

fontanel is easily located by following the sagittal suture toward the occiput. The posterior fontanel is triangular, usually measuring between 0.5 and 1 cm (<0.5 inch) at its widest part. The fontanels should feel flat, firm, and well demarcated against the bony edges of the skull. Frequently, pulsations are visible at the anterior fontanel. Coughing, crying, or lying down may temporarily cause the fontanels to bulge and become more taut.

Palpate the skull for any unusual masses or prominences, particularly those resulting from birth trauma, such as caput succedaneum or cephalhematoma (see [Chapter 8](#)). Because of the pliability of the skull, exerting pressure at the margin of the parietal and occipital bones along the lambdoid suture may produce a snapping sensation similar to the indentation of a ping-pong ball. This phenomenon, known as **physiologic craniotabes**, may be found normally, especially in newborns of breech birth, but also may indicate hydrocephalus, congenital syphilis, or rickets.

Assess the degree of head control. Although head lag is normal in newborns, the degree of ability to control the head in certain positions should be recognized. If a supine infant is pulled from the arms into a semi-Fowler position, marked head lag and hyperextension are noted ([Fig. 7-7, A](#)). However, as the infant is brought forward into a sitting position, the infant will attempt to control the head in an upright position. As the head falls forward onto the chest, many infants will attempt to right it into the erect position. Also, if the infant is held in ventral suspension (i.e., held prone above and parallel to the examining surface), the infant will hold the head in a straight line with the spinal column (see [Fig. 7-7, B](#)). When lying on the abdomen, newborns have the ability to lift the head slightly, turning it from side to side. Marked head lag is seen in neonates with Down syndrome, prematurity, hypoxia, and neuromuscular compromise.