arises from the lower part of the plexus, chiefly from the fourth cervical, it has also in general a filament or two from the brachial plexus, [and a root from the third cervical nerve;] the phrenic nerve, or, as it is also named, the internal respiratory nerve descends obliquely inwards, on the anterior scalenus muscle.

[At the junction of its roots from the third and fourth cervical nerves, it is at the outer edge of the scalenus muscle which it crosses obliquely, so as to enter the thorax at the inner edge of the muscle.]

At the lower part of the neck it communicates with the lower cervical ganglion, and often with the vagus or its recurrent, it then enters the thorax between the subclavian vein and artery, and descends to the diaphragm on the side of the pericardium between it and the pleura; the right phrenic is nearly perpendicular, the left takes an oblique course round the apex of the heart, it is therefore longer and lies more posterior than the right. On the diaphragm these nerves divide into several branches, some of which ramify on the superior surface of that muscle, others on its inferior accompanying the phrenic vessels. These branches on the right side send some filaments to the inferior vena cava and to the liver, and unite with the nerves of this organ and with those of the stomach; on the left side the phrenic nerve sends some filaments to the œsophagus and stomach, these communicate with the vagus and solar plexus. The external descending branches of the cervical plexus are numerous, some are superficial, others deep, the superficial descend to the clavicle and acromion process, supply the superficial muscles in their course, and terminate in the pectoral and deltoid muscles and in the integuments; the deep branches descend behind the clavicle, supply the deep muscles on the side of the neck and those connected to the scapula; one of these branches is remarkable for its length, it is of the same size as the phrenic, and is named the *external respiratory nerve* of the trunk; this nerve proceeds from the back part of the plexus, chiefly from the fourth cervical, it has also filaments connecting it to the third and second, and to the phrenic, it descends behind the scaleni muscles and beneath the trapezius and levator anguli scapulæ, and is almost exclusively distributed to the serratus magnus muscle.

The Brachial [or Axillary] Plexus is formed by the junction of the anterior branches of the fifth, sixth, seventh, and eighth cervical, and of the first dorsal; this plexus is broad and flat, the nerves forming it are very large, particularly the inferior; it is situated at the inferior and lateral part of the neck, between the scaleni muscles and above the subclavian artery, it then descends obliquely outwards beneath the clavicle and subclavian muscle and over the first rib, into the axilla, where it rests on the serratus magnus behind the axillary artery and vein. The fifth and sixth cervical unite first, the seventh cervical runs alone for some distance, the eighth cervical and first dorsal unite immediately, so that, at first, this plexus consists of three roots, these however soon unite; in the axilla they again separate and interlace [so as to surround the axillary artery like a braid,] and finally subdivide into the following branches, the thoracic, supra and sub-scapular, the internal and external cutaneous, the median, ulnar, musculo-spiral and circumflex.

1st. The *thoracic branches* arise principally from the upper part of the plexus, they are four or five in number, and divide into anterior and posterior; the former descend behind the clavicle in front of the axillary artery, subdivide into branches which accompany the thoracic arteries, supply the pectoral muscles, and communicate with cutaneous branches from the intercostal nerves; the posterior thoracic nerves descend behind the vessels to the serratus magnus, posterior scalenus and rhomboid muscles.

2nd. The *supra-scapular nerve* arises from the upper division of the plexus, descends obliquely backwards, parallel to the omo-hyoid muscle, to the superior costa of the scapula, and passes beneath the posterior ligament which converts the notch in this part of the bone into a foramen; it then gives off a considerable branch to the supra-spinatus muscle, and proceeds beneath the acromion process and behind the neck of the scapula to the infra-spinous fossa, where it is distributed to the infra-spinatus and teres minor muscles.

3rd. The *sub-scapular nerves* are three or four in number, they arise from different parts, but chiefly from the upper division of the plexus, they descend behind the vessels, and ramify in the sub-scapular, latissimus dorsi, and teres major muscles.

4th. *Internal cutaneous nerve* is a long but delicate nerve, it arises out of the lower division of the plexus, descends nearly perpendicularly along the inner side of the arm, at first covered by the brachial aponeurosis, near the elbow it becomes cutaneous, and runs parallel to the basilic vein, and divides into two branches, an external and internal; the external passes along the border of the biceps over the bend of the elbow to the fore arm, where it divides into several filaments, some of which descend in the integuments as low as the wrist, and communicate with the other cutaneous nerves; this branch generally crosses the median basilic vein, in some it lies superficial to it, in others behind it; the internal branch descends towards the internal condyle, and divides into several filaments, some of which descend along the inner, and others along the posterior part of the fore arm, they all terminate in the integuments.

5th. *External cutaneous nerve*, or *musculo-cutaneous* or *perforans Casserii*, is larger than the last, and arises from the upper division of the plexus, it descends obliquely outwards, through the fibres of the coraco-brachialis, and between the brachialis anticus and the biceps, it then descends along the outer border of the latter to the bend of the elbow, pierces the aponeurosis, becomes cutaneous, and descends along the radial side of the fore arm to the wrist; in the arm this nerve gives muscular branches to the coraco-brachialis, biceps, and brachialis anticus, in the latter muscle it frequently communicates with the median nerve. At the elbow this nerve is situated between the biceps and supinator longus, and behind the cephalic vein, along the fore arm it accompanies this vein, and is often superficial to it; near the wrist this nerve divides into an anterior and posterior branch, the former passes to the ball of the thumb and palm of the hand, the latter to its dorsum.

6th. *Median* or *brachial nerve* is the largest branch of the plexus, it generally arises by two roots, a small external one, which is in common with the external cutaneous from the upper part of the plexus, and a large internal one from the lower division of the plexus; the brachial artery in general separates these two roots, which soon unite into one thick cord.

[I have seen one specimen, in which the first root above described, came off as usual, but the second came off by two fasciculi, which soon united to form a single trunk, after which the two roots extended down the arm about three inches, and then united over the brachial artery, so as to form the median nerve.]

It descends obliquely outwards along the inner edge of the biceps, as far as the bend of the elbow, and in this part of its course it is covered only by the skin and fascia, situated rather to the outer side of the artery above, crossing over it about the middle of the arm, and to its ulnar side below; at the bend of the elbow it passes deep between the supinator longus and pronator teres, and on the brachialis anticus perforates the pronator, and then descends along the middle of the fore arm, between the superficial and deep flexors, passes beneath the annular ligament of the carpus, where its size is increased, and terminates in the palm of the hand by dividing into five branches. In the arm the median nerve gives but few branches, these are small and unimportant; in the fore arm it sends several considerable branches to the superficial and deep pronators and flexors, but not to the supinators, a little below the elbow it also gives off the anterior inter-osseal nerve, this accompanies the artery of the same name, along the anterior surface of the inter-osseous membrane, and supplies the deep flexors; at the pronator quadratus it divides into two branches, one to supply that muscle, the other traverses the inter-osseous space, and is lost on the dorsum of the carpus and metacarpus: a little above the wrist, the median nerve gives off a superficial branch, which passes over the annular ligament, and is lost in the integuments. In the palm of the hand, the median nerve divides into five digital branches, the two first pass one along either side of the thumb, the third goes to the radial side of the index finger, the fourth supplies the opposed sides of the index and middle finger, and the fifth, which is joined by a small branch from the ulnar nerve, supplies the opposed sides of the middle and ring fingers; these digital branches in the palm of the hand are superficial to the tendons, and form an arch nearly parallel to that formed by the ulnar artery, the branches of the latter and digital nerves then run together to the extremity of each finger; in this course they supply the lumbricales, the integuments of the hand and fingers, and near the last phalanx of each; the nerves, enlarge, become red and soft, and divide into numerous fine branches, which are lost in the papillæ of the cutis.

7th. *Ulnar nerve* arises from the lower part of the plexus, descends obliquely backwards along the triceps, and behind the elbow joint, through the groove between the inner condyle and the olecranon process; it then passes forwards, and descends along the ulnar side of the fore arm to the carpus, and passing over the annular ligament close to the pisiform bone, ends in the palm of the hand, in two branches, a superficial and a deep. In the arm this nerve is superficial, and gives off a few branches to the triceps and to the skin; in the fore arm it lies on the flexor profundus, and between the flexor sublimis and ulnaris; to these muscles, particularly the latter, it sends several filaments; a little above the wrist it gives off the dorsalis carpi ulnaris, a large branch which winds round the ulna to the back of the hand, and divides into several long branches which are lost in the integuments of that region and of the three inner fingers, and anastomose with the radial branch of the musculo-spiral nerve. Of the terminating branches of the ulnar nerve, the superficial is the larger, it divides into three branches, which supply the muscles and both sides of the little finger, also the ulnar side of the ring finger; the deep palmar branch passes beneath the flexor tendons, runs across the metacarpus, and assists in forming a deep palmar arch, the branches of which are lost in the interossei muscles.

8th. *Musculo-spiral nerve*, is a very large nerve, it proceeds from the middle and lower divisions of the plexus, descends obliquely backwards and outwards between the three portions of the triceps, round the humerus to its external side, it then turns obliquely forwards and downwards towards the elbow, between the supinator longus and the brachialis anticus, and there divides into two branches, an anterior or radial branch, and a posterior or interosseal branch. In its course down the arm this nerve sends several branches to the triceps, a little above the outer condyle it gives off a large cutaneous branch [*ramus superficialis dorsalis*] which branch descends along the radial side of the fore arm to the thumb: at the bend of the elbow this nerve sends several branches to the long and short supinators, also to the extensors of the carpus; on the surface of the supinator brevis it expands and divides into its terminating branches; the *anterior* or the *radial nerve* [*or ramus superficialis anterior*] descends along the inner side of the supinator longus, which it supplies, and external to the radial artery; about the middle of the fore arm or a little lower, this nerve passes behind the tendon of the supinator longus, and becoming cutaneous descends behind the radius to the back of the hand, where it divides into two considerable branches, one for the integuments of the thumb, the other expands on the dorsum of the hand and supplies the index and middle fingers, and communicates with the dorsalis ulnaris nerve. The *deep* branch of the musculo-spiral nerve or the *posterior inter-osseal nerve*, [*or ramus profundus dorsalis*] winds backwards round the upper part of the radius and the supinator brevis, it then descends along the back part of the fore arm, with the posterior inter-osseal artery, and divides into several branches superficial and deep, which supply the two layers of extensor muscles.

9th. *Circumflex or articular nerve*, arises from the lower part of the plexus, descends round the lower edge of the sub-scapular muscle, and passing backwards and outwards, leaves the axilla by a large opening between the humerus and the long head of the triceps, above the tendons of the latissimus dorsi and teres major muscles, and below the capsular ligament of the shoulder joint, it then winds round the neck of the humerus, attached to the internal surface of the deltoid; in this course the nerve sends some small branches to the sub-scapular and the adjacent muscles, it then divides into two branches, a superior and inferior, both of which encircle the neck of the humerus and send their numerous sub-divisions into the deltoid muscle.

The Dorsal Nerves are twelve in number, the first pair passes between the two first dorsal vertebræ, and the last pair below the last dorsal vertebra, they also all divide into a posterior and an anterior or intercostal branch; the posterior branches are small, pass backwards between the transverse processes, and supply the muscles and integuments of the back and loins; of the anterior branches that of the first dorsal is largest, it rises above the neck of the first rib, and joins the last cervical nerve in the brachial plexus: the anterior branches of the second and third are smaller, they proceed backwards and outwards between the corresponding ribs, and covered internally by the pleura; at the angle of each rib they pass between the intercostal muscles, run along the groove in the lower edge of each rib, supply the surrounding muscles, and opposite the axilla each sends a filament across this cavity to the integuments on the inner and back part of the arm; these filaments are named the *nerves of Wrisberg*, or the cutaneous nerves of the arm; these two intercostal or spinal nerves then continue on in their course below the first and second ribs, and ultimately end in small cutaneous and muscular branches, which are lost on the lateral and forepart of the thorax; the anterior or intercostal branches of the remaining nine dorsal nerves all pass in a similar manner between the ribs, and supply not only the intercostal but also the adjacent muscles; the two last are chiefly distributed to the abdominal muscles and to the diaphragm; the twelfth dorsal sends a branch close to the vertebræ to join the first lumbar; all these anterior branches of the dorsal nerves opposite the neck of each rib are connected by one or two short branches to the ganglions of the sympathetic.

Lumbar Nerves; of these there are five pair, they are larger than the dorsal, like them they divide into posterior and anterior branches; the posterior are distributed to the lumbar muscles; the anterior branches unite with each other in the substance of the psoas [magnus muscle] and form the *lumbar plexus;* this long and somewhat triangular plexus is situated along the sides of the four inferior lumbar vertebræ: it communicates above with the last dorsal and below with the first sacral, and divides into the following branches; inguino-cutaneous, anterior crural, obturator and lumbo-sacral. The *inguino-cutaneous* are generally three in number; they descend from the two first lumbar nerves, pass through the psoas, and descend behind the peritonæum; the *first* or the *external* descends obliquely outwards over the quadratus lumborum muscle and behind the kidney, to the middle of the crest of the ilium, it then sends several branches to the abdominal muscles, and divides into a cutaneous branch which passes to the integuments on the outer part of the thigh and into the external spermatic nerve which passes beneath the internal oblique muscle, attaches itself to the spermatic cord, and distributes its branches to the cremaster muscle and to the scrotum, in the male, or to the round ligament and labium, in the female; the *second*, or the *middle inguino-cutaneous*, descends internal to the last, pierces the abdominal muscles close to the anterior superior spine of the ilium, and is distributed to the skin on the outer part of the thigh; the *third*, or *internal in-*

guino-cutaneous, descend internal to the last, and divides near Poupart's ligament into two branches; one accompanies the supermatic vessels and is lost on the cord, the other follows the crural vessels and is lost in the integuments and glands of the groin. The *anterior crural nerve* arises in the lumbar plexus from the four superior nerves; it perforates the psoas, descends obliquely outwards along its external side, on the iliacus internus, covered by the iliac fascia, and passes beneath Poupart's ligament [at from a quarter to] half an inch external to the femoral artery; it is then covered by the fascia lata, becomes flat and broad, and divides into two fasciculi, a superficial and a deep; the superficial separates into four or five long branches which pierce the fascia lata and descend along the inner and forepart of the thigh to the knee, some of these accompany the saphena vein.

[Of these branches the four principal are the *cutaneus externus*, the *cutaneus medius*, *the cutaneus anterior*, and the *cutaneus internus*. The first is distributed to the integuments over the vastus externus and rectus muscles, as far as the patella; the second perforates the sartorius, near the inner edge of the rectus muscle, to the integuments over which it is distributed; the third is internal to the last, crosses the sartorius below it, and is distributed to the integuments over the vastus internus as far as the patella; the fourth is still more internal, and is distributed to the integuments over the adductor muscles, at the fore and inner part of the thigh, some of its filaments reach the knee.]

The deep fasciculus is larger, it immediately divides into numerous muscular branches, which supply the muscles on the outer and forepart of the thigh; they are divided into the external and internal branches, the former supply the vastus externus, rectus, iliacus internus, and tensor vaginæ muscles; the internal supply the sartorius, vastus internus, and cruræus; three or four accompany the femoral artery near to the knee; two or three of these pass into the adjoining muscles, and one, the *internal saphenus nerve*, continues to descend to the inner side of the knee between the tendons of the gracilis and sartorius; it then becomes attached to the saphena vein, and twines round this vessel as far as the inner side of the foot; in this course it gives numerous filaments to the integuments of the leg. The *obturator nerve* is smaller than the preceding, it arises chiefly from the third lumbar, it perforates the psoas, and descends obliquely inwards along the inner side of that muscle to the obturator foramen, through the upper part of which it escapes into the groin, where it is covered by the pectinæus, and where it divides into its two branches an anterior and posterior, having previously sent some twigs to the obturator internus; the anterior branch is lost in the adductor brevis, pectinæus, and vastus internus, and communicates with the anterior crural; the posterior branch supplies the gracilis the adductor magnus, and longus. The *lumbo-sacral nerve* proceeds from the fourth and fifth lumbar nerves into the pelvis, and soon divides into two branches, the superior glutæal, and the communicating; the *glutæal* escapes through the upper part of the sciatic notch, and is distributed to the glutæus medius and minimus muscles along with the branches of the glutæal artery; the *communicating* branch joins the first of the following nerves in the sacral or sciatic plexus.

The SACRAL NERVES are five pair, [sometimes six,] they divide within the spinal canal into their anterior and posterior branches, the latter, very small, pass through the posterior sacral holes and supply the muscles and integuments: the anterior branches are very large, particularly the three superior, the two last are much smaller; these five nerves, with the branch from the last lumbar, form the *sacral plexus*, large and flat, placed on the sacrum and pyriform muscle behind the rectum, and the other pelvic viscera, it sends off the following branches both internal and external; the internal or pelvic are the hæmorrhoidal and vesical, and in the female the uterine and the vaginal; the external branches are the inferior or lesser sciatic, the inferior glutæal, posterior cutaneous, pudic, and great sciatic or posterior crural. All these escape by the lower part of the great sciatic notch, below the pyriform muscle. The *hæmorrhoidal, vesical, uterine* and *vaginal* branches are all small nerves which arise from the upper part of the plexus, are entangled with accompanying vessels, and interlace with each other; they are distributed to the different pelvic viscera, as their names imply. The *lesser sciatic nerve* escapes from the pelvis with the sciatic artery, it then passes downwards to the space between the tuber ischii and trochanter major, but nearer to the former, round which it twines, and at its lower part divides into two sets of branches, a superficial and a deep; the former pass over the hamstring muscles with the posterior cutaneous nerve, and are lost in these muscles; and the latter pass under the muscles and are distributed to the quadratus femoris, upper part of the adductor magnus muscles, &c. and some go to the hip joint. *The inferior glutæal nerve* leaves the pelvis below the pyriform muscle, and divides at once into several branches, which are principally distributed to the glutæus maximus, some also pass to the perinæum and to the inner side of the thigh. The *posterior cutaneous nerve* of the thigh arises in common with the preceding from the second and third sacral nerves, escapes from the pelvis below the pyriform muscle, becomes cutaneous, and descends along the back part of the thigh and leg, and communicates with the cutaneous nerves in the latter region. The *pudic nerve* arises from the third and fourth sacral, passes through the great sciatic notch internal to the preceding; it then re-enters the pelvis by the lesser sciatic notch, and passing upwards and forwards along the internal surface of the tuber ischii towards the pubis, it divides into two branches, an inferior and superior; the inferior, [*the long inferior pudendal nerve*] ascends obliquely forwards and inwards along the ramus of the ischium to the perinæum, and is distributed to the muscles and integuments in that region, also to the scrotum; the superior branch [*the long superior pudendal nerve*] continues its course along the ramus of the pubis nearly to the symphysis, it then passes forwards along the dorsum of the penis, increases in size as it approaches the glans penis, in the subcutaneous cellular tissue of which it terminates; in the female the inferior branch of the pudic nerve supplies the labium, the superior, the clitoris.

The *great sciatic* or *posterior crural nerve* is the principal branch of the sacral plexus, and the largest nerve in the body; it proceeds from the four superior sacral nerves, escapes from the pelvis below the pyriform muscle, sometimes through it, it then descends along the back of the thigh over the gemelli, quadratus, and adductor magnus as far as the ham, where it divides into the external and internal popliteal nerves; in this course this nerve is covered superiorly by the glutæus maximus and the hamstring muscles, inferiorly by the fascia lata and the integuments.

[The sciatic nerve sometimes comes out from the pelvis in two trunks, one of these emerges beneath the pyriform muscle, the other perforates the substance of that muscle: they then descend separately, and one becomes the external, the other the internal popliteal nerve.]

The sciatic nerve sends off several cutaneous and muscular branches, the latter supply the hamstring muscles, the gracilis, and the adductor magnus. The *external popliteal*, or the *peronæal nerve*, descends obliquely outwards along with the biceps tendon to the external condyle of the femur, it then turns forwards through the peronæus longus, round the neck of the fibula, and divides into two branches, the musculo-cutaneous [or external peronæal] and anterior tibial; the peronæal nerve, before it arrives at the head of the fibula, sends off two long branches, termed the peroneo-cutaneous nerves of the leg.

[Of these, one, the internal peroneo-cutaneous, descends behind the gastrocnemius muscle, to below the middle of the leg, when it unites with the external saphenus, or communicans tibiæ a branch of the posterior tibial. The other, the external peroneo-cutaneous, is distributed to the integuments along the fibula.]

The musculo-cutaneous nerve descends between the peronæus longus and extensor digitorum longus; to these and to the short peronæi muscles it sends several muscular branches; about the middle of the leg, it perforates the fascia, and a little above the outer malleolus it divides into the internal and external tarsal nerves or dorsal nerves of the foot; the internal is distributed to the integuments of the first and second toes, and communicates with the internal saphenus nerve and with the anterior tibial; the external supplies the integuments on the three outer toes, and communicates with the internal branch and with the external saphenus nerve. The *anterior tibial nerve* descends obliquely forwards along with the anterior tibial artery between the tibialis anticus and the extensor digitorum longus and extensor pollicis, which muscles it supplies; it also sends branches through the fascia to the integuments; it then passes beneath the annular ligament of the tarsus, and runs to the inter-osseous muscle between the two first metatarsal bones; on the foot it sends a large branch to the extensor digitorum brevis, also several cutaneous and communicating filaments, and it terminates by supplying the first inter-osseal muscle and the integuments of the two internal toes; in the first inter-osseal space a small branch communicates with the plantar nerves. The *internal popliteal* or *posterior tibial nerve* is larger than the preceding; it descends nearly vertically between the heads of the gastrocnemius and solæus muscles, and behind the articulation of the knee and the poplitæus muscle; it then descends obliquely inwards beneath the solæus and on the tibialis posticus and flexor digitorum longus, to the arch beneath the heel and the internal ankle; it here divides into the internal and external plantar nerves. In the ham a quantity of fat separates this nerve from the popliteal vessels; below the knee it becomes more closely connected to them, lying superficial and a little to their inner or tibial side; at the lower edge of the poplitæus it passes to the outer or fibular side of the posterior tibial artery, and descends in that relation to this vessel as far as the internal malleolar region. The posterior tibial nerve above the knee gives off a small nerve, the posterior or external saphenus; this descends along the back of the leg, at first covered by the fascia, afterwards it is subcutaneous; it communicates superiorly with filaments from the cutaneous branch of the sciatic plexus and with the external cutaneous branches of the peronæal nerve; about the middle of the leg it is increased in size [by uniting with the internal peroneo-cutaneous nerve,] and accompanies the external saphena vein to the external malleolus, behind which it passes; it then curves forwards along the outer edge of the foot, communicating with the external dorsal nerves of the foot, and supplying the integuments and muscles on the outer side of this region. In the ham, the posterior tibial nerve gives off several very large muscular branches to the gastrocnemius, solæus, and plantaris; and in its course down the leg several smaller branches to the deep-seated muscles; it also sends numerous filaments around the artery; some very small twigs pass through the inter-osseous space along with the anterior tibial artery and join the anterior tibial nerve. The *internal plantar nerve* is larger than the external; it passes forwards along the inner side of the tarsus above the abductor pollicis, sends many branches to the plantar muscles and to the integuments, and arriving near the base of the great toe, divides into four digital branches; the first runs along the tibial side of the first toe; the second subdivides and supplies the opposed sides of the first and second toes; the third, in like manner, the second and third toes; and the fourth the opposed sides of the third and fourth toes: these digital nerves also supply the lumbricales, and communicate with the dorsal nerves of the foot. The *external plantar nerve* passes forwards and outwards above the flexor brevis to the fifth metatarsal bone, and divides into two branches; one, the superficial, supplies the little toe and the outer side of the fourth; the deep branch passes obliquely inwards across the metatarsus, and supplies the inter-ossei and the other deep plantar muscles.

SECTION III.

DISSECTION OF THE GANGLIONIC SYSTEM, OR GREAT SYMPATHETIC NERVES.

In addition to the small ganglions already noticed in the description of the cerebral nerves, viz. the lenticular or ophthalmic, the spheno-palatine, or Meckel's, and the submaxillary, also the several ganglions on the spinal nerves, we find one continued chain of these bodies placed anterior to the vertebral column on either side of the median line; these ganglions, on each side, are all connected to each other, and resemble a knotted cord; this cord receives the name of the sympathetic nerve.

The SYMPATHETIC NERVES, therefore, are two in number; they descend from the base of the cranium perpendicularly along the neck, placed on the rectus capitis and longus colli muscles, and behind the great vessels and nerves; at the upper end of the chest each of these nerves is divided by the subclavian artery into several branches, which encircle that vessel and unite below it in the thorax; through this cavity they descend at first obliquely backwards and outwards along the heads of the ribs and covered by the pleura; they then incline a little forwards, and pass behind the true ligamentum arcuatum into the abdomen; through this region they descend obliquely outwards on the fore part of the lumbar vertebræ and between the psoas muscle and the crus of the diaphragm; they then sink into the pelvis, keeping close to the sacrum, and descend along the anterior surface of this bone obliquely inwards; near its inferior extremity, or on the first part of the coccyx, these nerves unite and terminate in a small ganglion named coccygeal ganglion or ganglion impar. The superior extremity of each sympathetic nerve is connected by several filaments to several of the cerebral nerves; some of these connexions have been improperly termed the origin of the sympathetic; in their course along the spinal column each nerve regularly communicates with every pair of the spinal nerves, with each of the cervical nerves by one filament, and with each of the dorsal, lumbar, and sacral nerves by two; the sympathetic nerves may either be considered as independent parts of the nervous system communicating by numerous branches with every portion of that system, or they may each be regarded as a nervous cord formed by the union of branches from all the spinal and from several of the cerebral nerves; the latter is probably the more correct view. The sympathetic nerves send off numerous branches, which are chiefly destined to supply the heart and the coats of the great vessels and all the pelvic and abdominal viscera; these branches arise from the ganglions on these nerves; of these there are generally three in the neck; in the back and loins they correspond with the number of vertebræ in those regions, and in the pelvis there are three on each side and the coccygeal or impar ganglion below; these ganglions and their branches must be next examined.

The *Cervical Ganglions* are three, the superior, middle, and inferior; the *superior cervical ganglion* is of an oval figure and reddish colour, extending from the first to the third cervical vertebra, placed on the rectus capitis anticus, behind the carotid artery and jugular vein, and internal to the eighth and ninth cerebral nerves; this ganglion sends off several branches, viz. superior, inferior, internal, external, and anterior; the superior branches are two in number; they ascend in the carotid canal to the cavernous sinus, and communicate with the sixth, and with the vidian branch of the fifth; in this situation a plexus or rather a ganglion may be observed on the external surface of the artery; fine soft reddish filaments pass from this *cavernous* or *carotid ganglion* to the several nerves which compose the orbital plexus, but particularly to the filament of the nasal division of the ophthalmic which is destined to the lenticular ganglion, also to the Casserian ganglion of the fifth, and several continue attached to the carotid artery, and are lost on its cerebral branches and in the tissue of the brain, and its investing membrane. The inferior or descending branches of the superior ganglion are small filaments to join the laryngeal nerves and the vagus, the superior cardiac nerve, (to be described presently,) and the continued cord of the sympathetic itself. The internal branches unite with the pharyngeal plexus; the external join the superior cervical nerves, and the anterior unite with branches of the vagus and the facial, and form a plexus around the carotid artery; from this several branches extend along the external carotid, and form plexuses around each of its principal branches, which are named accordingly. The *middle cervical ganglion* is sometimes wanting, [as often as once in three cases, according to Meckel; Horner, however, has always found it, although sometimes very small.] It is smaller than the superior, of a triangular, often an irregular form, is situated behind the carotid near the curve of the inferior thyroid artery, opposite the fifth vertebra, and upon the longus colli muscle; it sends off branches in different directions which communicate with the cervical nerves and with the vagus; it also sends some filaments to join the cardiac nerves. The *inferior cervical ganglion* is of an irregular figure; it frequently appears to consist of several small ganglions connected to each other by reddish filaments; it is situated between the transverse process of the last cervical vertebra and the neck of the first rib, behind and on either side of the vertebral artery, and between the scalenus and longus colli muscles; filaments from it communicate with the phrenic nerve and with the brachial plexus; several also encircle the subclavian artery and extend along that trunk and its several branches, particularly along the vertebral artery; from it also the inferior cardiac nerves proceed. The student may next examine the *cardiac nerves;* there are three on each side, they are named superior, middle, and inferior; the *superior* cardiac nerve, though very small, takes a long course; it arises by two or three filaments from the superior cervical ganglion, descends along the side of the trachea behind the carotid artery to the chest; in this course it communicates with the laryngeal nerves, with the vagus, and with the inferior and middle ganglions of the sympathetic; there is sometimes a small ganglion upon it near the inferior thyroid artery; at the lower part of the neck it passes behind the subclavian vein and over the arteria innominata; it here divides into several filaments; some pass along the coats of that vessel to the aorta, others join the recurrent nerve and the middle and inferior cardiac nerves; the superior cardiac nerve on the left side has a similar origin and course in the neck, but it enters the chest in a deeper situation than the nerve of the right side; it descends between the left carotid and subclavian arteries, and arriving at the arch of the aorta, divides into branches, some of which pass behind that vessel and join the cardiac ganglion; others unite with the cardiac nerves from the sympathetic, or from the vagus and recurrent. The *middle* cardiac nerve on the right side is generally the largest of the cardiac nerves; on the left side it is sometimes wanting, the inferior in such a case will be of a greater size; it arises by several filaments from the middle cervical ganglion or from the sympathetic nerve about the middle of the neck; it descends either a single cord, or divided into several parallel filaments behind and internal to the carotid, and enters the thorax anterior to the subclavian artery; it here is joined by large branches from the vagus and recurrent nerves, it then descends obliquely inwards along the side of the arteria innominata, glides between the arch of the aorta and the division of the trachea, and terminates in the cardiac ganglion or plexus. On the left side the middle cardiac nerve sometimes arises from the inferior cervical ganglion; it enters the chest along the subclavian artery, and either joins the inferior cardiac nerve or enters the cardiac plexus. The *inferior* cardiac nerve or nerves proceed from the inferior cervical ganglion, and on the right side descend along the arteria innominata to the arch of the aorto, round which they pass to its forepart, and terminate principally in the anterior cardiac plexus; some branches pass between the aorta and pulmonary artery to the cardiac ganglion; these inferior cardiac nerves communicate with the preceding, and with the vagus and its recurrent; they form an irregular network or plexus in their course to the aorta; on the left side these nerves accompany the subclavian artery and partly join the middle cardiac nerve, and partly the cardiac plexus.

The *cardiac plexus* is situated behind the ascending aorta near its origin, and in front of the trachea and of the right pulmonary artery; it consists of a plexus of nerves formed by the cardiac nerves from opposite sides, also by branches from the eighth pair and the recurrent nerves; in the meshes of this plexus several small ganglions are enclosed, and to the aggregate of these the term *cardiac ganglion* is applied; this, which is of a greyish colour and irregular form, receives superiorly and laterally the middle cardiac nerves from each side, also some filaments from the superior cardiac, particularly on the left side, and also some from the inferior cardiac, particularly on the right side; the greater portion of the right superior cardiac joins the middle cardiac before the latter arrives at the plexus, and the inferior is chiefly distributed on the fore part of the aorta to the anterior cardiac plexus. From the great cardiac plexus branches proceed in various directions; some pass backwards, encircling the posterior coronary artery, and forming a plexus around it, and accompanying its branches into the substance of the heart, others pass forwards round the aorta, from the anterior cardiac plexus on it and on the right pulmonary artery, and vena cava; from this plexus branches descend over the right auricle, accompany the anterior coronary artery, and form plexuses around it and its several branches; from this ganglion also numerous nerves descend on either side along the pulmonary vessels, and communicate with the pulmonary plexus; on the left side these branches encircle the ductus arteriosus.

The sympathetic nerves in the thorax have twelve ganglions on each side, sometimes only eleven, the last cervical and first dorsal being then united; each of the *thoracic ganglions* is small and triangular, the base towards the spine, the apex externally, covered by the pleura and placed on the heads of the ribs; the first ganglion is the largest; they all communicate by one or two branches, which ascend obliquely outwards, with the anterior or intercostal branch of the spinal nerves; from the base or anterior edge of each ganglion small branches pass forwards to the mediastinum, ramify on the aorta and adjacent vessels, and communicate with the pulmonary plexus. From the six inferior ganglions the splanchnic nerves arise; these are two iu number on each side, the greater and lesser or upper and lower.

The *great splanchnic nerve* arises by four or five distinct roots from the sixth, seventh, eighth, ninth, and tenth ganglions, they descend obliquely forwards and unite on the tenth dorsal vertebra into one cord, which enters the abdomen either along with the aorta or separated from it by a fasciculus of the diaphragm; each nerve then expands into the semilunar ganglion. The *lesser splanchnic nerve* arises by two roots from the tenth and eleventh ganglions, they unite on the side of the last dorsal vertebra; this small nerve then enters the abdomen through the crus of the diaphragm external to the great splanchnic nerve, with which it communicates, and then ends [in two branches, one of which joins the great splanchnic nerve, while the other runs into the renal plexus.]

In the abdomen we find the semilunar and the lumbar ganglions on the sympathetic nerve of each side; the *semilunar* ganglion of each side is situated on the diaphragm, and partly on the aorta on either side of the cœliac axis, and above and behind the supra-renal capsule. These are the largest ganglions on the sympathetic, they communicate with each other by several filaments on which small ganglions are placed; this communication surrounds the cœliac axis, and is termed the *solar plexus;* this plexus is situated behind the stomach, in front of the aorta and above the pancreas; from it numerous nerves pass off in various directions; these nerves accompany the blood vessels, and form plexuses around each, which are named according to their destination, *hepatic*, *splenic*, and *gastric* [or *superior coronary;*] these plexuses communicate with the eighth pair; from the solar plexus, branches descend in front of the aorta; these subdivide at the renal and mesenteric arteries, accompany these vessels, form plexuses around each, which are named accordingly the *renal*, *superior*, and *inferior mesenteric* plexuses, into each of these, branches from the lumbar ganglions enter. The lesser splanchnic nerve enters the renal plexus; from which on each side descends the *spermatic* plexus, this in the male follows the spermatic vessels and supplies the testicle; in the female it enters the pelvis and supplies the ovarium and uterus. From the inferior mesenteric plexus branches descend to the edge of the pelvis, unite with others from the lumbar ganglions, and form a plexus around the internal iliac or hypogastric artery and its pelvic branches; this is termed the *hypogastric plexus;* it is joined by numerous filaments from the lumbar and sacral ganglions of the sympathetic, and it communicates with the pelvic branches of the sacral plexus.

The *lumbar* or *abdominal ganglions* of the sympathetic are five on each side, sometimes only four or three; they are situated on the anterior and lateral parts of the bodies of the vertebræ internal to the psoas muscle, are of an oval figure, but smaller than the cervical; each ganglion is connected by one or two communicating branches which pass through the psoas to the anterior branches of the spinal nerves;

from the fore part of each, several filaments pass in front of the aorta and assist in the formation of the different abdominal plexuses which are principally derived from the solar plexus.

The *sacral* or *pelvic ganglions* are three or four in number on each side; the first is oval, the remaining are of an irregular form: they each communicate with the sacral nerves and send filaments to the hypogastric and pelvic plexuses; from the last ganglion on each side a small branch passes inwards in front of the coccyx; these branches unite in the middle line and form a small plexus; sometimes a distinct ganglion (*ganglion impar*) is placed here: from the convexity of the arch which these branches form, filaments pass off to the coccygæi, levatores, and sphincter ani muscles.

CHAPTER IV.

ORGANS OF SENSE.

Under this head may be placed the anatomy of the nose, or the organ of smell; the tongue, or the organ of taste; the eye, or the organ of vision; and the ear, or the organ of hearing; to these may be added the integuments or the organs of touch.

SECTION I.

ANATOMY OF THE NOSE.

Several bones enter into the formation of this organ; these are all covered by a very delicate periosteum, which is almost inseparably united to the highly sensible lining mucous membrane; to the anterior part of the bones of the nose, the cartilages, which form the septum and alæ nasi, are attached. The nose is bounded, superiorly, by the nasal, frontal, ethmoid and sphenoid bones; the roof of the nose is arched, and has different aspects, the anterior part looks downwards and backwards, the middle perpendicularly downwards, and the posterior part downwards and forwards; the floor of the nose which is nearly horizontal, but with a slight inclination backwards, and concave in the transverse direction, is formed by the palatine plates of the maxillary and palate bones; the nose is bounded on either side by the superior maxillary, unguis, spongy, ethmoid and palate bones, and by the internal pterygoid plates. It is divided into two symmetrical portions (the nares) by the septum, which is composed of the azygos plate of the sphenoid, the nasal lamella of the ethmoid, the vomer, the spines of the palate and maxillary bones, and by a cartilage; the external wall of each naris is deeply grooved by three fossæ or meatuses, the superior, middle, and inferior, these are situated between the spongy bones, the middle is the widest. The nasal or lachrymal duct opens into the anterior third of the *inferior meatus*; the Eustachian tube opens behind, but on a level with the inferior spongy bone, and at the side of the septum anteriorly may be observed the superior orifice of the anterior palatine canal, which, although a distinct opening superiorly towards the cavity of the nose, yet inferiorly towards the mouth, forms with the one of the opposite side a common foramen; this communication, however, between the nose and mouth does not exist in the recent state in the human subject, but does so in some animals, and in these Jacobson has ascribed a peculiar office to it. Into the *middle meatus*, the antrum maxillare opens by a small oblique slit, which looks backwards and inwards, and although in the dry bone it appears tolerably large, yet in the recent state it admits only a crow quill on account of the mucous membrane being thrown into a small fold which surrounds it: in front of this is a groove, named the infundibulum, which leads from the frontal sinus, into this groove the anterior ethmoid cells open. Into the *upper meatus*, the posterior ethmoid cells and the sphenoid sinus open. Each naris opens posteriorly into the pharynx, above the velum, by an oblong oval opening; these are separated from each other by the vomer, the internal pterygoid plates bound them externally, the sphenoid above and the palate bones below.

To the anterior edge of each naris the cartilages composing the alæ nasi are attached, these are five in number, one in the centre, two at each side; the central cartilage is triangular and vertical, attached superiorly and posteriorly to the bony septum, its anterior edge is thick and sub-cutaneous, and attached on either side to the lateral cartilages; the lateral cartilages are two, one superior and triangular, attached to bone, the other inferior, and irregularly curved, convex externally, and attached to the preceding and to the septum; in the alæ nasi small pieces of cartilage also may be noticed distinct from the larger cartilages. All the internal surface of the nose and of the sinuses communicating with it, are lined by a soft, vascular, and highly sensible mucous membrane; this is the *pituitary* or *Schneiderian membrane;* this mucous membrane is continuous anteriorly with the integuments: it adheres to all the internal surface of the bones of the nose, lines the sinuses, is continuous through the nasal duct with the membrana conjunctiva of each orbit; round the lower extremity of each duct it forms a slight circular fold; and posteriorly it is continuous with the membrane of the pharynx and Eustachian tubes; this membrane adheres in some places inseparably to the periosteum, so as to deserve the name of a fibro-mucous membrane, in others it is villous, very vascular, soft and thick as on the septum and turbinated bones, and in these situations it and the submucous tissue are loose, cellular, or spongy, and probably possess some of the properties of erectile tissue: at the extremities of the latter it forms thick fleshy-looking folds or lips; in the sinuses it is pale and thin; it is constantly moistened with a mucous secretion, but mucous glands are not distinct in it. The olfactory or first pair of nerves are distributed to it on the septum and æthmoidal region in the form of numerous plexuses, it is also supplied very generally with branches from the ophthalmic and superior maxillary divisions of the fifth pair; the first pair are generally believed to endow the superior portion of this membrane with its peculiar sense or power of smelling; while its acute sense of touch depends on the fifth pair, the nerve of feeling for the head generally. Majendie, also, has recently made some experiments to prove that the branches of the fifth pair in the nose are very sensible to acid or pungent odours, in the same manner as the surface of the eye, and that so far they may be accessory to the function of this organ.

[The arterial distribution upon the lining membrane of the nose, is derived from the palatine, spheno-palatine, and infra-orbital branches of the internal maxillary artery; and from the anterior and posterior ethmoidal branches of the ophthalmic artery. The veins for the most part follow the course of the arteries.

The septum of the nose is sometimes inclined to the one side or the other, so as to divide the nares very unequally; sometimes the septum is deficient either in its bony or cartilaginous portion. In the museum of the college is a preparation, in which the anterior opening of the left naris, is very small, that of the right natural; posteriorly the nares are entirely cut off from the fauces, by a membrane, except on the right side, where there is an opening large enough to admit the end of the finger; no uvula is to be seen, and the malformation appears as though the velum had become adherent posteriorly, except at the opening referred to. A flexible bougie introduced into either of the anterior openings of the nose is easily carried down into the pharynx through the opening in the preternatural septum. This was probably a congenital malconformation, and it would have been a point of physiological interest, to have ascertained the condition of the sense of smell, but unfortunately it was a common dissecting room subject, and its history was unknown.

Another deformity which sometimes exists, is a deficiency of the bony septum, between the nose, and the mouth, or the cleft palate; this may occur either singly, or conjointly with hair lip; it may also be combined with a deficiency in the alveolar margin of the superior maxillary bone. There is a preparation in the college museum of the head of a negro, about forty years of age, in which the three defects above referred to were combined. In the first place there was a large hair lip, behind which was a fissure through the alveolar margin of the maxillary bone, behind which again, was a cleft through the palatal processes of the maxillary and palate bones, the vomer being reflected to the left side so that the left nostril is entirely separated from the mouth, while the right nostril and mouth form one cavity. Congenital deformity of the external nose is rare, but loss of substance from disease, sometimes occurs, for the cure of which deformity the rhinoplastic or taliacotian operations have been performed successfully. The spongy bones of the nose are sometimes destroyed by secondary syphilis. The lining membrane is the seat of acute and chronic inflammation and of hemorrhage or epistaxis. This membrane is also the seat of polypes, which occur at all ages, but most commonly in adults, and old people: they are of two kinds, malignant, and non-malignant; and are apt to recur after extirpation; they are also divided according to their structure, into gelatinous, fibrous, and vascular.]

SECTION II.

ORGAN OF TASTE.

The organ *af taste* resides in the mucous membrane of the tongue; this membrane is spread over the muscular substance of the tongue, adheres closely to it, and presents a number of projections or papillæ; the tongue is very vascular and is supplied with six nerves; the gustatory is distributed anteriorly and chiefly to the conical or erectile papillæ, also to two of the salivary glands on each side; the lingual to the inferior surface and to its muscular substance; the glosso-pharyngeal to the muscular substance and mucous membrane at its base; experiments have proved that the fifth nerve endows this organ with its peculiar sense, that of taste; and that the lingual or ninth is its motor nerve; the glosso-pharyngeal is probably a sentient nerve to the posterior part of the tongue, it may also connect this organ in sympathy with the stomach and the respiratory organs: the form and structure of the tongue have been already described under the anatomy of the mouth and pharynx, (see p. 39.)

SECTION III.

ANATOMY OF THE EAR.

THE parts composing this complicated organ may be divided into three classes; the first includes the external ear, or the cartilages and meatus externus; the second the tympanum with the Eustachian tube, ossicula auris with their muscles and nerves, the mastoid cells, the pyramid, promontory, &c.; the third, the labyrinth or internal ear, which includes the vestibule, semi-circular canals, cochlea, and meatus internus with the portio mollis.

[The muscles of the ear are arranged in three groups, the first group consists of three muscles, situated on the side of the head, and acting upon the external ear, so as to move it upon the head, these muscles are well developed and very active in the inferior animals. The second group consists of five muscles, is situated upon the auricle itself, and acts upon its different parts, so as to separate or approximate them; the muscles of this group are also better developed, and more active in the inferior animals, than in man. The third group consists of three muscles, some say of four, which are situated in the internal ear, and act upon the small bones of the ear so as to render the membrana tympani tense or relaxed as the case may be.

First Group, three Muscles.

Superior Auris, or Attollens, *Vide p.* 6.
Anterior Auris, or Attrahens,
Posterior Auris, or Retrahens, } *Vide p.* 7.

Second Group, five Muscles.

Tragicus,
Anti-Tragicus,
Helicis Major,
Helicis Minor,
Transversalis Auris, } *Vide p.* 356.

Third Group, three Muscles.

Stapedius,
Tensor Tympani,
Laxator Tympani, } *Vide p.* 358.

The auricle is united to the side of the head by three ligaments which lie directly behind the muscles, which move the auricle upon the head.]

The *external ear* consists of the pinna or auricle and the meatus externus; the *pinna* is composed of a thin fibro-cartilaginous plate, curved in different directions, so as to present different eminences and depressions; the convex edge which forms the outline of it is the *helix*, below this is a short semicircular fold, the *anti-helix*, this divides superiorly into two crura; the depression between these is the *fossa navicularis;* in front of the meatus is an eminence, the *tragus*, directed backwards over the meatus; opposite to this is a slight projection; the *anti-tragus;* within these several eminences is a deep conical cavity, the *concha*, which leads to the meatus externus, below this, is the pendulous fold of the integuments, or the *lobe* of the ear; these several eminences are supposed to be of use in protecting the internal parts, also in collecting and directing the sound towards the meatus. In some subjects pale muscular fibres may be found on these eminences, they have been named according to their situation, as distinct muscles, tragicus, anti-tragicus, major and minor helicis, and transversalis auris; these fibres may have some power in approximating these cartilages, and thus deepening the concha, they are seldom marked in the human subject, but in the lower classes of animals they are strong and distinct. The *meatus auditorius externus* extends from the concha to the membrana tympani, first forwards, upwards, and inwards, then downwards and inwards; it is therefore curved, or concave downwards, about an inch in length, one-half cartilaginous, the other osseous.

[In consequence of which when wishing to examine the bottom of the ear, the external ear must be drawn upwards, and backwards; the passage may also be distended in its cartilaginous portion by the use of the speculum auris; this canal is three lines in diameter.]

It is lined by the skin, beneath which are a number of ceruminous glands, it is also furnished with a number of fine hairs, which are longer and more obvious externally; the cuticle is continued also over the membrana tympani, from which it readily separates.

The *middle ear* consists of the tympanum and its appendages. The *membrana tympani* separates this cavity from the meatus externus, the latter must be cut vertically to expose this membrane; it is placed obliquely, its lower edge being more internal than the upper, or nearer the median line, it therefore looks downwards, outwards, and forwards; it is concave towards the meatus, convex towards the tympanum, being drawn in the latter direction by its connexion to the handle of the malleus; it consists of three layers, an external or cuticular, an internal or mucous, and a middle or fibrous, which is dry and elastic.

[On which in the elephant, Sir E. Home, found radiated muscular fibres.]

The *cavity of the tympanum* may be seen either by dividing the membrane just described, or without injuring the latter, the roof of the cavity may be broken or cut through at the lower and internal part of the squamous plate; this cavity is placed between the meatus externus and the labyrinth; it is of an irregular figure, rather circular; it presents on its internal side or wall a tubercular eminence, named the *promontory*, and two foramina, one above, the other below that eminence; the superior foramen, or *fenestra ovalis*, is closed by a membrane, to which the base of the stapes bone is attached, this opening communicates with the vestibule; the inferior or the *foramen rotundum* is also closed by a membrane, it communicates with the internal part of the cochlea or the scala tympani; the posterior wall of the tympanum presents superiorly the opening of a short canal, which leads to the mastoid cells, in this opening the short leg of the incus rests; these cells are of irregular form and differ in different subjects; beneath this is the *pyramid*, a small bony projection, hollow, containing the muscle of the stapes; beneath the pyramid is the small foramen leading from the aqueduct of Fallopius, and transmitting the corda tympani. The tympanum presents anteriorly the openings of two canals, one superior containing the tensor tympani muscle, the other, the inferior, is the *Eustachian tube;* this descends obliquely forwards and inwards, and terminates by a trumpet-shaped mouth, behind the posterior nares, on a level with the inferior spongy bone; this canal is small, and osseous posteriorly, anteriorly it is large and formed of membrane externally, and of a curved fibro-cartilage internally.

[It runs for six or eight lines in the petrous portion of the temporal bone, its entire length being about two inches, and its diameter a line and a half.]

It is lined by mucous membrane, which is prolonged from the pharynx into the tympanum; through this tube the atmosphere can pass from the fauces into the tympanum, to support the latter on its internal surface. In the superior boundary or wall of the tympanum are some small foramina for the passage of blood-vessels; its inferior boundary presents the glenoid fissure, through which pass the corda tympani, the tendon of the laxator tympani, and the processus gracilis of the malleus. Within the cavity of the tympanum are four small bones, first the malleus, attached to the membrana tympani, and resting on the second, the incus, one leg of which is connected to the third, the orbicular, which is articulated to the fourth, the stapes, which rests on the membrane of the fenestra ovalis, between which and the membrana tympani these bones form a connecting chain or spring, for the purpose of conveying the impressions of sound from the membrana tympani to the internal ear. The *malleus* is immediately behind the membrana tympani, it presents a head, neck, handle, a long and short process; the head is smooth and articulated behind with the incus, the neck is small, and gives origin anteriorly to the processus gracilis, which is about half an inch long, traverses the glenoid fissure, and gives attachment to the tendon of the laxator tympani muscle; the handle descends from the neck, adheres to the membrana tympani, and has a short process superiorly for the insertion of the tensor tympani muscle. The *incus* is internal and posterior to the malleus, presents a body, and a long and short crus; the body is directed forwards and upwards, and receives the head of the malleus, the superior crus is short, and lies in the foramen of the mastoid cells, the inferior long, and perpendicular, is articulated with the following;—The *os orbiculare*, extremely small, is between the incus and the following bone.

[In the adult subject it is very frequently fused into the incus, this sometimes occurs even in children.]

The *stapes* is placed horizontally, the base is on the fenestra ovalis, the head is articulated to the orbicular bone, the neck gives attachment to the stapedius muscle, the crura of the stirrup are separated by a space filled by membrane.

[There is a diarthrodial joint between the malleus and incus; but the other bones are connected by ligamentous tissue only.]

There are three muscles in the tympanum, viz. stapedius, tensor, and laxator tympani. *Stapedius arises* within the pyramid; its tendon is *inserted* into the neck of the stapes; its *use* is to raise the stapes, and to press its base against the fenestra ovalis. *Tensor tympani arises* in the canal in the petrous bone above the Eustachian tube, passes backwards into the tympanum, and is *inserted* into the short process below the neck of the malleus; *use* to draw the malleus into the tympanum, and thus to increase the concavity of the membrana tympani. *Laxator tympani arises* from the spinous process of the sphenoid bone, and from the Eustachian tube, ends in a delicate tendon which passes through the glenoid fissure along with the corda tympani, and is *in-*

serted into the processus gracilis of the malleus or the process of Raw. *Use*, to draw the malleus forwards, and thus to relax the membrana tympani.

The *labyrinth*, or the *internal ear*, consists of the vestibulum, cochlea, semicircular canals, and meatus internus, the cochlea is anterior, the canals are posterior. *Vestibulum* is a small elliptical cavity behind the cochlea and in front of the semicircular canals, the fenestra ovalis opens on its external side, the five orifices of the semicircular canals open superiorly and posteriorly, one opening from the cochlea is anteriorly, and posteriorly is the orifice of a small canal called the aqueduct of the vestibule, which opens on the posterior surface of the petrous bone, in a small cavity lined by dura mater, behind the meatus auditorius internus, and thus forms a communication between this cavity and the base of the cranium. A delicate but vascular membrane lines this cavity; it is filled by a peculiar fluid, and extends into the aqueduct of the vestibule. The *semicircular canals* are three in number, superior, posterior, and horizontal; the two first are vertical.

[Their diameter internally is half a line and that extremity of each, which is nearest the foramina ovale and rotundum, is enlarged, so as to constitute what is called the *ampulla*.]

They are surrounded by the petrous bone in front of the mastoid cells and behind the vestibule; the superior and posterior are joined by one end; there are, therefore, but five orifices of these canals in the vestibule; each of these tubes is lined by a vascular membrane filled with a fluid which communicates with that in the vestibule. The *cochlea* is in the anterior part of the petrous bone, is is somewhat conical, the base towards the meatus internus, the apex towards the carotid artery; the cochlea, internally, consists of a central pillar placed somewhat horizontally, named the modiolus, and of a spiral tube passing round this axis, two turns and a half; this tube is divided into two by a thin osseous and membranous plate, called lamina spiralis, and the two tubes are the scalæ of the cochlea; near the apex of the cochlea these scalæ communicate; near the base they separate; one, the scala vestibuli, communicates with the vestibule; the other, the scala tympani, with the tympanum through the fenestra rotunda; the modiolus is hollow and expanded towards the apex; this expansion is called the infundibulum; a branch of the auditory nerve passes through this cavity; the aqueduct of the cochlea terminates in a small slit-like opening on the inferior surface of the petrous bone, just before the foramen lacerum posterius. The *portio mollis* of the seventh pair of nerves descends along the meatus auditorius internus, divides into several fine branches, which are distributed to the membrane lining the vestibule, cochlea, and semicircular canals.

[The external ear is sometimes entirely wanting, sometimes the lobule alone is wanting, or it may exist, but adhere to the side of the head; the auditory canal is sometimes imperforate, sometimes obstructed by morbid growths, of which the polypus is most common. The membrane tympani is the seat of acute and chronic inflammation, which may go on to suppuration, ulceration, and the discharge of the bones of the ear, causing incurable deafness; these bones are sometimes wanting at birth. The eustachian tube is liable to congenital imperforation, or to accidental obstruction from various causes, the result is deafness, more or less complete. An instrument has been introduced into the pharyngeal extremity of this tube, for the purpose of clearing away obstructions; or to act on the principle of a bougie, dilating the passage, and thus curing deafness, by admitting air to the internal ear. Deafness is often caused, particularly in elderly persons, by an accumulation of wax upon the outer surface of the membrana tympani, and filling up the external passage. This is to be relieved by throwing in oil or tepid water so as to soften the wax, after which it may be readily removed.

The nerves of the ear are the auditory or portio mollis, the facial or portio dura, and the chorda tympani. The arteries of the ear, both external and internal, are derived principally from the posterior auricular, internal maxillary, and temporal branches, of the external carotid.]

SECTION IV.

ANATOMY OF THE EYE.

Under this head we shall examine not only the globe of the eye but its appendages; these are the eyelids, the lachrymal apparatus, and the muscles of the orbit: we shall commence with the latter.

The muscles of the orbit are seven in number, viz. the levator palpebræ superioris, the obliquus superior and inferior, and the four recti; to obtain a satisfactory view of these muscles, the roof and a considerable portion of the external side of the orbit must be removed; then the periosteum having been divided, the first muscle appears.

[The muscles which act upon the eye and its appendages, are eleven in number, and may be arranged in two groups, the one acting upon the appendages, and formed by five muscles, the other acting upon the ball of the eye itself, and formed by six muscles.

First Group, five Muscles.

Occipito Frontalis, Corrugator Supercilii, Levator Palpebræ Superioris, Orbicularis Palpebrarum, Tensor Tarsi,	*Vide p.* 361.

Second Group, six Muscles.

Superior Rectus, or Levator Oculi, Inferior Rectus, or Depressor Oculi, Internal Rectus, or Adductor Oculi, External Rectus, or Abductor Oculi,	" " 362.
Obliquus Superior, Obliquus Inferior,	" " 361.

The muscles of the first group are situated on the head, face, and in part, in the orbit: those of the second group are entirely within the orbit.]

Levator Palpebræ Superioris is the highest and longest muscle in the orbit; it *arises* narrow and tendinous from the upper edge of the foramen opticum, passes forwards and outwards beneath the frontal nerve, and becoming broader, bends down in front of the eye; it then ends in a dense cellular expansion which is *inserted* into the superior border of the tarsal cartilage and into the superior palpebral sinus of the conjunctiva behind the palpebral ligament. *Use*, to elevate and retract into the orbit the upper eyelid.

Obliquus Superior, at the upper and inner part of the orbit, *arises* on the inner side of the preceding, passes forwards along the os planum, ends in a round tendon which plays through the fibro-cartilaginous pulley which is attached to the inner angle of the os frontis; this tendon is then reflected backwards, outwards, and downwards, between the superior rectus and the eye, and then becoming broad and thin, is *inserted* into the sclerotic coat between the superior and external recti, about midway between the entrance of the nerve and the insertion of the superior rectus. *Use*, to draw the eye forwards and inwards, also to rotate it, so as to direct the cornea downwards, and according to some, inwards towards the tip of the nose: other authors consider it a rotator outwards.

Obliquus Inferior is situated at the inferior and anterior part of the orbit; it *arises* tendinous from the orbital edge of the superior maxillary bone above the infra-orbital foramen, and external to the lachrymal sac; it *ascends* obliquely outwards and backwards below the inferior rectus, and is *inserted* by a tendinous expansion into the sclerotic coat behind the transverse axis of the eye, and between the sclerotic coat and the external rectus. *Use*, to draw the globe forwards and inwards, and to rotate it upwards and outwards: the rotatory powers of the oblique muscles are involved in some obscurity, but no doubt exists as to their principal use, that of drawing forward the globe, so as to oppose the retracting influence of the recti.

Recti muscles are four in number, the superior is called *attollens oculi*, the inferior *depressor oculi*, the internal *adductor*, and the external *abductor oculi:* they all *arise* from the periosteum around the optic foramen; the external has an additional attachment to the foramen lacerum; they all pass forwards around the optic nerve, separated from it by the ciliary vessels and nerves, and by a great quantity of fat; a little beyond the middle of the eye they become tendinous, and are each *inserted* [into the *sclerotic* coat,] about a quarter of an inch behind the cornea; the four tendons are connected together by an aponeurosis which is attached to the conjunctiva; the *use* of these muscles is, collectively, to retract the eye into the orbit, and individually to move it, as their names imply.

Under the head of lachrymal apparatus we may consider the lachrymal gland, membrana conjunctiva, palpebræ, and lachrymal passages. The *lachrymal gland* is placed in the upper part of the orbit, behind the external angular process of the os frontis, above the external rectus and the conjunctiva; of a flattened oval figure.

[It is of a light pink color; it is convex above, concave below, and measures in length about ten lines, in breadth six lines, and at its thickest part two lines.]

It is separable into two or more lobes, which, like other conglomerate glands, can be separated into numerous granules; these are united by a loose capsule; from these, five or six small ducts proceed and open behind the upper eyelid along the line of reflection of the conjunctiva from the palpebra to the sclerotic.

The *Membrana Conjunctiva* is a mucous membrane lining each palpebra, and continuous at their margins with the integuments, it also covers the anterior part of the globe; near the inner canthus it is thrown into a semilunar fold, [the *plica semilunaris*,] and is continued through the puncta lachrymalia into the nasal sac and duct, and becomes continous with the mucous membrane of the nose. This membrane is more vascular on the palpebræ and caruncula than on the surface of the eye; it is loosely connected to the sclerotic coat to within half an inch of the cornea, it then becomes so delicate and so adherent that it is difficult to separate it further, and although it is generally described as being continued over the cornea, it is impossible to dissect it from it unless previously macerated or changed by disease; at the inner canthus of the orbit it is thrown forwards by a fleshy looking tubercle of a conical figure, the *caruncula lachrymalis*, this is composed of a few mucous follicles and the bulbs of some fine hairs that project from its surface. The conjunctiva is a secreting, and according to some, an absorbing surface; it is constantly moistened by the fluid it secretes, and occasionally by the lachrymal secretion; it serves, as its name implies, to join the eyelids to the eye, to facilitate the motions of the former, and thereby to clear the surface of the latter; it also closes the orbit against any extraneous substance, and serves to support and confine the eyeball in its several motions.

Palpebræ are composed of the skin, the orbicular muscle, a thin cartilage connected to the base of the orbit by a cellulo-ligamentous connexion, and lined by conjunctiva; in the superior there is also the expansion of the levator palpebræ muscle; the upper is larger than the lower eyelid, therefore, when they are closed the former descends below the transverse axis of the eye, and the inferior ascends but little to meet it; they are both concave posteriorly, adapted to the surface of the eye, their margins are thick, and furnished anteriorly with the eyelashes, posteriorly with numerous mucous follicles; their opposed edges are sloped off obliquely towards the eye, so that when the lids are closed a sort of triangular canal is formed, the base of which is the surface of the eye; along this canal the tears are supposed by some to be directed inwards towards the puncta, others, however, deny that any such space can exist, and affirm that the lachrymal secretion flows along each palpebral sinus, and is directed inwards by the action of the orbicular muscle; the skin of each palpebra is thin, the sub-cutaneous cellular tissue very loose and reticular; beneath this the orbicular muscle is expanded. (See p. 6.)

[The meeting of the palpebræ externally and internally, forms the *angles* or canthi, which are connected to the adjacent margins of the orbit by the external and internal palpebral ligaments, the latter of which is nearly half an inch long, and is made tense by drawing the lids outwards; it is the guide for the incision in the operation for fistula lachrymalis.]

The *tarsal cartilages* are thin elastic plates; the superior is semilunar and larger than the inferior which is long, narrow and nearly straight.

[The superior tarsus is six lines broad at its widest part, the centre; the inferior is nearly uniformly two lines wide. These cartilages are of use in preserving the form of the lids, and oppose the orbicularis muscle, which would otherwise pucker up the lids like the mouth of a bag, when closed by a drawing string.]

The ciliary margins are thick; their orbital edges thin and connected to the orbit by the palpebral ligaments which are a continuation of the periosteum; these ligaments are stronger towards the temple, where they decussate and attach the cartilages at their external canthus or commissure; the tendo oculi [or internal palpebral ligament] fixes them internally. Between each tarsal cartilage and the conjunctiva are the *Meibomian glands* or *follicles;* these are of a white or yellow colour, are arranged in nearly parallel vertical rows, and are more numerous in the upper eyelid; they secrete a thin sebaceous fluid, which is discharged by a row of small holes along the edge of each tarsus behind the cilia. The *cilia* arise from bulbs which are beneath the skin; those of the upper eyelid are more numerous than those in the lower; both are curved, convex towards each other.

[Overhanging the eye and placed upon the projection formed by the os frontis, are those hairs called the *supercilia* or eye-brows, separated from each other usually in the median line, by a bare space the glabella.]

The *Puncta Lachrymalia* are two small holes always open, directed backwards and outwards, opposite each other; they meet when the lids are closed; each is situated in a little cartilaginous projection, about two lines from the inner canthus; each is the orifice of the small lachrymal duct.

[Each is a line in depth and meets the duct at a right angle, so that in introducing a probe, it is to enter the punctum vertically, then it is to be brought to a right angle to its first position, and carried along the duct about half an inch; it is then again to be raised nearly parallel with its first position, after which it may be carried into the lachrymal sac.]

The *Lachrymal ducts* extend from the puncta to the lachrymal sac.

[They are half an inch in length and a line in diameter.]

The superior is longer and more curved than the inferior; the former is concave inferiorly; the latter is nearly straight, a little concave upwards; they both open into the external part of the sac a little above its middle, sometimes by one and sometimes by distinct orifices, behind the tendo oculi; each duct is surrounded by a process of that tendon, and lined by mucous membrane.

[The *plica semilunaris* is a valvular fold of the conjunctiva, at the angle of the eye and directly external to the caruncle, it is triangular in form, the apex being internal, and base external; its base is sometimes furnished with a small cartilage, more frequently in the negro according to Horner. The use of this fold, in the human subject, appears to be for the free abduction of the eye; it is also analagous to the third eyelid of animals; in which the third eyelid, is in inverse ratio to the others, until as we descend in the scale, it entirely supplies their place.]

The *Lachrymal sac* is a small oval pouch of mucous membrane, closed above and leading below into the nasal duct, it is situated in a fossa formed by the maxillary and unguis bones, covered by the skin, the tendo oculi, and some fleshy fibres of the orbicularis muscle, also by a strong fascia which is derived from that tendon and connected to the surrounding bony margin. A small muscle has been described by Mr. Horner as *arising* from the edge of the os unguis, and *inserted* into the lachrymal sac and ducts; he conceives it to have the power of compressing the sac, and directing the ducts and their contents towards it; it is not, however, in all subjects to be distinguished from the orbicular, which last can effect these purposes.

The *Nasal duct* (about three-fourths of an inch in length in the recent state) descends from the sack obliquely backwards and a little outwards, surrounded by the maxillary, unguis, and inferior spongy bones; beneath the latter it opens by a small slit-like orifice, which is surrounded by a circular fold of mucous membrane which is sometimes so loose as to appear as a valve, into the lower meatus, about an inch from the anterior part of the naris; this duct is formed of mucous membrane only, and which is closely connected to the periosteum. The nerves and vessels of the orbit have been already examined. The nerves of the palpebræ are derived from the portio dura of the seventh, from the lachrymal, frontal, and nasal branches of the ophthalmic, and from the infra-orbital branches of the fifth pair of nerves: the vessels are branches of the ophthalmic, temporal, and facial.

DISSECTION OF THE GLOBE OF THE EYE.

[The organs forming the ball of the eye, may be conveniently grouped as follows; first, three concentric laminæ, the sclerotic coat, choroid coat, and the retina: second, two vertical organs, or membranes, the cornea and the iris: third, three humours, the aqueous humour, the crystalline lens, or humour, and the vitreous humour.]

It will facilitate the student in learning the anatomy of the eye, to dissect this organ in some of the inferior animals; almost every part of importance may be examined with equal advantage in the eye of the sheep, ox, or pig, as in that of the human subject; many of the minute parts are even on a larger scale, and can be dissected with greater ease: we also have it in our power in general to dissect the eyes of the inferior animals in a perfectly fresh state.

The eye is situated at the anterior and internal part of the orbit, behind the conjunctiva, surrounded by muscles and fat, and connected posteriorly by the optic nerve; the axes of the eyes are parallel to each other, therefore not so to those of the orbits; each eye is nearly spherical; the antero-posterior axis, which is nearly an inch, being about one or two lines greater than the transverse or vertical axis; the cornea, which is a segment of a smaller sphere, and which forms about the anterior fifth of the globe, being superadded to the larger sphere, formed by the sclerotic; this spherical form favours the motion of the eyeball. The eye is composed of fluids or humours enclosed in different tunics, the latter are the sclerotic, choroid and retina, the first is a fibrous, the second a vascular and the third a nervous coat; the humours are the aqueous, crystalline and vitreous; these are also enclosed in distinct capsules.

Tunica Sclerotica is a dense, opaque, fibrous membrane, extending from the optic nerve to the cornea; the nerve perforates it about a line internal to its centre by a small conical aperture, which appears traversed by fibres, so as to present a cribriform appearance; it is doubtful, however, whether this indistinct appearance may not partly depend on the central vein and artery of the retina which accompany the nerve through this opening; the sheath of the optic nerve is continuous with the fibres of this membrane; the external surface of the sclerotic is rough and perforated by several holes; anteriorly it receives the cornea, and is so intimately connected to it, that maceration alone can separate them; both are sloped off obliquely as well as slightly grooved; the sclerotic overlaps the cornea.

[This is sometimes the case, but at other times the cornea overlaps the sclerotic, and in other cases the margin of the sclerotic is grooved, and the edge of the cornea is received into the groove, like the crystal of a watch inserted into the rim.]

Their connexion is still further secured by the conjunctiva externally, and by the membrane of the aqueous humour internally; a vertical section of this tunic from behind forwards will shew its great thickness near the optic nerve, and its thinness in the centre [being one line thick in the former situation, and half a line in the latter;] anteriorly it is again strengthened by the tendinous expansion of the recti muscles; this expansion has been improperly called the *tunica albuginea;* the sclerotic consists of fibres which run in every direction, but which do not form distinct laminæ; its internal surface is smooth and glistening; the ciliary vessels and nerves run between it and the choroid; from this surface a fine serous-like lamina may be raised; this is reflected on the choroid coat.

The *cornea* forms the anterior fifth of the eye; it is nearly circular, its transverse diameter being a little greater than its vertical; it is very smooth and transparent, of a laminated, not a fibrous texture; some fine cellular tissue connects the laminæ to each other; the cornea is more thick and pulpy in the child than in the adult; it is covered anteriorly by a fine and closely adhering membrane, which though generally considered a continuation of the conjunctiva, is very different from it in its structure and properties.

[That this membrane is continuous with the conjunctiva, is proved by the fact that it comes off with the conjunctiva and epidermis of those animals which shed their skin, as the locust, snake, &c. The lining membrane of the stomach and that of the uterus are different in their appearance, and in their secretion, yet both are considered as belonging to the mucous tissue.]

The concave surface of the cornea is lined by a fine elastic membrane, which is described by some as a part of the membrane of the aqueous humour; it is, however, a membrane *sui generis;* it is best seen in the eye of a horse, which has been macerated for some days, the external laminæ, which are now opaque, can be peeled off, leaving behind it this elastic cornea, which preserves its proper curve and transparency; if it be cut it will curl upon itself, thus exhibiting true elastic cartilaginous properties. Fix the eye in a small shallow vessel, which can be immersed occasionally under water, carefully raise a small portion of the sclerotic, pass in some air between it and the choroid, these membranes can thus be easily separated; then dissect off the sclerotic, this tunic can be readily detached as far as the cornea, here it adheres to the ciliary ligament; this connexion may be separated with the handle of the knife, the cornea, or one-half of it, may also be removed with the sclerotic and the next tunic of the eye will be exposed, the choroid, with its appendages, the ciliary ligament, ciliary processes, and iris.

The *Choroid coat* extends from the optic nerve all round the eye, between the sclerotic and retina, as far as the ciliary ligament, where it appears on the external surface to terminate, but when a portion of it is raised, its internal surface will be found to extend inwards, in the form of folds or processes, termed ciliary, to be examined presently; the external surface of the choroid is smooth, and loosely connected to the sclerotic by the ciliary vessels and nerves, and by fine cellular tissue; this surface is generally tinged by the pigment which transudes through it; on this layer of the choroid, numerous fine vascular ramifications running in parallel arches may be observed, these are connected chiefly with the veins and are termed the vasa vorticosa: raise a portion of the choroid, by tearing it from the retina with a forceps; its internal surface is covered by a brown pigment, which is thicker before than behind; for a small distance round the optic nerve it is deficient; wash off this pigment, the choroid will be found, if previously injected, to be very vascular and villous; this, the internal layer, which by dissection can be separated from the external, is termed *membrana Ruyschiana;* the ciliary arteries supply this coat with blood, for the purpose of secreting the pigment, which has the effect of absorbing all rays of light which strike the sides of the retina; the optic nerve passes through a round opening in this membrane, the edges of which are not connected to the nerve; this tunic is more dense anteriorly than posteriorly.

The *Ciliary Ligament* corresponds to the junction of the iris to the choroid, and of the cornea to the sclerotic; it forms a ring of grey colour, about two lines broad, of a soft and cellular texture, and has some resemblance to a nervous ganglion.

The *Ciliary Processes* are sixty or seventy small triangular folds of the choroid coat, which are arranged in a radiated manner around the lens on the forepart of the vitreous humour, each extends inwards and backwards from the ciliary ligament as far as the border of the lens; each of these processes, as well as the interstices between them, are covered by the pigmentum nigrum, the term *corona ciliaris* is applied to this part; the anterior edge of each process is connected to the ciliary ligament and iris, the posterior to the vitreous humour, and the internal is loose, and forms the circumference of the posterior chamber of the eye.

The *Iris* is a delicate circular membrane, floating in the aqueous humour and suspended vertically behind the cornea, so as to divide the space between this and the lens into two chambers, an anterior and a posterior, the former is the larger of the two; these chambers communicate through the central aperture in the iris, the *pupil:* this aperture is a little nearer its nasal than its temporal side; the external border of the iris is fixed to the ciliary ligament, its posterior surface is also in part attached to the same and to the ciliary processes; this surface is covered by pigment, and is named *uvea;* the anterior surface is covered by the fine membrane of the aqueous humour, and streaked with different coloured lines, some of which take a radiated course from the circumference towards the pupil, near which they cross, divide, and unite again, and appear to form or to end in a fasciculus of circular fibres, which bound the pupil, and which are of a darker tint.

[The anterior surface of the iris, is said to exhibit, one of two colors, light blue or orange, and the particular hue of the eye varies, according, as one or the other of these two colors predominates, and is combined with the darker color of the pigment, on the posterior surface of the organ.]

The iris, when examined with a magnifying glass, has a villous appearance; when the pigment is washed off the posterior surface, the fibrous structure is evident there also, and bristles may even be passed beneath some of the fasciculi; the iris is supplied with numerous arteries and nerves; the former are branches of the long and anterior ciliary, the latter are derived from the lenticular ganglion, and from the nasal nerve; it is not generally agreed on whether the fibrous appearance of the iris depends on the peculiar arrangement of its vessels and nerves, or whether it possesses a true muscular structure; its functions may lead one to incline to the latter opinion, as the pupil has the power of contracting rapidly when a strong light approaches the eye, and of again dilating when the light is weak; the use, therefore, of the iris is to regulate the quantity of light which is to enter the eye. The pupil is closed in the fœtus by a delicate but vascular membrane, the *membrana pupillaris;* this membrane is ruptured either at, or a short time previous to birth.

[This membrane does not disappear until some days after birth in certain of the inferior animals.]

The *Retina* may be best exposed by gently tearing off the choroid, (the eye being held under water,) and then placing an inverted glass globe, filled with clear diluted spirits, over the dissection; the retina will become slightly opaque, and have a magnified appearance. The optic nerve having pierced the choroid coat ends in this thin and delicate membrane, which is transparent in the very recent eye, but soon becomes opaque after death; the retina extends around the sides and forepart of the vitreous humour without adhering to it, as far forwards as within two lines of the lens; here the nervous matter ends by an abrupt line, along which a small blood-vessel runs. The retina is divisible into three layers: first, lamina serosa; second, lamina nervosa; and third, lamina vasculosa. The external or serous layer is extremely delicate, it may be separated by gentle pressure with the handle of the knife under water. This membrane was discovered by Dr. Jacob. The middle, or the nervous layer, is soft and grey, and continuous with the optic nerve; the internal or vascular layer is very delicate; it lies on the vitreous humour, and is continued on its forepart to the capsule of the lens, where it becomes adherent to the hyaloid membrane. Dissect off the posterior half of the retina from the vitreous humour, or cut transversely a fresh eye, and allow the humours to fall out, then look on the concave surface of the retina, and we may observe in the centre of the optic nerve a small dark point, the *porus opticus;* this is the central artery of the retina, which then spreads its branches in the internal layer of the retina; about two lines external to this, and in the axis of the eye, is a small yellow or orange spot, the *punctum aureum*, or spot of Sœmmerring; the retina is thrown into folds around this; some describe a perforation and deficiency of the retina at this spot, it rather appears, however, to depend on some peculiar organization. The humours of the eye are the aqueous, cystalline, and vitreous.

The *aqueous humour* is perfectly colourless, about five grains in quantity; it fills the anterior and posterior chambers, the former about two lines, the latter about half a line in depth. This fluid is supposed to be secreted by a fine membrane, which is continued from the cornea over the iris, and through its pupillary margin to its posterior surface; in the human eye, however, it is impossible to trace any such membrane through this extent. This fluid supports the cornea and the iris, the latter can float and move freely in a fluid of such thin consistence.

[This fluid is readily regenerated after having been lost, as in the operation for cataract.]

The *cystalline humour* is a transparent double convex lens, a little more prominent behind than before, imbedded in the forepart of the vitreous humour behind the anterior third of the eye, and a little nearer to its nasal than its temporal side. Its axis corresponds to that of the pupil: it is surrounded by a fine capsule, which is thin and soft posteriorly, but anteriorly dense, and peculiarly elastic; a small quantity of fluid (liquor Morgagni) is contained between the lens and its capsule; the lens is retained in its place by the hyaloid membrane, which splits into two laminæ at its border; these laminæ pass, one before, the other behind it, and become connected to the proper capsule; a small triangular canal (canal of Petit) is enclosed between these layers, the base is formed by the circumference of the lens. This canal is intersected by fine septa, it therefore presents a cellular or vesicular appearance when distended by air or injection. Some describe this canal as formed by the divison of the lamina vasculosa into two layers. The lens is soft and pulpy externally, more dense towards the centre, or a little internal to that point; maceration or boiling causes it to separate into wedge or triangular shaped pieces, the apices towards the centre; each piece appears composed of successive plates, and each plate has a fibrous structure. In the fœtus the lens is reddish and very soft; in the adult it is transparent, and in the old it has an amber or yellowish cast towards the centre: the capsule of the crystalline lens receives some fine vessels from the central artery of the retina. The lens refracts the rays of light, and causes them to converge to a focus on the retina.

The *vitreous humour* fills the two posterior thirds of the globe of the eye, it is thin and almost watery, but being enclosed in a fine membrane, it has a gelatinous consistence; this membrane is called *hyaloid*, it encloses the fluid, and sends processes into it, so as to divide the whole mass into numerous cells, which communicate so freely that air injected will rapidly distend them; or if one or two openings be made in this capsule, the whole of the fluid will gradually escape; anteriorly the crystalline lens is connected to this humour by the hyaloid membrane separating into two laminæ; external to the lens, the ciliary processes and the intervening pigment mark it in a striated manner, like the disk of a flower; this appearance, therefore, has been called the ciliary disk, or corona ciliaris: the vitreous humour serves to support and expand the retina, and the other tunics of the eye, also, in transmitting the rays of light from the lens, it prevents their too rapid convergence, and thus causes an image of larger size to be painted on the retina.

SECTION V.

OF THE SKIN.

The integument of the body is composed of one continued membrane, which is very dense, at the same time very extensible; at the several orifices, it is continuous with the mucous membranes, a vascular line alone marks the distinction between them: by maceration or putrefaction the skin may be divided into three laminæ, the cuticle, rete mucosum, and cutis vera.

The *cuticle* or *epidermis* is the external layer, it is dry, thin, and transparent, and destitute of nerves and vessels; it is most intimately connected to the cutis by numerous fine hairs which pass through it, also by the several exhalant and absorbent vessels that open on its surface by very minute pores; in some situations it is very dense and opaque as in the hands and feet; it is continued as a very fine pellicle into the different orifices, and can be traced for a considerable distance on the mucous membranes, thus, from the lips it extends over the pharynx and along the œsophagus as far as the cardiac orifice of the stomach, where it terminates in a fimbriated margin; from the external ear it extends along the meatus externus, and covers the membrana tympani; inferiorly also it is continued along the mucous lining of the urethra, vagina, and rectum; the cuticle serves to defend certain parts of the body from pressure, to protect its surface from contact, and to prevent evaporation.

The *rete mucosum* is a very thin, soft, vascular lamina, adhering to the cutis, connected to it by vessels, it has a villous appearance, and is tinged with a mucous fluid, which presents different shades of colour in different situations and in different individuals; the peculiar complexion or colour of the body depends upon this secretion: in the negro, it is very thick and black, while the cuticle is transparent, and the cutis vascular and red; some anatomists divide the rete mucosum into two, and some even into three or four laminæ.

The *cutis vera, dermis*, or *chorion*, is much more dense than either of the preceding laminæ, it is very tough and strong, in some situations more so than in others; its internal surface is cellular, its external is smooth and very vascular, [and is sometimes spoken of as a distinct laminæ, under the name of the *corpus* or *rete vasculosum*:] it is also highly sensible, particularly in some situations, as in the fingers and toes, where numerous nerves are distributed to it in the form of small conical or oval papillæ; these are very distinct at the end of each finger, they are very vascular, and into each a nervous filament can be traced, in these papillæ the sense of touch more particularly resides. Although this sense resides more exquisitely in these particular situations, yet many other parts of the body possess more or less of sensibility to the contact of foreign bodies, as well as to heat and cold: the skin generally is endowed with this faculty, also the voluntary muscles, the mucous surfaces too, as far as we are acquainted with them, possess it, and some as the conjunctiva, the membrane of the nose, mouth, fauces, larynx, &c. even in a more eminent degree than the surface of the body; the lining membrane of the rectum, urethra, vagina, &c. are all sensible to touch as well as to heat and cold. The sense of touch, as possessed by the voluntary muscles and by the integuments of the trunk and extremities, depends on the posterior or the ganglionic roots of the spinal nerves; that of the head, face, eyes, nose, mouth, &c. on the ganglionic portion of the fifth pair of cerebral nerves, and that of the pharynx, stomach, larynx, &c. on the glosso-pharyngeal and the vagi; the sensibility of the genito-urinary surfaces most probably depend on their supply of spinal nerves. How far the abdominal mucous surface, below the stomach, enjoys sensibility to touch is uncertain, most probably it possesses it only in a very faint degree, and this would lead to the question, are the branches of the sympathetic, sentient nerves? The greater portion of the alimentary canal being supplied from this source, and not being endowed with touch, would induce us to give a negative answer to this quere.

The *cellular membrane* is connected to the deep surface of the cutis, which is itself cellular; the sub-cutaneous cellular tissue is considered by some as a part of the integuments, and no doubt it serves as an additional covering to the body; this tissue is, however, extensively distributed throughout the system, it enters into the composition of every solid, it forms the basis of the osseous and muscular systems, it also serves to connect some parts together, to separate others, and to confine all within their appointed limits. In some parts of the body, particularly those exposed to pressure, the cells of the cellular membrane are filled with adeps, in other situations, where the parts are subject to motion, the cells are very loose, and only contain a fine serous exhalation as in the eyelids and on the aspect of expansion of the joints; the former species of cellular membrane has been named *adipose membrane* [or adipo-cellular tissue,] the latter *reticular membrane.*

[Or sero-cellular, being so named from the character of their respective secretions: they co-exist in an inverse ratio, and the former does not exist, in those situations where the presence of fat would interfere with the functions of the organs, as in the eye lids, the organs of generation, the brain, &c.]

In children the former abounds towards the surface and is in small quantity in the cavities; in the old, on the contrary, there is so little adeps beneath the skin, that the outline of the muscles can be seen, and the vessels and other deeper seated parts can be distincly felt, whereas it is then often found, even in emaciated subjects, in large quantity in the thoracic and abdominal cavities, in the former about the heart, in the latter in the omentum, around the kidneys, &c.; there is never any adipose matter within the cranium at any age, although cellular membrane can be demonstrated even in the tissue of the brain.

PART III.

CHAPTER I.

ANATOMY OF THE VASCULAR SYSTEM.

UNDER THIS HEAD WE MAY CONSIDER THE ANATOMY OF THE ARTERIES, VEINS, AND LYMPHATICS.

SECTION I.

ANATOMY OF THE ARTERIES.

THE principal blood-vessels have been already described in the anatomy of the different regions; in the present section the arteries shall be considered in a systematic manner, commencing with the aorta, and tracing its branches through all parts of the body.

AORTA arises from the upper part of the left ventricle, opposite the fourth or fifth dorsal vertebra, (see page 73,) ascends obliquely forwards and to the right side, then turns backwards and to the left, and then descends along the dorsal vertebræ; it thus forms the *arch* which terminates on the left side of the fourth vertebra: the *thoracic aorta* descends along the left side of the remaining dorsal vertebræ, inclining a little to their forepart inferiorly, and passes between the crura of the diaphragm: the *abdominal aorta* descends on the lumbar vertebræ, as far as the fourth or fifth, where it divides into the two common iliac arteries. The aorta is at first covered by the pericardium and the pulmonary artery; as it ascends it lies between this vessel and the vena cava; the arch lies on the trachea a little above its division, and on the bodies of the second and third vertebræ. In the posterior mediastinum the aorta descends on the left of the thoracic duct and vena azygos, and rather behind the œsophagus. In the abdomen it lies between the crura of the diaphragm and the psoæ muscles, on the left side of the vena cava and behind the vena porta, the pancreas and the peritonæum.

[*Varieties.* The aorta sometimes curves to the right instead of to the left, and this anomaly may or may not co-exist with a transposition of the thoracic and abdominal viscera. The aorta has been seen to arise by a single trunk, which soon dividing, one branch passed in front of the trachea, the other behind it; both then uniting to form the descending aorta. The aorta in many of the inferior mammalia, immediately after its origin, bifurcates, so as to form an ascending and a descending trunk, the former of which gives off the branches to the head, neck, and superior extremities, while the latter supplies the thorax, abdomino-pelvic cavity, and inferior extremities.

This variety is peculiar to mammalia with long necks, and has been seen in the human subject. The aorta has been seen to divide into two trunks directly at its origin, its orifice being large and presenting five semilunar valves ; the two trunks curved upwards to the right and left, and meeting above, joined to form the descending aorta; each trunk gave off three branches, the subclavian, the external, and the internal carotids. The sweep of the arch of the aorta differs in different subjects, being in some the arc of a small and in others of a large circle. This artery usually enters the abdomen, opposite the body of the twelfth dorsal vertebra, and terminates by bifurcating over the inter-vertebral substance between the fourth and fifth lumbar vertebræ: this however may take place, either above or below the point designated. In addition to the anomalies of the aorta itself there are no less than twenty-five well authenticated varieties, in the origins of the branches coming off from its arch; the description and delineation of which are given by Tiedemann, and after him, but in a smaller and more accessible form by Knox. Most of these varieties will be referred to, in the description of the individual vessels; many of them are analogous to the natural arrangement, in inferior animals. These anomalies may be arranged under the three heads, of community of origin, of multiplicity of origin, and of transposition of origin.

The number of branches coming off from the arch of the aorta, varies from two to six, but is most commonly three, being those named below, except the coronary arteries of the heart, which are not usually described as branches from the arch. The two varieties most frequently met with are, first, that in which the arteria innominata, and the left carotid artery arise by a short common trunk; and second, that in which the left vertebral artery arises directly from the arch of the aorta, between the roots of the left carotid and subclavian arteries. There are in the college museum preparations of many of the arterial varieties; several valuable preparations are also to be found in the private collection of Dr. Alfred C. Post, of this city.]

From the arch of the aorta five arteries arise, the right and left coronary, the innominata, the left carotid, and left subclavian.

The *right and left coronary arteries* arise above two of the sigmoid valves; the *right* proceeds along the base towards the right side of the heart, divides into several long branches, which supply the parietes of the right auricle and ventricle, and communicate with the left coronary: the *left* descends obliquely along the left side of the heart supplying the parietes of the left auricle and ventricle, and communicating with the former around the base and apex of the heart.

[*Varieties.* The coronary arteries sometimes arise by a large common trunk which soon bifurcates; sometimes there are three and even four of these arteries, arising separately.]

The *arteria innominata* arises from the upper part of the arch, ascends obliquely to the right side, in front of the trachea, and behind the sterno-thyroid muscle, and the left vena innominata; opposite the sternal end of the clavicle it divides into the right subclavian and right carotid arteries.

[*Varieties.* This artery though usually from an inch to an inch and a half in length, is occasionally two inches long. It is sometimes double, that is, there are two trunks, coming off from the arch of the aorta, which bifurcate so as to form the subclavian, and common carotid arteries, of both sides. This artery, also called the brachio-cephalic, is sometimes entirely wanting, the subclavian and common carotid of the right side arising separately from the arch of the aorta. Small branches sometimes arise from the arch of the aorta, or from the arteria innominata, to be distributed upon the thymus body and muscles, at the lower part of the neck; the inferior thyroid, and the internal mammary artery also sometimes arise from one or the other of the above mentioned trunks. The arteria innominata has been ligatured by Dr. Mott, but the patient died of secondary hemorrhage after the lapse of three weeks.]

The *right and left* [*common* or *primitive*] *carotid arteries;* the *right* arises from the arteria innominata, the *left* from the arch of the aorta; these vessels ascend obliquely outwards as high as the os hyoides, opposite which each divides into the internal and external; in this course they are covered inferiorly by the sterno-mastoid, hyoid, and thyroid, and omo-hyoid muscles; and superiorly, only by the skin, platysma, and fascia; the left is also covered inferiorly by the sternum and the vena innominata, and at its origin differs from the right in lying on the trachea, thoracic duct and œsophagus, but after this both ascend in front of the longus colli and rectus capitis muscles, the inferior thyroid artery, and the recurrent and sympathetic nerves, and are enclosed in a sheath of cellular membrane, along with and to the tracheal side of the vagus nerve and the internal jugular vein.

[*Varieties.* The right common carotid is shorter than the left, by the length of the innominata, the two are however equal in calibre, and their calibre is proportionably greater in man than in the inferior animals, which is in accordance with the greater development of the cerebrum in the former. These vessels sometimes result from the bifurcation of two brachio-cephalic arteries, and at other times they arise by a common trunk, which comes off from the arch of the aorta and soon bifurcates; in this case both subclavians arise directly from the arch, one on each side of the carotid trunk or else both of them to the left of that trunk; in other cases both carotids arise directly from the arch between the two subclavians, or to the right of them, or even alternating with them. Again, the two carotids, arise from a trunk common to them, and the left subclavian; and lastly, though most rarely, there is no common carotid artery, but the aorta being double, the external and internal carotids, arise directly from its two trunks. The left carotid artery not unfrequently arises from the arteria innominata. Usually, no branches are given off by the common carotid, previous to its bifurcation yet this sometimes happens; thus the inferior thyroid, a supernumerary thyroid called middle, the internal mammary, a thymus artery, have all been observed coming off from this trunk, and I have several times seen one or more small branches distributed upon the sterno-cleido-mastoid muscle, from which circumstance they might be called the *sterno-mastoid* arteries. The point of bifurcation of the common carotid, is not invariable, it usually is opposite the upper edge of the thyroid cartilage, but I have a preparation, taken from a female, about twenty-five years of age, in whom the bifurcation on the left side took place opposite the inferior edge of the thyroid cartilage, and on the right side, opposite the middle of the same cartilage: in fact the bifurcation may take place at almost any point, between the origin of the artery, and its usual termination.]

The *external carotid artery* ascends obliquely backwards to the forepart of the meatus auditorius, covered by the skin, platysma, and fascia, also by the lingual nerve, and digastric and stylo-hyoid muscles, the parotid gland and portio dura nerve: it lies superficial to the internal carotid, stylo-pharyngeus, and stylo-glossus muscles, the glosso-pharyngeal nerve, and part of the parotid gland; it gives off the following arteries, anteriorly, the superior thyroid, lingual, and labial; posteriorly, the muscular, auricular, and occipital; superiorly, the pharyngeal, transverse facial, temporal, and internal maxillary.

[*Variety.* This artery may arise directly from the aorta, it is smaller than the internal carotid in the adult, and much smaller in the child, and is situated rather at the internal edge of that artery near its origin; it may come off from the common carotid, at any point between the origin of that vessel, and the superior margin of the thyroid cartilage.]

The *superior thyroid artery* arises opposite the cornu of the thyroid cartilage, descends obliquely forwards and inwards beneath the sterno-thyroid, and omo-hyoid muscles, and sends off the following branches:—first, the *superficial*, distributed to the integuments and superficial muscles; second, the *laryngeal*, accompanying the superior laryngeal nerve between the os hyoides and thyroid cartilage, and distributed to the muscles and mucous membrane of the larynx; third, *hyoidean*, small and irregular, to the lower border of the os hyoides and adjacent muscles; and fourth, *superior thyroid*, is distributed to the thyroid body.

[*Varieties.* This artery is not unfrequently double, it may arise directly at the bifurcation of the common carotid, or fairly from the common carotid itself; from either point it may arise singly, or in common with the lingual artery and in like manner from its normal point of origin; the laryngeal artery sometimes arises directly from the common carotid, and sometimes from the lingual artery.]

The *lingual artery* arises immediately above the preceding, it ascends tortuously and obliquely forwards and inwards, above the os hyoides to the base of the tongue, between the hyo and the genio-hyo-glossi muscles, and then runs horizontally forwards towards the tip of the tongue; it gives off the following branches, first, *hyoidean*, small and irregular; second, *dorsalis linguæ*, which ascends to the dorsum of the tongue, and is lost on the mucous membrane, near its base, also on the velum and fauces; third, *sublingual*, passes forwards and outwards to the sublingual gland, mylo-hyoid muscle, and mucous membrane of the mouth; and fourth, *ranine*, which continues along the lingualis muscle to the tip of the tongue.

[*Varieties.* This artery may arise by a common trunk, with either the superior thyroid, or the facial artery; or it may be a branch of the former. The dorsal artery of the tongue sometimes arises from the superior thyroid; and the sublingual artery, by a trunk common to itself and the submental, from the facial or labial artery. The branches of the lingual artery do not anastomose freely across the median line, in the substance of the tongue, as has been already mentioned in the description of that organ.]

The *labial* [or *facial*,] or *external maxillary artery* arises opposite the os hyoides, ascends obliquely forwards behind the digastric and between the submaxillary gland and the base of the jaw, turns round the latter anterior to the masseter muscle, and then ascends obliquely forwards and inwards towards the side of the nose; in the neck it gives off, first, *inferior palatine*, which ascends along the side of the pharynx, and supplies the velum and the amygdala; the branch to the latter often arises distinctly; second, *glandular* to the sub-maxillary gland and adjoining lymphatic ganglia; third, *submental* runs along the mylo-hyoid muscle to the chin, and supplies the surrounding muscles. On the face it gives off, fourth, *inferior labial* to the muscle and integuments between the lip and the chin; fifth, the *inferior and superior coronary*, these run along the border of the lips close to the mucous membrane and directly join those from the opposite side; sixth, *lateralis nasi* to the muscles and skin on the side and dorsum of the nose; and seventh, *angularis*, which communicates with the ophthalmic.

[*Varieties.* This artery sometimes arises by a common trunk with the lingual; that of one side is very large, while that of the other side is very small; it terminates in the inferior or superior coronary artery, or the lateralis nasi, or it may be prolonged so as to form the frontal artery. The inferior labial, and inferior coronary arteries are in inverse ratio to each other as to size, one of them being sometimes very small, in which case the other is proportionably larger than usual.]

The *muscular artery* descends obliquely backwards, divides into several branches which are principally distributed to the sterno-mastoid muscle and to the surrounding cellular tissue and ganglia.

The *occipital artery* arises opposite the labial, ascends obliquely backwards behind the digastric muscle, then curves horizontally backwards between the mastoid process and the atlas, and near the mesial line it ascends on the occiput; it gives off several muscular branches, some to the mastoid and trapezius muscles, several to the deep muscles on the side and back of the neck, and on the occiput it divides into tortuous branches, which ascend in different directions in the scalp, and inosculate with the different arteries in that region.

[*Varieties.* This artery sometimes arises by a common trunk with the posterior auricular, or it may arise from the internal carotid; it sometimes gives off the stylo-mastoid artery, which is normally a branch of the auricular, and enters the stylo-mastoid foramen, to be distributed upon the internal ear.]

The *posterior auricular artery* arises above, often in common with the occipital; it ascends behind the parotid and between the meatus auditorius and the mastoid process; it divides into several branches which are lost in the integuments of the ear and in the scalp.

[*Variety.* This artery sometimes takes the place of the posterior branch of the superficial temporal artery on the side of the head.]

The *inferior* or *ascending pharyngeal artery* arises near the division of the common carotid, ascends vertically to the base of the skull, and sends off several pharyngeal and palatine branches, and ends in a small branch [the posterior meningeal] that passes through the foramen lacerum posterius, and supplies the dura mater at the base of the cranium.

[*Varieties.* This artery is sometimes double, it may arise from the external carotid as usual, from the angle of bifurcation of the common carotid, from the internal carotid, from the occipital, or from the superior thyroid artery.]

The *transverse artery of the face* arises from the carotid in the parotid gland, accompanies the duct of Steno, and is distributed to the muscles and integuments of the face, and joins the branches of the facial artery.

[*Variety.* This artery is often a branch of the temporal, and its calibre is in inverse ratio to that of the facial, the place of which it sometimes supplies upon the upper lip and nose.]

The *temporal artery* ascends through the parotid gland between the meatus auditorius and the articulation of the maxilla, behind the zygoma, and divides on the temporal fascia into an anterior and posterior branch; it gives off, 1st, *branches to the gland;* 2nd, *anterior auricular;* 3rd, the *middle temporal;* this pierces the fascia and is distributed to the temporal muscle; 4th, the *anterior* or *frontal* supplies the skin and muscles of the forehead, and joins the ascending branches of the ophthalmic artery; 5th, *posterior temporal* bends backwards and upwards in the scalp and inosculates with the occipital and auricular arteries.

The *internal maxillary artery* ascends obliquely forwards behind the neck of the maxilla, between the pterygoid muscles, then between the external pterygoid and the temporal muscle; it then bends down into the pterygo-maxillary fossa; it gives off the following branches, 1st, while internal to the neck of the maxilla, the *middle artery of the dura mater;* this ascends to the base of the cranium, passes through the spinous hole of the sphenoid bone, then runs outwards and forwards, and again ascends along the great wing of the sphenoid bone to the inferior angle of the parietal, which bone it grooves very deeply; it then ascends between this bone and the dura mater, divides into several branches, which ascend obliquely backwards, and are lost in the bone and the dura mater; 2nd, the *inferior dental* arises opposite the last, descends obliquely forwards between the bone and the internal lateral ligament, enters the dental foramen, and proceeds beneath the teeth, to the roots of which it sends very small arteries, and through the mental hole it sends a small branch to the muscles and mucous membrane, and to inosculate with branches of the labial artery; between the pterygoid muscles it sends off; 3rd, the *deep temporal* branches, one posterior, the other anterior; these supply the muscles and ascend close to the bone; 4th, *masseteric;* 5th, *pterygoid;* 6th, *buccal,* to the buccinator muscle, the fat and integuments of the cheek; 7th, *superior dental,* which winds round the maxillary tuberosity and sends branches into the alveoli and to the gums; in the spheno-maxillary fossa it gives off; 8th, *infra-orbital*, which passes along the canal of that name, is distributed to the muscles of the face, and communicates with the arteries of that region; 9th, *nasal* passes inwards through the spheno-palatine hole, and is distributed to the mucous membrane on the spongy bones and on the septum; 10th, the *superior palatine* descends along the posterior palatine canal, and is distributed to the muscles and to the mucous membrane of the palate, principally to the hard palate; 11th, the *vidian;* this is a small branch which passes backwards, and takes the course of the first part of the vidian nerve; these terminating branches of the internal maxillary artery are entangled with the divisions of the superior maxillary nerve.

[The extensive distribution of the internal maxillary artery may be seen by the following enumeration of the organs supplied by it: viz. the superior and inferior maxillary bones, and the corresponding teeth, the muscles of mastication, the palatine arches, the soft palate, and the pharynx; the nasal cavities, the internal ear, the muscles and integuments of the face, and the bones of the cranium and the dura mater.]

The *internal carotid artery* ascends along the vertebral column and the side of the pharynx from the common carotid, posterior and external to the external carotid, behind the digastric and styloid muscles, internal to the jugular vein and anterior to the vagus and sympathetic nerves, to the foramen caroticum in the petrous bone; it then bends tortuously forwards, upwards, and inwards, through the carotid canal accompanied by the superior branches of the sympathetic, enters the cavernous sinus, through which it makes two remarkable turns internal to the sixth pair of nerves, and arriving at the anterior clinoid process, it bends upwards and backwards, and a little outwards, and opposite the internal extremity of the fissure of Sylvius it divides into its three terminating branches, it first gives off the ophthalmic artery: in the neck, and in the carotid canal, it sends small and unimportant branches to the surrounding parts.

[*Variety.* This artery, though rarely, may arise directly from the aorta, as when the latter vessel is double. The calibre of this artery is in direct ratio with the development of the cerebrum, and in the animal scale, it is in proportion to that of the external carotid, as the development of the brain is to that of the face.]

The *ophthalmic artery* arises close to the anterior clinoid process, passes forward through the optic foramen, below the optic nerve and external to it; in the orbit it rises above this nerve and twines round it to the inner side of this cavity, along which it passes to the inner canthus where it terminates; while on the outer side of the optic nerve it sends off, 1st, *centralis retinæ*, which is very small, pierces the sheath of the optic nerve and passes along the centre of the latter, into the eye, where it divides into delicate ramifications; these spread along the internal layer of the retina, and one or two pierce the vitreous humour, and extend to the capsule of the lens; 2nd, the *lachrymal* passes along the external rectus muscle, and supplies the lachrymal gland, and the external part of the palpebræ: while above the optic nerve it gives off; 3rd, the *supra-orbital*, which passes forwards along the levator palpebræ, and through the superciliary notch, supplies the muscles and integuments of the eyebrow, and ascending on the forehead, divides into several branches, which are distributed to the scalp, and communicate with the temporal and occipital arteries; 4th, the *posterior ciliary*, ten or twelve in number, very small, surround the optic nerve, and pierce the back part of the sclerotic; pass between it and the choroid, and are distributed to the latter; some of their branches continue as far as the ciliary processes and the iris; 5th, *long ciliary*, one on each side; they pass horizontally forwards, between the sclerotic and choroid membranes, as far as the ciliary circle; here they divide, and form a circular inosculation round the circumference of the iris, from this several branches radiate inwards, and again unite in a circle near the pupil; 6th, *muscular arteries*, to the different muscles in the orbit; 7th, *ethmoidal*, passes through the posterior orbital foramen to the mucous membrane in the ethmoid cells; 8th, *superior and inferior palpebral*, to the palpebræ, caruncula, conjunctiva, and lachrymal sac; 9th, *nasal*, passes beneath the trochlea, along the side of the nose, and inosculates with the labial artery; 10th, *frontal*, ascends to the eyebrow and forehead.

The *posterior communicating artery* arises from the carotid, opposite the ophthalmic; passes backwards and inwards, external to the corpora mamillaria, and joins the posterior cerebral artery; this artery forms the lateral part of the circle of Willis; it sends several branches to the surrounding pia mater.

[*Variety.* This artery is sometimes the largest branch of the internal carotid, and then forms the principal origin of the posterior cerebral artery.]

The *anterior cerebral artery*, or *arteria callosa*, passes forwards and inwards above the optic nerve; anastomoses with the opposite, by a short transverse branch, (the anterior communicating artery,) it then bends upwards and backwards round the corpus callosum, on which it terminates by dividing into branches for the corresponding hemisphere of the cerebrum.

[*Variety.* The anterior communicating artery, is usually of large calibre, and from one to two lines in length, but sometimes it is so short, that the two anterior cerebral arteries appear to be confounded at that point; at other times its place is supplied by two smaller arteries.]

The *middle cerebral artery*, very large, passes outwards in the fissure of Sylvius, and divides into two tortuous branches, which supply the anterior and middle lobes of the cerebrum. (See page 291.)

The *subclavian arteries;* the *right* arises from the arteria innominata, and proceeds nearly transversely outwards, between the scaleni muscles, then obliquely downwards and outwards behind the clavicle; it is covered at first by the sterno-mastoid, hyoid, and thyroid muscles; by the internal jugular vein, the vagus, and branches of the sympathetic nerve; next, by the phrenic nerve and anterior scalenus muscle, and externally only by the skin, platysma, and fascia; it first passes over the recurrent nerve, the longus colli muscle, and sympathetic nerve; next, the pleura and middle scalenus muscle, and lastly, the first rib. The *left subclavian* arises from the posterior part of the arch of the aorta, ascends nearly vertically out of the chest; then turns outwards and downwards between the scaleni muscles, and over the first rib; in the chest this artery lies very deep, and is covered by the pleura and the lung, also by the vena innominata, the vagus, the sternum, and the muscles attached to it; it lies near the vertebræ, along the side of the œsophagus and thoracic duct; in the rest of its course, its relations are similar to those of the right; each sends off the following branches, vertebral, thyroid axis, internal mammary, superior intercostal, and deep cervical.

[*Varieties.* Both subclavian arteries sometimes arise directly from the arch of the aorta, one on either side of the carotids, both to the left of the carotids, or alternating with the carotids; the left subclavian may arise by a common trunk with the left carotid, forming a left arteria innominata; the right subclavian sometimes arises from the left extremity of the arch, even as low as the fourth dorsal vertebra, and then turning to the right, passes behind the œsophagus or between it and the trachea, or even in front of the latter: the right subclavian, is sometimes the second branch from the arch, and passes behind the carotid of the same side; the left subclavian sometimes arises by a trunk common to itself and both of the carotids.]

The *vertebral artery* arises from the upper and back part of the subclavian: ascends behind the inferior thyroid artery, enters the foramen in the transverse process of the fifth or sixth cervical vertebra, and ascends through the several foramina in the superior vertebræ as high as the second; it then bends backwards and outwards; passes through the foramen in the transverse process of the atlas; it then turns backwards aud inwards, round the articulation of this vertebra with the condyle, and pierces the dura mater; it then ascends obliquely inwards and forwards between the olivary and pyramidal bodies, and at the lower edge of the pons it unites with the opposite, to form the basilar artery; in this course it gives small branches to the spinal nerves and to the inter-vertebral muscles; at the foramen magnum it gives off, first and second, the *posterior and anterior spinal arteries*, which descend all along the spinal cord; third, the *inferior cereballar artery* often arises from the basilar; it runs tortuously around the medulla oblongata, below the vagus, and sends its numerous branches to the inferior surface of the cerebellum.

[*Varieties.* The two vertebral arteries sometimes differ very much in their calibre, that of the left side being more frequently the largest; these arteries usually enter the transverse foramina of the sixth cervical vertebræ, but they may enter those of the fifth, fourth, third, or second. The left vertebral artery seems most subject to anomalies of which the most frequent is its origin from the arch of the aorta between the left carotid and the left subclavian; it may also arise from the arch at the left of the subclavian; or by two roots, one coming off from the aorta, as in the first variety, the other from the left subclavian, and the two uniting at the fifth cervical vertebra; or again, both roots may arise from the subclavian. Both vertebral arteries sometimes arise from the arch of the aorta, their relations to the other branches varying in different subjects. The right vertebral artery sometimes arises from the angle of the bifurcation of the arteria innominata. The *anterior spinal arteries* unite soon after their origin to form a single trunk, which is continued down the spinal canal.]

The *basilar artery*, is formed by the confluence of the two vertebrals, it ascends in the median groove on the pons Varolii, sends small branches to the surrounding membrane, and at the upper edge of that body it divides into four branches, two for each side, first, the *superior cerebellar artery*, passes outwards and backwards, to the upper surface of each hemisphere of the cerebellum on which it spreads its branches; second, the *posterior cerebral artery*, this receives the posterior branch of the internal carotid, bends backwards and outwards, and spreads its ramifications on the posterior lobe of the cerebral hemisphere. (See page 351.)

The *thyroid axis*, arises from the upper part of the subclavian close to the scalenus and phrenic nerve, it immediately divides into the four following branches:—First, the *inferior thyroid*, ascends tortuously behind the common carotid, then bends downwards and inwards, sends branches to the trachea, œsophagus, &c., and is distributed to the thyroid gland, in which it inosculates with the superior thyroid, and with the arteries of the opposite side; second, the *ascending cervical* ascends along and is distributed to the anterior scalenus, longus colli, and rectus capitis anticus major muscles; third, *supra-scapular* runs obliquely outwards and downwards beneath the clavicle, passes above the notch in the superior costa of the scapula, supplies the supra-spinatus muscle, and descends beneath the acromion process to the infra-spinatus and teres minor muscles; fourth, *transversalis colli* ascends obliquely outwards round the scaleni muscles, and beneath the trapezius, it divides into branches, one, the *cervicalis superficialis*, supplies the superficial muscles on the side and back part of the neck; the other, the *posterior scapular artery*, descends beneath the lavator anguli scapulæ, and the rhomboid muscles along the base of the scapula as far as the inferior angle, where it inosculates with the subscapular artery; the posterior artery of the scapula, as also the supra-scapular in many subjects, arise distinctly from the subclavian artery.

[*Varieties.* The *inferior thyroid* artery may arise singly, or by a trunk common to itself and the supra-scapular, or the transversalis colli, or the internal mammary; it may arise from the common carotid; from the arteria innominata, or from the arch of the aorta, either between the innominata and the left carotid, or the left carotid and subclavian of the same side. When arising from either of the three last points, it is sometimes called the *middle* thyroid, and the usual inferior thyroids if existing, are but small branches, often not distributed at all upon the thyroid body. Sometimes there are two inferior thyroid arteries upon the one side or the other, one arising as usual, the other from the common carotid; occasionally this artery arises on one side only, and bifurcates to form the right and left thyroids. The *supra-scapular* artery sometimes arises in common with the inferior thyroid alone, or that and the transversalis colli, or sometimes even in common with the internal mammary; it may arise directly from the subclavian itself, or even from the axillary artery; in the latter case it is not so much exposed in ligaturing the subclavian behind the clavicle. The *transversalis colli* arises at different points, either to the inside of the scaleni muscles, between them, or more frequently on their outer side; it may arise in common with the inferior thyroid, or the supra-scapular.]

The *internal mammary artery* arises opposite the thyroid axis, it descends obliquely forwards and inwards, between the cartilages of the ribs and the pleura, as far as the ensiform cartilage, it gives branches to the pleura, pericardium, and mediastinum, a long branch to the diaphragm, which accompanies the phrenic nerve, also intercostal branches, which inosculate with the aortic intercostals; it terminates by sending branches to the diaphragm, and to the abdominal muscles, the latter inosculate with the epigastric artery.

[*Varieties.* This artery on the right side, has been seen to arise from the arch of the aorta, and from the arteria innominata, it also sometimes arises in common with the inferior thyroid.]

The *superior intercostal artery* arises between the scaleni, descends behind the pleura, in front of the neck of the first and second ribs, and supplies the two first pair of intercostal muscles.

The *cervicalis profunda* arises opposite the last, ascends obliquely backwards and outwards, between the transverse processes of the sixth and seventh cervical vertebræ, and ascending on the back of the neck, supplies the complexus and the other deep muscles in that region, and inosculates with the descending branches of the occipital artery.

[*Variety.* This artery sometimes arises in common with the superior intercostal. Cruveilhier says, that it invariably passes backwards between the transverse process of the seventh cervical vertebra and the first rib, and not as described above.]

The *axilliary artery* descends from the lower edge of the first rib, obliquely outwards to the tendon of the latissimus dorsi muscle, it is covered by the integuments, and at first by the external border of the great pectoral muscle, lower down by the great and lesser pectoral, and still lower down by the tendon of the great pectoral only; it passes over the first intercostal, and serratus magnus muscles, the brachial plexus, the subscapular, and the tendons of the latissimus dorsi and teres major muscles; the axillary vein descends along its inner and anterior part, and the brachial plexus lies posterior and external to it; it sends off the following arteries, the thoracica acromialis, the superior and long thoracic, the subscapular, the posterior and anterior circumflex.

[*Varieties.* The anomalies of this artery principally affect the origin of the ulna, the radial, and the interosseous arteries; the first of these is the one most commonly arising from the axillary, but sometimes all these come off from it simultaneously. This artery sometimes divides into two branches of equal size, of which one is muscular, and gives off some of the branches usually coming from the axillary, while the other is the brachial artery. It sometimes bifurcates so as to form two brachial arteries which re-unite low down upon the arm.]

The *acromial thoracic artery* arises from the front of the axillary below the subclavian muscle, above the lesser pectoral, and opposite the fissure between the great pectoral and deltoid muscles; it divides into several branches, which pass some to the pectoral muscles, others to the acromion process, deltoid muscle, and integuments of the shoulder and arm, one long branch accompanies the cephalic vein, [the *deltoid* artery.]

The *superior thoracic artery* arises a little below the preceding, sometimes in common with it, it passes forwards and inwards, and divides into branches which supply the cellular membrane and ganglia in the axilla, the pectoral muscles, the breast, and the integuments.

The *long thoracic artery* arises below the lesser pectoral, descends obliquely forwards, along the side of the chest, parallel to the lower edge of the great pectoral, to which it sends some branches, it terminates in the intercostal muscles and integuments, and inosculates with the internal mammary and the intercostal arteries.

[*Varieties.* This artery sometimes arises in common with the two last, sometimes in common with the subscapular, whose place it in part supplies in other cases.]

The *subscapular artery* arises opposite to and descends along the lower edge of the subscapular muscle, and soon divides into an anterior and posterior branch; the former continues to descend along the back part of the axilla, and supplies the subscapular, serratus magnus, and latissimus dorsi muscles; the latter passes backwards round the inferior costa of the scapula, behind the long tendon of the triceps; and above the latissimus and teres major muscles, it is distributed on the dorsum of the scapula to the infraspinatus and teres minor muscles, and inosculates with the supra-scapular artery.

[*Varieties.* This artery may arise in common with the circumflex, the long thoracic or the superior profound artery, and in the latter case is as large or even larger than the brachial.]

The *posterior circumflex artery* arises below the last, sometimes in common with it, it passes out of the axilla between the long tendon of the triceps and the humerus, turns round this bone between it and the deltoid muscle, to which last it sends numerous branches.

The *anterior circumflex artery* is smaller than the preceding, and arises either from it or from the axillary; it passes outwards round the anterior part of the humerus, beneath the deltoid, coraco-brachialis, and biceps; to these muscles it sends its branches; it also sends one long branch along the bicipital groove to the synovial membrane of the shoulder joint.

The *brachial artery* descends obliquely outwards to the bend of the elbow, where it divides into the radial and ulnar arteries; it is covered by the skin and brachial aponeurosis, and inferiorly by the fascia of the biceps, and the median basilic vein; it lies on the inner side of the coraco-brachialis and biceps, and passes over the upper part of the triceps, the coraco-brachialis, and the brachialis anticus; it is accompanied by a vein on either side, also by the median nerve, which above lies to its outer, and below to its inner side, it passes superficial to the artery about the middle of the arm; in addition to several muscular branches it sends off the superior and inferior profunda, and the anastomotica.

[*Varieties.* The anomalies of this artery as of the axillary, have reference principally to the high origin of the radial or ulnar arteries. This high bifurcation of the brachial artery may take place at any point between the axilla and the bend of the elbow: the interosseous artery may also arise from the brachial. The high origin of the ulna, is most commonly from the axillary artery, and that of the radial from the brachial artery, and in either case the branch is more superficial in its course than when coming off at the usual point: these high origins may occur in both arms, but they appear to be most common in the right arm. The brachial artery is sometimes double, that is the axillary bifurcates, and the two trunks thus formed descend to the bend of the elbow, and re-uniting form a short trunk which then gives off the ulna and radial. In the private museum of Dr. Alfred C. Post of this city, there is a remarkable variety of this artery, on the left side: "just below the axilla it gives off a branch, which runs superficially down the anterior surface of the arm, and a little below the elbow, joins the trunk of the radial artery, which bends abruptly forward to receive it." These varieties of the brachial artery should be borne in mind, even in the common operation of venesection, as in these cases there is danger of producing a traumatic aneurism, which accident has occurred.]

The *superior profunda* arises below the teres major, accompanies the musculo-spiral nerve obliquely downwards and outwards, between the three heads of the triceps, and in the musculo-spiral groove of the humerus; it divides into two large branches, one descends in the triceps to the olecranon, the other accompanies the radial nerve to the outer condyle, and communicates with the radial recurrent artery.

[*Varieties.* This artery may arise from the subscapular or either of the circumflex branches of the axillary artery: it sometimes gives off the next artery.]

The *inferior profunda* arises opposite the tendon of the coraco-brachialis, descends on the surface of the triceps, along with the ulnar nerve, to the inner condyle, and communicates with the ulnar recurrent.

The *anastomotica* arises about two inches above the joint, passes inwards, supplying the adjacent muscles, and inosculating with the preceding and with the ulnar recurrent arteries.

[*Variety.* This artery sometimes arises immediately below the superior profunda.]

In the triangular hollow at the bend of the elbow, the brachial artery divides into the radial and ulnar.

The *ulnar artery* is the larger of the two, it descends along the ulnar side of the fore arm to the palm of the hand, covered superiorly by the superficial flexors and pronators, and by the median nerve; inferiorly by the skin and fascia, overlapped, however, by the tendons of the flexor digitorum sublimis and flexor carpi ulnaris, between which it descends to the wrist; it passes over the brachialis anticus, flexor profundus, pronator quadratus, the annular ligament of the carpus, and the flexor tendons in the palm of the hand; it is accompanied by two veins, and by the ulnar nerve, the latter descends along its ulnar side; it gives off, first, the *anterior ulnar recurrent*, which ascends in front of the inner condyle, on the brachialis anticus, and inosculates with the anastomotica; second, the *posterior ulnar recurrent*, large and tortuous, ascends behind the inner condyle, along with the ulnar nerve, and anastomoses with the anastomotica and inferior profunda arteries; third, *inter-osseal artery*, passes backwards and divides into an anterior and posterior branch; the *anterior inter-osseal artery* descends along the forepart of the inter-osseal membrane, beneath the deep flexors, pierces that membrane near the pronator quadratus, and descends on the back part of the carpus, and is distributed to the carpal bones, and to the sheaths of the extensor tendons; the *posterior inter-osseal artery* passes backwards beneath the anconæus, and descends along the back of the fore arm, sending its branches to the extensor muscles; this artery superiorly sends a very large recurrent branch in the anconæus muscle to the olecranon, to communicate with the superior profunda; fourth, *muscular branches* to the two layers of flexor muscles, and to the skin; fifth, *dorsalis carpi ulnaris* turns round the lower end of the ulna, and spreads its branches on the back part of the wrist and hand; sixth, *superficial palmar*, forms the palmar arch, bends obliquely across the palm of the hand towards the thumb, and inosculates with branches of the radial artery; seventh, *ramus profundus*, passes beneath the flexor tendons, across the fifth and fourth metacarpal bones, and joins the deep palmar branch of the radial artery, and thus completes the deep palmar arch; from the superficial arch long digital branches pass, these divide and supply the opposite sides of all the fingers, except the radial side of the index finger and the thumb.

[*Varieties.* These may be arranged under two heads: first, varieties in the origin and course of the ulnar artery itself, and secondly, varieties in the origin and distribution of its branches. First, the ulnar artery may arise from the brachial, but this is rare; the point at which it comes off is usually about two inches above the bend of the elbow; it much more frequently arises from the axillary; in either of the above cases after reaching the bend of the elbow, it may take the usual course, but most commonly it is superficial in its whole extent, being placed either beneath the fascia of the arm and fore arm, or between it and the integuments. When the ulnar artery arises from the axillary, there is sometimes a large anastomotic trunk between it and the brachial artery. This artery may arise at the usual point, but run superficially down the fore arm. Secondly, varieties of the branches: the *interosseal artery* may arise from the radial, brachial, or even axillary arteries; it also sometimes supplies the place of the radial artery, which is in that case very small. Its *recurrent branch* sometimes arises directly from the interosseal, and perforates the interosseal ligament at a different point from the parent trunk.

Not unfrequently a branch arises either from the interosseal or the ulnar artery, which follows the course of the median nerve, passing into the palm of the hand either before or behind the annular ligament: from its relation to the median nerve, this artery has been called by Tiedemann and Cruveilhier, the *median artery*. It is often as large as the radial and ulnar arteries, and sometimes even it is very large, and supplies the place of those arteries which are then in a rudimentary state. It sometimes arises from the brachial artery. Its termination varies very much; in some cases it runs into the superficial palmer arch, in others it unites with the radial artery to supply the radial half of the palm of the hand; and in still other cases, it takes the place of the radial, and supplies the radial half of the hand, while the ulnar artery supplies the ulnar half. A knowledge of this artery is very important in a surgical point of view. There is great variety in the arrangement of the superficial palmar arch and the terminal branches of the ulnar artery. This artery is usually distributed to both sides of the little, ring, and middle fingers, and to the ulnar side of the fore finger; sometimes, however, it is distributed to the ulnar half of the hand only, while the radial half is supplied by the radial or the median artery; in other cases, the ulnar artery supplies both sides of the thumb, and all the fingers; sometimes the superficial palmar arch is not joined by the superficial volar artery; at other times there is no arch. There may be no anastomotic branch between the ulnar and the radial or median, or there may be one just at the lower edge of the annular ligament. The *digital arteries* sometimes arise from the deep palmar arch, of which there is a preparation in the valuable private collection of Dr. J. Kearny Rodgers, if this city, the whole of which collection has been deposited by him in the College Museum.]

The *radial artery* continues in the direction of the brachial artery; it passes along the radial side of the fore arm to the wrist, turns round the external lateral ligament of this joint, then passes forwards between the heads of the two first metacarpal bones into the palm of the hand, and terminates in three branches ; in the fore arm it is covered by the skin and fascia only, lies between the supinator longus externally, and the pronator teres, and flexor carpi radialis internally; it passes over the biceps, supinator brevis, pronator teres, flexor digitorum sublimis, flexor pollicis, and pronator quadratus; it is accompanied by two veins, and the radial nerve is to its external side in the middle of the fore arm; on the outer side of the wrist it is covered by the extensor tendons of the thumb, and on the back of the hand by the skin and fascia; it gives off, first, *radial recurrent*, large and tortuous, bends outwards and upwards along the supinators and extensors, to which it sends several branches, and inosculates with the superior profunda; second, *muscular branches* to the flexors and supinators; third, *superficialis volæ* passes over the annular ligament of the carpus, supplies the small muscles of the thumb, and inosculates with the ulnar artery; fourth, *dorsalis carpi radialis;* fifth, *dorsales pollicis*, these branches are distributed as their names imply; sixth, *radialis indicis*, runs along the radial side of the fore finger; seventh, *magna pollicis* runs along the first metacarpal bone, and divides into two branches, which pass along the opposite sides of the thumb to its last phalanx; eighth, *palmaris profunda* passes across the metacarpal bones, joins the deep branch of the ulnar, and thus forms the deep palmar arch, from which several branches proceed to the inter-osseal muscles, and to the bones and ligaments of the metacarpus.

[*Varieties.* This artery may arise from the axillary, but it comes off much more frequently from the brachial; it is sometimes very small, and its place is then supplied by the median artery. The radial artery of one side may be much smaller than that of the other side. When this artery arises high up, its entire course is usually superficial. Sometimes this artery, about the middle of the fore arm, crosses over its outer edges superficial to the supinator longus and the extensor muscles of the wrist and thumb, and descends rather on the back of the fore arm, while the superficialis volæ is continued in the usual course of the parent trunk. The *superficialis volæ* is sometimes very large, and forms a part of the superficial palmar arch; in other cases it is small, and may not even join the arch. The other varieties of the radial artery have been sufficiently referred to above.]

The THORACIC AORTA gives off the bronchial, œsophageal, and intercostal arteries.

The *bronchial arteries* are two or three in number, they arise from the fore part of the aorta, below the arch; they pass to either side, enter the back part of the root of each lung, and are lost in the cellular tissue of these organs; these arteries sometimes arise from the intercostal, they are very irregular in number and size.

[*Varieties.* There are sometimes as many as four of these arteries, and they arise separately, or by a common trunk; those of the right side are the largest, which accords with the greater volume of the right lung. A bronchial artery is sometimes found to arise from the subclavian, the internal mammary, the first, second, or third intercostal, or even the inferior thyroid artery.]

The *œsophageal arteries* are also irregular, generally three or four in number; they arise from different parts of the aorta, send branches to the mediastinum and œsophagus; on the latter some ascend, others descend; the former inosculate with the cervical arteries, the latter with the abdominal.

[*Variety.* There are sometimes as many as seven of these arteries.]

The *intercostal arteries*, in general ten on the left, nine on the right side, the superior intercostal on the right side being larger than that on the left; they arise from the back part of the aorta, pass obliquely outwards behind the pleura, and enter the intercostal spaces, run along the lower edge of each rib between the layers of muscles, and about the middle of the chest divide into an inferior and superior branch; the former, smaller, runs along the superior border of the lower rib; the latter continues in the groove in the upper; they both supply the intercostal muscles, and send branches through these to the pleura and to the superficial muscles of the chest; they inosculate with the internal mammary and with the thoracic arteries. Each intercostal artery, before it enters the intercostal space, sends a large branch backwards between the transverse processes of the vertebræ to the muscles on the posterior part of the trunk, these *dorsal branches* of the intercostal arteries also send small branches through the inter-vertebral holes along the spinal nerves to the medulla spinalis.

The Abdominal Aorta sends off the following branches; the phrenic, cœliac axis, superior mesenteric, inferior mesenteric, renal, supra-renal, spermatic, lumbar, and middle sacral.

The *phrenic arteries* arise in common, or near each other, from the fore part of the aorta; they both send branches to the supra-renal capsules, and to the crura of the diaphragm; the *right* ascends behind the vena cava; the *left* behind the œsophagus; on the diaphragm each divides into an external and internal branch; the former passes towards the circumference of the muscle, and inosculates with the internal mammary and the inferior intercostals; the latter encircles the central tendon, communicates with its fellow and with the phrenic branches of the mammary,

[*Varieties.* These arteries are sometimes three and four in number, and they may arise from the cœliac artery, or one of its branches; frequently one artery arises thus, while the other comes off as usual from the aorta. One or more of them may arise from the gastric, renal, or even the first lumbar artery. The gastric and phrenic arteries may form a common trunk.]

The *cœliac axis* arises from the fore part of the aorta opposite the last dorsal vertebra; it soon divides into three branches, first, the *gastric artery* ascends obliquely to the left side, to the cardiac orifice [of the stomach,] to which and to the œsophagus it sends several branches; it then bends along the lesser curvature towards the right side between the laminæ of the lesser omentum, and inosculates with the superior pyloric artery; it sends its branches to the anterior and posterior surfaces of the stomach; second, *hepatic artery* ascends obliquely towards the right side, in front and to the left side of the vena porta and ductus choledochus, and in the transverse fissure of the liver divides into right and left hepatic arteries; in this course it gives off the *superior pyloric*, which passes along the upper surface of the pylorus and joins the gastric artery; and the *gastro-duodenalis* which descends between the pylorus and the duodenum; this gives off *inferior pyloric* branches, and divides into the *pancreatico-duodenalis* and *gastro-epiploica dextra:* the former takes a curved course between the duodenum and the pancreas, sending branches to each, and inosculates with the superior mesenteric artery; the latter turns forwards, and to the left side along the great curvature of the stomach, between it and the laminæ of the great omentum, to which, as well as to the stomach, it sends numerous branches, and inosculates with the gastro-epiploica sinistra, a branch of the splenic artery; the right and left hepatic arteries then separate and plunge into the substance of the liver, accompanying the branches of the vena porta: the right hepatic is the larger, and before it enters the gland it gives off the *cystic artery* which supplies the parietes of the gall-bladder; third, the *splenic artery* is the longest branch of the cœliac axis; it passes backwards and to the left side along the upper edge of the pancreas, to which it sends several branches: near the spleen it gives off the *gastro-epiploica sinistra;* this bends forwards, and to the right side along the great curvature of the stomach, and between the laminæ of the great omentum, it inosculates with the corresponding branch from the hepatic artery; the splenic next sends off the *vasa brevia*, five or six small branches which pass to the great end of the stomach, and inosculate with the proper gastric arteries; the splenic artery then divides into several branches, which enter the foramina on the concave surface of the spleen, and ramify through its spongy substance.

[*Varieties.* The *gastric artery* sometimes gives off one of the hepatic arteries, and sometimes the left phrenic artery. The *hepatic artery* sometimes, though rarely, comes off separately from the aorta. It may also arise from the superior mesenteric artery. There are sometimes two hepatic arteries; one, the left, arising from the gastric, and the other from the superior mesenteric; and sometimes there is a third coming off from the cœliac. Sometimes when the hepatic artery is derived from the superior mesenteric, the *right gastro-epiploic* branch is given off by the cœliac. The *left gastro-epiploic artery* and the *vasa brevia* often come off from the terminal branches instead of the trunk of the splenic artery.]

The *superior mesenteric artery* arises a little below the cœliac, descends obliquely forwards and to the left behind the pancreas, and over the duodenum; it then passes between the layers of the mesentery, and takes an arched course towards the right iliac fossa; from its concave side arise three branches, the *ileo-colic*, *right colic*, and *middle colic;* these three branches proceed between the laminæ of the meso-colon to the large intestine, each divides into two branches which unite with those on either side, and form arches, from the convexities of which branches arise, some of which subdivide and unite again in the same manner as the first branches; near the intestine straight branches proceed on the anterior and posterior surface, and supply the muscular and mucous coats; from the convex side of the mesenteric artery eighteen or twenty branches arise, these proceed between the laminæ of the mesentery, divide, and form arches, from which new branches arise, these again divide, and again unite in an arched manner; these divisions and subsequent inosculations occur three or four times before the arteries arrive at the intestine; near the latter each branch divides into two, which proceed in a direct course, one on the anterior, the other on the posterior surface of the intestine, and are distributed principally to the mucous membrane.

[*Varieties.* This artery sometimes, though rarely, arises by a common trunk with the cœliac. I have seen this variety but once. The three branches given off from the concavity of the artery do not often arise separately, but by two roots, one of which bifurcates to form the ileo-colic and right colic arteries. The anastomosis between the superior and inferior mesenteric arteries is sometimes entirely wanting.]

The *inferior mesenteric artery* arises about two inches below the preceding; it descends towards the left iliac fossa and divides into three branches, left colic, sigmoid, and superior hæmorrhoidal; the *left colic* ascends in the left meso-colon, anastomoses with the middle colic branch of the superior mesenteric, and supplies the left part of the colon; the *sigmoid artery* is distributed to the sigmoid flexure of the colon; the *superior hæmorrhoidal* descends along the back part of the rectum, supplies the coats of this intestine, and inosculates with the middle and inferior hæmorrhoidal arteries.

The *renal arteries* arise from the sides of the aorta, between the superior and inferior mesenteric arteries; the right is longer than the left: it passes across the spine behind the vena cava: both pass behind their corresponding vein, and divide near the kidney into five or six branches, which ramify through the substance of this gland.

[*Varieties.* These arteries are more frequently the subject of anomalies, than almost any others in the body. Sometimes there is more than one on each side, or one on one side, and two or more on the other. They may arise from the aorta lower down than usual, or they may arise from the primitive or internal iliac arteries, in which cases, there is generally a corresponding transposition of the kidneys into the iliac fossæ, or the cavity of the pelvis. Cruveilhier has seen two renal arteries going to the kidney in the pelvis, one arising from the aorta opposite the inferior mesenteric, the other from the angle of bifurcation. The two renal arteries may arise by a common trunk from the front of the aorta; or again there may be but one renal artery, there being but one kidney, and that of unusual size, as in a prepation belonging to Dr. Alfred C. Post. Tiedemann represents a kidney having three arteries, one of which arises from the aorta as usual, the second from the angle of bifurcation of the aorta, and the third from the common iliac artery. I have seen three arteries going to the left kidney, all coming off from the aorta, within the space of half an inch, while on the right side of the same subject, there are two renal arteries coming off from the aorta at a distance of three inches from each other. I have a preparation in my possession, taken from a white female of about sixty years of age, in which on the left side there are two renal arteries arising near together; on the right side there are also two renal arteries arising near together; while a third arises some distance below, and passes *in front of the vena cava* to the kidney. I do not now recollect that this anomaly has been noticed before.]

The *capsular arteries* are two or three in number; they arise either from the renal arteries or from the aorta; they supply the renal capsules.

The *spermatic arteries* arise from the fore part of the aorta; the left frequently arises from the renal artery: they are long and tortuous, descend obliquely outwards, crossing in front of the psoas muscle and the ureter: in the male they accompany the vas deferens, through the inguinal canal, and supply the testicle and epididymis; in the female they pass to the ovarium, and also send branches to the Fallopian tubes, and to the sides of the uterus.

[*Varieties.* These arteries sometimes arise by a common root; occasionally there are two of them on one or both sides; they rarely arise from the aorta at the same level; they may arise, though rarely, above the renal arteries: one of the spermatics may arise from the capsular, the renal, the inferior mesenteric, or the internal iliac artery.]

The *lumbar arteries* are four or five pair; they arise from the back part of the aorta, pass obliquely outwards through the psoas muscle, send branches between the transverse processes of the lumbar vertebræ, to the muscles of the back and loins, and terminate in the abdominal muscles.

[*Varieties.* The first lumbar arteries are sometimes branches of the last intercostal: the fifth lumbar arteries may arise from the fourth lumbar, the middle sacral, the aorta, or the common iliac.]

The *middle sacral artery* arises from the back part of the aorta a little above the bifurcation; it descends nearly in the median line close to the sacrum, sends its branches to this bone, and communicates with the lateral sacral arteries.

[*Varieties.* This artery may arise from the left common iliac, or from the last lumbar artery: it sometimes arises by a common trunk with the two last lumbar arteries.]

The *common iliac arteries* descend obliquely outwards as far as the ilio-sacral articulations, opposite which each divides into the internal and external iliac; the right iliac is longer than the left, and passes over the commencement of the vena cava.

[*Varieties.* The length of this artery is generally about two inches, but frequently it is shorter, and this is the case more often on the left side. This artery does not usually give off any branches before its bifurcation; but I have several times seen one or two branches from it, distributed principally upon the psoas magnus muscle. In one case the right common iliac artery was entirely wanting, the external and internal iliacs coming off directly from the aorta, which ended by a division into three branches, the third being the left common iliac.]

The *internal iliac* or *hypogastric artery* passes downwards and forwards into the pelvis to the side and back part of the bladder, where it ends in a ligamentous substance, which ascends first along the side of the bladder, and then behind the recti muscles as far as the umbilicus; the internal iliac artery gives off the following branches, ilio-lumbar, lateral sacral, [middle] hæmorrhoidal, vesical, uterine and vaginal, the glutæal, sciatic, obturator, and [internal] pudic. First, the *ilio-lumbar* arises from the back part of the internal iliac, passes outwards behind the external iliac vessels and the psoas muscle, into the substance of the ilacus internus, in which it divides into ascending and descending branches. Second, the *lateral sacral* descends obliquely inwards in front of the sacral holes, through which it sends branches to the spinal nerves, also to the pyriform muscle, and to communicate with the middle sacral. Third, the *hæmorrhoidal* are two or three branches of uncertain origin, they pass to the sides of the rectum, and communicate with the superior and inferior hæmorrhoidal arteries. Fourth, the *vesical arteries* arise from the iliac, or from some of its branches; they ramify on the coats of the bladder; the inferior also supply the parts about the neck of this organ. Fifth, the *uterine* and *vaginal arteries* either arise from the internal iliac or from some of its branches, and are distributed as their names imply. Sixth, the *glutæal artery* passes backwards and outwards from the pelvis by the upper part of the sciatic notch, above the pyriform muscle, and divides into several branches, some of which supply the glutæus maximus, others pass forwards in a semicircular course towards the spine of the ilium, and supply the glutæus medius and minimus muscles. Seventh, the *obturator artery* passes out of the pelvis by the superior part of the thyroid hole into the upper part of the thigh beneath the pectinæus, and divides into several branches to supply the obturator and adductor muscles. Eighth, the *sciatic artery* passes over the pyriform muscle, and escapes from the pelvis by the lower part of the sciatic notch, along with the sciatic nerve; it sends several branches to the glutæus maximus, the hamstring, and adductor magnus muscles; also to the small capsular muscles and to the sciatic nerve; these communicate with the circumflex and perforating arteries. Ninth, the *internal pudic artery*, smaller than the preceding, leaves the pelvis along with it below the pyriform muscle, re-enters the cavity between the sciatic ligaments, and then ascends obliquely inwards and forwards along the tuber and ramus of the ischium and ramus of the pubis, and a little below the symphysis pubis divides into two branches. In the pelvis the pudic at first gives small branches to the adjoining viscera; as it is passing round the spine of the ischium, and between the sciatic ligaments, it gives small branches to the surrounding ligaments and muscles; when it has re-entered the pelvis it gives off, First, *external* or *inferior hæmorrhoidal arteries*, two or three, they pass transversely to the side of the rectum and anus, and supply the integuments and muscles in that region; second, the *perinæal artery* first descends, then turns forwards and upwards round the transversus perinæ, proceeds along the perinæum, and is distributed to the muscles and integuments in this situation, and to the scrotum;

third, *transversalis perinæi*, a small branch arising near to and often from the preceding; it takes the course of the muscle of that name, and is lost in the muscles and integuments; fourth, *artery of the bulb*, passes transversely between the layers of the triangular ligament, enters the spongy substance of the bulb, and spreads its branches through the corpus spongiosum urethræ; fifth and sixth, *artery of the corpus cavernosum* and *dorsalis penis;* the former enters and extends along the corpus cavernosum, the latter along the dorsum of the penis as far as the glans. In the female the pudic artery gives off branches to the perinæum and labia, and to the corpus cavernosum and dorsum of the clitoris, analogous to, but smaller than those in the male.

[*Varieties.* The internal iliac artery in one case came off on the right side from the aorta. The order in which its branches come off is very variable; sometimes they come off from the trunk; sometimes the trunk divides into two large branches, which give off the terminal branches. The *ilio-lumbar* branch is sometimes double on both sides; it may arise from either of the following sources, the common iliac, the external iliac, or the gluteal, and more rarely from the fourth lumbar or middle sacral artery. The *lateral sacral* arteries are frequently double on both sides; one of them arising from the internal iliac, the other from the gluteal, ischiatic, or ilio-lumbar artery: this artery sometimes arises from the common iliac. The *middle hæmorrhoidal* arteries may arise from the internal iliac, the lateral sacral, the internal pudic, or the ischiatic artery; they are sometimes wanting. The *vesical* arteries vary very much in number and origin; the sources from which they are derived are the internal iliac, internal pudic, ischiatic, middle hæmorrhoidal, obturator, and in the female also the vaginal and uterine arteries. The *uterine* artery sometimes forms a common trunk with the middle hœmorrhoidal. The origin of the *obturator* artery is very irregular, as it may come off from almost any of the larger branches of the internal iliac artery: it also frequently arises from the epigastric artery, or by a common trunk with it from the external iliac: this variety is said to occur once in three times. This artery may arise singly from the external iliac above the epigastric, or from the femoral artery below Poupart's ligament: these anomalies may exist on one side only, or on both sides, and they are of importance in the surgical anatomy of femoral hernia. The *ischiatic* artery frequently arises by a common trunk with the gluteal, or the internal pudic artery The *internal pudic* artery is often a branch of the ischiatic, and in some rare cases it does not pass out of the pelvis at the sacro-ischiatic notch. The *arteria dorsalis penis* sometimes arises from the internal iliac itself, and describes a long course within the pelvis, passing out under the symphisis pubis. It sometimes arises from the obturator, or from one of the external pudic arteries; and I have seen it in an adult negro coming off directly from the femoral artery, an inch below Poupart's ligament; it sometimes arises from the deep femoral artery. The *cavernous* artery is sometimes a branch of the obturator.]

The *external iliac artery* proceeds from the common iliac downwards and outwards to Poupart's ligament, beneath which it passes and receives the name of femoral; it lies along the inner side of the psoas muscle, the vein is internal and posterior to it, it gives off near the groin two branches; first, *circumflexa ilii* arises from its outer side, ascends obliquely outwards as far as the crest of the ilium, where it divides into several branches, some pass to the abdominal muscles, others to the iliacus internus and quadratus lumborum, and communicate with the ilio-lumbar artery; second, the *epigastric artery* arises from its fore part, a little above Poupart's ligament, it at first descends, then turns forwards and ascends between the abdominal muscles and the peritonæum, crosses behind the spermatic cord, a little internal to the internal inguinal ring; about three or four inches above the pubis it enters the sheath of the rectus, and divides into branches which ascend in this muscle to the umbilicus, and inosculate with the mammary artery.

[*Varieties.* The external iliac artery has been seen to arise directly from the end of the aorta; it rarely gives off any branches, except the two mentioned. I have, however, several times seen one or more branches from it, distributed upon the psoas magnus muscle. The *circumflex* artery is sometimes double, and sometimes arises from the upper part of the femoral artery. The *epigastric* artery sometimes arises an inch or even two inches above Poupart's ligament. It often arises by a common trunk with the obturator, and sometimes it is a branch of that artery. It may also arise from the femoral, or the deep femoral artery.]

The *femoral artery*, or the continuation of the external iliac, descends obliquely inwards from the middle of the crural arch, along the anterior and internal part of the thigh, covered superiorly by the skin, superficial fascia, inguinal ganglia, and fascia lata; in the middle of the thigh it is also covered by the sartorius, and beneath this by a strong aponeurosis connecting the vastus internus to the tendons of the adductor longus and magnus; at the inferior part of the middle third of the thigh, it passes obliquely backwards through a tendinous opening, bounded externally by the vastus internus, internally by the adductor magnus, superiorly by the adductors magnus and longus, and inferiorly by the adductor magnus and vastus internus; the femoral artery first passes over the psoas and iliacus, next over the pectinæus and short adductor, from which it is separated by a quantity of cellular membrane and by small vessels, it next passes over the tendon of the adductor longus; the femoral vein descends along with it, at first internal, afterwards posterior to it; the anterior crural nerve is external to it, two or three of its branches are very near it, above the middle of the thigh, one small nerve crosses the artery, and the saphenus nerve descends in its sheath along the forepart of the vessel; it sends off, 1st, three or four superficial branches, viz.:—*inguinal branches* to the inguinal ganglia, &c.; the *superficial pudic*, one or two in number, which pass towards the pubis and are lost in the integuments; the *superficial epigastric*, the longest and largest of these branches, ascends obliquely inwards towards the umbilicus, parallel to the internal epigastric, and is lost in the integuments; the *external circumflex ilii* extends along Poupart's ligament to the crest of the ilium, where it terminates in the skin; 2nd, the *profunda* is the largest branch of the femoral, it arises about two inches below the crural arch, from the outer and back part of the femoral artery, bends a little outwards at first, then descends obliquely inwards and backwards behind the femoral artery, and the tendon of the adductor longus, passing over the psoas, cruræus, and adductor brevis, at the back part of the thigh it terminates in two branches for the hamstring muscles; in this course it gives off the two circumflex, and the three perforating branches; the *external circumflex artery*, arises from the outer part of the profunda, passes transversely beneath the sartorius and rectus muscles, and divides into three fasciculi of branches, superior, middle, and inferior; the first ascend along the tensor vaginæ and glutæus medius muscles, and inosculate with the glutæal artery; the second pass round the bone to its back part, and inosculate with the glutæal, sciatic, and internal circumflex arteries; the third are the longest and largest branches, they descend towards the knee and supply the extensor muscles. The *internal circumflex artery* arises sometimes below, sometimes above the preceding, it often proceeds from the femoral itself, it passes backwards between the psoas and pectinæus, along the obturator externus tendon, to the back part of the thigh, first sending off several branches to the surrounding muscles, and to the hip joint, also some to inosculate with the obturator artery; at the back of the thigh it gives several branches to the gemelli, quadratus, glutæus maximus, and the hamstring muscles, and inosculates with the external circumflex and sciatic arteries; the *first* or *superior perforating artery* passes backwards beneath the lesser trochanter, between the pectinæus and adductor brevis, and through the adductor magnus, its branches are distributed to the latter and to the hamstring muscles; the *second* or *middle perforating artery*, larger than the first, passes through the adductor brevis and magnus, and spreads its branches among the muscles on the back of the thigh; the *third* or *inferior perforating artery* descends behind the adductor longus, and through the magnus to the hamstring muscles; on the back part of the thigh the profunda ends in two branches, one passes to the biceps, the other to the semi-membranosus.

After the origin of the profunda, the femoral gives off several small muscular and cutaneous twigs, and near the opening in the triceps, through which it passes, it gives off, 3rd, the *anastomotica magna;* this descends in front of the adductor tendon to the knee, sends several branches to the integuments, vastus internus, and to the patella; these inosculate with the long branches of the external circumflex artery above, and with the articular arteries below.

[*Varieties.* The femoral artery usually gives off the profunda at an inch and a half or two inches below Poupart's ligament, but the bifurcation may take place at any point above, even directly under the ligament, and in some rare cases the external iliac itself bifurcates above Poupart's ligament, so as to form the femoral and profunda arteries. Sometimes the femoral artery divides at Poupart's ligament into three branches, the third being the internal circumflex artery. Very rarely this artery divides high up, and the two branches again unite in the popliteal space; one of the external pudics sometimes comes off from the deep femoral, and sometimes one of them gives off the superficial epigastric. The number of branches coming off from the profunda, is variable, and sometimes its branches are derived from the femoral artery by two or three distinct trunks. The external *circumflex* artery sometimes arises directly from the femoral, and the same is true of the *internal circumflex;* which also sometimes arises from the external iliac. The *perforating arteries* are sometimes four in number, while at other times they arise by a single trunk, which then subdivides.]

The *popliteal artery* descends from the inner side of the femur, obliquely outwards to the inferior and central part of the popliteal space; it is covered by the skin and fascia, and overlapped superiorly by the semi-membranosus, and inferiorly by the gastrocnemius and plantaris muscles; the popliteal vein lies superficial and external to it; the sciatic nerve is still more superficial and external; its branches are, 1st, several muscular branches to the hamstring muscles, and to the gastrocnemius; 2nd, *superior articular*, encircle the lower extremity of the femur, turn round the sides, to the forepart of the joint, and communicate with the anastomotica and with the branches of the external circumflex; 3rd, *azygos* [or middle] *articular*, passes forwards through the posterior ligament of the joint, aud supplies the synovial membrane and the adipose substance in its cavity; 4th, *inferior articular arteries*, encircle the lower part of the joint; the internal passes round the head of the tibia, the external is beneath the external lateral ligament; these arteries pass round the joint to its forepart, inosculate with the preceding and with the anterior tibial recurrent; [5th, the *sural* or *gastrocnemial* arteries, are two branches, which are extensively distributed upon the gastrocnemius muscle.] At the lower part of the ham the popliteal divides into the anterior and posterior tibial arteries.

The *anterior* perforates the inter-osseous space close to the head of the fibula, descends obliquely forwards along the inter-osseous membrane and over the lower part of the tibia, the synovial membrane of the ankle, and the superior and internal part of the tarsus to the first inter-osseal space; in the leg it is overlapped by the tibialis anticus internally, by the extensor communis and extensor pollicis externally; it passes beneath the annular ligament of the ankle; on the tarsus it is covered by the skin and by the internal tendon of the extensor brevis; it is accompanied by two veins; the anterior tibial nerve descends superficial and external to it; it gives off, 1st, the *recurrent*, which passes upwards and inwards, and is lost around the articulation of the knee; 2nd, *muscular* branches, very numerous, to the muscles on the outer and anterior part of the leg; 3rd, *malleolar branches*, which ramify on the external and internal malleoli; on the former they inosculate with the anterior peronæal; 4th and 5th, *tarsal* and *metatarsal*, are distributed to the bones and ligaments of the tarsus and metatarsus; between the two first metatarsal bones it divides into, 6th and 7th, the *arteria pollicis* and the *communicans:* the former supplies the integuments of the great toe; the latter the first inter-osseal muscle, and inosculates with the plantar arteries.

[*Varieties.* The anterior tibial artery is sometimes very small, or even entirely wanting, and its place is then supplied by branches from the posterior tibial and peroneal arteries; when this artery is small, that part of it on the dorsum of the foot called the *dorsal artery*, is supplied by the anterior peroneal artery, which is then very large, while the tibial is either lost upon the lower part of the leg, or else anastomoses with the dorsal branch of the peroneal; the *external plantar artery* is sometimes continued on to the dorsum of the foot, to supply the place of a small anterior tibial. The anterior tibial sometimes gives off a large branch, above the ankle, which descending gives off the internal malleolar artery, and finally anastomoses with the dorsal artery of the foot. The *malleolar*, and *tarsal arteries* present varieties as to their points of origin and sometimes the one or the other of them is wanting.]

The *posterior tibial artery* descends obliquely inwards between the superficial and deep layer of muscles on the back of the leg, to the space between the heel and inner ankle, where it divides into the internal and external plantar arteries; it is covered by the gastrocnemius and solæus, and lies on the tibialis posticus, flexor communis, and inferiorly on the tibia ; it is accompanied by two veins, and by the posterior tibial nerve, which lies to its external side ; it gives off, 1st, several muscular branches to the deep and superficial muscles ; 2nd, the *peronæal artery* arises about an inch below the popliteal, descends obliquely outwards towards the external ankle, between the fibula and flexor pollicis ; sends numerous branches to the muscles of the leg, and about two inches above the ankle divides into the *anterior* and *posterior peronæal* branches ; the former pierces the inter-osseous ligament, and inosculates with the external malleolar ; the latter spreads its branches on the outer side of the heel and of the foot ; between the heel and inner ankle the posterior tibial divides into the internal and external plantar ; the *internal plantar* proceeds along the internal side of the sole of the foot, supplying the muscles and integuments of the great toe, and inosculating with the adjacent vessels both on the dorsum and in the sole of the foot ; the *external plantar*, much larger than the preceding, passes forwards and outwards above the flexor digitorum brevis, as far as the fifth metatarsal bone ; it then bends across the metatarsus, along the transversalis pedis, as far as the first metatarsal bone, where it joins the anterior tibial, and thus forms the plantar arch, from which proceed numerous muscular branches, and the digital arteries ; these last arise from the anterior or convex edge of the arch, pass forwards, supplying the lumbricales and interossei muscles, and divide each into two branches to supply the opposite sides of the toes.

[*Varieties.* The posterior tibial artery is sometimes very small, and its place is then supplied by the peroneal artery, whose calibre is in inverse ratio to that of the tibial arteries. The posterior tibial and peroneal arteries sometimes form a large common trunk, to within two or three inches of the ankle joint when they separate. The *peroneal artery* is sometimes wanting, and its place is supplied by small branches from the posterior tibial. The *anterior peroneal artery* is sometimes given off by the posterior tibial, a short distance above the ankle joint, the posterior peroneal having been given off as usual ; this last artery sometimes supplies the two plantar arteries, the posterior tibial being in that case very small. The *dorsal artery* of the foot, and its branches, as already stated, are sometimes derived from the peroneal. There are several varieties in the arrangement of the plantar arteries, and formation of the plantar arch. Sometimes the *external plantar artery*, supplies all the digital branches, at other times the two plantars enter equally into the formation of the plantar arch : in some cases the *internal plantar artery* takes the place of the external plantar, which is then small, and in other cases, the latter artery is very large, and supplies the place of the dorsal artery of the foot.

In concluding the description of the arterial anomalies, it is proper to state that almost all the departures from the normal arrangement, are analogous to the natural distribution of the vessels in inferior animals; also that I am led to believe that varieties in the arterial distribution are much more frequent in the negro, than in the white subject, at least such is the opinion of many practical anatomists of the present day, and such is my own impression although I have not those certain data, which can only be obtained by the numerical method of investigation.]

SECTION II.

ANATOMY OF THE VEINS.

In addition to the veins which accompany the arteries, the relative situations of which have been already considered, there are also several veins which run independent of these, and take a superficial or subcutaneous course. It is impossible to fix the exact point at which a vein commences; it is generally considered that the arteries having terminated in minute ramifications or capillaries, the veins commence from these, so that in reality each vein is a returning artery, only altered in structure; some veins are said to commence from cells, as in the spleen and corpora cavernosa penis; we shall describe the veins then as proceeding from the extreme parts of the body towards the centre or towards the heart; and 1st,

The *veins* of the *head* and *neck;* the small arteries which ramify on the side and fore part of the scalp are accompanied each by two veins, these all terminate in the *temporal veins*, which sink into the parotid gland, and there join the *internal maxillary* vein, which is formed by the confluence of the several small veins which accompany the branches of the internal maxillary artery; the union of these two veins is the commencement of the *external jugular vein*, which descends a little backwards nearly parallel to the fibres of the platysma, across the sterno-mastoid muscle, and at a little distance above the clavicle enters the subclavian vein, or some of its branches; near the angle of the jaw this vein receives a branch from the facial vein, and in its course down the neck it is joined by several cutaneous branches; it also not unfrequently communicates with the internal jugular vein by one or two small branches near the os hyoides.

[*Varieties.* The *external jugular vein*, is sometimes double, either because the branches which form it, do not unite until they reach the lower part of the neck; or because it gives off above a small collateral branch, which again empties into it below; or, lastly because it bifurcates, before it empties, into the subclavian vein. The branches which form this vein are uncertain, although usually, those mentioned above; hence its size is variable and often differs on the two sides of the neck, as a general rule however its calibre is in inverse ratio, to that of the other jugular veins.

The *anterior jugular vein.* This vein collects the blood from the fore part of the neck, in the supra-hyoideal region and then descends superficially near the median line, to the lower part of the neck, where it passes behind the sterno-mastoid muscle and empties into the subclavian vein, either by itself, or in common with the external jugular; the vein on one side, is usually larger than the other, sometimes there is but one and again both may be wanting; these veins anastomose with each other and with the external and internal jugular veins; their calibre is in inverse ratio to that of the external jugulars, which they sometimes exceed in size; the branches by which they are formed are irregular. (For the sinuses of the dura mater, See page 285.)]

The *internal jugular vein* commences in the foramen lacerum posterius basis cranii, from the termination of the lateral sinus, it descends along the outer side of the carotid artery, receives the facial, laryngeal, and several muscular veins, and opposite the sternal end of the clavicle joins the subclavian vein.

[This vein receives the blood from the cavity of the cranium and most of the head and face; its calibre is generally unequal on the two sides; sometimes it is very small on one side, the external jugular in that case being unusually developed; they are always in inverse ratio, this is owing to the fact that the facial vein returning all the blood from the exterior of the face, and other veins, in one subject empty into the internal, in another into the external jugular vein.]

The *veins of the upper extremity* are superficial and deep, the *superficial* are the cephalic, basilic and median.

The *cephalic vein* commences on the outer and back part of the carpus from the junction of the several dorsal veins of the hand, it ascends along the radial side of the fore arm to the bend of the elbow, is there joined by the median cephalic, it then continues to ascend along the outer side of the biceps; near the shoulder it turns forwards and passes towards the clavicle between the pectoral and deltoid muscles, and then sinks deep to join the axillary vein.

The *basilic vein* commences near the lower end of the ulna, one branch from the little finger is named the *vena salvatella*, the others are irregular in number and size, it ascends along the ulnar side of the fore arm, before the internal condyle, where it is joined by the median basilic vein, it then continues to ascend along the inner side of the arm, accompanying the brachial vessels, and near the axilla it joins one of the venæ comites or the axillary vein itself.

The *median vein* arises a little above the wrist, ascends along the middle of the fore arm to the bend of the elbow, it here divides into two branches, one (median basilic) joins the basilic vein, the other (median cephalic) joins the cephalic vein, sometimes a third branch joins one of the deep veins.

[The superficial veins of the superior extremity particularly on the fore arm, present many varieties which need not be specially described; the *median vein* may be double, or it may be wanting; the *cephalic vein*, or *radial* as it is called, on the fore arm, may be double, while above the elbow it may be very small. With the normal arrangement of the veins at the bend of the elbow, the median cephalic, is usually the preferable vein for the operation of venesection, as there we avoid those dangers which render it objectionable, to bleed in the median basilic. These dangers are three, we may divide or puncture the filaments of the internal cutaneous nerve, which lie before and behind the vein, or we may transfix the vein and puncture the brachial artery which usually lies directly beneath it, or we may puncture the tendon of the biceps flexor muscle, thus giving rise to an inflammation, which may prove troublesome.]

The *deep* veins accompany the brachial artery and its branches in the arm and fore arm, two with each; these end in the *axillary vein*, which ascends in front of the artery, receives the thoracic veins, passes beneath the clavicle, and is then named *subclavian vein;* this passes inwards, over the anterior scalenus, receives several veins from the shoulder and side of the neck, also the external jugular and vertebral veins, and opposite the sterno-clavicular articulation unites with the internal jugular vein to form the *vena innominata*, which on the right side is a short trunk that descends into the thorax behind the sterno-thyroid muscle, and opposite the cartilage of the first rib joins that from the left side, which is longer, and takes a more transverse course as it enters the chest, in front of the trachea, and of the arteria innominata; this vein receives several branches from the thyroid body and from the anterior mediastinum. The *vena cava superior* or *descendens* commences opposite the first costal cartilage on the right side, descends obliquely inwards in front of the right pulmonary vessels, enters the pericardium, and opposite the third or fourth cartilage it opens into the right auricle; as it enters the pericardium it is joined by the *vena azygos*, which commences by a small branch on the first lumbar vertebra, which often communicates with the renal veins or with the inferior cava; this vein then ascends through the aortic opening of the diaphragm into the posterior mediastinum, along the right side of the dorsal vertebræ and of the aorta, receiving the intercostal veins from each side, also the œsophageal and bronchial; at the fourth vertebra it curves forwards round the root of the right lung, and opens into the back part of the vena cava: in general a similar, only smaller, vein exists on the left side of the dorsal vertebræ, which receives the left intercostal and bronchial veins, and crosses the spine opposite to about the fifth vertebra, and joins the right vena azygos, this vessel is named the left or lesser vena azygos.

[*Varieties.* The *vena cava descendens* is sometimes though rarely double, the two brachio-cephalic veins, or innominatæ not uniting, but descending separately to the right auricle of the heart, this is the normal arrangement in some of the inferior animals.

The *vena azygos* sometimes arises directly from the ascending vena cava, or from the last intercostal or first lumbar vein; this vein does not communicate with the renal vein as frequently as the lesser azygos.]

The veins of the lower extremity are superficial and deep; the *former* are the internal and external saphena; the *external* passes from the dorsum of the foot behind the external malleolus, ascends along the back of the leg to the ham, and joins the popliteal vein. The *internal saphena* commences on the upper and inner part of the foot, ascends in front of the inner ankle along the inner side of the leg, and behind the internal condyle of the knee; it then inclines to the internal and anterior part of the thigh, and ascends to within about two inches of Poupart's ligament, it then passes through the saphenic opening in the fascia lata and joins the femoral vein.

[*Varieties.* The *internal saphena vein* is sometimes double on the leg or thigh, or even in both situations, that is it gives off a large collateral branch, which sooner or later again empties into it. Opposite the knee the *external saphena vein* sometimes gives off a branch, which passes upwards to the front of the thigh and empties into the internal saphena, just before that vein opens into the femoral.]

The *deep veins* of the leg accompany the arteries, two with each, they terminate in the *popliteal vein*, which ascends superficial and external to the artery; this vein then receives the name of *femoral*, and is closely connected to the artery, lying posterior to it below, and on its inner side above; this then passes behind the crural arch and becomes the *external iliac*, which lies internal and rather posterior to the accompanying artery; opposite the ilio-sacral symphysis this is joined by the *internal iliac vein*, which arises from the union of the several veins that accompanied the branches of the internal iliac artery; the union of the external and internal iliac veins constitutes the *common iliac* which ascend on each side towards the right side of the fourth lumbar vertebra, and unite to form the inferior vena cava; the left common iliac vein is longer than the right, and runs obliquely across the spine; both are posterior to the corresponding arteries. The *inferior vena cava* ascends along the right side of the lumbar vertebræ, on the psoas muscle, and left crus of the diaphragm, to the liver, passes through a groove in this organ between the right and middle lobes, and then through the large quadrangular opening in the tendon of the diaphragm, perforates the pericardium, and opens into the lower and back part of the right auricle; it receives the middle sacral, the spermatic, the renal, and capsular, and lastly the hepatic and the phrenic veins.

[*Varieties.* Sometimes the *common iliac veins* do not unite to form the ascending cava, until they reach the level of the renal veins. The *spermatic vein* of the left side almost always empties into the left renal vein; the *left renal vein* itself generally passes in front of the aorta, but sometimes it divides and one branch goes in front of the aorta, while the other passes behind it; anomalies of the renal veins are very much less common than those of the renal arteries; the left renal vein sometimes anastomoses with the superior mesenteric vein. The *hepatic veins* generally empty into the vena cava, below the diaphragm, but occasionally they perforate that organ separately and empty above it.]

The *vena portæ* receives the blood from all the abdominal viscera except the kidneys, bladder, uterus, and [liver]; a large vein commences on the back of the rectum, (*hæmorrhoidal,*) ascends towards the meso-colon, and becomes the *inferior mesenteric* vein, which accompanies the artery of the same name; about the second lumbar vertebra this unites with the *superior mesenteric* vein, which accompanies the artery of that name also; behind the pancreas this trunk is joined by a very large vein, *the splenic*, which returns the blood from the spleen, and also receives the veins from the great and lesser curvatures of the stomach, from the duodenum and pancreas; this large vein passes transversely behind the pancreas and below the splenic artery; thus the vena portæ is formed by the union of the splenic and mesenteric veins, in front of the aorta, and behind the pancreas; it then ascends to the right side, enclosed in the lesser omentum and behind the hepatic artery and ductus choledochus; in this course it receives small veins from the omentum, pancreas, and gall-bladder; at the transverse fissure it divides at right angles into a right and left branch, which pass horizontally for a short distance, and form what is termed the *sinus of the vena portæ*; this rests on the lobulus caudatus; these branches then enter the liver, and ramify through its substance in a transverse direction or from its centre towards its circumference, along with the branches of the hepatic artery and duct, all of which are surrounded by the capsule of Glisson.

The vena portæ has no valves, whereas all the veins of the extremities are furnished with these, also the superficial veins of the neck; the deep veins of the neck, the vena azygos and the pelvic veins are deprived of valves; the coats of the vena portæ are more dense and fibrous than those of most other veins; the femoral vein also possesses such a very dense structure, that when divided it will often remain open like an artery.

SECTION III.

ANATOMY OF THE LYMPHATIC SYSTEM.

The lymphatic vessels have a great resemblance to veins, they are furnished with numerous valves, and are arranged in two sets, a superficial and deep; both of these accompany the veins, that is, proceed from the extreme parts towards the centre, the greater number terminate in the thoracic duct, some however end in the veins on the right side, and recent observations seem to prove, that in different situations the lymphatic and venous system are more closely allied than was formerly believed; the lymphatics are extremely minute, in some situations they cannot be demonstrated, as in the brain, in such probably the veins perform the additional office of absorption; it is uncertain in what manner these vessels commence, whether by open mouths in the different structures, or whether they are fine returning arteries, taking the same course as the veins, and only differing from the latter in their delicacy of size, in having more numerous valves, in not transmitting the coloured particles of the blood, and in being connected with the lymphatic or conglobate ganglia.

The lymphatics of the lower extremities are *superficial* and *deep*, the first accompany the external and internal saphena veins; those which take the course of the external saphena, end in the popliteal ganglia, where they unite with the deep lymphatic vessels which take the course of the tibial and fibular veins and arteries; the lymphatics which accompany the internal saphena vein ascend to the groin, pass through the inguinal ganglia, and communicate not only with all the deep lymphatics of the limb, but also with the superficial vessels from the abdomen, perinæum, and genital organs; the deep-seated lymphatics about the hip and the perinæum accompany the branches of the internal iliac artery and vein into the pelvis, where they pass through the pelvic lymphatic ganglia; the lymphatics from the inferior extremities and from the pelvis ascend towards the spine, form a plexus round the iliac arteries, and pass behind the aorta close to the vertebræ, and terminate in the receptaculum chyli, or the commencement of the thoracic duct, into which numerous lymphatic or lacteal vessels open from the intestinal canal. The lacteal or chyliferous vessels commence from open mouths on the surface of the intestine, and thence pass through the mesenteric ganglia, increasing in size and diminising in number, towards the spine. The lymphatics of the stomach take the course of the arteries of that viscus, also towards the spine, and join the thoracic duct. The lymphatics of the liver are superficial and deep, the former are very distinct, some pass back towards the spine, others ascend along the falciform ligament, enter the thorax, and proceed through the anterior mediastinum to the thoracic duct near its termination; the deep lymphatics pass, some out of the transverse fissure, others from the posterior edge of the liver on the diaphragm; all then pass back towards the spine.

The *thoracic canal* commences on the body of the second or third lumbar vertebra by a large dilatation, named the *receptaculum chyli;* it then ascends between the crura of the diaphragm into the posterior mediastinum, and is situated on the right of the aorta, on the left of the vena azygos, and behind the æsophagus; with these relations, it rises to about the fifth dorsal vertebra, and then crosses the spine obliquely to the left side, passing behind the œsophagus and the arch of the aorta; it then again ascends, and is placed beneath the left pleura between the left carotid and subclavian arteries, and along the left side of the œsophagus; it now rises into the neck, as high as the sixth vertebra, behind the carotid and thyroid arteries, and jugular vein; it then curves outwards and downwards, and opens into the left subclavian vein, close to the jugular. Two valves internally protect this opening, these are situated one at either side. The thoracic duct receives in its course along the thorax several branches from the lungs, the heart, and the parietes of the chest; in the neck, the lymphatics from the left arm and left side of the head, face and neck open into it. The lymphatics of the upper extremities are superficial and deep, the former accompany the sub-cutaneous veins to the elbow, and a little above the bend of this joint they pass inwards through a small ganglion that is situated above the inner condyle; they then join the deep lymphatics, and ascend along the inner side of the arm to the axilla, pass through the axillary conglobate ganglia, surround the axillary artery, and pass with it beneath the clavicle into the neck, where they are joined by the lymphatics from the neck and shoulder. On the left side these branches end in the thoracic duct; on the right side they form a short canal, (called the right or lesser thoracic duct,) which opens into the right or left vena innominata, at the upper part of the anterior mediastinum.

[*Varieties.* The *thoracic duct* sometimes divides into many branches which form a sort of plexus; sometimes it divides into two unequal trunks, which re-unite sooner or later. In some cases it terminates in the left subclavian and internal jugular veins by several trunks; in others it bifurcates superiorly and one trunk terminates as usual, while the other empties into the right subclavian vein, uniting with the right duct. Sometimes the thoracic duct empties into the right subclavian vein, and then the lesser duct is formed on the left side. Again this duct occasionally empties into the vena azygos, which is said to be its normal termination in some mammalia.]

Arteries, veins, and lymphatics, are composed of tunics whose number and properties differ in each class: arteries and some veins possess three laminæ, but most veins and all the absorbent system have only two. The *first* or *internal coat* is common to all vessels, it is smooth, polished, and moistened with a fine unctuous exhalation to favour the course of the contained fluid, it bears much resemblance to serous membrane, though in many respects it differs from this tissue; in the veins and lymphatics it is thrown into numerous semilunar folds or valves, also at the commencement of the two great arteries. The *second* or *middle coat* is very distinct in the arteries, also in some of the large veins, it is absent in the greater portion of the venous and in all the absorbent system; it consists of circular fibres which are yellowish, dry, brittle and elastic; in the large veins they are of a reddish brown, and softer than in the arteries, this coat possesses much elasticity, it is also, particularly in the smaller arteries contractile, by these two properties it materially assists the circulation of the blood; by some this has been named the muscular coat, but it is now more generally denominated the fibrous or elastic. The *third* or *cellular* coat is common to all vessels; it consists of cellular tissue so condensed as to appear fibrous, it has a whitish and in some places a yellowish colour, it is very elastic, particularly in the length of the vessel; it is so closely connected to the middle coat of the arteries as to be difficult of separation.

The coats of vessels are well nourished by numerous capillaries from the neighbouring vessels, these are the "*vasa vasorum*," they are also very well supplied with nerves though they are rather insensible to the touch, these are derived from the sympathetic, the vagi, and in the limbs partly from the spinal system.

ANATOMY OF THE FŒTAL CIRCULATION.

THE *umbilical vein*, which arises by numerous branches from the placenta, and extends along the umbilical cord, twisted round the umbilical arteries, enters the umbilicus of the fœtus, ascends obliquely backwards, enclosed in the duplicature of the falciform ligament, behind the linea alba, and the right rectus muscle; it arrives at the notch in the anterior edge of the liver, proceeds backwards along the horizontal fissure, sending branches to either side, particularly to the left lobe, which at this period of life is of considerable size. When the umbilical vein arrives near the transverse fissure, it divides into two branches; the right or communicating, the left or the ductus venosus; the *right* is the larger, it passes transversely for about an inch, and joins the trunk of the vena portæ: *left*, or the *ductus venosus*, ascends between the left and Spigelian lobes towards the diaphragm, and joins the middle hepatic veins just as these are about to join the vena cava. The right auricle, distended with blood from the superior and inferior vena cava, then contracts and propels its contents partly into the right ventricle, but principally through the foramen ovale into the left auricle. From the right ventricle the blood is propelled into the pulmonary artery; this vessel in the fœtus divides into three branches, one for either lung small, and one in the centre very large, the *ductus arteriosus*, this is about half an inch in length, passes backwards and downwards, and joins the aorta a little below its arch; but little blood passes through the lateral branches, the principal portion passing through the ductus arteriosus into the aorta.—That portion of blood which was transmitted directly from the right auricle, through the foramen ovale into the left auricle, descends into the left ventricle, from which it is also propelled into the aorta, the superior branches of which circulate the blood through the upper parts of the body, whence it is returned to the heart by the veins that form the superior vena cava. The descending aorta conveys the blood to the abdominal viscera, and at the fourth lumbar vertebra this vessel divides into the external and internal iliac arteries, the former are small in the child, the latter are very large, and are named the umbilical or hypogastric arteries, these pass forwards and upwards along the sides of the bladder, approach each other, and ascend to the umbilicus; these arteries then twine around the umbilical vein in the cord, and arriving at the placenta divide into numerous branches, which ramify through this organ; thus at this age these arteries serve the office of veins. The external iliac arteries descend as in the adult, and the blood which they circulate is returned by the corresponding veins. The iliac veins unite at the fourth lumbar vertebra, and commence the inferior vena cava, which ascends, and, as in the adult, passes through the liver, is joined by the hepatic veins, and then terminates in the right auricle of the heart.

In connexion with the fœtal heart, the student may remark the *thymus body;* this body fills the upper part of the anterior mediastinum, ascending as high as the thyroid body, and descending in front of the pericardium, and of the great vessels, nearly as low as the diaphragm; it consists of two lobes of an oval figure, close in the centre, but separated at either end. It lies on the trachea, the left vena innominata, the arch of the aorta, and the pericardium, is covered by the sternum and sterno-thyroid muscles, and is surrounded by a loose capsule of cellular membrane. It consists of several small lobules which are filled with a whitish fluid, these are connected by fine cellular tissue, numerous lymphatics also are on the surface and penetrate the substance of this body. Several organs in the body present peculiarities in the fœtus, these have been already noticed in the description given of each in the adult state.

PART IV.

DESCRIPTION OF THE BONES.

THE osseous structure is the hardest in the body; it is composed chiefly of phosphate of lime, with a little carbonate deposited in a cartilaginous substance which is perfectly organized and well supplied with vessels for its nourishment and growth. The bones present great variety of figure: they are commonly classed into the *flat*, *long*, and *irregular*.

[Some also make a class of short bones, including those of the carpus and the tarsus.]

They support and protect the soft parts, give the general form to the whole body as well as to its different parts, they also serve as the passive organs of locomotion, affording a series of levers by means of which the muscles effect the various motions and actions of the body.

When all the bones are connected by their ligaments the collection is called a *natural skeleton;* when united by art, an *artificial skeleton.* The skeleton is divided into the trunk and extremities.

[A better division of the skeleton is into the head, trunk and extremities.]

The *trunk* consists of the middle part and two extremities; the middle of the trunk is formed by the vertebral column and the chest; the upper extremity of the trunk is the head, the lower the pelvis.

The *vertebral column* consists of twenty-four vertebræ, which are divided into three classes according to the three regions, viz. seven cervical, twelve dorsal, and five lumbar.

The *chest* or *thorax* is formed before by the sternum, which in the adult consists of two pieces, with the xiphoid appendix, on either side by the twelve ribs, and behind by the dorsal vertebræ.

The *head* comprises the cranium and the face: the *cranium* or *skull* is composed of eight, or according to some, of eighteen bones, viz. the frontal, the two temporal, two aprietal, the occipital, the ethmoid and the sphenoid; to these may be added the ten following, viz. the two small turbinated bones of the sphenoid or of Bertin, and the four auricular bones in each temporal bone, which have been already described in the anatomy of the ear.

The *face* is divided into the upper and lower jaw; the *upper* consists of thirteen bones, viz. the two superior maxillary, two palatine, two lachrymal, two nasal, two malar, two inferior turbinated bones, and the vomer; to these may be added the sixteen teeth. The *lower jaw* consists of the inferior maxillary bone, which contains sixteen teeth; some consider the os hyoides as an appendix to the bones of the face; this bone, however, has been already noticed in the description of the larynx.

The *pelvis* is the lower extremity of the trunk; it consists of the sacrum, the ossa coccygis, and the two ossa innominata.

The *superior* or *thoracic extremities* are composed each of four parts, the shoulder, which consists of two bones, the clavicle and scapula; the arm, of the humerus, [more properly called the os brachii, or bone of the arm; humerus, meaning the shoulder;] the fore arm of two, the radius and ulna; and the hand, which is subdivided into the carpus, metacarpus, and fingers. The carpus consists of eight small bones: the metacarpus of five, and the fingers of fourteen, each consisting of three phalanges except the thumb, which has only two.

[Besides which the thumb has two ossa sesamoidea, at the metacarpo-phalangeal articulation.]

The *inferior* or *abdominal extremities* are each divided into three parts; the thigh, which consists of but one bone, the femur; the leg, which consists of three, the patella, tibia, and fibula; and the foot, which is divided into three parts, the tarsus, metatarsus, and toes; the tarsus consists of seven irregular bones, the metatarsus of five long bones, and the toes of fourteen, each consisting of three phalanges, except the great toe, which has only two.

[In addition to which the great toe has two ossa sesamoidea, at the metatarso-phalangeal articulation; sesamoid bones are also frequently found at other points upon the hand and foot.]

In the adult skeleton the number of bones amounts to two hundred and forty-two, including the bones of the ear and the teeth, but excluding the os hyoides and the sesamoid bones. This number is, however, variously stated by different writers, some bones being separated into more parts by some authors than by others.

THE VERTEBRÆ.

The *vertebræ* are twenty-four in number, they belong to the class of irregular bones, are placed one above the other, and connected by ligaments so as to form one solid, yet flexible column, placed in the middle and back part of the trunk, and extending from the head to the sacrum. The sacrum and coccyx, from their likeness to the true vertebræ, have been named the "false vertebræ." All the true vertebræ agree in the general outline, which is as follows: each vertebra consists of a body and of several projections or processes. The *body* occupies the anterior central part; it is thick and spongy, and rather circular or oval; its flat surfaces above and below give attachment to the intervertebral ligaments; the margin of each is tipped with a compact white substance; anteriorly it is transversely convex and very porous, posteriorly concave, so as to form part of the spinal canal or foramen; this surface is perforated by several holes for vessels. The processes of each vertebra are nine, two lateral or the laminæ, two transverse, four oblique or articulating, and one spinous.

The *lateral processes*, or *laminæ*, arise, one on each side by a sort of pedicle from the posterior part of the body; they pass backwards, bounding the sides of the spinal hole, and unite posteriorly in the spinous process; they are broad behind, but narrow where they join the body, being grooved out above and below into a notch; the inferior of these is the larger; these *notches*, when the vertebræ are joined, form the intervetebral holes for the passage of the spinal nerves. The *spinous process* is the most projecting part of the vertebræ in the posterior median line; its base is bifurcated, its apex generally ends in a point or tubercle. The *transverse processes* arise from the laminæ, and are directed outwards on each side. The *articular* or *oblique processes* arise from the roots of the transverse, two ascend, two descend; they are covered with cartilage, and articulate with the corresponding processes of the vertebræ above and below. The *spinal hole* or *canal* is bounded by the body and processes; it is oval or triangular. The processes of the vertebræ are of a more compact structure than the bodies, which are very light and spongy. A vertebra is generally developed by three points of bone, one for the body, and one on each side for the laminæ and articulating processes; sometimes a fourth point is deposited for the spinous; this process is seldom found ossified in the fœtus, but remains cartilaginous for some time. In addition to these three principal ossific points, there are frequently accessory points or epiphyses found in the processes, as well as on the surfaces of the body. These are the general characters of all the vertebræ, but each of the three classes presents some peculiarity.

The *lumbar vertebræ* are five; these are the largest in the column; the *body* of each is very broad transversely, compared with its height; its upper and lower surfaces are flat, and bordered with hard projecting edges, which render it concave from above downwards on its forepart. The *laminæ* are thick, broad, but short; the *notches*, particularly the lower, are very large; the *spinous process* is broad, flat, and square, and ends not in a point, but in a thick rough border: the *articulating processes* are oval, strong, and vertical; the superior are concave, look inwards and a little backwards; the inferior are convex, look outwards and a little forwards; are nearer to each other than the former, and are, therefore, received into those of the vertebra below: the *transverse processes* are long, thin, and horizontal, and more anterior than those of the dorsal vertebræ, but posterior to those of the cervical; the spinal foramen is triangular, and larger than in the back; the body of the fifth lumbar vertebra is cut off obliquely below, so as to be much deeper before than behind; its transverse processes are short, strong, and rounded.

The *dorsal vertebræ* are twelve in number, and of an intermediate size between the cervical and lumbar: they decrease from the first to the fourth, and then increase to the last, so that the fourth and fifth are the smallest. The *body* is thicker behind than before, and in most, longer from before backwards than transversely, flat above and below, and round, except in the first, whose surfaces are heart-shaped, and very convex anteriorly; on either side it presents two small depressions or notches, covered with cartilage; the superior is the larger; when the vertebræ are conjoined two of these notches form an oval depression for the head of each rib; the *laminæ* are broad and thick; the *notches* are large and anterior to the oblique processes: the *transverse processes* are long and large, and directed backwards; on the front of each, near the end, except of the two last, there is a small depression covered with cartilage for articulating with the tubercle of the rib; the *oblique processes* are vertical, the superior directed backwards, the inferior forwards; the *spinal hole* or canal is small and oval; the *spinous processes* are long, of a prismatic or triangular form, bent downwards very much, or imbricated, and tubercular at their extremities. The first has the body long transversely, and on either side a full depression above for the head of the first rib, and half of a similar cavity below for the upper part of the head of the second rib; its spinous process is thick, long, and horizontal, and its articular processes are oblique: the tenth has also a full depression on its body for the tenth rib, the eleventh and twelfth in like manner, these two last also want the articulating depressions on the transverse processes, and they somewhat resemble the lumbar vertebræ, in the shape of their body, and inferior articular processes.

The *cervical vertebræ* are seven in number and smaller than the others; their *body* is long transversely, a little deeper before than behind; the lower surface is concave from behind forwards, the upper is larger or broader, and concave from side to side; the structure is more compact than in the dorsal and lumbar; the *laminæ* are long and narrow, sharp and small superiorly, round and large inferiorly, so as to overlap those below; the *spinal hole* is large and triangular; the *notches* are small and anterior to the articular processes in all, except on both surfaces of the atlas, and of course on the upper surface of the second; they are nearly of equal size above and below; the *spinous process* is short, horizontal and bifid; the *transverse process* is short, bifid, grooved above for the nerves, and perforated near its base by a round hole for the vertebral vessels; it is on a plane anterior to the transverse processes of the back or loins, and appears, on account of its foramen, to have a second or anterior root from the body of the vertebra; the *articular processes* are oblique, the superior oval, slightly convex, look upwards and backwards; the inferior also oval, are concave, and directed downwards and forwards.

The first cervical vertebra or *atlas* differs from the remaining, in being a mere bony ring, without any distinct body or spinous process, the anterior part of this ring is tubercular before, but presents posteriorly a smooth and concave oval articulating surface which receives the odontoid process of the second vertebra; the margin of this ring gives attachment to ligaments; it is round and thick behind, with a tubercle, instead of spine for the attachment of the recti muscles; the *spinal hole* is very large and divided into two by the transverse ligament, which arises from two tubercles placed on the inner side of the superior articulating processes; the anterior portion, small, receives the tooth-like process of the second vertebra, the posterior forms the spinal canal; the *laminæ* are thick and round behind, but, near the articulating processes are grooved above for the vertebral artery and first cervical or sub-occipital nerve, and below for the second cervical nerve;

before these notches are the *articular processes*, the superior horizontal, concave, oval from before backwards, look upwards and inwards, and receive the occipital condyles; the inferior are nearly flat, circular, and inclined a little inwards and downwards; the *transverse processes* are long, and end in an obtuse point, the anterior root is slender, the posterior is long and large, the hole between these is larger than in the other vertebræ, and is directed upwards and backwards; from this a groove for the vertebral artery winds backwards round the superior articular process. In the adult the atlas is very compact; in the fœtus its ossification takes place from five points, one for the anterior arch, two for the posterior, and one for each lateral part.

The *axis* or second vertebra is remarkable for the length of its *body*, which has anteriorly a central ridge between two depressions for muscles, and from its upper part there rises by a sort of a neck, a large, round, dentiform (*odontoid*) process, the forepart of which is received into the small articulating cavity on the anterior arch of the atlas, while posteriorly it presents a small, smooth convexity, which moves against the smooth surface of the transverse ligament of the atlas; the apex is rather pointed, to it and to the sides of this process the lateral or check ligaments are attached; the *laminæ* are very strong; the superior *notches* are behind, the inferior before the articular processes; the *spinal hole* is large and heart-shaped; the *spinous process* is forked and very strong. its under surface is channeled; the superior *oblique processes* are slightly convex, nearly horizontal, and look a little outwards; the inferior are smaller, flat, and look downwards and forwards; the *transverse processes* are short, arise from the outside of the superior articular processes, are bent downwards, and are not bifid; the hole is directed obliquely upwards and outwards. This vertebra in the fœtus has an additional or fourth point of ossification in the odontoid process. It is articulated directly with the atlas and third vertebra, and indirectly with the occipital bone.

The *seventh* cervical vertebra is large, its spine is very prominent, and not bifid; its transverse process is seldom perforated, as in the other cervical vertebræ; when there is a foramen in it, it transmits the vertebral vein and not the artery.

[I have repeatedly examined the seventh cervical vertebra with a view to this point, and have *always* found the transverse process perforated. The vertebral artery usually enters the foramen in the transverse process of the sixth vertebra, but may enter that of the fifth or fourth. I have several times seen two foramina in the transverse processes of the cervical vertebræ, one for the vertebral artery and the other for the vertebral vein.]

In this vertebra an additional point of ossification is found in the pedicle which connects the processes to the body; this sometimes increases beyond the transverse processes of the vertebral column, so as to resemble a supernumerary or a cervical rib.

The length of the vertebral column is generally about a third of that of the whole body; the lumbar and cervical regions are nearly equal, and each about half the length of the dorsal, the latter commonly measures twelve inches, and each of the former about six. Its general form is that of a pyramid, the base below; but when accurately examined it will be found to represent three pyramids; the first has its apex in the third cervical vertebra, surmounted by the axis and atlas, and its base is in the first dorsal, which is also the base of the second pyramid whose apex is in the fifth dorsal, where also is the apex of the third pyramid, whose base is at the sacrum, the vertebræ diminishing in size about the fourth and fifth dorsal. The column is convex anteriorly in the neck, concave in the back, and convex in the loins; these curvatures are caused partly by the different thickness of the bodies of the vertebræ before and behind, but principally by that of the intervertebral ligaments in these three situations. A perpendicular line passed through the centre of the apex and base of the column will be found anterior to the dorsal, and posterior to the cervical and lumbar vertebræ. In the dorsal region there is generally a lateral curvature also, which is usually concave to the left side; this direction of this curve has been by some ascribed to the pressure of the aorta on the left side, by others, and with more probability, to the effect of muscular action, for as the muscles of the right arm are the most used, the points of the spine to which these are attached will be drawn towards that side; in the several violent exertions also, such as pulling forcibly, the body is usually bent to the left side. The column is covered anteriorly by the anterior common ligament, and in the neck by the recti and longi muscles, in the back by the last named muscles above, and below, by the vena azygos, aorta, &c., and in the loins by the crura of the diaphragm, the aorta, vena cava, and sympathetic nerves; posteriorly the column presents in the median line, the spinous processes short, horizontal and separate in the cervical and lumbar, but close and bent over one another in the dorsal region; on each side of these are the vertebral grooves, which are wide in the neck, but deep and narrow in the back and loins; these are filled by the extensor muscles:

the apertures between the laminæ are closed by the yellow ligaments, and covered by these muscles; outside these grooves in the neck and loins lie the oblique or articular processes, but in the back the transverse processes, which in this region are on a plane posterior to those in the neck and loins: the intervertebral or the holes of conjunction in the dorsal and lumbar regions are before the transverse processes, but in the neck between them; in the back they are behind the cavities for the heads of the ribs. The spine supports the head and chest, and combines strength with lightness and flexibility; it serves as the centre of all the motions of the trunk, and transmits the weight it bears to the sacrum and pelvis; it gives insertion to numerous muscles, and lodges and protects the medulla spinalis in the spinal canal; this canal is large and triangular in the neck and loins, round and contracted in the back. The spinal column is nearly straight or perpendicular in the child; in the fœtus the pyramidal figure is reversed, the base being in the cervical and dorsal vertebræ, the apex in the lumbar and sacral.

[There are occasionally varieties in the number of the vertebræ; there may be but six cervical vertebræ; there may be eleven or thirteen dorsal vertebræ, and usually there is a corresponding difference in the number of the ribs; and there may be four or six lumbar vertebræ, of which last variety I have a specimen, which also exhibits a strong lateral inclination of the spine. The transverse processes of the last cervical and of the first lumbar vertebræ are sometimes very much developed, and even detached from the rest of the bone, so as to resemble supernumerary ribs. The vertebræ are sometimes bifid, or the spinous process is entirely wanting, so that the interior of the canal is exposed; this may occur in the lumbar region only; or in acephalous monsters it may involve a few of the cervical vertebræ, or even the whole column; this anomaly is called *spina bifida*.

The vertebræ are sometimes fractured, but usually by violence so great as to cause immediate death: or death may ensue from the subsequent inflammation. The operation of trepaning has been performed upon a fracture of the posterior arch of a vertebra attended with depression. The articulation of the first and second vertebræ is occasionally the seat of dislocation.

A great number of muscles are attached to the vertebræ, for example, five pair *arise* from the *atlas*, the rectus capitis anticus minor, rectus capitis lateralis, obliquus capitis superior, and levator anguli scapulæ from the transverse processes, and the rectus capitis posticus minor from the spinous process; five pair also are *inserted* into the atlas, the longus colli into its forepart, obliquus capitis inferior, splenius colli, and first intertransverse into the transverse processes, and the first interspinous into the spine.

From the *axis arise* six pair, the rectus capitis posticus major, obliquus capitis inferior, multifidus spinæ, and first interspinous from the spinous process, and the levator anguli scapulæ and first intertransverse from the transverse processes: five pair are *inserted* into the axis, the longus colli into its forepart, the splenius colli and the second intertransverse into the transverse processes, spinalis colli and second interspinous into the spine. The muscles connected with the other vertebræ more or less extensively, may be arranged under three groups; first, those which arise from the vertebræ to be inserted into other bones; second, those which arise from certain vertebræ to be inserted into others; and third, those which arise from other bones to be inserted into the vertebræ; and this arrangement may be applied both to those which are situated posteriorly, and those anteriorly. *Posteriorly*, they are *first*, the trapezius, latissimus dorsi, levator anguli scapulæ, rhomboidei major and minor: serrati postici superior and inferior; splenius capitis, sacro-lumbalis, longissimus dorsi, trachelo-mastoideus, complexus, levatores costarum; *second*, the splenius colli, longissimus dorsi, spinalis dorsi and colli, semi-spinalis dorsi, transversalis colli, multifidus spinæ, inter and supra spinales and intertransversales; *third*, the cervicalis ascendens and longissimus dorsi, which last is common to all three groups.

Anteriorly they are *first* the rectus capitis anticus major, scaleni anticus, medius, and posticus, the crura of the diaphragm, the psoas magnus and parvus, obliquus internus and transversalis abdominis; second, the longus colli; and third, the quadratus lumborum.

Articulations. The vertebræ are articulated to each other, to the os occipitis above, to the ribs laterally on either side, and to the sacrum below.]

THE THORAX OR CHEST,

Is formed by the twelve dorsal vertebræ, already described, by the sternum and twelve pair of ribs.

The *sternum* is situated at the forepart of the chest, in the median line, and in a direction from above downwards and forwards; of a flat and elongated form, broad above, narrow in the middle, and pointed below; its anterior surface is covered by the skin and pectoral aponeurosis, is marked by four transverse lines which indicate its original division into five pieces, the two upper lines are most prominent. Although it can be divided in the adult into two pieces in addition to the xiphoid cartilage, we shall describe the whole as one bone; its posterior surface is smooth and concave, gives attachment to muscles, and looks towards the anterior mediastinum; the edges are thick, and present seven depressions for the cartilages of the true ribs; the superior of these is round, and the margin of it is often continuous with the first costal cartilage; the remaining depressions are angular, and most of them correspond to the transverse lines or ridges; hence these sockets are more distinct in the young than in the old; they are all covered with cartilage and separated from each other by notches.

The upper or clavicular end of the sternum is broad, thick, and concave from side to side, for the lodgment of the inter-clavicular ligament, and is hollowed out at each angle for articulation with the clavicle, into a shallow sigmoid cavity covered with cartilage and directed outwards and backwards; this surface is slightly convex from before backwards; the inferior extremity is long and thin, and ends in a cartilaginous epiphysis, the *xiphoid* or *ensiform cartilage;* this is sometimes pointed, sometimes bifid, thick or thin, turned forwards or backwards, and sometimes perforated by a central hole; it remains cartilaginous to a late period of life; to it the abdominal muscles and the costo-xiphoid ligament are attached. The sternum in the fœtus is separable into four or five pieces, in the adult into two, and the ensiform cartilage which is frequently ossified and continuous with the lower portion of the sternum. The upper piece is the larger and thicker of the two, and somewhat square, its edges receive the clavicles and the cartilages of the first rib, and half of those of the second; its lower edge is nearly straight, and united to the second piece by a cartilage which sometimes admits of slight motion between the two, but which in old persons is generally found ossified: a foramen is sometimes observed in this piece of the sternum. The second piece is longer and narrower than the first, its edges are marked by five depressions for the five lower true costal cartilages, and at its superior angle by half a notch, which joined to a similar notch in the first piece, formed the cavity for the second cartilage: the five lower notches approximate, and the last is frequently completed by the xiphoid cartilage. This bone consists of a very spongy, cellular, and vascular tissue, covered on each surface by a compact layer.

[The sternum is sometimes deficient either to a considerable extent or in circumscribed points, forming foramina. I have a specimen exhibiting two of these perforations, which were closed up by dense fibrous tissue. This bone may be fractured, and if depressed, the trephine and elevator may be used. In the private collection of Dr. J. Kearny Rodgers, there is an admirable specimen of fracture of the sternum, exhibiting the efforts of nature to produce a reunion, and her partial success.

Muscles. Nine pair of muscles and a single muscle are attached to this bone, five pair and the single muscle *arise* from it, the sterno-mastoid, sterno-hyoid, and sterno-thyroid superiorly and posteriorly; the pectoralis major from its anterior surface, the triangularis sterni from its posterior surface, and the diaphragm from the posterior surface of the xiphoid cartilage; four pair are *inserted* into it, the rectus abdominis into the front of the xiphoid cartilage, and the obliqui externus and internus, and transversalis abdominis into its edge.

Articulations. This bone is articulated usually to sixteen bones, the clavicles and seven true ribs on either side.]

The *ribs* are twelve on each side; they extend in an arched manner from the vertebræ towards the sternum, to which the seven superior are attached by the separate cartilages; these are the *true* or the sternal ribs; the five inferior do not form complete circles, and are connected anteriorly to each other, and to the cartilage of the last true rib, and are named *false;* the two last of these are sometimes called the *floating* ribs; the length of the ribs gradually increases from the first to the eighth, and then diminishes to the last; the breadth gradually diminishes from the first to the twelfth, but in each rib it is greatest near the sternum; the first is nearly horizontal, the succeeding gradually incline downwards, so as to be lower before than behind; the external surface of each is convex and smooth, and gives attachment to different muscles; the internal is concave, and lined by the pleura; the upper border is round and smooth, and gives attachment to the intercostal muscles; the inferior is thin, and marked with a groove for the intercostal vessels, which is deep posteriorly and superficial anteriorly; its edges also give attachment to the intercostal muscles. The posterior end of the rib presents a head, neck, and tuberosity; the *head* is round, and divided by a ridge into two articular surfaces, the inferior of which is the larger, these are received into the depressions in the dorsal vertebræ; an intervertebral ligament is attached to the middle ridge. The head is supported by the *neck*, which is narrow and round, and lies in front of the transverse process, to which it is connected posteriorly by the middle costo-transverse ligament. Beyond or external to the neck is the *tubercle*, which looks backwards and downwards, and is divided into two portions: the internal of these is smooth for articulation with the transverse process of the inferior of the two vertebræ, to whose bodies the head of the rib is connected; the outer portion is rough for the insertion of the external costo-transverse ligament. External to the tubercle is a rough line, which marks the turn or *angle* of the rib; this ridge gives insertion to the tendon of the sacro-lumbalis muscle; it descends obliquely forwards; it is close to the tubercle on the first, but the distance between these increases in the succeeding ribs to the eleventh; the angle is not distinct on the twelfth. The anterior or *sternal end* is thin, broad, and hollowed into an oval pit for the insertion of the costal cartilage. The first rib is shorter, broader, and nearer the axis of the chest than the others, has no angle, and therefore is not twisted, but represents nearly a horizontal semi-circle; its external surface is directed upwards, and is marked by two grooves for the subclavian vein and artery, into the intervening ridge the anterior scalenus muscle is inserted; the head of this rib is undivided, there is no groove, the sternal end is very strong; the eleventh rib has no groove or tubercle, its head is also undivided: the twelfth has neither angle, tubercle, or groove, and is very short. The ribs are formed of a cellular structure, covered by compact and strong laminæ, which often present a scaly appearance; they are hard and elastic. In the fœtus each rib presents three points of ossification, one for the head, another for the tubercle, and the third for the body or shaft.

The *costal cartilages* are twelve in number; the first is very broad but short, the length increases in the succeeding to the seventh, and then decreases to the last; the first descends a little, the second is nearly horizontal, the succeeding ascend more and more; the costal end of each is convex, and implanted in the rib; the sternal ends of the seven superior are also convex, and are received into the sternum, those of the three superior false are blended together, and those of the two last are pointed and unattached. The costal cartilages are the strongest and longest in the body; they are flexible and elastic, and have a great tendency, particularly the four or five superior, to ossification, the costal end is more prone to this change than the sternal; they then become opaque and very compact; in their natural state they appear destitute of vessels, nerves, or any organic texture, but are enveloped by a vascular membrane.

[Sometimes there are thirteen ribs on each side, and the supernumerary may be either a cervical or a lumbar rib; in other cases, there are but eleven ribs; the costal cartilages also may be but eleven, or there may be thirteen on a side, even though there are but twelve ribs, and then the supernumerary cartilage is lost in the thickness of the adjoining muscles, sometimes the anterior extremity of a rib, and the adjoining extremity of its cartilage are bifurcated, circumscribing a foramen, closed by dense fibrous tissue; sometimes the cartilage of the eighth rib on the left side runs up to the ensiform cartilage, to the side of which it is articulated; specimens of both of these anomalies may be seen in the College Museum.

The ribs may be fractured, and the middle ribs from their position are most exposed to this accident; the cartilages may be separated from the ends of the ribs by external violence, and they are very prone to be converted into bone, particularly in advanced life, the ossification commencing at innumerable points.

Muscles. Thirty-three pair of muscles and a single muscle are attached to the ribs and their cartilages, but the intercostals both arise from and are inserted into them; thirty-two pair and a single muscle *arise* from them, the sterno-hyoid, sterno-thyroid, and subclavius superiorly, pectorales major and minor anteriorly, the external and internal intercostals from their inferior edges, the transversalis abdominis and diaphragm internally, serratus magnus anticus and obliquus externus laterally, and cervicalis ascendens and latissimus dorsi posteriorly ; forty-five pair are *inserted* into them, the scaleni anticus, medius and posticus superiorly, the rectus abdominis anteriorly, the obliquus internus anteriorly and inferiorly, the external and internal intercostals at their superior edges, triangularis sterni internally, quadratus lumborum inferiorly and posteriorly, serrati postici superior and inferior, sacro lumbalis, longissimus dorsi, and levatores costarum posteriorly.

Articulations. Each rib is articulated posteriorly to the bodies of two dorsal vertebræ, except the first, eleventh, and twelfth, and sometimes the tenth; and all except the eleventh and twelfth are articulated to the transverse processes of the vertebræ. Anteriorly each rib is attached to its cartilage ; the seven superior cartilages are attached to the sternum, the three next to the seventh, and the two last are free.]

The *thorax*, which is composed of the foregoing bones and cartilages, resembles, when the arms are detached, a truncated cone, the base below, the apex above, flattened before and behind ; in some, from the effect of dress, it is of an ovoid form, being contracted at the lower part and wide in the middle ; the anterior wall leads obliquely downwards and forwards, and is shorter than the posterior, which is more vertical, and rendered very irregular by the vertebral grooves, and the angles of the ribs ; the sides are convex, particularly behind : the intercostal spaces are short, but wide above, long and narrow in the middle, and again short below ; they are broader before than behind. The apex is small, transversely oval, and very oblique from behind forwards and downwards ; it is bounded by the first ribs, sternum, and vertebral column ; the trachea, œsophagus, and the cervical vessels and nerves pass through it ; the base is very large, also transversely oval, and very oblique from before backwards and downwards, it is bounded by the xiphoid cartilage, the conjoined cartilages of the false ribs, and the vertebral column ; it presents a great notch anteriorly, in which the xiphoid cartilage is, and posteriorly a small notch on each side for the vertebral column. The axis of the chest is oblique from above downwards and forwards, in consequence of the oblique direction of the sternum, hence if a line be made to ascend perpendicularly from the base, it will pierce the upper part of the sternum ; and not pass through the apex of the cavity. The dimensions, and even the form of the chest, vary in different individuals and at different ages.

THE PELVIS.

The *pelvis* is the deep circular cavity at the lower end of the trunk, bounded by the sacrum, coccyx, and two ossa innominata; the latter in the young subject can be separated each into three, the ilium, ischium, and pubis.

The *sacrum*, in the erect position of the body, is placed at the upper and back part of the pelvis between the last lumbar vertebra above, the coccyx below, and the ossa innominata on either side; of a triangular form, the base resembles a vertebra, looks upwards and forwards, is very broad transversely, and presents in the middle an oval surface or body cut off obliquely from before backwards and upwards, and covered with cartilage for articulation with the last lumbar vertebra, its anterior edge is named the promontory; behind it, is the triangular aperture of the sacral or spinal canal, and on each side is a smooth convex surface (or transverse process) directed forwards and continuous with the iliac fossa; on either side of the spinal canal is the oblique or articular process, concave, and looking backwards and inwards to receive the articular processes of the last lumbar vertebra; anterior to each is a groove, which contributes with the notch in the last vertebra to form the last of the holes of conjunction for the passage of the last of the lumbar spinal nerves, and behind the oblique processes are the laminæ, which are sharp, and give attachment to the last of the ligamenta flava. The inferior extremity or apex is directed downwards, and presents a small oval convex surface to articulate with the coccyx, on each side of which is a small notch for the last sacral nerve; the anterior surface is concave from above downwards, flat from side to side, marked by four transverse lines, which indicate its original division into five pieces resembling so many vertebræ, (hence sometimes called false vertebræ;) the first of these divisions is convex, the remaining are concave; on either side of the median line are the four anterior sacral holes, the two upper large, the two lower small; they are all round and smooth, communicate with the sacral canal, and transmit the anterior sacral nerves; grooves lead outwards from these holes, along which the nerves run; these are analogous to the intervertebral holes, and the intermediate grooved bone to the transverse processes in the vertebral column above; external to these is a depressed surface, which gives attachment to the pyriform muscle. The posterior or spinal surface is convex and very rough, presenting in the median line four horizontal eminences analogous to the spinous processes, which are often united into one ridge; inferior to these the sacral canal ends in a triangular channel, which is only closed behind by ligament and bounded on each side by two tubercles or cornua, beneath which is a notch for the last of the sacral nerves; these cornua are sometimes joined to the base of the coccyx; at either side of the median spine are the four posterior holes, smaller and more irregularly formed than the anterior; they transmit the posterior sacral nerves; external to these are a range of tubercles analogous to the oblique processes; the sides or iliac surfaces are uneven, triangular, broad above, and consisting of two portions, one superior, broad and irregular, covered with cartilage for articulation with the ilium; the other inferior, thin, and attached to the sacro-sciatic ligaments. The sacrum, though very thick, is yet light and spongy, and covered by a thin lamina of compact substance; it is long and narrow in the male, broad and short and more curved in the female; in the latter it is about four inches and a half long, its breadth above is nearly the same, but below only half an inch; in the fœtus it is nearly straight, and consists of five pieces, in each of which ossification commences in several points.

[The sacrum is sometimes affected with spina bifida; it is occasionally contorted or twisted, so as to give the spine a strong lateral inclination, and has on one side four and on the other *five* anterior sacral foramina, as in a specimen belonging to Dr. J. K. Rodgers. This bone may be broken, but only by such violence as usually to cause death; both this bone and the vertebræ are the common seat of caries.

Muscles. Seven pair are attached to this bone; five pair *arise* from it, the pyriformis anteriorly, the gluteus maximus, latissimus dorsi, longissimus dorsi, and sacro-lumbalis posteriorly; two pair are *inserted* into it, multifidus spinæ behind, and coccygeus laterally and inferiorly.

Articulations. The sacrum is articulated to four bones, the last lumbar vertebra above, the coccyx below, and the ossa innominata laterally.]

The *ossa coccygis* are placed at the extremity of the sacrum, and consist of three or four pieces, which in the old are often united into one or two, but in the young and adult are always distinctly divisible into three parts, we may describe these, however, as forming a single bony piece which in the adult is triangular, and serves to prolong the curve of the sacrum anteriorly, the base is above, with a smooth oval surface adapted to the sacrum, and on either side of this posteriorly is a small horn or process which is also connected to the sacrum by bone or ligament; beneath this is a notch for the last sacral nerve; the apex is irregularly tubercular, and gives attachment to the muscles of the rectum; the anterior or pelvic surface is smooth, supports the rectum, and is marked by two or three transverse lines, which indicate its original division into distinct pieces; the posterior or spinal surface is rough for the attachment of muscles; it is soft and spongy, its ossification commences by four or five points, it becomes united to the sacrum earlier in the male than in the female, and is longer in the former than in the latter.

[This bone is analogous to the caudal vertebræ of inferior animals, it sometimes consists of five pieces. In the adult it usually consists of two pieces, the upper immoveably fixed to the sacrum, and the other moving upon the first, so as to enlarge the antero-posterior diameter of the inferior strait of the pelvis; this motion is lost in after life, but is said to exist longer in the female than in the male. This bone may be fractured by external violence, or by internal pressure, as in females who become parturient for the first time at a late period of life.

Muscles. Three pair and a single muscle are attached to this bone; the gluteus maximus and sphincter ani *arise* from it, and the coccygeus and levator ani are *inserted* into it.

Articulation. It is articulated to the sacrum only.]

OSSA INNOMINATA.

As each os innominatum is divisible in early life into three bones, the ilium, ischium, and pubis, it will be found more convenient to describe each of these separately, in preference to considering the os innominatum as a single bone, which, however, it really becomes after puberty.

The *os ilium* is situated at the upper and outer part of the pelvis, and forms that projection commonly called the hip; it is broad, flat and triangular, the base above, and semicular, the apex below forming the upper and outer part of the acetabulum; it may be divided into the body, ala, and processes. The *body* is the inferior constricted portion which presents three surfaces, one, external, smooth and concave, forms the upper and outer side of the acetabulum; the second is anterior, small, triangular, and united to the pubis; the third is posterior and joined to the ischium. The *ala* is the broad fan-like portion which ascends, inclines outwards and a little forwards; its external surface or dorsum is irregularly convex, rough, and marked by two curved lines from which the glutæus medius and minimus arise; above and behind the upper line the bone is rough for the origin of the glutæus maximus; this surface is also irregularly convex, being a little hollowed anteriorly, it is next much raised, it then becomes very concave, and lastly, it is convex as far as its posterior border. The internal surface of the ala is divided into three parts; one superior and anterior, is the iliac fossa, which gives origin to the internal iliac muscle; the second is posterior, rough, and united to the sacrum, and the third is smooth and small, and is the only portion of the ilium that enters into the side of the true pelvis; this pelvic portion of the ilium is above the sacro-sciatic notch, and is separated from the iliac fossa by an obtuse ridge which is continuous behind with the promontory of the sacrum, and before with a similar ridge of the pubis; this line is named ilio-pectinea, and into the iliac portion of it the tendon of the psoas parvus and the iliac fascia are inserted. The *processes* are, first the *crest*, which in the young subject is an epiphysis, it forms the upper border of the ala, it is curved inwards before and outwards behind, and gives attachment to the three layers of abdominal muscles. Second, *anterior superior spine*, is that prominent projection at the upper and forepart of the crest and ala, it gives attachment to the muscles and to Poupart's ligament; between this and the next process is a notch; third, *anterior inferior spine* is above the outer part of the acetabulum, it gives attachment to one head of the rectus femoris muscle; the notch between these two spinous processes is filled by the sartorius and iliacus muscles; internal to the inferior spine is a superficial groove along which the psoas and iliac muscles pass; this groove is bounded internally by the ilio-pectineal eminence, which is common to the ilium and pubis; fourth, the *posterior superior spine* is the posterior termination of the crest, below which is a notch; and fifth, the *posterior inferior spine;* these two processes give attachment to ligaments and muscles, beneath the inferior is the commencement of the sacro-sciatic notch.

The *ischium* is placed at the lower, outer, and back part of the pelvis, and presents a body and processes; the *body* forms the outer, lower, and back part of the acetabulum, more than two-fifths of which it forms, and presents a prominent line or border; beneath this is a horizontal groove, which lodges the tendon of the obturator externus, and from this a rough ridge leads down to the tuber of the bone, and gives attachment to the quadratus femoris muscle; the anterior part of the body is thin and sharp, and bounds the obturator or thyroid hole; the posterior part joins the ilium, and bounds the sacro-sciatic notch. The processes are, first the *spine*, which arises from its posterior part just below the sacro-sciatic notch; it projects backwards and inwards, gives attachment to the superior gemellus and the lesser sciatic ligament, and bounds the great sciatic notch inferiorly; below the spinous process, between it and the following, is the smooth pulley round which the tendon of the obturator internus muscle turns; second, the *tuberosity* is beneath this pulley, and the lesser sacro-sciatic notch, on this process the body rests in the sitting posture, it is broad behind and covered with cartilage, it gives attachment to the adductor magnus and to the hamstring muscles; on its internal side is a groove for the tendon of the obturator externus; third, the *ramus* ascends from the tuber forwards and inwards, and joins that of the pubis; it is thin and flat, one border is thin and bounds the thyroid hole, the other is thick and in part bounds the low aperture of the pelvis; to it are attached the crus penis, and the compressor penis muscle.

The *os pubis* is situated at the forepart of the pelvis, and internal part of the acetabulum; it may be divided into its body and processes; the *body* is the most external, it is thick, and forms the internal and superior part of the acetabulum, above which it joins the ilium in the ilio-pectineal eminence, and below it is united to the body of the ischium; from this the first process proceeds, the *horizontal ramus*, forwards and inwards, smooth and flat superiorly, and covered by the pectinæus, smooth also posteriorly towards the cavity of the pelvis, and grooved beneath for the obturator foramen; a sharp ridge separates its superior from its posterior surface; this ridge is the anterior part of the linea innominata or ilio-pectinea, into it the pectinæus muscle, Gimbernaut's ligament, and the fascia lata are inserted; at the internal extremity of this ramus and of this line is the second process, the *tuberosity* or *spine;* this is a prominent tubercle into which Poupart's ligament is inserted; from this spine the third process, the *crest*, leads transversely inwards; it is about an inch in length; the rectus abdominis and pyramidalis muscles arise from it; at its internal end is the fourth process, the *symphysis;* this descends nearly vertical, and is joined to the opposite one by an intervening cartilage; as the symphisis turns down from the transverse crest there is the *angle* of the pubis; from the lower part of the symphysis descends the fifth process, the *inferior* or *descending ramus*, in an oblique direction backwards and outwards, to meet the ramus of the ischium; this, with the ramus of the opposite pubis, forms the *arch af the pubis*, its outer edge assists in bounding the thyroid hole.

The *acetabulum*, or articular cavity for the head of the thigh bone, is formed by the junction of the bodies of these three bones in different proportions; the ischium constitutes a little more than two-fifths, the ilium somewhat less than two-fifths, and the pubis the remainder; it is surrounded by a prominence which is deficient or notched at only one point, this *notch* in the border is opposite the thyroid hole, between the ischium and pubis, but chiefly in the former bone, it is situated at the anterior and inferior part, it may serve to admit of more free adduction of the limb, and it also allows the articular vessels to enter the joint; a rough surface, the only part uncovered by cartilage, leads from it to the centre of the cavity, to this the articular ligament and a quantity of adipose membrane are connected; this cotyloid cavity looks outwards, downwards, and forwards, the upper and outer portion, by which the weight of the head and trunk are transmitted to the thigh, is the deepest, it is shallow at the lower and internal part.

The *pelvis*, which is thus made up of the ossa innominata, the sacrum, and ossa coccygis may next be examined as one great portion of the skeleton, both on its external and internal surfaces; externally it presents in front the symphysis and crests of the pubes; the ilio-pectineal eminences, and beneath these the acetabula and the thyroid holes, more laterally is the dorsum of the ilium, marked by its curved lines, posteriorly the sacral spines occupy the median line; external to these are the sacral foramina, beyond these on each side is a rough surface for the attachment of ligaments and muscles; and lastly, the great sacro-sciatic notches, which are bounded by the sacrum, ilium, and ischium. The *superior* circumference or *base* of the pelvis which is inclined upwards and forwards, is formed on each side by the crest of the ilium, posteriorly by the promontory of the sacrum, on each side of which is a deep notch, which is filled by muscles, anteriorly by the iliac spines, ilio-pubal eminences, the intervening grooves, and by the ossa pubis. The *lower* or *perinæal* circumference or strait or apex of the pelvis, is directed downwards and backwards, and bounded by the rami of the pubes, the rami and tubera ischii, the sacrum and coccyx, and in the recent state by the sacro-sciatic ligaments of each side, but when the latter have been removed as in the artificial skeleton, then this strait presents three great notches: first, the arch of the pubis, triangular, and placed beneath the symphysis, the second and third are placed between the sacrum and os innominatum of each side, very large in the dried bones, but in the recent state they are divided by the sciatic ligaments, each into two, viz. the great or superior, the lesser or inferior sacro-sciatic notch; the former transmits the pyriform muscle, the glutæal, sciatic, and pudic vessels and nerves, the latter the tendon of the internal obturator muscle, and the pudic vessels and nerves. The internal surface of the pelvis is divided into two by the prominent line before mentioned, the linea ilio-pectinea, which leads from the spine of the pubis to the promontory of the sacrum, below this line is the *true* pelvis, above it is the *false* pelvis, which is rather a portion of the abdomen; this line is more distinct posteriorly than anteriorly; this abdominal or *upper strait* of the pelvis is somewhat elliptical, the greatest diameter being transverse; it is measured by four lines or diameters; first, the antero-posterior or sacro-pubic is smaller on account of the projection of the sacrum; second, the transverse or iliac, which crosses the first at right angles, and is the greatest; third and fourth, the oblique, which leads from one ilio-sacral articulation to the opposite ilio-pubal eminence, or the cotyloid wall. Above this strait the great or false pelvis expands and is deficient in bone anteriorly, being only closed by the abdominal muscles. Beneath this strait is the *true* pelvis, which is a sort of curved canal, longer than the false pelvis and wider about the centre than at either strait, with smooth walls, concave posteriorly from above downwards, concave anteriorly in the transverse direction, and on either side nearly plane: the sacrum and coccyx bound it posteriorly, the pubes and thyroid foramina anteriorly, and on either side a portion of the ilium and ischium, the sciatic notches and ligaments. The true pelvis is placed in an oblique direction, its upper orifice looking forwards, so that if a line be passed horizontally from the upper border of the symphysis pubis backwards, it will meet the middle or rather the lower end of the sacrum. The lower orifice looks backwards aud downwards, the axis of the two orifices therefore is not the same, that of the superior, if produced, would pass anteriorly through the abdominal muscles, between the pubis and umbilicus, and posteriorly it would rest against the lower third of the sacrum; the axis of the lower strait, if produced from below directly upwards, would touch the promontory of the sacrum, these lines therefore will decussate near the centre of the pelvis, and form an obtuse angle forwards. The axis of the false pelvis is nearly vertical, while that of the true cavity is oblique from above and from before downwards and backwards. The *female pelvis* differs from that of the male in several circumstances, it is wider and larger, but not so deep, the alæ of the ilium are more expanded, the prominence of the sacrum is less, the upper strait is rounder and wider, the sacrum is broad and more concave, the pubic arch more round and open, the symphisis pubis is not so deep, the sciatic tuberosities are directed more outwards, and the acetabula are more distant from each other; the *male* pelvis is deeper, narrower, and stronger. The dimensions of the male and female pelvis are given by Meckel, as follows, tom. i. p. 473.

	In the Male. Inches.	Lines.	In the Female. Inches.	Lines.
The transverse diameter of the great pelvis between the anterior superior spinous processes of the ilia, - - - - - -	7	8	8	6
Distance between the cristæ of the ilia, - -	8	3	9	4
Transverse diameter of the superior strait, -	4	6	5	0
Oblique do. of do. - -	4	5	4	5
Antero-posterior do. of do. - -	4	0	4	4
Transverse diameter of the cavity, - -	4	0	4	8
Oblique do. of do. - - -	5	0	5	4
Antero-posterior do. of do. - - -	5	0	4	8
Transverse diameter of the lower strait or outlet	3	0	4	5
Antero-posterior do. of do. - -	3	3	4	4

The latter may be increased to 5 inches, from the mobility of the coccyx.

The ossa innominata are composed of two thin but compact laminæ with an intervening diploe, the latter is nearly wanting in the iliac fossa, where the bone is transparent, as well as in the cotyloid cavity. In the fœtus each os innominatum is developed from three points of ossification, one in the iliac fossa, one in the sciatic tubercle, and one near the spine of the pubis; these three soon unite in the cotyloid cavity. Some years after birth the iliac crest is developed as a distinct epiphysis, the sciatic tubercle and anterior inferior spine of the ilium are also covered by distinct plates of bone, and in some the angle of the pubis; in some females also, a plate of bone or epiphysis constitutes the spine of the pubis, and occasionally grows so large and remains so moveable, as to resemble the rudiments of a marsupial bone. In the fœtus, the pelvis is very small and deep, and narrow transversely; the true and false are nearly in the same perpendicular line, the acetabula are nearer the middle line and look more outwards, they are not beneath the pelvis as in the adult, hence the thigh bones in the infant cannot support or balance the weight of the trunk.

[The os innominatum is sometimes fractured by great external violence, and severe inflammation of the soft parts will ensue: sometimes the bone is perforated at the bottom of the iliac fossa which is by some supposed to be natural, by others to result from absorption of the bone. The articulation at the symphysis pubis is relaxed in some inferior animals during parturition, but no such relaxation takes place in the human female; or if it does occur, it is morbid, and followed by serious consequences.

Muscles. Thirty-two pair of muscles are attached to this bone; thirty pair *arise* from it; the latissimus dorsi, internal oblique, transversalis abdominis, and quadratus femoris from the crest of the ilium; the tensor vaginæ femoris and sartorius from its anterior superior spine; the rectus femoris from its anterior inferior spine; the pectineus, adductor longus, adductor brevis and gracilis, from the upper and fore part of the pubis; the pyramidalis, and rectus abdominis from its crest; erector penis and adductor magnus from the rami of the pubis and ischium; the biceps flexor cruris, semitendinosus, semimembranosus, quadratus femoris, transversus perinei, and gemellus inferior from the tuber ischii; the gemellus superior from the spine of the ischium; the glutei maximus, medius and minimus from the external surface of the ilium; the iliacus internus from its internal surface; the obturator externus from the external circumference of the thyroid foramen, and the obturator internus from its internal circumference; the coccygeus and levator ani from the inner surface of the ischium principally; two pair are *inserted* into it, the obliquus externus into the crest of the ilium and the pubis, and the psoas parvus into the pubis at the linea ilio-pectinea.

Articulations. The os innominatum is articulated to the sacrum behind to its fellow before, and to the femur laterally.]

THE HEAD.

The *head* stands at the upper extremity of the vertebral column, is of a spheroid figure, compressed on the sides; it contains the brain and the principal organs of sense, and is divided into the cranium and the face. The *cranium* or skull is of an oval figure, the narrow extremity before; it contains the brain, and is formed of eight bones, the frontal, two parietal, two temporal, the occipital, sphenoid and ethmoid; these bones are all closely united by sutures, in some of these are small bones called ossa triquetra or Wormii; the frontal is considered as common to the cranium and face, but the temporal, ethmoid, and sphenoid are equally entitled to this distinction. The anterior region of the skull is named synciput or forehead; the posterior, occiput; the lateral, the temples; the upper part the vertex or bregma; and the lower, the base. The frontal, occipital, ethmoid and sphenoid bones occupy the median line, the others are lateral and symmetrical, even the single bones are composed of parts perfectly similar on each side of the median line.

The *frontal bone* at the upper and anterior part of the skull forms the forehead, part of the temples, of the orbits and nose; it is of a semicircular form, convex and smooth anteriorly, concave posteriorly, and irregular below, it may be divided into the *superior* or *frontal* portion, and the *inferior* or *orbital;* the external surface of the frontal part presents in the median line a longitudinal depression, in some not very distinct, in others there is an elevation; this corresponds to the line of union, of the two pieces of which the bone when young consisted, it is parallel to the longitudinal sinus internally, a suture frequently exists in it, particularly below; at the lower part of this line is the nasal prominence, longer in the old than in the young; the bone here is frequently very porous, it terminates in a rough edge for articulation with the nasal and superior maxillary bones; from the centre of it projects the *nasal* *spine* or *process*, which supports the nasal bones before, and the ethmoid bone behind, on each side of this is a groove which forms part of the superior nasal fossæ. On either side of the median line of the frontal bone, and proceeding from above downwards, we observe, first, a smooth surface, covered by the occipito-frontalis muscle; second, the frontal eminence, which is particularly prominent in the young; beneath this is a slight depression, bounded below by the *superciliary arch*, towards the inner third of which is the supra-orbital hole, or notch, which is completed into a hole by a ligament, and which transmits the supra-orbital nerve and vessels; from this notch a small foramen leads obliquely into the diploe of the bone; immediately above the internal third of this arch is the prominence of the frontal sinus, and below it is the edge of the orbit, at each extremity of which are the *angular processes;* the *external* is prominent and joins the malar bone, the *internal* is thin and broad, covers some cells. and joins the unguis; above and outside the external is the *temporal* ridge or *process*, which is prominent below and leads upwards and backwards to join a similar ridge on the parietal bone, this separates the forehead from the temple, and gives attachment to the temporal muscle and fascia. On the cerebral or internal surface of this portion of the frontal bone, we observe in the median line a groove for the longitudinal sinus; inferiorly the edges of this groove unite into a ridge to which the falx adheres, and which extends down to a small hole, the foramen cæcum, which is between this bone and the ethmoid; on either side of this median line are numerous irregularities, corresponding to the convolutions of the brain, in general, but not uniformly, for occasionally a prominent part of the bone is opposed to an eminence of the brain; these are named the mammillary eminences, and the digital impressions, in some of the latter the bone is often very thin. The circumference of the os frontis is thick, rough, and serrated to join the parietal bones; the tables are cut unequally, the internal being deficient above, the external below, so that it rests on or binds down the two parietal bones above, and supports or is overlapped by these below; below the temporal process it is bevelled off thin and rough, and is inserted under and between the laminæ of the ala of the sphenoid bone. The *inferior portion* of the frontal bone presents the deep ethmoidal notch in the centre, in front of which is the nasal spine and the orifices of the frontal sinuses, its edges are cellular to unite to and communicate with the cells of the ethmoid bone; along its margins are two foramina, the anterior and posterior orbital, they are common to this and to the ethmoid bone, the anterior transmits the nasal twig of the ophthalmic nerve and anterior ethmoidal artery, the posterior, the posterior ethmoidal artery; on either side are the *orbital processes*, smooth, concave, and triangular, the apex behind presenting near the external angular process a deep pit for the lachrymal gland, and near the internal a slight depression for the cartilaginous pulley of the superior oblique muscle of the eye, instead of a depression there is sometimes a small spine; the cerebral surface of these processes is convex, but very uneven, marked by the brain and vessels; their posterior margins are thin, and cut obliquely to support the lesser wings of the sphenoid bone. The processes of this bone, enumerated by anatomists, are eleven, viz., two orbital, four angular, two superciliary, two temporal, and one nasal; the foramina are nine, viz., one, the foramen cœcum; two and three, the frontal sinuses, between the nasal and internal angular processes; four and five, the supra-orbital; six and seven, the anterior; and eight and nine the posterior orbital; these last, as well as the foramen cœcum, are often common to this and the ethmoid bone. The os frontis is joined to four bones of the cranium, viz., the two parietal, the sphenoid and ethmoid, and to eight bones of the face, viz., the nasal, superior maxillary, lachrymal, and malar. The structure is thick towards the nasal protuberance and superciliary ridges, but very thin in the orbital plates; it is composed of two compact laminæ and an intervening diploe, by the absorption of the latter and the greater separation of the plates, the cavities called the frontal sinuses are formed; these do not exist in childhood, and in the adult their extent is very variable; they generally extend from the ethmoid notch upwards and outwards for one-third of the superciliary arch, sometimes much further; they are generally separated by a septum; their use is not fully ascertained. This bone is developed from two points of ossification, one in each frontal prominence; from this, ossification extends in rays which unite in the middle line, but occasionally a suture remains between them; this has been said, but without sufficient foundation, to be more frequent in women than in men.

[The os frontis is sometimes developed by three pieces, which are distinct at the time of birth, the third piece being situated upon the median line, ovoid in form, and separating the two lateral parts; of this there is a specimen in the Museum. The frontal suture is rather rare, I have seen six or eight specimens of it. The frontal sinuses sometimes spread over a large portion of the orbit, and one case is recorded in which they extended upwards and backwards, beyond the coronal or temporo-frontal suture; they are lined with mucous membrane, which is sometimes the seat of inflammation; they communicate with the anterior ethmoidal cells.

Muscles. Four pair are attached to this bone; three pair *arise* from it, the temporal from its temporal ridge and surface; the orbicularis palpebrarum and corrugator supercilii from its internal angular processes; and the occipito frontalis is *inserted* into the integuments over its front and lower part.]

The *parietal bones* are symmetrical, and form the upper and lateral parts of the cranium; each is nearly square, convex and smooth externally, about the centre is the protuberance, which is better marked in children, below this is the curved temporal ridge continuous with the process of that name on the os frontis, to this the temporal aponeurosis adheres; below this it is rough for the attachment of the temporal muscle; of the four edges, the upper or perietal is the longest, it is serrated, and with the opposite bone forms the sagittal suture; the anterior or frontal edge is also serrated to join the os frontis in the coronal suture; the posterior or occipital edge is very irregular, and joins the occipital bone in the lambdoid suture: in this suture small bones called ossa Wormii or triquetra are often found; the inferior or temporal edge is the shortest, it is concave, and joins the temporal bone by the squamous suture; of its four angles the anterior superior is nearly right, in the child this is deficient and the fontanelle exists; the superior posterior angle is somewhat rounded; near this in general is a foramen[parietal]which transmits small vessels from the pericranium to the dura mater, the inferior anterior is long and curved, and joins the sphenoid bone, the inferior posterior is very irregular and joins the mastoid portion of the temporal bone: the cerebral surface is marked by the convolutions of the brain, and by the branches of the middle artery of the dura mater; this vessel is in a groove, sometimes in a perfect canal or tube in the anterior inferior angle, and from this the branches pass upwards and backwards, a large one ascends a little posterior to the coronal edge; along the parietal border is half a groove, which with that in the opposite bone, lodges the longitudinal sinus; and near this in the adult skull are irregular depressions for the glandulæ Pacchioni or the granulations of the dura mater; the posterior inferior angle is grooved and lodges part of the lateral sinus: the structure of the perietal bone is similar to that of the frontal; it is devoloped from one point of ossification, which is in the parietal prominence; it is joined to five bones, viz. the frontal, sphenoid, temporal, occipital, and to its fellow.

Muscles. One muscle only is attached to this bone, the temporal, which *arises* from it; the occipito-frontalis slides over it to some extent.]

The *occipital bone* is curved and of a rhomboidal figure, placed at the posterior and inferior part of the cranium; it presents two surfaces, the external or posterior, or basilar, is convex, smooth above, presents near the centre the great *protuberance* to which the cervical ligament is connected; from each side of this leads the superior transverse ridge, to which the occipito-frontales, trapezii, and complexi muscles are attached; midway between this and the foramen magnum, is the inferior transverse ridge, to which the splenii, recti majores and obliqui superiores are attached; from the tuberosity a spine leads down vertically in the median line as far as the foramen magnum; this latter is of an oval figure, and transmits the medulla spinalis, the vertebral vessels, and the sub-occipital nerves; it is larger internally than externally, in front of this is the *basilar process*, which is very thick and strong, it passes forwards and a little upwards into the base of the skull to join the sphenoid bone; its sides are rough and contiguous to the petrous bones; it is also rough inferiorly, for the attachment of muscles and the mucous membrane of the pharynx. Near the forepart of the foramen are the *condyles*, smooth and oblong, covered with cartilage, looking downwards, outwards, and backwards, and converging anteriorly; their anterior and inner edges are the deepest, their long axis is from before backwards, in which direction, as also from side to side they are convex, they are uneven internally near their centre, for the insertion of the lateral ligaments from the odontoid process; they are articulated to the atlas; behind these is a fossa in which there is generally a small foramen through which a vein and small artery pass, and before them is another fossa in which there is always a foramen for the ninth pair of nerves, [the *posterior* and *anterior condyloid foramina*.] External to each condyle is the *jugular eminence*, semilunar, bounding posteriorly the foramen lacerum posterius in the base of the cranium and giving attachment to the rectus lateralis muscle. The upper angle is acute; the edges very irregular as also along the sides; ossa triquetra are often entangled in the notches. The internal or cerebral surface is concave, and marked by two lines which cross about the centre, or opposite the tuberosity, these bound four fossæ, the two superior receive the posterior lobes of the cerebrum, and are marked by their convolutions, the inferior are smooth, and lodge the hemispheres of the cerebellum, to the vertical ridge is attached the falx cerebri above and falx cerebelli below; the lower extremity of the latter is bifurcated, the upper half is grooved for the longitudinal sinus; to the transverse ridge the tentorium is attached, it is grooved for the lateral sinus; the basilar process is concave from side to side, to support the pons Varolii and the basilar artery; on either margin of it is a slight groove for the inferior petrosal sinus; on each side of the foramen magnum above the jugular processes is a groove for the lower extremity of the lateral sinus. This bone is joined to six bones, viz. the two parietal, two temporal, the sphenoid, and the atlas. Its processes are six, namely, two condyles, two jugular, the basilar, and the tuberosity. Its foramina are five proper and two common; the proper are, the magnum, the two anterior and two posterior condyloid; the common are, the foramina lacera postica basis cranii, these foramina are completed by the petrous bone, each is imperfectly divided into two, a small anterior portion which transmits the eighth pair of nerves, and a large posterior one, or thimble-like fossa, which lodges the lateral sinus as it ends in the jugular vein. This is a very hard bone, although thin throughout except at the ridges and processes; it is developed from four points, one for the basilar process, one for each condyle, and one for the upper and back part.

[The whole of this bone above the superior transverse ridge is sometimes composed of three or four large ossa triquetra; this bone and the sphenoid become inseperably united in the adult subject, which is also true of some inferior animals, hence the two are described as a single bone by some anatomists under the name of os basilare; the groove for the right lateral sinus is usually larger and deeper than that for the left, and sometimes it is continued almost vertically from the longitudinal sinus towards the foramen magnum, near which it diverges to reach the foramen lacerum posterius.

Muscles. Thirteen pair are attached to this bone; two pair *arise* from it, the occipito-frontalis and trapezius from the superior transverse ridge; eleven pair are *inserted* into it; the sterno-mastoid into the superior transverse ridge, the splenius capitis externally and the complexus internally into the space between the two transverse ridges; recti capitis postici major and minor, and obliquus capitis superior, between the inferior transverse ridge and the foramen magnum; the rectus capitis lateralis into the jugular process; the recti capitis antici major and minor, and superior and middle constrictor muscles of the pharynx into the basilar process.]

The *temporal bones* are situated at the lateral, middle, and inferior parts of the skull, of a very irregular shape, thin above and before, and thick behind and below; each may be divided into three portions, the squamous, the mastoid, and the petrous. The *pars squamosa* is the superior division, it is flat, thin, and scaly, forms part of the temporal fossa, is bounded above by a semicircular edge, and below by the *zygomatic process*, which is horizontal and arises by two roots, one anterior covered by cartilage, narrow externally, broad internally, runs transversely in front of the glenoid cavity, the other passes horizontally backwards, and bifurcates, one portion turns in to the glenoid fissure, the other is gradually lost above the mastoid process; where these two roots of the zygoma, the one transverse, the other horizontal, unite, there is a small tubercle to which the external lateral ligament of the lower jaw is attached; the zygoma thence bends forwards and downwards, slightly curved, convex outwards, and ends in a serrated edge which joins and rests on the malar bone; between the root of this process and the squamous plate there is a smooth trochlea, over which the posterior part of the temporal muscle moves; behind the transverse root of this process is the articular or glenoid cavity, which is crossed by the Glasserian fissure; this leads inwards and forwards, into it the capsular ligament is inserted, and near its centre is a small hole through which the corda tympani nerve and the laxator tympani muscle pass; to this fissure also, the processus gracilis of the malleus is attached; the anterior part only of this cavity enters into the maxillary articulation, the posterior is filled by the parotid gland, and is bounded by the *auditory process;* this leads inwards and forwards behind the glenoid cavity from the external auditory hole, which is between the two divisions of the outer root of the zygoma; this process or meatus is a twisted plate of bone, united above to the squamous plate, but presenting below a rugged edge to which the cartilage of the ear is attached; the meatus takes a direction forwards, inwards, and a little downwards, it is narrower about the centre than at the extremities, it leads to the membrana tympani. The squamous plate internally is marked by vessels and by the convolutions of the brain, like the other bones of the cranium; its upper edge is bevelled off and is very rough to overlap the parietal bone. The *mamillary* or *mastoid* is the posterior inferior portion, it is joined to the parietal bone above, and to the occipital behind, by a very deeply serrated edge, inferiorly it is prolonged into a rough nipple-like process, the *mastoid*, internal to which is a groove for the occipital artery, and another partly behind it for the digastric muscle, above and behind it, is a hole [the mastoid foramen] through which a vein and small artery pass; this process is hollowed out into cells which communicate with the tympanum, it gives attachment to the sterno-mastoid muscle; the cerebral surface is deeply grooved for the lateral sinus. The *petrous portion* passes from the junction of the mastoid and squamous forwards and inwards into the base of the skull, it is of a triangular form, the base behind and very irregular, with a deep notch which assists the occipital bone in forming the foramen lacerum posterius; the apex is anterior, contiguous to the body of the sphenoid bone, and completing with it the foramen lacerum anterius, which in the recent state is filled up with cartilage; this bone is peculiarly hard and rugged; on its inferior surface we remark in front of the foramen lacerum posterius a minute hole which leads to the cochlea, and is named the aqueduct of the cochlea; more anteriorly and externally is the *styloid process* which descends obliquely inwards and forwards, and gives attachment to three muscles; it is surrounded at its base or root by a plate of bone most prominent anteriorly and externally, this is named the *vaginal process;* it separates the glenoid fossa from the carotid foramen; behind and outside the styloid process, between it and the mastoid, is the stylo-mastoid hole or the lower end of the aqueduct of Fallopius, this transmits the portio dura or the facial nerve; in front of the styloid process, and a little internal to it, is the carotid hole which leads into a canal that winds forwards, upwards, and inwards, and which opens within the cranium above the foramen lacerum anterius by the side of the body of the sphenoid bone, it transmits the carotid artery and branches of the sympathetic nerve: in front of the carotid hole is a flat rough surface to which the muscles of the palate are attached. The apex of the petrous bone is very irregular, it lies in the foramen lacerum anterius, the internal opening of the carotid canal is in it; into the angle between the petrous and squamous portions the spinous part of the sphenoid bone is wedged; in this angle there are two holes separated by a thin lamina of bone, the upper transmits the tensor tympani muscle, the lower is the extremity of the bony part of the Eustachian tube. The superior or cerebral surface presents a prismatic form, a sharp angular ridge to which the tentorium cerebelli is attached, separates its two surfaces, one looks forwards and upwards, the other backwards and inwards; on the superior we observe anteriorly a slight depression which corresponds to the Casserian ganglion of the fifth pair of nerves; leading from this is a delicate groove which conducts to a small opening, the *hiatus Fallopii,* through which the superior branch of the Vidian nerve passes in order to enter the aqueduct of Fallopius; the remainder of this surface is marked by the convolutions of the brain, and by the eminence of the superior semicircular canal; on the posterior surface is the *meatus auditorius internus,* through which pass the two portions of the seventh pair of nerves, it is directed forwards, and outwards, is lined by dura mater, and is terminated abruptly by a vertical bony process, beneath which is a sort of cribriform plate, through this the auditory nerves pass, and above this the portio dura enters the aqueduct of Fallopius; the latter is a very long canal, which leads outwards and downwards behind the tympanum; the hiatus Fallopii and some canals from the tympanum open into it, it ends in the stylo-mastoid foramen; behind the meatus is a small depression lined by the dura mater, and posterior to this is a narrow short slit in which the canal of the vestibule ends, from this slit a groove descends to the jugular opening. The petrous bone contains within it the complicated apparatus of the organ of hearing which has been already described, (page 89.) The temporal bone is connected to five bones, the parietal, malar, sphenoid, occipital, and inferior maxillary, and in some to the os hyoides. In the fœtus it consists of two portions, the squamous and petrous, the latter is large and well developed, and the ossicula auditus which it contains are perfect, and nearly as large as in the adult, the mastoid portion is not formed, the styloid process is cartilaginous, and is distinct from the rest of the bone, the external auditory meatus is wanting, a bony ring supplies its place and encircles the tympanum. The processes enumerated are five, viz. the mastoid, auditory, zygomatic, styloid, and vaginal; the holes are ten proper and two common; the proper are, the external auditory, glenoidal, stylomastoid, aqueductus cochleæ, carotid, Eustachian, hiatus Fallopii, internal auditory, and aqueductus vestibuli; the common are the foramen lacerum anticum, and posticum or jugular.

[The mastoid foramen may be wholly in the mastoid portion, or wholly in the os occipitis, or common to the two.

Muscles. Fourteen muscles are attached to the bone of each side; eleven *arise* from it; the temporal from the squamous plate; the masseter from the zygoma; the occipito-frontalis, digastricus and retrahens aurem from the mastoid process; the stylo-hyoideus, styloglossus, and stylo-pharyngeus from the styloid process; the levator palati, tensor tympani and stapedius from the petrous portion: three are *inserted* into it the splenius capitis, sterno-mastoid and trachelomastoid into the mastoid portion.]

The *ethmoid bone* is situated in the notch between the orbital plates of the frontal bone, and forms the roof of the nostrils; it is so named from its cribriform or sieve-like appearance, it is of a cuboid figure, and composed of many thin, brittle, semi-transparent laminæ, placed in every direction so as to form cells, these enlarge the surface of the nose without increasing the size or weight, for this bone is remarkably light. It consists of a middle perpendicular lamina and two symmetrical portions, its superior or cerebral surface is broad and covered by the dura mater, in its posterior edge is a notch which receives a process of the sphenoid bone, along the middle line is a hard ridge, which anteriorly rises into a remarkable process, the *crista galli*, to which the beginning of the falx is attached, this process ends before in two short wings which join the os frontis, and which often assist in bounding the foramen cœcum; on either side of this process is a channel deeper before than behind, these lodge the olfactory nerves; anterior to each of these, and nearer to the process, is a small slit [the foramen ovale] which transmits the nasal branch of the ophthalmic nerve; this entire surface is perforated by numerous holes, about ten or twelve of these are large, and are placed over the lateral parts of the bone, the remainder are very small and are on either side of the median line, they each lead into a small vertical canal lined by dura mater; from the inferior surface of this plate, there descends the nasal *lamella* in the middle and a large spongy cellular mass on either side; the *nasal lamella* is in the median line, it is thick above and behind where it joins the sphenoid, thin below where it joins the vomer and nasal cartilage, and very thick before where it unites to the nasal process of the os frontis and to the nasal bones, its sides are marked with the canals for the olfactory nerves, short and oblique before, vertical and very long in the middle and behind, they descend for about half the depth of the plate, and become converted into mere grooves; on either side of this septum is a deep channel, which forms the roof of each naris, on each side of this we observe an irregular long structure which consists of three parts, an internal curved lamina, (the superior turbinated bone,) a middle range of cells, and externally towards the orbit a smooth square plate, the os planum. First, the *turbinated* or *spongy bone* is a very thin plate descending at first vertically, and then bending outwards, and rolled upon itself for nearly half a turn; in the posterior extremity of this is a depression or sort of cleft, which is called the superior meatus of the nose, this channel or meatus extends along the posterior half of the ethmoid, it is closed before, except in a small aperture which leads into the posterior ethmoid cells; the portion of the turbinated plate which extends below this fossa is named the *middle spongy bone*, it is larger than the upper portion, more curved, and very concave outwardly, beneath this is a deep fossa named the middle meatus of the nose; second, the *ethmoid cells* are external to the turbinated plates, bounded above by the cribriform plate, and externally by the os planum and os unguis, the cells are about twelve or fourteen in number, and are divided by a bony septum into an anterior and posterior set, the *posterior* are small, and open into the superior meatus, and sometimes one of the uppermost communicates with the sphenoid sinus or opens into the fossa of its turbinated plate; the *anterior* cells are larger and more numerous, they open into the middle meatus, one of the most anterior is curved into a sort of tube, the *infundibulum*, into this the frontal sinus opens above, and it terminates before the orifice of the great maxillary sinus or antrum; all these cells are lined by the pituitary membrane, which, however, is less vascular and thick than that on the nasal lamella or turbinated bones; on this membrane, particularly that covering the superior spongy bone, and the square surface before it, the external olfactory canals chiefly end; from the lower surface of the ethmoidal cells thin plates of bone often descend very irregularly to join the superior maxillary. External to the cells on each side is the third part, the *os planum* or orbital plate, very smooth and polished, articulated above to the frontal, before to the lachrymal, behind to the sphenoid, and below to the maxillary and palate bones, the upper border has often a notch or two which assist the frontal in forming the internal orbital holes. The ethmoid bone contributes to form the base of the cranium, the nose, and the orbits; it has little or no cellular tissue in its composition except in the turbinated plates and the crista galli. It is developed by three points of ossification, one for the central lamella and one for each side, the latter appear first, the turbinated plates are not distinct until five years of age: it is joined to two bones of the cranium, the frontal and sphenoid, and to eleven of the face, the nasal, superior maxillary, lachrymal, palate, inferior spongy, and the vomer.

[There are no muscles attached to this bone; its use being to offer in a small space a large surface upon which the impression of odoriferous particles may be received.]

The *sphenoid bone* is so named from the manner in which it is wedged into the base of the skull, in the middle of which it is placed, it is articulated to all the bones of the cranium, and to many of those of the face, it is of a very irregular form, and has been compared to a bat, to which it bears some resemblance, particularly if the ethmoid remain attached; it may be divided into a body and processes, the body is in the centre, and resembles a square box; from its median line inferiorly and anteriorly proceeds the *azygos process*, or the rostrum, which is received between the layers of the vomer, on each side of this is a small groove for vessels; the body is flat and rough posteriorly for attachment to the basilar process, [of the os-occipitis] its centre is hollowed out into two cavities or sinuses which are separated by a septum, which is continuous with the azygos process, anteriorly it presents the two small round openings of the sphenoid sinus, beneath which are often found two small triangular bones, the *spongy* or *turbinated bones* of the sphenoid, or of Bertin; the superior or cerebral surface of the body presents several remarkable appearances, it is hollowed from before backwards into the deep depression called sella turcica, this lodges the pituitary gland, and is perforated by several holes through which small vessels pass to the nose, posteriorly it is bounded by a thin plate which rises perpendicularly, and has a slight knob at each angle named the *posterior clinoid process*, to each of these the extremity of the convex edge of the falx is attached; anterior to the sella is the *olivary* eminence or *middle clinoid process*, on it is a transverse depression for the optic commissure, on each side of which are the *anterior clinoid processes*, two thick tubercles to which the extremity of the concave edge of the tentorium is attached, each of these is perforated by the optic foramen, which is transversely oval and transmits the ophthalmic artery and the optic nerve; sometimes the anterior is united to the posterior clinoid process by bone, and sometimes to the olivary process; from each anterior clinoid process there extends forwards and outwards a thin plate of bone, the *transverse spine* or lesser wing, or wing of Ingrassias, this is united anteriorly to the frontal bone, and forms a part of the orbit, it ends in a point, its posterior edge is thick and rounded, the sphenoidal fold of the dura mater is attached to it, and both occupy the fissure of Sylvius on the base of the cerebrum between its anterior and middle lobes; each side of the sella turcica is grooved by the carotid artery; from its forepart extends a small plate to join the ethmoid bone, (*ethmoidal process;*) from each side of the body the ala is continued outwards, forwards, and upwards; it presents three surfaces, one anterior, smooth and square, forms part of the outer wall of the orbit, and is named *orbital process*, another is elongated and concave, and together with the temporal bone supports the middle lobe of the cerebrum; the third or external surface is named the *temporal process*, this is divided into two by a crest, the upper part forms a portion of the temporal fossa, and the lower of the zygomatic fossa, some fibres of the temporal and external pterygoid muscles are attached to the crest itself; from the posterior part of each wing the *spinous process* extends backwards, and curves a little downwards and outwards, and occupies the angle between the squamous and petrous portions of the temporal bone, it terminates in a spine, the *styloid process*, on the inner side of the articulation of the lower jaw; near this process is a small foramen (*spinosum*) which transmits the middle or spinous artery of the dura mater, anterior to this is the *foramen ovale* opening directly downwards for the passage of the inferior maxillary nerve; still more anterior is the *foramen rotundum*, which leads forwards and transmits the superior maxillary nerve; between the lesser and great wing is a long slit, the *foramen lacerum orbitale*, wide internally, narrow externally where the frontal bone sometimes assists in closing it, it transmits the third, fourth, first branch of the fifth and the sixth pair of nerves from the cranium to the orbit: from the angle between the body and ala, the *pterygoid* plate descends perpendicularly, internally it bounds the posterior naris, externally the external pterygoid muscle is attached to it, anteriorly the palate bone is connected to it, posteriorly it is hollowed into the pterygoid fossa, which lodges the internal pterygoid muscle, and in a small depression internal to this the tensor *palati muscle;* this fossa thus divides this process into two plates, the *external* is broad and rough, the *internal* is longer and narrower, and ends in the *hamular* process, a small delicate hook, convex inwards, concave outwards, and covered by a bursa, round this the tendon of the tensor palati muscle turns: in the inferior notch between these plates the palate bone is received; above the internal pterygoid plate is the *Vidian hole* or canal, this opens anteriorly on the inner side of the foramen rotundum, into the spheno-maxillary fossa, and posteriorly very small into the foramen lacerum anterius, it transmits the Vidian nerve and vessels.

The structure of the sphenoid bone is very compact, except the body which is cellular; the latter about ten years of age undergoes the process of absorption, whereby the cavities called the sphenoid sinuses are formed; these open into the upper and back part of the nose; in front of them in the adult is a small curved plate of bone, the *sphenoidal turbinated bone*, it is of a pyramidal form, the base anteriorly connected to the posterior ethmoid cells, the apex posteriorly, and joined to the forepart of the sinus, it lies above the *spheno-palatine foramen*, a hole which is below the body of the sphenoid, and between the orbital processes of the palate bone; this hole leads from the nose to the spheno- or pterygo-maxillary space; these superior spongy bones are wanting in the child and sometimes in the adult. The sphenoid is articulated to the seven bones of the cranium and to five of the face, viz., the two malar, two palate, and the vomer, and in some cases to the superior maxillary by the pterygoid plates, the palate bones however in general intervene; the processes enumerated are twenty-seven, viz., five clinoid, one ethmoidal, two lesser wings, one vomer or azygos, two spongy or triangular, two great wings, two temporal, two orbital, two spinous, two styloid, four pterygoid, and two hamular; the foramina are fourteen proper and eight common; the proper are, two optic, two lacerated orbital, two round, two oval, two spinal, two Vidian, and the two sinuses: the common are, two foramina lacera antica basis-cranii, two spheno-maxillary fissures, one in each orbit bounded by the orbital plates of the sphenoid, malar, maxillary, and palate bones, two spheno-palatine, and two posterior palatine canals between the pterygoid processes and the superior maxillary tuberosities. At birth, the sphenoid bone consist of three pieces, one is the body to which the clinoid processes and lesser wings are attached, the lateral pieces consist of the pterygoid processes and the great wing of each side.

[*Muscles.* Twelve pair are attached to this bone; and all *arise* from it, the temporal, external and internal pterygoids, constrictor pharyngis superior, tensor palati, laxator tympani, levator palpebræ superioris, the superior oblique and four recti muscles of the eye.]

The bones of the cranium are connected to each other by *suture*, that is, the edge of each is serrated or cut into irregular teeth like processes, these indigitate or lock into each other, so as to unite the two edges in a very strong and motionless manner, the indentations are irregular and oblique in very thick bones, but where the edges are thin, the suture is more straight and regular; they are more distinct in the young than in the old, and on the outer than the inner surface of the cranium; there are seven sutures noticed by most anatomists, (some however unnecessarily enumerate a greater number,) the sphenoidal, ethmoidal, coronal, sagittal, lambdoid, and two squamous. The *sphenoidal suture* is very extensive, it follows the irregular edge of the sphenoid bone, and connects it to the occipital, the temporal, inferior angle of the parietal, the frontal, and the ethmoid. The *ethmoidal* suture in like manner encircles the ethmoid bone and connects it to the frontal. The *frontal*, or *coronal suture* proceeds from the upper extremity of the sphenoidal about an inch behind the external angle of the os frontis, ascends vertically inclining a little backwards, and then descends to the same point on the opposite side, it connects the frontal and parietal bones in the manner before explained. The *sagittal suture* leads from the superior angle of the occipital bone directly forwards between the two parietal to the centre of the coronal suture, and is sometimes continued along the median line of the frontal bone down to the nose. The *lambdoid suture* extends on either side from the posterior extremity of the sagittal suture, downwards and forwards to the mastoid process of the temporal bone; a suture named the *additamentum of the lambdoid* continues down between this process and the occipital bone as far as the foramen lacerum posterius; the lambdoid suture is very rough, and frequently contains ossa triquetra of very irregular size, it connects the occipital and the two parietal bones; the additamentum is very little serrated, but presents uneven thick edges, it connects the occipital to the mastoid portion of the temporal bone, the mastoid hole is frequently in it, it nearly corresponds to the lateral sinus. The *squamous suture* on each side is continued from the extremity of the sphenoidal in an arched direction upwards and backwards, as far as the inferior angle of the parietal, it is then continued under the name of *additamentum of the squamous suture*, directly backwards for about an inch; the structure of the squamous differs from that of the other sutures, the bones are not serrated but thin and scaly, and overlap each other, it unites the temporal to the parietal; the additamentum is serrated and connects the inferior angle of the parietal to the upper part of the mastoid portion of the temporal bone, it corresponds to the course of the lateral sinus internally; a small os triquetrum is sometimes found at the anterior part of this suture, and seldom in any other situation.

[The bones of the cranium belong for the most part to the class of flat bones, and are developed by fibres radiating from a centre. In the adult, the flat bones of the head consist of three laminæ, an *external table* of compact tissue, an *internal* table of compact tissue, more dense and brittle than the other, and hence called the *tabula vitrea*, and a middle lamina of spongy tissue, the *diploe;* this does not exist in the infant and child, but subsequently is developed, apparently at the expense of the contiguous surfaces of the compact tables, which seem to recede from each other, so as to form the diploe and the frontal sinuses. In the old subject, the diploe is absorbed, and the two compact tables fall together again; in advanced life the sutures are liable to become obliterated, so that the bones form a solid inseparable mass; a suture may be confounded with a fissure. All the bones of the cranium may be fractured; but those parts above a line subtending the supra-orbital arches, the external openings of the ears, and the occipital protuberance are of course most exposed to external violence; those parts in the base of the cranium may be fractured by very great violence, or by a counter fissure. The internal table may be fissured, the external being entire; and both tables may be driven in without a division of the soft parts over them. There are some situations in which we are directed not to apply the trephine, as over the longitudinal sinus, over the trunk of the middle meningeal artery, &c.; but under certain circumstances we must operate in those places; the trephine cannot be applied below the superior transverse ridge of the occipital bone. After a piece of bone has been removed by the trephine, its place is subsequently supplied by a fibro-cartilaginous membrane, of which there are some fine specimens in the collection of Dr. Sabine.]

OF THE SKULL IN GENERAL.

THE *outer* surface of the skull presents four regions, the *superior* is smooth and even, has no remarkable appearance deserving more particular attention; the *lateral* regions are each divided into two, anterior or temporal, and the posterior or mastoid; the *inferior* region extends from the nasal notch to the occipital protuberance, and is bounded laterally by the zygomatic arches, and by a ridge which is continued from these processes round the skull with but little interruption; this region may be divided into three portions, anterior, middle, and posterior; the *anterior* extends from the superciliary ridges of the os frontis to the roots of the pterygoid processes of the os-sphenoides; it presents the nasal spine and process of the os frontis, the ethmoid bone, the orbital plates of the os frontis, bounded by its angular processes before, and by the orbitar plates of the sphenoid behind; in this division are the supra-orbital, the anterior and posterior orbital holes, the openings of the frontal and ethmoid cells, the optic and lacerated holes of the orbits, the Vidian canals and the foramina rotunda. The *middle* division extends from the roots of the pterygoid to the styloid processes of the temporal bones, it presents the azygos process, the basilar process of the os occipitis, the anterior points of the petrous portions of the temporal bones; the spinous processes of the sphenoid, and the glenoid cavities of the temporal bones. The holes in this division are the oval, spinous, carotid, external, auditory, glenoidal, and the Eustachian tubes. The *posterior* division extends from the styloid processes of the temporal to the tuberosity of the occipital bone; it presents the foramen magnum, the two condyles, the jugular ridge, the styloid processes of the temporal bones, surrounded by their vaginal processes, the mammillary processes, the digastric pits, the inferior and superior transverse arches, the spine, protuberance, and pits of the occipital bone; the foramina in this division are the stylo-mastoid, mastoid, magnum, lacera postica, anterior and posterior condyloid.

The skull is divided internally into the arch or vault and the base; on the vault is to be observed the sulcus for the longitudinal sinus, the frontal crest, the grooves for the middle arteries of the dura mater, the depressions for the convolutions of the brain, and for the granulations or glandulæ

Pacchionæ; the base of the skull is very uneven, and presents three portions, regions, or fossæ on different planes, the anterior or frontal, the middle or spheno-temporal, and the posterior or occipital; the first is formed of the orbital plates of the frontal bone, the cribriform plate of the ethmoid, and the lesser wings of the sphenoid; the foramina in this division are the cæcum, olfactory, and optic. The second division is bounded before by the transverse spinous processes of the sphenoid, on the sides by the squamous portions of the temporal, and behind by the superior angles of the petrous portions of the same bone, and by the posterior clinoid processes of the sphenoid; in the middle is the sella turcica, on each side of which, but below it, is a groove for the carotid artery, and for the cavernous sinus, and below this is a shallow groove for the superior maxillary nerve; further out on each side, are the cavities to lodge the middle lobes of the brain; and on the anterior surface of the petrous bones are seen the juttings of the vertical semicircular canals. The foramina in this division are, the foramina lacera orbitaria superiora, rotunda, ovalia, carotica, spinosa, lacera basis cranii anteriora, and innominata or hiatus Fallopii. The third or occipital portion is bounded before by the basilar process, and by the posterior surface of the petrous bones, and behind by the occipital, it presents the basilar process, the foramen magnum, the perpendicular ridge of the occipital crossed by the transverse, by which this bone is divided into four fossæ, the superior angles of the petrous bones having a shallow groove for the superior petrosal sinuses, the transverse occipital ridge, with a deep one for the lateral sinuses, which last are continued over the inferior angles of the parietal bones, and thence descend inwards along the mastoid portions of the temporal bone, and then again groove the occipital bone, and pass forwards on it to the posterior foramina lacera; the perpendicular ridge is grooved above for the longitudinal sinus, which terminates sometimes in the left, and at other times in the right lateral sinus; the same ridge below the tentorium gives attachment to the falx minor, and is slightly grooved for the occipital sinuses. The foramina in this division are the foramina auditiva, aqueductus vestibulorum, foramina lacera postica, foramen magnum, foramina condyloidea antica and postica.

THE BONES OF THE FACE.

These consist of six pair and two single bones; the six pair are the malar, superior maxillary, lachrymal, nasal, palatine, and inferior spongy; the two single bones are the vomer and the inferior maxillary.

The *malar* or *cheek bone* is placed at the outer and under part of the orbit, and forms the prominence of the cheek; it is of an irregular square form, convex externally, and covered by the skin and orbicularis palpebrarum; it presents one or two small holes for vessels and nerves; its upper and outer edge is named,[*superior* or]*external obital process*, and joins the frontal bone; its inner end is cut off obliquely and serrated, is attached to and overlaps the maxillary bone, this is the *maxillary process;* its anterior edge between these two processes is round, smooth, and concave, forms about one-third of the base or circumference of the orbit, and ends internally in a long angle, named the *inferior orbital process;* the lower edge is thick and uneven, and gives attachment to the masseter muscle, it ends posteriorly in the *zygomatic process*, which passes backwards, and terminates in a serrated edge which supports the zygomatic process of the temporal bone; behind this the malar bone is smooth, and forms part of the temporal fossa; from the posterior surface a thin plate extends into the orbit, and is named the *internal orbital process;* the posterior edge of this is notched to close the spheno-maxillary fissure anteriorly. The malar bone is thick, strong, and cellular; it is well developed in the fœtus. It is joined to four bones, the frontal, sphenoid, temporal, and superior maxillary; the processes are five, the superior, inferior, and internal orbital, the malar, and zygomatic; the foramina are two or three proper and one common, viz., the spheno-maxillary fissure, or the foramen lacerum orbitale inferius.

[*Muscles.* Four muscles *arise* from this bone, the zygomatici major and minor, the masseter, and the temporal; the orbicularis palpebrarum spreads over it.]

The *superior maxillary bone* is of a very irregular figure, and attached to all the bones of the upper jaw; it forms part of the front of the face, a portion of the orbit, nose, and palate; it may be divided into the body and processes. The *body* is concave anteriorly, to form the infra-orbital or canine fossa, in the upper part of which is the infra-orbital hole; it is bounded externally and above by a rough serrated surface, *the malar process*, which is smooth and hollowed out behind for the temporal muscle; springing from the inner and upper part of the body, is the *nasal process* of a pyramidal form, perforated by one or two small holes for vessels, serrated above to join the os frontis, prominent below, slightly grooved anteriorly to receive the nasal bone and the alar cartilage, and deeply grooved behind to form part of the lachrymal fossa and duct: its internal surface forms part of the nasal fossa, and is connected to the ethmoid bone above, below this is a channel that leads to the middle meatus, and inferior to this is a crest for the spongy bone; between the nasal and malar processes is the *orbital plate*, of a triangular form, the base joined to the ethmoid, lachrymal, and palate bones; this process looks downwards and forwards; its outer and posterior edge bounds the spheno-maxillary fissure: the infra-orbital canal, which runs along it in a direction forwards and inwards, lodges the vessels and nerves of that name; this canal divides anteriorly into two, the smaller is the *anterior dental*, which descends in the anterior wall of the antrum, where it terminates by communicating with the anterior alveoli, the other or the proper *infra-orbital canal* is wider, and ends in the infra-orbital hole; the edge of the bone above this hole is round to form part of the contour of the orbit, behind which the inferior oblique muscle of the eye arises; behind and below this plate is the *tuberosity*, this is more prominent in the young, as it contains the last molar tooth, after the protrusion of which it diminishes, near this are three or four small holes, the *posterior dental canals*, which lead to the posterior alveoli; beneath the orbital plate, the body of the bone is excavated into a large cavity, the *antrum highmorianum*, [or maxillary sinus,] of somewhat a triangular figure, the base towards the nose, the apex towards the malar process; this is the largest sinus connected with the nose, it is sometimes divided by septa as well as by the anterior dental canal into two or more cells; the infra-orbital canal runs along its roof, through the floor, one or two of the molar alveoli project and sometimes open, the canine fossa is in front of it, and the tuber bounds it behind, this cavity is lined by the membrane of the nose; in the skeleton the opening in its base is very large and irregular, but in the natural state it is contracted by the ethmoid bone above, by the palate bone behind, and by the inferior spongy bone below, also by the lining membrane of the nose; it opens by one or two small oblique openings into the middle meatus of the nose, anterior to which is the *infundibulum*, a deep groove leading downwards, backwards, and inwards, from the frontal sinus and the anterior ethmoid cells, and opening into the middle meatus; the body of this bone is bounded below by a strong horizontal plate, the *palatine process*, the upper surface of which is smooth and concave, and forms the floor of the nose, the lower is rough, and forms the roof of the mouth; it is thick before, thin and serrated behind to join the palate bone, internally it is thick and rough, and joins the opposite bone, by a suture, in the anterior part of which is the anterior palatine canal, which opens inferiorly on the palate by the foramen incisivum, and superiorly by two distinct holes, one in each nostril; this internal edge is raised so as to form the *nasal spine* or *crest* to receive the vomer, anteriorly this projects so as to form the anterior *nasal spine*, to which the cartilaginous septum of the nose is attached; between this and the nasal process the bone is very concave and forms the anterior opening of the nares.

The palate plate is bounded anteriorly and externally by the curved *alveolar edge* or *process;* this is very thick, particularly behind, and is divided into several, generally eight, conical cavities for the teeth; the partitions between these are formed of dense cellular texture which is less compact posteriorly. The superior maxillary bone is connected to two bones of the cranium, the frontal and ethmoid, and to seven bones of the face, the nasal, lachrymal, malar, palate, inferior spongy, vomer, and to its fellow of the opposite side, also to the teeth; it is sometimes connected to the pterygoid processes of the sphenoid. The processes are eight, the nasal, orbital, malar, tuberosity, alveolar, palatine, nasal crest, and nasal spine: the foramina are three proper and four common; the proper are the infra-orbital, the foramen antri, and foramen incisivum; the common are the spheno-maxillary fissure, the posterior palatine hole or canal, the anterior nares, and the nasal or lachrymal duct; this bone is well developed in the fœtus, with the exception of the alveoli and sinus, the former commence about the end of the first year, the latter about the seventh.

[*Muscles.* Eight are attached to this bone; seven *arise* from it, the obliquus oculi inferior, levator and depressor labii superioris alæque nasi, levator anguli oris, compressor nasi, buccinator and masseter; the orbicularis palpebrarum is *inserted* into it.]

The *palate bone* is situated at the outer and back part of the nose, between the pterygoid processes [of the sphenoid] and the superior maxillary bone, it is of a very irregular figure and may be divided into four parts; first, the horizontal or palate plate; second, the nasal or perpendicular plate, at the lower and outer angle of which is, third, the pterygoid process; and fourth, at the upper extremity of the nasal is the orbital portion. The *palate process* or plate is nearly square, flat, and rough below, smooth above, and concave from side to side to form part of the floor of the nose, posteriorly it has a thin edge to which the velum palati is attached; its anterior border is serrated to join the palate plate of the maxillary bone, its inner edge rises into a *spine* or *crest* to support the vomer, and is continued posteriorly into the *posterior nasal spine;* its centre is thinner than its edges. The *nasal process* or vertical plate is broad and thin, rests partly on the maxillary bone, its inner or nasal surface forms part of the nasal fossa, and is marked by two depressions which assist in forming the lower and middle meatus of the nose, the ridge between these supports the lower spongy bone, externally it is uneven and grooved for the posterior palatine vessels and nerves: the anterior edge of this plate is thin and brittle, and prolonged for some way over the antrum, the posterior edge joins the pterygoid processes [of the sphenoid.] The *tuberosity* or the *pterygoid process* arises from the lower and outer angle, is thick and wedge-shaped, it inclines backwards and outwards, and presents three fossæ, one at each side for each pterygoid plate [of the sphenoid,] and one in the middle which assists in forming the pterygoid fossa; the innermost of these fossæ is the deepest: this process is perforated by one or two small holes which lead from the palatine canal; at the upper extremity of the nasal plate are the *orbital* and *sphenoidal processes*, separated from each other by a deep notch: the orbital is the larger and anterior of the two, it is triangular and bent a little outwards, it appears in the most remote part of the floor of the orbit, where it is joined to the maxillary bone by one edge, to the os planum by the second, while the third enters into the spheno-maxillary fissure; the sphenoidal or posterior orbital process is smaller, and is articulated to the body and spongy plate of the sphenoid bone; both these processes are cellular, the cells communicate with those of the ethmoid and sphenoid bones; the notch between these two processes forms the spheno-palatine hole. The palate bone is joined to the maxillary, inferior spongy, vomer, sphenoid and ethmoid, and to the opposite palate bone; it is composed of thin compact substance, and is well formed in the fœtus; its processes are seven, palate, nasal, pterygoid, orbital, sphenoidal, posterior nasal spine and crest; its foramina are one proper and three common. The proper is the posterior palatine hole or holes; the common are the posterior palatine or pterygo-maxillary canal, the spheno-maxillary fissure, or the foramen-lacerum orbitale inferius, and the spheno-palatine hole; the latter is above the nasal plate, below the body of the sphenoid, and between the orbital processes of the palate bone, it transmits the nasal nerve and artery from the spheno-maxillary fossa into the nose.

[*Muscles.* With the exception of the azygos or motor uvulæ no muscle arises to any extent from this bone; the tensor palati and pterygoid muscles are slightly attached to it.]

The *inferior spongy* or *turbinated bone*, placed on the lower part of the outer side of the nose, elongated from before backwards, presents a wrinkled or a rugged surface, is convex towards the nose, concave outwards, its lower edge is loose, spongy, and curled outwards; the upper edge is uneven, thin, and joined to the unguis, and to the maxillary and palate bones; it is connected to the unguis by a thin pyramidal process, which completes the nasal duct; it is also in general united to a descending oblique process of the ethmoid, it is composed of very thin brittle substance; marked with pores and little spines.

[No muscles are attached to this bone, or to the vomer, these and the ethmoid being the only bones of the head and face which have no muscular relations.]

The *os unguis* or *lachrymal bone* is placed at the inner and forepart of the orbit; below the os frontis, behind the nasal process of the superior maxillary and before the ethmoid bone, it is of an oblong square shape, and very thin, it covers the anterior ethmoidal cells; externally it is divided by a perpendicular ridge, which terminates below in a little hook-like process, into two unequal plates, the posterior or *orbital plate* is short and broad, the anterior *lachrymal plate* is concave, long, and narrow, and forms part of the lachrymal or nasal fossa and duct. The os unguis is joined above to the internal angular and orbitar processes of the os frontis; behind to the os planum of the ethmoid, below to the orbitar plate of the maxillary, before to the nasal process of the same, and before and below to the inferior spongy bone; its structure is thin but compact.

[This bone is sometimes wanting, and its place is then supplied by the superior maxillary and ethmoid bones: this bone co-exists with the lachrymal secretion, and is said not to be found in those animals, who, living in water, have no lachrymal gland. The tensor tarsi arises from this bone.]

The *nasal bones* are situated beneath the nasal process of the frontal and between the nasal processes of the superior maxillary bones, they are small, narrow, and thick above, thin and expanded below; they form the bridge of the nose; the external surface of each is slightly concave from above downwards, convex from side to side, and perforated with one or two small holes; the internal surface is concave and grooved for the nasal nerves; the superior margin is thick and deeply denticulated to join the nasal process and spine of the frontal and the nasal plate of the ethmoid bones; its external edge is grooved and received into the nasal process of the superior maxillary, its inner edge is flat to join with its fellow, and its lower edge is thin and irregular, joins the alar cartilages, and is notched for the passage of the nasal branches of the ophthalmic nerve.

[*Muscles.* No muscles are attached to this bone, but the pyramidalis and compressor nasi are *inserted* into the integuments over it.]

The *vomer;* this azygos bone resembles a ploughshare; it stands in the median line, although it often bends a little to one side, is thin and flat, and covered by the pituitary membrane, it presents four edges; the upper or sphenoidal is hollowed to receive the azygos process; the anterior is slightly grooved to receive the ethmoidal lamina and the nasal cartilage; the posterior or pharyngeal is round and smooth and unattached; the inferior or palatine edge is the longest, and is received between the laminæ of the nasal crest of the maxillary and palate bones; it is attached to the maxillary, palate, ethmoid, and sphenoid bones, also to the turbinated bones of the latter; its structure is compact, but thin and transparent: all the bones of the upper jaw are well developed in the fœtus.

[The bones of the upper jaw generally will only be fractured by very severe violence; but the nasal bones are most exposed and most frequently broken; congenital deficiencies are occasionally met with, as in cleft palate, in which parts of the superior maxillary and palate bones are wanting, and the vomer is either wanting, or bent to one side. In acephalous monsters the bones of the face may be perfect, but there is great deformity and deficiency in the cranial bones. Large masses of the upper jaw extending even to the sinus and orbit have been successfully removed on account of malignant disease.]

The *inferior maxillary bone*, or the lower jaw, is the largest of the facial bones, it is of a semicircular figure situated at the lower part of the face and extending along its sides and back part to the base of the skull; it is divided into the body or chin, the sides, the rami, and the processes. The *body* is the anterior prominent portion with a vertical ridge in the centre, the *symphysis*, or the line of union of the two symmetrical pieces of which this bone in infancy consisted; inferiorly the body projects into the mental process or chin, above this on each side is a depression for the muscles of the lower lip, external to which and looking backwards is the oval oblique opening of the dental canal, called the *mental hole*, through which a vessel and nerve of the same name pass; posteriorly the body of the bone is concave, and lined above by the mucous membrane, in the middle it presents, in the line of the symphysis, a chain of eminences, to the superior of which the frænum linguæ adheres, to the middle the genio-hyo-glossi, and to the inferior the genio-hyoidæi muscles; above and on each side of these are depressions for the sublingual glands, and at the lower border are two depressions for the digastric muscles. The *sides* of the maxilla have a direction backwards and outwards, on their outer surface is an oblique line which passes backwards and upwards to the anterior edge of the coronoid process, it gives attachment before to the platysma and depressor anguli oris, and behind to the buccinator muscles; internally also is an oblique line, parallel to, but more prominent than the external, to this is attached the mylo-hyoid muscle anteriorly, and the superior constrictor of the pharynx posteriorly; beneath this line is a slight groove which contains the mylo-hyoid nerve, and below this an oblong depression for the submaxillary gland; the lower edge or base of the jaw is rounded, thick before, thin behind, and grooved opposite the second molar tooth for the facial artery; the upper or alveolar edge is broad posteriorly and bent a little inwards; it has usually sixteen alveoli, which, as in the upper jaw, vary in form according to that of the teeth. The *angle* of the jaw is more or less obtuse, and often bent a little outwards; the masseter adheres to it externally, the internal pterygoid internally, and the stylo-maxillary ligament to the border of it. The *ramus* ascends a little backwards, is thick and round posteriorly, and is enveloped by the parotid gland, externally it is covered by the masseter, internally it presents a deep groove which leads to a large hole, the *inferior dental* or *maxillary;* this is situated near the centre of the ramus, and is protected internally by a prominent spine into which the internal lateral ligament is inserted, a slight groove leads from this hole to the mylo-hyoid muscle; the dental hole leads into a canal which traverses the side of the bone beneath the alveoli, with each of which it communicates; it contains the dental nerve and vessels; below the incisors this canal turns back a little, and ends at the mental hole; this canal is nearer the inner surface of the jaw behind, and the outer surface before; the ramus ends above in a notch and two processes, the anterior or coronoid, the posterior or condyloid; the notch is traversed by the masseter nerve and vessels. The *coronoid process* is triangular, the apex is inclined a little outwards, it is embraced by the insertion of the temporal muscle. The *condyle* is an oblong convex process supported by a neck which is most depressed anteriorly, for the insertion of the external pterygoid muscle; the condyle is curved forwards and most convex in that direction; it is directed obliquely backwards and inwards, so that its internal extremity is posterior, it is also higher than the external; its posterior surface is nearly straight, and almost free from cartilage. By these processes the lower maxilla is articulated with the temporal bones; on the external edge of each is a tubercle for the insertion of the external lateral ligament. The lower jaw in the young subject always consists of two symmetrical pieces, each angle is very obtuse, and the condyles are directed more upwards than in the adult.

[In many of the inferior animals th's bone consists of two pieces during life; and in serpents there is motion at the symphysis; the angle is obtuse in children, nearly right in the adult, and obtuse again in old age: fractures of this bone may occur in the body or rami; and portions of it have been successfully removed for osteosarcoma.

Muscles. Fourteen pair are attached to this bone; eight pair *arise* from it; the levator and depressor labii inferioris, depressor anguli oris and buccinator from its anterior surface; the mylo-hyoideus and constrictor pharyngis superior from the mylo-hyoid ridge; and the genio-hyo-glossus and genio-hyoideus from the posterior surface of the symphysis. Six pair are *inserted* into it; the masseter at the junction of the body and ramus; a few fibres of the platysma myoides; the digastric into the digastric fossa; the temporal into the coronoid process; and the pterygoidei internus and externus into the internal surface of the ramus and neck.]

The *teeth* are small, hard bones, thirty-two in number in the adult, sixteen in each jaw; their form is generally conical, the apex in the aveoli; in each tooth we distinguish the crown, neck, and root; the *crown* is external to the alveolus, it has no periosteum, but is covered by a firm, white, vitreous substance, named enamel: the *neck* is surrounded by the gum, and the *root* is firmly held in the alveolus by a mode of connexion called gomphosis. The teeth are divided into three classes, the incisores, the canini and the molares: the *incisores* are four in each jaw, the crown of these is sharp and wedge-shaped, convex before, and thickly covered with enamel; those in the upper are stronger than those in the lower jaw; the former are broader, their edge is like a chisel, cut off posteriorly, the latter are more vertical, their anterior surface is bevelled off, but they are not so sharp as those in the upper jaw, their roots are larger; the *canine teeth* or *cuspidati* are two in each jaw, the crown is conical, a little blunt, convex before, their root is single but very long; the *grinders* or *molares* are ten in each jaw, the crown of these is broad and irregular, the roots are more or less divided; the upper grinders are stronger than the lower, the axis of the former is directed outwards, in the latter it is vertical; the two first molar are called *bicuspidati*, and are smaller than the canine; they have only two tubercles on the crown and the fang is single, but sometimes it is double; the posterior grinders are the true molar or *multicuspidati*, these are large, the crown has four or five tubercles, the root has three or four divisions, and each is perforated by a small hole. The teeth are composed of a very compact bone or ivory, less brittle than the enamel; the latter only covers the crown as far as the neck; the ivory has no cells in it, its fracture is silky; in addition to the component parts of bone it also contains some fluate of lime; it possesses the power of resisting the action of the air a long time; the enamel is very white, and so hard as to strike fire with steel; it is composed of fibres which are perpendicular to the surface of the crown, it is thicker where the teeth are exposed to much friction, it does not contain any vessels or nerves, and is not regenerated when once destroyed; each root is perforated with a small hole which leads into the cavity in the crown; this cavity contains a pulp which is very vascular and nervous.

[In the infant the germs of fifty-two teeth exist; of these twenty make their appearance during the period of lactation, and hence they are called the milk teeth; they are also called nonpermanent or deciduous; they are divided, according to form and function, into *incisores*, four in each jaw, cuspidati, two in each jaw, and molares, four in each jaw; generally these teeth begin to appear about the sixth month, and are complete from the twenty-fourth to the thirtieth month; at about six years they begin to give way to the permanent teeth, which are usually all complete about the twelfth year, except the two last molar of each jaw, the *dentes sapientiæ*, which make their appearance from the eighteenth to the twentieth year. The time at which the different teeth appear, however, varies much in different subjects; sometimes children are born with teeth, and sometimes a third set appears in extreme old age. Supernumerary teeth are not very rare, generally but one or two in number, occasionally more; in the collection of Dr. J. K. Rodgers, there is an inferior maxilla, which had twenty or twenty-two teeth. Caries is the most common disease of the teeth; the *tartar* which accumulates round the teeth is looked upon as a secretion from the gums.]

The bones of the face are connected by sutures in the same manner as those of the cranium, it is unnecessary to describe these individually, as they are all named from the particular bones they unite. The facial bones, in addition to forming the general outline of the face, also bound several regions, namely, the nose, orbits, and the palate, also the temporal, zygomatic, and spheno or pterygo-maxillary fossæ. The bones entering into the nose, have been already mentioned in the description of the organs of sense: on the other regions we shall make a few remarks.

The *orbits* are of a pyramidal figure, the base looking outwards and forwards, the apex backwards and inwards: seven bones enter into the parietes of each, the frontal, sphenoid, ethmoid, lachrymal, maxillary, palate, and malar; the upper wall or the roof of each orbit is formed by the frontal and the lesser wing of the sphenoid, it is concave, and presents the optic hole posteriorly and the depressions for the lachrymal gland and for the trochlea anteriorly; the floor is nearly plane and looks outwards and downwards, it is formed of the malar, maxillary, and palate bones, the infra-orbital canal extends along it: the external wall is formed by the sphenoid and malar bones, and the internal, which is smooth and plane, is formed by the lachrymal, ethmoid, and sphenoid bones. The bones which form the base of the orbit are the frontal, malar and maxillary; the foramina in the base of the orbit are four, viz. the supra-orbital, the infra-orbital, the malar, and the nasal duct; within the orbit are five, viz. the optic, which is in the upper, inner and posterior part, the foramen lacerum superius which leads from the apex upwards and outwards, the internal orbital holes which are found in or close to the suture along the internal wall, and the spheno-maxillary fissure or the inferior lacerated hole which leads from the back of the orbit forwards and outwards along the floor, this slit-like opening is bounded by the sphenoid, palate, maxillary and malar bones. The axes of the two orbits are oblique lines, which, if produced posteriorly, would decussate about the sella turcica, while anteriorly they would diverge.

The *palatine region* is composed of the palate plates of the superior maxillary and of the palate bones, and is bounded by the alveolar arch, by the pterygoid processes of the palate bones and by the hamular processes of the sphenoid; to its posterior edge the soft palate and uvula are attached; anteriorly it presents the foramen incisivum or the anterior palatine canal, and posteriorly the orifices of the two posterior palatine canals.

The *temporal fossa* is placed on the side of the cranium and face; it is bounded internally by the frontal, sphenoid, parietal and temporal bones; its extent superiorly is defined by the semilunar ridge on the side of the cranium, which is marked on the frontal and parietal bones, anteriorly by the malar bone, posteriorly by the pulley-like root of the zygomatic process, and inferiorly and externally by the zygomatic arch which is formed by the processes of that name from the temporal and malar bones; this arch is concave above and internally, convex below and externally.

The *zygomatic fossa* is continuous with the lower part of the last described region, from which it is distinguished by a transverse ridge or crest upon the root of the great wing of the sphenoid bone, from this it extends to the tuberosity of the maxillary bone, and is bounded externally by the ramus of the lower jaw.

The *pterygo-maxillary fossa* is a very narrow space, is enclosed between the pterygoid processes behind, the tuberosity of the maxillary bone before, and bounded internally by the nasal lamella of the palate bone, which separates it from the nose; it contains the spheno-palatine ganglion and the internal maxillary artery. It is immediately below and behind the orbit, with which it communicates by the spheno-maxillary fissure, it also communicates with the palate by the posterior palatine canals, with the nose by the spheno-palatine hole, with the face by the infra-orbital canal, and it also opens directly into the temporal and zygomatic fossæ; the branches of the second division of the fifth pair of nerves pass off through these several communications.

THE BONES OF THE EXTREMITIES.

The *extremities* are two superior, and two inferior.

The *inferior extremity* is divided into three parts, the thigh, leg, and foot; the latter is subdivided into the tarsus, metatarsus, and toes: the thigh has one bone, the femur; the leg three, the patella, tibia, and fibula; the tarsus seven, the astragalus, calcaneum, cuboid, scaphoid, and three cuneiform; the metatarsus five, and the toes fourteen: thirty bones in all, [exclusive of the two sesamoid bones of the great toe.]

The *femur* is the longest bone in the system, it consists of the body or shaft and two extremities; the body is slightly twisted, thick above, very broad below, contracted and nearly cylindrical in the centre, arched and smooth before and concave behind, with a sharp, rough ridge down the centre, named the *linea aspera*, this extends along the middle third of the bone, parallel to its axis, and divides above and below into two ridges, these pass superiorly one to each trochanter, that to the inner being the shorter; and inferiorly one to either condyle; these inferior divisions separate further, and enclose a flat triangular space, the popliteal; this line is very prominent about the centre, and presents two lips and an interstice, for the attachment of different muscles: the anterior convex surface of the femur is broader towards either end than in the centre, it is a little concave superiorly, the sides are slightly flattened, and the external is somewhat narrower than the internal, particularly above; above the middle of the linea aspera one or two holes may be seen to enter obliquely upwards, these transmit the nutritious or the medullary vessels of the bone; to the linea aspera in the middle of the thigh, the vastus externus, the adductor tendons, and the vastus internus, are attached; to its superior external branch which leads to the great trochanter and is very long, the adductor magnus, glutæus maximus, and vastus externus are attached; the internal branch is short and not very distinct, it leads to the lesser trochanter, and gives attachment to the adductor brevis, pectinæus, vastus internus, and some fibres of the iliacus internus; to the lower and external branch of the linea aspera, the vastus externus and short head of the biceps are attached, and to the lower and internal, the vastus internus and adductor magnus adhere; these lines continue as low as the condyles, the internal is smooth and nearly obliterated near its middle for the passage of the crural artery.

The upper or pelvic extremity of the femur presents three eminences, the head for articulation with the cotyloid cavity, and the trochanters for the insertion of muscles. The *head* is of a globular figure, and forms a considerable segment of a sphere, it is directed upwards, forwards, and inwards; a little below its centre, there is a rough depression for the insertion of the round or articular ligament; with the exception of this depression the head is covered throughout with cartilage; it is supported by an elongated process, the *neck*, which forms an angle, more or less obtuse, with the shaft of the bone, the direction of this process is upwards, inwards, and a little forwards, it is flattened before and behind, thicker at the shaft than at the head, its lower edge is longer but smaller than the upper; a rough irregular line separates the head from the neck, beyond which the articular cartilage does not extend, and at its juncture to the shaft two rough [intertrochanteric] lines extend inwards and downwards, from the great to the lesser trochanter, one on the fore, the other on the back part of the bone, into these the capsular ligament is inserted. The *great trochanter* is continuous with the external side of the shaft, and nearly in a line with its axis, it is on a little lower level than the head, it is thick, rough and square, externally it is broad and convex, the tendon of the glutæus maximus moves over this surface and an intervening bursa, a prominent ridge bounds it below, to this some fibres of the vastus externus are attached, internally it presents a pit or digital cavity which receives the tendons of the external rotators of the limb, namely, the pyriform, gemelli, and obturators; the summit of the trochanter is thick and rough, the glutæus medius is inserted into it, the anterior edge is broad, and gives attachment to the glutæus minimus, into the posterior, which is round and thick the quadratus femoris is inserted. The *lesser trochanter* is a conical projection at the posterior and inner side of the shaft, and is considerably below the great trochanter; it looks backwards and inwards, the tendons of the psoas and iliac muscles are inserted into it behind its apex, a bursa is connected to it anteriorly. The inferior or *tibial end* of the femur is very large and broad, and divided into two eminences or *condyles* which are separated posteriorly by a deep [intercondyliac] notch; the *condyles* articulate with the tibia; the *external* is larger, and projects more forward than the internal, its articulating surface is also broader and ascends higher, externally it is rough and presents a tuberosity which gives attachment to the external lateral ligament of the knee joint; this is less prominent than the internal tubercle; beneath this tubercle is a groove which receives the tendon of the poplitæus muscle in the flexed position of the joint: internally this condyle presents a rough surface, towards the posterior part of which the anterior crucial ligament is inserted, it is very convex behind, flat before, and broad below. The *internal condyle* is narrower, less prominent before but prolonged more behind; it is also longer than the external, and therefore descends lower when the femur is vertical, but both are nearly on a level when the bone is in its ordinary oblique direction; on its inner side is the tubercle for the attachment of the internal lateral ligament of the knee and for the adductor tendon; to its outer side, which is rough, the posterior crucial ligament adheres; both condyles are more convex behind than before, they are separated posteriorly by a deep uneven notch, which lodges the crucial ligaments and is deprived of articular cartilage; anteriorly they are continued into each other, and unite in a pulley-like surface which is convex from above downwards, and concave from side to side, higher externally than internally; this *trochlea* is chiefly formed on the external condyle, it supports the patella: the femur is articulated superiorly with the ilium, inferiorly with the tibia, and anteriorly with the patella; like all long bones it is composed of compact tissue in the centre and cellular at the extremities, the compact has a fibrous appearance, the whole shaft is traversed by a distinct medullary canal, which is crossed by numerous bony laminæ; the femur is developed by five points of ossification, one for the shaft, one for the tibial end, one for the head, and one in each tronchanter.

[This bone is the seat of various fractures; as fracture of the neck within the capsular ligament, fracturing off of the trochanter major, fracture below the trochanters, fracture at almost any point of the shaft, and fracturing off of one or the other condyle. It is also the seat of several diseases affecting either the compact tissue of the shaft, or the spongy tissue of the extremities.

Muscles. Twenty-two muscles are attached to this bone on each side; seven *arise* from it: the vasti externus and internus, and crureus from its surfaces and linea aspera; the short head of the biceps flexor cruris from the external lip of the linea aspera below its middle; the gastrocnemius from both condyles posteriorly; and the popliteus and plantaris from the external condyle: fifteen are *inserted* into it; the glutei medius and minimus into the trochanter major; the pyriformis, two gemelli, and two obturatores into the digital fossa; the quadratus femoris into the posterior intertrochanteric line; the psoas magnus and iliacus internus into the trochanter minor; the pectineus and three adductors into the linea aspera by its internal lip; and the gluteus maximus into the superior half of its external lip.]

The bones of the *leg* are the patella, tibia and fibula.

The *patella* or *rotula* or knee cap is a small bone in front of the knee joint, of a triangular figure, the base above, the apex below, its anterior surface is convex and covered by skin, a bursa, and some tendinous fibres, it is marked by several longitudinal lines, and presents a very fibrous appearance; the posterior surface is covered with cartilage and divided by a prominent vertical line into two lateral portions, of these the external is larger and deeper than the internal; beneath these is a small triangular depressed surface into which the ligament of this bone is inserted; the upper edge is round and cut off obliquely backwards and downwards, to it the extensor tendons are attached; the patella is of a cellular structure, and covered by a compact lamina which is very dense, and traversed by longitudinal striæ; it is developed from a single point of ossification, and remains for a long time cartilaginous; it is articulated with the condyles of the femur, and connected to the tibia by a powerful ligament; it protects the forepart of the knee, and serves as a medium of connexion between the extensor tendons and the leg.

[This bone is the seat of three fractures, the longitudinal, transverse, and stellated. *Four* muscles are *inserted* into this bone, the two vasti, the rectus femoris and crureus.]

The *tibia*, next to the femur, is the longest bone in the skeleton, it occupies the anterior and inner part of the leg, its upper extremity is thick and expanded from side to side, its circumference is somewhat circular or oval, convex on the front and sides, but slightly grooved behind; on either side is a protuberance, that on the internal is the more prominent for the insertion of the internal lateral ligament and the tendon of the semi-membranosus muscle; a little behind the external tuberosity is a small rounded surface looking downwards, covered with cartilage for articulation with the head of the fibula; on the anterior part of the head is a convex triangular surface looking forwards and downwards, pierced with many vascular holes, and terminating in a tubercle, to the upper part of which a bursa adheres, and into the lower the ligamentum patellæ is inserted. The upper or femoral surface of the tibia presents two concave or articulating surfaces or *condyles* covered with cartilage, for articulating with the femur, the *internal* is oval and the deeper of the two, it is also larger from before backwards; the *external* is nearly circular, very superficial, and looks obliquely downwards and outwards; these are separated by a *spine*, which is of a pyramidal form, inclines upwards and inwards, and is surmounted by two tubercles; it is nearer the back than the forepart of the bone; a large, flat, depressed surface lies anterior to it, and a smaller depression behind it; the semilunar cartilages and the crucial ligaments are inserted into these; the *body* of the tibia is triangular, its size diminishes from its head for about two-thirds down, it then increases somewhat towards its lower end; its inner side is convex above and a little concave below, it is directed obliquely forwards, is covered superiorly by the tendinous expansions of the sartorius, gracilis, and semitendinosus, but the remainder of it is subcutaneous; the external side appears a little twisted, it is concave above to support the tibialis anticus muscle, but convex below to support the tendon of that muscle, as also those of the extensors; its posterior surface, which is also broader above than below, is slightly convex; it presents superiorly a prominent line passing obliquely downwards and outwards for the insertion of the poplitæus and the origin of the solæus and the deep flexors; near this line is the opening of the large canal that leads the vessels to the medullary membrane, it slants obliquely downwards and forwards. The tibia presents three edges, one is anterior and commences from the tuberosity, it is very prominent about the middle, but less so above and rounded below, this line is subcutaneous, it is twisted like the tibia itself, and is commonly called the crest or the shin, the inner edge is thick and round, and more distinct below than above, the outer edge is thin, and gives attachment to the interosseous ligament; it is less distinct and bifurcated below. The lower or *tarsal end* of the tibia is somewhat square, presents an anterior convex edge covered by the extensor tendons, a posterior nearly smooth edge traversed by a groove for the tendon of the flexor pollicis longus; externally is a concave triangular surface, rough above for ligaments, and smooth and cartilaginous below to receive the lower end of the fibula; internally the tibia ends in a thick, flattened, perpendicular process, the *internal malleolus* or ankle; it is convex and subcutaneous, it lies anterior to the superior internal tuberosity or condyle, on account of the twisting of the bone; the outer side of this process is smooth and cartilaginous, and joined at right angles to the cavity at the lower end of the bone; it is articulated to the side of the astragalus, its anterior edge is convex and gives attachment to ligaments, its posterior edge is grooved superficially for the tendons of the tibialis posticus and flexor communis; the extremity of this process is broad and descends lower before than behind, it gives origin to the internal lateral ligament of the ankle; the lower surface of the tibia is quadrilateral, concave from before backwards, and somewhat convex from side to side, being traversed from before backwards by a very superficial ridge or prominence, this surface is broader externally, it is bounded internally by the internal malleolus, and externally by the fibula; the tibia is articulated to the femur, the fibula, and astragalus, [and to the patella by the ligamentum patellæ;] its ossification commences in three points, one for the shaft, and one for each extremity, the tubercle at the upper end of the crest, and the malleolus are sometimes found as epiphyses.

[This bone may be fractured at almost any point of its shaft, but is most liable to break at the thinnest part, the junction of the middle and lower thirds; one of the condyles may be fractured off obliquely, and sometimes the malleolus internus is broken off.

Muscles. Ten are attached to this bone; five *arise* from it; the tibialis anticus and extensor longus digitorum from its anterior surface; the soleus, tibialis posticus, and flexor longus digitorum from its posterior surface: five are *inserted* into it; the sartorius, gracilis, and semitendinosus into the upper part of its inner face; the semimembranosus and popliteus into its upper and back part.]

The *fibula* is very slender and nearly as long as the tibia; it is placed at the side of the leg, nearly vertical, its lower end inclined a little forwards; the superior or *femoral end* is small and circular, and presents a slight cavity forwards, upwards, and inwards, to articulate with the tuberosity on the external condyle of the tibia, behind this is a slight pyramidal projection, [the *styloid process*,] its whole circumference is rough for the insertion of ligaments which attach it to the tibia, also for the external lateral ligament of the knee joint, and for the tendon of the biceps; below this the bone is round and slender like a *neck*; the *body* then becomes triangular; is a little curved backwards and inwards above, but is twisted forwards below; this [the internal surface] is divided into two portions by the internal edge into which the interosseous ligament is inserted, the anterior portion gives attachment to the extensors, and the posterior, which is larger, is grooved for the tibialis posticus, its external surface is covered by the peronæi muscles, the posterior surface gives attachment to the solæus above and to the flexor pollicis below; in this surface we perceive the orifice of the vascular canal leading downwards; the internal edge, which is turned a little forwards, gives attachment to muscles above and to the interosseous ligament below, the external edge is turned backwards, and gives attachment to the solæus, flexor pollicis, and peronæi musclus; and the anterior sharp edge to the extensor digitorum and to the peronæi; inferiorly this edge turns outwards and bifurcates, enclosing a triangular surface, which is subcutaneous: the *lower* or *tarsal end* is larger than the head, it is elongated into a long oval process, the *external malleolus* or *ankle;* this is larger, more prominent and posterior to the inner ankle, it is convex and subcutaneous externally, internally it is smooth and triangular, a little concave from behind forwards, and convex in the perpendicular direction, it articulates with the astragalus; above this is a triangular rough surface to articulate with the tibia, anteriorly this process is rough but thin for the origin of ligaments, its posterior edge is broader and grooved for the peronæal tendons, internal to which is a depression for the origin of the posterior external lateral ligament of the ankle joint; from the point of this process the external lateral ligament arises; the fibula is articulated at both ends to the tibia and below to the astragalus.

[This bone may be broken either alone or with the tibia, being most liable to fracture at the junction of the middle with the lower third; it is often broken in conjunction with a wrench at the ankle joint. The malleolus externus may be broken off.

Muscles. Nine muscles are attached to this bone; eight *arise* from it; the peronei longus and brevis from its external surface; the extensor longus digitorum, extensor pollicis proprius, and peroneus tertius in front of the interosseous ligament; the tibialis posticus behind it, all from the internal surface: the soleus and flexor pollicis longus, from its posterior surface; one muscle only is *inserted* into it the biceps flexor cruris at its styloid process and head.]

The *foot* is divided into the tarsus, metatarsus, and toes. The bones of the *tarsus* are seven, astragalus, calcaneum, navicular, cuboid, and three cuneiform.

The *astragalus* is next to the calcaneum in point of size, it is of an irregular twisted shape, somewhat cubical, larger above and to the outside, than internally or posteriorly; it is situated at the upper and middle part of the tarsus, where it is wedged between the two malleoli, its superior surface presents in its two posterior thirds a large pulley-like articular surface, which is convex from behind forwards, and concave transversely, the reverse of the form of the end of the tibia, it is inclined a little backwards, is broader before than behind, and more prominent externally than internally; anterior to this surface is a rough depression, on the neck of the bone, for the insertion of ligaments; inferiorly, it presents two articular surfaces for the os calcis, one is posterior and external, broad and concave, the other is anterior and internal and convex; these surfaces are separated by a deep groove, which is narrow behind, broad before, and directed forwards and outwards; strong ligaments pass from this groove to the os calcis; the posterior surface of the astragalus is narrow and slightly grooved in an oblique direction downwards and inwards, for the tendon of the flexor pollicis; it also presents externally a pointed eminence to which the external lateral ligament of the ankle joint is attached; the anterior extremity is a smooth round head, supported by a sort of neck, which is perforated by many small holes for vessels, it is directed forwards, inwards, and downwards, and is articulated with the navicular bone; the external side presents a triangular, smooth surface, concave from above downwards, and a little convex from before backwards, it is articulated with the fibula; the inner side is rough for ligaments, except a cartilaginous surface near the upper part, which is smaller than that on the outer side, and broader before than behind, this is articulated with the internal malleolus.

The *calcaneum* or *os calcis* is the largest bone in the tarsus, at the lower and posterior part of which it is placed, it is elongated posteriorly into a process called the heel, its upper surface presents two articulating surfaces to support the astragalus; the posterior is convex, broad, and directed forwards and outwards, the anterior is internal, narrow and concave; these are separated by a deep, rough, transverse groove into which strong ligaments are inserted; internal to this the bone is uneven, and projects into a sort of process, into which the internal lateral ligament of the ankle joint is inserted; the inferior surface is smaller than the superior, and is nearly flat, it presents small tubercles for the attachment of muscles and ligaments; the posterior extremity is slightly convex, smooth above and covered by a bursa, and rough below for the insertion of the tendo Achillis; the anterior extremity is smaller, and presents an articular surface for the cuboid bone, which is concave from above downwards, and convex from side to side; externally it is rather flat, being marked with two shallow grooves, for the peronæal tendons, a spine separates these, into this the external lateral ligament of the ankle joint is inserted, internally it is broad and hollowed out into an arch, under which the flexor tendons, the tibialis posticus and the plantar vessels and nerves pass, the tendon of the flexor pollicis runs in a distinct groove; the os calcis is attached above to the astragalus and before to the cuboid.

[The groove for the tendon of the peroneus longus is sometimes converted into a large osseous pulley, projecting about three lines from the body of the bone; of this I have two specimens from the same subject.

Muscles. Nine are attached to this bone; six *arise* from it; the extensor digitorum brevis from its upper and outer part; abductor pollicis, abductor minimi digiti, flexor brevis digitorum, flexor accessorius, and flexor brevis pollicis inferiorly from its tubercles and margins; three are *inserted* into it, the gastrocnemius, soleus, and plantaris posteriorly.]

The *navicular* or *scaphoid bone* is situated about the middle of the tarsus and at its upper and internal part; of an oval form, its long axis directed downwards and inwards, its posterior surface is smooth and concave, to form a sort of superficial or glenoid cavity for the head of the astragalus, the latter, however, is much larger and projects inferiorly, in which direction it is supported by the strong calceo-scaphoid ligament, and by the tendon of the tibialis posticus, which here generally contains a sesamoid bone; the anterior surface is convex, and divided by two vertical ridges into three surfaces for the three cuneiform bones; the circumference is irregular for the attachment of ligaments, internally it is rather smooth, but inferiorly it presents a tubercle into which the tibialis posticus is inserted; on its external side there is in general a small, flat articular surface for the cuboid bone; the scaphoid is connected to five bones, viz. the astragalus, the three cuneiform, and the cuboid.

[*Muscles.* One, the tibialis posticus is *inserted* into this bone.]

The *cuboid bone* is situated at the outer and anterior part of the tarsus external to the navicular, and anterior to the calcaneum; although of a cubical form, it is yet thicker and longer internally than externally, its upper surface is flat and rough for the attachment of ligaments and muscles, the lower surface is irregular, rough, and tubercular, behind for the calceo-cuboid ligament, and grooved before for the tendon of the peronæus longus, its posterior surface is smooth, concave transversely, but convex from above downwards, this slightly pulley-like surface is articulated with the calcaneum, anteriorly it presents two articular surfaces, the internal is square and supports the fourth metatarsal bone, the external is triangular and supports the fifth; the external side is narrow, the internal is rough posteriorly, but presents anteriorly two articulating surfaces, the posterior for the scaphoid, and the anterior for the external cuneiform bone; the cuboid is articulated with the calcaneum, the scaphoid, the external cuneiform, and the two external metatarsal bones.

[*Muscles.* Several of the small muscles of the foot, to some extent *arise* from this bone, as the extensor brevis digitorum superiorly, and the flexor brevis pollicis, adductor pollicis, and flexor brevis minimi digiti inferiorly.]

The *cuneiform bones:* these three wedge-shaped bones are situated at the anterior part of the tarsus, between the scaphoid and the three internal metatarsal bones; the first or the *internal* is the largest of the three, its base is below, and its long axis is from above downwards, it is articulated posteriorly to the scaphoid bone, anteriorly to the first and externally to the second metatarsal bone, and to the middle cuneiform, inferiorly its presents a tubercle for the insertion of the tibialis anticus, and for a portion of the tendon of the tibialis posticus; the *middle cuneiform* is the smallest, and is wedged in between the two others; it is also articulated behind to the scaphoid and before to the second metatarsal bone; the third or *external cuneiform* bone is situated between the last and the cuboid bone, it is articulated anteriorly with the third metatarsal bone: posteriorly with the scaphoid, internally with the middle cuneiform and with the second metatarsal bone, and externally with the cuboid, and with the fourth metatarsal bone.

[*Muscles.* The tibialis anticus and posticus are *inserted;* the first internally, the second inferiorly into the internal cuneiform bone; and the flexor brevis pollicis *arises* somewhat from the others.]

All the bones of the tarsus are composed of a soft, spongy, vascular tissue covered by a compact but thin lamina; they are each developed from one point of ossification, except the calcaneum and the astragalus, which commence each in two points.

The *metatarsal bones* are five in number, the first or internal is the shortest and thickest, convex above, concave and sharp below, its posterior end is oval, concave, and rests on the internal cuneiform bone, the anterior end round and smooth, supports the first or great toe, this extremity is grooved below, and lodges the sesamoid bones, the peronæus longus is also inserted into it; the second is the longest of the metatarsal bones, its tarsal end is wedged in between the three cuneiform bones, and is articulated to each of them; the outer side of its base is also joined to the third metatarsal bone, its anterior extremity or head is round, and supports the second toe, it is marked internally and externally by the depressions for the lateral ligaments, a groove separates the head from the body of the bone; the third *metatarsal bone* is a little shorter than the second, but of the same form; its base rests on the third cuneiform bone; the fourth *metatarsal bone* is a little shorter, it rests on the cuboid bone, and the inner side of its base also rests against the third cuneiform bone; the fifth is the shortest except the first, it rests on the cuboid bone; the heads of all the metatarsal bones are round like those of the metacarpus, the bases flat to articulate with the tarsus, the sides of their bases are also flat to join one another; all these bones possess a similar structure, and resemble the class of long bones.

The *toes* are five in number, the first or the great toe has only two phalanges, all the others have three; there are, therefore, fourteen phalanges in all; the *first phalanges* are longest, they are convex above, concave below; their posterior end is larger and presents, as in the hand, a round concavity for the head of the metatarsal bone; the anterior end is convex from above downwards, and concave from side to side, so as to form a ginglymoid joint with the second phalanx. The *second phalanges* are very short, the great toe has none, the posterior end of each is concave from above downwards, but convex transversely, being divided by a vertical ridge; the anterior extremity is smaller than that of the first phalanx, its condyles are less prominent. The *third phalanges* are all very small except that of the great toe, they are of a pyramidal form, and support the nails, their posterior extremity being very large and similar to that of the middle phalanges, their anterior end is tubercular and attached to the cellulo-vascular texture at the extremity of each; at the base of the first phalanx of the great toe there are in general two *sesamoid bones* into which the small muscles of this toe are inserted, frequently also there is another at the base of the second phalanx, sometimes one is found at the first joint of the second toe, and another at that of the fifth.

[*Muscles.* All the small muscles of the foot are *inserted* into the metatarsal and phalangeal bones; besides which the peroneus longus is *inserted* into the metatarsal bone of the great toe, and the peronei brevis and tertius into that of the fifth toe; the flexor longus digitorum, flexor longus pollicis, extensor longus digitorum, and extensor proprius pollicis are *inserted* superiorly and inferiorly into the last phalangeal bones. The bones of the tarsus are sometimes fractured, but only by great violence; the metatarsal and phalangeal bones are not often broken.]

THE SUPERIOR EXTREMITIES.

Each *superior* or *thoracic extremity* consists of the shoulder, arm, fore arm, wrist and hand; the whole limb comprises thirty-two bones, the sesamoid not included; the shoulder is composed of the clavicle and scapula; the arm of the humerus; the fore arm of the radius and ulna; the wrist of the eight small carpal bones; the hand of the five metacarpal and fourteen phalangeal bones.

The *clavicle* extends from the summit of the sternum obliquely across the first rib, upwards, backwards, and outwards to the acromion process of the scapula, it is curved somewhat like an italic *ſ*, particularly in the male, in the female it is straighter and longer; it consists, like all long bones, of two extremities and a body or shaft. The *internal* or *sternal end* is thick, it presents a triangular articulating surface, inclined forwards and downwards, convex from above downwards, concave from before backwards, large above and before, small and pointed below and behind, the circumference is rough for the attachment of ligaments. The *body* is nearly cylindrical towards the sternal, but flat and expanded towards the acromial end, smooth above and mostly subcutaneous, inferiorly it is rough and presents about an inch from the sternal end a ridge or process for the rhomboid or costo-clavicular ligament, external to this is a groove for the subclavian muscle, in this also is a foramen for the nutritious vessels, and near the scapular end is a rough ridge leading backwards and outwards for the attachment of the coraco-clavicular ligaments; its anterior edge is convex in the inner half, and gives attachment to the great pectoral muscle; the outer half is concave, to it the deltoid is attached; the posterior is smooth and concave in the inner half towards the great vessels, and rough and convex externally for the attachment of the trapezius muscle. The *acromial end* of the clavicle passes over the coracoid process upwards and backwards, is flat and broad, rough above and below, and perforated by vessels; it presents at its termination a small articulating surface for the acromion scapulæ; this surface is oval from before backwards, and cut obliquely from above and from without downwards and inwards, its aspect is outwards, forwards and downwards, so that it rather rests on or over the articulating surface of the acromion scapulæ, its circumference is rough for the attachment of ligaments. The clavicle serves to support the scapula, and to prevent it from falling too much forwards or inwards, it thereby allows it a greater freedom of motion, it also serves as a fixed point for certain muscles, and it protects the vessels and nerves of the upper extremity; it is very perfect in the fœtus, and is developed from a single point of ossification; it has no perfect epiphysis, although in the young subject there is an osseous crust at each extremity, which is at first separable from the rest of the bone.

[This bone is the common seat of fracture, which usually occurs in its middle third. This bone has been successfully removed, both in part and in whole.

Muscles. Six are attached to this bone ; four *arise* from it ; the sterno-mastoid and sterno-hyoid from its sternal end ; the pectoralis major and deltoid from its anterior border ; two are *inserted* into it, the trapezius posteriorly, and subclavius inferiorly.]

The *scapula* is situated at the upper, lateral and posterior part of the chest, and extends from the second to the seventh rib, it is irregularly flat and triangular, it presents an internal and an external surface, three edges and three angles. The internal or anterior surface or *subscapular fossa* looks towards the ribs, is slightly concave, and divided by three or four prominent lines which run obliquely from above downwards, and from without inwards into several broad grooves, which are filled by the fasciculi of the subscapular muscle, the aponeurosis of which is attached to those ridges ; above and below these is a smooth flat surface to which the serratus magnus is attached. The external or posterior surface or the dorsum is divided transversely into two unequal parts by a ridge or *spine* which commences about the upper third of the posterior border of the scapula, from a smooth, polished, flat, triangular surface, it proceeds forwards and becomes more elevated, flattened above and below, and bounded by a long, irregular, undulated margin, which is rough above for the attachment of the trapezius, and below for that of the deltoid muscle, a vascular hole is observed on its upper and under surface : this spine is a little contracted anteriorly and externally, and terminates in an eminence named the *acromion process ;* this surmounts the shoulder joint, about an inch above it, is flattened in a direction contrary to that of the spine, its external surface looks a little upwards and backwards, is convex, rather rough and covered by the integuments, its inferior or internal surface is smooth and concave, its upper edge is directed backwards, gives attachment to the trapezius, and presents near its termination a small and nearly horizontal, oval, articulating surface for the clavicle, the aspect of this surface is a little oblique upwards, inwards and backwards ; the lower edge gives attachment to the deltoid, its apex is rounded for the insertion of the triangular, or coraco-acromial ligament. Above the spine is the *supra-spinata fossa*, which is wider behind than before, this is filled by the supra-spinous muscle ; the *fossa infra-spinata* is larger, is convex above and concave and grooved inferiorly ; between this and the inferior costa is a raised surface extending from the inferior angle to the glenoid cavity ; this surface is divided into two by an oblique line, the posterior portion is flat and somewhat square, and gives attachment to the teres major muscle, the anterior to the teres minor; into the ridge between these is inserted an aponeurosis common to these two muscles. The *superior* or *cervical* costa or border of the scapula is the shortest and thinnest; at its forepart is a [semilunar] notch which is converted into a hole by ligament and sometimes by bone; it is traversed by the supra-scapular nerve, and sometimes by the vessels of that name, to this costa, the supra-spinatus, subscapular and omo-hyoid muscles are attached. From the anterior part of this border in front of the notch arises the *coracoid process*, which is long and narrow, and directed at first upwards and forwards and then downwards, is convex and rough above for the attachment of the conoid and trapezoid ligaments, smooth and concave below; it overhangs the inner and upper part of the glenoid cavity, the pectoralis minor is inserted into it anteriorly, the biceps and coraco-brachialis into its summit, and the triangular ligament into its external border. The *base* of the scapula or the posterior or vertebral edge is nearer the spine above than below; the spinati muscles adhere to its outer lip, the subscapular to its inner, and the rhomboid to its middle; about one-fourth from its upper extremity is a blunt projection formed by the smooth triangular root of the spine; at the union of the base and upper costa is the *superior posterior angle*, which is embraced by the levator anguli muscle. The *anterior* or inferior or external or *axillary costa* is very thick, and inclines downwards and forwards, at its junction with the base it forms the *inferior angle*, on which is a long flat surface which gives origin to the teres major, and to a few fibres of the latissimus dorsi muscle; to the upper part of it the long head of the triceps is attached; at the convergence of this and of the superior costa, the glenoid cavity and the neck of the scapula are situated. The *neck* is that contracted portion, which gives attachment to the capsular ligament, it is most distinct externally and inferiorly. The *glenoid cavity* is superficial, oval, broader and deeper below, covered with cartilage, and in the recent subject deepened by the fibrous glenoid ligament, which is chiefly derived from the long tendon of the biceps, which is attached to the upper extremity of this cavity; it is inclined a little downwards, outwards and forwards, its aspect however varies, as the scapula is made to turn in all the rotatory motions of the arm. The scapula is composed of two compact laminæ and an intervening cellular tissue, the latter prevails in the processes, the neck and the inferior angle; in the middle of the fossæ there is but little of it, and the compact substance is there thin and transparent. The scapula is developed by several points of ossification, one in the centre of the body, one for each of the processes, one for the inferior angle and one for the posterior or vertebral edge.

[This bone may be broken in its body, either by gun-shot wounds or blows; the acromion process may be broken; and fracture of the neck may occur, and be confounded with fracture of the neck of the os brachii or dislocation of that bone.

Muscles. Sixteen are attached to this bone; ten *arise* from it; the supra and infra spinatus, and subscapularis from the several fossæ of the same name and their edges; the omo-hyoid from over the semilunar notch; the teres major and minor, and long head of the triceps extensor cubiti, from the anterior margin: the deltoid from the lower edge of the spine and acromion; the long head of the biceps flexor from the apex of the glenoid cavity and its short head, and the coraco-brachialis from the coracoid process; six are *inserted* into it; the trapezius into the upper edge of the spine; the levator anguli scapulæ into the superior angle; the rhomboidei major and minor, and serratus magnus anticus into the base, and pectoralis minor into the coracoid process.]

The *os humeri* is attached to the scapula above and to the radius and ulna below; it is the longest and largest bone in the upper extremity, it presents two extremities and a body or shaft; the *upper* or *scapular extremity* is the larger, it consists of the head, neck and two tubercles. The *head* is semi-spherical, inclined upwards, inwards and backwards, smooth and covered with cartilage for articulating with the glenoid cavity of the scapula. The *neck* is the slightly contracted line around the head, it is rough for the attachment of the capsular ligament, and a little longer below and before than above or behind; the axis of the neck and head forms an obtuse angle with that of the shaft. The *tuberosities* are two, the *greater* or lesser; the *great* or *external* is also posterior, it is round, and presents three depressions; to the anterior of these the supra-spinous muscle is attached, to the middle the infra-spinous and to the posterior the teres minor. The *internal* or *lesser tuberosity* is also anterior, it is more prominent, and gives insertion to the subscapular tendon; between these tubercles is the deep groove for the long tendon of the biceps, into the anterior or outer edge of which the tendon of the great pectoral is inserted, and into its posterior or inner those of the teres major and latissimus dorsi, this groove leads downwards and inwards. The *body* or *shaft* of the humerus is thick and round above, twisted in the middle, expanded and somewhat triangular inferiorly; its posterior surface is round above and twisted a little inwards, below it looks outwards and is flat and broad; this surface is covered by and gives attachment to the triceps muscle, a small vascular foramen may be observed about the centre. The anterior surface is divided for about one-fourth of its length by the bicipital groove into two unequal portions, the internal of which is smooth, and presents near its centre a lineal elevation for the insertion of the coraco-brachialis, in the lower part of which is an oblique vascular foramen; the external portion is rough above for the insertion of the deltoid muscle, and is grooved obliquely below for the passage of the musculo-spiral nerve and artery; these surfaces are separated by two prominent lines, one is external and anterior, the other is internal and posterior, these lines are more distinct below than above, they give attachment to the inter-muscular ligaments, and lead down to either condyle; the external is interrupted about the middle by the musculo-spiral groove, but is very prominent below, curved forwards, and gives attachment to the brachialis anticus, the supinators and extensors, the triceps and the external intermuscular ligament; on the anterior surface of the humerus there is also a prominent line continued from the anterior edge of the bicipital groove, it is gradually flattened below, and covered by the brachialis anticus muscle.

The *lower extremity* of the humeris is flattened, elongated transversely, and twisted a little forwards, it presents internally the *internal condyle*, which is very prominent and turned somewhat backwards; this gives attachment to the common tendon of the pronators and flexors, and to the internal lateral ligament of the elbow joint; externally is the *external condyle*, not so prominent as the internal, and situated lower down, it gives attachment to the external lateral ligament, and to the supinator and extensor muscles. Between and below these condyles is an articulating surface turned forwards and presenting externally a *small round head* which articulates with the radius, above and internal to which is a slight depression corresponding to the margin of the radius, internal to this is a sharp semicircular ridge which separates the radius and ulna, and next to this is the *trochlea* for articulation with the ulna, this is so much below the level of the small head and of the outer portion of the articular surface, as to give the whole bone an oblique direction outwards when its lower end is placed on a horizontal plane; at the anterior extremity of this trochlea is a small depression for the reception of the coronoid process in flexion of the joint, and at the posterior is a large fossa which lodges the olecranon process in the extended state of the fore arm.

[The *anterior* and *posterior semilunar cavities* which sometimes communicate through a perforation in the bone; this is said to occur most frequently in the negro.]

The humerus, like the femur, is compact in the structure of its body, and cellular in that of its extremities, it contains a large medullary canal, and is developed from eight points of ossification, one for the head, one for each tuberosity, one for the shaft, one for the trochlea, one for the small head, and one for each condyle.

[This bone may be fractured between the head and tuberosities, or beneath the tuberosities, or at any point of its shaft, or lastly one of the condyles may be broken off.

Muscles. Twenty-four are attached to this bone; fifteen *arise* from it; the middle and short heads of the triceps extensor and brachialis anticus from the shaft; the supinatores radii longus and brevis, extensores carpi radialis longior and brevior, extensor carpi ulnaris, extensor communis digitorum, extensor minimi digiti, and anconeus from the external condyle and ridge leading to it; the pronator radii teres, flexor carpi radialis, flexor carpi ulnaris, palmaris longus, and flexor sublimis digitorum from the internal condyle and ridge leading to it. Nine are *inserted* into it; the subscapularis into the lesser tuberosity; the supra and infra spinati and teres minor into the greater tuberosity; the pectoralis major into the anterior lip of the bicipital groove; and the teres major and latissimus dorsi into its posterior lip; the coraco-brachialis and deltoid into the shaft.]

The *ulna* is situated at the inner side of the fore arm, it is longer than the radius, and is divided into the body and two extremities; the *upper extremity* is larger than the lower, and presents two processes and an intervening cavity. The posterior process, or the *olecranon*, is the highest part of the bone, its superior border gives attachment to the triceps extensor; posteriorly it presents a smooth triangular surface, covered by skin and by a bursa, anteriorly it is concave and covered with cartilage. The *coronoid process* is anterior and inferior to the preceding, anteriorly it gives insertion to the brachialis anticus muscle, internally to the flexors and pronators, and to the internal lateral ligament, and externally it is hollowed out into the *lesser sigmoid cavity,* which receives the head of the radius; this cavity is oval, its greatest diameter being from before backwards, it leads superiorly into the *great sigmoid cavity,* which moves on the trochlea of the humerus in flexion and extension of the fore arm; this sigmoid cavity has a great resemblance to the letter C, if viewed in profile; its posterior vertical portion is larger than the anterior horizontal; it is divided by a middle ridge into two lateral portions, of which the internal is the larger; these are each again divided by a transverse furrow, which ends in a notch at either margin, this surface is all covered with cartilage, except the furrow, in which some fatty matter is lodged. The *body* of the ulna is divided into three surfaces by three lines; these surfaces are larger above than below; the anterior is slightly grooved for the flexor profundus, and presents superiorly a vascular foramen, directed obliquely upwards; the internal surface is broad and concave above, and covered by muscles, below it is round and subcutaneous: the posterior surface is irregular; it is divided into two portions by a prominent line; of these the superior and internal is broad, and gives attachment to the anconæus; the inferior and outer portion is long and narrow, and covered by the extensors of the thumb; the anterior edge is round and gives insertion to the flexor profundus and pronator quadratus; the posterior edge is very distinct above, and gives attachment to an aponeurosis, common to the flexor profundus and flexor and extensor carpi ulnaris; the external edge is sharp for the three superior fourths, and gives attachment to the interosseus ligament. The *lower* or *carpal end* of the ulna is small and round, and presents two eminences; the external is named the *head*, it is round and covered with cartilage, and is received into the cavity in the inner border of the radius, and is contiguous inferiorly with the fibro-cartilage of the wrist; the internal eminence or the *styloid process* is more prominent, and on a level with the posterior surface of the bone; it is conical, elongated and a little everted; it gives attachment to the internal lateral ligament of the wrist; these processes are separated posteriorly by a groove for the tendon of the extensor carpi ulnaris, and inferiorly by a depression for the insertion of the triangular fibro-cartilage. The ulna is articulated above to the humerus and radius, and below to the radius, and inter-articular cartilage; it is developed from three points of ossification, one for the shaft, and one for each extremity.

[This bone may be broken either alone or with the radius at almost any point of its shaft; the olecranon or the coronoid process may be broken off.

Muscles. Fourteen are attached to this bone; eleven *arise* from it; the flexor carpi ulnaris, pronator radii teres, flexor sublimis digitorum, flexor profundus digitorum, and pronator radii quadratus anteriorly; extensor carpi ulnaris, extensor ossis metacarpi pollicis, extensores primi and secundi inter-nodii pollicis, extensor indicis, extensor digitorum communis posteriorly; three are *inserted* into it; the triceps extensor into the olecranon; the brachialis anticus into the coronoid process, and the anconeus into the upper and back part.]

The *radius* is shorter than the ulna by the length of the olecranon; it is situated at the outer and anterior part of fore arm, is larger below than above, is curved about the centre, and is convex outwards and backwards; it is divided into the body and two extremities; the *upper* or *humeral end* presents a head, neck, and tubercle. The *head* is a circular superficial cavity, its surface and most of its circumference covered with cartilage; the former to articulate with the small head of the humerus, and the latter with the sigmoid cavity of the ulna, and with the annular or coronary ligament; the internal or ulnar portion of the circumference is broader than the external. The *neck* is about an inch long, it descends obliquely outwards, it is contracted and circular; at its lower extremity is the *tubercle*, this process is directed backwards and inwards, into its external rough surface the tendon of the biceps is inserted; anteriorly it is smooth, and covered by a bursa. The *body* or shaft of the radius is somewhat triangular, and presents three surfaces, separated by three margins or angles; the anterior surface is broad below and covered by the pronator quadratus, narrow above where it gives attachment to the flexor pollicis; about one-third from the head is the orifice of the vascular canal, slanting obliquely upwards; the posterior surface is convex above and covered by the supinator brevis, concave in the middle for the extensors of the thumb, and convex below; the external surface is round and convex, and presents near the centre a rough surface for the insertion of the pronator teres; of the angles or edges the inner is most distinct; it is sharp, and gives attachment to the interosseous ligament. The lower or *carpal end* of the radius is square, its anterior prominent edge gives attachment to the anterior carpal ligament; posteriorly it presents three grooves for the extensor tendons; one nearly in the middle line, narrow and oblique, lodges the tendon of the extensor secundi internodii pollicis, the second is at the ulnar side of this, is broad, and transmits the tendons of the extensor communis and indicator, and the third, which is to the radial side of the first, is divided into two for the tendons of the extensor carpi radialis, longus and brevis; along the external border of this bone, is another groove leaning downwards and forwards, and divided into two for the extensor ossis metacarpi and primi internodii pollicis; the border between these two last grooves is prolonged down into the *styloid process*, from which the external lateral ligament of the wrist arises; on the internal border is an oblong smooth cavity, to receive the lower end of the ulna; inferiorly the radius presents an articular surface, divided by a line from before backwards, into two unequal portions; the external is large and triangular, and meets the scaphoid bone; the internal is smaller, somewhat square, and meets the lunar bone. The radius, like other long bones, is of a cellular structure at each extremity and compact in the centre, where it also contains a medullary canal, which is larger above than below; it is developed from three points of ossification, one for the shaft and one for each extremity.

[Fractures of this bone, alone or with the ulna may occur at any point of the shaft; more frequently both bones are broken below the middle; fracture of the neck of the radius is very rare, and when occurring, unites by fibro-ligamentous substance. I have a specimen of this fracture and mode of union.

Muscles. Nine are attached to this bone; four *arise* from it; flexor sublimis digitorum, flexor longus pollicis from its anterior surface; extensor ossis metacarpi pollicis, and extensor primi inter-nodii posteriorly; five are *inserted* into it; the biceps flexor into the bicipital protuberance; supinator brevis and pronator teres into the middle of the outer surface, pronator quadratus into the lower part of its anterior edge, and the supinator longus into the outer surface low down.]

The *hand* consists of the carpus, metacarpus, and fingers.

The *carpus* is composed of eight bones, arranged in two rows; the *first row* consists of the scapoid, lunar, cuneiform and pisiform; the *second* of the trapezium, trapezoid, magnum and unciform; enumerating them from the radial to the ulnar side, or from without inwards.

The *scaphoid* or *navicular* is the largest in the upper row, at the radial or outer side of which it is situated; it presents four articular surfaces; it is elongated and convex on the upper or radial surface, adapted to the external depression on the end of the radius; the inferior surface, directed a little outwards and backwards, is triangular, smooth and convex, to articulate with the trapezium and trapezoides; into the posterior narrow surface, ligaments are inserted; to the external or radial side, the external lateral ligament is attached; the inner or ulnar side presents two smooth articulating surfaces; one superior, narrow, to articulate with the lunar bone; the other inferior, large and concave, to articulate with the head of the magnum: it thus meets five bones.

[*Muscles.* Three *arise* from this bone, the abductor pollicis, opponens pollicis, and flexor pollicis brevis.]

The *lunar* or *semicircular bone* is smaller than the scaphoid; it presents four articulating surfaces; smooth and convex above to meet the radius, concave below to articulate with the magnum and unciform: its ulnar side is flat to meet the cuneiform, and its external to meet the scaphoid; its anterior surface is larger than its posterior and it projects a little into the palmar arch: it is articulated to five bones.

The *cuneiform*, or *pyramidal bone*. The base of this wedge-shaped bone looks outwards and articulates with the lunar, the apex is inwards; it is convex and smooth above to meet the carpal fibro-cartilage; concave and smooth below to articulate with the unciform bone; rough posteriorly and internally for ligaments; anteriorly it presents a flat circular cartilaginous surface for the pisiform bone; it is articulated to three bones and to the fibro-cartilage.

The *pisiform bone*. This small pea-shaped bone is the smallest in the carpus, at the upper and inner part of which it is placed; it is also on a plane anterior to the first row; it is articulated to the cuneiform bone by a small circular surface; its circumference is rough for the attachment of ligaments; the flexor carpi ulnaris is inserted into it above, and the abductor minimi digiti [*arises* from it] below.

The *trapezium* is the most external of the second row of the carpus; it is concave above to meet the scaphoid, below it is convex from behind forwards and concave transversely, to support the metacarpal bone of the thumb by a pulley-like surface; anteriorly it is marked with a groove for the tendon of the flexor carpi radialis; internally it is articulated to the trapezoid, and beneath this by a small surface to the second metacarpal bone: it joins four bones.

[*Muscles.* Three are attached to this bone; two *arise* from it, the abductor pollicis and flexor pollicis brevis; and one is *inserted* into it, the extensor ossis metacarpi pollicis by one of its tendons.]

The *trapezoid* is of a very irregular shape, and smaller than the trapezium; above it is smooth and concave to meet the scaphoid, externally it articulates with the trapezium, internally with the magnum, and inferiorly with the second metacarpal bone: it joins four bones.

The *os magnum* is the largest of the carpal bones; it presents superiorly a round and hemispherical head, which is received into the socket formed by the scaphoid and lunar bones; this head is supported by a contracted neck, its greatest convexity is turned backwards and outwards; the inferior surface of the magnum is divided into three articulating surfaces; these support the second, third, and fourth metacarpal bones; that for the the third is the largest, and for the fourth the smallest; its posterior surface is broad and convex below, and a little concave above; externally it joins the trapezoid, and internally the unciform; both anteriorly and posteriorly it gives attachment to the ligaments: it articulates with seven bones.

[*Muscles.* One head of the flexor pollicis brevis *arises* from this bone.]

The *unciform bone* is next in size to the os magnum; it is situated at the lower and inner part of the carpus, is rather wedge-shaped, the base below, articulated with the fourth and fifth metacarpal bones; its upper surface is narrow, and meets the semilunar bone; its external side joins the magnum, its internal the cuneiform; its posterior surface is rough for ligaments; from its anterior projects a small hooked process, curved outwards for the attachment of the annular ligament and some of the muscles of the little finger.

[*Muscles.* Two *arise* from this bone, the flexor brevis minimi digiti and adductor minimi digiti.]

All the bones of the carpus, like those of the tarsus, are composed of a loose spongy vascular tissue, invested by a thin compact lamina; they are developed each from a single point of ossification, except the unciform, which has two; the pisiform is the latest to ossify.

The *metacarpal bones* belong to the class of long bones; they are five in number, are placed nearly parallel to each other, except the first or that of the thumb, which is on a plane anterior to the others; the first is thick and short, the third is the longest. They are all concave on the palmar surface, convex on the dorsal, and large at each extremity; the *posterior end* is of an irregular figure; the *anterior* presents a round head; the *palmar surface* of each is narrow, and presents a median prominent line; the *posterior surface* of the first is convex, but on the second, third, and fourth, it presents a prominent longitudinal line, which bifurcates and forms the sides of a flat triangular surface, extending for near two-thirds of their length; into their edges the interossei muscles are inserted; the dorsal surface of the fifth is divided by an oblique line diagonally, the outer portion is concave, and lodges the fourth interosseous muscle, the inner convex and broad, and covered by the extensor tendon of the little finger.

The carpal end or base of the first is concave from before backwards, and convex transversely, to articulate with the trapezium; the base of the second is concave, and articulates with the trapezoides, and presents also externally a small smooth surface for the trapezium, and internally two smooth surfaces, one for the magnum, the other for the base of the third metacarpal; the base of the third is nearly plane, and rests on the magnum, and presents on either side articulating surfaces for the contiguous metacarpal bones; the base of the fourth presents two articulating surfaces, one for the magnum and one for the unciform; on the radial side two, and on the ulnar side one articulating surface, for the adjacent metacarpal bones; the base of the fifth presents a concave surface, directed outwards to articulate with the unciform; its radial side articulates with the base of the fourth metacarpal bone. The anterior, or digital ends of all the metacarpal bones are convex, their smooth surfaces are broader and extend further on the palmar than on the dorsal surfaces of each; they are articulated with the bases of the first phalanges.

The *fingers* are composed each of three phalanges, except the thumb, which has only two; there are therefore fourteen phalanges in all; the *first*, or those next the metacarpus, are the largest, the *third* are the smallest, the second or middle are of an intermediate size. The metacarpal or the first phalanges are five in number; the base or posterior end of each presents a cavity transversely oval for the head of the metacarpal bone; the anterior extremity of each presents two small condyles, separated by a groove; these are prolonged anteriorly, and articulate with the second or middle phalanx; the anterior surface of each is arched from before backwards, hollowed from side to side, to lodge the flexor tendon, the sheath of which is attached to its lateral edges; the posterior surface is convex and arched. The *second* or middle phalanges are four in number, they are smaller than the first; the base of each presents two small cavities and a middle ridge, or a sort of pulley-like surface to articulate with the first, with which it forms a ginglymoid joint; about the centre of their anterior surface is a rough depression for the insertion of the tendon of the flexor sublimis; the anterior or digital extremity of each resembles the anterior end of the first phalanx, and is convex from before backwards, and concave from side to side; the two articulating condyles being prolonged on the palmar further than on the dorsal surface, so as to increase the extent of flexion; the thumb wants this second phalanx. The *third* or last or *ungual phalanges* are five in number, they are the smallest and somewhat of a pyramidal form, the base articulates with the second phalanx, and presents a pulley-like surface, having two small cavities and a middle ridge, such as the base of the second phalanx; their posterior surface, convex, supports the nail, their anterior is rough and irregularly concave, for the attachment of the flexor tendon and ligaments; its anterior extremity or apex is irregularly tuberculated to support the extremity of the finger. The phalanges in structure resemble metacarpal bones; the last or the ungual are more cellular, and have no medullary canal; they are developed each from two points of ossification, one for the shaft, and one for the anterior extremity; the posterior end is continued from the shaft.

[*Muscles.* All the small muscles of the hand, except the palmaris brevis, are *inserted* into the metacarpal and phalangeal bones; besides which the extensor ossis metacarpi pollicis is *inserted* by one of its tendons into the metacarpal bone of the thumb; the extensor carpi radialis longus, and flexor carpi radialis into that of the index finger; the extensor carpi radialis brevis into that of the middle finger; extensor carpi ulnaris, and flexor carpi ulnaris slightly into that of the little finger, the flexor digitorum sublimis into the second phalanges; the flexor digitorum profundus, and flexor longus pollicis into the last phalanges; the extensor digitorum communis into the second and third phalanges of the four fingers; the extensor indicis into those of the index finger; the extensor digiti minimi into those of the little finger; and the extensor primi internodii, and extensor secundi internodii pollicis into the first and last phalanges of the thumb. The carpal bones are not often broken, it requiring great violence to fracture them; the metacarpal and phalangeal bones are more frequently broken than those of the feet, from being more exposed; in cases of supernumerary fingers and toes we find additional phalangeal bones, and sometimes a supernumerary metacarpal or tarsal bone; but more commonly one of these seems to spread or bifurcate, so as to sustain two toes; this malformation is often hereditary.]

On the fore part of the articulation between the metacarpal bone and the first phalanx of the thumb there are generally two *sesamoid bones*, and sometimes one in the corresponding joint of the index finger; these bones, like those in the foot, as well as in other situations, where they are occasionally found, as behind the condyles of the femur, in the heads of the gastrocnemii muscles, &c. do not properly belong to the osseous system, they are rather accessories to the tendons of muscles; they are found in the limbs only, and generally in the direction of flexion. They are developed from cartilage, which is deposited in tendinous or ligamentous structure, and which is very slow to ossify; the patella has some resemblance to bones of this class, it is, however, more perfect, and is placed on the aspect of extension. The sesamoid bones serve to strengthen the articulations to which they are attached, they also increase the power of the muscles, by altering the direction of their tendons, and removing them further from the axis of the bone which they are intended to move.

PART V.

DISSECTION OF THE JOINTS.

When all the muscles, vessels, nerves, &c., have been dissected, the student may examine the anatomy of the joints; different sections of these should be made, and when the principal soft parts are removed, they should be subjected to maceration for two or three days. The several parts of the osseous system when connected either by natural or artificial media, constitute the skeleton; the attachment between two or more bones is denominated an articulation or a joint, of which there are great varieties in the frame; they may, however, all be reduced to three classes, the moveable or diarthrosis, the immoveable or synarthrosis, and the mixed or amphiarthrosis.

1. Diarthrosis, or the moveable, includes all the perfectly moveable joints, and presents three species, viz. *enarthrosis, arthrodia, ginglymus;* the first resembles the ball and socket; the second is a modification of the first, the surfaces being nearly plane; the third is the hinge or trochlea, and is more complex.

2. Synarthrosis, or the immoveable includes four species, viz. *suture, gomphosis, schyndylesis,* and *symphysis. Suture* is the serrated interlocking observable between the bones of the head, in most instances the opposed edges are indented like the teeth of a saw, in some few they meet by rather plane surfaces, (harmonia,) and in others they are scaly, and one overlaps the other, (squamous suture.) *Gomphosis* is seen in the connexion between the teeth and their sockets, and *schyndelesis* between the vomer and the other parts composing the septum narium; *symphysis* is seen in the pelvis, between the ossa ilii and the sacrum, and between the ossa pubis; the last named example, however, is placed by some among the mixed articulations.

3. Amphiarthrosis, or the mixed, include those cases in which the bones are connected by an intervening substance,

and enjoy very obvious motion, as the bodies of the vertebræ, &c.

All the moveable articulations include several structures differing in use and organization, viz. the extremities of two or more bones, these are covered by cartilage; a synovial membrane, covered by a fibrous capsule, or by accessory ligaments and fasciæ, they may also contain inter-articular cartilages and ligaments, also reddish vascular adipose masses. The articular or incrusting cartilages adhere almost inseparably to the ends of the bones, they are smooth and elastic, composed of fibres which are placed perpendicular to the bone, they are thickest on the most convex part of the heads of bones, and on the circumference of the articular cavities.

The *inter-articular cartilages* or *fibro-cartilages* are very elastic, the fibrous tissue in some of them is very evident; many of these are attached to the circumference of the cavities forming the glenoid or cotyloid ligaments which serve to deepen the cavity, and to prevent the hard edges of the bones striking against each other; some inter-articular cartilages are moveable, as in the temporo-maxillary and knee joints, all these bodies serve either to deepen the cavities, or to attach the bones more closely, or to lessen shocks.

Synovial membranes of joints are very thin sacs similar to the bursæ, allied also to the great serous membranes, inasmuch as they exhale and absorb a fluid, and are shut bags without any opening, they are on the whole, however, more vascular and less elastic than the true serous membrane; the synovia also, or the fluid which the former secrete, is a glairy unctuous-feeling fluid, very different from the fine exhalation of the latter. Every synovial membrane lines the fibrous capsule or accessory coverings, is thence reflected over the inter-articular cartilages or ligaments when present, and over the articular or incrusting cartilages, and in some cases over portions of the bones themselves; on the cartilages the membrane is so fine and delicate as to be incapable of perfect demonstration, except under the influence of maceration or disease. In some articulations, the synovial membrane is complicated in its arrangement, being folded round tendons or ligaments as in the hip and shoulder, or thrown into processes which contain fat and vessels so as to resemble a vascular or glandular mass; such growths exist in the knee and in many other joints, and have been improperly considered glands or follicles by Havers and others.

[The term articulation or arthrosis is generic, and we may properly divide arthrosis into three classes, which division is founded upon two circumstances; on the one hand, the existence or non-existence, of a synovial membrane and on the other hand, the amount of motion allowed to the articulation. Thus in the first class, diarthrosis there is always a synovial membrane more or less extensive, and a synovial fluid more or less abundant. In the second and third classes synarthrosis and amphiarthrosis, there is no synovial membrane. Again in diarthrosis there is free motion, in synarthrosis there is no motion, and in amphiarthrosis there is a certain amount of motion, but still no synovial membrane. Each of these classes are modified in particular joints, so as to present us, with several varieties, diarthrosis has three varieties, *arthrodia* in which the head of one bone is received upon the superficial cavity of another bone, as at the shoulder joint; *enarthrosis* in which the head of one bone is received into a deep cavity in another bone, as at the hip joint; *ginglymus* or hinge joint of two forms, *angular*, as the elbow joint, *lateral* or *rotatory*, as between the radius and ulna. The most perfect specimen of the hinge like joint is at the ankle. Synarthrosis (which means without articulation or without motion,) has four varieties; *sutura* having serrated edges, as in most of the bones of the cranium; *Harmonia*, when two edges nearly even are placed in apposition, as in some of the articulations of the head and face; *Gomphosis*, resembling the junction between a nail and the board into which it is driven, as in the articulations of the teeth, with the alveolæ; *Schyndylesis*, where the edge of one bone is grooved and the other sharp as in the articulations of the vomer; this articulation is like the junction between the chrystal and the rim of a watch; *Amphiarthrosis*, (from derivatives signifying both and articulation, because it partakes of the characters of both of the other classes, in not having a synovial membrane, and yet having motion,) has three varieties; *Syndesmosis* or articulation by ligaments, exceedingly common, and found at all of the diarthrodial joints; *Syssarcosis*, or junction by means of muscles, of which the most perfect example, is in the union of the scapula with the trunk; *Synchrondrosis* or articulation by means of cartilage or fibro-cartilage, as between the bodies of the vertebæ; there are several articulations of this latter variety, which are looked upon by some, as a fourth variety and which are called *symphyses* viz. the *symphysis pubis*, the two sacro iliac *symphyses*, and the *symphysis menti* of the child.

The following table will present at a glance the different classes and varieties of articulation.

Arthrosis,	Diarthrosis,	Arthrodia	
		Enarthrosis,	Angular, Lateral
		Ginglymus,	or Rotatory,
	Synarthrosis,	Sutura,	
		Harmonia,	
		Gomphosis,	
		Schindylesis,	
	Amphiarthrosis,	Syndesmosis,	
		Syssarcosis,	
		Synchrondrosis,	Symphysis.

Of all these articulations those which have the most free and extensive motion of the diarthrodial class, are the most liable to dislocation, and of these the shoulder joint, is the one most often luxated. When dislocated, those joints are most easily reduced in which the articular surfaces are most plane, but it is more difficult to keep them in place after reduction, while the reverse of these propositions is true in the decided ball and socket joints. Again the diarthrodial joints are those most liable to disease, particularly in strumous habits; of these joints the hip and the knee are more often affected than any others. The disease may involve all the structures of the joint, that is, the synovial membrane, the cartilage, and the bone, or it may be confined to one structure only; in the latter case, it is the synovial membrane which suffers, and the inflammation may terminate by resolution, or assume a more chronic form, and present an hydrops articuli. In other cases, the inflammation may extend to the cartilage and even to the bone, attended by suppuration, ulceration, and absorption. This absorption in the hip joint, is sometimes so great as to cut off the head of the femur, and produce a displacement of the bone, resembling dislocation on the dorsum of the ilium.

Inflammations of the joints not unfrequently terminate in *anchylosis*, which occurs under two forms, partial and complete. Partial anchylosis is the result of adhesive inflammation of the synovial membrane, and effusion of fibrine around the joint causing a stiffness of the ligaments, and a thickening of the cellular tissue; these cases may often times be cured by passive motion, either manual or instrumental, and other collateral means, the modus operandi of which is chiefly to produce absorption of the effused substances. True or complete anchylosis occurs in those cases, where there is an absolute loss of the synovial membrane and the cartilage, so that the bones come in contract and are fused together, or united by the adhesive inflammation. This form occurs most commonly at the knee, hip, and elbow joints, and is incurable except by resorting to a severe surgical operation. There is one point of great practical importance to be attended to, in the treatment of cases where we apprehend anchylosis, if the disease is in the hip, or the knee joint, the limb should be kept in the extended position, if in the elbow joint, the fore arm should be about semi-flexed upon the arm, or in other words, the limb should become anchylosed in that position, in which it will be of most use to the patient. In old people it is not at all uncommon to find the bones of the head anchylosed, and also the bodies of the vertebræ by the ossification of the inter-vertebral cartilages. In the diarthroidal joints, most commonly at the knee and elbow, *false cartilages* sometimes form, they are at first connected with the synovial membrane, by a small pedicle which is frequently broken, and they then float in the joint, and getting between the bones, throw the patient down; they vary in number from one to twenty-five, usually not more than three or four, and in size, from a mustard seed to a large pea, but occasionally are much larger. They may be removed by a valvular incision into the joint and when nicely dried, resemble a grain of popped corn.]

TEMPORO-MAXILLARY ARTICULATIONS.

These are examples of double arthrodia, they have also some of the characters of ginglymus. Each condyle of the inferior maxilla, being received into that portion of the glenoid cavity of the temporal bone which is anterior to the fissure, each also moves on the transverse root of the zygoma ; these joints are strengthened by an external and internal lateral, an inter and a stylo-maxillary ligament, and by an imperfect but rather strong capsular ligament, which contains an inter-articular cartilage and two synovial membranes.

The *external lateral ligament* is short and narrow, it *arises* from the root of the zygomatic process of the temporal bone, descends obliquely backwards, and is *inserted* narrow into the outer side of the neck of the condyle of the lower jaw: it is covered by the skin and the parotid gland, and it adheres to the capsular ligament, of which it seems to be but a thickened fasciculus.

The *internal lateral ligament* is thinner and longer than the external, it *arises* narrow from the spinous process of the sphenoid bone, descends obliquely forwards, and is *inserted* broad into the inner margin of the orifice of the inferior dental canal ; this aponeurotic band corresponds externally to the capsule and to the external pterygoid muscle above, and lower down to the internal maxillary vessels, and to the dental vessels and nerve which intervene between it and the bone; its inner surface rests on the internal pterygoid muscle, which it thus bears off from compressing the dental nerve and vessels.

The *inter-maxillary ligament* scarcely deserves the name of ligament, it is rather a dense vertical aponeurotic band, common to the buccinator and superior constrictor of the the pharynx, attached *above* to the external pterygoid process and adjacent surface of the superior maxillary bone, and *below* to the root of the coronoid process of the inferior maxilla.

The *stylo-maxillary ligament* is a thin aponeurosis, which *arises* from the styloid process of the temporal bone, passes forwards and outwards ; is connected to the cervical fascia, and to the stylo-glossus muscle, and is *inserted* into the angle of the lower maxilla, between the masseter and internal pterygoid muscles, and between the parotid and sub-maxillary glands ; this ligament does not properly belong to the articulation, it is rather intended to strengthen the cervical fascia, and to increase the surface of attachment for the stylo-glossus muscle.

The *capsular ligament* consists of dense fibres which *arise* from the margin of the zygomatic eminence, and from the glenoid fissure, as they descend they *adhere* to the synovial membranes and to the inter-articular cartilage, and are *inserted* into the neck of the lower jaw; this ligament is covered posteriorly by the parotid gland and adipose substance, externally and internally by the lateral ligaments, and in part by the external pterygoid muscles, it is deficient at the anterior and internal part to admit the insertion of the external pterygoid muscle, into the inter-articular cartilage, and into the neck of the bone; it is wider above than below, and it is prolonged very low down upon the bone behind.

The *synovial membranes*, one the larger or superior, covers the cartilaginous surface of the zygomatic eminence and the glenoid cavity, and is reflected over the upper surface of the inter-articular cartilage: the other, the lower or smaller, covers the under surface of the inter-articular cartilage and is reflected over the condyle on which it is prolonged more posteriorly than in front, these sacs in general have no communication with each other.

The *inter-articular fibro-cartilage* is transversely oval, thick in its circumference, thin in the centre. Its upper surface is adapted to the articular eminence, and to the forepart of the glenoid cavity, being concave before and convex behind, and its lower surface, which is smaller fits on the condyle. Some fibres of the external pterygoid are attached to its forepart, the capsular and external lateral ligament also adheres to it: sometimes there is a hole in the centre of it, through which the synovial membranes may communicate. This cartilage is composed of very close concentric fibres, which are more distinct at the circumference, it has no direct attachment to bone as the inter-articular cartilages in some other joints, it therefore partakes less of a ligamentous nature; it serves to strengthen the articulation, and thus to guard against displacement by presenting to each condyle a moveable socket, which prevents its slipping off the articular eminence of the temporal bone, on which the condyle rests every time the mouth is fully opened; this cartilage also serves to lessen friction in the joint, as well as the effects of concussion generally. The motions of the lower jaw are not very conspicuous at the articulations but are considerable towards the forepart of the bone; this can be depressed, elevated, moved backwards, forwards, and towards either side; in depression of the chin the condyles advance and descend a little so as to rest on the transverse roots of the zygomatic processes; in elevation the condyles are behind these roots in the glenoid depressions, in rotation the condyles move alternately, one being the fixed point for the other, thus, in moving the chin to the right side, the right condyle is fixed in the glenoid cavity, while the left advances and descends a little, and the contrary state occurs in moving the chin towards the left side; these motions occur rapidly and alternately in masticating or grinding the food; they have been fully explained in the chapter on the muscles, (page 24.) The condyles of the lower jaw are very liable, one or both, to dislocation, this can only occur in the anterior direction; when both condyles are thus displaced, the accident is termed a perfect dislocation, when only one condyle, it is a partial dislocation; in the perfect form the mouth is opened and cannot be closed, as the coronoid process strikes against the malar and maxillary bones, the teeth of the lower jaw are on a plane anterior to those of the upper, there is also a depression in front of each ear, and the temporal muscles seem elongated, articulation and deglutition are much impaired. When the partial dislocation occurs, the chin is turned a little towards the opposite side, and the other symptoms exist in a less marked degree; dislocation of this bone, either perfect or partial, is caused by the spasmodic action not merely of the depressing muscles, but principally of the external pterygoid, assisted by the internal pterygoid and the superficial lamina of the masseter; when the mouth is wide open, we can readily conceive how those muscles, particularly the external pterygoid, can draw forwards the condyles from off the articular eminences of the zygomatic processes, into the temporal fossæ under the zygoma, and place them between the arch and the temporal muscle: in general, but little injury is inflicted on any of the ligaments of the articulation, the internal lateral and part of the capsule may be lacerated, the elevator muscles are tense, also the inter-maxillary ligament, the external pterygoid, and the depressors are relaxed. Dislocations of this bone cannot occur in the child under four years of age, in consequence of the peculiar form of the jaw, the angle being so obtuse, and the ramus directed so obliquely forwards and downwards.

ARTICULATION OF THE OCCIPUT WITH THE ATLAS.

This is a double arthrodia, the condyles of the occipital bone being received into the superior oblique processes of the atlas, and secured by capsular ligaments, by synovial membranes which cover the opposed cartilaginous surfaces, and by an anterior and posterior ligament.

The *capsular ligament* on each side, *arises* from the circumference of the condyle, and is *inserted* into that of the glenoid cavity of the atlas; these ligaments are sufficiently loose to allow of slight motion, and are strongest externally. The *synovial membranes* line the interior of each capsule, and are reflected over the opposed cartilaginous surfaces of the condyle and the cavity.

Anterior and *posterior occipito-atlantal ligaments, arise* from the edges of the foramen magnum, and are *inserted* into the upper border of the atlas, before and behind its oblique processes; they are covered by the deep seated muscles of the spine, the obliqui and recti both before and behind; the anterior, which is narrow, rests on the odontoid process and its ligaments, the posterior, which is broader, is on the dura mater, and is pierced on either side for the vertebral vessels and sub-occipital nerves, In these arthrodial articulations, no horizontal rotatory motion can occur; flexion and extension, or a forward and backward movement of the head, and a very slight lateral flexion, or what are termed the "nodding actions" of the head, are the only motions which can take place.

ARTICULATION OF THE OCCIPUT WITH THE AXIS OR SECOND VERTEBRA.

The occipital bone, though not in contact with, is yet connected to the axis by the two lateral or moderator ligaments, and by the apparatus ligamentosus colli, this may therefore be considered as an example of amphiarthrosis or syndesmosis. To expose these ligaments, the cervical portion of the spine must be divided vertically, immediately behind the oblique processes; so as to separate the spinous processes with their crura, from the bodies, the dura mater being then removed from the fore part of the section, we obtain a view of the cuneiform process of the occiput, and of the posterior surface of the bodies of the vertebræ covered by ligaments.

The *apparatus ligamentosus* is a flat fasciculus of fibres, which descends from the lower part of the cuneiform process, behind the odontoid process, and is inserted in the middle thin into the superior part of the transverse ligament of the atlas, and below this into the body of the second vertebra, and on either side very thick into the bodies of the second, third and fourth vertebræ; on the latter it becomes continuous with the posterior common vertebral ligament; this ligament, therefore, is common to the occiput, and to the three or four superior cervical vertebræ: the central band of this is the perpendicular ligament of old writers, and has been described incorrectly as inserted into the point of the odontoid process. This ligament covers the odontoid process and the following ligament; it serves to attach the head to the cervical vertebræ, and to bind down and secure the lateral ligaments, it also resists too much flexion of the neck.

The *lateral* [*oblique* or *moderator*] *ligaments* arise one from each side of the odontoid process, they ascend obliquely outwards, and are inserted into a depression on the inner side of each condyle; these short and strong ligaments are covered posteriorly or towards the canal by that last described, anteriorly they are covered by cellular tissue, and by the anterior occipito-atlantal ligaments. These ligaments have little or no influence over flexion or extension, but they check or regulate the degree of rotatory motion between the axis and the atlas, and in rotation of the head, the occiput and the atlas form but one system, which rolls on the pivot-like process of the second vertebra or axis. To the point of the odontoid process there is no ligament attached, a little filamentous cellular tissue sometimes ascends from it to the anterior edge of the foramen magnum.

ARTICULATION BETWEEN THE FIRST AND SECOND VERTEBRÆ, OR THE ATLAS AND AXIS.

These two vertebræ present three articulations, one in the centre between the odontoid process and the body of the atlas, and two lateral between the oblique processes, these may all be considered arthrodial surfaces, the atlas being the recipient for the three, the central one is vertical and the deepest, the lateral are horizontal and superficial. The central articulation is secured by a transverse ligament and two synovial membranes, and the lateral joints possess the usual capsular and synovial apparatus; the two vertebræ are also connected by an anterior and posterior ligament similar to the occipito-atlantal.

The *transverse ligament* is behind the odontoid process, it describes the fourth of a circle, it is thick, broad and fibro-cartilaginous in the centre, is attached on each side to the inner edge of each oblique process of the atlas, and is connected in the centre by some of the fibres of the apparatus ligamentosus, to the cuneiform process superiorly, and to the body of the axis inferiorly. The *synovial membranes* are connected one to the posterior surface of the odontoid process, and to the anterior surface of this ligament, the other synovial membrane covers the opposed cartilaginous surfaces of the atlas and the processus dentatus: by means of this ligament a circular chamber or collar is formed, which encloses the axoid process and binds it to the atlas, while the two synovial sacs are beautiful provisions to admit of the partial rotation of the latter around the former, in which movements the head and atlas may be considered as one solid piece, they not having any independent or separate rotatory motion. The importance of the transverse ligament is great and obvious, hence when ruptured as has happened in disease of this central articulation, death has been instantaneous, the head has fallen forwards and the odontoid process projecting backwards has either compressed or pierced the medulla oblongata.

The lateral articulations are secured by *capsular ligaments* and *synovial membranes*, which are sufficiently lax to admit of the necessary rotatory motions, these ligaments are attached to the circumference of the oblique processes, and are lined by loose and well moistened synovial membranes, which are thence reflected on the cartilaginous surfaces of the opposed bones; the vertebral vessels are in contact with these capsules.

The *anterior* and *posterior atlanto axoid ligaments* are of but little importance, their name implies their attachment; the anterior is narrower and stronger than the posterior, which is thin, broad and weak.

THE COMMON ARTICULATIONS OF THE VERTEBRÆ.

The vertebral column consists of a great number of parts, which are so connected as to combine with considerable elasticity and flexibility sufficient strength to support the whole frame, as well as to afford security to the important nervous organ it contains; from the inferior surface of the second cervical to that of the last lumbar vertebra, one similar series of ligaments, though somewhat differently modified in the different regions, serves to unite the several vertebræ to each other and to connect the whole into one upright and powerful column. The bodies of every pair are an example of amphiarthrosis, the oblique processes, of very flat arthrodia, and the other processes of syndesmosis.

The ligaments are classed into two sets, those which unite the bodies, and those which unite the processes; the first comprise the anterior and posterior common vertebral ligaments and the intervertebral fibro-cartilages or ligaments; the second set include the capsules and synovial membranes of the oblique processes, the infra-spinous or yellow ligaments or the ligaments of the laminæ or crura of the spinous processes, the inter-spinous, the supra-spinous, and the inter-transverse.

The bodies of the vertebræ are united by an anterior, a posterior, and an inter-vertebral ligament.

The *anterior vertebral ligament* is a strong band of fibres extending from the axis to the sacrum, and adhering to the bones, particularly to their edges and to the intervertebral substances: some of the fasciculi are very long, others very short, and some of the deep fibres cross obliquely between the bodies of the vertebræ; this ligament is narrow in the cervical and superior lumbar regions, broader and more distinct in the dorsal and lower lumbar: in the neck and loins its edges are confounded with the adjacent tendons; its relations are obvious; it serves to attach the vertebræ, to strengthen the inter-vertebral ligaments, and to oppose excessive extension of the column.

The *posterior vertebral ligament* is partly prolonged from the apparatus ligamentosus, it extends down the back part of the bodies of the vertebræ, along the front of the spinal canal; it consists of smooth glistening fibres, is narrow in the dorsal, and broad in the cervical region: it adheres more closely to the edges of the vertebræ and to the intervertebral ligaments than to the middle of each vertebra, from which it is separated by vessels; the dura mater can be easily detached from it, its margins present a series of lunated processes from its being prolonged more laterally on each intervertebral ligament than on the vertebra itself where it is narrowed; this ligament, like the last, gives strength to the spine, it also opposes too much flexion of the column.

The *intervertebral ligaments* or *fibro-cartilages* are placed between the bodies of all the vertebræ except that of the first and second: these substances partake of the fibrous or ligamentous character much more than the cartilaginous; they are united above and below to the flat surfaces of the vertebræ in so intimate a manner that maceration alone can separate them completely, and their own strength and cohesion surpass even that of the bones themselves, they are covered and bound down by the anterior and posterior ligaments: in the neck and loins they are thicker in front than behind, and the contrary in the back, hence in a great degree the peculiar curvatures of the spinal column. Their structure is peculiar and complex, it is best examined in the lumbar region; a horizontal section exhibits an arrangement of tough, fibrous laminæ apparently concentric, yet not exactly so, for they decussate or intersect and overlap each other, these laminæ are more numerous in front and on the sides than behind; towards the surface they are very compact and close, but as they pass more inwards they leave interstices which are filled with a soft, pulpy, whitish, semi-fluid substance, and towards the centre or a little behind that point, the fibrous tissue becomes rather cellular, the areolæ being filled with this viscid pulp: the external layers are the strongest and most elastic, and often present a cartilaginous appearance, and in old persons, some portions of these are occasionally found ossified; a vertical section of these substances also exhibits the fibrous structure and the different density of its different portions; in this view, the fibres are distinctly seen passing from one bone to another in such oblique courses that they completely decussate; in this section also the ligamentous tissue swells out and expands beyond the limit of the bony surfaces, owing partly to the elastic resistance of the external layers being then removed; when these ligaments are subjected to maceration, they swell, become very full and tense, and if cut horizontally the central fluid portion will be found to rise up like a conical pulpy pivot. The intervertebral substance is more perfect in the adult than in the very young or very aged, in the latter the pulpy substance is less, and is yellowish and dry, and the whole ligament is diminished in depth and in elasticity, whereas in the very young the fluid portion is thinner and in greater quantity, it is also of a lighter colour, and sometimes presents a rosy tint. These ligaments serve to increase the height or length of the spine without adding much to its weight, to connect most firmly its several component pieces, to complete the spinal canal, also the sockets for the heads of the ribs, to permit of yielding or flexibility in the column to a great degree, to restore the spine to its vertical bearing by their elasticity, which is one of their most remarkable and superior properties, to lessen the effects of concussion, and to prevent shocks being transmitted from the lower limbs to the brain; they constitute the spine a sort of strong, flexible, and elastic spring, in which, while they admit of sufficient yielding in every direction, they at the same time resist too much flexion, extension, lateral or rotatory motion.

The oblique, or articulating processes of the vertebræ are connected by *synovial* membranes, and by ligamentous fibres extended irregularly around these, so as to form imperfect capsular ligaments.

The *ligamenta subflava* are between the back parts of the plates of the vertebræ; these ligaments close the intervals between the vertebræ, and thus complete the back part of the spinal canal: they exist between all the vertebræ from the second to the sacrum, are most distinct in the loins, and are seen best from the interior of the canal; they are composed of dense, yellow, elastic fibres, united angularly to each other towards the base of each spinous process: these ligaments close the spinal canal posteriorly between the spinous processes, they also resist too much flexion of the column. The spinous processes of the vertebræ are also connected to each other by ligamentous bands, termed *supra-spinous* and *inter-spinous* (the ligamenta sub-flava may be called *infra*-spinous.) Between the transverse processes also ligamentous fibres exist which are named *inter-transverse ligaments.*

[The *ligamentum nuchæ* is attached to the occipital protuberance superiorly, and is attached to the spines of the cervical vertebræ as low as the seventh, and is lost upon the cervical aponeurosis. It tends to support the head in the erect position, and to prevent its too great flexion. In the human subject it is comparatively very small, but in quadrupeds, it is very strong and large, so as to support the weight of the head, which is placed at the end of a long horizontal lever (the vertebral column ;) it is however very extensible and elastic, as is shown, by the ease with which these animals carry their heads to the ground, as in grazing, and raise them again, to the natural position, which last motion is effected by the elasticity of the ligament and the powerful muscles of the neck.]

A dislocation of the head from the atlas has been only found in consequence of disease. The first cervical vertebra may be dislocated from the second, either as a consequence of disease or by a violent rotation of the head, or by a fracture of the processus dentatus. Dislocation of one vertebra is extremely rare, and is perhaps never simple but complicated with violent injury to the bones, ligaments, and muscles.

ARTICULATION BETWEEN THE PELVIS AND THE SPINE :—LIGAMENTS OF THE PELVIS.

The last lumbar vertebra is joined to the sacrum in the same manner as the other vertebræ are joined to each other.

The two last lumbar vertebræ are connected to the ilium by the *ilio-lumbar ligament ;* this is sometimes divided into two, it *arises* from the transverse processes of the fifth and fourth lumbar vertebræ and from the back part of the sacrum, proceeds horizontally outwards, and is *inserted* into the posterior superior spinous process and crest of the ilium.

The several bones of the pelvis are connected together by ligaments and cartilages ; the ilium and sacrum are firmly united by a cartilage which consists of two thin layers, they are each somewhat semi-circular, and adhere to each bone ; behind this they are connected by short ligamentous fibres, which are intermingled with a soft cellular tissue ; the synchondrosis in front of this is rather loose in the child, and presents an indistinct synovial surface with a little reddish fluid ; in the adult a soft yellowish matter intervenes, the surfaces are then, however, very uneven and appear indented with one another; in the aged they are sometimes anchylosed.

[The junctions between the sacrum and ossa innominata are called the right and left *sacro iliac symphyses*, and the ligamentous fibres are divided into the *sacro spinous*, and the *sacro iliac* ligaments. The first extends between the posterior superior spinous process of the ilium, and the third and fourth spines of the sacrum; the second surrounds the articulation, and is strongest posteriorly.]

The *sacro-sciatic* are two in number on each side; first, the *posterior* or *great sacro-sciatic ligament*, *arises* broad from the lower and back part of the posterior inferior spine of the ilium and from the back part of the sacrum and coccyx; descends obliquely outwards, becomes narrow and thick, and is *inserted* again broad into the lower and inner edge of the tuber ischii; its posterior surface is covered by the glutæus maximus; a falciform process is continued forwards along the ramus of the ischium, to this the obturator fascia is attached, this serves to conduct and protect the pudic vessels and nerves.

Second, the *anterior* or *lesser sacro-sciatic* ligament crosses in front of the former, is triangular, *arises* broad from the side of the sacrum and coccyx, passes outwards and is *inserted* narrow into the spine of the ischium. These four ligaments are situated at the lower and back part of the pelvis, they serve to secure the sacrum and ossa coccygis to the ossa innominata, they also assist in forming the parietes of the pelvis, and by their decussation they constitute the two openings on each side known by the names of the greater and lesser sacro-sciatic notches, the larger and superior of which transmits the glutæal nerves and vessels, the pyriform muscle and the sciatic and pudic nerves and vessels; through the inferior or lesser the internal obturator tendon and the pudic vessels pass.

The coccyx is united to the sacrum by ligamentous bands before and behind, [the *anterior* and *posterior sacro coccygeal* ligaments] also by a substance resembling the inter-vertebral, but which is not so laminated, nor does it contain any of the pulpy material.

The oval surfaces of the ossa pubis are closely attached by several laminæ of fibro-cartilage, which resemble the inter-vertebral, and which are thicker before than behind where a little fluid separates these bones which are each covered by cartilage, the fibres pass in vertical concentric laminæ which intersect each other, some of these are continued all round, others are deficient behind, they are thicker above and below; in the centre there is generally a little viscid fluid, and an imperfect membranous appearance, a strong tendino-ligamentous substance covers it in front [the *anterior pubic ligament;*] this articulation is strengthened inferiorly by the [*sub-* or *inter*]-*pubic ligament*, which is very dense, it adheres to and passes from the ramus of one bone to the opposite.

[This articulation is called the *symphysis pubis*.]

The *obturator ligament* is a thin fascia adhering to the margin of the obturator hole, except superiorly, where it is deficient to allow the thyroid nerve and vessels to pass out obliquely.

[This ligament by its two surfaces gives origin to the external and internal obturator muscles.]

ARTICULATIONS OF THE RIBS.

The true ribs are joined to the vertebræ behind and to the sternum before; the false or the five inferior ribs are only indirectly connected to the latter: each of the vertebral articulations, with few exceptions [the first, eleventh, and twelfth, sometimes the tenth,] involves two vertebræ and the intermediate substance, the head of each rib presents two slight convex surfaces, which are received into the depression on the sides of the bodies of two vertebræ, and the intermediate ridge or angle is connected by ligaments to the inter-vertebral substance; the tubercle of each rib is also articulated to the concavity on the forepart of the transverse process of the inferior of the two vertebræ, with whose bodies the head of the rib is articulated: [except the eleventh and twelfth which have no tubercle;] thus the posterior end of each rib presents three articulations, two on the head and one on the tubercle; these all belong to the class arthrodia, the vertebræ forming the recipient surfaces; the internal vertebral articulation, or that of the head of the rib, is secured by an anterior or stellate ligament, two synovial membranes, and the inter-articular ligament: the tubercle is secured in its socket by a synovial membrane, and by an external, posterior, and superior costo-transverse ligament.

First, the *capsular* or *stellate* or *anterior ligament, arises* from the front of the head of the rib, and thence extends over the two synovial membranes in a radiated manner, and is *inserted* by three bands into the side of the vertebra above and below, and into the inter-vertebral substance.

The *inter-articular ligament arises* from the projecting ridge in the articular surface of the rib, is short and somewhat yellowish, and is *inserted* into the cavity in the inter-vertebral substance in which the head is received.

[This ligament is wanting at the first, eleventh, and twelfth ribs, because they are articulated to the corresponding vertebræ only; the same is sometimes true of the tenth.]

The upper and lower divisions of this joint are lined by distinct synovial membranes, which do not communicate; the stellate ligament and these synovial membranes are covered by the pleura, the thoracic ganglions of the sympathetic nerve, and on the right side by the vena azygos; the first, eleventh, and twelfth, have only one synovial membrane and no inter-articular ligament, there being only one articulating surface on their heads, which are joined to only one vertebra each.

The tubercle of each rib presents two surfaces separated by a ridge, the external is rough for the attachment of ligaments, the internal is convex and covered with cartilage, and is received into the articulating depression at the summit of the transverse process of the inferior of the two vertebræ, to the bodies of which the head is attached; a synovial membrane and three ligaments secure this articulation.

The synovial membranes of these external costo-vertebral joints, are more loose and distinct than those of the heads of the ribs: the eleventh and twelfth ribs are not articulated to transverse processes, and have only very slight tubercles.

There are three ligaments termed costo-transverse; the posterior, the middle, and the anterior; these secure the connexion of the ribs to the transverse processes of the vertebræ, the two first of these connect the rib to its corresponding vertebra or transverse process, but the last connects this transverse process to the rib beneath; thus, these three ligaments arise from the one transverse process, two are attached to the corresponding rib, and the third to the rib beneath.

Posterior or external costo-transverse ligament, flat, and somewhat square, *arises* from the posterior surface of the extremity of the transverse process, passes outwards, and is *inserted* into the rough non-articular portion of the tubercle of the corresponding rib; this ligament exists on all the ribs, though very loose on the two last.

The *middle costo-transverse ligament*, connects the back part of the rib to the front of the corresponding transverse process, it is a short, thick, inter-osseous ligament, which cannot be seen until a horizontal section of the part be made, or the rib forcibly torn from the process.

[This ligament is wanting at the eleventh and twelfth ribs, which have no tubercle.]

Anterior or internal costo-transverse is wanting in the first and twelfth ribs, *arises* narrow from the lower border of the transverse process, descends obliquely inwards and forwards, and is *inserted* broad into the upper edge of the rib beneath, the inter-costal vessels and nerves lie upon it, externally it is continuous with the inter-costal aponeurosis, internally it bounds the opening through which the posterior branches of the inter-costal nerves and vessels pass. From the double mode of articulation of the ribs, but little motion can occur, and that only a slight elevation and depression with a very little rotation: from the length however of the ribs, this motion has a considerable effect anteriorly and laterally in enlarging the thorax; all these ligaments are relaxed during inspiration. Simple dislocations of the vertebral ends of the ribs can never occur.

The cartilages of the ribs at their costal ends are convex, and are very closely united to the concave surfaces in the extremities of the bones, by symphysis or rather gomphosis. The sternal ends of the cartilages of the seven true ribs, except the first, are convex, adapted to the hollows in the edge of the sternum; these hollows are covered by cartilage and by synovial membranes; each joint is strengthened by ligamentous bands, which proceed from the cartilage before and behind the articulation, and are expanded upon the sternum.

[These may be called the *costo sternal ligaments.*]

There is no distinct joint between the first rib and the sternum, the cartilage and bone appear to be continuous; that of the second is sometimes divided into two cavities; the cartilages of the three superior false ribs are connected to that of the last of the true ribs, and the two last are unconnected.

[The cartilage of the eighth rib on one side, is sometimes articulated to the sternum; we have seen this on the left side. The cartilage of the seventh rib is usually connected by a ligament running from its inferior margin to the front of the xiphoid cartilage the *costo xiphoid* ligament.]

Dislocations of the costal or outer ends of the cartilages of the ribs are very rare; they sometimes however occur; those of the sternal end are still more uncommon.

LIGAMENTS OF THE SUPERIOR EXTREMITIES.

These comprise first, the ligaments which connect the clavicle to the sternum; second, those connecting the clavicle to the scapula: third, those proper to the scapula; fourth, those connecting the humerus to the scapula; fifth, those connecting the bones of the elbow joint, which will be afterwards subdivided; sixth, those of the wrist joint; seventh, those of the metacarpus; eighth, those of the phalanges of the fingers.

1. STERNO-CLAVICULAR ARTICULATION.

The articulating end of the clavicle is larger than the surface of the sternum, the former is triangular, the apex behind and below, the surface of the sternum is slightly convex from before backwards, and concave from within and from above downwards and outwards, the cartilage of the first rib assists in forming its lower extremity, this articulating surface on the sternum is inclined outwards and a little backwards, and is more on the posterior than the anterior aspect of the bone: the circumference of the clavicle is rough for ligamentous attachment, its articulating surface is inclined downwards and forwards, is uneven and slightly concave from before backwards, and convex from above downwards. This articulation is secured by an anterior, posterior, inferior, and inter-clavicular ligament, also by an inter-articular cartilage and two synovial membranes.

The *anterior* [*sterno-clavicular*] *ligament arises* narrow from the end of the clavicle, descends inwards, and is *inserted* broad into the forepart of the sternum, this broad ligament is covered by the skin, and by the tendon of the sterno-mastoid muscle, it covers and adheres closely to the synovial membranes and to the inter-articular cartilage.

The *posterior* [*sterno-clavicular*] *ligament* takes a course behind the joint parallel to the preceding, it is narrower and weaker than the last.

The *inferior* or the *costo-clavicular* or *rhomboid ligament*, passes from the lower surface of the sternal end of the clavicle downwards, forwards, and inwards, and is *inserted* into the cartilage of the first rib, this ligament closes the angle between the clavicle and the first rib, its upper or posterior surface is in contact with the subclavian vein, it serves to confine the clavicle in its place, and to resist its dislocation upwards, it also prevents the sterno-mastoid muscle separating the clavicle from the chest.

The *inter-clavicular ligament* extends from the posterior surface of one clavicle to the other, the deep cervical fascia is attached to the upper concave edge of this ligament, its lower border is generally attached to the posterior lip of the sternum, it is covered by the integuments, and it lies on the sterno-hyoid muscles, it connects the clavicles to each other and to the sternum, it also protects the soft parts immediately above the latter.

The *inter-articular cartilage* is nearly circular, it is thin below and attached to the sternum, thick above and attached to the clavicle, it is very thin and often perforated in the centre, the sterno-clavicular ligaments adhere to it before and behind ; it serves to adapt the two slanting bony surfaces to each other, it also binds them together like a true ligament.

The *synovial membranes* are connected to each surface of this cartilage, they are generally very dry and often intercepted by ligamentous bands.

2. SCAPULO-CLAVICULAR ARTICULATION.

THE oval end of the clavicle is connected to the end of the acromion process, in a plane arthrodial joint, which is secured by a *superior* and *inferior* [*acromio clavicular*] *ligament*, these are attached to the surfaces of each bone; there is also an indistinct synovial membrane between both ; and sometimes there is an inter-articular cartilage, the deltoid and trapezius muscles also strengthen this articulation considerably, and adhere very closely to these ligaments. The two following ligaments do not properly belong to this articulation, they are, however, very essential in connecting the scapula and clavicle, they are about an inch to the inner side of the scapulo-clavicular articulation ; these are the conoid and trapezoid [or *anterior and posterior coraco clavicular*] ligaments.

The *conoid* is the posterior and the smaller of the two, its base is attached to a tubercle on the lower surface of the clavicle, its apex to the broad part of the coracoid process.

The *trapezoid* is more anterior and external, it is also broader and stronger than the conoid, it is about an inch distant from the articulation, and is attached above to an oblique line on the clavicle, thence it descends obliquely inwards to the upper part of the coracoid process ; these ligaments are united posteriorly and externally, anteriorly they are distinct, the extremity of the subclavian muscle intervening, and sometimes a small bursa. The coraco or costo-clavicular fascia, though not a ligament, serves to strengthen the connexion between the clavicle and scapula, as also between both these and the first rib. (See page 69.)

[This is sometimes called the ligamentum bicorne.]

The clavicle at its sternal end may be dislocated forwards. Displacement upwards or backwards is too rare to merit any notice.

[The dislocation backwards is usually caused by curvature of the spine, and hence is for the most part irremediable. In this case the sternal end of the clavicle projects behind the sternum and compresses the trachea and œsophagus, so as to interfere with respiration and deglutition.]

In a perfect dislocation forwards the anterior, posterior, costo-clavicular and inter-clavicular ligaments are ruptured; and occasionally the tendinous expansion of the sterno-cleido-mastoid muscle. At its scapular extremity, the clavicle may be displaced either above or below the acromion; the latter case is extremely rare, almost unknown; dislocation of this end of the clavicle is less frequent than that of the sternal extremity: when the clavicle passes above the acromion, the shoulder inclines in, being unsupported by this bone, and its extremity projects under the skin of the shoulder. The superior, inferior, and some fibres of the coraco-clavicular ligaments are ruptured. The clavicular portion of the trapezius, by elevating the clavicle, assists in this displacement.

3. LIGAMENTS OF THE SCAPULA.

THESE are two in number, an anterior and posterior.

The *anterior* or the *deltoid* or *coraco-acromial*, *arises* broad from the coracoid process, passes upwards, and is *inserted* narrow into the point of the acromion process; this broad thin triangular ligament is often deficient or weak in the centre, it is covered by the deltoid muscle and the clavicle, and it lies over the large bursa which covers the tendon of the supra-spinatus muscle: this ligament completes the protecting arch or vault which the acromion and coracoid processes nearly complete over the shoulder joint.

[This is sometimes called the *triangular* ligament.]

The *posterior* or *coracoid ligament arises* from the costa of the scapula behind the notch, passes forwards, and is *inserted* into the base of the coracoid process; it converts the notch into a foramen: this ligament is sometimes wanting, then the notch is completed into a hole by bone: the supra scapular nerve usually passes beneath this ligament, while the vessels of this name run above it.

[This is also called the ligamentum posticum scapulæ.]

4. HUMERO-SCAPULAR OR SHOULDER ARTICULATION.

THE head of the humerus is retained in the glenoid cavity by the capsular and coraco-humeral or accessory ligaments, the joint is also furnished with the glenoid ligament, and a synovial membrane: this joint may be regarded as an enarthrosis, though in the dry skeleton it appears to be only an arthrodia.

The *glenoid ligament* deepens the glenoid cavity; this fibrous border is partly derived from the tendon of the biceps; is thick where it adheres to the bone, its free edge is thin, it is covered on both surfaces by synovial membrane.

The *capsular ligament arises* around the neck of the scapula, increasing in size it encircles the head of the humerus, and is *inserted* into its neck; it is dense above and below, thin internally and externally; this capsule is very loose and long, the tendons of the four capsular muscles are identified with it, and to these it is principally indebted for its strength; it is almost perfectly covered by these, a small portion, however, inferiorly, and a little internally, that is, between the tendon of the sub-scapular muscle and that of the long portion of the triceps is deprived of this support, accordingly in this situation, although the ligament itself is here rather strong, dislocations of this joint usually occur.

The *coraco-humeral* or *accessory ligament* extends obliquely downwards and outwards from the coracoid process to the anterior part of the great tuberosity, where it becomes confounded with the capsule and with the tendon of the supra-spinatus muscle.

The *synovial membrane* is reflected over the glenoid surface, around the glenoid ligament, it then lines the fibrous capsule and the tendons of the adjacent muscle, and is next reflected over the head of the humerus, it also lines the bicipital groove by a process of about an inch and a half long: there are generally small, red, fatty masses under this membrane near the edge of the scapula, and on the neck of the humerus.

The shoulder joint, from the great extent of its motions and form of its articulating surfaces, is more liable to dislocation than any other in the body; this accident may be primary or secondary.

Primary dislocations of the humerus may occur downwards or into the axilla, forwards or under the pectoral muscles, or backwards into the infra-spinous fossa: this latter species is extremely rare; a dislocation upwards could not occur without fracture of the acromion, and therefore cannot be considered among simple dislocations. A primary dislocation, either directly backwards or directly forwards, is not likely to happen, as the strong attachments of the teres minor, supra and infra-spinati muscles to the greater tubercle of the humerus, and that of the sub-scapular to the lesser tubercle, respectively offer powerful resistance in either of these directions. It is plain from the construction of this joint, that a dislocation downwards is the most likely to occur; for the lower part of the capsular ligament being unsupported by muscles, is most weak; and the action of the levator muscles of the shoulder, by rotating the head of the humerus from above down, will bring the head of the bone near the inferior edge of the glenoid cavity, and thus place it in a situation most favourable for displacement, when violence is applied to the extended arm. The greater extent however of the glenoid cavity from above down than across, tends to guard against this accident, also the mobility of the scapula and the glenoid cavity being held opposed to the head of the humerus by different muscles, but above all by those which cover and adhere to the capsule.

When the humerus is dislocated downwards, the head of the bone is found resting on the inferior or sternal costa of the scapula, between the long head of the triceps and sub-scapularis. The lower portion of the capsular ligament is ruptured, together with the tendon of the sub-scapularis. The tendons of the supra and infra-spinati muscles and of the teres minor are sometimes lacerated, and occasionally the tubercles are broken. Some of the fibres of the deltoid, pectoralis major, and coraco-brachialis are also sometimes torn; the long tendon of the biceps usually but not always remains unbroken. Independent of external violence, the elevating muscles of the humerus, and of the whole arm, (if the elbow joint be fixed,) with the pectoralis major, latissimus dorsi, and teres major, may, under certain circumstances, effect this displacement of the bone. The deltoid and supra-spinatus muscles are those which most powerfully resist reduction.

When the head of the humerus is dislocated forwards, it lies on the inner side of the neck of the scapula, between it and the second and third ribs, the serratus magnus and sub-scapularis generally intervene. The internal portion of the capsular ligament and sometimes the tendon of the sub-scapularis are ruptured.

In dislocation of the humerus backwards, the head of the bone lies in immediate contact with the scapula, under the infra-spinatus muscle. The humerus is sometimes partially dislocated in cases of paralysis of the deltoid and of the capsular muscles, or in very aged and debilitated persons.

[A partial luxation of the os brachii is sometimes spoken of, in which the head of the bone is thrown inwards, against the coracoid process of the scapula. Another luxation described as consecutive, is that in which the head of the bone, is lodged against the middle of the clavicle. When the shoulder joint has been once luxated, it is liable to a repetition of the displacement. We have known a case of a man of about thirty-five years old, whose shoulder had been luxated thirty times.]

5. HUMERO-CUBITAL ARTICULATION, OR THE ELBOW JOINT.

In this, which is one of the most perfect ginglymoid articulations, the opposed extremities of the humerus, ulna, and radius mutually receive each other, and are attached together by an external and internal lateral and by an anterior and posterior ligament, all these ligaments are so closely connected to the surrounding muscles as to be with difficulty separated; there is no distinct capsular ligament, although the aggregate of these might be considered as such.

The *external lateral* [or *brachio radial*] *ligament* is short and flat, *arises* narrow from the external condyle, and is *inserted* broad into the annular ligament of the radius; this ligament is confounded with the tendons of the supinator and extensor muscles.

The *internal lateral* [or *brachio ulnar ligament*] *arises* narrow from the inner condyle, and is inserted in a radiated manner into the inner edge of the coronoid and olecranon processes, it is longer and broader than the external, is somewhat triangular, and divides inferiorly into two fasciculi, the anterior of which extends to the coronoid process, and is confounded with the common tendinous origin of the muscles of the fore arm, the posterior is inserted into the olecranon process, is covered by the ulnar nerve and connected to the adjacent muscles; both portions adhere to the synovial membrane. These lateral ligaments steady and strengthen this articulation, they also in some measure restrain its motions, the anterior portion of each, particularly of the internal, being tense in extension, the posterior in flexion of the joint: a distinct band of fibres extends from the anterior to the posterior part of the insertion of the internal lateral ligament, or from the coronoid to the olecranon process; in fracture of the latter, the broken piece is often retained in its situation, according to Sir A. Cooper, by this ligament.

The *anterior ligament* consists of thin fibres which take an irregular direction over the forepart of the joint; they *arise* chiefly from above the internal condyle, and the depression on the forepart of the humerus; they thence spread over the synovial membrane, and over some reddish fatty matter which is behind the brachialis anticus; some are *inserted* into the annular ligament of the radius, and the remainder are gradually lost on the synovial membrane.

The *posterior ligament* is not so distinct as the anterior, unless the fore arm be flexed; the fibres chiefly extend in a transverse direction from one condyle to the other; they are attached to the synovial membrane, and covered by the triceps, and anconæus.

The *synovial membrane* is common to the humero-cubital, and cubito-radial articulations; this membrane descends from the forepart of the humerus behind the anterior ligament, and a quantity of reddish fatty matter which intervenes, to the neck of the radius and annular ligament; round which it forms a cul de sac, is prolonged into the two sigmoid cavities of the ulna, and thence is reflected to the lateral ligaments and to the triceps tendon, which leads it to the posterior depression on the humerus, it is thence expanded over the articular eminences at the lower end of this bone, it is looser before and behind than on the sides, it is also thicker in those situations.

RADIO-ULNAR ARTICULATIONS.

THESE are two, a superior and an inferior, they are both of the arthrodial class; in the *superior* the head of the radius is received into the lesser sigmoid cavity of the ulna, and is retained in it by the following ligament.

The *annular* [or *coronary*] *ligament* forms about three-fourths of a circle, the lesser sigmoid depression in the ulna completing it; it *arises* from the anterior, and is *inserted* into the posterior border of the lesser sigmoid cavity of the ulna; this ligament is lined by the synovial membrane of the joint, it encircles the head and neck of the radius; it often presents a cartilaginous structure.

The *oblique* [or *round*] *ligament* is a small round, fibrous cord, but weak and irregular, it *arises* from the root of the coronoid process of the ulna, descends obliquely outwards, and is *inserted* into the radius below its tubercle; it is on a plane anterior to the inter-osseous ligament, and it separates the flexor digitorum sublimis from the supinator radii brevis muscle, it is made tense in supination.

The most frequent dislocation of the elbow-joint is that of both radius and ulna backwards. This accident is sometimes complicated with a fracture of the coronoid process. The relation of the articulating surfaces in the semi-flexed position of the arm is such, that if external violence be applied, the coronoid process slips behind the articular pulley of the humerus and is lodged in the sigmoid fossa, while the humerus is thrown forwards on the radius and ulna. The external, internal, and sometimes the annular ligament of the radius are ruptured, though the accident may occur without injury to any of these parts; occasionally even the biceps and brachialis internus suffer from the violent projection of the humerus, and the brachial artery has been known to have been ruptured in this manner. The flexor muscles of the arm, by keeping it bent, and the triceps by its contraction, are the muscles which oppose reduction. The internal condyle of the humerus and the olecranon present two prominent points, which are of great importance in assisting us to detect injuries about the elbow-joint. In the extended position of the arm they are nearly on the same line, and any displacement of the bones will cause a corresponding displacement of these two prominences.

The form of the bones, the strength of the lateral ligaments, and the numerous muscles surrounding the joint, prevent a complete lateral luxation of both ulna and radius, while a luxation forwards cannot occur without fracture of the olecranon.

The ulna may be dislocated backwards on the os humeri without being accompanied by the radius. The coronoid process is forced over the pulley of the humerus into the sigmoid fossa, and the olecranon forms a prominent projection at the back part, the fore arm and hand are twisted inwards. The annular and accessory ligaments are ruptured, and sometimes a small portion of the inter-osseous. The action of the triceps will contribute to keep the bone in this position, while on the contrary, the brachialis internus assists in the reduction.

The radius may be dislocated at its humeral extremity, either backwards or forwards. When it is driven through the back part of the capsular ligament it is found to rest above the external condyle of the humerus, supported by the brachial fascia. The accessory and annular ligaments are torn, and sometimes the inter-osseous ligament suffers at its superior part.

In dislocation forwards of the radius, the head of the bone rests above the external condyle of the os humeri, and resists sudden flexion. The accessory and annular ligaments, with a portion of the inter-osseous ligament, are ruptured in this luxation as in the former. The biceps muscle becomes shorter by contraction and thus may resist, though not in any great degree, reduction.

The opposed edges of the shafts of both radius and ulna are connected by a thin aponeurosis, the *inter-osseal membrane* or *ligament;* it is composed of long fibres which descend obliquely inwards from the radius to the ulna, others occasionally cross it in a contrary direction; this ligament is deficient above and below, and in many places is perforated by vessels; it is not made very tense in any position of the limb, it serves to give attachment to muscles.

In the *inferior radio-ulnar articulation* the round head of the ulna is received into the sigmoid cavity of the radius, and retained in it by a loose *synovial membrane* or the *sacciform ligament*, which is covered before and behind by some ligamentous fibres, which form an imperfect capsule, it passes from the radius to the ulna, and forms a very loose sac above the following ligament or cartilage; it always contains a large quantity of synovia.

The *fibro-cartilage* is triangular, it *arises* narrow from the styloid process of the ulna, and is *inserted* broad into the inner edge of the carpal end of the radius below the depression for the ulna, which bone it separates from the wrist joint or from the cuneiform bone, its anterior and posterior edges are connected to the ligamentous fibres that pass from the ulna to the radius. Sometimes it is perforated, then the wrist joint and this articulation will communicate: this cartilage appears to be a prolongation of the encrusting cartilage of the lower end of the radius, it serves to unite the radius and ulna very securely, while at the same time it allows the former to roll round the latter as on a pivot, this cartilage also completes the ulnar side of the carpal articulation.

The carpal extremity of the radius may be dislocated either forwards or backwards; in the first of these accidents, which is much the more frequent, this bone is thrown forwards on the scaphoid and os trapezium; the capsular and anterior ligaments alone are ruptured. In the dislocation backwards the back part of the capsule, the posterior, and sometimes the external lateral ligament are ruptured. The bone projects under the skin at the back of the wrist.

The carpal extremity of the ulna may be dislocated forwards or backwards, the latter is more frequent; the accident is obvious, and the dislocation is easily reduced, but there is much difficulty in keeping the bone in its place, in consequence of the rupture of the sacciform ligament.

6. RADIO-CARPAL ARTICULATION, OR THE WRIST JOINT.

In this arthrodial joint, the lower end of the radius and the inter-articular cartilage form a socket for the scaphoid, lunar and cuneiform bones, the two former are received into the radius, the latter corresponds to the fibro-cartilage, which separates it from the ulna and excludes this bone from the joint: the wrist joint is secured by an external and internal lateral, by a posterior and anterior ligament, and by a synovial membrane.

The *external lateral* or *radio-carpal ligament*, *arises* from the styloid process of the radius, and is *inserted* into the scaphoid bone; some fibres extend to the annular ligament and to the os trapezium.

The *internal lateral or ulna carpal ligament*, is round and long, *arises* from the styloid process of the ulna, extends obliquely downwards and forwards, and is *inserted* into the cuneiform bone.

The *anterior* and *posterior ligaments* descend from the radius and inter-articular cartilage, anteriorly and posteriorly, and are *inserted* into the superior row of the carpus, the anterior is strong and tense, the posterior is weaker and looser, its fibres however are more distinct, the former is covered by the flexor, the latter by the extensor tendons; these two ligaments together with the two lateral may be regarded and have been described by some, as the capsular ligament.

The *synovial membrane* covers the superior row of the carpal bones, is thence reflected to line the ligaments, and is continued over the articular surface of the radius, and of the inter-articular cartilage; it is very loose and contains much synovia; when the bones are pressed together the membrane may be seen projecting through the ligamentous covering like small vesicles.

The wrist joint may be dislocated either by the radius and ulna being both thrown forwards, or both backwards: lateral dislocations seldom occur, and are always partial. These displacements almost always occur by falls on the ground, or other violence, by which the hand is forcibly bent forwards or backwards, on the bones of the fore arm; extensive laceration of the capsular, anterior, or posterior ligaments, and considerable synovial effusion and swelling accompany them. The tendons also of the flexor and extensor muscles are more or less displaced, and some of them may be ruptured. The form of the arch of the first range of carpal bones favours the dislocation backwards, since from their greater convexity in this direction, they do not afford as much support to the bones of the fore arm.

ARTICULATIONS OF THE BONES OF THE CARPUS.

The bones of the carpus are arranged in two rows, three in the superior, and four in the inferior, between these rows a certain degree of motion takes place, but between the individual bones in each row there is little or none. The bones of the first row are the scaphoid, lunar, and cuneiform, these are connected in the following manner:—

First, *inter-osseous ligaments;* these are short and compact dense tissues, placed between the upper borders of the scaphoid and lunar, and lunar and cuneiform, they range on a level with the carpal convexity of these bones, and are covered by the synovial membrane of the carpus.

Second and third, the *dorsal* and *palmar ligaments* are composed of strong bands which pass in different directions from one bone to another.

The pisiform bone, which is the smallest bone of the carpus, does not properly belong to either row, it is articulated to the fore part of the cuneiform only by a flat surface, which is furnished with a loose synovial membrane; two strong ligaments also connect it, one to the cuneiform bone, and the other to the fifth metacarpal bone, the tendon 5
of the flexor carpi ulnaris and the muscles of the little finger, also serve to retain it in its situation, and to attach it to the annular ligament and palmar fascia.

The four bones of the second row of the carpus, like those of the first, are connected together by inter-osseous substance, and by dorsal and palmar bands which run in every direction; there is no inter-osseous substance between the trapezium and trapezoid. The second row is articulated to the first by an enarthrosis in the centre, and an arthrodia at either side; the central joint is between the round head of the magnum and the cavity of the scaphoid and lunar bones, the lateral arthodiæ are between the scaphoid and cuneiform bones above and the trapezium, the trapezoid and unciform below. These two rows are attached by strong lateral and by anterior and posterior ligaments, the former seem continuations of the lateral ligaments, of the wrist, the latter pass from the circumference of one row to that of the other, the aggregate might be considered as a capsular ligament.

The *synovial membrane* between the first and second row is very loose and distinct, and may be considered as common to almost all the joints of the carpus; it lines all the inferior surface of the first and sends two processes upwards, one at either side of the lunar bone as high as the inter-osseous ligament, from the first row it is reflected on the anterior and posterior ligaments, and thence to the second row, and is very distinct on the magnum, being continued round its neck; from this row it sends down three prolongations between the four bones of the second row, these also extend beneath these to line the articulations between the carpus and four of the metacarpal bones, and some are even still further prolonged, between the lateral articulating surfaces of the heads of the second and third, and fourth and fifth metacarpal bones; thus this synovial membrane is almost common to all the carpal and metacarpal articulations, there are however some parts excepted, thus between the pisiform and cuneiform there is a distinct synovial membrane, another also between the trapezium and the metacarpal bone of the thumb, and also one between the third and fourth metacarpal bones. The continuity of this one synovial membrane through so many articulations, and its contiguity to the other membranes in this region are well exemplified in cases of synovial inflammation or disease of the carpus. The bones of the carpus are also firmly connected to each other by the *annular ligament*, which is *inserted* externally into the trapezium and scaphoid, and internally into the cuneiform, pisiform, and unciform bones.

[On the back of the wrist is the *ligamentum corpi dorsale*, which extends from the outer or styloid edge of the radius, to the inner or styloid edge of the ulnar; it is divided into six compartments or canals for the transmission of appropriate tendons, which is its use, rather than to bind the bones together.]

The close connexion of the bones of the carpus and the numerous ligaments spread in all directions over the back and front of the hand, present powerful obstacles to complete dislocations of any of these bones; the only one at all likely to occur, is that of the head of the os magnum backwards from the depression in the semi-lunar and scaphoid bones; here the quantity of motion is greatest, and the joint is very weak and loose in some feeble persons; however this luxation is almost invariably incomplete.

THE ARTICULATIONS BETWEEN THE CARPUS AND METACARPUS.

These joints are secured before and behind by transverse and oblique fibrous bands, which cover the synovial membranes and pass in different directions: the synovial membrane between the trapezium and the metacarpal bone of the thumb is distinct from the rest, and possesses a capsular ligament, the pulley-like surfaces of this joint admit of very free motion, adduction, abduction, flexion, and extension, and slight rotation. The other joints are also furnished with synovial membranes, which are prolonged from that between the first and the second row of the carpus, except in the case of the third and fourth, which possess a distinct sac. The second metacarpal bone is articulated to the trapezium, trapezoid, magnum, and to the third metacarpal bone; the third to the magnum, and to the second and fourth metacarpal bones; the fourth to the magnum, unciform, and to the third and fifth metacarpal bones; the fifth to the unciform and to the fourth metacarpal bone. The anterior or lower extremities of the metacarpal bones are not in contact, but are connected by a strong transverse band of ligamentous fibres, [the *transverse* or *inferior palmar* ligament.]

Dislocations of the metacarpal bones from the carpus seldom occur, except in the case of the first metacarpal bone, which may be dislocated from its articulation with the trapezium forwards or backwards; in the backward luxation the carpal extremity of the bone is driven through the posterior part of the capsular ligament; the lateral ligaments may or may not be ruptured. The flexor ossis metacarpi, and flexor brevis and longus, with the adductor, offer great resistance to reduction when delayed for any time. In the dislocation forwards the metacarpal bone is thrown between the trapezium and the root of the second metacarpal bone; the thumb is bent back, and cannot be flexed: the external lateral ligament is in this case more likely to be torn than in the former. The extensors of the thumb are the muscles which offer resistance to reduction of this dislocation.

ARTICULATION BETWEEN THE METACARPUS AND THE PHALANGES.

These arthrodial joints are furnished with capsular ligaments and synovial membranes; the sockets do not receive the entire head of each bone, the latter being much larger, particularly on their posterior aspect; the capsules are weak and lax behind, strong on the sides like distinct lateral ligaments, and very close and compact in front, often with somewhat of a cartilaginous structure; in the thumb this ligament lodges the sesamoid tubercles, in this finger also this articulation differs from that in the other fingers, in possessing but little motion in any direction except that of flexion and extension, whereas the others possess also the power of adduction, abduction, and rotation; these articulations are much strengthened by the tendons of the flexors, extensors, lumbricales, and inter-ossei muscles.

The ginglymoid articulations of the phalanges are secured by synovial membranes, and by very strong lateral and anterior ligaments, posteriorly the synovial membranes are only partially covered by the extensor tendons; but anteriorly they are perfectly protected by the flexor tendons and their sheaths.

Tne first phalanx of the thumb is the only joint of this series very liable to dislocation, it is frequently dislocated backwards, from the head of the metacarpal bone. The lateral ligaments remain uninjured and become very tense. This dislocation is interesting from the great difficulty of reducing it when neglected even for a short time. The phalanges of the other fingers may be dislocated either backwards or forwards, these accidents are obvious, and when recent easily admit of reduction.

ILIO-FEMORAL ARTICULATION, OR HIP JOINT.

This is the strongest and most perfect enarthrosis in the system, it includes the head of the femur and the acetabulum, both of which are encrusted with cartilage, and is secured by a capsular and an accessory ligament, a synovial membrane, an inter-articular, cotyloid, and a transverse ligament: the cartilage on the head of the femur is deficient a little below its centre, as also that of the acetabulum in a space extending from the notch to its centre, the former lodges the insertion of the inter-articular ligament, the latter a mass of articular fat.

The capsular ligament is the strongest in the body, it has some analogy to that of the shoulder joint, but is not so loose, neither are the surrounding tendons so identified with it; there is a large bursa on its anterior surface, between it and the tendon of the psoas, in some rare cases this communicates with the cavity of the joint; another bursa is placed more externally; between the great trochanter and the tendon of the glutæus maximus, there are also several large bursæ connected to the surrounding tendons.

The capsular ligament *arises* from the dorsum of the acetabulum, encloses the cotyloid ligament as it ascends, but does not adhere to it except at the notch, it is also connected to the inferior spine of the ilium, and to the obturator ligament, it is *inserted* into the base of the neck of the femur; being longer behind and below than in any other situation, it is weaker behind and below than above or before; at the lower and internal part it is so thin in children, and the fibres so scattered, that the synovial membrane can be seen through it; the fibres of this ligament take different directions, the superficial are long and vertical.

[This ligament includes the neck of the femur to such an extent, that a fracture of the neck within the capsular ligament can and does take place, usually however in old subjects. The ligament includes the neck more completely anteriorly, where it extends as far as to the anterior intertrochanteric line, whereas posteriorly the ligament is lost upon the periosteum several lines within the posterior intertrochanteric line.]

Accessory or *ilio-femoral* ligament is a strong fibrous band, incorporated with the capsular, *arising* from the inferior spinous process of the ilium, it descends obliquely inwards, becomes broader, and is *inserted* near the lesser trochanter, this strengthens the capsule anteriorly, and opposes the head of the femur in extension of the thigh. These external ligaments derive additional strength from the surrounding muscles, viz. anteriorly, from the psoas, iliacus, and rectus; externally or superiorly from the glutæus minimus, which adheres closely to the capsule; posteriorly from the quadratus femoris, pyriformis, gemelli and obturator internus, and internally from the obturator externus and pectinæus.

The *synovial membrane* is exposed by dividing the capsular ligament, whose internal surface it lines to a great extent, it is continued from the head of the femur around the neck near to its base, but not so far as the fibrous capsule; on the neck it is loose in some parts, and thrown into little folds or wrinkles which adhere to strong fibrous bands, thickened portions of periosteum, which extend from the head along the neck to the capsular ligament; from the neck the synovial membrane is reflected to the capsule, along which it is conducted to the outer circumference of the acetabulum, it then covers both surfaces of the cotyloid ligament, lines the acetabulum, adheres to the fatty mass at the bottom of this cavity, and is then reflected along the inter-articular ligament to the head of the femur. The articular fatty mass has a peculiar reddish appearance, it fills the rough surface in the acetabulum, and is confined in its place by a number of decussating tendinous bands, it receives a great number of blood vessels and nerves chiefly from the obturator; there are also red fatty masses around the neck of the femur, and one at the insertion of the inter-articular ligament in the head of the bone.

The *cotyloid ligament* may be next noticed, this is the fibro-cartilaginous lip which deepens the acetabulum, and at the same time narrows its orifice, so as to hold or retain the head of the femur even after the capsular ligament and all the muscles have been divided; it is composed of strong circular fibres, these pass in deeper in those particular situations where the acetabulum in infancy was separable into three parts; it serves to deepen the cavity, and to prevent the neck of the femur striking against the sharp edge of the cavity.

Transverse ligament consists of ligamentous bands, which pass across the notch in the border of the acetabulum, some pass from the pubis to the ischium, others decussate these and pass from ischium to pubis; it completes the margin of the cavity and leaves sufficient space above it for the passage of vessels and nerves.

Inter-articular ligament, or *ligamentum teres*, is about an inch and a half in length, it consists of fine ligamentous fibres covered rather loosely by synovial membrane; though called round, it is rather of a triangular form, the base attached to the notch and to the depression in the acetabulum, the apex to the head of the femur; it *arises* by two flat bands, the superior of which is the smaller, from the margins of the cotyloid notch, these soon unite being enveloped by the synovial membrane, the ligament then runs upwards, backwards and outwards, contracting in size, between the articular fatty mass and the head of the bone, into the depression on which it is *inserted.*

[This ligament is frequently described incorrectly. By one extremity it is attached to the depression on the head of the femur, towards the other it divides into two roots; of which one may be traced around the lower edge of the cotyloid notch, until it is finally lost upon the face of the ischium, between its tuberosity and the edge of the acetabulum; the other root may be traced to the upper end of the notch, where it is lost near the edge of the acetabulum; hence this ligament is not necessarily torn off in the dislocation of the femur, into the obturator foramen, for in this displacement the two extremities of the ligament are approximated.]

This ligament is very rarely wanting, it serves to conduct blood-vessels from the acetabulum to the head and neck of the femur, which from its position in respect to the shaft of the bone, may require a nutritious supply from this source; some consider it may also limit too much abduction of the thigh. This joint enjoys free motion in every direction, flexion, extension, abduction, adduction, rotation and circumduction; the depth of the acetabulum, the strength of its capsular ligament, together with the surrounding muscles, all seem well adapted to prevent luxation, such accidents, however, not unfrequently occur.

This joint is not so liable to dislocation as that of the shoulder for several reasons; in the first place, its motions are much more limited both in number and extent; second, the glenoid cavity affords little mechanical security, while the cotyloid on the contrary permits the head of the femur to sink into it; third, the oblique direction also of the head of the thigh bone presents an additional obstacle; fourth, the capsular ligament of this joint is much stronger and shorter than that of the shoulder, and it is further protected by very strong accessory fibres on the outer and upper part, which descend from the inferior anterior spine of the ilium, and by some on the inner side from the superior part of the foramen ovale.

The joint of the hip may be dislocated in four ways, backwards and upwards on the dorsum of the ilium, backwards on the ischiatic notch, forwards and upwards on the pubes, and forwards and downwards on the foramen obturatorium.

[One case has occurred of a dislocation of the femur into the perineum; this was probably a secondary displacement, supervening upon a primary dislocation into the obturator foramen. This case has never been published, but the minutes of it, are in the possession of Dr. Parker, Prof. of Surgery in the college.]

The situation of the trochanter major is a point of great importance in discriminating accidents about the hip joint, and its relation to some other prominent points should be well kept in mind; in the erect position of the body, the superior part of the trochanter major is nearly on the same level with the body of the pubes, the distance between the anterior superior spine of the ilium and the trochanter major is less than from this projection to the os pubis, or from the os pubis to the anterior superior spine, lines connecting these three points will form nearly a right angled triangle, of which the longest side is the line connecting the superior spine to the pubis, and the shortest, that which joins the spine to the trochanter. In dislocation upwards or backwards the trochanter is brought nearer the superior anterior spine of the ilium, but is much less prominent than natural: in the luxation backward it is removed from the body of the pubis, and is also less prominent than natural: in the dislocation into the obturator foramen, the distance between the trochanter major and the body of the pubis is lessened, while that between this process and the anterior superior spine is greater than usual.

In dislocation upwards and backwards, which is by far the most frequent, the head of the bone rests on the dorsum of the ilium, the upper part of the capsular ligament is ruptured, and the accessory and round ligaments are torn: the limb is shortened about two inches, and is inverted and almost fixed. In rotation inwards the head of the femur is pressed against the back part of the capsular ligament, and if the rotation be carried far, a considerable portion of the bone is outside the cotyloid cavity: hence the species of dislocation now described is most likely to occur when rotation inwards is accompanied by external violence, that is by the individual falling or receiving a blow when the knee and foot are turned inwards. When this dislocation has occurred the three glutæi muscles are those principally concerned in keeping the head of the bone fixed on the dorsum of the ilium; but when the limb has been extended and the head of the bone is sufficiently raised to pass over the edge of the acetabulum, the psoas and iliacus with the obturator externus and pectinalis, will assist to bring it into the proper situation. Although in common cases of dislocation we may presume, from the rapid recovery of the patient, that no other injury is done to the joint than what has been already described, yet the dissection of a case of luxation upwards and backwards has been published, in which the gemelli, pyriformis, obturators, and quadratus femoris, were completely torn across, with laceration of some fibres of the pectinalis

In the dislocation backwards, and which is also a little upwards, or that into the ischiatic notch, the head of the bone rests on the pyriformis muscle and between it and the sciatic ligaments, the limb is a little shortened, it is also inverted, but much less so than in the dislocation on the dorsum of the ilium. This dislocation also is most likely to happen when the thigh is rotated inwards and bent towards the abdomen.

When the femur is dislocated forwards on the obturator foramen, the capsular ligament and the internal accessory fibres are lacerated. The ligamentum teres is, according to Sir A. Cooper, always ruptured: the limb is lengthened about two inches, the knee advanced and abducted with slight eversion, the great trochanter is much less prominent than usual.

In dislocation upwards and forwards the head of the bone rests on the ramus of the pubis under Poupart's ligament, where it may be plainly felt; the limb is shortened, slightly flexed, and everted.

A calculation has been made, that out of twenty dislocations of the hip joint, twelve will take place on the dorsum ilii, five on the ischiatic notch, two on the foramen ovale, and one on the pubis.

FEMORO-TIBIAL ARTICULATION, OR THE KNEE-JOINT.

The condyles of the femur, the head of the tibia, and the patella, enter into this arthroidal ginglymoid articulation, the fibula is only remotely connected with it. The ligaments which secure it may be classed into those external and those internal to the synovial membrane, although strictly they are all internal to it; the external ligaments are, the ligamentum patellæ, ligamentum posticum, and the internal and external lateral ligaments. Several *bursæ* are in its vicinity, three are placed on its anterior aspect, these may be named the superior, middle, and inferior; the first and last are deep seated, the second is cutaneous, being placed on the patella, and partially covered by an imperfect fascia, its cavity is frequently intersected by tendinous bands. The superior bursa is placed on the forepart of the femur, behind the extensor tendons and surrounded by fat, it is very thin and almost always communicates with the cavity of the joint, it often appears as the prolonged synovial membrane of the joint itself. The inferior bursa is small and delicate, is situated between the tubercle of the tibia and the ligament of the patella, there are various other small bursæ connected to the adjacent tendons. Although there is no regular capsular ligament to this joint, yet its place is in a great degree supplied by the fascia lata and by the aponeuroses from the lateral muscles, tendons and ligaments, which give it a very perfect covering. The bony surfaces which compose this joint have been already described, these are covered in the usual way with a compact cartilage; on the femur this extends much higher on the condyles in front and behind, and does not at all cover their sides; on the tibia it is thicker in the centre than at the circumference, contrary to the general condition in arthrodial surfaces; this apparent anomaly, however, is removed by attending to the position of the semi-lunar cartilages, which deepen the border of these cavities so considerably.

The *ligamentum patellæ* consists of strong, parallel, glistening, tendinous fibres, which descend obliquely outwards and backwards from the inferior angle of the patella, and are *inserted* into the tubercle of the tibia, a little below the small bursa which lies behind this ligament; it is partly a continuation of the extensor tendon in which the patella was developed at first in the form of cartilage, in the same manner as the sesamoid bones are; this ligament is about two inches long, and narrower in the centre than at either end, it is covered by the skin and fascia lata, and it lies upon a quantity of soft adeps and upon the small inferior bursa.

The *posterior ligament* [or ligament of Winslow], has been noticed in the dissection of the semi-membranosus muscle from the tendon of which this quadrilateral ligament *arises;* it then ascends obliquely from behind the inner condyle of the tibia to the external condyle of the femur, it separates the gastrocnemii and plantaris from the synovial membrane to which it adheres, it is made very tense and resisting in extension of the leg, in flexion it is relaxed and drawn a little backwards, and in this state the synovial membrane is drawn out of the angle of the joint in consequence of its attachment to this aponeurosis. (See page 262.)

The *internal lateral ligament* is flat and broader in the centre than at either end, it *arises* from the internal condyle of the femur, descends obliquely forwards, and is *inserted* into the internal condyle of the tibia, and into the semilunar cartilage; this ligament is closely applied to the synovial membrane and to the semilunar cartilage, the tendon of the semi-membranosus and some articular vessels separate it near its insertion from the tibia, it is covered by the aponeurotic expansion of the gracilis, sartorius, and semi-tendinosus.

The *external lateral ligament* or *ligaments arise* from the external condyle, above the fossa for the poplitæal tendon, are thick, round and short, descend backwards, and are *inserted* into the head of the fibula; a portion of the biceps tendon sometimes separates these ligaments; in many cases they form but a single cord; when there are two, the long one is superficial; the external lateral ligament has little or no connexion to the synovial membrane, being separated from it by the poplitæus tendon, the articular vessels, and a portion of the biceps tendon; a portion of the short or deep ligament is commonly found connected to the semi-lunar cartilage.

The external and internal lateral ligaments are situated a little behind the centre of the articulation, hence they become relaxed in flexion and tense in extension of the limb, they serve to connect the several bones together, to confine the semi-lunar cartilages in their places, and to prevent any lateral displacement, they also resist rotation of the femur on the tibia inwards, but admit of rotation outwards, whereas they admit of the tibia or the leg rotating inwards but not outwards; the ligamentum patellæ, the internal and external lateral ligaments favour rotation of the tibia inwards and oppose it outwards. To see the internal ligaments, separate the extensor tendons from the patella, and open the synovial membrane above and behind the latter.

The *synovial membrane* of the knee is the largest membrane of this class in the body; from the lower extremity of the extensor tendon it passes back to the forepart of the femur a little above the condyles, it rises higher above the outer than the inner of these processes; where the bursa and synovial membrane communicate freely they appear but one membrane rising on the femur to a height of two or three inches above the condyle; it is continued over the condyles, and covers their sides although they are deficient of cartilaginous incrustation, it ascends higher on the internal side of the inner condyle than of the outer, posteriorly it is also continued above the inner to a greater height than above the outer; from the back part of the femur it is reflected on the head of the gastrocnemii on each side, and on the posterior ligament in the centre; from the depression between the condyles, but rather from the external, a fold of this membrane descends obliquely forwards and inwards to the mass of articular fat at the lower and anterior part of the joint, this is termed the ligamentum mucosum; it is also continued from the femur along the crucial ligaments to the head of the tibia; from the lateral parts of the joint this membrane is continued to the upper surface of the semi-lunar cartilages, on which it spreads, it then turns round their sharp, thin edge to their lower surface, and thence to the upper surface of the tibia, where it meets the reflections which have descended along the crucial ligaments; from the tibia it is continued anteriorly to the mass of soft adeps, which it covers, and where it joins the ligamentum mucosum, it then passes to the posterior and upper part of the ligamentum patellæ, and lastly it covers the back part of the patella at the upper border of which we commenced its description: as the poplitæal tendon is continued from the outer condyle, a process of this membrane is reflected round three-fourths of it, as far as the head of the fibula, where this process touches the synovial membrane of the tibio-peronæal articulation, and in some instances the synovial membranes of these two articulations, though very generally distinct, communicate.

The internal ligaments in this joint are, the alar, mucous, transverse, crucial, and the semi-lunar cartilages.

The *alar ligaments* are only folds of the synovial membrane, in some measure produced by the displacement of the patella, they are one on either side of this bone, they diverge above and uniting below are lost in the fatty mass; the internal is the most distinct.

The *ligamentum mucosum* is also a small fold of the same membrane, passing from the fatty substance behind the ligamentum patellæ, backwards, upwards and a little outwards to the hollow between the condyles; it serves to regulate the position of the fat, to keep it opposite the notch of the femur, and thus preserve a more even surface.

The *transverse ligament* extends between and is attached to the anterior convex portions of the two semilunar cartilages, and above the fatty substance before alluded to; it serves to retain the adipose mass in its situation, and to prevent its receding into the cavity of the joint, it also in some measure secures the semilunar cartilages in their proper situation.

The crucial ligaments are the most important of the inter-articular ligaments, they are two strong, shining, twisted, fibrous cords, which pass from the notch in the femur to the median line of the head of the tibia, they are very close to each other about the centre of the joint, but thence they separate, crossing each other as they pass to their respective attachments: when viewed anteriorly or posteriorly this decussation resembles the letter X, they cross also in the lateral view; to see the ligaments distinctly the patella must be thrown completely down, the ligamentum mucosum divided, also the lateral and posterior ligaments, and the synovial membrane dissected from these fibrous cords, for although they appear within the cavity of the joint, they are really without and behind it, and in the latter aspect, the membrane can easily be detached from them at its reflection without its cavity being opened.

The *anterior*, or *horizontal*, or *external crucial ligament arises* from the inner and posterior part of the external condyle, descends obliquely forwards and inwards, and is *inserted* near the forepart of the head of the tibia, where it also joins the anterior cornu of the internal semilunar cartilage; this ligament is best seen when the joint is flexed.

The *posterior*, or *internal* or *perpendicular crucial ligament arises* from the outer and forepart of the internal condyle, descends nearly vertical, and is *inserted* partly into the external semilunar cartilage, and partly into the depression on the back of the tibia behind its median spine : this ligament is larger than the anterior, its origin is seen anteriorly behind the ligamentum mucosum, its insertion is broad, and is best seen posteriorly, when the joint is extended and the ligament of Winslow and a quantity of fat removed.

The crucial ligaments serve to attach the femur to the tibia, they steady the one bone upon the other, and strengthen the back part of the joint in the same manner as the patella does in front, they also tend to prevent any lateral displacement; they are both made tense, and of course prevent too much rotation of the tibia inwards, and they are relaxed and separate, somewhat in rotation outwards; in extension also they are both very tense, especially the posterior, in flexion the anterior is so, but in a less degree; in fine they resist too great rotation inwards, also excessive extension or flexion, but they admit of rotation outwards; the posterior ligament also, by its attachment to the external semilunar cartilage, serves to retain or restore this cartilage to its place, as in rotation of the leg outwards the cartilage is allowed to yield or move backwards. If the crucial ligaments be divided the femur may be detached, and the twisted structure of the former can be seen. The semilunar cartilages and their ligaments may be next examined.

The *semilunar cartilages* are placed upon the articular surfaces of the tibia; the convex margin of each is thick and connected by its edges to the synovial membrane, and between these to the external ligaments and fascia, this latter aponeurotic attachment has been called the coronary ligament of each cartilage; the internal concave margin has a sharp edge, which is loose in the cavity of the joint: each cartilage presents above an excavated surface adapted to the condyles, and below a flat surface adapted to the head of the tibia. The anterior and posterior extremities of each are fibrous and fixed to the head of the tibia, before and behind its middle protuberance, these insertions are termed the oblique ligaments. The two cartilages are united in front by the transverse ligament; the external cartilage is more circular, and more moveable than the internal, which is a segment of an oval figure; the anterior extremity of the internal is connected to the anterior crucial ligament, while the posterior crucial is attached to the external cartilage. The median line of the tibia presents the insertion of these several parts in the following order, from before backwards; first, is the anterior cornu of the internal semilunar cartilage; second, the insertion of the anterior crucial ligament; thirdly, the anterior cornu of the external cartilage, the insertion of the anterior crucial ligament is intimately connected to the anterior cornua of both cartilages, particularly of the internal; fourthly, the posterior cornu of the external cartilage, only separated from its anterior by a portion of the insertion of the anterior crucial ligament; fifthly, the posterior cornu of the internal cartilage; and sixthly, the insertion of the posterior crucial ligament. The semilunar cartilages serve to deepen the articular surfaces of the tibia, and thus to retain the condyles of the femur, the mobility of the external one also favours rotation of the leg and thigh outwards, in the latter motion the outer condyle of the femur glides a little backwards, the condyle of the tibia being bevelled off posteriorly, the external cartilage is enabled to accompany the femur, and thus to secure and facilitate its motion.

Dislocation of the patella may take place either upwards, inwards, or outwards, the latter is the more frequent form; a dislocation upwards could not occur without rupture of the inferior ligament of the patella, which is so strong that frequently in violent action of the extensor muscles, the patella itself snaps across before this ligament gives way. When the knee is much bent dislocation in either direction cannot take place. The extent of the articulating surfaces of the femur, and the force with which the patella is pressed in between the condyles, prevents such an accident. The position most favourable to this luxation is where the knee is slightly bent and inclined inwards. When complete luxation of the patella outwards has taken place, the patella rests over the external condyle of the femur, in which place it is fixed by the rectus, crureus, and vasti muscles; hence the necessity for bending the thigh on the pelvis, in order to relax these muscles as much as possible. The extent of the synovial membrane permits this displacement to occur without any rupture.

Dislocation of the patella inwards is so similar in its nature to the outward luxation that it does not require any notice.

The tibia may be dislocated from the femur in four directions, backwards, forwards, or to either side, the two former, particularly that backwards, may be complete, the latter are incomplete. There is no joint in the body so well supported by ligaments as that of the knee; on the sides we have the lateral ligaments; in front the ligament of the patella and the tendinous insertion of the extensor muscles; behind the posterior ligament of Winslow; and more particularly the strong crucial ligaments. Additional ligamentous bands are also occasionally seen. When the tibia is completely dislocated backwards into the ham, the ligamentous attachments of the patella either above or below must give way, and the leg is shortened. The crucial and posterior ligaments are also torn. The flexor muscles of the leg, which are attached to the tibia, will contribute to keep the bone in the luxated position. Complete forward dislocations of the tibia have occurred, but they are very rare; in such case all the ligaments of the joint must give way, and the heads of the gastrocnemii and popliteus muscles would also probably suffer.

The semilunar cartilages are sometimes displaced, particularly the internal one, it usually arises from a sudden twist of the knee inwards, and in persons whose knee joints are distended from frequent injury or chronic rheumatism; but little is known of the true pathology of this injury

SUPERIOR TIBIO-FIBULAR ARTICULATION.

This is a very plane arthrodia, the surface of the tibia being slightly convex, to meet the head of the fibula. The tibio-fibular articulations can scarcely admit of any comparison with the radio-ulnar, though analogous to them in position, but little motion occurring in the former, and very free motion in the latter. This articulation is secured by a distinct synovial membrane, which, as has been before mentioned, sometimes communicates with that of the knee joint; there is also a distinct anterior and posterior [*tibio fibular*] ligament, each composed of strong fibres passing from one bone to the other; the external lateral ligament and the tendon of the biceps still further secure this joint; in which the fibula enjoys a very obvious motion forwards, backwards, and a little upwards; this latter, though to a small extent, yet permits the outer ankle, and, of course, the whole foot to move more freely outwards.

Luxation of the upper head of the fibula is usually the consequence of disease; for the application of a force sufficient to dislocate the bone is much more likely to break it. The action of the biceps flexor, the only muscle inserted into the fibula, could not alone produce this accident. When the head of the fibula is thrown back, the anterior ligament and the accessory fibres from the tendon of the biceps, with the synovial capsule, are ruptured. Boyer mentions a case in which the whole fibula was driven directly upwards in consequence of a dislocation outwards of the ankle.

The shafts of these two bones are connected by the inter-osseous membrane, which consists of aponeurotic fibres descending obliquely from the tibia to the fibula; they are deficient above and below, the tibialis anticus and the extensors of the foot cover it in front, and the flexors behind.

INFERIOR TIBIO-FIBULAR ARTICULATION.

The inferior extremity of the fibula is received into a depression in the tibia, and connected to it by a strong anterior and posterior ligament, which are each of a triangular form, the base below attached to the fibula, also by a small portion of the synovial membrane continued from that of the ankle joint, and above this by an inter-osseous, dense, fibrous substance: some fibres of the posterior ligament extend from one malleolus to the other, strengthen the ankle joint, and assist in forming the socket for the astragalus, very little motion occurs in this joint, beyond a little yielding or shuffling of one surface against the other.

ARTICULATION OF THE ANKLE.

This is the most perfect ginglymoid joint in the body, excepting that between the ulna and humerus, a deep mortise-like cavity is formed by the lower surface of the tibia and by the two malleoli, the latter deepened the cavity considerably at each side, the tibio-fibular ligaments also, particularly the posterior, complete the margins before and behind; the tibia is the principal bone in this cavity, the fibula forms little more than its outer wall, this, however, though narrow, passes down very low and affords it considerable defence in this aspect; the internal malleolus is not so long or deep, but is broader, and extends more forwards than the outer ankle, hence the foot inclines outwards more freely than inwards: this joint is secured by very strong lateral ligaments, and also by a synovial membrane, and an anterior ligament.

The *internal lateral* or *deltoid ligament* is very dense, it *arises* from the internal malleolus, descends in a radiated manner, and is *inserted* into the astragalus, os naviculare, and calcis; the posterior fibres are short and thick, the anterior are long and thin: in flexion the posterior fibres are tense, in extension the anterior; this ligament is close to the synovial membrane of the joint, and has equally closely connected to it the synovial and tendinous sheaths of the tibialis posticus, and of the flexor tendons which wind around it, and which give additional strength to this region of the joint.

The *external lateral ligaments* are three, a posterior, middle, and anterior; they all *arise* from the external malleolus; the posterior is very strong and tense, passes obliquely backwards and inwards to the ridge on the back of the astragalus, which separates the ankle joint from the articulation of the astragalus to the os calcis; its superior border is continued some way on the synovial membrane of the ankle to the tibia; it not only secures the ankle articulation, but it also binds the fibula inwards towards the tibia, it is not much altered by the motions of the joint; the *middle* is round, descends almost vertically but a little backwards, and is *inserted* into the os calcis; it is supported by the peronæal tendons; the *anterior* is *inserted* into the upper and outer part of the astragalus.

The *anterior ligament* of the ankle is often indistinct; it *arises* from the anterior edge of the tibia, and is *inserted* into the upper and outer part of the astragalus.

The synovial membrane is large and loose before and behind, it always contains some fluid, it lines the anterior surface of the tibia and of the two malleoli, and ascends a little way between the tibia and fibula, it covers the superior and lateral articular surfaces of the astragalus, and is prolonged a little way on the upper surface of its neck, it is looser anteriorly than in any other direction, to admit of more free extension. Almost the only motions in this joint are flexion and extension, the latter is more free than the former, both can be carried to a considerable extent, but particularly extension, an excess of either motion is resisted by the opposed bony edges coming into contact, and by the tension of the tendons and ligaments; when the joint is flexed, as when we stand in the erect posture, or when it is even more flexed, as when we bend the body forward there is scarcely any lateral motion whatever, but when the ankle joint is extended, even to a slight degree, as in walking, the head of the astragalus being less locked in the socket, a slight lateral motion can occur to either side, but chiefly to the outer, in consequence of the outer malleolus being on a posterior plane to the internal: in this outward lateral motion, the fibula recedes a little and rises vertically; this latter motion is of great use, and is obvious if the superior articular head of the bone be examined at the time.

This lateral or slight rotatory motion at the ankle joint, is not to be confounded with the general abduction and adduction enjoyed by the different articulations in the tarsus, particularly at that between the astragalus and navicular bones: these motions, though different from, yet materially add to that which has been just alluded to in the ankle joint itself.

The ankle joint is the frequent seat of injury; the lower extremity of the fibula is very liable to fracture, and the tibia to luxation, complete or incomplete; when any such accidents occur, the foot suffers proportional deformity and displacement. Such displacements ought, in conformity to the language applied to the corresponding injuries in other joints, to be denominated luxations of the foot, whereas writers usually notice the upper bone or bones engaged in the injury. Thus the tibia is described as liable to partial or perfect dislocation inwards, outwards, forwards, and backwards; it might be more correct to describe each of these injuries as perfect or imperfect dislocations of the foot outwards, inwards, backwards, and forwards. When the tibia is luxated *internally*, which is by far the most frequent accident in this region, and which is almost always accompanied with and indeed in a great measure the consequence of a fracture of the lower end of the fibula, the internal malleolus projects on the inner side of the astragalus and os calcis, the outer side of the foot and malleolus look upwards, and the sole of the foot is directed somewhat outwards, so that the leg has no longer its proper bearing on the foot, the axis of the former inclining inwards, whilst the foot is twisted outwards; the synovial membrane is ruptured, and in many cases there is laceration of the deltoid and anterior ligaments of the tibia, and of the posterior transverse band from the tibia to the fibula. After the accident has taken place, the contraction of the gastrocnemii, solæi, and especially of the peronei muscles, which rotate the foot outwards, and draw it upwards, sometimes offer much resistance to reduction; this, however, is usually overcome by placing these muscles in a relaxed position.

If the tibia be dislocated *outwards*, the astragalus is forced outwards below the external malleolus, which latter projects considerably, the foot is turned inwards, the sole looking upwards and the internal malleolus is sunk in a deep hollow: in this accident the malleolus internus must be broken off obliquely, the deltoid ligament is not ruptured, the fibula is usually broken, but if not, the external lateral, anterior, and posterior ligaments of this bone are lacerated.

In the dislocation *forwards*, the fibula and malleolus internus are broken, the tibia rests on the anterior part of the astragalus and on the os naviculare ; the posterior part of the deltoid ligament, and the transverse band from the tibia to the fibula are ruptured ; dislocation forwards is an accident of rare occurrence, it cannot happen when the foot is flexed on the tibia, for then the tibia sinks down on the back part of the astragalus, and nothing but considerable force could raise it over the upper portion of the bone, which, in this position, extends like a bridge before it; it can only occur when the ankle is forcibly and suddenly extended, in this luxation the foot is lengthened behind, and shortened in front, and presents a considerable projection in the latter situation, caused by the tibia and the several tendons it supports.

Luxation *backwards* is even still more rare. Were such an accident to take place, all the tibial ligaments would be broken, and the fibula most probably fractured. There is no accurate account of a well authenticated case of this accident on record, indeed it is difficult even to conceive how it could possibly occur.

ARTICUTATIONS OF THE BONES OF THE TARSUS.

The seven bones of the tarsus are connected in such a close and firm manner as to admit of but little motion between any two, except at the articulation between the astragalus and the scaphoid, which is somewhat analogous to that of the os magnum in the carpus.

ARTICULATIONS OF THE ASTRAGALUS.

The astragalus rests on the os calcis by two arthrodial surfaces, the posterior is concave, external, and larger than the anterior or internal, which is convex ; a deep groove, leading forwards and outwards, separates these two joints. These two bones are connected by a strong inter-osseous substance, which arises from the groove in the astragalus between the two articular surfaces, and is inserted into that on the os calcis ; there are also two synovial membranes, the posterior is confined to these two bones, but the anterior is continuous with the synovial membrane, between the astragalus and the scaphoid ; these synovial membranes are strengthened by strong accessory bands on either side ; the lateral ligaments of the ankle joint also serve to attach these bones more closely.

The anterior end or the head of the astragalus, is received into the concave surface of the scaphoid bone, which, together with the strong fibro-cartilaginous calcaneo-scaphoid ligament, and a small portion of the os calcis, completes the socket for the astragalus. This joint approaches to the class of enarthrosis, and possesses very free motion on which the mobility of the tarsus and toes greatly depends; it is furnished with a synovial membrane, which is covered superiorly by strong but short tendinous fibres, and below by the *calcaneo scaphoid ligament*, which extends from the anterior inferior part of the os calcis to the lower surface of the scaphoid, it supports the head of the astragalus, and is itself much strengthened by the tendon of the tibialis posticus which winds round beneath it; this tendon also, or this ligament usually contains a sesamoid tubercle or a sort of cartilaginous patella in this place; this ligament supports the great weight of the body, while its elasticity lessens the effects of those concussions to which the body is subject in the many violent exercises in which it is engaged: the synovial membrane of this joint is continuous with that on the anterior and inferior surface of the astragalus.

Simple as well as compound dislocations not unfrequently occur in this articulation, the head of the astragalus being usually thrown forwards so as to form a prominence on the instep: the reduction is in general attended with great difficulty, and in some cases is found impracticable: in some instances the bone has been completely turned round, so that its lower concave surface has held a firm hold of the end of the tibia.

[It is sometimes impossible to reduce a dislocated astragalus, and it has been extirpated on this account by Dr. Alex. H. Stevens, where the dislocation was attended with an external wound.]

ARTICULATIONS OF THE SCAPHOID BONE.

The scaphoid bone is articulated to all the tarsal bones; by direct apposition, to the astragalus behind, to the three cuneiform bones before, and to the cuboid externally, and indirectly to the os calcis by the strong inferior calcaneo-scaphoid ligament just described.

ARTICULATIONS OF THE CUBOID BONE.

The cuboid is articulated with the os calcis behind, with the fifth and fourth metatarsal bones before, and internally with the scaphoid and external cuneiform bones; the arthrodial surfaces of the cuboid and os calcis are connected by very distinct ligaments both on the dorsum and on the sole of the foot. The calcaneo-cuboid and astragalo-scaphoid articulations are on a transverse level, the line of which is occasionally selected for amputation in diseases of the toes. The *superior* or *dorsal calcaneo-cuboid ligaments* are broad but short, are close to the synovial membrane, and are covered by the tendon of the peronæus tertius.

The *inferior* calcaneo-cuboid ligaments are very distinct; they are long but thick, and can be divided into laminæ, they are of a bright shining appearance, they arise from the under surface of the os calcis, pass forwards, and are inserted into the cuboid bone, into the sheath for the long peronæal tendon, and into the base of the third and fourth metatarsal bones. The cuboid is connected to the scaphoid and to the external cuneiform bones by synovial membranes, by dorsal and plantar ligaments, and by short, strong, inter-osseous fibres; sometimes there is no synovial membrane between it and the scaphoid bone.

ARTICULATIONS OF THE CUNEIFORM BONES.

THE three arthrodial articulations between the cuneiform bones and the scaphoid are secured by a synovial membrane which is common to all, and by strong dorsal and plantar ligamentous bands.

Dislocations of any of the other articulations of the tarsus are very rare, except in very severe accidents, and where complicated injuries are inflicted on the foot; cases however are on record of simple dislocation of the cuboid bone from the os calcis; also of the internal cuneiform bone being separated from the navicular in a direction upwards and inwards.

TARSO-METATARSAL ARTICULATIONS.

THE three internal metatarsal bones are joined to the three cuneiform, and the fourth and fifth metatarsal to the cuboid. The tarso-metatarsal articular range presents a slightly waving line, as the second metatarsal bone extends further back than the others. But little motion exists in any of these plain arthrodial articulations, they are furnished with synovial membranes and transverse dorsal and plantar bands. The first metatarsal and the internal cuneiform possess a distinct synovial membrane, the second metatarsal is furnished with a synovial membrane, which is common to it and to the three cuneiform bones: another connects the third metatarsal and third cuneiform bones, and the adjacent metatarsal surfaces; and the two last metatarsal bones and the cuboid are also furnished with a distinct synovial membrane; on the whole these articulations resemble those of the metacarpal bones in all essential circumstances.

The anterior end of each metatarsal bone is connected to the first phalanx of each toe, and the phalanges of all the toes are articulated to each other by synovial membranes and by lateral ligaments as are those of the fingers, and therefore they do not require any elaborate or distinct description.

The phalanges of the toes are but rarely dislocated either from each other or from the metatarsal bones; the most frequent accident of this class, is a dislocation of the first phalanx of the great toe from the metatarsal bone.

THE END.

APPENDIX.

DIRECTIONS FOR MAKING DRIED PREPARATIONS OF THE ARTERIES AND VEINS.

[Furnished to the Publishers by a Medical Gentleman.]

ALTHOUGH in every anatomical school competent persons are retained for the purpose of injecting arteries and veins; still the student may wish to do it for himself, or he may be placed in such situations that he cannot command any kind of assistance: to him, more particularly, the few remarks which we purpose making on the method of injecting and of preserving arterial preparations, may be considered applicable.

Injections are of two kinds, coarse and fine; there are many descriptions of coarse injections; with the fine we have nothing to do, as it is used by anatomists only for the purpose of imitating the natural vascularity which membranes and other structures lose after death. Coarse injections may be employed either hot or cold, formerly the hot injection was the only one used, but now the cold one is very frequently employed. As much of the success of the injection depends on the state of the subject, great care should be observed in the choice; if possible a young and thin one should always be employed, as the arteries in old subjects are so often ossified and inelastic, that we can never be certain that they will not burst from the force employed, and extravasate the injection between the muscles and into the different cavities; another objection to the use of old subjects is, that the constant oozing of oily matter from preparations made of them renders them filthy, and almost useless, particularly in warm weather; however, some old subjects may be filled with the cold (or paint) injection, if care be taken not to use too much force. When the student has made up his mind to employ the hot injection, it may be useful to him to follow a few rules. In the first place, the pipe should be tied so firmly in the opening into the vessel, that there will be no possibility of its slipping out; secondly, the nozzle of the syringe should always be introduced into the pipe, for the purpose of exhausting the artery of air or coagulated blood; this being done, the stopcock should be immediately turned; and lastly, particular care should be taken that the syringe, pipe, and stopcock are free and in good order.

To inject with the hot injection, it is necessary that the subject should be thoroughly heated; this is best done by opening the cavities of the thorax and abdomen, and filling them with water of a temperature that the hand can bear; the body at the same time should be immersed in water of the same temperature, taking care to exclude atmospheric air as much as possible. The process of heating should be carried on until the subject has acquired a temperature resembling the natural heat of the living body. While this is going on, the injection should be particularly attended to, as the materials are very inflammable, and if care be not taken, or much heat be employed, there will be danger of burning the chimney or house; heat, slowly applied, will melt the injection without any admixture of air, or endangering the loss of colour, which strong heat would certainly effect.

[The better plan is to melt the injection, by placing the materials in an earthen vessel and then putting this vessel into a water bath; by this method the materials are perfectly melted and equally heated without danger of boiling or burning. It is also better not to stir in the coloring matter until the injection is thoroughly melted, and about to be used; for some of the colouring substances are apt to cake or form lumps in the injection if subjected to too much heat. For immediate demonstration chrome yellow is a good coloring substance for arterial injection, because it offers a greater contrast to the color of the muscles than vermilion: as the putrefactive process goes on, however, it is apt to turn black; this is also an objection to red lead. In making arterial preparations this objection is obviated by pencilling the vessels over with vermilion paint after they are perfectly dry.—*Amer. Ed.*]

When the subject and injection are sufficiently heated, the injection should be sucked up twice or thrice, so as to mix it well with the coloring matter, which always falls to the bottom: before the syringe is introduced into the pipe, it should be held up and the piston pressed till the injection appears, by which any air that may be in the syringe will be permitted to escape; taking the wings of the pipe into the left hand, the syringe is to be introduced, and the piston is to be pushed down slowly and gradually with the right hand, until the syringe is emptied; this action is to be repeated, till we feel resistance made to the further passage of the fluid in the arteries: if after this resistance is felt, any further force be used, there will be great danger of rupturing the arteries and producing extravasation. As soon as we are satisfied that the body is injected, it should be put in cold water, where it should remain for a few hours. Either of the following hot injections may be used:

Wax ℥xvi.
Resin ℥viii.
Turpentine Varnish ℥viii.
Chinese Vermilion ℥i.

This makes a very handsome injection, but it is liable to the inconvenience of melting in warm weather, and in this way producing a flattened appearance in the blood vessels. A much cheaper and better injection for common purposes than the above has been employed; it is made of—

Tallow 2lbs.
Magnesia Usta ℥ss.
Chinese Vermilion ℥i.

This possesses all the advantages of the wax injection without any of its inconveniences; it is as transparent nearly as the wax, never melts in the hottest weather, and is not disposed to crack; if this injection be used very hot, an extremity may be injected without having been previously heated; but this should never be done except by persons skilled in the art of injecting.

If we wish to trace the minute branches of arteries and examine the various communications, there are no injections better adapted for common purposes than that of tallow and red led well mixed and heated, or the *cold paint injection;* if the latter be well thrown in, the minutest arteries, for instance the ciliary, will be injected; it is made of—

White Lead, well ground, 2lbs.
Turpentine Varnish ℥xii.
Drying Oil ℥vi.

The lead is intimately mixed with the varnish, and then the oil is to be added; they are all to be well mixed up together, to the consistence of cream, and in this state it is to be thrown into the arteries: the same precautions, with regard to the exclusion of air from the syringe, and the degree of force to be used, are to be observed in this as well as in the hot injection. Arteries are always injected from the aorta or some other large trunk; while veins are injected differently: in making preparations of veins, it is necessary to inject them from the extreme branches towards the trunks, on account of the direction of the valves: for instance, the veins of the arm are to be injected from a small branch on the back of the hand, and those of the leg and thigh from some branch on the dorsum of the foot. Previously to the injection being made, it is necessary that the veins should be well washed out with warm water, to remove the coagula of blood which they generally contain: if the veins of the arm are to be injected, an opening should be made on the subclavian vein, to allow the warm water and coagula to pass out; when this has happened, a ligature previously applied, is to be firmly tied round the vessel, which will prevent the injection from flowing out; the same rule applies to the injection of veins in the lower extremity. The veins of the head and neck are generally injected from the superior longitudinal sinus: it is scarcely necessary to mention that veins are filled with blue fluid, and the arteries with white or red; for the blue injection smalt blue is usually employed. To inject the arteries a transverse cut is to be made in the aorta, as close to its origin from the heart as possible. Care must be taken that the extremity of the pipe does not project so far as to pass into the innominata, or one of the vessels arising from the left side of the arch, as this would give only a partial injection. The nozzle of the pipe being carefully inserted into the opening of the vessel, two pieces of twine are to be introduced under the vessel; one of these is to be firmly tied round the artery, this will embrace the nozzle of the pipe; its loose extremities, when the knot is firmly tied, are to be fixed to the wings of the pipe in order to prevent any chance of its slipping out of the vessel. The other ligature is to remain loose under the vessel, beyond the nozzle of the pipe about one inch. After the injection is thrown in, this ligature is also to be firmly tied round the vessel, leaving the pipe clear; the use of it is, that the injection may not return back when the pipe is removed from the aorta. This precaution is more particularly necessary when the paint injection is used. In inserting a pipe into a small artery or vein, some difficulty may arise in the introduction, from the pipe being larger than the calibre of the vessel; in this case the point of a scissors should be introduced into the vessel, and gradual dilatation produced by slowly opening its blades. When the injection has remained sufficiently long to set well in the vessels, dissection may be commenced, and here it is a rule which should be invariably followed, that the dissection be completed in as short a time as is consistent with a proper display of the vessels, for many preparations are lost in consequence of the part first dissected becoming spoiled before the remainder is prepared for drying. Particular care should be taken to remove all the cellular substance from the coats of the vessels; if this be not done, the preparation will always have a dirty appearance. The fatty matter is likewise to be removed, but no muscle is to be taken away or pushed from its situation unless perfectly unavoidable. The student should always remember that the utility of a dried preparation consists in its preserving, as far as possible, the natural relations of parts; on this account, the use of pieces of stick or other substances to separate the muscles and exhibit the course of the vessels, unless absolutely necessary, is to be condemned. One side of the subject ought to be appropriated to the exhibition of the superficial vessels, the other may be used for the deep-seated. When the dissection is completed, the extremity, or whatever portion of the body it may be, should be hung up in a dry and airy situation (but not exposed to the sun) until the muscles acquire firmness, and no exudation appears on the surface. The preparation now fit for use, is to be brushed over with copal or mastich varnish, which makes the vessels more distinct, and materially assists in its future preservation.

[Students in the country need never be at a loss for an injecting apparatus; the common anal syringe will answer the purpose, by casting a pewter pipe, on a wooden or paper mould; one end of which pipe shall fit the nozzle of the syringe, and the other go into the artery. It is better to use a syringe which will hold about the quantity which it is intended to throw in. A very convenient point from which to inject is the femoral artery, just below Poupart's ligament and above the profunda. When injecting the veins, it is convenient to inject the large trunks from the femoral, and then to throw in injection from the extremities. The veins which form the portal system may be injected from the vena porta just before it enters the transverse fissure of the liver; these veins not being obstructed by valves, the injection will reach the mucous membrane of the intestines, as low as the anus; the better plan is to throw in first spirits of turpentine, colored with lamp black, and on top of this the hard injection; by this method the whole mucous membrane may be colored by the injection. In making dry preparations, the parts, as dissected, should be repeatedly washed over with a solution of arsenic or of corrosive sublimate; this hardens the tissues, and is an effectual preservative against insects; the preparations also present a solid appearance. For the purpose of preserving subjects during a long dissection, a solution of creosote in alcohol, of corrosive sublimate in the same, or of arsenic in boiling water, may be thrown into the vessels twenty-four or forty-eight hours before the permanent injection. These solutions percolate through the tissues, condense them, and preserve them effectually, even in warm weather, particularly the arsenic. An injection always accessible in the country, is composed of—

Yellow beeswax, 1 lb.
Tallow, ℥xii.
Resin, ℥viii.
Vermilion, or chrome yellow, q. s.

This injection is easily prepared, and is sufficiently hard for dry preparations. The Annydrous plaster of Paris makes a very neat and minute cold injection. The colouring matter should be well stirred in with the plaster which should then be gradually poured into water, being briskly stirred until the mixture is about the consistence of cream, and then it should be thrown in rapidly, as it hardens quickly. With this injection we have in one instance injected the arteries of the retina from the femoral artery.—*Amer. Ed.*]

LAENNEC'S DIVISION OF THE REGIONS OF THE THORAX.

The chest of a healthy person, when slightly struck, ought to yield over its whole extent a clear and distinct sound. The character of the sound derived from percussion, is different in the different parts of the chest; on which account it has been divided by Laennec into fifteen regions, twelve of which are double.

1. *Subclavian region.* This includes merely that portion of the chest covered by the clavicle. When struck about the middle or sternal extremity, this bone yields a clear sound, but its humeral extremity gives rather a dull sound: a knowledge of the morbid or natural sounds of the chest in this region is of great importance; for from it are usually derived the first signs of the development of tubercles in the lungs, which are found in the upper part of the left lung, even where they exist in no other part of the chest.

2. *Anterior-superior region.* This is bounded by the clavicle and by the fourth rib (inclusive) below. The sound, though clear, is somewhat less so than over the sternal end of the clavicle.

3. *Mammary region.* This begins below the fourth rib, and terminates with the eighth. In the female, the mammary gland, in the male, the inferior edge of the pectoralis major prevents this region from yielding as good a sound as the anterior-superior region.

4. *Submammary region.* This extends from the eighth to the cartilaginous border of the false ribs. On the right side the sound is often dull, caused by the size of the liver; while on the left, the sound is frequently more clear than natural, which is attributed to the presence of the stomach distended with gas.

Sternal regions, 5. superior, 6. middle, and 7. inferior. The sound is as clear over the whole extent of the sternum, as on the sternal end of the clavicle. However, the inferior region sometimes yields a duller sound, in consequence of the accumulation of fat about the heart.

8. *Axillary region.* This extends from the axilla to the fourth rib inclusive; the sound here is naturally clear.

9. *Lateral region.* This is bounded by the fourth rib above, and terminates with the eighth. The sound is always good on the left side; on the right side it is altered frequently by the liver rising higher than usual, and compressing the right lung.

10. *Inferior lateral region.* This is bounded above by the eighth rib, and terminates at the border of the false ribs. This region also, on account of the liver, yields often a completely dull sound on the right side, while on the contrary the left, for reasons before mentioned, gives a clearer sound than natural, even where there be effusion of fluid into the pleura, or where the inferior portion of the left lung be obstructed.

11. *Acromial region.* This is comprehended between the clavicle, the upper edge of the trapezius, the head of the humerus, and the lower part of the neck. The soft parts interposed in this place prevent all sound from percussion.

12. *Upper scapular region.* This corresponds to the supra-spinous fossa of the scapula, and yields hardly any sound on account of the muscle which fills it. The spine of the scapula, which forms the inferior boundary of this region, sometimes yields a faint sound when the arms are strongly compressed across.

13. *Lower scapular region.* This corresponds to the infra-spinous portion of the scapula. It yields no sound on percussion, because this portion of the scapula is covered by the infra-spinous muscle.

14. *Inter-scapular region.* This includes the space between the dorsal edge of the scapula and the spine, when the arms are crossed on the breast. The muscles of this region necessarily render every sound dull; sometimes, however, in thin persons, it gives a low but distinct sound, if the head be bent and the arms crossed in order to make tense the trapezius and rhomboidei muscles. The spine in this region gives a good sound; as likewise that portion of the chest included between the superior dorsal angle of the scapula and the first dorsal vertebra.

15. *Inferior dorsal region.* This begins at the level of the inferior angle of the scapula, terminating at the twelfth dorsal vertebra. Percussion of this region should be made in a transverse direction, on the angle of the ribs; in the upper part, the sound is sufficiently good; in the lower it is slight, or often does not exist, especially on the right side, from the presence of the liver; on the left side it frequently gives an unnaturally clear sound, on account of the distended state of the stomach.

OPENING THE CRANIUM, THORAX, AND ABDOMEN.

The operation of opening the cranium with the hammer, as described in a former part of this work, requires less labour and time than that done with a saw, and ought always to be preferred, except in cases where there is a wish to preserve the skull, or in private houses, where the feelings of the relatives are likely to be offended by the noise made with the hammer. When the saw is used, the head is to be placed on a block, the cut is to be carried round in the same direction, and the same precautions observed as described in using the hammer: if much caution be not used, the saw is very likely to lacerate the substance of the brain, owing to the inequality of thickness of the bone. In cases however where the head is to be opened for examination into the causes of death, without an intention of pursuing the dissection further, a different mode is generally practised; this is done by making an incision, by the introduction of the point of a knife under the scalp, commencing at one ear, and carried over the vertex to the other: in this way we avoid cutting the hair, which in a female might be troublesome, and the flaps made by the dissection of the scalp, being reflected over the face and neck, prevent those parts from being soiled.

For the purpose of examining the morbid appearances after death in the thorax and abdomen, these cavities are generally opened at the same time; an incision carried down from the top of the sternum, and ending at the symphysis pubis, dividing the integuments, muscles, and peritoneum, will bring the latter cavity into view; next let the skin and muscles covering the front of the thorax be turned back, which will expose the cartilages connecting the ribs with the sternum; immediately at their point of connexion with the bone, the cartilages are to be cut; in doing this some caution is to be used; if not, the viscera will sometimes be wounded by the point of the knife slipping down further than is intended; holding the knife horizontally between the thumb and the middle finger, while the fore finger is placed on the back of the instrument as a guide, will always obviate this inconvenience.

In some old subjects, where the cartilages of the ribs are in some degree ossified, they will not yield to the knife, and here a saw is to be employed: all the cartilages, except those of the first ribs being divided, the sternum may now be raised like the lid of a box, and a very convenient hinge is made by cutting the articulation of the first joint of the sternum on the inside, directly opposite the second rib; by following this rule the figure of the thorax will be preserved, after the examination is completed, and a view sufficiently extensive for common purposes be obtained of its contents. The practice of making a crucial incision for the purpose of examining the contents of the abdomen, should always be condemned, and should never supersede the longitudinal, as a view sufficiently extensive for every purpose is obtained by the latter: while the escape of fluids, and the unsightly appearances of the seams produced by the former method, are entirely prevented.

The urinary and generative organs may be removed from the body for examination through the pelvis, and if the integuments in the perinæum, and some of the external organs be left uninjured, and the several outlets secured, any portion which is interesting as presenting diseased appearances, or which may be required for more accurate examination, may be removed without the external appearance of the body being much disfigured, and without a protrusion of any of the remaining viscera.

III.

THE NEW TEMPERANCE PRIZE ESSAY.

BACCHUS.

An Essay on the Nature, Causes, Effects and Cure of Intemperance. By Ralph Barnes Grindrod.—First American, from the Third English Edition. Edited by CHARLES A. LEE, A. M. M. D., &c.

"This work is the prize essay, for which the Brittish and Foreign Temperance Society, awarded to the author the premium of one hundred sovereigns. This essay is admirably full and complete, and is written with much ability, and furnishes abundant evidence of the industry and research of the author. An appendix is added to the American edition, containing some valuable matter connected with the subject of Intemperance—the whole constituting, perhaps, the most useful and valuable book on the subject, which has ever appeared."—*New Yorker.*

"The author is evidently a man of great industry and untiring research; he has brought together an immense amount of valuable information on the subject on which he treats. The work is such a thorough examination of the theme, that it must serve as a text book to all succeeding writers, and a manual for every person who is at all interested in the important subject of Temperance reform."—*Pennsylvanian.*

"We never met with a work on any subject more comprehensive; it embraces all possible historical, statistical, medical and moral information on the subject of which it treats, and is so clearly and methodically arranged, that it makes an excellent volume of reference for every library. In its influence, it must be wide as excellent; for it is a complete library of itself—presenting facts which the ordinary general reading of no gentleman would convey to him. We commend the work to the special attention of every body."—*Tattler.*

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"Nothing short of an attentive perusal of this work, can convey a just idea of the invaluable treasury of *facts* here collected together for the illustration of the subject discussed. It is full of interest, because full of instruction, gathered from sources, not within the reach of one in thousands of our community. Its circulation, will doubtless be wide, and cannot be otherwise than salutary."—*Boston Recorder,* IV.

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V.

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VI.

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