CHAPTER 7

Axial Skeleton

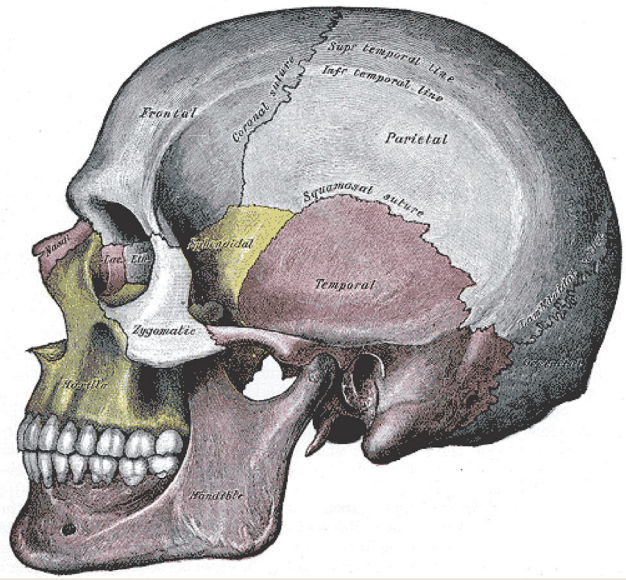


FIGURE 7.1 Lateral View of the Human Skull

Chapter Objectives

After studying this chapter, you will be able to:

- Describe the functions of the skeletal system and define its two major subdivisions
- Identify the bones and bony structures of the skull, the cranial suture lines, the cranial fossae, and the openings in the skull
- Discuss the vertebral column and regional variations in its bony components and curvatures
- Describe the components of the thoracic cage
- Discuss the embryonic development of the axial skeleton

INTRODUCTION The skeletal system forms the rigid internal framework of the body. It consists of the bones, cartilages, and ligaments. Bones support the weight of the body, allow for body movements, and protect internal organs. Cartilage provides flexible strength and support for body structures such as the thoracic cage, the external ear, and the trachea and larynx. At joints of the body, cartilage can also unite adjacent bones or provide cushioning between them. Ligaments are the strong connective tissue bands that hold the bones at a moveable joint together and serve to prevent excessive movements of the joint that would result in injury. Providing movement of the skeleton are the muscles of the body, which are firmly attached to the skeleton via connective tissue structures called tendons. As muscles contract, they pull on the bones to produce movements of the body. Thus, without a skeleton, you would not be able to stand, run, or even feed yourself!

Each bone of the body serves a particular function, and therefore bones vary in size, shape, and strength based on these functions. For example, the bones of the lower back and lower limb are thick and strong to support your body weight. Similarly, the size of a bony landmark that serves as a muscle attachment site on an individual bone is related to the strength of this muscle. Muscles can apply very strong pulling forces to the bones of the skeleton. To resist these forces, bones have enlarged bony landmarks at sites where powerful muscles attach. This means that not only the size of a bone, but also its shape, is related to its function. For this reason, the identification of bony landmarks is important during your study of the skeletal system.

Bones are also dynamic organs that can modify their strength and thickness in response to changes in muscle strength or body weight. Thus, muscle attachment sites on bones will thicken if you begin a workout program that increases muscle strength. Similarly, the walls of weight-bearing bones will thicken if you gain body weight or begin pounding the pavement as part of a new running regimen. In contrast, a reduction in muscle strength or body weight

will cause bones to become thinner. This may happen during a prolonged hospital stay, following limb immobilization in a cast, or going into the weightlessness of outer space. Even a change in diet, such as eating only soft food due to the loss of teeth, will result in a noticeable decrease in the size and thickness of the jaw bones.

7.1 Divisions of the Skeletal System

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss the functions of the skeletal system
- Distinguish between the axial skeleton and appendicular skeleton
- Define the axial skeleton and its components
- Define the appendicular skeleton and its components

The skeletal system includes all of the bones, cartilages, and ligaments of the body that support and give shape to the body and body structures. The **skeleton** consists of the bones of the body. For adults, there are 206 bones in the skeleton. Younger individuals have higher numbers of bones because some bones fuse together during childhood and adolescence to form an adult bone. The primary functions of the skeleton are to provide a rigid, internal structure that can support the weight of the body against the force of gravity, and to provide a structure upon which muscles can act to produce movements of the body. The lower portion of the skeleton is specialized for stability during walking or running. In contrast, the upper skeleton has greater mobility and ranges of motion, features that allow you to lift and carry objects or turn your head and trunk.

In addition to providing for support and movements of the body, the skeleton has protective and storage functions. It protects the internal organs, including the brain, spinal cord, heart, lungs, and pelvic organs. The bones of the skeleton serve as the primary storage site for important minerals such as calcium and phosphate. The bone marrow found within bones stores fat and houses the blood-cell producing tissue of the body.

The skeleton is subdivided into two major divisions—the axial and appendicular.

The Axial Skeleton

The skeleton is subdivided into two major divisions—the axial and appendicular. The **axial skeleton** forms the vertical, central axis of the body and includes all bones of the head, neck, chest, and back (Figure 7.2). It serves to protect the brain, spinal cord, heart, and lungs. It also serves as the attachment site for muscles that move the head, neck, and back, and for muscles that act across the shoulder and hip joints to move their corresponding limbs.

The axial skeleton of the adult consists of 80 bones, including the **skull**, the **vertebral column**, and the **thoracic cage**. The skull is formed by 22 bones. Also associated with the head are an additional seven bones, including the **hyoid bone** and the **ear ossicles** (three small bones found in each middle ear). The vertebral column consists of 24 bones, each called a **vertebra**, plus the **sacrum** and **coccyx**. The thoracic cage includes the 12 pairs of **ribs**, and the **sternum**, the flattened bone of the anterior chest.

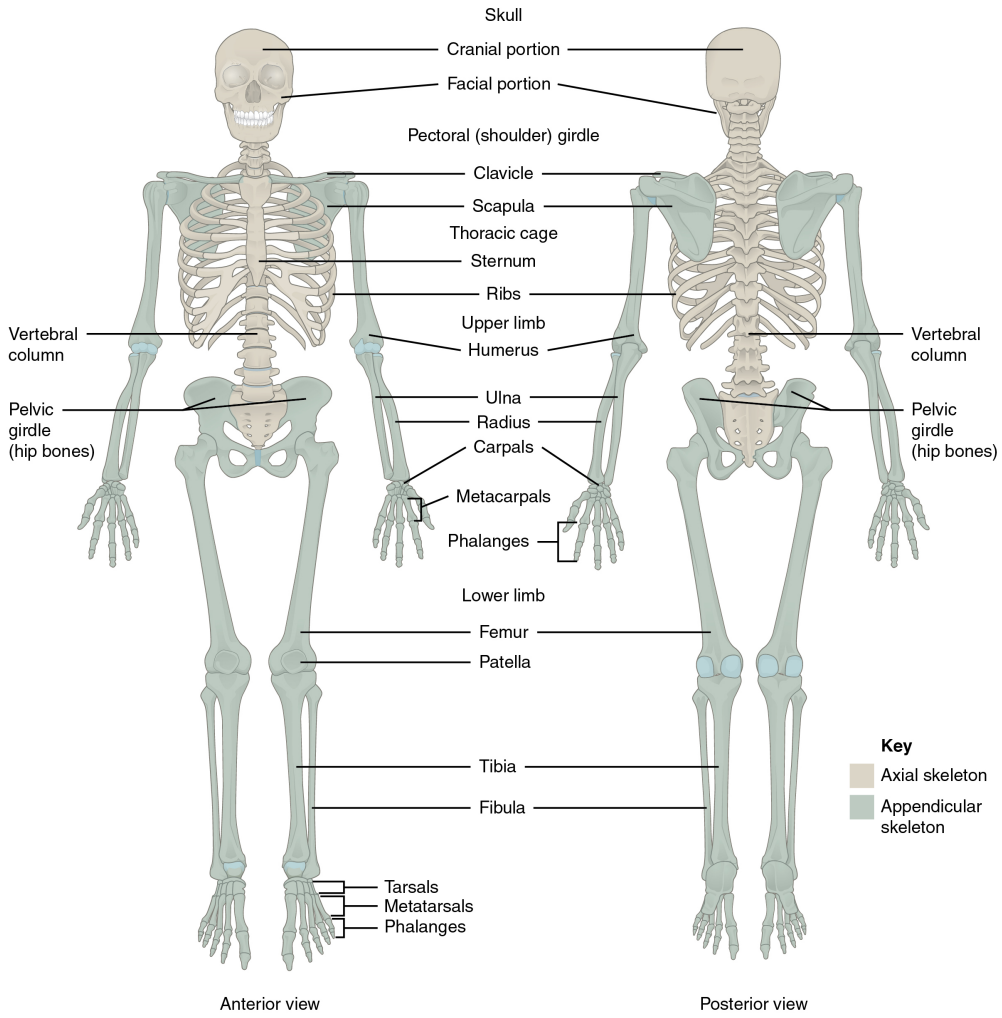


FIGURE 7.2 Axial and Appendicular Skeleton The axial skeleton supports the head, neck, back, and chest and thus forms the vertical axis of the body. It consists of the skull, vertebral column (including the sacrum and coccyx), and the thoracic cage, formed by the ribs and sternum. The appendicular skeleton is made up of all bones of the upper and lower limbs.

The Appendicular Skeleton

The **appendicular skeleton** includes all bones of the upper and lower limbs, plus the bones that attach each limb to the axial skeleton. There are 126 bones in the appendicular skeleton of an adult. The bones of the appendicular skeleton are covered in a separate chapter.

7.2 The Skull

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- List and identify the bones of the brain case and face
- Locate the major suture lines of the skull and name the bones associated with each
- Locate and define the boundaries of the anterior, middle, and posterior cranial fossae, the temporal fossa, and infratemporal fossa
- Define the paranasal sinuses and identify the location of each
- Name the bones that make up the walls of the orbit and identify the openings associated with the orbit
- Identify the bones and structures that form the nasal septum and nasal conchae, and locate the hyoid bone
- Identify the bony openings of the skull

The **cranium** (skull) is the skeletal structure of the head that supports the face and protects the brain. It is subdivided into the **facial bones** and the **brain case**, or cranial vault (Figure 7.3). The facial bones underlie the facial

structures, form the nasal cavity, enclose the eyeballs, and support the teeth of the upper and lower jaws. The rounded brain case surrounds and protects the brain and houses the middle and inner ear structures.

In the adult, the skull consists of 22 individual bones, 21 of which are immobile and united into a single unit. The 22nd bone is the **mandible** (lower jaw), which is the only moveable bone of the skull.

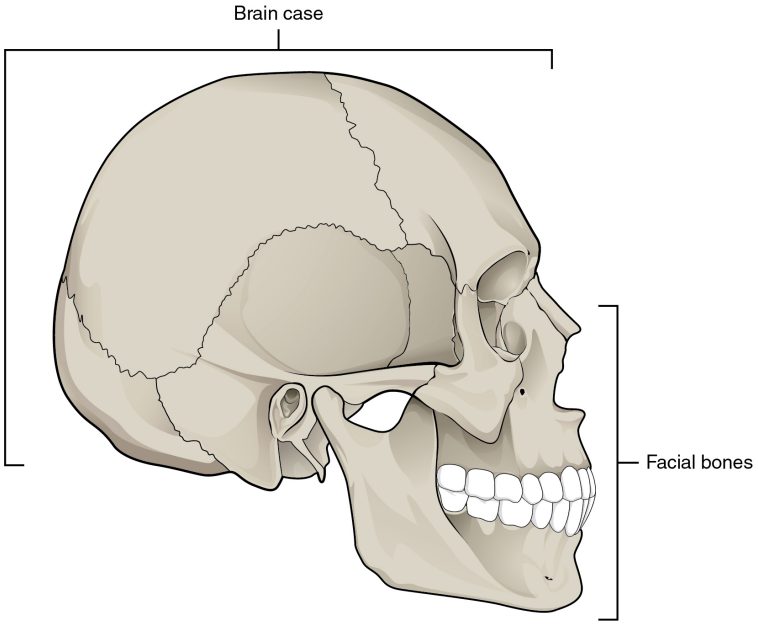


FIGURE 7.3 Parts of the Skull The skull consists of the rounded brain case that houses the brain and the facial bones that form the upper and lower jaws, nose, orbits, and other facial structures.

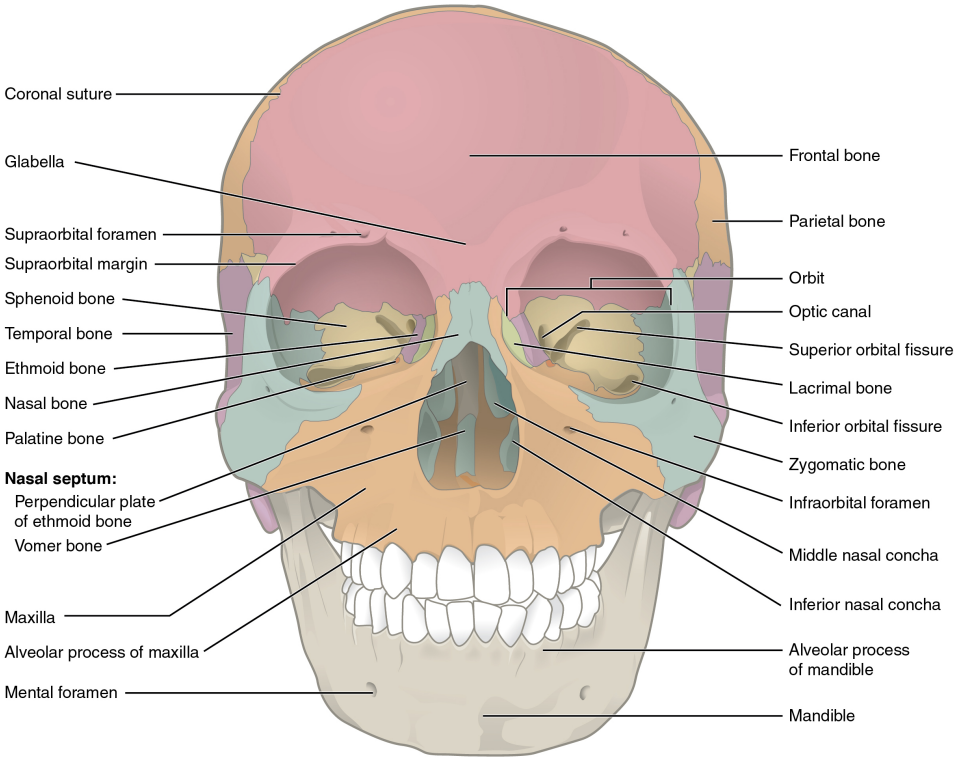
INTERACTIVE LINK

Watch this video (http://openstax.org/l/skull1) to view a rotating and exploded skull, with color-coded bones. Which bone (yellow) is centrally located and joins with most of the other bones of the skull?

Anterior View of Skull

The anterior skull consists of the facial bones and provides the bony support for the eyes and structures of the face. This view of the skull is dominated by the openings of the orbits and the nasal cavity. Also seen are the upper and lower jaws, with their respective teeth (Figure 7.4).

The **orbit** is the bony socket that houses the eyeball and muscles that move the eyeball or open the upper eyelid. The upper margin of the anterior orbit is the **supraorbital margin**. Located near the midpoint of the supraorbital margin is a small opening called the **supraorbital foramen**. This provides for passage of a sensory nerve to the skin of the forehead. Below the orbit is the **infraorbital foramen**, which is the point of emergence for a sensory nerve that supplies the anterior face below the orbit.



Anterior view

FIGURE 7.4 Anterior View of Skull An anterior view of the skull shows the bones that form the forehead, orbits (eye sockets), nasal cavity, nasal septum, and upper and lower jaws.

Inside the nasal area of the skull, the **nasal cavity** is divided into halves by the **nasal septum**. The upper portion of the nasal septum is formed by the **perpendicular plate of the ethmoid bone** and the lower portion is the **vomer bone**. Each side of the nasal cavity is triangular in shape, with a broad inferior space that narrows superiorly. When looking into the nasal cavity from the front of the skull, two bony plates are seen projecting from each lateral wall. The larger of these is the **inferior nasal concha**, an independent bone of the skull. Located just above the inferior concha is the **middle nasal concha**, which is part of the ethmoid bone. A third bony plate, also part of the ethmoid bone, is the **superior nasal concha**. It is much smaller and out of sight, above the middle concha. The superior nasal concha is located just lateral to the perpendicular plate, in the upper nasal cavity.

Lateral View of Skull

A view of the lateral skull is dominated by the large, rounded brain case above and the upper and lower jaws with their teeth below (Figure 7.5). Separating these areas is the bridge of bone called the zygomatic arch. The **zygomatic arch** is the bony arch on the side of skull that spans from the area of the cheek to just above the ear canal. It is formed by the junction of two bony processes: a short anterior component, the **temporal process of the zygomatic bone** (the cheekbone) and a longer posterior portion, the **zygomatic process of the temporal bone**, extending forward from the temporal bone. Thus the temporal process (anteriorly) and the zygomatic process (posteriorly) join together, like the two ends of a drawbridge, to form the zygomatic arch. One of the major muscles that pulls the mandible upward during biting and chewing arises from the zygomatic arch.

On the lateral side of the brain case, above the level of the zygomatic arch, is a shallow space called the **temporal fossa**. Below the level of the zygomatic arch and deep to the vertical portion of the mandible is another space called the **infratemporal fossa**. Both the temporal fossa and infratemporal fossa contain muscles that act on the mandible during chewing.

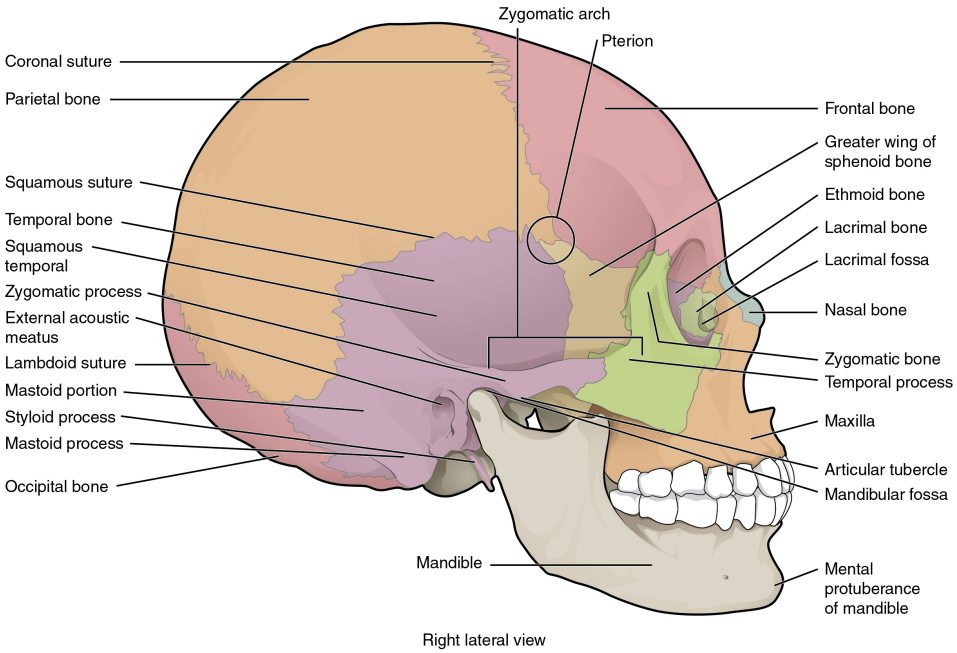


FIGURE 7.5 Lateral View of Skull The lateral skull shows the large rounded brain case, zygomatic arch, and the upper and lower jaws. The zygomatic arch is formed jointly by the zygomatic process of the temporal bone and the temporal process of the zygomatic bone. The shallow space above the zygomatic arch is the temporal fossa. The space inferior to the zygomatic arch and deep to the posterior mandible is the infratemporal fossa.

Bones of the Brain Case

The brain case contains and protects the brain. The interior space that is almost completely occupied by the brain is called the **cranial cavity**. This cavity is bounded superiorly by the rounded top of the skull, which is called the **calvaria** (skullcap), and the lateral and posterior sides of the skull. The bones that form the top and sides of the brain case are usually referred to as the "flat" bones of the skull.

The floor of the brain case is referred to as the base of the skull. This is a complex area that varies in depth and has numerous openings for the passage of cranial nerves, blood vessels, and the spinal cord. Inside the skull, the base is subdivided into three large spaces, called the **anterior cranial fossa**, **middle cranial fossa**, and **posterior cranial fossa** (fossa = "trench or ditch") (Figure 7.6). From anterior to posterior, the fossae increase in depth. The shape and depth of each fossa corresponds to the shape and size of the brain region that each houses. The boundaries and openings of the cranial fossae (singular = fossa) will be described in a later section.

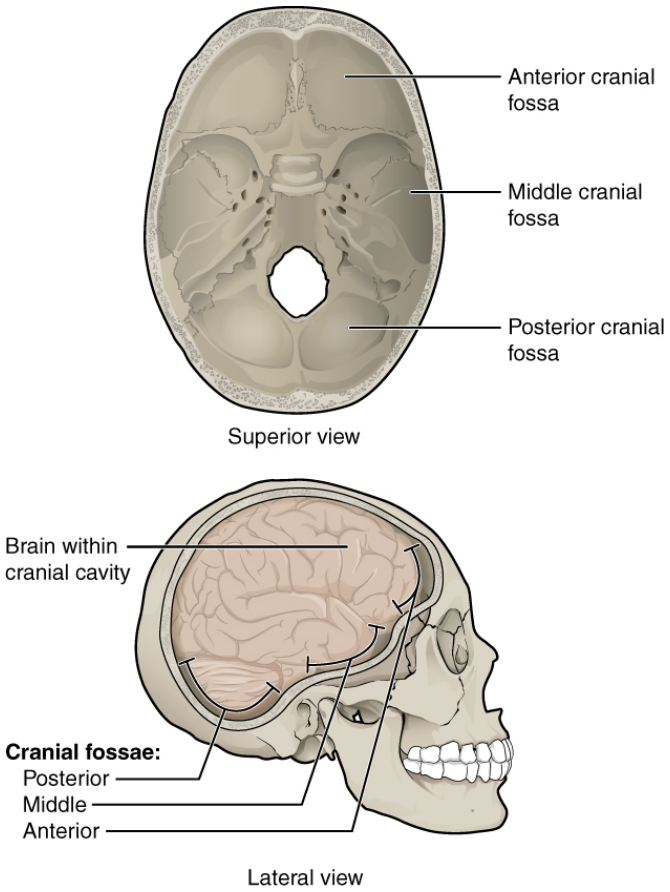


FIGURE 7.6 Cranial Fossae The bones of the brain case surround and protect the brain, which occupies the cranial cavity. The base of the brain case, which forms the floor of cranial cavity, is subdivided into the shallow anterior cranial fossa, the middle cranial fossa, and the deep posterior cranial fossa.

The brain case consists of eight bones. These include the paired parietal and temporal bones, plus the unpaired frontal, occipital, sphenoid, and ethmoid bones.

Parietal Bone

The **parietal bone** forms most of the upper lateral side of the skull (see Figure 7.5). These are paired bones, with the right and left parietal bones joining together at the top of the skull. Each parietal bone is also bounded anteriorly by the frontal bone, inferiorly by the temporal bone, and posteriorly by the occipital bone.

Temporal Bone

The **temporal bone** forms the lower lateral side of the skull (see Figure 7.5). Common wisdom has it that the temporal bone (temporal = “time”) is so named because this area of the head (the temple) is where hair typically first turns gray, indicating the passage of time.

The temporal bone is subdivided into several regions (Figure 7.7). The flattened, upper portion is the squamous portion of the temporal bone. Below this area and projecting anteriorly is the zygomatic process of the temporal bone, which forms the posterior portion of the zygomatic arch. Posteriorly is the mastoid portion of the temporal bone. Projecting inferiorly from this region is a large prominence, the **mastoid process**, which serves as a muscle attachment site. The mastoid process can easily be felt on the side of the head just behind your earlobe. On the interior of the skull, the petrous portion of each temporal bone forms the prominent, diagonally oriented **petrous ridge** in the floor of the cranial cavity. Located inside each petrous ridge are small cavities that house the structures of the middle and inner ears.

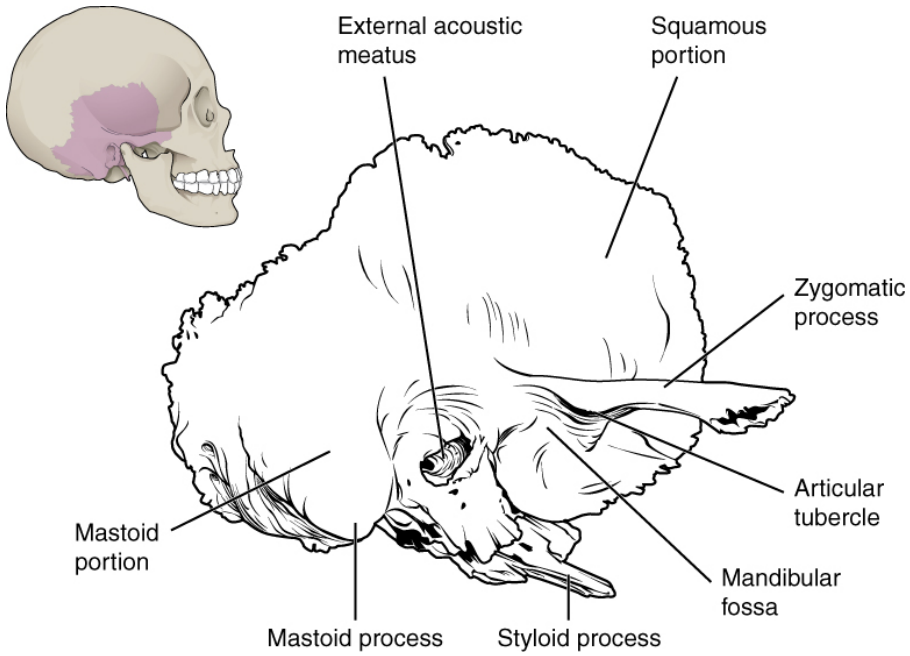


FIGURE 7.7 Temporal Bone A lateral view of the isolated temporal bone shows the squamous, mastoid, and zygomatic portions of the temporal bone.

Important landmarks of the temporal bone, as shown in Figure 7.8, include the following:

- **External acoustic meatus** (ear canal)—This is the large opening on the lateral side of the skull that is associated with the ear.
- **Internal acoustic meatus**—This opening is located inside the cranial cavity, on the medial side of the petrous ridge. It connects to the middle and inner ear cavities of the temporal bone.
- **Mandibular fossa**—This is the deep, oval-shaped depression located on the external base of the skull, just in front of the external acoustic meatus. The mandible (lower jaw) joins with the skull at this site as part of the temporomandibular joint, which allows for movements of the mandible during opening and closing of the mouth.
- **Articular tubercle**—The smooth ridge located immediately anterior to the mandibular fossa. Both the articular tubercle and mandibular fossa contribute to the temporomandibular joint, the joint that provides for movements between the temporal bone of the skull and the mandible.
- **Styloid process**—Posterior to the mandibular fossa on the external base of the skull is an elongated, downward bony projection called the styloid process, so named because of its resemblance to a stylus (a pen or writing tool). This structure serves as an attachment site for several small muscles and for a ligament that supports the hyoid bone of the neck. (See also Figure 7.7.)
- **Stylomastoid foramen**—This small opening is located between the styloid process and mastoid process. This is the point of exit for the cranial nerve that supplies the facial muscles.
- **Carotid canal**—The carotid canal is a zig-zag shaped tunnel that provides passage through the base of the skull for one of the major arteries that supplies the brain. Its entrance is located on the outside base of the skull, anteromedial to the styloid process. The canal then runs anteromedially within the bony base of the skull, and then turns upward to its exit in the floor of the middle cranial cavity, above the foramen lacerum.

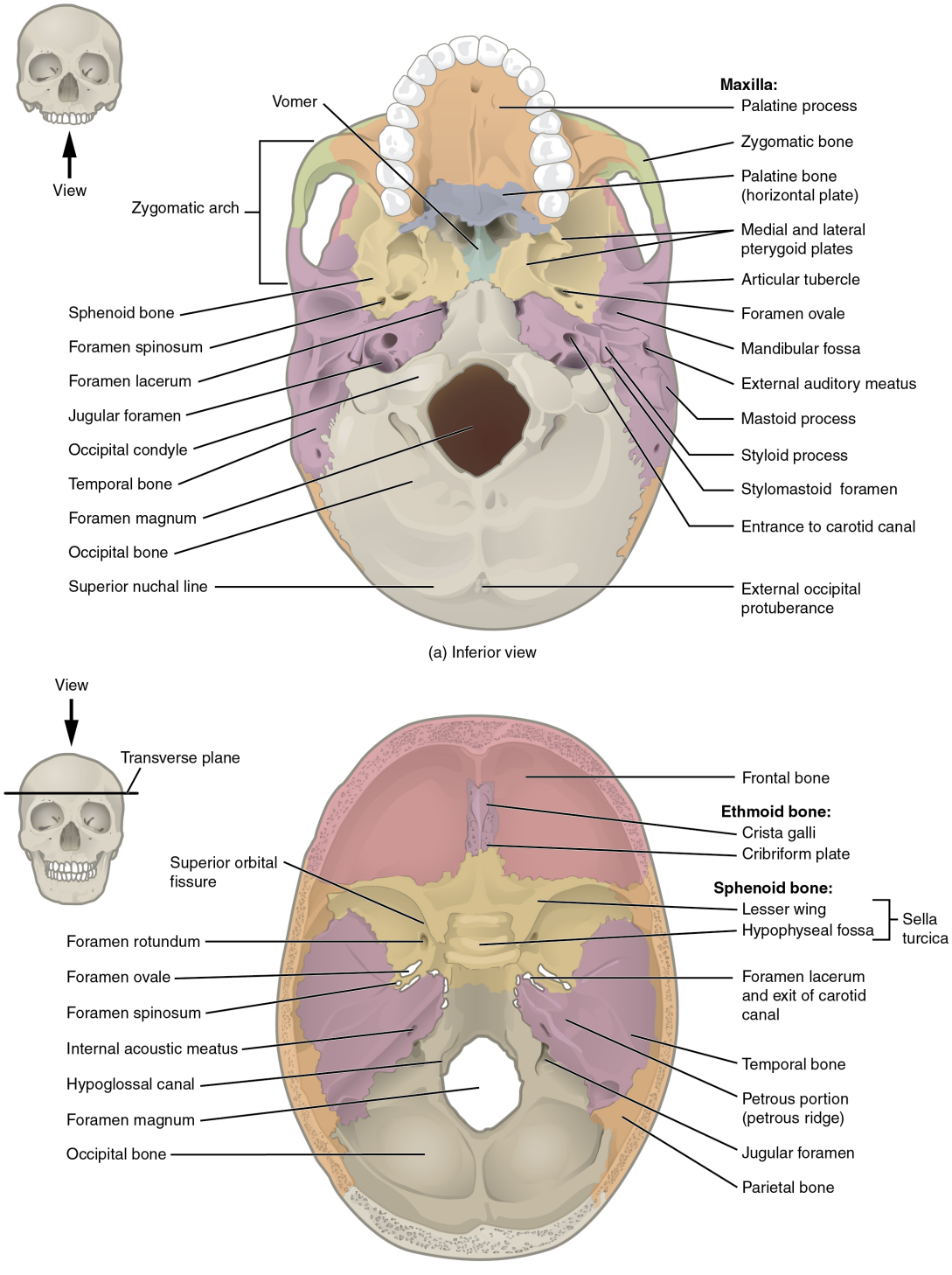


FIGURE 7.8 External and Internal Views of Base of Skull (a) The hard palate is formed anteriorly by the palatine processes of the maxilla bones and posteriorly by the horizontal plate of the palatine bones. (b) The complex floor of the cranial cavity is formed by the frontal, ethmoid, sphenoid, temporal, and occipital bones. The lesser wing of the sphenoid bone separates the anterior and middle cranial fossae. The petrous ridge (petrous portion of temporal bone) separates the middle and posterior cranial fossae.

Frontal Bone

The **frontal bone** is the single bone that forms the forehead. At its anterior midline, between the eyebrows, there is a slight depression called the **glabella** (see Figure 7.4). The frontal bone also forms the supraorbital margin of the orbit. Near the middle of this margin, is the supraorbital foramen, the opening that provides passage for a sensory nerve to the forehead. The frontal bone is thickened just above each supraorbital margin, forming rounded brow

ridges. These are located just behind your eyebrows and vary in size among individuals, although they are generally larger in males. Inside the cranial cavity, the frontal bone extends posteriorly. This flattened region forms both the roof of the orbit below and the floor of the anterior cranial cavity above (see Figure 7.8**b**).

Occipital Bone

The **occipital bone** is the single bone that forms the posterior skull and posterior base of the cranial cavity (Figure 7.9; see also Figure 7.8). On its outside surface, at the posterior midline, is a small protrusion called the **external occipital protuberance**, which serves as an attachment site for a ligament of the posterior neck. Lateral to either side of this bump is a **superior nuchal line** (nuchal = "nape" or "posterior neck"). The nuchal lines represent the most superior point at which muscles of the neck attach to the skull, with only the scalp covering the skull above these lines. On the base of the skull, the occipital bone contains the large opening of the **foramen magnum**, which allows for passage of the spinal cord as it exits the skull. On either side of the foramen magnum is an oval-shaped **occipital condyle**. These condyles form joints with the first cervical vertebra and thus support the skull on top of the vertebral column.

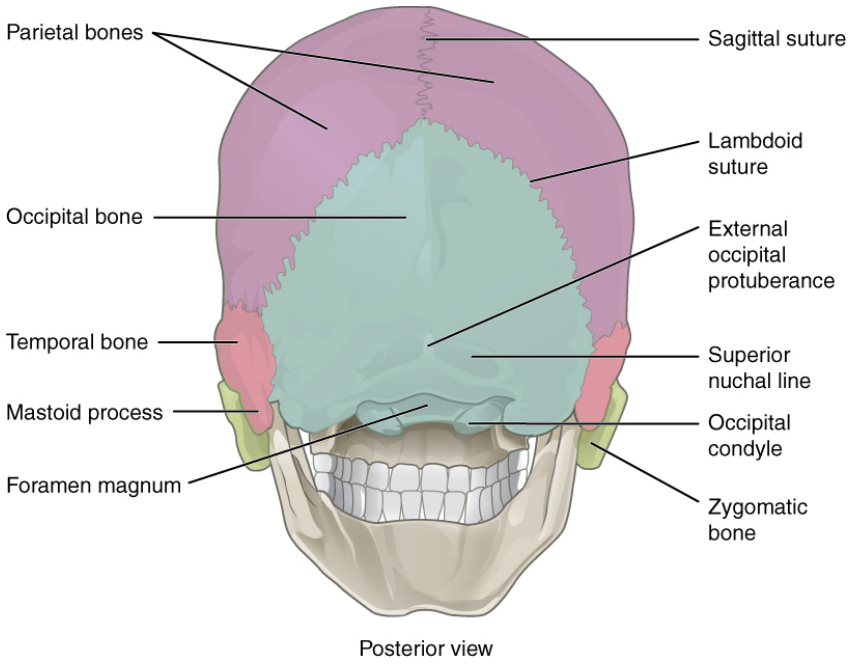
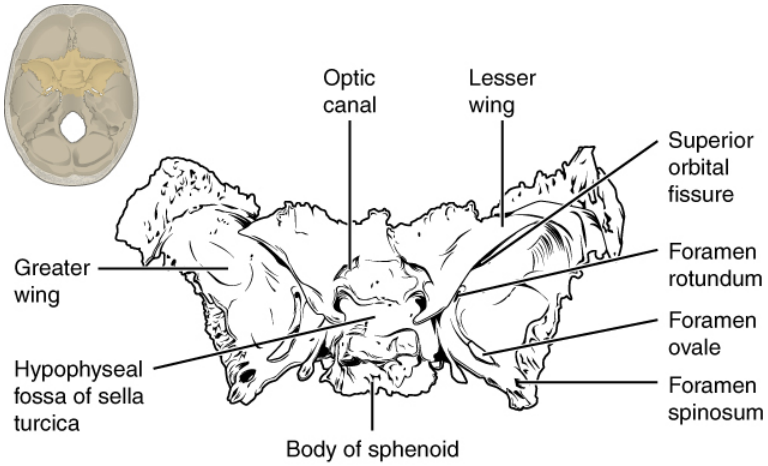


FIGURE 7.9 Posterior View of Skull This view of the posterior skull shows attachment sites for muscles and joints that support the skull.

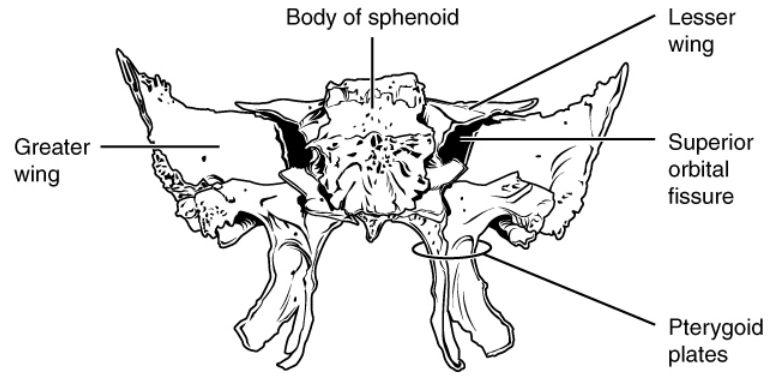
Sphenoid Bone

The **sphenoid bone** is a single, complex bone of the central skull (Figure 7.10). It serves as a "keystone" bone, because it joins with almost every other bone of the skull. The sphenoid forms much of the base of the central skull (see Figure 7.8) and also extends laterally to contribute to the sides of the skull (see Figure 7.5). Inside the cranial cavity, the right and left **lesser wings of the sphenoid bone**, which resemble the wings of a flying bird, form the lip of a prominent ridge that marks the boundary between the anterior and middle cranial fossae. The **sella turcica** ("Turkish saddle") is located at the midline of the middle cranial fossa. This bony region of the sphenoid bone is named for its resemblance to the horse saddles used by the Ottoman Turks, with a high back and a tall front. The rounded depression in the floor of the sella turcica is the **hypophyseal (pituitary) fossa**, which houses the pea-sized pituitary (hypophyseal) gland. The **greater wings of the sphenoid bone** extend laterally to either side away from the sella turcica, where they form the anterior floor of the middle cranial fossa. The greater wing is best seen on the outside of the lateral skull, where it forms a rectangular area immediately anterior to the squamous portion of the temporal bone.

On the inferior aspect of the skull, each half of the sphenoid bone forms two thin, vertically oriented bony plates. These are the **medial pterygoid plate** and **lateral pterygoid plate** (pterygoid = "wing-shaped"). The right and left medial pterygoid plates form the posterior, lateral walls of the nasal cavity. The somewhat larger lateral pterygoid plates serve as attachment sites for chewing muscles that fill the infratemporal space and act on the mandible.



(a) Superior view



(b) Posterior view

FIGURE 7.10 Sphenoid Bone Shown in isolation in (a) superior and (b) posterior views, the sphenoid bone is a single midline bone that forms the anterior walls and floor of the middle cranial fossa. It has a pair of lesser wings and a pair of greater wings. The sella turcica surrounds the hypophyseal fossa. Projecting downward are the medial and lateral pterygoid plates. The sphenoid has multiple openings for the passage of nerves and blood vessels, including the optic canal, superior orbital fissure, foramen rotundum, foramen ovale, and foramen spinosum.

Ethmoid Bone

The **ethmoid bone** is a single, midline bone that forms the roof and lateral walls of the upper nasal cavity, the upper portion of the nasal septum, and contributes to the medial wall of the orbit (Figure 7.11 and Figure 7.12). On the interior of the skull, the ethmoid also forms a portion of the floor of the anterior cranial cavity (see Figure 7.8**b**).

Within the nasal cavity, the perpendicular plate of the ethmoid bone forms the upper portion of the nasal septum. The ethmoid bone also forms the lateral walls of the upper nasal cavity. Extending from each lateral wall are the superior nasal concha and middle nasal concha, which are thin, curved projections that extend into the nasal cavity (Figure 7.13).

In the cranial cavity, the ethmoid bone forms a small area at the midline in the floor of the anterior cranial fossa. This region also forms the narrow roof of the underlying nasal cavity. This portion of the ethmoid bone consists of two parts, the crista galli and cribriform plates. The **crista galli** (“rooster’s comb or crest”) is a small upward bony projection located at the midline. It functions as an anterior attachment point for one of the covering layers of the brain. To either side of the crista galli is the **cribriform plate** (cribrum = “sieve”), a small, flattened area with numerous small openings termed olfactory foramina. Small nerve branches from the olfactory areas of the nasal cavity pass through these openings to enter the brain.

The lateral portions of the ethmoid bone are located between the orbit and upper nasal cavity, and thus form the lateral nasal cavity wall and a portion of the medial orbit wall. Located inside this portion of the ethmoid bone are several small, air-filled spaces that are part of the paranasal sinus system of the skull.

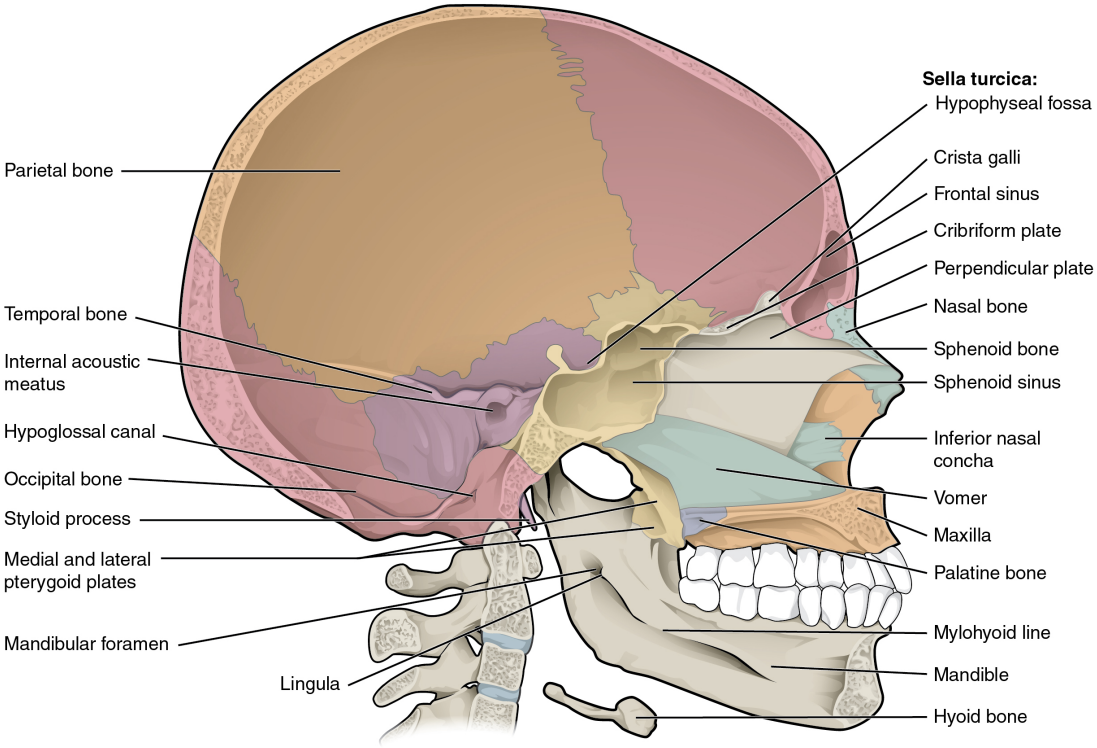


FIGURE 7.11 Sagittal Section of Skull This midline view of the sagittally sectioned skull shows the nasal septum.

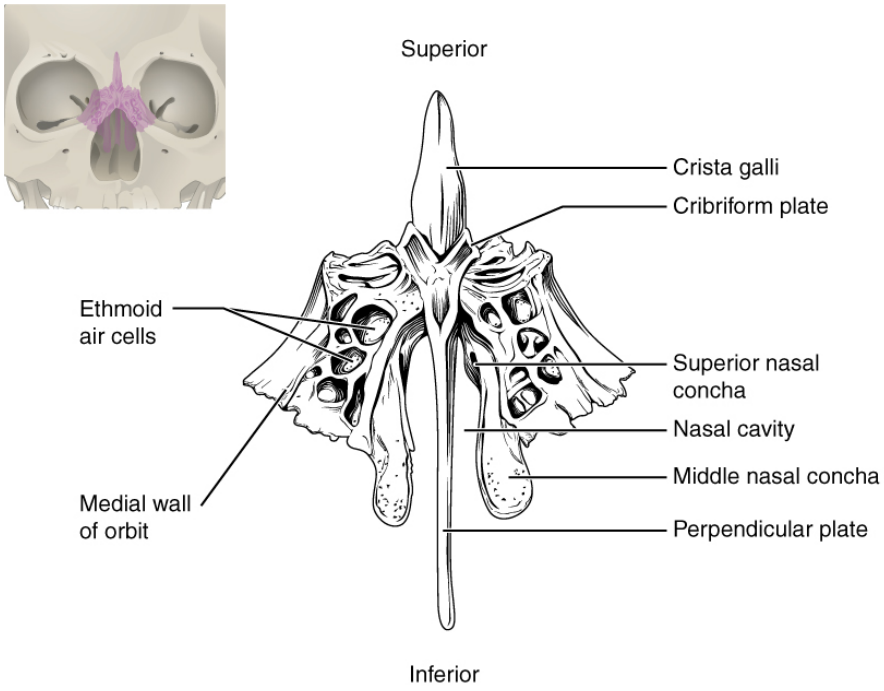


FIGURE 7.12 Ethmoid Bone The unpaired ethmoid bone is located at the midline within the central skull. It has an upward projection, the crista galli, and a downward projection, the perpendicular plate, which forms the upper nasal septum. The cribriform plates form both the roof of the nasal cavity and a portion of the anterior cranial fossa floor. The lateral sides of the ethmoid bone form the lateral walls of the upper nasal cavity, part of the medial orbit wall, and give rise to the superior and middle nasal conchae. The ethmoid bone also contains the ethmoid air cells.

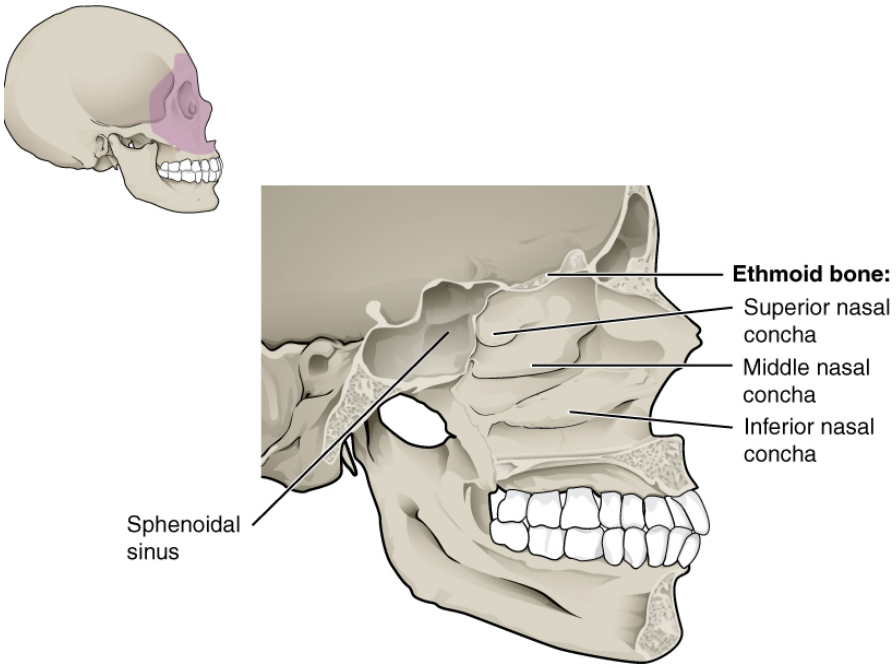


FIGURE 7.13 Lateral Wall of Nasal Cavity The three nasal conchae are curved bones that project from the lateral walls of the nasal cavity. The superior nasal concha and middle nasal concha are parts of the ethmoid bone. The inferior nasal concha is an independent bone of the skull.

Sutures of the Skull

A **suture** is an immobile joint between adjacent bones of the skull. The narrow gap between the bones is filled with dense, fibrous connective tissue that unites the bones. The long sutures located between the bones of the brain case are not straight, but instead follow irregular, tightly twisting paths. These twisting lines serve to tightly interlock the adjacent bones, thus adding strength to the skull for brain protection.

The two suture lines seen on the top of the skull are the coronal and sagittal sutures. The **coronal suture** runs from side to side across the skull, within the coronal plane of section (see Figure 7.5). It joins the frontal bone to the right and left parietal bones. The **sagittal suture** extends posteriorly from the coronal suture, running along the midline at the top of the skull in the sagittal plane of section (see Figure 7.9). It unites the right and left parietal bones. On the posterior skull, the sagittal suture terminates by joining the lambdoid suture. The **lambdoid suture** extends downward and laterally to either side away from its junction with the sagittal suture. The lambdoid suture joins the occipital bone to the right and left parietal and temporal bones. This suture is named for its upside-down "V" shape, which resembles the capital letter version of the Greek letter lambda (Λ). The **squamous suture** is located on the lateral skull. It unites the squamous portion of the temporal bone with the parietal bone (see Figure 7.5). At the intersection of four bones is the **pterion**, a small, capital-H-shaped suture line region that unites the frontal bone, parietal bone, squamous portion of the temporal bone, and greater wing of the sphenoid bone. It is the weakest part of the skull. The pterion is located approximately two finger widths above the zygomatic arch and a thumb's width posterior to the upward portion of the zygomatic bone.

DISORDERS OF THE...

Skeletal System

Head and traumatic brain injuries are major causes of immediate death and disability, with bleeding and infections as possible additional complications. According to the Centers for Disease Control and Prevention (2010), approximately 30 percent of all injury-related deaths in the United States are caused by head injuries. The majority of head injuries involve falls. They are most common among young children (ages 0–4 years), adolescents (15–19 years), and the elderly (over 65 years). Additional causes vary, but prominent among these are automobile and motorcycle accidents.

Strong blows to the brain-case portion of the skull can produce fractures. These may result in bleeding inside the skull with subsequent injury to the brain. The most common is a linear skull fracture, in which fracture lines radiate from the point of impact. Other fracture types include a comminuted fracture, in which the bone is broken into several pieces at the point of impact, or a depressed fracture, in which the fractured bone is pushed inward. In a contrecoup (counterblow) fracture, the bone at the point of impact is not broken, but instead a fracture occurs on the opposite side of the skull. Fractures of the occipital bone at the base of the skull can occur in this manner, producing a basilar fracture that can damage the artery that passes through the carotid canal.

A blow to the lateral side of the head may fracture the bones of the pterion. The pterion is an important clinical landmark because located immediately deep to it on the inside of the skull is a major branch of an artery that supplies the skull and covering layers of the brain. A strong blow to this region can fracture the bones around the pterion. If the underlying artery is damaged, bleeding can cause the formation of a hematoma (collection of blood) between the brain and interior of the skull. As blood accumulates, it will put pressure on the brain. Symptoms associated with a hematoma may not be apparent immediately following the injury, but if untreated, blood accumulation will exert increasing pressure on the brain and can result in death within a few hours.

INTERACTIVE LINK

View this animation (http://openstax.org/l/headblow) to see how a blow to the head may produce a contrecoup (counterblow) fracture of the basilar portion of the occipital bone on the base of the skull. Why may a basilar fracture be life threatening?

Facial Bones of the Skull

The facial bones of the skull form the upper and lower jaws, the nose, nasal cavity and nasal septum, and the orbit. The facial bones include 14 bones, with six paired bones and two unpaired bones. The paired bones are the maxilla, palatine, zygomatic, nasal, lacrimal, and inferior nasal conchae bones. The unpaired bones are the vomer and mandible bones. Although classified with the brain-case bones, the ethmoid bone also contributes to the nasal septum and the walls of the nasal cavity and orbit.

Maxillary Bone

The **maxillary bone**, often referred to simply as the maxilla (plural = maxillae), is one of a pair that together form the upper jaw, much of the hard palate, the medial floor of the orbit, and the lateral base of the nose (see Figure 7.4). The curved, inferior margin of the maxillary bone that forms the upper jaw and contains the upper teeth is the **alveolar process of the maxilla** (Figure 7.14). Each tooth is anchored into a deep socket called an alveolus. On the anterior maxilla, just below the orbit, is the infraorbital foramen. This is the point of exit for a sensory nerve that supplies the nose, upper lip, and anterior cheek. On the inferior skull, the **palatine process** from each maxillary bone can be seen joining together at the midline to form the anterior three-quarters of the hard palate (see Figure 7.8**a**). The **hard palate** is the bony plate that forms the roof of the mouth and floor of the nasal cavity, separating the oral and nasal cavities.

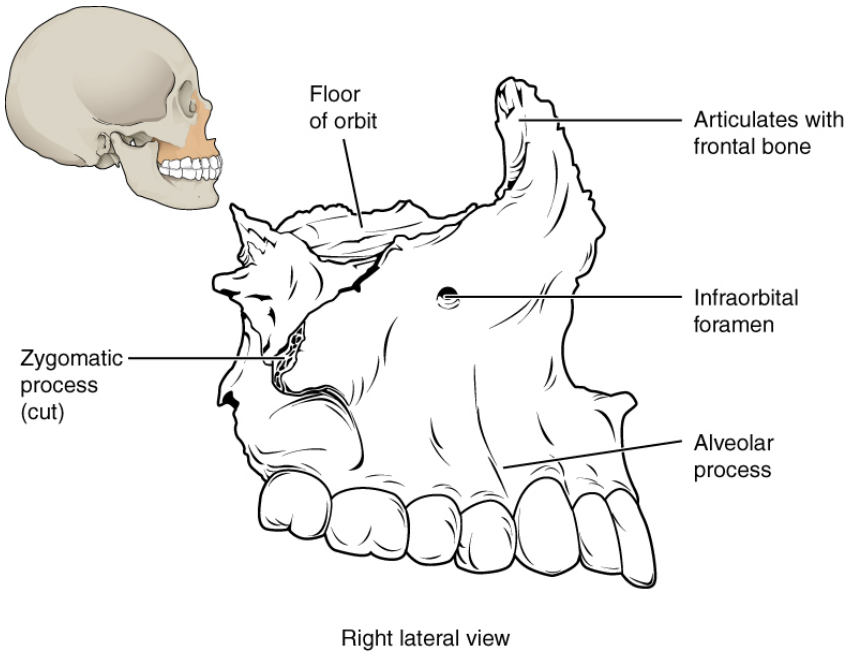


FIGURE 7.14 Maxillary Bone The maxillary bone forms the upper jaw and supports the upper teeth. Each maxilla also forms the lateral floor of each orbit and the majority of the hard palate.

Palatine Bone

The **palatine bone** is one of a pair of irregularly shaped bones that contribute small areas to the lateral walls of the nasal cavity and the medial wall of each orbit. The largest region of each of the palatine bone is the **horizontal plate**. The plates from the right and left palatine bones join together at the midline to form the posterior quarter of the hard palate (see Figure 7.8**a**). Thus, the palatine bones are best seen in an inferior view of the skull and hard palate.

HOMEOSTATIC IMBALANCES

Cleft Lip and Cleft Palate

During embryonic development, the right and left maxilla bones come together at the midline to form the upper jaw. At the same time, the muscle and skin overlying these bones join together to form the upper lip. Inside the mouth, the palatine processes of the maxilla bones, along with the horizontal plates of the right and left palatine bones, join together to form the hard palate. If an error occurs in these developmental processes, a birth defect of cleft lip or cleft palate may result.

Cleft lip is a common development defect that affects approximately 1:1000 births, most of which are male. This defect involves a partial or complete failure of the right and left portions of the upper lip to fuse together, leaving a cleft (gap).

A more severe developmental defect is cleft palate, which affects the hard palate. The hard palate is the bony structure that separates the nasal cavity from the oral cavity. It is formed during embryonic development by the midline fusion of the horizontal plates from the right and left palatine bones and the palatine processes of the maxilla bones. Cleft palate affects approximately 1:2500 births and is more common in females. It results from a failure of the two halves of the hard palate to completely come together and fuse at the midline, thus leaving a gap between them. This gap allows for communication between the nasal and oral cavities. In severe cases, the bony gap continues into the anterior upper jaw where the alveolar processes of the maxilla bones also do not properly join together above the front teeth. If this occurs, a cleft lip will also be seen. Because of the communication between the oral and nasal cavities, a cleft palate makes it very difficult for an infant to generate the suckling needed for nursing, thus leaving the infant at risk for malnutrition. Surgical repair is required to correct cleft palate defects.

Zygomatic Bone

The **zygomatic bone** is also known as the cheekbone. Each of the paired zygomatic bones forms much of the lateral wall of the orbit and the lateral-inferior margins of the anterior orbital opening (see Figure 7.4). The short temporal process of the zygomatic bone projects posteriorly, where it forms the anterior portion of the zygomatic arch (see Figure 7.5).

Nasal Bone

The **nasal bone** is one of two small bones that articulate (join) with each other to form the bony base (bridge) of the nose. They also support the cartilages that form the lateral walls of the nose (see Figure 7.11). These are the bones that are damaged when the nose is broken.

Lacrimal Bone

Each **lacrimal bone** is a small, rectangular bone that forms the anterior, medial wall of the orbit (see Figure 7.4 and Figure 7.5). The anterior portion of the lacrimal bone forms a shallow depression called the **lacrimal fossa**, and extending inferiorly from this is the **nasolacrimal canal**. The lacrimal fluid (tears of the eye), which serves to maintain the moist surface of the eye, drains at the medial corner of the eye into the nasolacrimal canal. This duct then extends downward to open into the nasal cavity, behind the inferior nasal concha. In the nasal cavity, the lacrimal fluid normally drains posteriorly, but with an increased flow of tears due to crying or eye irritation, some fluid will also drain anteriorly, thus causing a runny nose.

Inferior Nasal Conchae

The right and left inferior nasal conchae form a curved bony plate that projects into the nasal cavity space from the lower lateral wall (see Figure 7.13). The inferior concha is the largest of the nasal conchae and can easily be seen when looking into the anterior opening of the nasal cavity.

Vomer Bone

The unpaired vomer bone, often referred to simply as the vomer, is triangular-shaped and forms the posterior-inferior part of the nasal septum (see Figure 7.11). The vomer is best seen when looking from behind into the posterior openings of the nasal cavity (see Figure 7.8**a**). In this view, the vomer is seen to form the entire height of the nasal septum. A much smaller portion of the vomer can also be seen when looking into the anterior opening of the nasal cavity.

Mandible

The **mandible** forms the lower jaw and is the only moveable bone of the skull. At the time of birth, the mandible consists of paired right and left bones, but these fuse together during the first year to form the single U-shaped mandible of the adult skull. Each side of the mandible consists of a horizontal body and posteriorly, a vertically oriented **ramus of the mandible** (ramus = “branch”). The outside margin of the mandible, where the body and ramus come together is called the **angle of the mandible** (Figure 7.15).

The ramus on each side of the mandible has two upward-going bony projections. The more anterior projection is the flattened **coronoid process of the mandible**, which provides attachment for one of the biting muscles. The posterior projection is the **condylar process of the mandible**, which is topped by the oval-shaped **condyle**. The condyle of the mandible articulates (joins) with the mandibular fossa and articular tubercle of the temporal bone. Together these articulations form the temporomandibular joint, which allows for opening and closing of the mouth (see Figure 7.5). The broad U-shaped curve located between the coronoid and condylar processes is the **mandibular notch**.

Important landmarks for the mandible include the following:

- **Alveolar process of the mandible**—This is the upper border of the mandibular body and serves to anchor the lower teeth.
- **Mental protuberance**—The forward projection from the inferior margin of the anterior mandible that forms the chin (mental = “chin”).
- **Mental foramen**—The opening located on each side of the anterior-lateral mandible, which is the exit site for a sensory nerve that supplies the chin.
- **Mylohyoid line**—This bony ridge extends along the inner aspect of the mandibular body (see Figure 7.11). The muscle that forms the floor of the oral cavity attaches to the mylohyoid lines on both sides of the mandible.
- **Mandibular foramen**—This opening is located on the medial side of the ramus of the mandible. The opening

leads into a tunnel that runs down the length of the mandibular body. The sensory nerve and blood vessels that supply the lower teeth enter the mandibular foramen and then follow this tunnel. Thus, to numb the lower teeth prior to dental work, the dentist must inject anesthesia into the lateral wall of the oral cavity at a point prior to where this sensory nerve enters the mandibular foramen.

- **Lingula**—This small flap of bone is named for its shape (lingula = "little tongue"). It is located immediately next to the mandibular foramen, on the medial side of the ramus. A ligament that anchors the mandible during opening and closing of the mouth extends down from the base of the skull and attaches to the lingula.

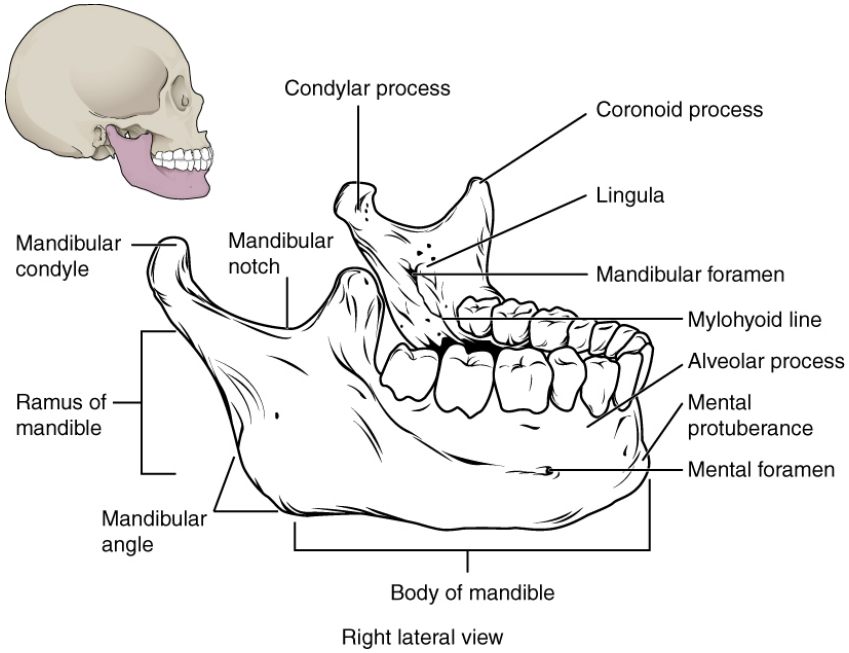


FIGURE 7.15 Isolated Mandible The mandible is the only moveable bone of the skull.

The Orbit

The orbit is the bony socket that houses the eyeball and contains the muscles that move the eyeball or open the upper eyelid. Each orbit is cone-shaped, with a narrow posterior region that widens toward the large anterior opening. To help protect the eye, the bony margins of the anterior opening are thickened and somewhat constricted. The medial walls of the two orbits are parallel to each other but each lateral wall diverges away from the midline at a 45° angle. This divergence provides greater lateral peripheral vision.

The walls of each orbit include contributions from seven skull bones (Figure 7.16). The frontal bone forms the roof and the zygomatic bone forms the lateral wall and lateral floor. The medial floor is primarily formed by the maxilla, with a small contribution from the palatine bone. The ethmoid bone and lacrimal bone make up much of the medial wall and the sphenoid bone forms the posterior orbit.

At the posterior apex of the orbit is the opening of the **optic canal**, which allows for passage of the optic nerve from the retina to the brain. Lateral to this is the elongated and irregularly shaped superior orbital fissure, which provides passage for the artery that supplies the eyeball, sensory nerves, and the nerves that supply the muscles involved in eye movements.

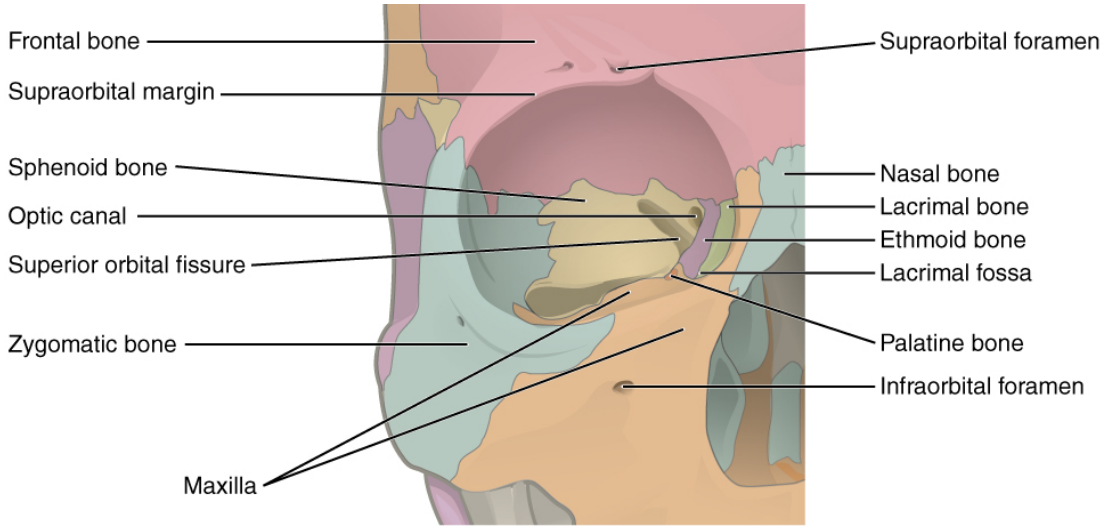


FIGURE 7.16 Bones of the Orbit Seven skull bones contribute to the walls of the orbit. Opening into the posterior orbit from the cranial cavity are the optic canal and superior orbital fissure.

The Nasal Septum and Nasal Conchae

The **nasal septum** consists of both bone and cartilage components (Figure 7.17; see also Figure 7.11). The upper portion of the septum is formed by the perpendicular plate of the ethmoid bone. The lower and posterior parts of the septum are formed by the triangular-shaped vomer bone. In an anterior view of the skull, the perpendicular plate of the ethmoid bone is easily seen inside the nasal opening as the upper nasal septum, but only a small portion of the vomer is seen as the inferior septum. A better view of the vomer bone is seen when looking into the posterior nasal cavity with an inferior view of the skull, where the vomer forms the full height of the nasal septum. The anterior nasal septum is formed by the **septal cartilage**, a flexible plate that fills in the gap between the perpendicular plate of the ethmoid and vomer bones. This cartilage also extends outward into the nose where it separates the right and left nostrils. The septal cartilage is not found in the dry skull.

Attached to the lateral wall on each side of the nasal cavity are the superior, middle, and inferior **nasal conchae** (singular = concha), which are named for their positions (see Figure 7.13). These are bony plates that curve downward as they project into the space of the nasal cavity. They serve to swirl the incoming air, which helps to warm and moisturize it before the air moves into the delicate air sacs of the lungs. This also allows mucus, secreted by the tissue lining the nasal cavity, to trap incoming dust, pollen, bacteria, and viruses. The largest of the conchae is the inferior nasal concha, which is an independent bone of the skull. The middle concha and the superior conchae, which is the smallest, are both formed by the ethmoid bone. When looking into the anterior nasal opening of the skull, only the inferior and middle conchae can be seen. The small superior nasal concha is well hidden above and behind the middle concha.

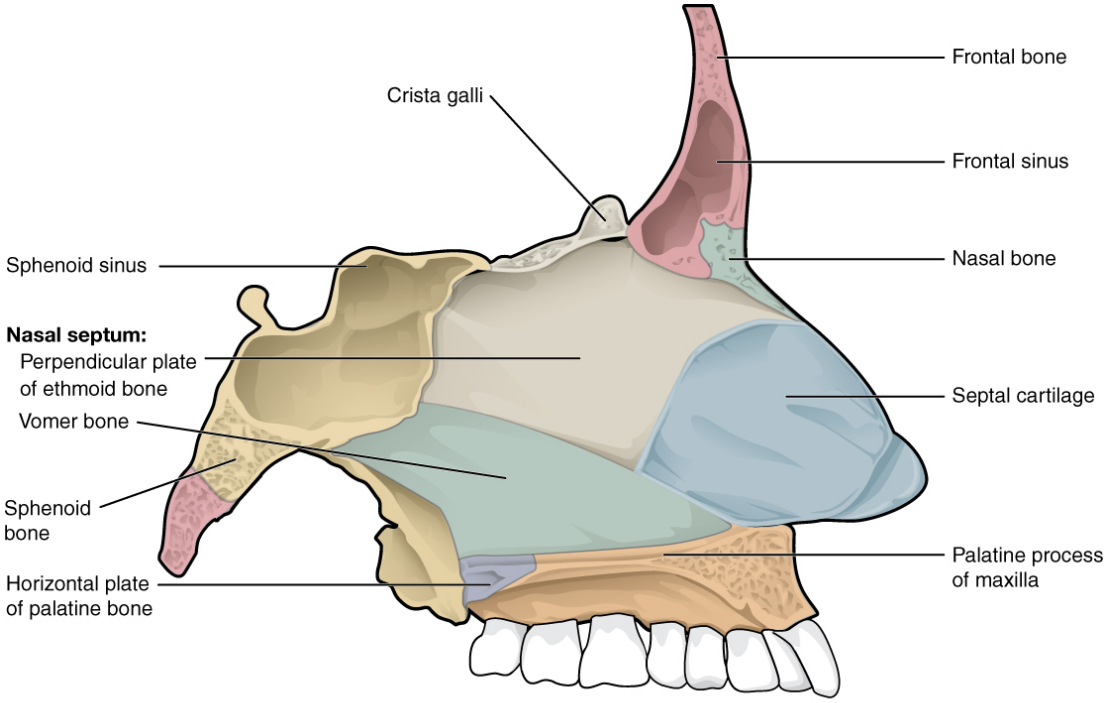


FIGURE 7.17 Nasal Septum The nasal septum is formed by the perpendicular plate of the ethmoid bone and the vomer bone. The septal cartilage fills the gap between these bones and extends into the nose.

Cranial Fossae

Inside the skull, the floor of the cranial cavity is subdivided into three cranial fossae (spaces), which increase in depth from anterior to posterior (see Figure 7.6, Figure 7.8**b**, and Figure 7.11). Since the brain occupies these areas, the shape of each conforms to the shape of the brain regions that it contains. Each cranial fossa has anterior and posterior boundaries and is divided at the midline into right and left areas by a significant bony structure or opening.

Anterior Cranial Fossa

The anterior cranial fossa is the most anterior and the shallowest of the three cranial fossae. It overlies the orbits and contains the frontal lobes of the brain. Anteriorly, the anterior fossa is bounded by the frontal bone, which also forms the majority of the floor for this space. The lesser wings of the sphenoid bone form the prominent ledge that marks the boundary between the anterior and middle cranial fossae. Located in the floor of the anterior cranial fossa at the midline is a portion of the ethmoid bone, consisting of the upward projecting crista galli and to either side of this, the cribriform plates.

Middle Cranial Fossa

The middle cranial fossa is deeper and situated posterior to the anterior fossa. It extends from the lesser wings of the sphenoid bone anteriorly, to the petrous ridges (petrous portion of the temporal bones) posteriorly. The large, diagonally positioned petrous ridges give the middle cranial fossa a butterfly shape, making it narrow at the midline and broad laterally. The temporal lobes of the brain occupy this fossa. The middle cranial fossa is divided at the midline by the upward bony prominence of the sella turcica, a part of the sphenoid bone. The middle cranial fossa has several openings for the passage of blood vessels and cranial nerves (see Figure 7.8).

Openings in the middle cranial fossa are as follows:

- **Optic canal**—This opening is located at the anterior lateral corner of the sella turcica. It provides for passage of the optic nerve into the orbit.
- **Superior orbital fissure**—This large, irregular opening into the posterior orbit is located on the anterior wall of the middle cranial fossa, lateral to the optic canal and under the projecting margin of the lesser wing of the sphenoid bone. Nerves to the eyeball and associated muscles, and sensory nerves to the forehead pass through this opening.

- **Foramen rotundum**—This rounded opening (rotundum = "round") is located in the floor of the middle cranial fossa, just inferior to the superior orbital fissure. It is the exit point for a major sensory nerve that supplies the cheek, nose, and upper teeth.
- **Foramen ovale of the middle cranial fossa**—This large, oval-shaped opening in the floor of the middle cranial fossa provides passage for a major sensory nerve to the lateral head, cheek, chin, and lower teeth.
- **Foramen spinosum**—This small opening, located posterior-lateral to the foramen ovale, is the entry point for an important artery that supplies the covering layers surrounding the brain. The branching pattern of this artery forms readily visible grooves on the internal surface of the skull and these grooves can be traced back to their origin at the foramen spinosum.
- **Carotid canal**—This is the zig-zag passageway through which a major artery to the brain enters the skull. The entrance to the carotid canal is located on the inferior aspect of the skull, anteromedial to the styloid process (see Figure 7.8**a**). From here, the canal runs anteromedially within the bony base of the skull. Just above the foramen lacerum, the carotid canal opens into the middle cranial cavity, near the posterior-lateral base of the sella turcica.
- **Foramen lacerum**—This irregular opening is located in the base of the skull, immediately inferior to the exit of the carotid canal. This opening is an artifact of the dry skull, because in life it is completely filled with cartilage. All the openings of the skull that provide for passage of nerves or blood vessels have smooth margins; the word lacerum ("ragged" or "torn") tells us that this opening has ragged edges and thus nothing passes through it.

Posterior Cranial Fossa

The posterior cranial fossa is the most posterior and deepest portion of the cranial cavity. It contains the cerebellum of the brain. The posterior fossa is bounded anteriorly by the petrous ridges, while the occipital bone forms the floor and posterior wall. It is divided at the midline by the large foramen magnum ("great aperture"), the opening that provides for passage of the spinal cord.

Located on the medial wall of the petrous ridge in the posterior cranial fossa is the internal acoustic meatus (see Figure 7.11). This opening provides for passage of the nerve from the hearing and equilibrium organs of the inner ear, and the nerve that supplies the muscles of the face. Located at the anterior-lateral margin of the foramen magnum is the **hypoglossal canal**. These emerge on the inferior aspect of the skull at the base of the occipital condyle and provide passage for an important nerve to the tongue.

Immediately inferior to the internal acoustic meatus is the large, irregularly shaped **jugular foramen** (see Figure 7.8**a**). Several cranial nerves from the brain exit the skull via this opening. It is also the exit point through the base of the skull for all the venous return blood leaving the brain. The venous structures that carry blood inside the skull form large, curved grooves on the inner walls of the posterior cranial fossa, which terminate at each jugular foramen.

Paranasal Sinuses

The **paranasal sinuses** are hollow, air-filled spaces located within certain bones of the skull (Figure 7.18). All of the sinuses communicate with the nasal cavity (paranasal = "next to nasal cavity") and are lined with nasal mucosa. They serve to reduce bone mass and thus lighten the skull, and they also add resonance to the voice. This second feature is most obvious when you have a cold or sinus congestion. These produce swelling of the mucosa and excess mucus production, which can obstruct the narrow passageways between the sinuses and the nasal cavity, causing your voice to sound different to yourself and others. This blockage can also allow the sinuses to fill with fluid, with the resulting pressure producing pain and discomfort.

The paranasal sinuses are named for the skull bone that each occupies. The **frontal sinus** is located just above the eyebrows, within the frontal bone (see Figure 7.17). This irregular space may be divided at the midline into bilateral spaces, or these may be fused into a single sinus space. The frontal sinus is the most anterior of the paranasal sinuses. The largest sinus is the **maxillary sinus**. These are paired and located within the right and left maxillary bones, where they occupy the area just below the orbits. The maxillary sinuses are most commonly involved during sinus infections. Because their connection to the nasal cavity is located high on their medial wall, they are difficult to drain. The **sphenoid sinus** is a single, midline sinus. It is located within the body of the sphenoid bone, just anterior and inferior to the sella turcica, thus making it the most posterior of the paranasal sinuses. The lateral aspects of the ethmoid bone contain multiple small spaces separated by very thin bony walls. Each of these spaces is called an

ethmoid air cell. These are located on both sides of the ethmoid bone, between the upper nasal cavity and medial orbit, just behind the superior nasal conchae.

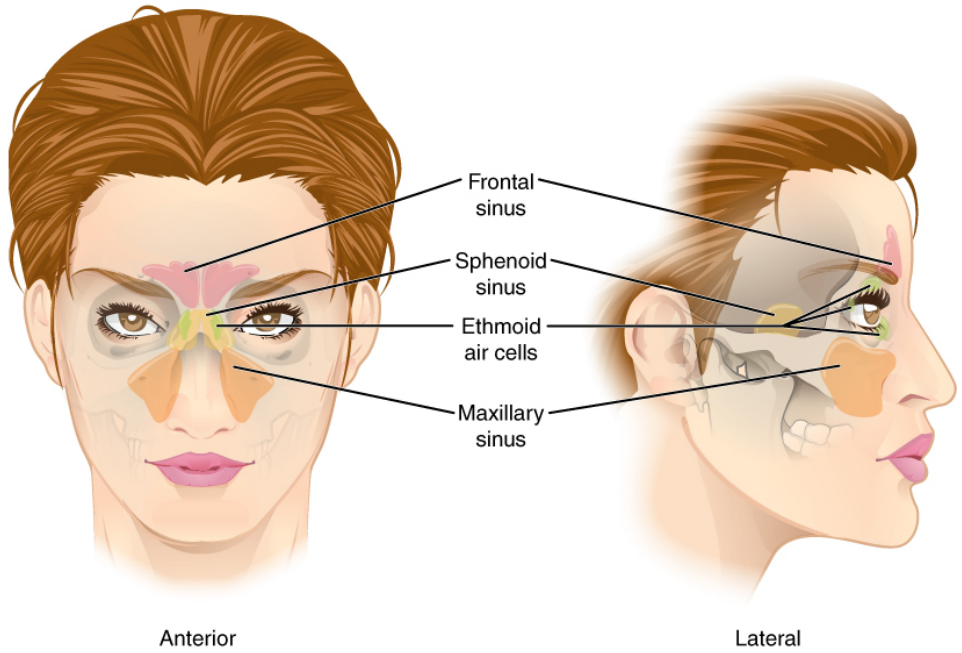


FIGURE 7.18 Paranasal Sinuses The paranasal sinuses are hollow, air-filled spaces named for the skull bone that each occupies. The most anterior is the frontal sinus, located in the frontal bone above the eyebrows. The largest are the maxillary sinuses, located in the right and left maxillary bones below the orbits. The most posterior is the sphenoid sinus, located in the body of the sphenoid bone, under the sella turcica. The ethmoid air cells are multiple small spaces located in the right and left sides of the ethmoid bone, between the medial wall of the orbit and lateral wall of the upper nasal cavity.

Hyoid Bone

The hyoid bone is an independent bone that does not contact any other bone and thus is not part of the skull (Figure 7.19). It is a small U-shaped bone located in the upper neck near the level of the inferior mandible, with the tips of the “U” pointing posteriorly. The hyoid serves as the base for the tongue above, and is attached to the larynx below and the pharynx posteriorly. The hyoid is held in position by a series of small muscles that attach to it either from above or below. These muscles act to move the hyoid up/down or forward/back. Movements of the hyoid are coordinated with movements of the tongue, larynx, and pharynx during swallowing and speaking.

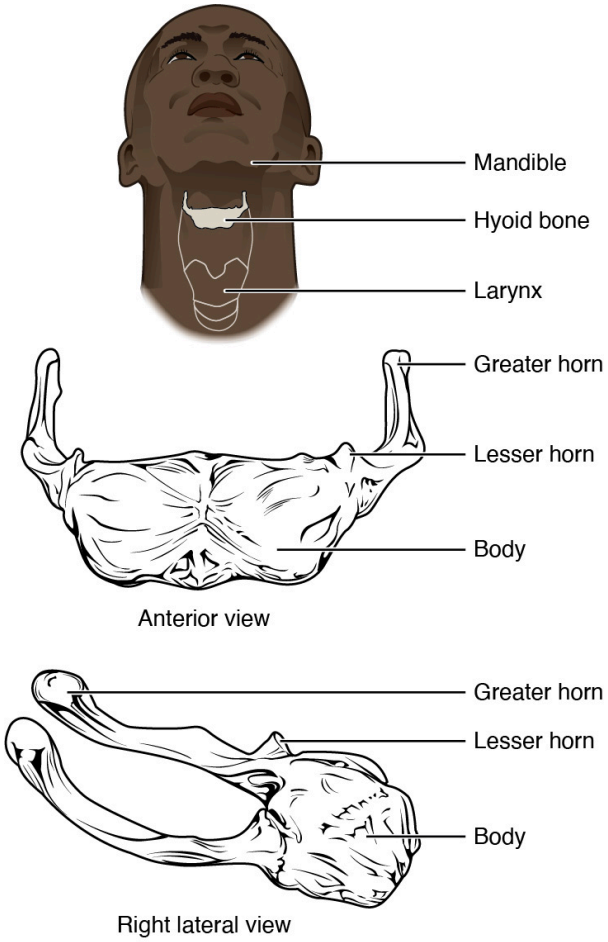


FIGURE 7.19 Hyoid Bone The hyoid bone is located in the upper neck and does not join with any other bone. It provides attachments for muscles that act on the tongue, larynx, and pharynx.

7.3 The Vertebral Column

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Describe each region of the vertebral column and the number of bones in each region
- Discuss the curves of the vertebral column and how these change after birth
- Describe a typical vertebra and determine the distinguishing characteristics for vertebrae in each vertebral region and features of the sacrum and the coccyx
- Describe the structure of an intervertebral disc
- Determine the location of the ligaments that provide support for the vertebral column

The vertebral column is also known as the spinal column or spine (Figure 7.20). It consists of a sequence of vertebrae (singular = vertebra), each of which is separated and united by an **intervertebral disc**. Together, the vertebrae and intervertebral discs form the vertebral column. It is a flexible column that supports the head, neck, and body and allows for their movements. It also protects the spinal cord, which passes down the back through openings in the vertebrae.

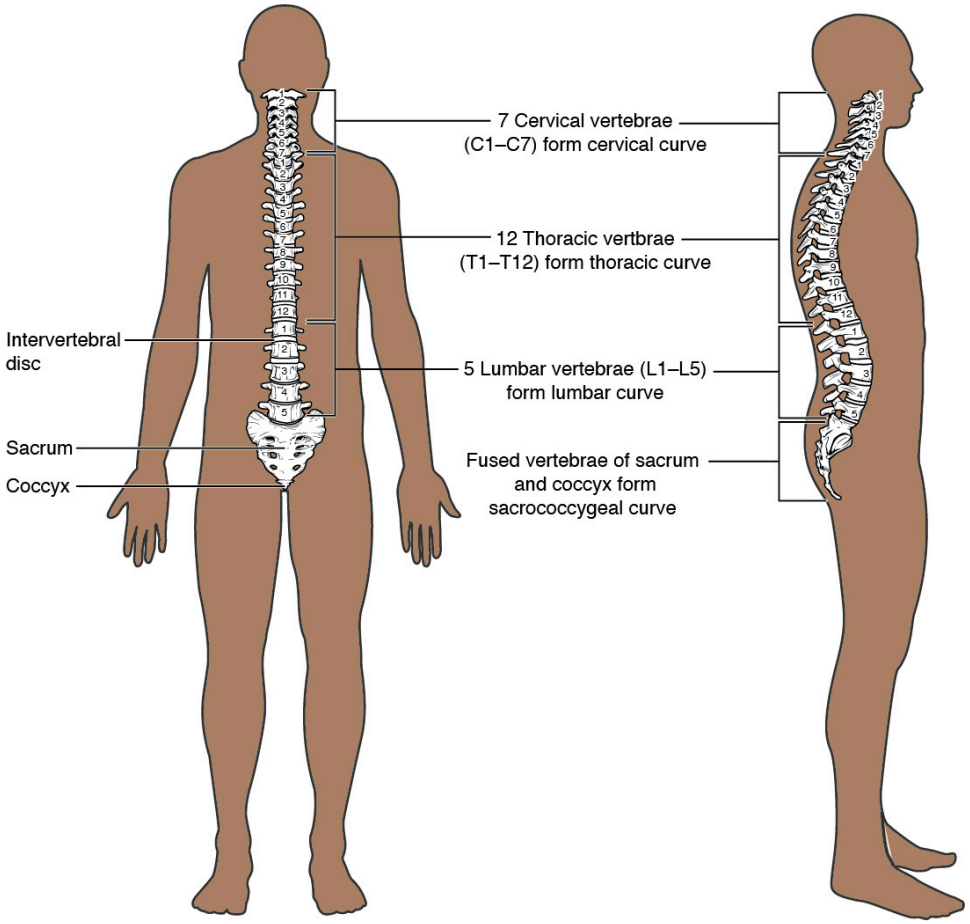


FIGURE 7.20 Vertebral Column The adult vertebral column consists of 24 vertebrae, plus the sacrum and coccyx. The vertebrae are divided into three regions: cervical C1–C7 vertebrae, thoracic T1–T12 vertebrae, and lumbar L1–L5 vertebrae. The vertebral column is curved, with two primary curvatures (thoracic and sacrococcygeal curves) and two secondary curvatures (cervical and lumbar curves).

Regions of the Vertebral Column

The vertebral column originally develops as a series of 33 vertebrae, but this number is eventually reduced to 24 vertebrae, plus the sacrum and coccyx. The vertebral column is subdivided into five regions, with the vertebrae in each area named for that region and numbered in descending order. In the neck, there are seven cervical vertebrae, each designated with the letter "C" followed by its number. Superiorly, the C1 vertebra articulates (forms a joint) with the occipital condyles of the skull. Inferiorly, C1 articulates with the C2 vertebra, and so on. Below these are the 12 thoracic vertebrae, designated T1–T12. The lower back contains the L1–L5 lumbar vertebrae. The single sacrum, which is also part of the pelvis, is formed by the fusion of five sacral vertebrae. Similarly, the coccyx, or tailbone, results from the fusion of four small coccygeal vertebrae. However, the sacral and coccygeal fusions do not start until age 20 and are not completed until middle age.

An interesting anatomical fact is that almost all mammals have seven cervical vertebrae, regardless of body size. This means that there are large variations in the size of cervical vertebrae, ranging from the very small cervical vertebrae of a shrew to the greatly elongated vertebrae in the neck of a giraffe. In a full-grown giraffe, each cervical vertebra is 11 inches tall.

Curvatures of the Vertebral Column

The adult vertebral column does not form a straight line, but instead has four curvatures along its length (see Figure 7.20). These curves increase the vertebral column's strength, flexibility, and ability to absorb shock. When the load on the spine is increased, by carrying a heavy backpack for example, the curvatures increase in depth (become more curved) to accommodate the extra weight. They then spring back when the weight is removed. The four adult curvatures are classified as either primary or secondary curvatures. Primary curves are retained from the original fetal curvature, while secondary curvatures develop after birth.

During fetal development, the body is flexed anteriorly into the fetal position, giving the entire vertebral column a single curvature that is concave anteriorly. In the adult, this fetal curvature is retained in two regions of the vertebral column as the **thoracic curve**, which involves the thoracic vertebrae, and the **sacrococcygeal curve**, formed by the sacrum and coccyx. Each of these is thus called a **primary curve** because they are retained from the original fetal curvature of the vertebral column.

A **secondary curve** develops gradually after birth as the child learns to sit upright, stand, and walk. Secondary curves are concave posteriorly, opposite in direction to the original fetal curvature. The **cervical curve** of the neck region develops as the infant begins to hold their head upright when sitting. Later, as the child begins to stand and then to walk, the **lumbar curve** of the lower back develops. In adults, the lumbar curve is generally deeper in females.

Disorders associated with the curvature of the spine include **kyphosis** (an excessive posterior curvature of the thoracic region), **lordosis** (an excessive anterior curvature of the lumbar region), and **scoliosis** (an abnormal, lateral curvature, accompanied by twisting of the vertebral column).

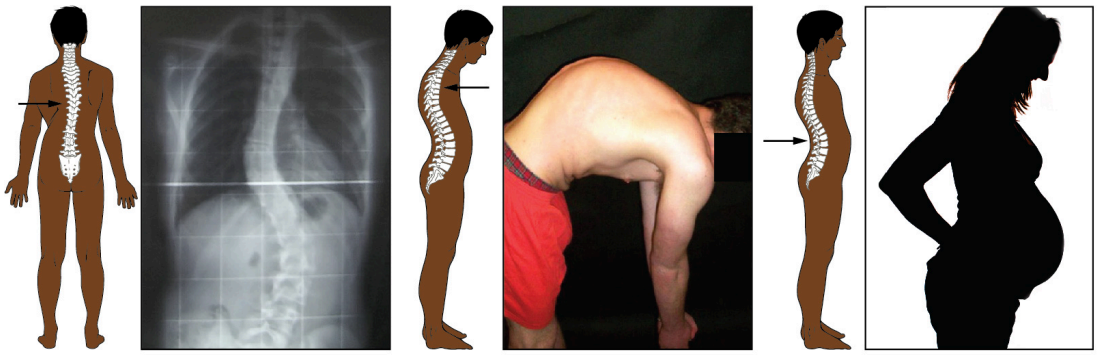
DISORDERS OF THE...

Vertebral Column

Developmental anomalies, pathological changes, or obesity can enhance the normal vertebral column curves, resulting in the development of abnormal or excessive curvatures (Figure 7.21). Kyphosis, also referred to as humpback or hunchback, is an excessive posterior curvature of the thoracic region. This can develop when osteoporosis causes weakening and erosion of the anterior portions of the upper thoracic vertebrae, resulting in their gradual collapse (Figure 7.22). Lordosis, or swayback, is an excessive anterior curvature of the lumbar region and is most commonly associated with obesity or late pregnancy. The accumulation of body weight in the abdominal region results an anterior shift in the line of gravity that carries the weight of the body. This causes in an anterior tilt of the pelvis and a pronounced enhancement of the lumbar curve.

Scoliosis is an abnormal, lateral curvature, accompanied by twisting of the vertebral column. Compensatory curves may also develop in other areas of the vertebral column to help maintain the head positioned over the feet. Scoliosis is the most common vertebral abnormality among girls. The cause is usually unknown, but it may result from weakness of the back muscles, defects such as differential growth rates in the right and left sides of the vertebral column, or differences in the length of the lower limbs. When present, scoliosis tends to get worse during adolescent growth spurts. Although most individuals do not require treatment, a back brace may be recommended for growing children. In extreme cases, surgery may be required.

Excessive vertebral curves can be identified while an individual stands in the anatomical position. Observe the vertebral profile from the side and then from behind to check for kyphosis or lordosis. Then have the person bend forward. If scoliosis is present, an individual will have difficulty in bending directly forward, and the right and left sides of the back will not be level with each other in the bent position.



(a) Scoliosis (b) Kyphosis (c) Lordosis

FIGURE 7.21 Abnormal Curvatures of the Vertebral Column (a) Scoliosis is an abnormal lateral bending of the vertebral column. (b) An excessive curvature of the upper thoracic vertebral column is called kyphosis. (c) Lordosis is an excessive curvature in the lumbar

region of the vertebral column.

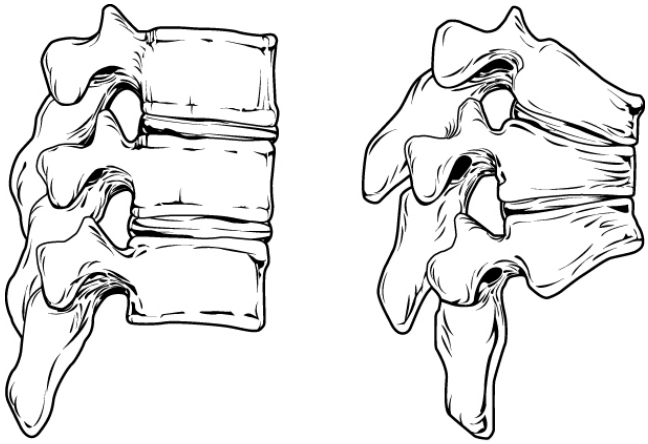


FIGURE 7.22 Osteoporosis Osteoporosis is an age-related disorder that causes the gradual loss of bone density and strength. When the thoracic vertebrae are affected, there can be a gradual collapse of the vertebrae. This results in kyphosis, an excessive curvature of the thoracic region.

INTERACTIVE LINK

Osteoporosis is a common age-related bone disease in which bone density and strength is decreased. Watch this video (http://openstax.org/l/osteoporosis) to get a better understanding of how thoracic vertebrae may become weakened and may fracture due to this disease. How may vertebral osteoporosis contribute to kyphosis?

General Structure of a Vertebra

Within the different regions of the vertebral column, vertebrae vary in size and shape, but they all follow a similar structural pattern. A typical vertebra will consist of a body, a vertebral arch, and seven processes (Figure 7.23).

The body is the anterior portion of each vertebra and is the part that supports the body weight. Because of this, the vertebral bodies progressively increase in size and thickness going down the vertebral column. The bodies of adjacent vertebrae are separated and strongly united by an intervertebral disc.

The **vertebral arch** forms the posterior portion of each vertebra. It consists of four parts, the right and left pedicles and the right and left laminae. Each **pedicle** forms one of the lateral sides of the vertebral arch. The pedicles are anchored to the posterior side of the vertebral body. Each **lamina** forms part of the posterior roof of the vertebral arch. The large opening between the vertebral arch and body is the **vertebral foramen**, which contains the spinal cord. In the intact vertebral column, the vertebral foramina of all of the vertebrae align to form the **vertebral (spinal) canal**, which serves as the bony protection and passageway for the spinal cord down the back. When the vertebrae are aligned together in the vertebral column, notches in the margins of the pedicles of adjacent vertebrae together form an **intervertebral foramen**, the opening through which a spinal nerve exits from the vertebral column (Figure 7.24).

Seven processes arise from the vertebral arch. Each paired **transverse process** projects laterally and arises from the junction point between the pedicle and lamina. The single **spinous process** (vertebral spine) projects posteriorly at the midline of the back. The vertebral spines can easily be felt as a series of bumps just under the skin down the middle of the back. The transverse and spinous processes serve as important muscle attachment sites. A **superior articular process** extends or faces upward, and an **inferior articular process** faces or projects downward on each side of a vertebrae. The paired superior articular processes of one vertebra join with the corresponding paired inferior articular processes from the next higher vertebra. These junctions form slightly moveable joints between the adjacent vertebrae. The shape and orientation of the articular processes vary in different regions of the vertebral column and play a major role in determining the type and range of motion available in each region.

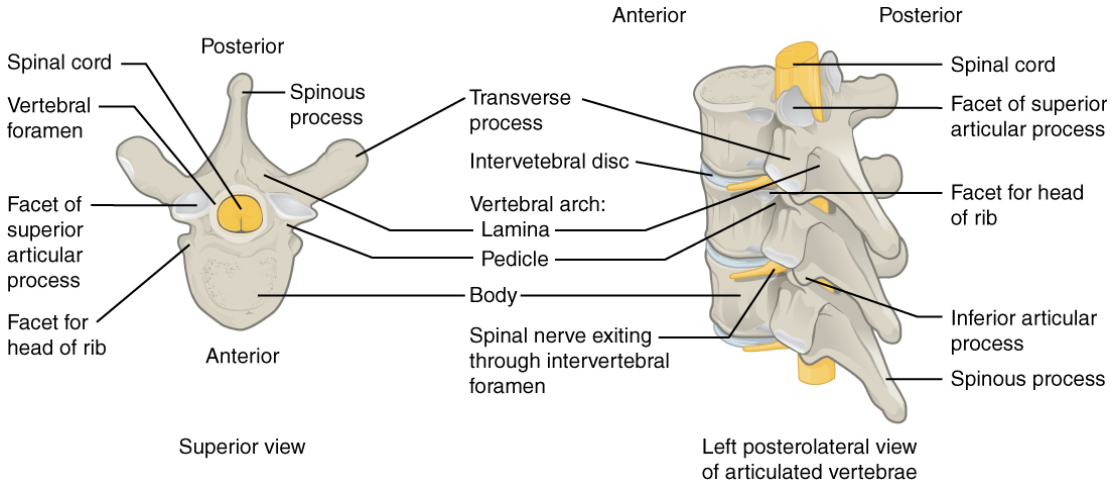


FIGURE 7.23 Parts of a Typical Vertebra A typical vertebra consists of a body and a vertebral arch. The arch is formed by the paired pedicles and paired laminae. Arising from the vertebral arch are the transverse, spinous, superior articular, and inferior articular processes. The vertebral foramen provides for passage of the spinal cord. Each spinal nerve exits through an intervertebral foramen, located between adjacent vertebrae. Intervertebral discs unite the bodies of adjacent vertebrae.

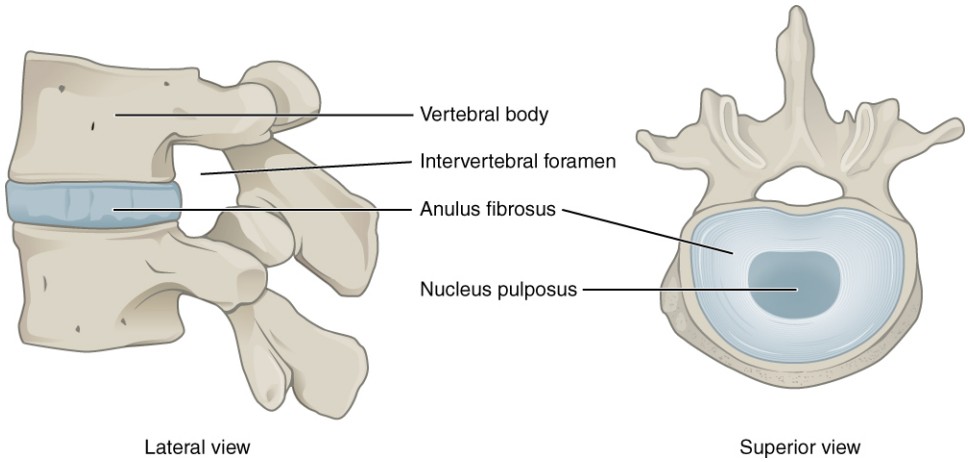


FIGURE 7.24 Intervertebral Disc The bodies of adjacent vertebrae are separated and united by an intervertebral disc, which provides padding and allows for movements between adjacent vertebrae. The disc consists of a fibrous outer layer called the anulus fibrosus and a gel-like center called the nucleus pulposus. The intervertebral foramen is the opening formed between adjacent vertebrae for the exit of a spinal nerve. See the section on Intervertebral Discs and Ligaments of the Vertebral Column for more information.

Regional Modifications of Vertebrae

In addition to the general characteristics of a typical vertebra described above, vertebrae also display characteristic size and structural features that vary between the different vertebral column regions. Thus, cervical vertebrae are smaller than lumbar vertebrae due to differences in the proportion of body weight that each supports. Thoracic vertebrae have sites for rib attachment, and the vertebrae that give rise to the sacrum and coccyx have fused together into single bones.

Cervical Vertebrae

Typical **cervical vertebrae**, such as C4 or C5, have several characteristic features that differentiate them from thoracic or lumbar vertebrae (Figure 7.25). Cervical vertebrae have a small body, reflecting the fact that they carry the least amount of body weight. Cervical vertebrae usually have a bifid (Y-shaped) spinous process. The spinous processes of the C3–C6 vertebrae are short, but the spine of C7 is much longer. You can find these vertebrae by running your finger down the midline of the posterior neck until you encounter the prominent C7 spine located at the base of the neck. The transverse processes of the cervical vertebrae are sharply curved (U-shaped) to allow for passage of the cervical spinal nerves. Each transverse process also has an opening called the **transverse foramen**. An important artery that supplies the brain ascends up the neck by passing through these openings. The superior and inferior articular processes of the cervical vertebrae are flattened and largely face upward or downward, respectively.

The first and second cervical vertebrae are further modified, giving each a distinctive appearance. The first cervical (C1) vertebra is also called the **atlas**, because this is the vertebra that supports the skull on top of the vertebral column (in Greek mythology, Atlas was the god who supported the heavens on his shoulders). The C1 vertebra does not have a body or spinous process. Instead, it is ring-shaped, consisting of an **anterior arch** and a **posterior arch**. The transverse processes of the atlas are longer and extend more laterally than do the transverse processes of any other cervical vertebrae. The superior articular processes face upward and are deeply curved for articulation with the occipital condyles on the base of the skull. The inferior articular processes are flat and face downward to join with the superior articular processes of the C2 vertebra.

The second cervical (C2) vertebra is called the **axis**, because it serves as the axis for rotation when turning the head toward the right or left. The axis resembles typical cervical vertebrae in most respects, but is easily distinguished by the **dens** (odontoid process), a bony projection that extends upward from the vertebral body. The dens joins with the inner aspect of the anterior arch of the atlas, where it is held in place by the transverse ligament.

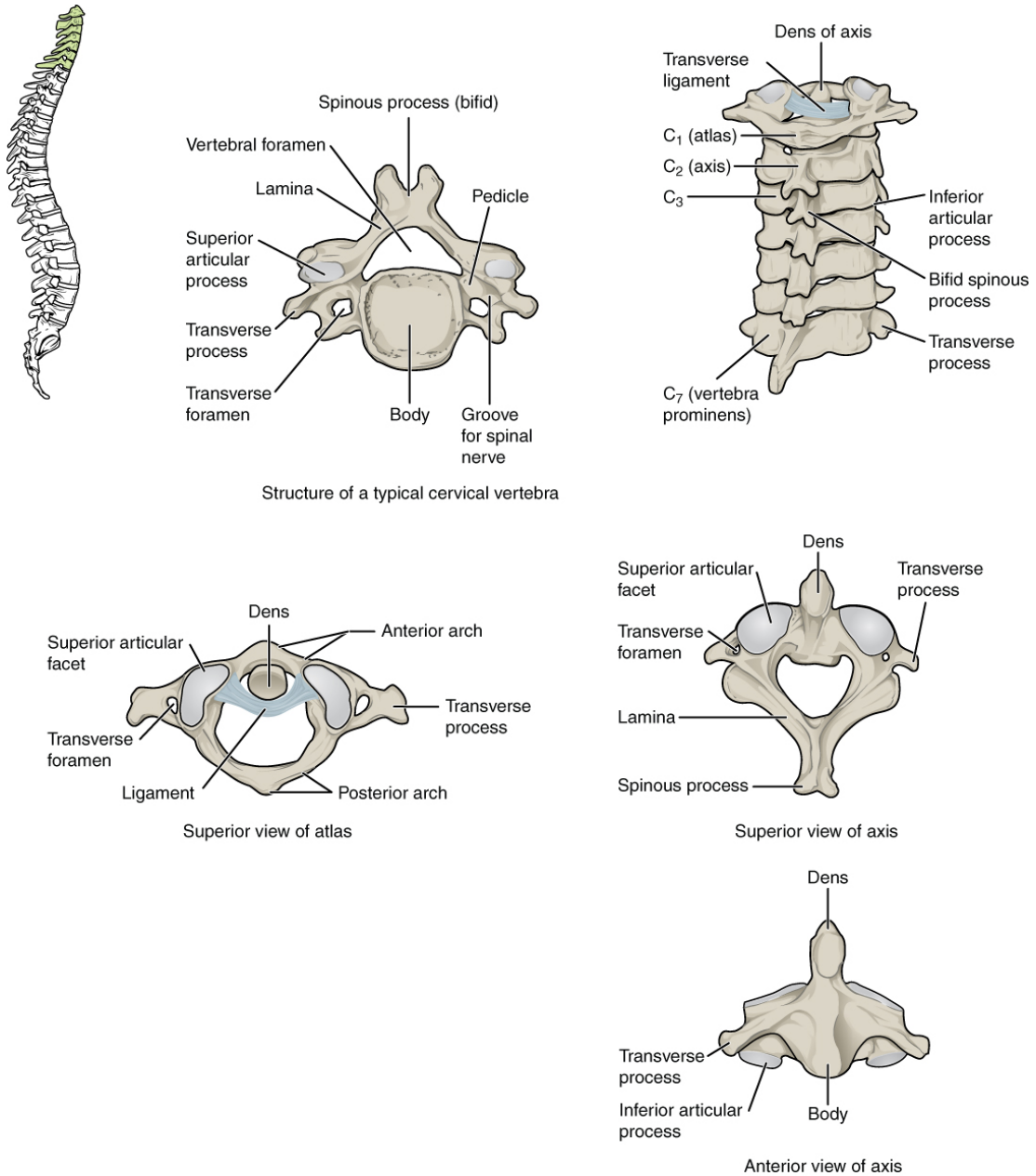


FIGURE 7.25 Cervical Vertebrae A typical cervical vertebra has a small body, a bifid spinous process, transverse processes that have a transverse foramen and are curved for spinal nerve passage. The atlas (C1 vertebra) does not have a body or spinous process. It consists of an anterior and a posterior arch and elongated transverse processes. The axis (C2 vertebra) has the upward projecting dens, which articulates with the anterior arch of the atlas.

Thoracic Vertebrae

The bodies of the **thoracic vertebrae** are larger than those of cervical vertebrae (Figure 7.26). The characteristic feature for a typical midthoracic vertebra is the spinous process, which is long and has a pronounced downward angle that causes it to overlap the next inferior vertebra. The superior articular facets of thoracic vertebrae face posteriorly and the inferior facets face anteriorly. These orientations are important determinants for the type and range of movements available to the thoracic region of the vertebral column.

Thoracic vertebrae have several additional articulation sites, each of which is called a **facet**, where a rib is attached. Most thoracic vertebrae have two facets located on the lateral sides of the body, each of which is called a **costal facet** (costal = "rib"). These are for articulation with the head (end) of a rib. An additional facet is located on the transverse process for articulation with the tubercle of a rib.

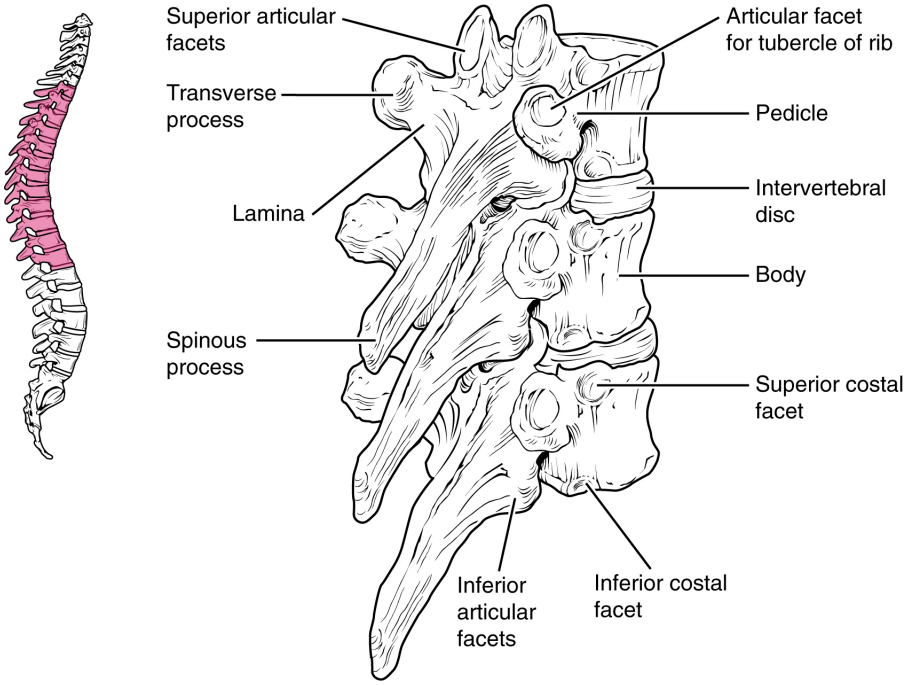


FIGURE 7.26 Thoracic Vertebrae A typical thoracic vertebra is distinguished by the spinous process, which is long and projects downward to overlap the next inferior vertebra. It also has articulation sites (facets) on the vertebral body and a transverse process for rib attachment.

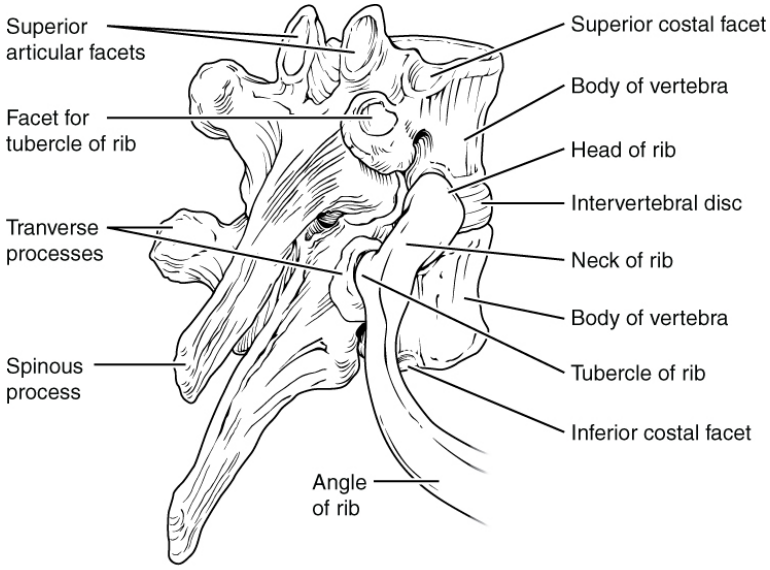


FIGURE 7.27 Rib Articulation in Thoracic Vertebrae Thoracic vertebrae have superior and inferior articular facets on the vertebral body for articulation with the head of a rib, and a transverse process facet for articulation with the rib tubercle.

Lumbar Vertebrae

Lumbar vertebrae carry the greatest amount of body weight and are thus characterized by the large size and thickness of the vertebral body (Figure 7.28). They have short transverse processes and a short, blunt spinous process that projects posteriorly. The articular processes are large, with the superior process facing medially and the inferior facing laterally.

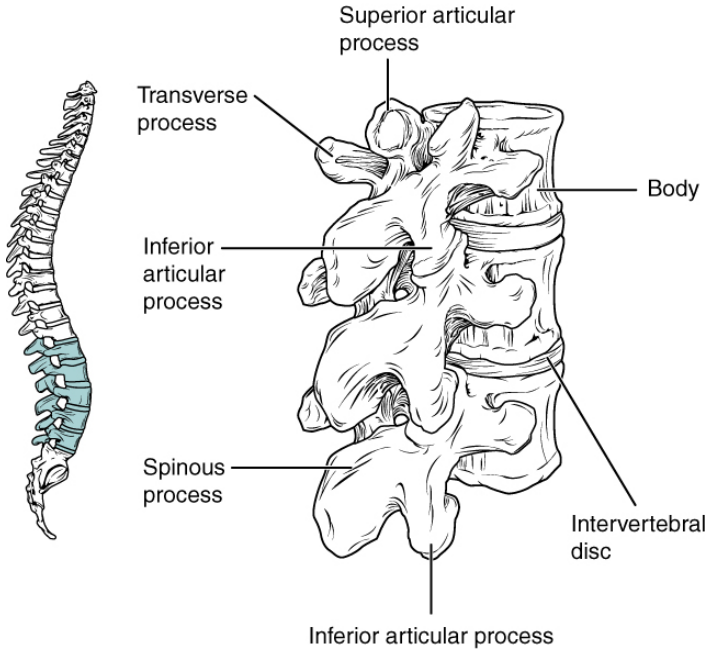


FIGURE 7.28 Lumbar Vertebrae Lumbar vertebrae are characterized by having a large, thick body and a short, rounded spinous process.

Sacrum and Coccyx

The sacrum is a triangular-shaped bone that is thick and wide across its superior base where it is weight bearing and then tapers down to an inferior, non-weight bearing apex (Figure 7.29). It is formed by the fusion of five sacral vertebrae, a process that does not begin until after the age of 20. On the anterior surface of the older adult sacrum, the lines of vertebral fusion can be seen as four transverse ridges. On the posterior surface, running down the midline, is the **median sacral crest**, a bumpy ridge that is the remnant of the fused spinous processes (median = "midline"; while medial = "toward, but not necessarily at, the midline"). Similarly, the fused transverse processes of the sacral vertebrae form the **lateral sacral crest**.

The **sacral promontory** is the anterior lip of the superior base of the sacrum. Lateral to this is the roughened auricular surface, which joins with the ilium portion of the hipbone to form the immobile sacroiliac joints of the pelvis. Passing inferiorly through the sacrum is a bony tunnel called the **sacral canal**, which terminates at the **sacral hiatus** near the inferior tip of the sacrum. The anterior and posterior surfaces of the sacrum have a series of paired openings called **sacral foramina** (singular = foramen) that connect to the sacral canal. Each of these openings is called a **posterior (dorsal) sacral foramen** or **anterior (ventral) sacral foramen**. These openings allow for the anterior and posterior branches of the sacral spinal nerves to exit the sacrum. The **superior articular process of the sacrum**, one of which is found on either side of the superior opening of the sacral canal, articulates with the inferior articular processes from the L5 vertebra.

The coccyx, or tailbone, is derived from the fusion of four very small coccygeal vertebrae (see Figure 7.29). It articulates with the inferior tip of the sacrum. It is not weight bearing in the standing position, but may receive some body weight when sitting.

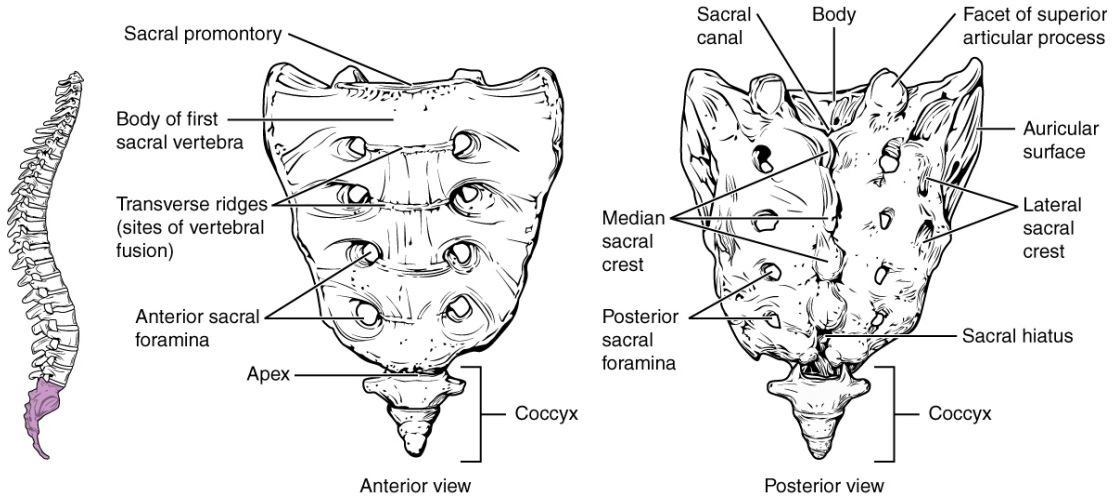


FIGURE 7.29 Sacrum and Coccyx The sacrum is formed from the fusion of five sacral vertebrae, whose lines of fusion are indicated by the transverse ridges. The fused spinous processes form the median sacral crest, while the lateral sacral crest arises from the fused transverse processes. The coccyx is formed by the fusion of four small coccygeal vertebrae.

Intervertebral Discs and Ligaments of the Vertebral Column

The bodies of adjacent vertebrae are strongly anchored to each other by an intervertebral disc. This structure provides padding between the bones during weight bearing, and because it can change shape, also allows for movement between the vertebrae. Although the total amount of movement available between any two adjacent vertebrae is small, when these movements are summed together along the entire length of the vertebral column, large body movements can be produced. Ligaments that extend along the length of the vertebral column also contribute to its overall support and stability.

Intervertebral Disc

An **intervertebral disc** is a fibrocartilaginous pad that fills the gap between adjacent vertebral bodies (see Figure 7.24). Each disc is anchored to the bodies of its adjacent vertebrae, thus strongly uniting these. The discs also provide padding between vertebrae during weight bearing. Because of this, intervertebral discs are thin in the cervical region and thickest in the lumbar region, which carries the most body weight. In total, the intervertebral discs account for approximately 25 percent of your body height between the top of the pelvis and the base of the skull. Intervertebral discs are also flexible and can change shape to allow for movements of the vertebral column.

Each intervertebral disc consists of two parts. The **anulus fibrosus** is the tough, fibrous outer layer of the disc. It forms a circle (anulus = “ring” or “circle”) and is firmly anchored to the outer margins of the adjacent vertebral bodies. Inside is the **nucleus pulposus**, consisting of a softer, more gel-like material. It has a high water content that serves to resist compression and thus is important for weight bearing. With increasing age, the water content of the nucleus pulposus gradually declines. This causes the disc to become thinner, decreasing total body height somewhat, and reduces the flexibility and range of motion of the disc, making bending more difficult.

The gel-like nature of the nucleus pulposus also allows the intervertebral disc to change shape as one vertebra rocks side to side or forward and back in relation to its neighbors during movements of the vertebral column. Thus, bending forward causes compression of the anterior portion of the disc but expansion of the posterior disc. If the posterior anulus fibrosus is weakened due to injury or increasing age, the pressure exerted on the disc when bending forward and lifting a heavy object can cause the nucleus pulposus to protrude posteriorly through the anulus fibrosus, resulting in a herniated disc (“ruptured” or “slipped” disc) (Figure 7.30). The posterior bulging of the nucleus pulposus can cause compression of a spinal nerve at the point where it exits through the intervertebral foramen, with resulting pain and/or muscle weakness in those body regions supplied by that nerve. The most common sites for disc herniation are the L4/L5 or L5/S1 intervertebral discs, which can cause sciatica, a widespread pain that radiates from the lower back down the thigh and into the leg. Similar injuries of the C5/C6 or C6/C7 intervertebral discs, following forcible hyperflexion of the neck from a collision accident or football injury, can produce pain in the neck, shoulder, and upper limb.

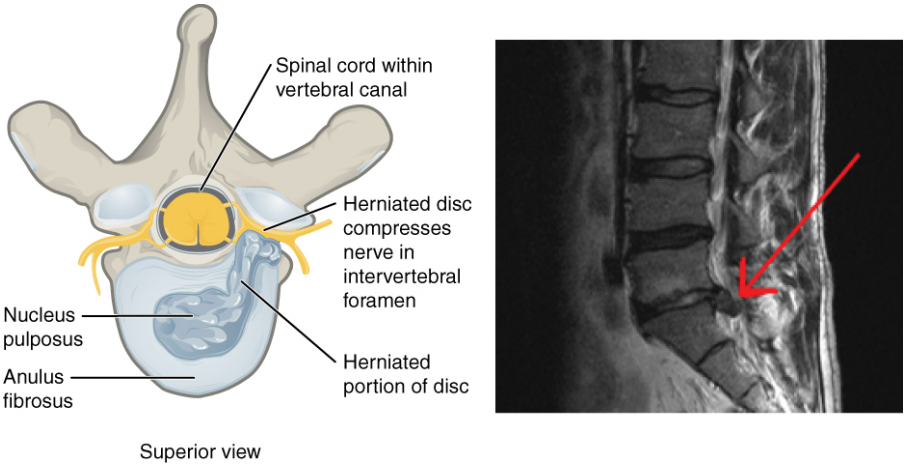


FIGURE 7.30 Herniated Intervertebral Disc Weakening of the anulus fibrosus can result in herniation (protrusion) of the nucleus pulposus and compression of a spinal nerve, resulting in pain and/or muscle weakness in the body regions supplied by that nerve.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/herndisc1) to learn about a herniated disc. Watch this second video (http://openstax.org/l/herndisc2) to see one possible treatment for a herniated disc, removing the damaged portion of the disc. How could lifting a heavy object produce pain in a lower limb?

Ligaments of the Vertebral Column

Adjacent vertebrae are united by ligaments that run the length of the vertebral column along both its posterior and anterior aspects (Figure 7.31). These serve to resist excess forward or backward bending movements of the vertebral column, respectively.

The **anterior longitudinal ligament** runs down the anterior side of the entire vertebral column, uniting the vertebral bodies. It serves to resist excess backward bending of the vertebral column. Protection against this movement is particularly important in the neck, where extreme posterior bending of the head and neck can stretch or tear this ligament, resulting in a painful whiplash injury. Prior to the mandatory installation of seat headrests, whiplash injuries were common for passengers involved in a rear-end automobile collision.

The **supraspinous ligament** is located on the posterior side of the vertebral column, where it interconnects the spinous processes of the thoracic and lumbar vertebrae. This strong ligament supports the vertebral column during forward bending motions. In the posterior neck, where the cervical spinous processes are short, the supraspinous ligament expands to become the **nuchal ligament** (nuchae = “nape” or “back of the neck”). The nuchal ligament is attached to the cervical spinous processes and extends upward and posteriorly to attach to the midline base of the skull, out to the external occipital protuberance. It supports the skull and prevents it from falling forward. This ligament is much larger and stronger in four-legged animals such as cows, where the large skull hangs off the front end of the vertebral column. You can easily feel this ligament by first extending your head backward and pressing down on the posterior midline of your neck. Then tilt your head forward and you will fill the nuchal ligament popping out as it tightens to limit anterior bending of the head and neck.

Additional ligaments are located inside the vertebral canal, next to the spinal cord, along the length of the vertebral column. The **posterior longitudinal ligament** is found anterior to the spinal cord, where it is attached to the posterior sides of the vertebral bodies. Posterior to the spinal cord is the **ligamentum flavum** (“yellow ligament”). This consists of a series of short, paired ligaments, each of which interconnects the lamina regions of adjacent vertebrae. The ligamentum flavum has large numbers of elastic fibers, which have a yellowish color, allowing it to stretch and then pull back. Both of these ligaments provide important support for the vertebral column when bending forward.

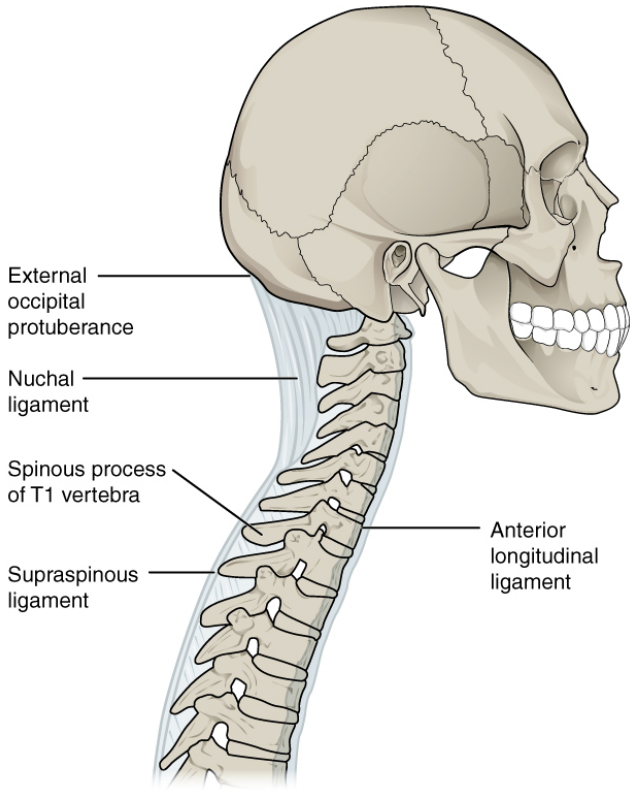


FIGURE 7.31 Ligaments of Vertebral Column The anterior longitudinal ligament runs the length of the vertebral column, uniting the anterior sides of the vertebral bodies. The supraspinous ligament connects the spinous processes of the thoracic and lumbar vertebrae. In the posterior neck, the supraspinous ligament enlarges to form the nuchal ligament, which attaches to the cervical spinous processes and to the base of the skull.

INTERACTIVE LINK

Use this tool (http://openstax.org/l/vertcolumn) to identify the bones, intervertebral discs, and ligaments of the vertebral column. The thickest portions of the anterior longitudinal ligament and the supraspinous ligament are found in which regions of the vertebral column?

CAREER CONNECTION

Chiropractor

Chiropractors are health professionals who use nonsurgical techniques to help patients with musculoskeletal system problems that involve the bones, muscles, ligaments, tendons, or nervous system. They treat problems such as neck pain, back pain, joint pain, or headaches. Chiropractors focus on the patient's overall health and can also provide counseling related to lifestyle issues, such as diet, exercise, or sleep problems. If needed, they will refer the patient to other medical specialists.

Chiropractors use a drug-free, hands-on approach for patient diagnosis and treatment. They will perform a physical exam, assess the patient's posture and spine, and may perform additional diagnostic tests, including taking X-ray images. They primarily use manual techniques, such as spinal manipulation, to adjust the patient's spine or other joints. They can recommend therapeutic or rehabilitative exercises, and some also include acupuncture, massage therapy, or ultrasound as part of the treatment program. In addition to those in general practice, some chiropractors specialize in sport injuries, neurology, orthopaedics, pediatrics, nutrition, internal disorders, or diagnostic imaging.

To become a chiropractor, students must have 3–4 years of undergraduate education, attend an accredited, four-year Doctor of Chiropractic (D.C.) degree program, and pass a licensure examination to be licensed for practice in

their state. With the aging of the baby-boom generation, employment for chiropractors is expected to increase.

7.4 The Thoracic Cage

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss the components that make up the thoracic cage
- Identify the parts of the sternum and define the sternal angle
- Discuss the parts of a rib and rib classifications

The thoracic cage (rib cage) forms the thorax (chest) portion of the body. It consists of the 12 pairs of ribs with their costal cartilages and the sternum (Figure 7.32). The ribs are anchored posteriorly to the 12 thoracic vertebrae (T1–T12). The thoracic cage protects the heart and lungs.

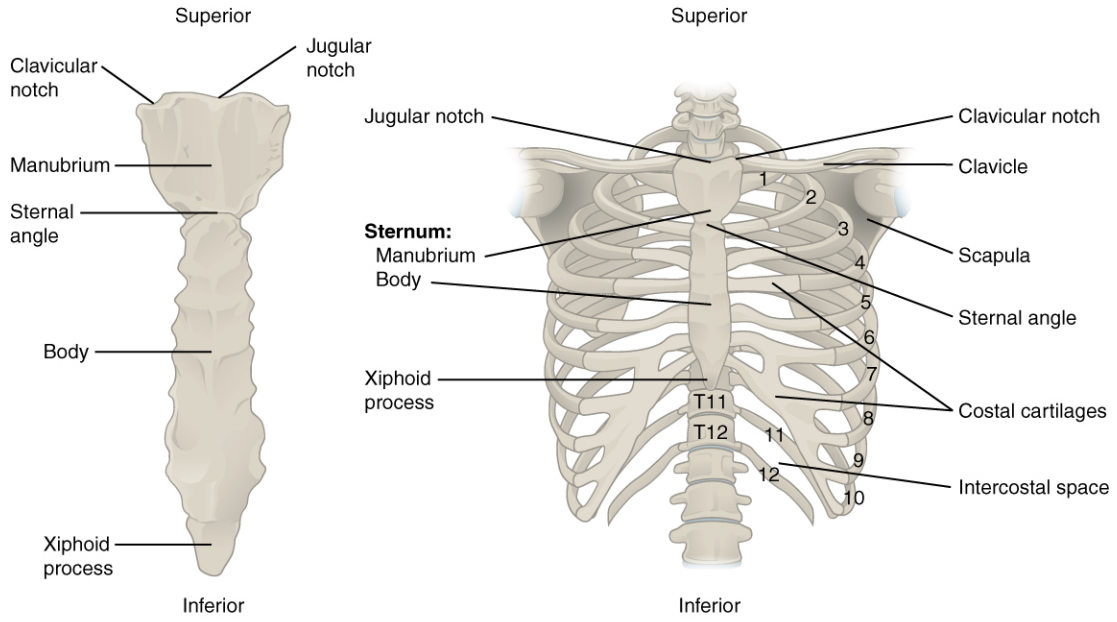


FIGURE 7.32 Thoracic Cage The thoracic cage is formed by the (a) sternum and (b) 12 pairs of ribs with their costal cartilages. The ribs are anchored posteriorly to the 12 thoracic vertebrae. The sternum consists of the manubrium, body, and xiphoid process. The ribs are classified as true ribs (1–7) and false ribs (8–12). The last two pairs of false ribs are also known as floating ribs (11–12).

Sternum

The sternum is the elongated bony structure that anchors the anterior thoracic cage. It consists of three parts: the manubrium, body, and xiphoid process. The **manubrium** is the wider, superior portion of the sternum. The top of the manubrium has a shallow, U-shaped border called the **jugular (suprasternal) notch**. This can be easily felt at the anterior base of the neck, between the medial ends of the clavicles. The **clavicular notch** is the shallow depression located on either side at the superior-lateral margins of the manubrium. This is the site of the sternoclavicular joint, between the sternum and clavicle. The first ribs also attach to the manubrium.

The elongated, central portion of the sternum is the body. The manubrium and body join together at the **sternal angle**, so called because the junction between these two components is not flat, but forms a slight bend. The second rib attaches to the sternum at the sternal angle. Since the first rib is hidden behind the clavicle, the second rib is the highest rib that can be identified by palpation. Thus, the sternal angle and second rib are important landmarks for the identification and counting of the lower ribs. Ribs 3–7 attach to the sternal body.

The inferior tip of the sternum is the **xiphoid process**. This small structure is cartilaginous early in life, but gradually becomes ossified starting during middle age.

Ribs

Each rib is a curved, flattened bone that contributes to the wall of the thorax. The ribs articulate posteriorly with the

T1–T12 thoracic vertebrae, and most attach anteriorly via their costal cartilages to the sternum. There are 12 pairs of ribs. The ribs are numbered 1–12 in accordance with the thoracic vertebrae.

Parts of a Typical Rib

The posterior end of a typical rib is called the **head of the rib** (see Figure 7.27). This region articulates primarily with the costal facet located on the body of the same numbered thoracic vertebra and to a lesser degree, with the costal facet located on the body of the next higher vertebra. Lateral to the head is the narrowed **neck of the rib**. A small bump on the posterior rib surface is the **tubercle of the rib**, which articulates with the facet located on the transverse process of the same numbered vertebra. The remainder of the rib is the **body of the rib** (shaft). Just lateral to the tubercle is the **angle of the rib**, the point at which the rib has its greatest degree of curvature. The angles of the ribs form the most posterior extent of the thoracic cage. In the anatomical position, the angles align with the medial border of the scapula. A shallow **costal groove** for the passage of blood vessels and a nerve is found along the inferior margin of each rib.

Rib Classifications

The bony ribs do not extend anteriorly completely around to the sternum. Instead, each rib ends in a **costal cartilage**. These cartilages are made of hyaline cartilage and can extend for several inches. Most ribs are then attached, either directly or indirectly, to the sternum via their costal cartilage (see Figure 7.32). The ribs are classified into three groups based on their relationship to the sternum.

Ribs 1–7 are classified as **true ribs** (vertebrosternal ribs). The costal cartilage from each of these ribs attaches directly to the sternum. Ribs 8–12 are called **false ribs** (vertebrochondral ribs). The costal cartilages from these ribs do not attach directly to the sternum. For ribs 8–10, the costal cartilages are attached to the cartilage of the next higher rib. Thus, the cartilage of rib 10 attaches to the cartilage of rib 9, rib 9 then attaches to rib 8, and rib 8 is attached to rib 7. The last two false ribs (11–12) are also called **floating ribs** (vertebral ribs). These are short ribs that do not attach to the sternum at all. Instead, their small costal cartilages terminate within the musculature of the lateral abdominal wall.

7.5 Embryonic Development of the Axial Skeleton

LEARNING OBJECTIVES

By the end of this section, you will be able to:

- Discuss the two types of embryonic bone development within the skull
- Describe the development of the vertebral column and thoracic cage

The axial skeleton begins to form during early embryonic development. However, growth, remodeling, and ossification (bone formation) continue for several decades after birth before the adult skeleton is fully formed. Knowledge of the developmental processes that give rise to the skeleton is important for understanding the abnormalities that may arise in skeletal structures.

Development of the Skull

During the third week of embryonic development, a rod-like structure called the **notochord** develops dorsally along the length of the embryo. The tissue overlying the notochord enlarges and forms the neural tube, which will give rise to the brain and spinal cord. By the fourth week, mesoderm tissue located on either side of the notochord thickens and separates into a repeating series of block-like tissue structures, each of which is called a **somite**. As the somites enlarge, each one will split into several parts. The most medial of these parts is called a **sclerotome**. The sclerotomes consist of an embryonic tissue called mesenchyme, which will give rise to the fibrous connective tissues, cartilages, and bones of the body.

The bones of the skull arise from mesenchyme during embryonic development in two different ways. The first mechanism produces the bones that form the top and sides of the brain case. This involves the local accumulation of mesenchymal cells at the site of the future bone. These cells then differentiate directly into bone producing cells, which form the skull bones through the process of intramembranous ossification. As the brain case bones grow in the fetal skull, they remain separated from each other by large areas of dense connective tissue, each of which is called a **fontanelle** (Figure 7.33). The fontanelles are the soft spots on an infant's head. They are important during birth because these areas allow the skull to change shape as it squeezes through the birth canal. After birth, the

fontanelles allow for continued growth and expansion of the skull as the brain enlarges. The largest fontanelle is located on the anterior head, at the junction of the frontal and parietal bones. The fontanelles decrease in size and disappear by age 2. However, the skull bones remained separated from each other at the sutures, which contain dense fibrous connective tissue that unites the adjacent bones. The connective tissue of the sutures allows for continued growth of the skull bones as the brain enlarges during childhood growth.

The second mechanism for bone development in the skull produces the facial bones and floor of the brain case. This also begins with the localized accumulation of mesenchymal cells. However, these cells differentiate into cartilage cells, which produce a hyaline cartilage model of the future bone. As this cartilage model grows, it is gradually converted into bone through the process of endochondral ossification. This is a slow process and the cartilage is not completely converted to bone until the skull achieves its full adult size.

At birth, the brain case and orbits of the skull are disproportionally large compared to the bones of the jaws and lower face. This reflects the relative underdevelopment of the maxilla and mandible, which lack teeth, and the small sizes of the paranasal sinuses and nasal cavity. During early childhood, the mastoid process enlarges, the two halves of the mandible and frontal bone fuse together to form single bones, and the paranasal sinuses enlarge. The jaws also expand as the teeth begin to appear. These changes all contribute to the rapid growth and enlargement of the face during childhood.

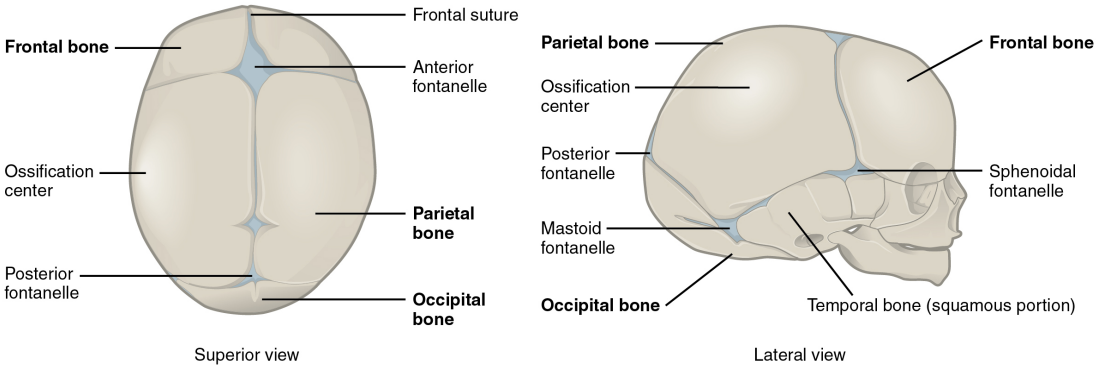


FIGURE 7.33 Newborn Skull The bones of the newborn skull are not fully ossified and are separated by large areas called fontanelles, which are filled with fibrous connective tissue. The fontanelles allow for continued growth of the skull after birth. At the time of birth, the facial bones are small and underdeveloped, and the mastoid process has not yet formed.

Development of the Vertebral Column and Thoracic cage

Development of the vertebrae begins with the accumulation of mesenchyme cells from each sclerotome around the notochord. These cells differentiate into a hyaline cartilage model for each vertebra, which then grow and eventually ossify into bone through the process of endochondral ossification. As the developing vertebrae grow, the notochord largely disappears. However, small areas of notochord tissue persist between the adjacent vertebrae and this contributes to the formation of each intervertebral disc.

The ribs and sternum also develop from mesenchyme. The ribs initially develop as part of the cartilage model for each vertebra, but in the thorax region, the rib portion separates from the vertebra by the eighth week. The cartilage model of the rib then ossifies, except for the anterior portion, which remains as the costal cartilage. The sternum initially forms as paired hyaline cartilage models on either side of the anterior midline, beginning during the fifth week of development. The cartilage models of the ribs become attached to the lateral sides of the developing sternum. Eventually, the two halves of the cartilaginous sternum fuse together along the midline and then ossify into bone. The manubrium and body of the sternum are converted into bone first, with the xiphoid process remaining as cartilage until late in life.

INTERACTIVE LINK

View this video (http://openstax.org/l/skullbones) to review the two processes that give rise to the bones of the skull and body. What are the two mechanisms by which the bones of the body are formed and which bones are formed by each mechanism?

HOMEOSTATIC IMBALANCES

Craniosynostosis

The premature closure (fusion) of a suture line is a condition called craniosynostosis. This error in the normal developmental process results in abnormal growth of the skull and deformity of the head. It is produced either by defects in the ossification process of the skull bones or failure of the brain to properly enlarge. Genetic factors are involved, but the underlying cause is unknown. It is a relatively common condition, occurring in approximately 1:2000 births, with males being more commonly affected. Primary craniosynostosis involves the early fusion of one cranial suture, whereas complex craniosynostosis results from the premature fusion of several sutures.

The early fusion of a suture in primary craniosynostosis prevents any additional enlargement of the cranial bones and skull along this line. Continued growth of the brain and skull is therefore diverted to other areas of the head, causing an abnormal enlargement of these regions. For example, the early disappearance of the anterior fontanelle and premature closure of the sagittal suture prevents growth across the top of the head. This is compensated by upward growth by the bones of the lateral skull, resulting in a long, narrow, wedge-shaped head. This condition, known as scaphocephaly, accounts for approximately 50 percent of craniosynostosis abnormalities. Although the skull is misshapen, the brain still has adequate room to grow and thus there is no accompanying abnormal neurological development.

In cases of complex craniosynostosis, several sutures close prematurely. The amount and degree of skull deformity is determined by the location and extent of the sutures involved. This results in more severe constraints on skull growth, which can alter or impede proper brain growth and development.

Cases of craniosynostosis are usually treated with surgery. A team of physicians will open the skull along the fused suture, which will then allow the skull bones to resume their growth in this area. In some cases, parts of the skull will be removed and replaced with an artificial plate. The earlier after birth that surgery is performed, the better the outcome. After treatment, most children continue to grow and develop normally and do not exhibit any neurological problems.

Key Terms

alveolar process of the mandible upper border of mandibular body that contains the lower teeth

alveolar process of the maxilla curved, inferior margin of the maxilla that supports and anchors the upper teeth

angle of the mandible rounded corner located at outside margin of the body and ramus junction

angle of the rib portion of rib with greatest curvature; together, the rib angles form the most posterior extent of the thoracic cage

anterior (ventral) sacral foramen one of the series of paired openings located on the anterior (ventral) side of the sacrum

anterior arch anterior portion of the ring-like C1 (atlas) vertebra

anterior cranial fossa shallowest and most anterior cranial fossa of the cranial base that extends from the frontal bone to the lesser wing of the sphenoid bone

anterior longitudinal ligament ligament that runs the length of the vertebral column, uniting the anterior aspects of the vertebral bodies

anulus fibrosus tough, fibrous outer portion of an intervertebral disc, which is strongly anchored to the bodies of the adjacent vertebrae

appendicular skeleton all bones of the upper and lower limbs, plus the girdle bones that attach each limb to the axial skeleton

articular tubercle smooth ridge located on the inferior skull, immediately anterior to the mandibular fossa

atlas first cervical (C1) vertebra

axial skeleton central, vertical axis of the body, including the skull, vertebral column, and thoracic cage

axis second cervical (C2) vertebra

body of the rib shaft portion of a rib

brain case portion of the skull that contains and protects the brain, consisting of the eight bones that form the cranial base and rounded upper skull

calvaria (also, skullcap) rounded top of the skull

carotid canal zig-zag tunnel providing passage through the base of the skull for the internal carotid artery to the brain; begins anteromedial to the styloid process and terminates in the middle cranial cavity, near the posterior-lateral base of the sella turcica

cervical curve posteriorly concave curvature of the cervical vertebral column region; a secondary curve of the vertebral column

cervical vertebrae seven vertebrae numbered as C1–C7 that are located in the neck region of the vertebral column

clavicular notch paired notches located on the superior-lateral sides of the sternal manubrium, for articulation with the clavicle

coccyx small bone located at inferior end of the adult vertebral column that is formed by the fusion of four coccygeal vertebrae; also referred to as the "tailbone"

condylar process of the mandible thickened upward projection from posterior margin of mandibular ramus

condyle oval-shaped process located at the top of the condylar process of the mandible

coronal suture joint that unites the frontal bone to the right and left parietal bones across the top of the skull

coronoid process of the mandible flattened upward projection from the anterior margin of the mandibular ramus

costal cartilage hyaline cartilage structure attached to the anterior end of each rib that provides for either direct or indirect attachment of most ribs to the sternum

costal facet site on the lateral sides of a thoracic vertebra for articulation with the head of a rib

costal groove shallow groove along the inferior margin of a rib that provides passage for blood vessels and a nerve

cranial cavity interior space of the skull that houses the brain

cranium skull

cribriform plate small, flattened areas with numerous small openings, located to either side of the midline in the floor of the anterior cranial fossa; formed by the ethmoid bone

crista galli small upward projection located at the midline in the floor of the anterior cranial fossa; formed by the ethmoid bone

dens bony projection (odontoid process) that extends upward from the body of the C2 (axis) vertebra

ear ossicles three small bones located in the middle ear cavity that serve to transmit sound vibrations to the inner ear

ethmoid air cell one of several small, air-filled spaces located within the lateral sides of the ethmoid bone, between the orbit and upper nasal cavity

ethmoid bone unpaired bone that forms the roof and upper, lateral walls of the nasal cavity, portions of the floor of the anterior cranial fossa and medial wall of orbit, and the upper portion of the nasal septum

external acoustic meatus ear canal opening located

on the lateral side of the skull

external occipital protuberance small bump located at the midline on the posterior skull

facet small, flattened area on a bone for an articulation (joint) with another bone, or for muscle attachment

facial bones fourteen bones that support the facial structures and form the upper and lower jaws and the hard palate

false ribs vertebrochondral ribs 8–12 whose costal cartilage either attaches indirectly to the sternum via the costal cartilage of the next higher rib or does not attach to the sternum at all

floating ribs vertebral ribs 11–12 that do not attach to the sternum or to the costal cartilage of another rib

fontanelle expanded area of fibrous connective tissue that separates the brain case bones of the skull prior to birth and during the first year after birth

foramen lacerum irregular opening in the base of the skull, located inferior to the exit of carotid canal

foramen magnum large opening in the occipital bone of the skull through which the spinal cord emerges and the vertebral arteries enter the cranium

foramen ovale of the middle cranial fossa oval-shaped opening in the floor of the middle cranial fossa

foramen rotundum round opening in the floor of the middle cranial fossa, located between the superior orbital fissure and foramen ovale

foramen spinosum small opening in the floor of the middle cranial fossa, located lateral to the foramen ovale

frontal bone unpaired bone that forms forehead, roof of orbit, and floor of anterior cranial fossa

frontal sinus air-filled space within the frontal bone; most anterior of the paranasal sinuses

glabella slight depression of frontal bone, located at the midline between the eyebrows

greater wings of sphenoid bone lateral projections of the sphenoid bone that form the anterior wall of the middle cranial fossa and an area of the lateral skull

hard palate bony structure that forms the roof of the mouth and floor of the nasal cavity, formed by the palatine process of the maxillary bones and the horizontal plate of the palatine bones

head of the rib posterior end of a rib that articulates with the bodies of thoracic vertebrae

horizontal plate medial extension from the palatine bone that forms the posterior quarter of the hard palate

hyoid bone small, U-shaped bone located in upper neck that does not contact any other bone

hypoglossal canal paired openings that pass anteriorly from the anterior-lateral margins of the foramen magnum deep to the occipital condyles

hypophyseal (pituitary) fossa shallow depression on top of the sella turcica that houses the pituitary (hypophyseal) gland

inferior articular process bony process that extends downward from the vertebral arch of a vertebra that articulates with the superior articular process of the next lower vertebra

inferior nasal concha one of the paired bones that project from the lateral walls of the nasal cavity to form the largest and most inferior of the nasal conchae

infraorbital foramen opening located on anterior skull, below the orbit

infratemporal fossa space on lateral side of skull, below the level of the zygomatic arch and deep (medial) to the ramus of the mandible

internal acoustic meatus opening into petrous ridge, located on the lateral wall of the posterior cranial fossa

intervertebral disc structure located between the bodies of adjacent vertebrae that strongly joins the vertebrae; provides padding, weight bearing ability, and enables vertebral column movements

intervertebral foramen opening located between adjacent vertebrae for exit of a spinal nerve

jugular (suprasternal) notch shallow notch located on superior surface of sternal manubrium

jugular foramen irregularly shaped opening located in the lateral floor of the posterior cranial cavity

kyphosis (also, humpback or hunchback) excessive posterior curvature of the thoracic vertebral column region

lacrimal bone paired bones that contribute to the anterior-medial wall of each orbit

lacrimal fossa shallow depression in the anterior-medial wall of the orbit, formed by the lacrimal bone that gives rise to the nasolacrimal canal

lambdoid suture inverted V-shaped joint that unites the occipital bone to the right and left parietal bones on the posterior skull

lamina portion of the vertebral arch on each vertebra that extends between the transverse and spinous process

lateral pterygoid plate paired, flattened bony projections of the sphenoid bone located on the inferior skull, lateral to the medial pterygoid plate

lateral sacral crest paired irregular ridges running down the lateral sides of the posterior sacrum that

was formed by the fusion of the transverse processes from the five sacral vertebrae

lesser wings of the sphenoid bone lateral extensions of the sphenoid bone that form the bony lip separating the anterior and middle cranial fossae

ligamentum flavum series of short ligaments that unite the lamina of adjacent vertebrae

lingula small flap of bone located on the inner (medial) surface of mandibular ramus, next to the mandibular foramen

lordosis (also, swayback) excessive anterior curvature of the lumbar vertebral column region

lumbar curve posteriorly concave curvature of the lumbar vertebral column region; a secondary curve of the vertebral column

lumbar vertebrae five vertebrae numbered as L1–L5 that are located in lumbar region (lower back) of the vertebral column

mandible unpaired bone that forms the lower jaw bone; the only moveable bone of the skull

mandibular foramen opening located on the inner (medial) surface of the mandibular ramus

mandibular fossa oval depression located on the inferior surface of the skull

mandibular notch large U-shaped notch located between the condylar process and coronoid process of the mandible

manubrium expanded, superior portion of the sternum

mastoid process large bony prominence on the inferior, lateral skull, just behind the earlobe

maxillary bone (also, maxilla) paired bones that form the upper jaw and anterior portion of the hard palate

maxillary sinus air-filled space located with each maxillary bone; largest of the paranasal sinuses

medial pterygoid plate paired, flattened bony projections of the sphenoid bone located on the inferior skull medial to the lateral pterygoid plate; form the posterior portion of the nasal cavity lateral wall

median sacral crest irregular ridge running down the midline of the posterior sacrum that was formed from the fusion of the spinous processes of the five sacral vertebrae

mental foramen opening located on the anterior-lateral side of the mandibular body

mental protuberance inferior margin of anterior mandible that forms the chin

middle cranial fossa centrally located cranial fossa that extends from the lesser wings of the sphenoid bone to the petrous ridge

middle nasal concha nasal concha formed by the ethmoid bone that is located between the superior and inferior conchae

mylohyoid line bony ridge located along the inner (medial) surface of the mandibular body

nasal bone paired bones that form the base of the nose

nasal cavity opening through skull for passage of air

nasal conchae curved bony plates that project from the lateral walls of the nasal cavity; include the superior and middle nasal conchae, which are parts of the ethmoid bone, and the independent inferior nasal conchae bone

nasal septum flat, midline structure that divides the nasal cavity into halves, formed by the perpendicular plate of the ethmoid bone, vomer bone, and septal cartilage

nasolacrimal canal passage for drainage of tears that extends downward from the medial-anterior orbit to the nasal cavity, terminating behind the inferior nasal conchae

neck of the rib narrowed region of a rib, next to the rib head

notochord rod-like structure along dorsal side of the early embryo; largely disappears during later development but does contribute to formation of the intervertebral discs

nuchal ligament expanded portion of the supraspinous ligament within the posterior neck; interconnects the spinous processes of the cervical vertebrae and attaches to the base of the skull

nucleus pulposus gel-like central region of an intervertebral disc; provides for padding, weight-bearing, and movement between adjacent vertebrae

occipital bone unpaired bone that forms the posterior portions of the brain case and base of the skull

occipital condyle paired, oval-shaped bony knobs located on the inferior skull, to either side of the foramen magnum

optic canal opening spanning between middle cranial fossa and posterior orbit

orbit bony socket that contains the eyeball and associated muscles

palatine bone paired bones that form the posterior quarter of the hard palate and a small area in floor of the orbit

palatine process medial projection from the maxilla bone that forms the anterior three quarters of the hard palate

paranasal sinuses cavities within the skull that are connected to the conchae that serve to warm and humidify incoming air, produce mucus, and lighten the weight of the skull; consist of frontal, maxillary, sphenoidal, and ethmoidal sinuses

parietal bone paired bones that form the upper, lateral sides of the skull

pedicle portion of the vertebral arch that extends from the vertebral body to the transverse process

perpendicular plate of the ethmoid bone downward, midline extension of the ethmoid bone that forms the superior portion of the nasal septum

petrous ridge petrous portion of the temporal bone that forms a large, triangular ridge in the floor of the cranial cavity, separating the middle and posterior cranial fossae; houses the middle and inner ear structures

posterior (dorsal) sacral foramen one of the series of paired openings located on the posterior (dorsal) side of the sacrum

posterior arch posterior portion of the ring-like C1 (atlas) vertebra

posterior cranial fossa deepest and most posterior cranial fossa; extends from the petrous ridge to the occipital bone

posterior longitudinal ligament ligament that runs the length of the vertebral column, uniting the posterior sides of the vertebral bodies

primary curve anteriorly concave curvatures of the thoracic and sacrococcygeal regions that are retained from the original fetal curvature of the vertebral column

pterion H-shaped suture junction region that unites the frontal, parietal, temporal, and sphenoid bones on the lateral side of the skull

ramus of the mandible vertical portion of the mandible

ribs thin, curved bones of the chest wall

sacral canal bony tunnel that runs through the sacrum

sacral foramina series of paired openings for nerve exit located on both the anterior (ventral) and posterior (dorsal) aspects of the sacrum

sacral hiatus inferior opening and termination of the sacral canal

sacral promontory anterior lip of the base (superior end) of the sacrum

sacrococcygeal curve anteriorly concave curvature formed by the sacrum and coccyx; a primary curve of the vertebral column

sacrum single bone located near the inferior end of the adult vertebral column that is formed by the fusion of five sacral vertebrae; forms the posterior portion of the pelvis

sagittal suture joint that unites the right and left parietal bones at the midline along the top of the skull

sclerotome medial portion of a somite consisting of mesenchyme tissue that will give rise to bone, cartilage, and fibrous connective tissues

scoliosis abnormal lateral curvature of the vertebral column

secondary curve posteriorly concave curvatures of the cervical and lumbar regions of the vertebral column that develop after the time of birth

sella turcica elevated area of sphenoid bone located at midline of the middle cranial fossa

septal cartilage flat cartilage structure that forms the anterior portion of the nasal septum

skeleton bones of the body

skull bony structure that forms the head, face, and jaws, and protects the brain; consists of 22 bones

somite one of the paired, repeating blocks of tissue located on either side of the notochord in the early embryo

sphenoid bone unpaired bone that forms the central base of skull

sphenoid sinus air-filled space located within the sphenoid bone; most posterior of the paranasal sinuses

spinous process unpaired bony process that extends posteriorly from the vertebral arch of a vertebra

squamous suture joint that unites the parietal bone to the squamous portion of the temporal bone on the lateral side of the skull

sternal angle junction line between manubrium and body of the sternum and the site for attachment of the second rib to the sternum

sternum flattened bone located at the center of the anterior chest

styloid process downward projecting, elongated bony process located on the inferior aspect of the skull

stylomastoid foramen opening located on inferior skull, between the styloid process and mastoid process

superior articular process bony process that extends upward from the vertebral arch of a vertebra that articulates with the inferior articular process of the next higher vertebra

superior articular process of the sacrum paired processes that extend upward from the sacrum to articulate (join) with the inferior articular processes from the L5 vertebra

superior nasal concha smallest and most superiorly located of the nasal conchae; formed by the ethmoid bone

superior nuchal line paired bony lines on the posterior skull that extend laterally from the external occipital protuberance

superior orbital fissure irregularly shaped opening

between the middle cranial fossa and the posterior orbit

supraorbital foramen opening located on anterior skull, at the superior margin of the orbit

supraorbital margin superior margin of the orbit

supraspinous ligament ligament that interconnects the spinous processes of the thoracic and lumbar vertebrae

suture junction line at which adjacent bones of the skull are united by fibrous connective tissue

temporal bone paired bones that form the lateral, inferior portions of the skull, with squamous, mastoid, and petrous portions

temporal fossa shallow space on the lateral side of the skull, above the level of the zygomatic arch

temporal process of the zygomatic bone short extension from the zygomatic bone that forms the anterior portion of the zygomatic arch

thoracic cage consists of 12 pairs of ribs and sternum

thoracic curve anteriorly concave curvature of the thoracic vertebral column region; a primary curve of the vertebral column

thoracic vertebrae twelve vertebrae numbered as T1–T12 that are located in the thoracic region (upper back) of the vertebral column

transverse foramen opening found only in the transverse processes of cervical vertebrae

transverse process paired bony processes that extends laterally from the vertebral arch of a vertebra

true ribs vertebrosternal ribs 1–7 that attach via their costal cartilage directly to the sternum

tubercle of the rib small bump on the posterior side of a rib for articulation with the transverse process of a thoracic vertebra

vertebra individual bone in the neck and back regions of the vertebral column

vertebral (spinal) canal bony passageway within the vertebral column for the spinal cord that is formed by the series of individual vertebral foramina

vertebral arch bony arch formed by the posterior portion of each vertebra that surrounds and protects the spinal cord

vertebral column entire sequence of bones that extend from the skull to the tailbone

vertebral foramen opening associated with each vertebra defined by the vertebral arch that provides passage for the spinal cord

vomer bone unpaired bone that forms the inferior and posterior portions of the nasal septum

xiphoid process small process that forms the inferior tip of the sternum

zygomatic arch elongated, free-standing arch on the lateral skull, formed anteriorly by the temporal process of the zygomatic bone and posteriorly by the zygomatic process of the temporal bone

zygomatic bone cheekbone; paired bones that contribute to the lateral orbit and anterior zygomatic arch

zygomatic process of the temporal bone extension from the temporal bone that forms the posterior portion of the zygomatic arch

Chapter Review

7.1 Divisions of the Skeletal System

The skeletal system includes all of the bones, cartilages, and ligaments of the body. It serves to support the body, protect the brain and other internal organs, and provides a rigid structure upon which muscles can pull to generate body movements. It also stores fat and the tissue responsible for the production of blood cells. The skeleton is subdivided into two parts. The axial skeleton forms a vertical axis that includes the head, neck, back, and chest. It has 80 bones and consists of the skull, vertebral column, and thoracic cage. The adult vertebral column consists of 24 vertebrae plus the sacrum and coccyx. The thoracic cage is formed by 12 pairs of ribs and the sternum. The appendicular skeleton consists of 126 bones in the adult and includes all of the bones of the upper and lower limbs plus the bones that anchor each limb to the axial skeleton.

7.2 The Skull

The skull consists of the brain case and the facial bones. The brain case surrounds and protects the brain, which occupies the cranial cavity inside the skull. It consists of the rounded calvaria and a complex base. The brain case is formed by eight bones, the paired parietal and temporal bones plus the unpaired frontal, occipital, sphenoid, and ethmoid bones. The narrow gap between the bones is filled with dense, fibrous connective tissue that unites the bones. The sagittal suture joins the right and left parietal bones. The coronal suture joins the parietal bones to the frontal bone, the lambdoid suture joins them to the occipital bone, and the squamous suture joins them to the temporal bone.

The facial bones support the facial structures and form the upper and lower jaws. These consist of 14 bones, with the paired maxillary, palatine, zygomatic, nasal, lacrimal, and inferior conchae bones and the unpaired

vomer and mandible bones. The ethmoid bone also contributes to the formation of facial structures. The maxilla forms the upper jaw and the mandible forms the lower jaw. The maxilla also forms the larger anterior portion of the hard palate, which is completed by the smaller palatine bones that form the posterior portion of the hard palate.

The floor of the cranial cavity increases in depth from front to back and is divided into three cranial fossae. The anterior cranial fossa is located between the frontal bone and lesser wing of the sphenoid bone. A small area of the ethmoid bone, consisting of the crista galli and cribriform plates, is located at the midline of this fossa. The middle cranial fossa extends from the lesser wing of the sphenoid bone to the petrous ridge (petrous portion of temporal bone). The right and left sides are separated at the midline by the sella turcica, which surrounds the shallow hypophyseal fossa. Openings through the skull in the floor of the middle fossa include the optic canal and superior orbital fissure, which open into the posterior orbit, the foramen rotundum, foramen ovale, and foramen spinosum, and the exit of the carotid canal with its underlying foramen lacerum. The deep posterior cranial fossa extends from the petrous ridge to the occipital bone. Openings here include the large foramen magnum, plus the internal acoustic meatus, jugular foramina, and hypoglossal canals. Additional openings located on the external base of the skull include the stylomastoid foramen and the entrance to the carotid canal.

The anterior skull has the orbits that house the eyeballs and associated muscles. The walls of the orbit are formed by contributions from seven bones: the frontal, zygomatic, maxillary, palatine, ethmoid, lacrimal, and sphenoid. Located at the superior margin of the orbit is the supraorbital foramen, and below the orbit is the infraorbital foramen. The mandible has two openings, the mandibular foramen on its inner surface and the mental foramen on its external surface near the chin. The nasal conchae are bony projections from the lateral walls of the nasal cavity. The large inferior nasal concha is an independent bone, while the middle and superior conchae are parts of the ethmoid bone. The nasal septum is formed by the perpendicular plate of the ethmoid bone, the vomer bone, and the septal cartilage. The paranasal sinuses are air-filled spaces located within the frontal, maxillary, sphenoid, and ethmoid bones.

On the lateral skull, the zygomatic arch consists of two parts, the temporal process of the zygomatic bone anteriorly and the zygomatic process of the temporal bone posteriorly. The temporal fossa is the shallow space located on the lateral skull above the level of the zygomatic arch. The infratemporal fossa is located below the zygomatic arch and deep to the ramus of the mandible.

The hyoid bone is located in the upper neck and does not join with any other bone. It is held in position by muscles and serves to support the tongue above, the larynx below, and the pharynx posteriorly.

7.3 The Vertebral Column

The vertebral column forms the neck and back. The vertebral column originally develops as 33 vertebrae, but is eventually reduced to 24 vertebrae, plus the sacrum and coccyx. The vertebrae are divided into the cervical region (C1–C7 vertebrae), the thoracic region (T1–T12 vertebrae), and the lumbar region (L1–L5 vertebrae). The sacrum arises from the fusion of five sacral vertebrae and the coccyx from the fusion of four small coccygeal vertebrae. The vertebral column has four curvatures, the cervical, thoracic, lumbar, and sacrococcygeal curves. The thoracic and sacrococcygeal curves are primary curves retained from the original fetal curvature. The cervical and lumbar curves develop after birth and thus are secondary curves. The cervical curve develops as the infant begins to hold up the head, and the lumbar curve appears with standing and walking.

A typical vertebra consists of an enlarged anterior portion called the body, which provides weight-bearing support. Attached posteriorly to the body is a vertebral arch, which surrounds and defines the vertebral foramen for passage of the spinal cord. The vertebral arch consists of the pedicles, which attach to the vertebral body, and the laminae, which come together to form the roof of the arch. Arising from the vertebral arch are the laterally projecting transverse processes and the posteriorly oriented spinous process. The superior articular processes project upward, where they articulate with the downward projecting inferior articular processes of the next higher vertebrae.

A typical cervical vertebra has a small body, a bifid (Y-shaped) spinous process, and U-shaped transverse processes with a transverse foramen. In addition to these characteristics, the axis (C2 vertebra) also has the dens projecting upward from the vertebral body. The atlas (C1 vertebra) differs from the other cervical vertebrae in that it does not have a body, but instead consists of bony ring formed by the anterior and posterior arches. The atlas articulates with the dens from the axis. A typical thoracic vertebra is distinguished by its long, downward projecting spinous

process. Thoracic vertebrae also have articulation facets on the body and transverse processes for attachment of the ribs. Lumbar vertebrae support the greatest amount of body weight and thus have a large, thick body. They also have a short, blunt spinous process. The sacrum is triangular in shape. The median sacral crest is formed by the fused vertebral spinous processes and the lateral sacral crest is derived from the fused transverse processes. Anterior (ventral) and posterior (dorsal) sacral foramina allow branches of the sacral spinal nerves to exit the sacrum. The auricular surfaces are articulation sites on the lateral sacrum that anchor the sacrum to the hipbones to form the pelvis. The coccyx is small and derived from the fusion of four small vertebrae.

The intervertebral discs fill in the gaps between the bodies of adjacent vertebrae. They provide strong attachments and padding between the vertebrae. The outer, fibrous layer of a disc is called the anulus fibrosus. The gel-like interior is called the nucleus pulposus. The disc can change shape to allow for movement between vertebrae. If the anulus fibrosus is weakened or damaged, the nucleus pulposus can protrude outward, resulting in a herniated disc.

The anterior longitudinal ligament runs along the full length of the anterior vertebral column, uniting the vertebral bodies. The supraspinous ligament is located posteriorly and interconnects the spinous processes of the thoracic and lumbar vertebrae. In the neck, this ligament expands to become the nuchal ligament. The nuchal ligament is attached to the cervical spinous processes and superiorly to the base of the skull, out to the external occipital protuberance. The posterior longitudinal ligament runs within the vertebral canal and unites the posterior sides of the vertebral bodies. The ligamentum flavum unites the lamina of adjacent vertebrae.

7.4 The Thoracic Cage

The thoracic cage protects the heart and lungs. It is composed of 12 pairs of ribs with their costal cartilages and the sternum. The ribs are anchored posteriorly to the 12 thoracic vertebrae. The sternum consists of the manubrium, body, and xiphoid process. The manubrium and body are joined at the sternal angle, which is also the site for attachment of the second ribs.

Ribs are flattened, curved bones and are numbered 1–12. Posteriorly, the head of the rib articulates with the costal facets located on the bodies of thoracic vertebrae and the rib tubercle articulates with the facet located on the vertebral transverse process. The angle of the ribs forms the most posterior portion of the thoracic cage. The costal groove in the inferior margin of each rib carries blood vessels and a nerve. Anteriorly, each rib ends in a costal cartilage. True ribs (1–7) attach directly to the sternum via their costal cartilage. The false ribs (8–12) either attach to the sternum indirectly or not at all. Ribs 8–10 have their costal cartilages attached to the cartilage of the next higher rib. The floating ribs (11–12) are short and do not attach to the sternum or to another rib.

7.5 Embryonic Development of the Axial Skeleton

Formation of the axial skeleton begins during early embryonic development with the appearance of the rod-like notochord along the dorsal length of the early embryo. Repeating, paired blocks of tissue called somites then appear along either side of notochord. As the somites grow, they split into parts, one of which is called a sclerotome. This consists of mesenchyme, the embryonic tissue that will become the bones, cartilages, and connective tissues of the body.

Mesenchyme in the head region will produce the bones of the skull via two different mechanisms. The bones of the brain case arise via intramembranous ossification in which embryonic mesenchyme tissue converts directly into bone. At the time of birth, these bones are separated by fontanelles, wide areas of fibrous connective tissue. As the bones grow, the fontanelles are reduced to sutures, which allow for continued growth of the skull throughout childhood. In contrast, the cranial base and facial bones are produced by the process of endochondral ossification, in which mesenchyme tissue initially produces a hyaline cartilage model of the future bone. The cartilage model allows for growth of the bone and is gradually converted into bone over a period of many years.

The vertebrae, ribs, and sternum also develop via endochondral ossification. Mesenchyme accumulates around the notochord and produces hyaline cartilage models of the vertebrae. The notochord largely disappears, but remnants of the notochord contribute to formation of the intervertebral discs. In the thorax region, a portion of the vertebral cartilage model splits off to form the ribs. These then become attached anteriorly to the developing cartilage model of the sternum. Growth of the cartilage models for the vertebrae, ribs, and sternum allow for enlargement of the thoracic cage during childhood and adolescence. The cartilage models gradually undergo ossification and are converted into bone.

Interactive Link Questions

1. Watch this video (http://openstax.org/l/skull1) to view a rotating and exploded skull with color-coded bones. Which bone (yellow) is centrally located and joins with most of the other bones of the skull?
2. View this animation (http://openstax.org/l/headblow) to see how a blow to the head may produce a contrecoup (counterblow) fracture of the basilar portion of the occipital bone on the base of the skull. Why may a basilar fracture be life threatening?
3. Osteoporosis is a common age-related bone disease in which bone density and strength is decreased. Watch this video (http://openstax.org/l/osteoporosis) to get a better understanding of how thoracic vertebrae may become weakened and may fractured due to this disease. How may vertebral osteoporosis contribute to kyphosis?
4. Watch this video (http://openstax.org/l/herndisc1) to learn about a herniated disc. Watch this second video (http://openstax.org/l/herndisc2) to see one possible treatment for a herniated disc, removing the damaged portion of the disc. How could lifting a heavy object produce pain in a lower limb?
5. Use this tool (http://openstax.org/l/vertcolumn) to identify the bones, intervertebral discs, and ligaments of the vertebral column. The thickest portions of the anterior longitudinal ligament and the supraspinous ligament are found in which regions of the vertebral column?
6. View this video (http://openstax.org/l/skullbones) to review the two processes that give rise to the bones of the skull and body. What are the two mechanisms by which the bones of the body are formed and which bones are formed by each mechanism?

Review Questions

7. Which of the following is part of the axial skeleton?
   a. shoulder bones
   b. thigh bone
   c. foot bones
   d. vertebral column

8. Which of the following is a function of the axial skeleton?
   a. allows for movement of the wrist and hand
   b. protects nerves and blood vessels at the elbow
   c. supports trunk of body
   d. allows for movements of the ankle and foot

9. The axial skeleton _____.
   a. consists of 126 bones
   b. forms the vertical axis of the body
   c. includes all bones of the body trunk and limbs
   d. includes only the bones of the lower limbs

10. Which of the following is a bone of the brain case?
    a. parietal bone
    b. zygomatic bone
    c. maxillary bone
    d. lacrimal bone

11. The lambdoid suture joins the parietal bone to the _____.
    a. frontal bone
    b. occipital bone
    c. other parietal bone
    d. temporal bone

12. The middle cranial fossa _____.
   a. is bounded anteriorly by the petrous ridge
   b. is bounded posteriorly by the lesser wing of the sphenoid bone
   c. is divided at the midline by a small area of the ethmoid bone
   d. has the foramen rotundum, foramen ovale, and foramen spinosum

13. The paranasal sinuses are _____.
   a. air-filled spaces found within the frontal, maxilla, sphenoid, and ethmoid bones only
   b. air-filled spaces found within all bones of the skull
   c. not connected to the nasal cavity
   d. divided at the midline by the nasal septum

14. Parts of the sphenoid bone include the _____.
   a. sella turcica
   b. squamous portion
   c. glabella
   d. zygomatic process

15. The bony openings of the skull include the _____.
   a. carotid canal, which is located in the anterior cranial fossa
   b. superior orbital fissure, which is located at the superior margin of the anterior orbit
   c. mental foramen, which is located just below the orbit
   d. hypoglossal canal, which is located in the posterior cranial fossa

16. The cervical region of the vertebral column consists of _____.
   a. seven vertebrae
   b. 12 vertebrae
   c. five vertebrae
   d. a single bone derived from the fusion of five vertebrae

17. The primary curvatures of the vertebral column _____.
   a. include the lumbar curve
   b. are remnants of the original fetal curvature
   c. include the cervical curve
   d. develop after the time of birth

18. A typical vertebra has _____.
   a. a vertebral foramen that passes through the body
   b. a superior articular process that projects downward to articulate with the superior portion of the next lower vertebra
   c. lamina that spans between the transverse process and spinous process
   d. a pair of laterally projecting spinous processes

19. A typical lumbar vertebra has _____.
   a. a short, rounded spinous process
   b. a bifid spinous process
   c. articulation sites for ribs
   d. a transverse foramen

20. Which is found only in the cervical region of the vertebral column?
   a. nuchal ligament
   b. ligamentum flavum
   c. supraspinous ligament

d. anterior longitudinal ligament

21. The sternum _____.
a. consists of only two parts, the manubrium and xiphoid process
b. has the sternal angle located between the manubrium and body
c. receives direct attachments from the costal cartilages of all 12 pairs of ribs
d. articulates directly with the thoracic vertebrae

22. The sternal angle is the _____.
a. junction between the body and xiphoid process
b. site for attachment of the clavicle
c. site for attachment of the floating ribs
d. junction between the manubrium and body

23. The tubercle of a rib _____.
a. is for articulation with the transverse process of a thoracic vertebra
b. is for articulation with the body of a thoracic vertebra
c. provides for passage of blood vessels and a nerve
d. is the area of greatest rib curvature

24. True ribs are _____.
a. ribs 8–12
b. attached via their costal cartilage to the next higher rib
c. made entirely of bone, and thus do not have a costal cartilage
d. attached via their costal cartilage directly to the sternum

25. Embryonic development of the axial skeleton involves _____.
a. intramembranous ossification, which forms the facial bones.
b. endochondral ossification, which forms the ribs and sternum
c. the notochord, which produces the cartilage models for the vertebrae
d. the formation of hyaline cartilage models, which give rise to the flat bones of the skull

26. A fontanelle _____.
a. is the cartilage model for a vertebra that later is converted into bone
b. gives rise to the facial bones and vertebrae
c. is the rod-like structure that runs the length of the early embryo
d. is the area of fibrous connective tissue found at birth between the brain case bones

Critical Thinking Questions

27. Define the two divisions of the skeleton.

28. Discuss the functions of the axial skeleton.

29. Define and list the bones that form the brain case or support the facial structures.

30. Identify the major sutures of the skull, their locations, and the bones united by each.

31. Describe the anterior, middle, and posterior cranial fossae and their boundaries, and give the midline structure that divides each into right and left areas.

32. Describe the parts of the nasal septum in both the dry and living skull.

33. Describe the vertebral column and define each region.

34. Describe a typical vertebra.

35. Describe the sacrum.

36. Describe the structure and function of an intervertebral disc.

37. Define the ligaments of the vertebral column.

38. Define the parts and functions of the thoracic cage.

39. Describe the parts of the sternum.

40. Discuss the parts of a typical rib.

41. Define the classes of ribs.

42. Discuss the processes by which the brain-case bones of the skull are formed and grow during skull enlargement.

43. Discuss the process that gives rise to the base and facial bones of the skull.

44. Discuss the development of the vertebrae, ribs, and sternum.