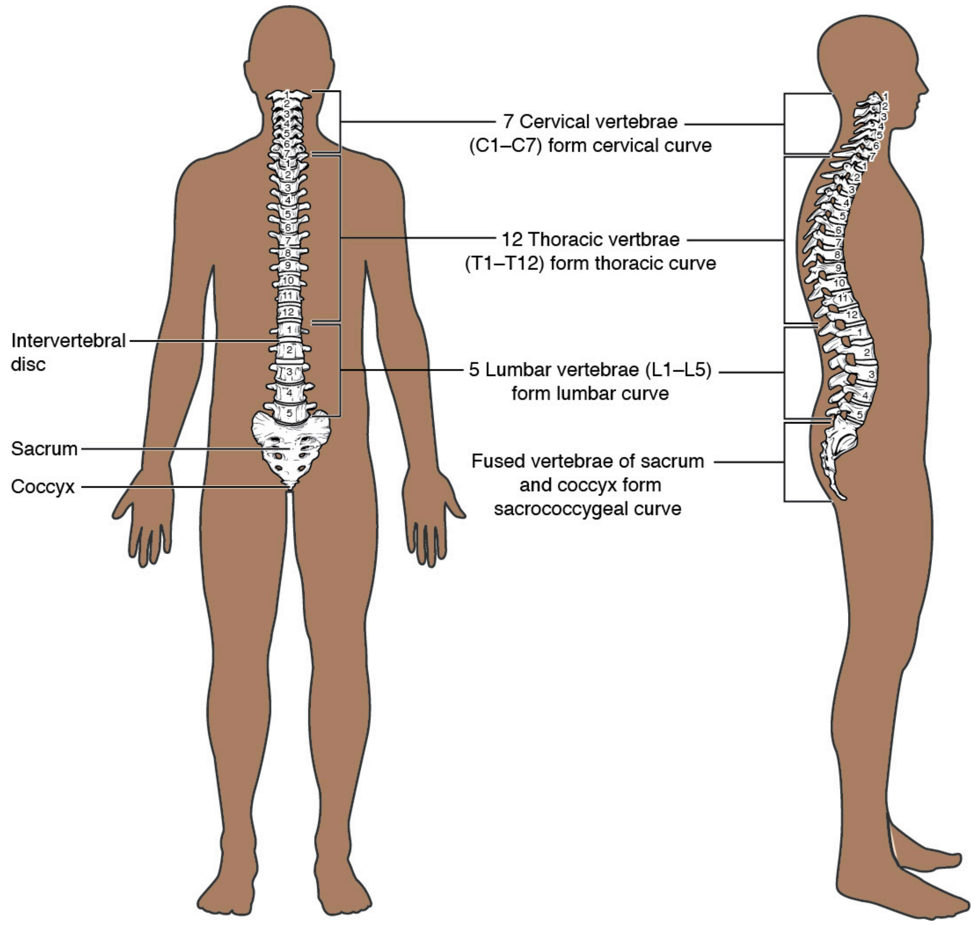


FIGURE 7.20 **Vertebral Column** The adult vertebral column consists of 24 vertebrae, plus the sacrum and coccyx. The vertebrae are divided into three regions: cervical C1–C7 vertebrae, thoracic T1–T12 vertebrae, and lumbar L1–L5 vertebrae. The vertebral column is curved, with two primary curvatures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

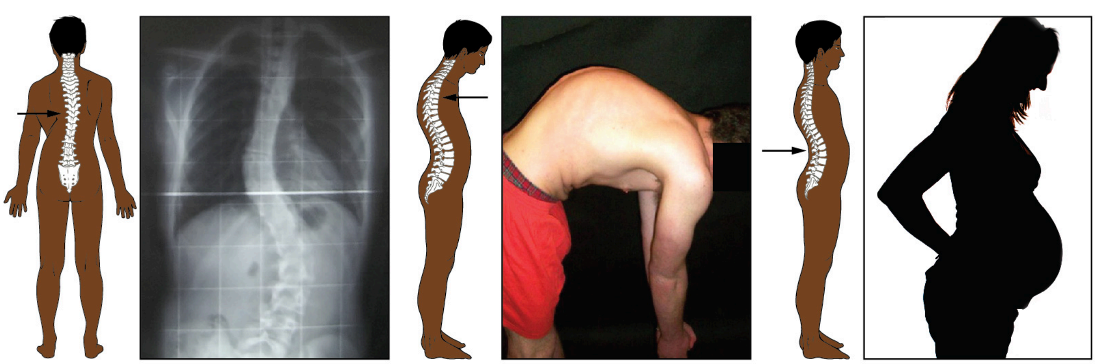
Disorders of the...

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.

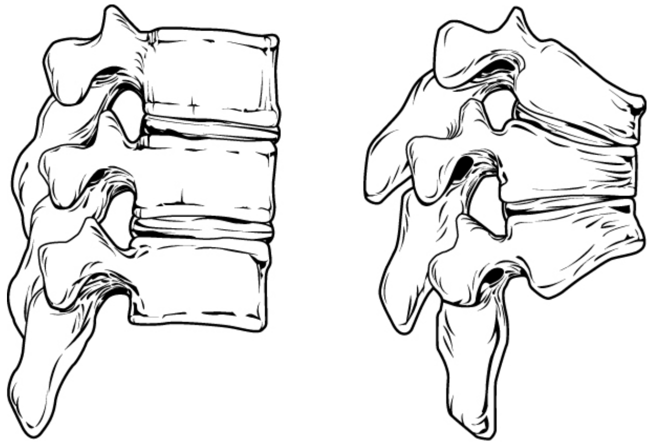


FIGURE 7.22 **Osteoporosis** Osteoporosis is an age-related disorder that causes the gradual loss of bone density and strength. When the thoracic vertebrae are affected, there can be a gradual collapse of the vertebrae. This results in kyphosis, an excessive curvature of the thoracic region.

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.

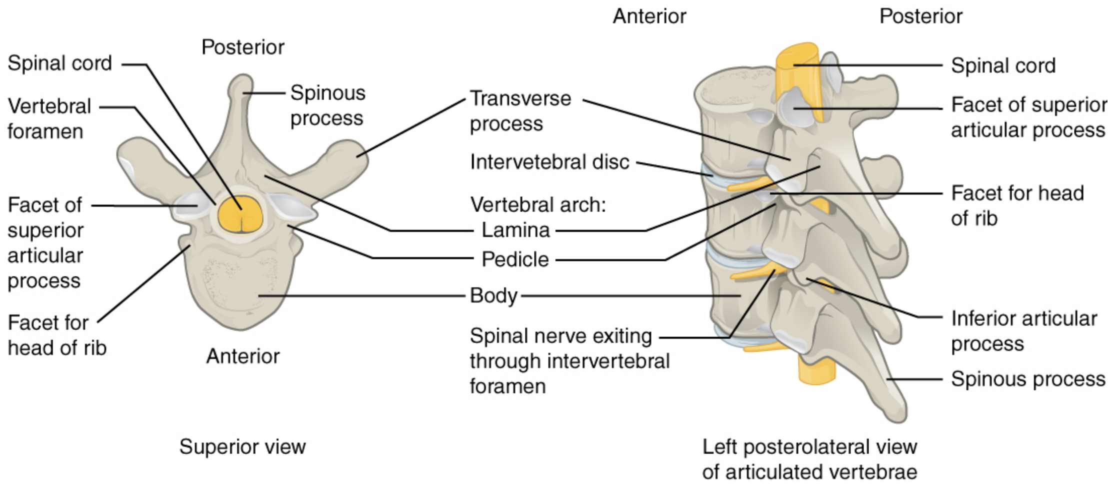


FIGURE 7.23 **Parts of a Typical Vertebra** A typical vertebra consists of a body and a vertebral arch. The arch is formed by the paired pedicles and paired laminae. Arising from the vertebral arch are the transverse, spinous, superior articular, and inferior articular processes. The vertebral foramen 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.

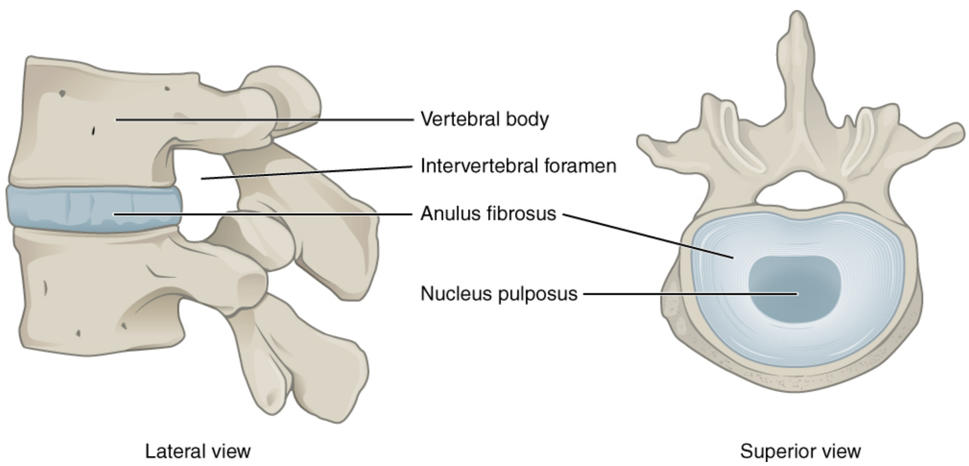


FIGURE 7.24 **Intervertebral Disc** The bodies of adjacent vertebrae are separated and united by an intervertebral disc, which provides padding and allows for movements between adjacent vertebrae. The disc consists of a fibrous outer layer called the anulus fibrosus and a gel-like center called the nucleus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

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.

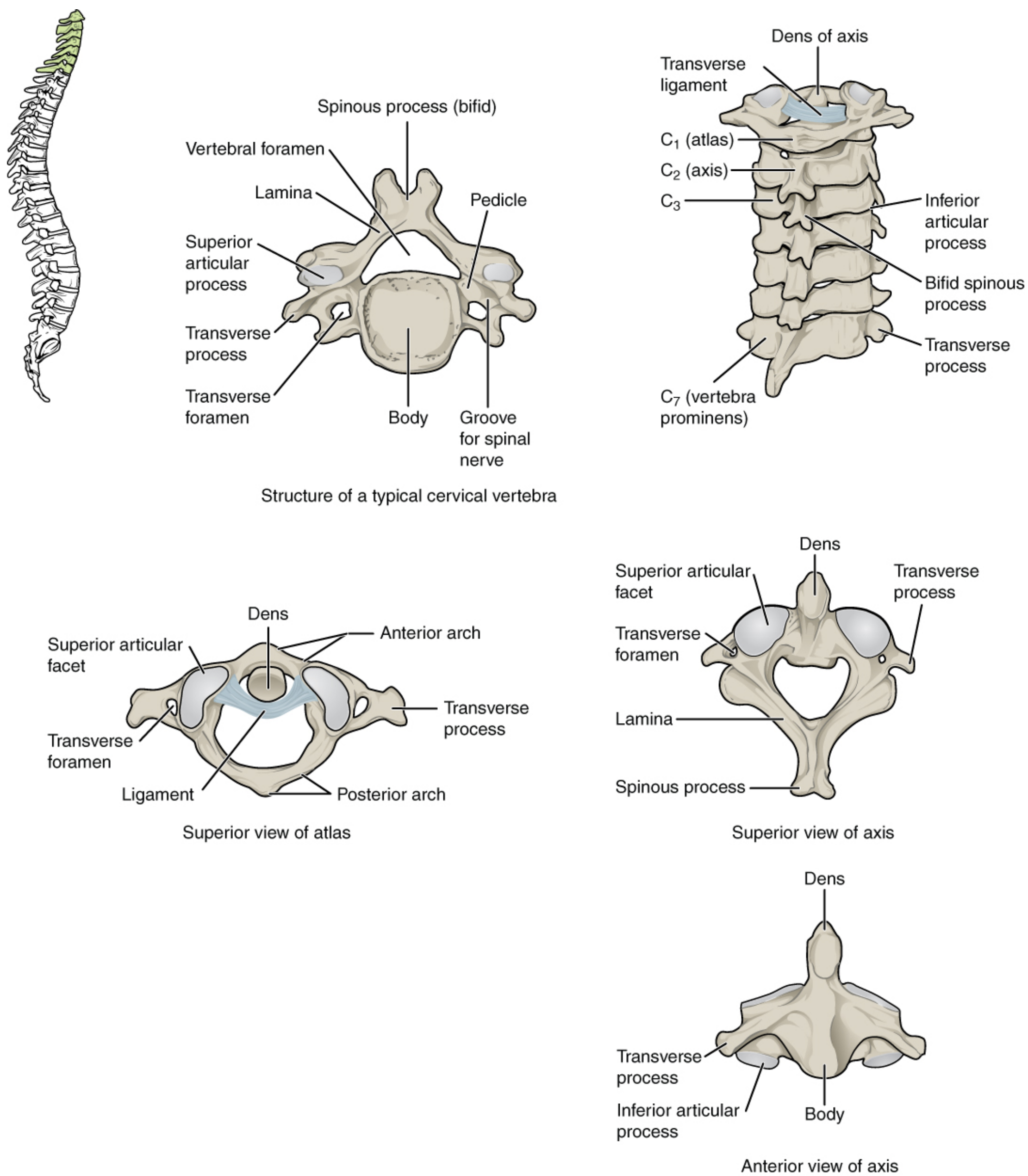


FIGURE 7.25 **Cervical Vertebrae** A typical cervical vertebra has a small body, a bifid spinous process, transverse processes that have a transverse foramen and are curved for spinal nerve passage. The atlas (C1 vertebra) does not have a body or spinous process. It consists of an anterior and a posterior 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 processes of thoracic vertebrae face anteriorly and the inferior processes face posteriorly. 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.

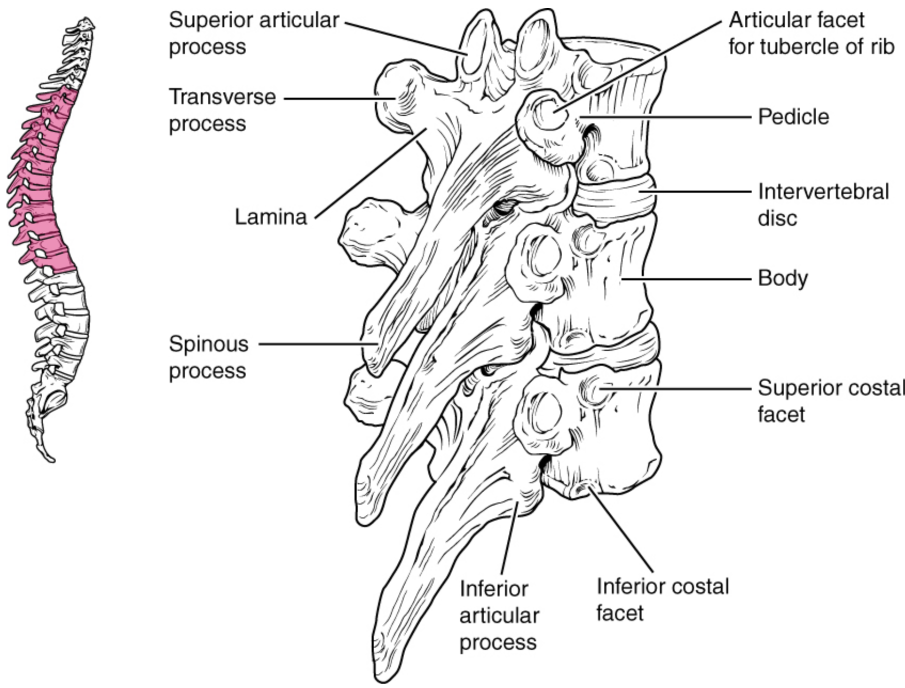


FIGURE 7.26 **Thoracic Vertebrae** A typical thoracic vertebra is distinguished by the spinous process, which is long and projects downward to overlap the next inferior vertebra. It also has articulation sites (facets) on the vertebral body and a transverse process for rib attachment.

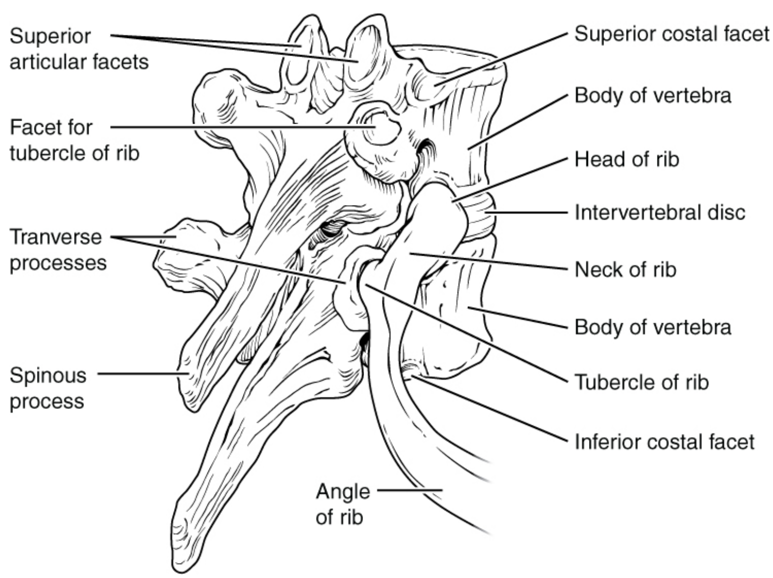


FIGURE 7.27 **Rib Articulation in Thoracic Vertebrae** Thoracic vertebrae have superior and inferior articular facets on the vertebral body for articulation with the head of a rib, and a transverse process facet for articulation with the rib tubercle.

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 backward and the inferior facing forward.

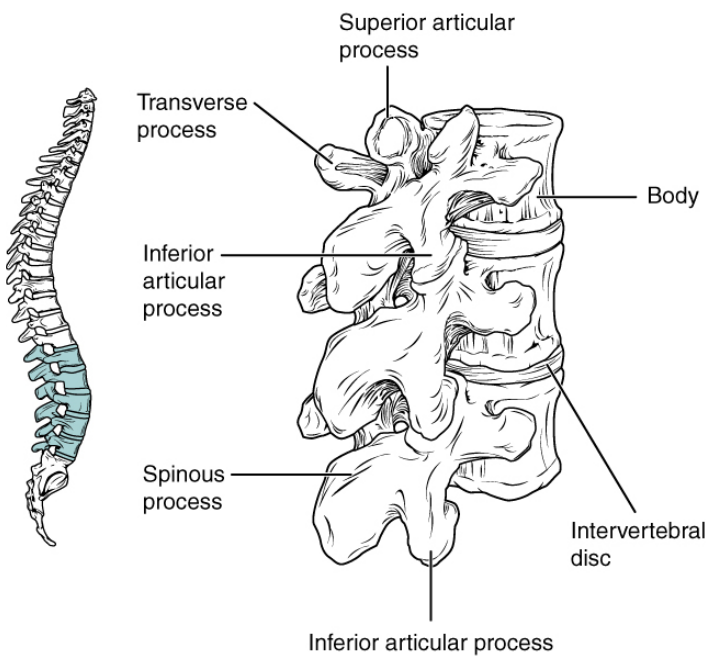


FIGURE 7.28 **Lumbar Vertebrae** Lumbar vertebrae are characterized by having a large, thick body and a short, rounded spinous process.

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.

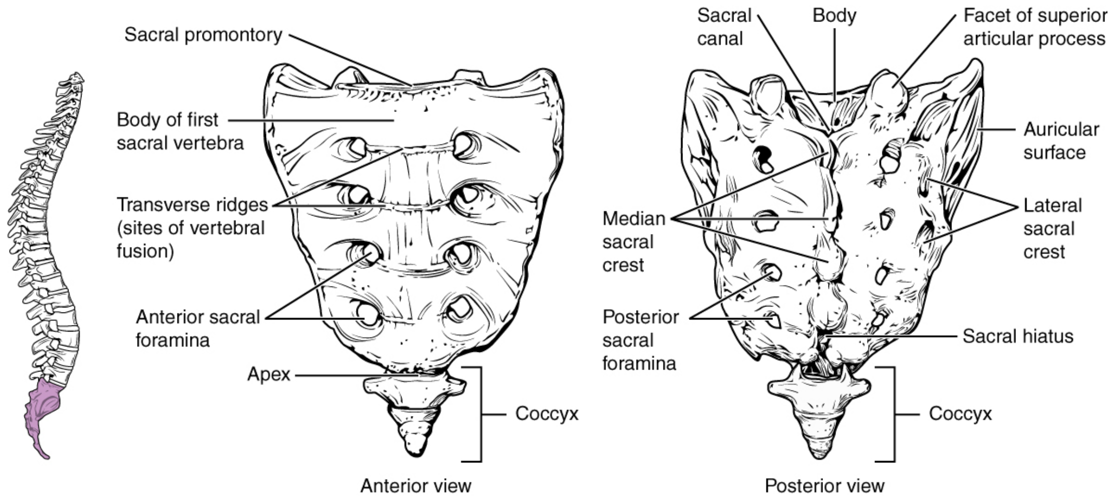


FIGURE 7.29 **Sacrum and Coccyx** The sacrum is formed from the fusion of five sacral vertebrae, whose lines of fusion are indicated by the transverse ridges. The fused spinous processes form the median sacral crest, while the lateral sacral crest arises from the fused transverse processes. The coccyx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

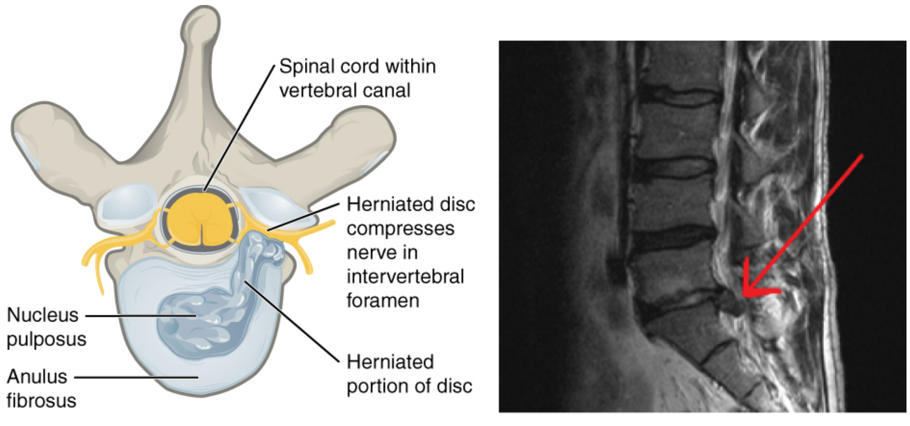


FIGURE 7.30 **Herniated Intervertebral Disc** Weakening of the anulus fibrosus can result in herniation (protrusion) of the nucleus pulposus and compression of a spinal nerve, resulting in pain and/or muscle weakness in the body regions supplied by that nerve.

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.

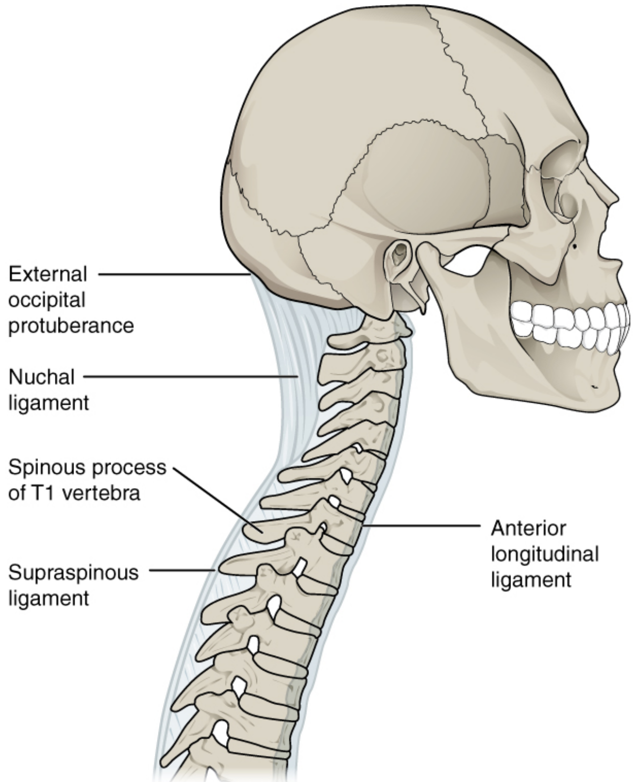


FIGURE 7.31 **Ligaments of Vertebral Column** The anterior longitudinal ligament runs the length of the vertebral column, uniting the anterior sides of the vertebral bodies. The supraspinous ligament connects the spinous processes of the thoracic and lumbar vertebrae. In the posterior neck, the supraspinous 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.

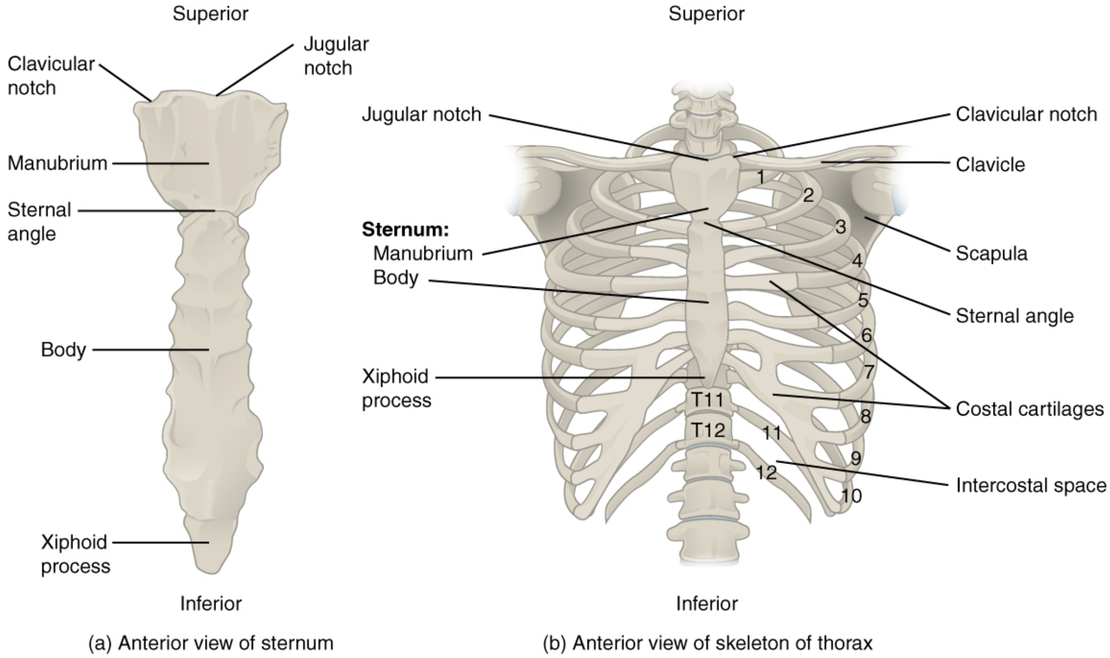


FIGURE 7.32 **Thoracic Cage** The thoracic cage is formed by the (a) sternum and (b) 12 pairs of ribs with their costal cartilages. The ribs are anchored posteriorly to the 12 thoracic vertebrae. The sternum consists of the manubrium, body, and xiphoid process. The ribs are classified as true ribs (1–7)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

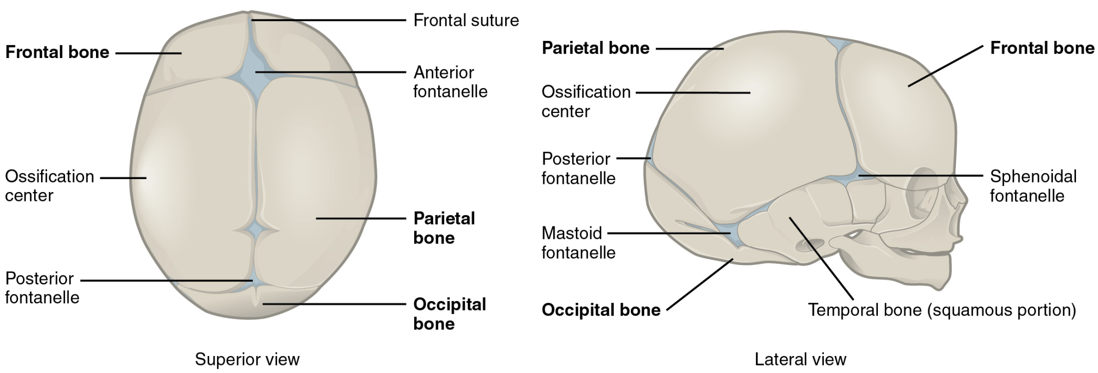


FIGURE 7.33 **Newborn Skull** The bones of the newborn skull are not fully ossified and are separated by large areas called fontanelles, which are filled with fibrous connective tissue. The fontanelles allow for continued growth of the skull after birth. At the time of birth, the facial bones are small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

CHAPTER 8
The Appendicular Skeleton

Figure 8.1 **Dancer** The appendicular skeleton consists of the upper and lower limb bones, the bones of the hands and feet, and the bones that anchor the limbs to the axial skeleton. (credit: Melissa Dooley/flickr)

CHAPTER OBJECTIVES

After studying this chapter, you will be able to:

- Discuss the bones of the pectoral and pelvic girdles, and describe how these unite the limbs with the axial skeleton
- Describe the bones of the upper limb, including the bones of the arm, forearm, wrist, and hand
- Identify the features of the pelvis and explain how these differ between the adult male and female pelvis
- Describe the bones of the lower limb, including the bones of the thigh, leg, ankle, and foot
- Describe the embryonic formation and growth of the limb bones

INTRODUCTION Your skeleton provides the internal supporting structure of the body. The adult axial skeleton consists of 80 bones that form the head and body trunk. Attached to this are the limbs, whose 126 bones constitute the appendicular skeleton. These bones are divided into two groups: the bones that are located within the limbs themselves, and the girdle bones that attach the limbs to the axial skeleton. The bones of the shoulder region form the pectoral girdle, which anchors the upper limb to the thoracic cage of the axial skeleton. The lower limb is attached to the vertebral column by the pelvic girdle.

Because of our upright stance, different functional demands are placed upon the upper and lower limbs. Thus, the bones of the lower limbs are adapted for weight-bearing support and stability, as well as for body locomotion via walking or running. In contrast, our upper limbs are not required for these functions. Instead, our upper limbs are highly mobile and can be utilized for a wide variety of activities. The large range of upper limb movements, coupled with the ability to easily manipulate objects with our hands and opposable thumbs, has allowed humans to construct the modern world in which we live.

8.1 The Pectoral Girdle

LEARNING OBJECTIVES

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

- Describe the bones that form the pectoral girdle
- List the functions of the pectoral girdle

The appendicular skeleton includes all of the limb bones, plus the bones that unite each limb with the axial skeleton

(Figure 8.2). The bones that attach each upper limb to the axial skeleton form the pectoral girdle (shoulder girdle). This consists of two bones, the scapula and clavicle (Figure 8.3). The clavicle (collarbone) is an S-shaped bone located on the anterior side of the shoulder. It is attached on its medial end to the sternum of the thoracic cage, which is part of the axial skeleton. The lateral end of the clavicle articulates (joins) with the scapula just above the shoulder joint. You can easily palpate, or feel with your fingers, the entire length of your clavicle.

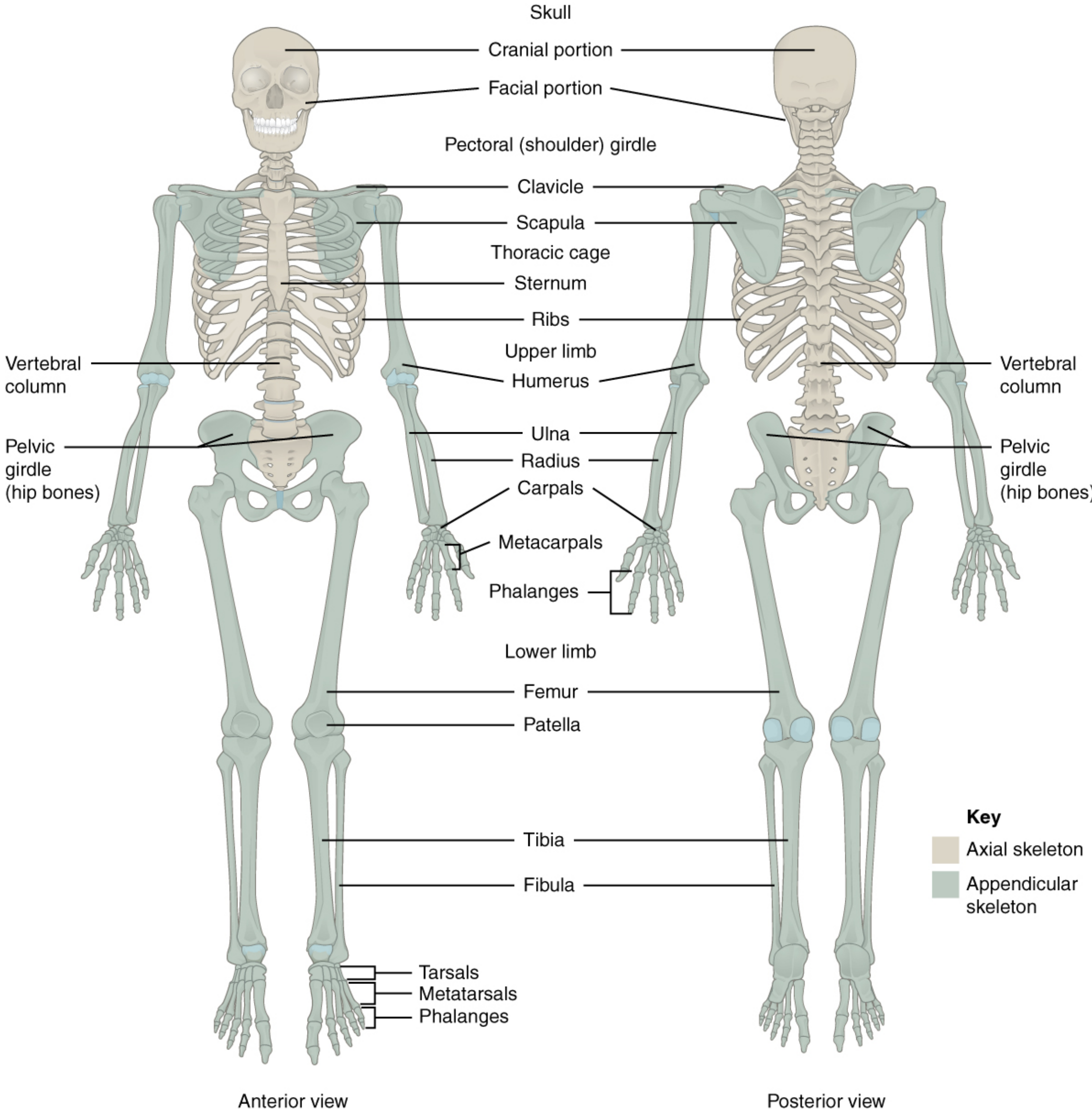


FIGURE 8.2 **Axial and Appendicular Skeletons** The axial skeleton forms the central axis of the body and consists of the skull, vertebral column, and thoracic cage. The appendicular skeleton consists of the pectoral and pelvic girdles, the limb bones, and the bones of the hands and feet.

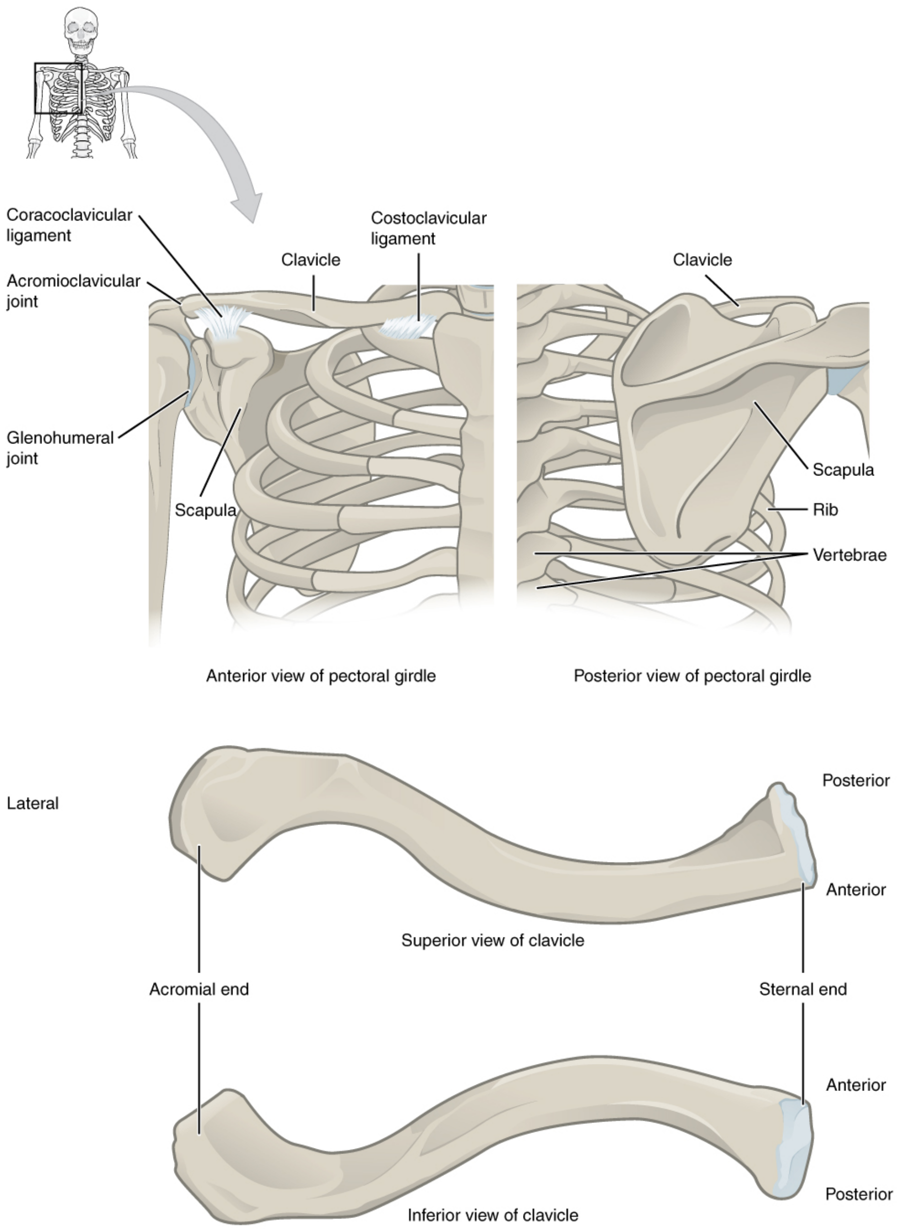


FIGURE 8.3 **Pectoral Girdle** The pectoral girdle consists of the clavicle and the scapula, which serve to attach the upper limb to the sternum of the axial skeleton.

The **scapula** (shoulder blade) lies on the posterior aspect of the shoulder. It is supported by the **clavicle** and articulates with the humerus (arm bone) to form the shoulder joint. The scapula is a flat, triangular-shaped bone with a prominent ridge running across its posterior surface. This ridge extends out laterally, where it forms the bony tip of the shoulder and joins with the lateral end of the clavicle. By following along the clavicle, you can palpate out to the bony tip of the shoulder, and from there, you can move back across your posterior shoulder to follow the ridge of the scapula. Move your shoulder around and feel how the clavicle and scapula move together as a unit. Both of these bones serve as important attachment sites for muscles that aid with movements of the shoulder and arm.

The right and left pectoral girdles are not joined to each other, allowing each to operate independently. In addition, the clavicle of each **pectoral girdle** is anchored to the axial skeleton by a single, highly mobile joint. This allows for the extensive mobility of the entire pectoral girdle, which in turn enhances movements of the shoulder and upper limb.

Clavicle

The clavicle is the only long bone that lies in a horizontal position in the body (see Figure 8.3). The clavicle has several important functions. First, anchored by muscles from above, it serves as a strut that extends laterally to support the scapula. This in turn holds the shoulder joint superiorly and laterally from the body trunk, allowing for maximal freedom of motion for the upper limb. The clavicle also transmits forces acting on the upper limb to the sternum and axial skeleton. Finally, it serves to protect the underlying nerves and blood vessels as they pass between the trunk of the body and the upper limb.

The clavicle has three regions: the medial end, the lateral end, and the shaft. The medial end, known as the **sternal end of the clavicle**, has a triangular shape and articulates with the manubrium portion of the sternum. This forms the **sternoclavicular joint**, which is the only bony articulation between the pectoral girdle of the upper limb and the axial skeleton. This joint allows considerable mobility, enabling the clavicle and scapula to move in upward/downward and anterior/posterior directions during shoulder movements. The sternoclavicular joint is indirectly supported by the **costoclavicular ligament** (costo- = “rib”), which spans the sternal end of the clavicle and the underlying first rib. The lateral or **acromial end of the clavicle** articulates with the acromion of the scapula, the portion of the scapula that forms the bony tip of the shoulder. There are some sex differences in the morphology of the clavicle. In females, the clavicle tends to be shorter, thinner, and less curved. In males, the clavicle is heavier and longer, and has a greater curvature and rougher surfaces where muscles attach, features that are more pronounced in manual workers.

The clavicle is the most commonly fractured bone in the body. Such breaks often occur because of the force exerted on the clavicle when a person falls onto their outstretched arms, or when the lateral shoulder receives a strong blow. Because the sternoclavicular joint is strong and rarely dislocated, excessive force results in the breaking of the clavicle, usually between the middle and lateral portions of the bone. If the fracture is complete, the shoulder and lateral clavicle fragment will drop due to the weight of the upper limb, causing the person to support the sagging limb with their other hand. Muscles acting across the shoulder will also pull the shoulder and lateral clavicle anteriorly and medially, causing the clavicle fragments to override. The clavicle overlies many important blood vessels and nerves for the upper limb, but fortunately, due to the anterior displacement of a broken clavicle, these structures are rarely affected when the clavicle is fractured.

Scapula

The scapula is also part of the pectoral girdle and thus plays an important role in anchoring the upper limb to the body. The scapula is located on the posterior side of the shoulder. It is surrounded by muscles on both its anterior (deep) and posterior (superficial) sides, and thus does not articulate with the ribs of the thoracic cage.

The scapula has several important landmarks (Figure 8.4). The three margins or borders of the scapula, named for their positions within the body, are the **superior border of the scapula**, the **medial border of the scapula**, and the **lateral border of the scapula**. The **suprascapular notch** is located lateral to the midpoint of the superior border. The corners of the triangular scapula, at either end of the medial border, are the **superior angle of the scapula**, located between the medial and superior borders, and the **inferior angle of the scapula**, located between the medial and lateral borders. The inferior angle is the most inferior portion of the scapula, and is particularly important because it serves as the attachment point for several powerful muscles involved in shoulder and upper limb movements. The remaining corner of the scapula, between the superior and lateral borders, is the location of the **glenoid cavity** (glenoid fossa). This shallow depression articulates with the humerus bone of the arm to form the **glenohumeral joint** (shoulder joint). The small bony bumps located immediately above and below the glenoid cavity are the **supraglenoid tubercle** and the **infraglenoid tubercle**, respectively. These provide attachments for muscles of the arm.

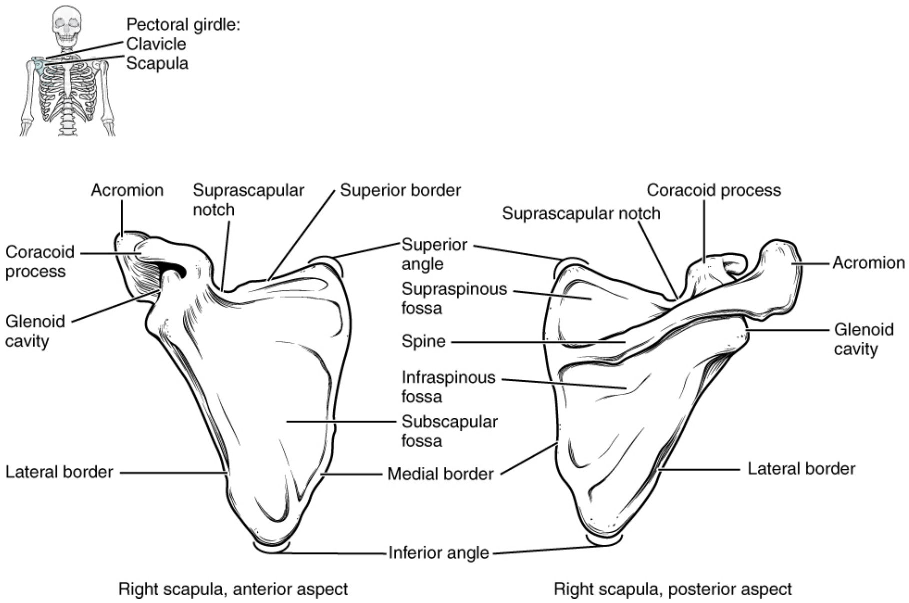


FIGURE 8.4 **Scapula** The isolated scapula is shown here from its anterior (deep) side and its posterior (superficial) side.

The scapula also has two prominent projections. Toward the lateral end of the superior border, between the suprascapular notch and glenoid cavity, is the hook-like **coracoid process** (coracoid = "shaped like a crow's beak"). This process projects anteriorly and curves laterally. At the shoulder, the coracoid process is located inferior to the lateral end of the clavicle. It is anchored to the clavicle by a strong ligament, and serves as the attachment site for muscles of the anterior chest and arm. On the posterior aspect, the **spine of the scapula** is a long and prominent ridge that runs across its upper portion. Extending laterally from the spine is a flattened and expanded region called the **acromion** or **acromial process**. The acromion forms the bony tip of the superior shoulder region and articulates with the lateral end of the clavicle, forming the **acromioclavicular joint** (see Figure 8.3). Together, the clavicle, acromion, and spine of the scapula form a V-shaped bony line that provides for the attachment of neck and back muscles that act on the shoulder, as well as muscles that pass across the shoulder joint to act on the arm.

The scapula has three depressions, each of which is called a **fossa** (plural = fossae). Two of these are found on the posterior scapula, above and below the scapular spine. Superior to the spine is the narrow **supraspinous fossa**, and inferior to the spine is the broad **infraspinous fossa**. The anterior (deep) surface of the scapula forms the broad **subscapular fossa**. All of these fossae provide large surface areas for the attachment of muscles that cross the shoulder joint to act on the humerus.

The acromioclavicular joint transmits forces from the upper limb to the clavicle. The ligaments around this joint are relatively weak. A hard fall onto the elbow or outstretched hand can stretch or tear the acromioclavicular ligaments, resulting in a moderate injury to the joint. However, the primary support for the acromioclavicular joint comes from a very strong ligament called the **coracoclavicular ligament** (see Figure 8.3). This connective tissue band anchors the coracoid process of the scapula to the inferior surface of the acromial end of the clavicle and thus provides important indirect support for the acromioclavicular joint. Following a strong blow to the lateral shoulder, such as when a hockey player is driven into the boards, a complete dislocation of the acromioclavicular joint can result. In this case, the acromion is thrust under the acromial end of the clavicle, resulting in ruptures of both the acromioclavicular and coracoclavicular ligaments. The scapula then separates from the clavicle, with the weight of the upper limb pulling the shoulder downward. This dislocation injury of the acromioclavicular joint is known as a "shoulder separation" and is common in contact sports such as hockey, football, or martial arts.

8.2 Bones of the Upper Limb

LEARNING OBJECTIVES

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

- Identify the divisions of the upper limb and describe the bones in each region
- List the bones and bony landmarks that articulate at each joint of the upper limb

The upper limb is divided into three regions. These consist of the **arm**, located between the shoulder and elbow joints; the **forearm**, which is between the elbow and wrist joints; and the **hand**, which is located distal to the wrist. There are 30 bones in each upper limb (see Figure 8.2). The **humerus** is the single bone of the upper arm, and the **ulna** (medially) and the **radius** (laterally) are the paired bones of the forearm. The base of the hand contains eight bones, each called a **carpal bone**, and the palm of the hand is formed by five bones, each called a **metacarpal bone**. The fingers and thumb contain a total of 14 bones, each of which is a **phalanx bone of the hand**.

Humerus

The humerus is the single bone of the upper arm region (Figure 8.5). At its proximal end is the **head of the humerus**. This is the large, round, smooth region that faces medially. The head articulates with the glenoid cavity of the scapula to form the glenohumeral (shoulder) joint. The margin of the smooth area of the head is the **anatomical neck** of the humerus. Located on the lateral side of the proximal humerus is an expanded bony area called the **greater tubercle**. The smaller **lesser tubercle** of the humerus is found on the anterior aspect of the humerus. Both the greater and lesser tubercles serve as attachment sites for muscles that act across the shoulder joint. Passing between the greater and lesser tubercles is the narrow **intertubercular groove (sulcus)**, which is also known as the **bicipital groove** because it provides passage for a tendon of the biceps brachii muscle. The **surgical neck** is located at the base of the expanded, proximal end of the humerus, where it joins the narrow **shaft of the humerus**. The surgical neck is a common site of arm fractures. The **deltoid tuberosity** is a roughened, V-shaped region located on the lateral side in the middle of the humerus shaft. As its name indicates, it is the site of attachment for the deltoid muscle.

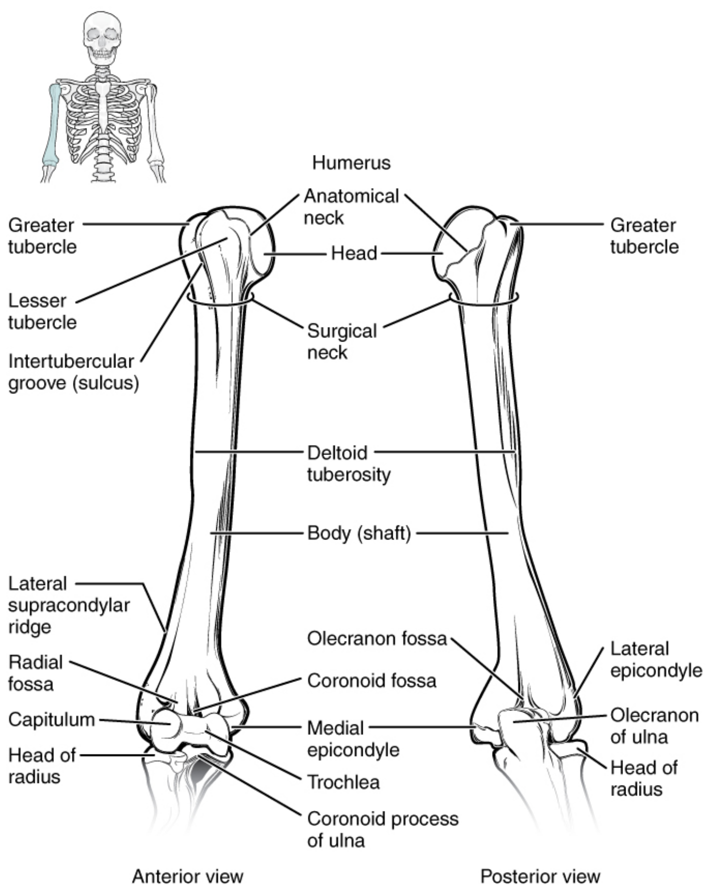


FIGURE 8.5 Humerus and Elbow Joint The humerus is the single bone of the upper arm region. It articulates with the radius and ulna bones of the forearm to form the elbow joint.

Distally, the humerus becomes flattened. The prominent bony projection on the medial side is the **medial epicondyle of the humerus**. The much smaller **lateral epicondyle of the humerus** is found on the lateral side of the distal humerus. The roughened ridge of bone above the lateral epicondyle is the **lateral supracondylar ridge**. All of these areas are attachment points for muscles that act on the forearm, wrist, and hand. The powerful grasping muscles of the anterior forearm arise from the medial epicondyle, which is thus larger and more robust than the lateral epicondyle that gives rise to the weaker posterior forearm muscles.

The distal end of the humerus has two articulation areas, which join the ulna and radius bones of the forearm to form the **elbow joint**. The more medial of these areas is the **trochlea**, a spindle- or pulley-shaped region (trochlea = "pulley"), which articulates with the ulna bone. Immediately lateral to the trochlea is the **capitulum** ("small head"), a knob-like structure located on the anterior surface of the distal humerus. The capitulum articulates with the radius bone of the forearm. Just above these bony areas are two small depressions. These spaces accommodate the forearm bones when the elbow is fully bent (flexed). Superior to the trochlea is the **coronoid fossa**, which receives the coronoid process of the ulna, and above the capitulum is the **radial fossa**, which receives the head of the radius when the elbow is flexed. Similarly, the posterior humerus has the **olecranon fossa**, a larger depression that receives the olecranon process of the ulna when the forearm is fully extended.

Ulna

The ulna is the medial bone of the forearm. It runs parallel to the radius, which is the lateral bone of the forearm (Figure 8.6). The proximal end of the ulna resembles a crescent wrench with its large, C-shaped **trochlear notch**. This region articulates with the trochlea of the humerus as part of the elbow joint. The inferior margin of the trochlear notch is formed by a prominent lip of bone called the **coronoid process of the ulna**. Just below this on the anterior ulna is a roughened area called the **ulnar tuberosity**. To the lateral side and slightly inferior to the trochlear notch is a small, smooth area called the **radial notch of the ulna**. This area is the site of articulation between the proximal radius and the ulna, forming the **proximal radioulnar joint**. The posterior and superior portions of the proximal ulna make up the **olecranon process**, which forms the bony tip of the elbow.

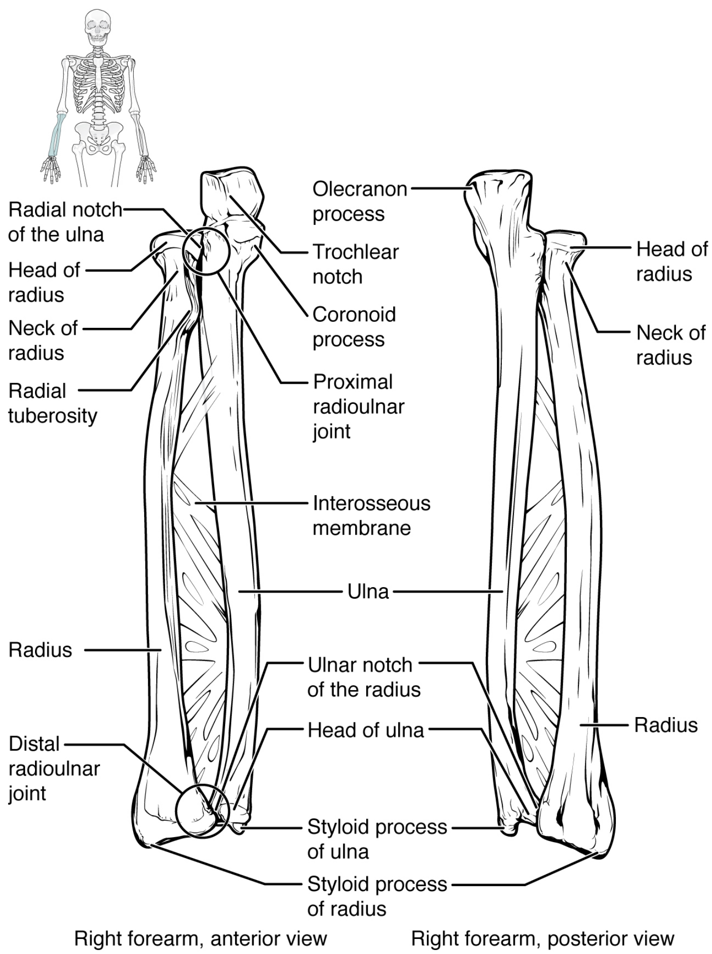


FIGURE 8.6 **Ulna and Radius** The ulna is located on the medial side of the forearm, and the radius is on the lateral side. These bones are attached to each other by an interosseous membrane.

More distal is the **shaft of the ulna**. The lateral side of the shaft forms a ridge called the **interosseous border of the**

ulna. This is the line of attachment for the **interosseous membrane of the forearm**, a sheet of dense connective tissue that unites the ulna and radius bones. The small, rounded area that forms the distal end is the **head of the ulna**. Projecting from the posterior side of the ulnar head is the **styloid process of the ulna**, a short bony projection. This serves as an attachment point for a connective tissue structure that unites the distal ends of the ulna and radius.

In the anatomical position, with the elbow fully extended and the palms facing forward, the arm and forearm do not form a straight line. Instead, the forearm deviates laterally by 5–15 degrees from the line of the arm. This deviation is called the carrying angle. It allows the forearm and hand to swing freely or to carry an object without hitting the hip. The carrying angle is larger in females to accommodate their wider pelvis.

Radius

The radius runs parallel to the ulna, on the lateral (thumb) side of the forearm (see Figure 8.6). The **head of the radius** is a disc-shaped structure that forms the proximal end. The small depression on the surface of the head articulates with the capitulum of the humerus as part of the elbow joint, whereas the smooth, outer margin of the head articulates with the radial notch of the ulna at the proximal radioulnar joint. The **neck of the radius** is the narrowed region immediately below the expanded head. Inferior to this point on the medial side is the **radial tuberosity**, an oval-shaped, bony protuberance that serves as a muscle attachment point. The **shaft of the radius** is slightly curved and has a small ridge along its medial side. This ridge forms the **interosseous border of the radius**, which, like the similar border of the ulna, is the line of attachment for the interosseous membrane that unites the two forearm bones. The distal end of the radius has a smooth surface for articulation with two carpal bones to form the **radiocarpal joint** or wrist joint (Figure 8.7 and Figure 8.8). On the medial side of the distal radius is the **ulnar notch of the radius**. This shallow depression articulates with the head of the ulna, which together form the **distal radioulnar joint**. The lateral end of the radius has a pointed projection called the **styloid process of the radius**. This provides attachment for ligaments that support the lateral side of the wrist joint. Compared to the styloid process of the ulna, the styloid process of the radius projects more distally, thereby limiting the range of movement for lateral deviations of the hand at the wrist joint.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/fractures) to see how fractures of the distal radius bone can affect the wrist joint. Explain the problems that may occur if a fracture of the distal radius involves the joint surface of the radiocarpal joint of the wrist.

Carpal Bones

The wrist and base of the hand are formed by a series of eight small carpal bones (see Figure 8.7). The carpal bones are arranged in two rows, forming a proximal row of four carpal bones and a distal row of four carpal bones. The bones in the proximal row, running from the lateral (thumb) side to the medial side, are the **scaphoid** ("boat-shaped"), **lunate** ("moon-shaped"), **triquetrum** ("three-cornered"), and **pisiform** ("pea-shaped") bones. The small, rounded pisiform bone articulates with the anterior surface of the triquetrum bone. The pisiform thus projects anteriorly, where it forms the bony bump that can be felt at the medial base of your hand. The distal bones (lateral to medial) are the **trapezium** ("table"), **trapezoid** ("resembles a table"), **capitate** ("head-shaped"), and **hamate** ("hooked bone") bones. The hamate bone is characterized by a prominent bony extension on its anterior side called the **hook of the hamate bone**.

A helpful mnemonic for remembering the arrangement of the carpal bones is "So Long To Pinky, Here Comes The Thumb." This mnemonic starts on the lateral side and names the proximal bones from lateral to medial (scaphoid, lunate, triquetrum, pisiform), then makes a U-turn to name the distal bones from medial to lateral (hamate, capitate, trapezoid, trapezium). Thus, it starts and finishes on the lateral side.

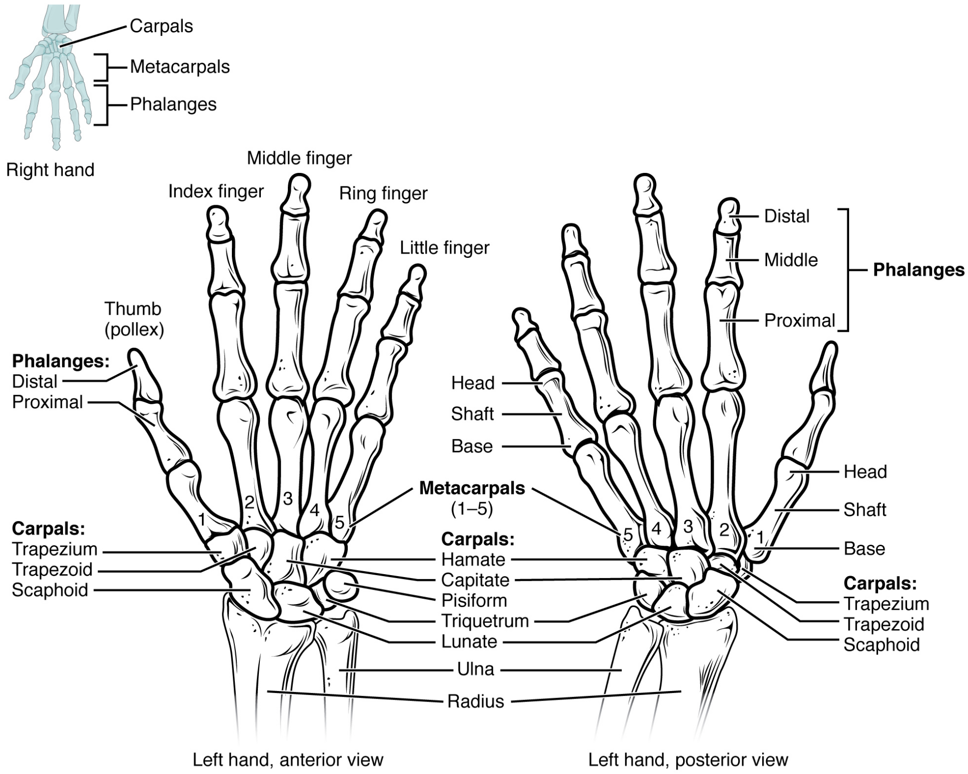


FIGURE 8.7 **Bones of the Wrist and Hand** The eight carpal bones form the base of the hand. These are arranged into proximal and distal rows of four bones each. The metacarpal bones form the palm of the hand. The thumb and fingers consist of the phalanx bones.

The carpal bones form the base of the hand. This can be seen in the radiograph (X-ray image) of the hand that shows the relationships of the hand bones to the skin creases of the hand (see Figure 8.8). Within the carpal bones, the four proximal bones are united to each other by ligaments to form a unit. Only three of these bones, the scaphoid, lunate, and triquetrum, contribute to the radiocarpal joint. The scaphoid and lunate bones articulate directly with the distal end of the radius, whereas the triquetrum bone articulates with a fibrocartilaginous pad that spans the radius and styloid process of the ulna. The distal end of the ulna thus does not directly articulate with any of the carpal bones.

The four distal carpal bones are also held together as a group by ligaments. The proximal and distal rows of carpal bones articulate with each other to form the **midcarpal joint** (see Figure 8.8). Together, the radiocarpal and midcarpal joints are responsible for all movements of the hand at the wrist. The distal carpal bones also articulate with the metacarpal bones of the hand.

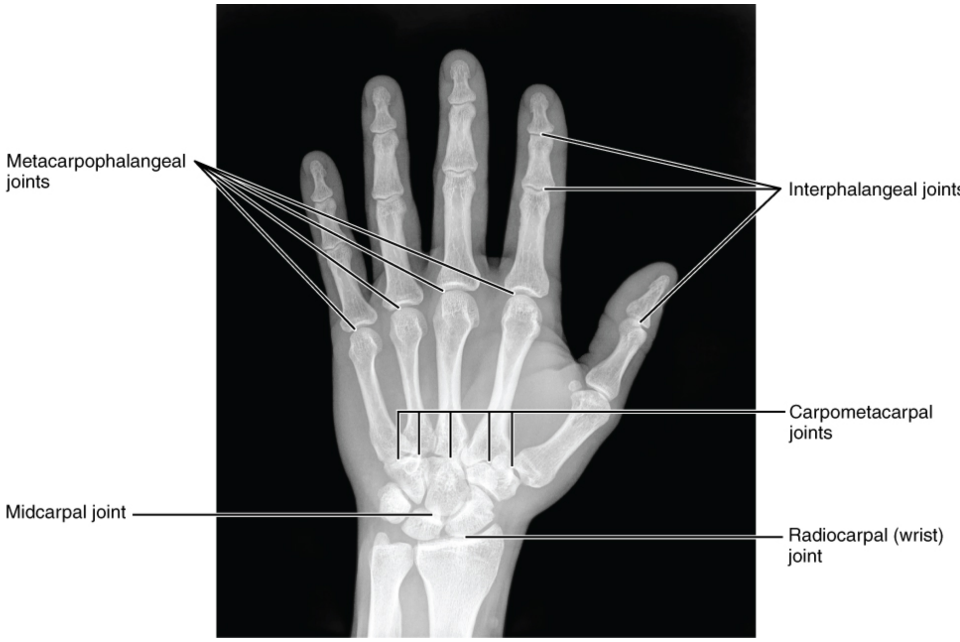


FIGURE 8.8 **Bones of the Hand** This radiograph shows the position of the bones within the hand. Note the carpal bones that form the base of the hand. (credit: modification of work by Trace Meek)

In the articulated hand, the carpal bones form a U-shaped grouping. A strong ligament called the **flexor retinaculum** spans the top of this U-shaped area to maintain this grouping of the carpal bones. The flexor retinaculum is attached laterally to the trapezium and scaphoid bones, and medially to the hamate and pisiform bones. Together, the carpal bones and the flexor retinaculum form a passageway called the **carpal tunnel**, with the carpal bones forming the walls and floor, and the flexor retinaculum forming the roof of this space (Figure 8.9). The tendons of nine muscles of the anterior forearm and an important nerve pass through this narrow tunnel to enter the hand. Overuse of the muscle tendons or wrist injury can produce inflammation and swelling within this space. This produces compression of the nerve, resulting in carpal tunnel syndrome, which is characterized by pain or numbness, and muscle weakness in those areas of the hand supplied by this nerve.

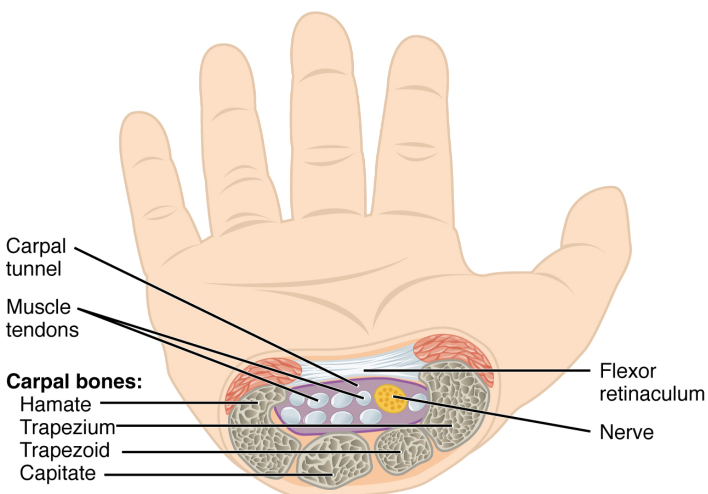


FIGURE 8.9 **Carpal Tunnel** The carpal tunnel is the passageway by which nine muscle tendons and a major nerve enter the hand from the anterior forearm. The walls and floor of the carpal tunnel are formed by the U-shaped grouping of the carpal bones, and the roof is formed by the flexor retinaculum, a strong ligament that anteriorly unites the bones.

Metacarpal Bones

The palm of the hand contains five elongated metacarpal bones. These bones lie between the carpal bones of the wrist and the bones of the fingers and thumb (see Figure 8.7). The proximal end of each metacarpal bone articulates with one of the distal carpal bones. Each of these articulations is a **carpometacarpal joint** (see Figure 8.8). The expanded distal end of each metacarpal bone articulates at the **metacarpophalangeal joint** with the proximal phalanx bone of the thumb or one of the fingers. The distal end also forms the knuckles of the hand, at the base of the fingers. The metacarpal bones are numbered 1–5, beginning at the thumb.

The first metacarpal bone, at the base of the thumb, is separated from the other metacarpal bones. This allows it a freedom of motion that is independent of the other metacarpal bones, which is very important for thumb mobility. The remaining metacarpal bones are united together to form the palm of the hand. The second and third metacarpal bones are firmly anchored in place and are immobile. However, the fourth and fifth metacarpal bones have limited anterior-posterior mobility, a motion that is greater for the fifth bone. This mobility is important during power gripping with the hand (Figure 8.10). The anterior movement of these bones, particularly the fifth metacarpal bone, increases the strength of contact for the medial hand during gripping actions.

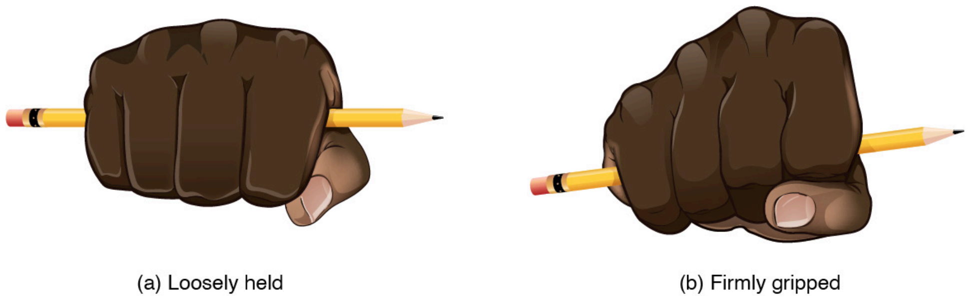


FIGURE 8.10 **Hand During Gripping** During tight gripping—compare (b) to (a)—the fourth and, particularly, the fifth metatarsal bones are pulled anteriorly. This increases the contact between the object and the medial side of the hand, thus improving the firmness of the grip.

Phalanx Bones

The fingers and thumb contain 14 bones, each of which is called a phalanx bone (plural = phalanges), named after the ancient Greek phalanx (a rectangular block of soldiers). The thumb (**pollex**) is digit number 1 and has two phalanges, a proximal phalanx, and a distal phalanx bone (see Figure 8.7). Digits 2 (index finger) through 5 (little finger) have three phalanges each, called the proximal, middle, and distal phalanx bones. An **interphalangeal joint** is one of the articulations between adjacent phalanges of the digits (see Figure 8.8).

INTERACTIVE LINK

Visit this site (http://openstax.org/l/handbone) to explore the bones and joints of the hand.

Disorders of the...

Appendicular System: Fractures of Upper Limb Bones

Due to our constant use of the hands and the rest of our upper limbs, an injury to any of these areas will cause a significant loss of functional ability. Many fractures result from a hard fall onto an outstretched hand. The resulting transmission of force up the limb may result in a fracture of the humerus, radius, or scaphoid bones. These injuries are especially common in elderly people whose bones are weakened due to osteoporosis.

Falls onto the hand or elbow, or direct blows to the arm, can result in fractures of the humerus (Figure 8.11). Following a fall, fractures at the surgical neck, the region at which the expanded proximal end of the humerus joins with the shaft, can result in an impacted fracture, in which the distal portion of the humerus is driven into the proximal portion. Falls or blows to the arm can also produce transverse or spiral fractures of the humeral shaft.

In children, a fall onto the tip of the elbow frequently results in a distal humerus fracture. In these, the olecranon of the ulna is driven upward, resulting in a fracture across the distal humerus, above both epicondyles (supracondylar fracture), or a fracture between the epicondyles, thus separating one or both of the epicondyles from the body of the humerus (intercondylar fracture). With these injuries, the immediate concern is possible compression of the artery to the forearm due to swelling of the surrounding tissues. If compression occurs, the resulting ischemia (lack of oxygen) due to reduced blood flow can quickly produce irreparable damage to the forearm muscles. In addition, four major nerves for shoulder and upper limb muscles are closely associated with different regions of the humerus, and thus, humeral fractures may also damage these nerves.

Another frequent injury following a fall onto an outstretched hand is a Colles fracture ("col-lees") of the distal radius (see Figure 8.11). This involves a complete transverse fracture across the distal radius that drives the separated distal fragment of the radius posteriorly and superiorly. This injury results in a characteristic "dinner fork" bend of the forearm just above the wrist due to the posterior displacement of the hand. This is the most frequent forearm fracture and is a common injury in persons over the age of 50, particularly in older people with osteoporosis. It also commonly occurs following a high-speed fall onto the hand during activities such as snowboarding or skating.

The most commonly fractured carpal bone is the scaphoid, often resulting from a fall onto the hand. Deep pain at the lateral wrist may yield an initial diagnosis of a wrist sprain, but a radiograph taken several weeks after the injury, after tissue swelling has subsided, will reveal the fracture. Due to the poor blood supply to the scaphoid bone, healing will be slow and there is the danger of bone necrosis and subsequent degenerative joint disease of the wrist.

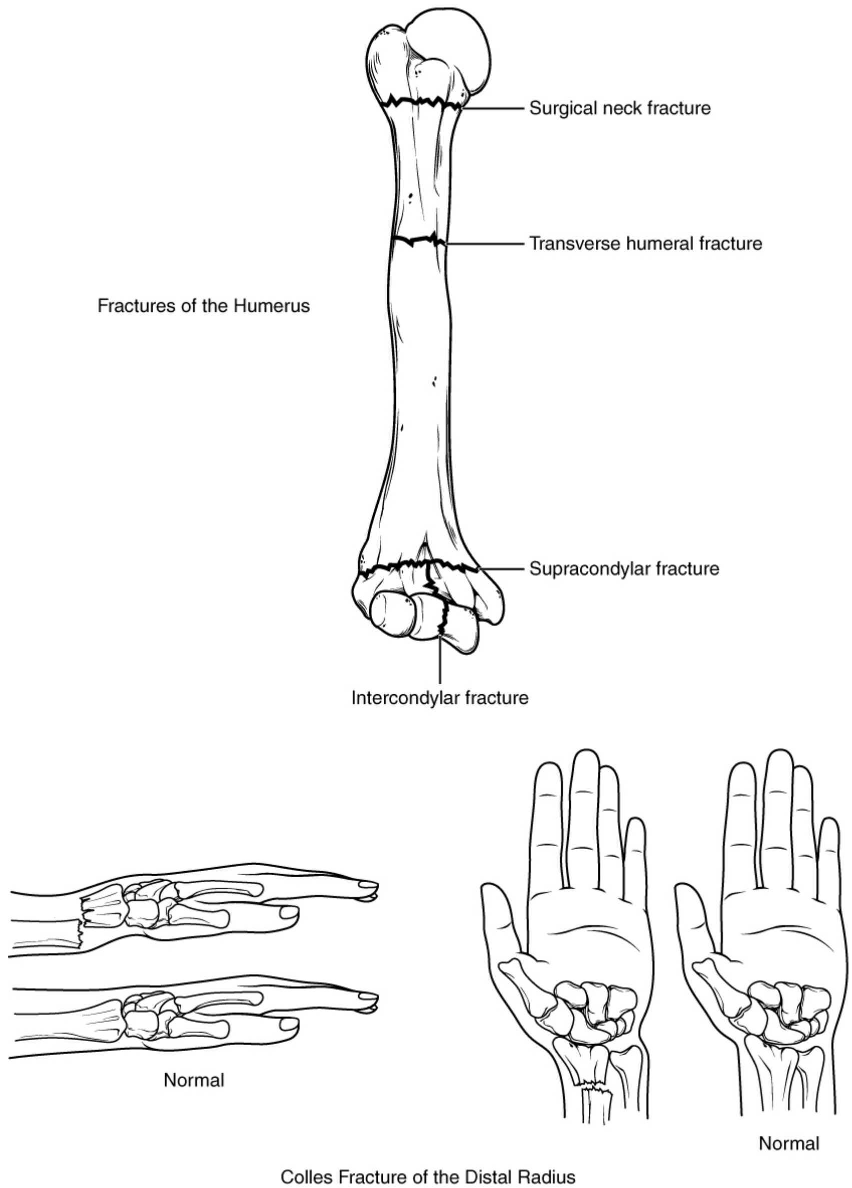


FIGURE 8.11 **Fractures of the Humerus and Radius** Falls or direct blows can result in fractures of the surgical neck or shaft of the humerus. Falls onto the elbow can fracture the distal humerus. A Colles fracture of the distal radius is the most common forearm fracture.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/colles) to learn about a Colles fracture, a break of the distal radius, usually caused by falling onto an outstretched hand. When would surgery be required and how would the fracture be repaired in this case?

8.3 The Pelvic Girdle and Pelvis

LEARNING OBJECTIVES

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

- Define the pelvic girdle and describe the bones and ligaments of the pelvis
- Explain the three regions of the hip bone and identify their bony landmarks
- Describe the openings of the pelvis and the boundaries of the greater and lesser pelvis

The **pelvic girdle** (hip girdle) is formed by a single bone, the **hip bone** or **coxal bone** (coxal = “hip”), which serves as the attachment point for each lower limb. Each hip bone, in turn, is firmly joined to the axial skeleton via its attachment to the sacrum of the vertebral column. The right and left hip bones also converge anteriorly to attach to each other. The bony **pelvis** is the entire structure formed by the two hip bones, the sacrum, and, attached inferiorly to the sacrum, the coccyx (Figure 8.12).

Unlike the bones of the pectoral girdle, which are highly mobile to enhance the range of upper limb movements, the bones of the pelvis are strongly united to each other to form a largely immobile, weight-bearing structure. This is important for stability because it enables the weight of the body to be easily transferred laterally from the vertebral column, through the pelvic girdle and hip joints, and into either lower limb whenever the other limb is not bearing weight. Thus, the immobility of the pelvis provides a strong foundation for the upper body as it rests on top of the mobile lower limbs.

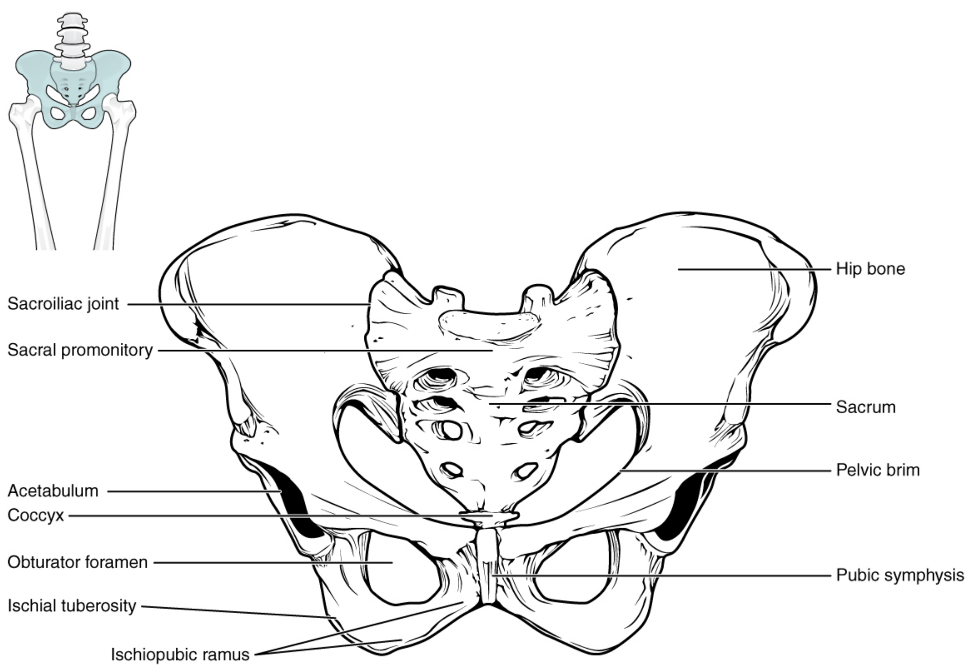


FIGURE 8.12 **Pelvis** The pelvic girdle is formed by a single hip bone. The hip bone attaches the lower limb to the axial skeleton through its articulation with the sacrum. The right and left hip bones, plus the sacrum and the coccyx, together form the pelvis.

Hip Bone

The hip bone, or coxal bone, forms the pelvic girdle portion of the pelvis. The paired hip bones are the large, curved bones that form the lateral and anterior aspects of the pelvis. Each adult hip bone is formed by three separate bones that fuse together during the late teenage years. These bony components are the ilium, ischium, and pubis (Figure 8.13). These names are retained and used to define the three regions of the adult hip bone.

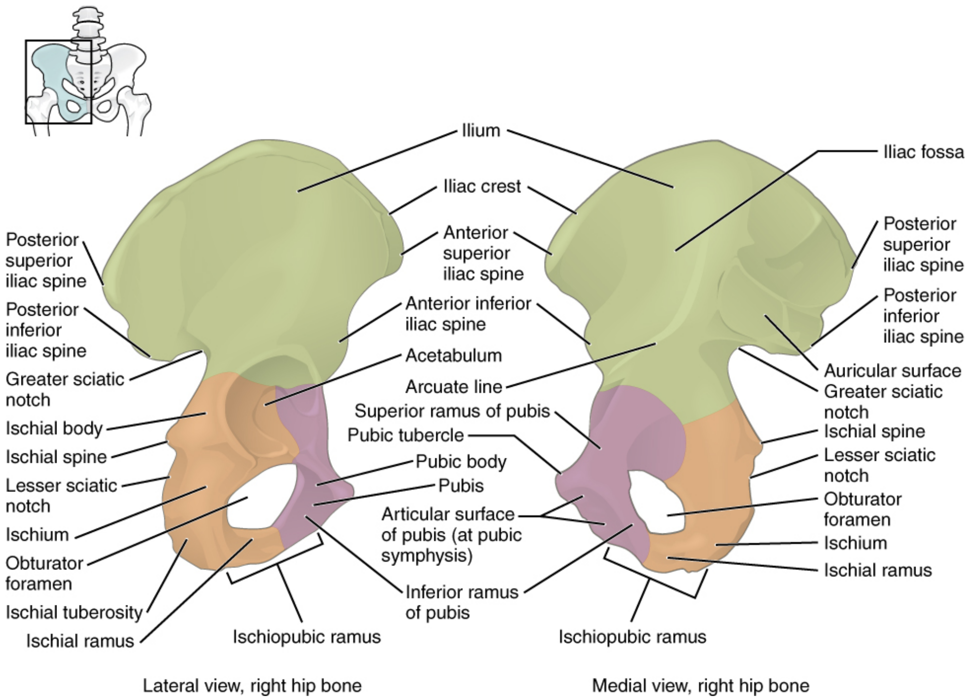


FIGURE 8.13 **The Hip Bone** The adult hip bone consists of three regions. The ilium forms the large, fan-shaped superior portion, the ischium forms the posteroinferior portion, and the pubis forms the anteromedial portion.

The **ilium** is the fan-like, superior region that forms the largest part of the hip bone. It is firmly united to the sacrum at the largely immobile **sacroiliac joint** (see Figure 8.12). The **ischium** forms the posteroinferior region of each hip bone. It supports the body when sitting. The **pubis** forms the anterior portion of the hip bone. The pubis curves medially, where it joins to the pubis of the opposite hip bone at a specialized joint called the **pubic symphysis**.

Ilium

When you place your hands on your waist, you can feel the arching, superior margin of the ilium along your waistline (see Figure 8.13). This curved, superior margin of the ilium is the **iliac crest**. The rounded, anterior termination of the iliac crest is the **anterior superior iliac spine**. This important bony landmark can be felt at your anterolateral hip. Inferior to the anterior superior iliac spine is a rounded protuberance called the **anterior inferior iliac spine**. Both of these iliac spines serve as attachment points for muscles of the thigh. Posteriorly, the iliac crest curves downward to terminate as the **posterior superior iliac spine**. Muscles and ligaments surround but do not cover this bony landmark, thus sometimes producing a depression seen as a “dimple” located on the lower back. More inferiorly is the **posterior inferior iliac spine**. This is located at the inferior end of a large, roughened area called the **auricular surface of the ilium**. The auricular surface articulates with the auricular surface of the sacrum to form the sacroiliac joint. Both the posterior superior and posterior inferior iliac spines serve as attachment points for the muscles and very strong ligaments that support the sacroiliac joint.

The shallow depression located on the anteromedial (internal) surface of the upper ilium is called the **iliac fossa**. The inferior margin of this space is formed by the **arcuate line of the ilium**, the ridge formed by the pronounced change in curvature between the upper and lower portions of the ilium. The large, inverted U-shaped indentation located on the posterior margin of the lower ilium is called the **greater sciatic notch**.

Ischium

The ischium forms the posterolateral portion of the hip bone (see Figure 8.13). The large, roughened area of the inferior ischium is the **ischial tuberosity**. This serves as the attachment for the posterior thigh muscles and also carries the weight of the body when sitting. You can feel the ischial tuberosity if you wiggle your pelvis against the seat of a chair. Projecting superiorly and anteriorly from the ischial tuberosity is a narrow segment of bone called the **ischial ramus**. The slightly curved posterior margin of the ischium above the ischial tuberosity is the **lesser sciatic notch**. The bony projection separating the lesser sciatic notch and greater sciatic notch is the **ischial spine**.

Pubis

The pubis forms the anterior portion of the hip bone (see Figure 8.13). The enlarged medial portion of the pubis is the **pubic body**. Located superiorly on the pubic body is a small bump called the **pubic tubercle**. The **superior pubic ramus** is the segment of bone that passes laterally from the pubic body to join the ilium. The narrow ridge running along the superior margin of the superior pubic ramus is the **pectineal line** of the pubis.

The pubic body is joined to the pubic body of the opposite hip bone by the pubic symphysis. Extending downward and laterally from the body is the **inferior pubic ramus**. The **pubic arch** is the bony structure formed by the pubic symphysis, and the bodies and inferior pubic rami of the adjacent pubic bones. The inferior pubic ramus extends downward to join the ischial ramus. Together, these form the single **ischiopubic ramus**, which extends from the pubic body to the ischial tuberosity. The inverted V-shape formed as the ischiopubic rami from both sides come together at the pubic symphysis is called the **subpubic angle**.

Pelvis

The pelvis consists of four bones: the right and left hip bones, the sacrum, and the coccyx (see Figure 8.12). The pelvis has several important functions. Its primary role is to support the weight of the upper body when sitting and to transfer this weight to the lower limbs when standing. It serves as an attachment point for trunk and lower limb muscles, and also protects the internal pelvic organs. When standing in the anatomical position, the pelvis is tilted anteriorly. In this position, the anterior superior iliac spines and the pubic tubercles lie in the same vertical plane, and the anterior (internal) surface of the sacrum faces forward and downward.

The three areas of each hip bone, the ilium, pubis, and ischium, converge centrally to form a deep, cup-shaped cavity called the **acetabulum**. This is located on the lateral side of the hip bone and is part of the hip joint. The large opening in the anteroinferior hip bone between the ischium and pubis is the **obturator foramen**. This space is largely filled in by a layer of connective tissue and serves for the attachment of muscles on both its internal and external surfaces.

Several ligaments unite the bones of the pelvis (Figure 8.14). The largely immobile sacroiliac joint is supported by a pair of strong ligaments that are attached between the sacrum and ilium portions of the hip bone. These are the **anterior sacroiliac ligament** on the anterior side of the joint and the **posterior sacroiliac ligament** on the posterior side. Also spanning the sacrum and hip bone are two additional ligaments. The **sacrospinous ligament** runs from the sacrum to the ischial spine, and the **sacrotuberous ligament** runs from the sacrum to the ischial tuberosity. These ligaments help to support and immobilize the sacrum as it carries the weight of the body.

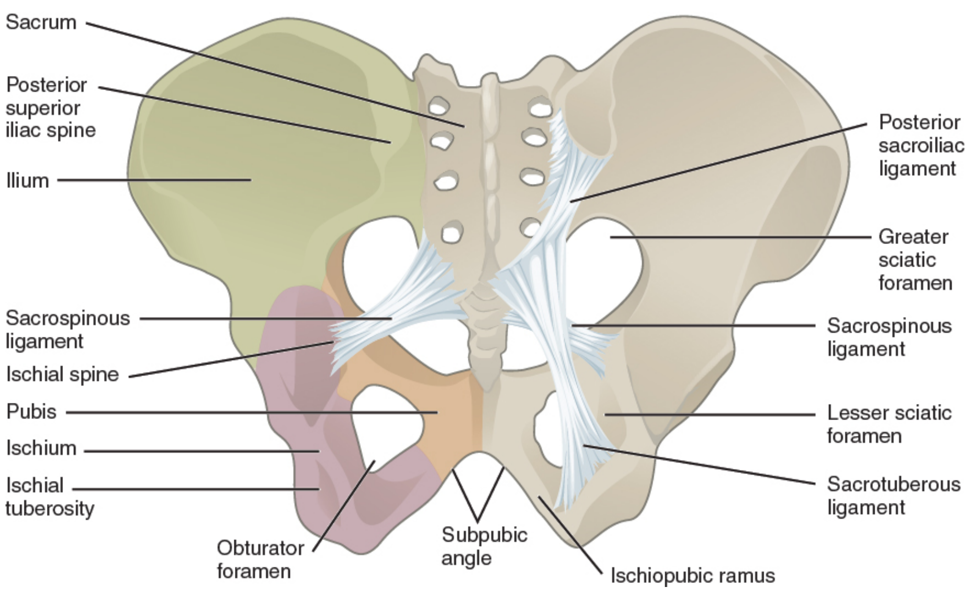


FIGURE 8.14 **Ligaments of the Pelvis** The posterior sacroiliac ligament supports the sacroiliac joint. The sacrospinous ligament spans the sacrum to the ischial spine, and the sacrotuberous ligament spans the sacrum to the ischial tuberosity. The sacrospinous and sacrotuberous ligaments contribute to the formation of the greater and lesser sciatic foramina.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/3Dpelvis) for a 3-D view of the pelvis and its associated ligaments. What is the large opening in the bony pelvis, located between the ischium and pubic regions, and what two parts of the pubis contribute to the formation of this opening?

The sacrospinous and sacrotuberous ligaments also help to define two openings on the posterolateral sides of the pelvis through which muscles, nerves, and blood vessels for the lower limb exit. The superior opening is the **greater sciatic foramen**. This large opening is formed by the greater sciatic notch of the hip bone, the sacrum, and the sacrospinous ligament. The smaller, more inferior **lesser sciatic foramen** is formed by the lesser sciatic notch of the hip bone, together with the sacrospinous and sacrotuberous ligaments.

The space enclosed by the bony pelvis is divided into two regions (Figure 8.15). The broad, superior region, defined laterally by the large, fan-like portion of the upper hip bone, is called the **greater pelvis** (greater pelvic cavity; false pelvis). This broad area is occupied by portions of the small and large intestines, and because it is more closely associated with the abdominal cavity, it is sometimes referred to as the false pelvis. More inferiorly, the narrow, rounded space of the **lesser pelvis** (lesser pelvic cavity; true pelvis) contains the bladder and other pelvic organs, and thus is also known as the true pelvis. The **pelvic brim** (also known as the **pelvic inlet**) forms the superior margin of the lesser pelvis, separating it from the greater pelvis. The pelvic brim is defined by a line formed by the upper margin of the pubic symphysis anteriorly, and the pectineal line of the pubis, the arcuate line of the ilium, and the sacral promontory (the anterior margin of the superior sacrum) posteriorly. The inferior limit of the lesser pelvic cavity is called the **pelvic outlet**. This large opening is defined by the inferior margin of the pubic symphysis anteriorly, and the ischiopubic ramus, the ischial tuberosity, the sacrotuberous ligament, and the inferior tip of the coccyx posteriorly. Because of the anterior tilt of the pelvis, the lesser pelvis is also angled, giving it an anterosuperior (pelvic inlet) to posteroinferior (pelvic outlet) orientation.

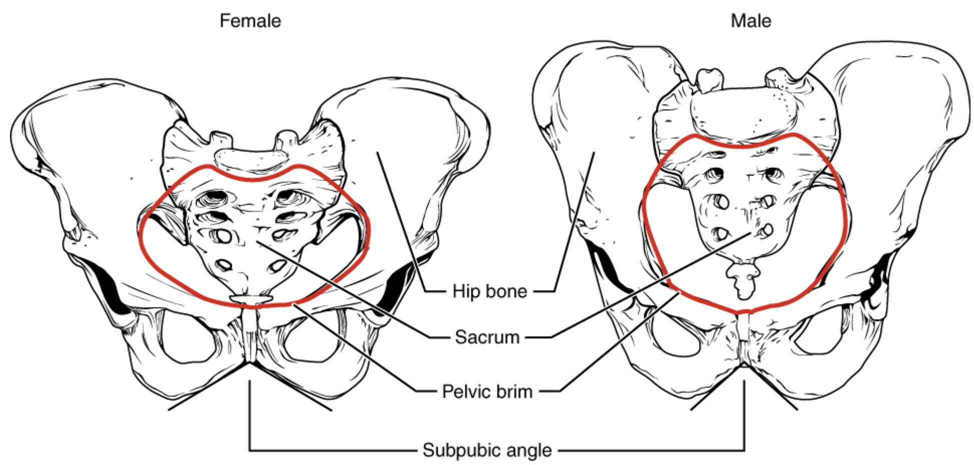


FIGURE 8.15 **Male and Female Pelvis** The female pelvis is adapted for childbirth and is broader, with a larger subpubic angle, a rounder pelvic brim, and a wider and more shallow lesser pelvic cavity than the male pelvis.

Comparison of the Female and Male Pelvis

The differences between the adult female and male pelvis relate to function and body size. In general, the bones of the male pelvis are thicker and heavier, adapted for support of the male's heavier physical build and stronger muscles. The greater sciatic notch of the male hip bone is narrower and deeper than the broader notch of females. Because the female pelvis is adapted for childbirth, it is wider than the male pelvis, as evidenced by the distance between the anterior superior iliac spines (see Figure 8.15). The ischial tuberosities of females are also farther apart, which increases the size of the pelvic outlet. Because of this increased pelvic width, the subpubic angle is larger in females (greater than 80 degrees) than it is in males (less than 70 degrees). The female sacrum is wider, shorter, and less curved, and the sacral promontory projects less into the pelvic cavity, thus giving the female pelvic inlet (pelvic brim) a more rounded or oval shape compared to males. The lesser pelvic cavity of females is also wider and more shallow than the narrower, deeper, and tapering lesser pelvis of males. Because of the obvious differences between female and male hip bones, this is the one bone of the body that allows for the most accurate sex determination. Table 8.1 provides an overview of the general differences between the female and male pelvis.

Overview of Differences between the Female and Male Pelvis

	Female pelvis	Male pelvis
Pelvic weight	Bones of the pelvis are lighter and thinner	Bones of the pelvis are thicker and heavier
Pelvic inlet shape	Pelvic inlet has a round or oval shape	Pelvic inlet is heart-shaped
Lesser pelvic cavity shape	Lesser pelvic cavity is shorter and wider	Lesser pelvic cavity is longer and narrower
Subpubic angle	Subpubic angle is greater than 80 degrees	Subpubic angle is less than 70 degrees
Pelvic outlet shape	Pelvic outlet is rounded and larger	Pelvic outlet is smaller

TABLE 8.1

CAREER CONNECTION

Forensic Pathology and Forensic Anthropology

A forensic pathologist (also known as a medical examiner) is a medically trained physician who has been specifically trained in pathology to examine the bodies of the deceased to determine the cause of death. A forensic pathologist applies understanding of disease as well as toxins, blood and DNA analysis, firearms and ballistics, and other factors to assess the cause and manner of death. At times, a forensic pathologist will be called to testify under oath in situations that involve a possible crime. Forensic pathology is a field that has received much media attention on television shows or following a high-profile death.

While forensic pathologists are responsible for determining whether the cause of someone's death was natural, by suicide, accidental, or by homicide, there are times when uncovering the cause of death is more complex, and other skills are needed. Forensic anthropology brings the tools and knowledge of physical anthropology and human osteology (the study of the skeleton) to the task of investigating a death. A forensic anthropologist assists medical and legal professionals in identifying human remains. The science behind forensic anthropology involves the study of archaeological excavation; the examination of hair; an understanding of plants, insects, and footprints; the ability to determine how much time has elapsed since the person died; the analysis of past medical history and toxicology; the ability to determine whether there are any postmortem injuries or alterations of the skeleton; and the identification of the decedent (deceased person) using skeletal and dental evidence.

Due to the extensive knowledge and understanding of excavation techniques, a forensic anthropologist is an integral and invaluable team member to have on-site when investigating a crime scene, especially when the recovery of human skeletal remains is involved. When remains are bought to a forensic anthropologist for examination, they must first determine whether the remains are in fact human. Once the remains have been identified as belonging to a person and not to an animal, the next step is to approximate the individual's age, sex, race, and height. The forensic anthropologist does not determine the cause of death, but rather provides information to the forensic pathologist, who will use all of the data collected to make a final determination regarding the cause of death.

8.4 Bones of the Lower Limb

LEARNING OBJECTIVES

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

- Identify the divisions of the lower limb and describe the bones of each region
- Describe the bones and bony landmarks that articulate at each joint of the lower limb

Like the upper limb, the lower limb is divided into three regions. The **thigh** is that portion of the lower limb located between the hip joint and knee joint. The **leg** is specifically the region between the knee joint and the ankle joint. Distal to the ankle is the **foot**. The lower limb contains 30 bones. These are the femur, patella, tibia, fibula, tarsal bones, metatarsal bones, and phalanges (see Figure 8.2). The **femur** is the single bone of the thigh. The **patella** is the kneecap and articulates with the distal femur. The **tibia** is the larger, weight-bearing bone located on the medial side of the leg, and the **fibula** is the thin bone of the lateral leg. The bones of the foot are divided into three groups. The posterior portion of the foot is formed by a group of seven bones, each of which is known as a **tarsal bone**, whereas the mid-foot contains five elongated bones, each of which is a **metatarsal bone**. The toes contain 14 small bones, each of which is a **phalanx bone of the foot**.

Femur

The femur, or thigh bone, is the single bone of the thigh region (Figure 8.16). It is the longest and strongest bone of the body, and accounts for approximately one-quarter of a person's total height. The rounded, proximal end is the **head of the femur**, which articulates with the acetabulum of the hip bone to form the **hip joint**. The **fovea capitis** is a minor indentation on the medial side of the femoral head that serves as the site of attachment for the **ligament of the head of the femur**. This ligament spans the femur and acetabulum, but is weak and provides little support for the hip joint. It does, however, carry an important artery that supplies the head of the femur.

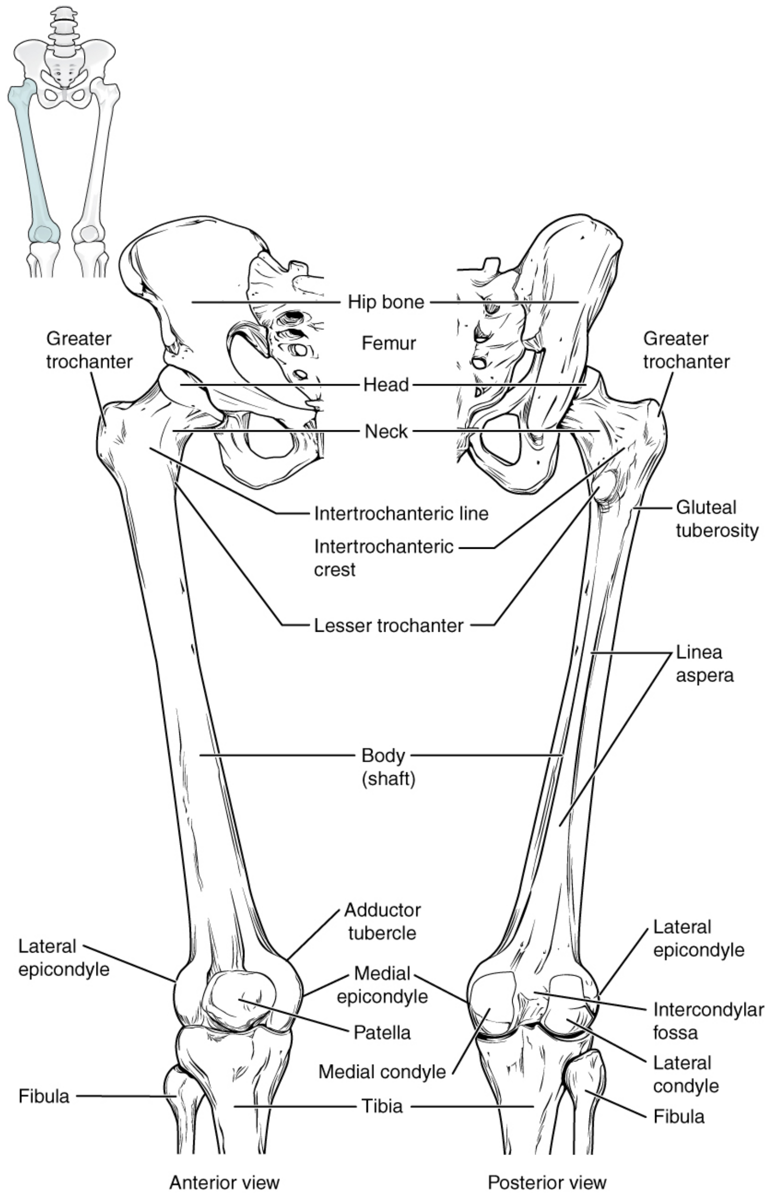


FIGURE 8.16 **Femur and Patella** The femur is the single bone of the thigh region. It articulates superiorly with the hip bone at the hip joint, and inferiorly with the tibia at the knee joint. The patella only articulates with the distal end of the femur.

The narrowed region below the head is the **neck of the femur**. This is a common area for fractures of the femur. The **greater trochanter** is the large, upward, bony projection located above the base of the neck. Multiple muscles that act across the hip joint attach to the greater trochanter, which, because of its projection from the femur, gives additional leverage to these muscles. The greater trochanter can be felt just under the skin on the lateral side of your upper thigh. The **lesser trochanter** is a small, bony prominence that lies on the medial aspect of the femur, just below the neck. A single, powerful muscle attaches to the lesser trochanter. Running between the greater and lesser trochanters on the anterior side of the femur is the roughened **intertrochanteric line**. The trochanters are also connected on the posterior side of the femur by the larger **intertrochanteric crest**.

The elongated **shaft of the femur** has a slight anterior bowing or curvature. At its proximal end, the posterior shaft has the **gluteal tuberosity**, a roughened area extending inferiorly from the greater trochanter. More inferiorly, the gluteal tuberosity becomes continuous with the **linea aspera** ("rough line"). This is the roughened ridge that passes distally along the posterior side of the mid-femur. Multiple muscles of the hip and thigh regions make long, thin attachments to the femur along the linea aspera.

The distal end of the femur has medial and lateral bony expansions. On the lateral side, the smooth portion that covers the distal and posterior aspects of the lateral expansion is the **lateral condyle of the femur**. The roughened area on the outer, lateral side of the condyle is the **lateral epicondyle of the femur**. Similarly, the smooth region of the distal and posterior medial femur is the **medial condyle of the femur**, and the irregular outer, medial side of this is the **medial epicondyle of the femur**. The lateral and medial condyles articulate with the tibia to form the knee joint. The epicondyles provide attachment for muscles and supporting ligaments of the knee. The **adductor tubercle** is a small bump located at the superior margin of the medial epicondyle. Posteriorly, the medial and lateral condyles are separated by a deep depression called the **intercondylar fossa**. Anteriorly, the smooth surfaces of the condyles join together to form a wide groove called the **patellar surface**, which provides for articulation with the patella bone. The combination of the medial and lateral condyles with the patellar surface gives the distal end of the femur a horseshoe (U) shape.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/midfemur) to view how a fracture of the mid-femur is surgically repaired. How are the two portions of the broken femur stabilized during surgical repair of a fractured femur?

Patella

The patella (kneecap) is largest sesamoid bone of the body (see Figure 8.16). A sesamoid bone is a bone that is incorporated into the tendon of a muscle where that tendon crosses a joint. The sesamoid bone articulates with the underlying bones to prevent damage to the muscle tendon due to rubbing against the bones during movements of the joint. The patella is found in the tendon of the quadriceps femoris muscle, the large muscle of the anterior thigh that passes across the anterior knee to attach to the tibia. The patella articulates with the patellar surface of the femur and thus prevents rubbing of the muscle tendon against the distal femur. The patella also lifts the tendon away from the knee joint, which increases the leverage power of the quadriceps femoris muscle as it acts across the knee. The patella does not articulate with the tibia.

INTERACTIVE LINK

Visit this site (http://openstax.org/l/kneesurgery) to watch a virtual knee replacement surgery. The prosthetic knee components must be properly aligned to function properly. How is this alignment ensured?

HOMEOSTATIC IMBALANCES

Runner's Knee

Runner's knee, also known as patellofemoral syndrome, is the most common overuse injury among runners. It is most frequent in adolescents and young adults, and is more common in females. It often results from excessive running, particularly downhill, but may also occur in athletes who do a lot of knee bending, such as jumpers, skiers, cyclists, weight lifters, and soccer players. It is felt as a dull, aching pain around the front of the knee and deep to the patella. The pain may be felt when walking or running, going up or down stairs, kneeling or squatting, or after sitting with the knee bent for an extended period.

Patellofemoral syndrome may be initiated by a variety of causes, including individual variations in the shape and movement of the patella, a direct blow to the patella, or flat feet or improper shoes that cause excessive turning in or out of the feet or leg. These factors may cause in an imbalance in the muscle pull that acts on the patella, resulting in an abnormal tracking of the patella that allows it to deviate too far toward the lateral side of the patellar surface on the distal femur.

Because the hips are wider than the knee region, the femur has a diagonal orientation within the thigh, in contrast to the vertically oriented tibia of the leg (Figure 8.17). The Q-angle is a measure of how far the femur is angled laterally away from vertical. The Q-angle is normally 10–15 degrees, with females typically having a larger Q-angle due to their wider pelvis. During extension of the knee, the quadriceps femoris muscle pulls the patella both superiorly and laterally, with the lateral pull greater in females due to their large Q-angle. This makes females more vulnerable to developing patellofemoral syndrome than males. Normally, the large lip on the lateral side of the patellar surface of the femur compensates for the lateral pull on the patella, and thus helps to maintain its proper tracking.

However, if the pull produced by the medial and lateral sides of the quadriceps femoris muscle is not properly balanced, abnormal tracking of the patella toward the lateral side may occur. With continued use, this produces pain and could result in damage to the articulating surfaces of the patella and femur, and the possible future development of arthritis. Treatment generally involves stopping the activity that produces knee pain for a period of time, followed by a gradual resumption of activity. Proper strengthening of the quadriceps femoris muscle to correct for imbalances is also important to help prevent reoccurrence.

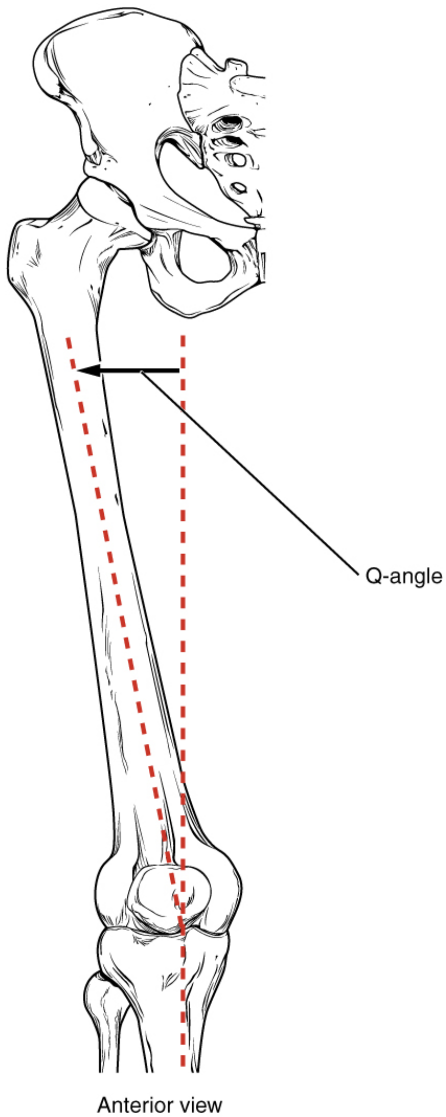


FIGURE 8.17 The Q-Angle The Q-angle is a measure of the amount of lateral deviation of the femur from the vertical line of the tibia. Adult females have a larger Q-angle due to their wider pelvis than adult males.

Tibia

The tibia (shin bone) is the medial bone of the leg and is larger than the fibula, with which it is paired (Figure 8.18). The tibia is the main weight-bearing bone of the lower leg and the second longest bone of the body, after the femur. The medial side of the tibia is located immediately under the skin, allowing it to be easily palpated down the entire length of the medial leg.

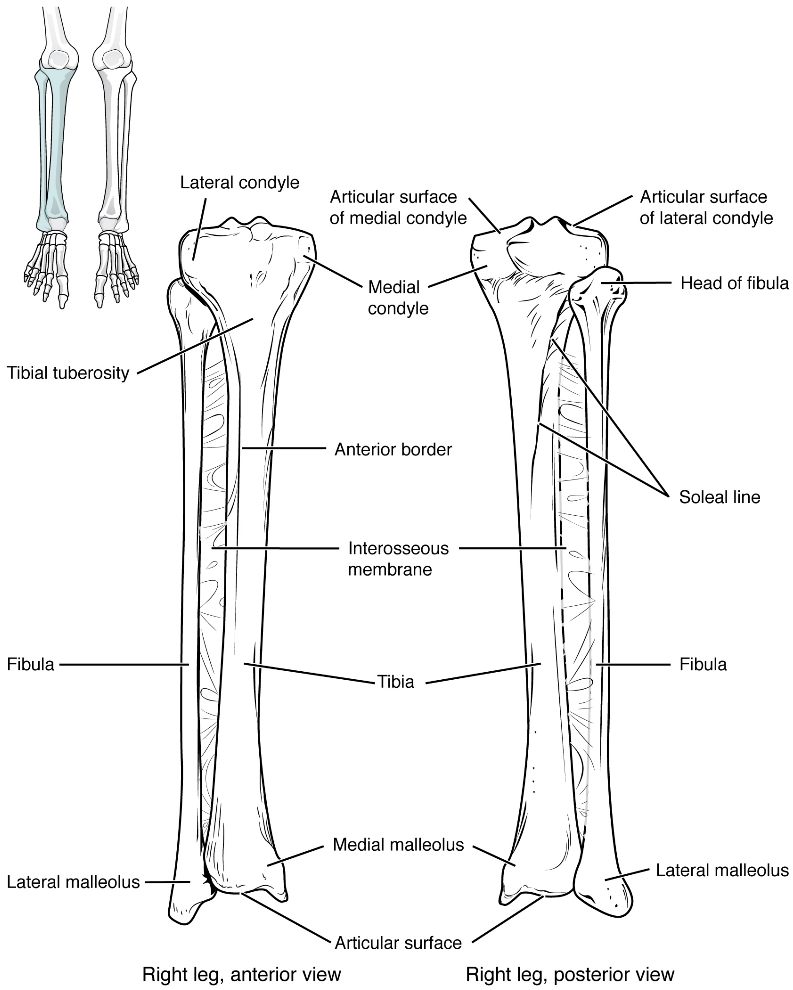


FIGURE 8.18 **Tibia and Fibula** The tibia is the larger, weight-bearing bone located on the medial side of the leg. The fibula is the slender bone of the lateral side of the leg and does not bear weight.

The proximal end of the tibia is greatly expanded. The two sides of this expansion form the **medial condyle of the tibia** and the **lateral condyle of the tibia**. The tibia does not have epicondyles. The top surface of each condyle is smooth and flattened. These areas articulate with the medial and lateral condyles of the femur to form the **knee joint**. Between the articulating surfaces of the tibial condyles is the **intercondylar eminence**, an irregular, elevated area that serves as the inferior attachment point for two supporting ligaments of the knee.

The **tibial tuberosity** is an elevated area on the anterior side of the tibia, near its proximal end. It is the final site of attachment for the muscle tendon associated with the patella. More inferiorly, the **shaft of the tibia** becomes triangular in shape.

The anterior apex of this triangle forms the **anterior border of the tibia**, which begins at the tibial tuberosity and runs inferiorly along the length of the tibia. Both the anterior border and the medial side of the triangular shaft are located immediately under the skin and can be easily palpated along the entire length of the tibia. A small ridge running down the lateral side of the tibial shaft is the **interosseous border of the tibia**. This is for the attachment of the **interosseous membrane of the leg**, the sheet of dense connective tissue that unites the tibia and fibula bones. Located on the posterior side of the tibia is the **soleal line**, a diagonally running, roughened ridge that begins below the base of the lateral condyle, and runs down and medially across the proximal third of the posterior tibia. Muscles of the posterior leg attach to this line.

The large expansion found on the medial side of the distal tibia is the **medial malleolus** (“little hammer”). This forms the large bony bump found on the medial side of the ankle region. Both the smooth surface on the inside of the medial malleolus and the smooth area at the distal end of the tibia articulate with the talus bone of the foot as part of the ankle joint. On the lateral side of the distal tibia is a wide groove called the **fibular notch**. This area articulates with the distal end of the fibula, forming the **distal tibiofibular joint**.

Fibula

The fibula is the slender bone located on the lateral side of the leg (see Figure 8.18). The fibula does not bear weight. It serves primarily for muscle attachments and thus is largely surrounded by muscles. Only the proximal and distal ends of the fibula can be palpated.

The **head of the fibula** is the small, knob-like, proximal end of the fibula. It articulates with the inferior aspect of the lateral tibial condyle, forming the **proximal tibiofibular joint**. The thin **shaft of the fibula** has the **interosseous border of the fibula**, a narrow ridge running down its medial side for the attachment of the interosseous membrane that spans the fibula and tibia. The distal end of the fibula forms the **lateral malleolus**, which forms the easily palpated bony bump on the lateral side of the ankle. The deep (medial) side of the lateral malleolus articulates with the talus bone of the foot as part of the ankle joint. The distal fibula also articulates with the fibular notch of the tibia.

Tarsal Bones

The posterior half of the foot is formed by seven tarsal bones (Figure 8.19). The most superior bone is the **talus**. This has a relatively square-shaped, upper surface that articulates with the tibia and fibula to form the **ankle joint**. Three areas of articulation form the ankle joint: The superomedial surface of the talus bone articulates with the medial malleolus of the tibia, the top of the talus articulates with the distal end of the tibia, and the lateral side of the talus articulates with the lateral malleolus of the fibula. Inferiorly, the talus articulates with the **calcaneus** (heel bone), the largest bone of the foot, which forms the heel. Body weight is transferred from the tibia to the talus to the calcaneus, which rests on the ground. The medial calcaneus has a prominent bony extension called the **sustentaculum tali** ("support for the talus") that supports the medial side of the talus bone.

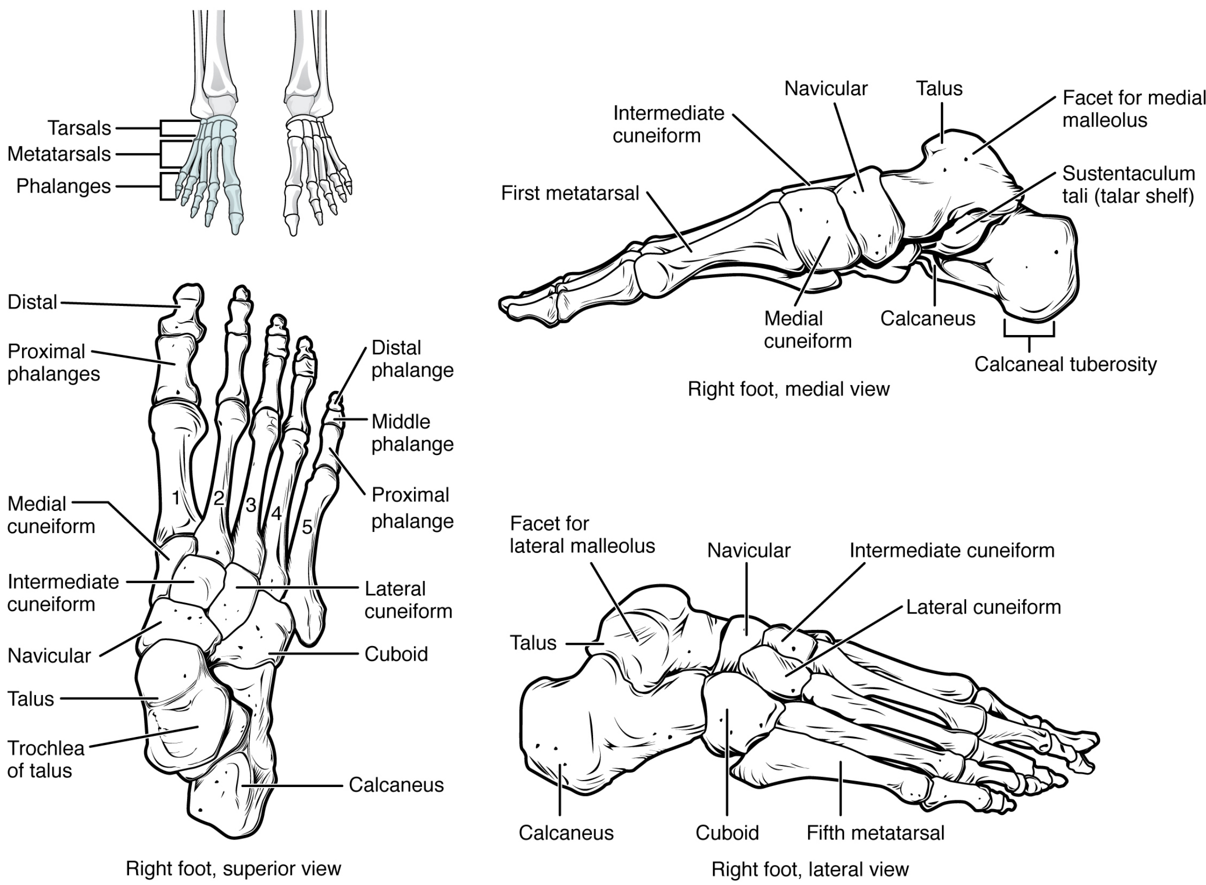


FIGURE 8.19 **Bones of the Foot** The bones of the foot are divided into three groups. The posterior foot is formed by the seven tarsal bones. The mid-foot has the five metatarsal bones. The toes contain the phalanges.

The **cuboid** bone articulates with the anterior end of the calcaneus bone. The cuboid has a deep groove running across its inferior surface, which provides passage for a muscle tendon. The talus bone articulates anteriorly with the **navicular** bone, which in turn articulates anteriorly with the three cuneiform (“wedge-shaped”) bones. These bones are the **medial cuneiform**, the **intermediate cuneiform**, and the **lateral cuneiform**. Each of these bones has a broad superior surface and a narrow inferior surface, which together produce the transverse (medial-lateral) curvature of the foot. The navicular and lateral cuneiform bones also articulate with the medial side of the cuboid bone.

INTERACTIVE LINK

Use this tutorial (http://openstax.org/l/footbones) to review the bones of the foot. Which tarsal bones are in the proximal, intermediate, and distal groups?

Metatarsal Bones

The anterior half of the foot is formed by the five metatarsal bones, which are located between the tarsal bones of the posterior foot and the phalanges of the toes (see Figure 8.19). These elongated bones are numbered 1–5, starting with the medial side of the foot. The first metatarsal bone is shorter and thicker than the others. The second metatarsal is the longest. The **base of the metatarsal bone** is the proximal end of each metatarsal bone. These articulate with the cuboid or cuneiform bones. The base of the fifth metatarsal has a large, lateral expansion that provides for muscle attachments. This expanded base of the fifth metatarsal can be felt as a bony bump at the midpoint along the lateral border of the foot. The expanded distal end of each metatarsal is the **head of the metatarsal bone**. Each metatarsal bone articulates with the proximal phalanx of a toe to form a **metatarsophalangeal joint**. The heads of the metatarsal bones also rest on the ground and form the ball (anterior end) of the foot.

Phalanges

The toes contain a total of 14 phalanx bones (phalanges), arranged in a similar manner as the phalanges of the fingers (see Figure 8.19). The toes are numbered 1–5, starting with the big toe (**hallux**). The big toe has two phalanx bones, the proximal and distal phalanges. The remaining toes all have proximal, middle, and distal phalanges. A joint between adjacent phalanx bones is called an interphalangeal joint.

INTERACTIVE LINK

View this link (http://openstax.org/l/bunion) to learn about a bunion, a localized swelling on the medial side of the foot, next to the first metatarsophalangeal joint, at the base of the big toe. What is a bunion and what type of shoe is most likely to cause this to develop?

Arches of the Foot

When the foot comes into contact with the ground during walking, running, or jumping activities, the impact of the body weight puts a tremendous amount of pressure and force on the foot. During running, the force applied to each foot as it contacts the ground can be up to 2.5 times your body weight. The bones, joints, ligaments, and muscles of the foot absorb this force, thus greatly reducing the amount of shock that is passed superiorly into the lower limb and body. The arches of the foot play an important role in this shock-absorbing ability. When weight is applied to the foot, these arches will flatten somewhat, thus absorbing energy. When the weight is removed, the arch rebounds, giving “spring” to the step. The arches also serve to distribute body weight side to side and to either end of the foot.

The foot has a transverse arch, a medial longitudinal arch, and a lateral longitudinal arch (see Figure 8.19). The transverse arch forms the medial-lateral curvature of the mid-foot. It is formed by the wedge shapes of the cuneiform bones and bases (proximal ends) of the first to fourth metatarsal bones. This arch helps to distribute body weight from side to side within the foot, thus allowing the foot to accommodate uneven terrain.

The longitudinal arches run down the length of the foot. The lateral longitudinal arch is relatively flat, whereas the medial longitudinal arch is larger (taller). The longitudinal arches are formed by the tarsal bones posteriorly and the metatarsal bones anteriorly. These arches are supported at either end, where they contact the ground. Posteriorly, this support is provided by the calcaneus bone and anteriorly by the heads (distal ends) of the metatarsal bones. The talus bone, which receives the weight of the body, is located at the top of the longitudinal arches. Body weight is then conveyed from the talus to the ground by the anterior and posterior ends of these arches. Strong ligaments unite the adjacent foot bones to prevent disruption of the arches during weight bearing. On the bottom of the foot, additional ligaments tie together the anterior and posterior ends of the arches. These ligaments have elasticity, which allows them to stretch somewhat during weight bearing, thus allowing the longitudinal arches to spread. The stretching of these ligaments stores energy within the foot, rather than passing these forces into the leg. Contraction of the foot muscles also plays an important role in this energy absorption. When the weight is removed, the elastic ligaments recoil and pull the ends of the arches closer together. This recovery of the arches releases the stored energy and improves the energy efficiency of walking.

Stretching of the ligaments that support the longitudinal arches can lead to pain. This can occur in overweight individuals, with people who have jobs that involve standing for long periods of time (such as a waitress), or walking or running long distances. If stretching of the ligaments is prolonged, excessive, or repeated, it can result in a gradual lengthening of the supporting ligaments, with subsequent depression or collapse of the longitudinal arches, particularly on the medial side of the foot. This condition is called pes planus (“flat foot” or “fallen arches”).

8.5 Development of the Appendicular Skeleton

LEARNING OBJECTIVES

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

- Describe the growth and development of the embryonic limb buds
- Discuss the appearance of primary and secondary ossification centers

Embryologically, the appendicular skeleton arises from mesenchyme, a type of embryonic tissue that can differentiate into many types of tissues, including bone or muscle tissue. Mesenchyme gives rise to the bones of the upper and lower limbs, as well as to the pectoral and pelvic girdles. Development of the limbs begins near the end of the fourth embryonic week, with the upper limbs appearing first. Thereafter, the development of the upper and lower limbs follows similar patterns, with the lower limbs lagging behind the upper limbs by a few days.

Limb Growth

Each upper and lower limb initially develops as a small bulge called a **limb bud**, which appears on the lateral side of the early embryo. The upper limb bud appears near the end of the fourth week of development, with the lower limb bud appearing shortly after (Figure 8.20).

FIGURE 8.20 **Embryo at Seven Weeks** Limb buds are visible in an embryo at the end of the seventh week of development (embryo derived from an ectopic pregnancy). (credit: Ed Uthman/flickr)

Initially, the limb buds consist of a core of mesenchyme covered by a layer of ectoderm. The ectoderm at the end of the limb bud thickens to form a narrow crest called the **apical ectodermal ridge**. This ridge stimulates the underlying mesenchyme to rapidly proliferate, producing the outgrowth of the developing limb. As the limb bud elongates, cells located farther from the apical ectodermal ridge slow their rates of cell division and begin to differentiate. In this way, the limb develops along a proximal-to-distal axis.

During the sixth week of development, the distal ends of the upper and lower limb buds expand and flatten into a paddle shape. This region will become the hand or foot. The wrist or ankle areas then appear as a constriction that develops at the base of the paddle. Shortly after this, a second constriction on the limb bud appears at the future site of the elbow or knee. Within the paddle, areas of tissue undergo cell death, producing separations between the growing fingers and toes. Also during the sixth week of development, mesenchyme within the limb buds begins to differentiate into hyaline cartilage that will form models of the future limb bones.

The early outgrowth of the upper and lower limb buds initially has the limbs positioned so that the regions that will become the palm of the hand or the bottom of the foot are facing medially toward the body, with the future thumb or big toe both oriented toward the head. During the seventh week of development, the upper limb rotates laterally by 90 degrees, so that the palm of the hand faces anteriorly and the thumb points laterally. In contrast, the lower limb undergoes a 90-degree medial rotation, thus bringing the big toe to the medial side of the foot.

INTERACTIVE LINK

Watch this animation (http://openstax.org/l/limbbuds) to follow the development and growth of the upper and lower limb buds. On what days of embryonic development do these events occur: (a) first appearance of the upper limb bud (limb ridge); (b) the flattening of the distal limb to form the handplate or footplate; and (c) the beginning of limb rotation?

Ossification of Appendicular Bones

All of the girdle and limb bones, except for the clavicle, develop by the process of endochondral ossification. This process begins as the mesenchyme within the limb bud differentiates into hyaline cartilage to form cartilage models for future bones. By the twelfth week, a primary ossification center will have appeared in the diaphysis (shaft) region of the long bones, initiating the process that converts the cartilage model into bone. A secondary ossification center will appear in each epiphysis (expanded end) of these bones at a later time, usually after birth. The primary and secondary ossification centers are separated by the epiphyseal plate, a layer of growing hyaline cartilage. This plate is located between the diaphysis and each epiphysis. It continues to grow and is responsible for the lengthening of the bone. The epiphyseal plate is retained for many years, until the bone reaches its final, adult size, at which time the epiphyseal plate disappears and the epiphysis fuses to the diaphysis. (Seek additional content on ossification in the chapter on bone tissue.)

Small bones, such as the phalanges, will develop only one secondary ossification center and will thus have only a single epiphyseal plate. Large bones, such as the femur, will develop several secondary ossification centers, with an epiphyseal plate associated with each secondary center. Thus, ossification of the femur begins at the end of the seventh week with the appearance of the primary ossification center in the diaphysis, which rapidly expands to ossify the shaft of the bone prior to birth. Secondary ossification centers develop at later times. Ossification of the distal end of the femur, to form the condyles and epicondyles, begins shortly before birth. Secondary ossification centers also appear in the femoral head late in the first year after birth, in the greater trochanter during the fourth year, and in the lesser trochanter between the ages of 9 and 10 years. Once these areas have ossified, their fusion to the diaphysis and the disappearance of each epiphyseal plate follow a reversed sequence. Thus, the lesser trochanter is the first to fuse, doing so at the onset of puberty (around 11 years of age), followed by the greater trochanter approximately 1 year later. The femoral head fuses between the ages of 14–17 years, whereas the distal condyles of the femur are the last to fuse, between the ages of 16–19 years. Knowledge of the age at which different epiphyseal plates disappear is important when interpreting radiographs taken of children. Since the cartilage of an epiphyseal plate is less dense than bone, the plate will appear dark in a radiograph image. Thus, a normal epiphyseal plate may be mistaken for a bone fracture.

The clavicle is the one appendicular skeleton bone that does not develop via endochondral ossification. Instead, the clavicle develops through the process of intramembranous ossification. During this process, mesenchymal cells differentiate directly into bone-producing cells, which produce the clavicle directly, without first making a cartilage model. Because of this early production of bone, the clavicle is the first bone of the body to begin ossification, with ossification centers appearing during the fifth week of development. However, ossification of the clavicle is not complete until age 25.

Disorders of the...

Appendicular System: Congenital Clubfoot

Clubfoot, also known as talipes, is a congenital (present at birth) disorder of unknown cause and is the most common deformity of the lower limb. It affects the foot and ankle, causing the foot to be twisted inward at a sharp angle, like the head of a golf club (Figure 8.21). Clubfoot has a frequency of about 1 out of every 1,000 births, and is twice as likely to occur in a male child as in a female child. In 50 percent of cases, both feet are affected.

FIGURE 8.21 **Clubfoot** Clubfoot is a common deformity of the ankle and foot that is present at birth. Most cases are corrected without surgery, and affected individuals will grow up to lead normal, active lives. (credit: James W. Hanson)

At birth, children with a clubfoot have the heel turned inward and the anterior foot twisted so that the lateral side of the foot is facing inferiorly, commonly due to ligaments or leg muscles attached to the foot that are shortened or abnormally tight. These pull the foot into an abnormal position, resulting in bone deformities. Other symptoms may include bending of the ankle that lifts the heel of the foot and an extremely high foot arch. Due to the limited range of motion in the affected foot, it is difficult to place the foot into the correct position. Additionally, the affected foot may be shorter than normal, and the calf muscles are usually underdeveloped on the affected side. Despite the appearance, this is not a painful condition for newborns. However, it must be treated early to avoid future pain and impaired walking ability.

Although the cause of clubfoot is idiopathic (unknown), evidence indicates that fetal position within the uterus is not a contributing factor. Genetic factors are involved, because clubfoot tends to run within families. Cigarette smoking during pregnancy has been linked to the development of clubfoot, particularly in families with a history of clubfoot.

Previously, clubfoot required extensive surgery. Today, 90 percent of cases are successfully treated without surgery using new corrective casting techniques. The best chance for a full recovery requires that clubfoot treatment begin during the first 2 weeks after birth. Corrective casting gently stretches the foot, which is followed by the application of a holding cast to keep the foot in the proper position. This stretching and casting is repeated weekly for several weeks. In severe cases, surgery may also be required, after which the foot typically remains in a cast for 6 to 8 weeks. After the cast is removed following either surgical or nonsurgical treatment, the child will be required to wear a brace part-time (at night) for up to 4 years. In addition, special exercises will be prescribed, and the child must also wear special shoes. Close monitoring by the parents and adherence to postoperative instructions are imperative in minimizing the risk of relapse.

Despite these difficulties, treatment for clubfoot is usually successful, and the child will grow up to lead a normal, active life. Numerous examples of individuals born with a clubfoot who went on to successful careers include Dudley Moore (comedian and actor), Damon Wayans (comedian and actor), Troy Aikman (three-time Super Bowl-winning quarterback), Kristi Yamaguchi (Olympic gold medalist in figure skating), Mia Hamm (two-time Olympic gold medalist in soccer), and Charles Woodson (Heisman trophy and Super Bowl winner).

Key Terms

acetabulum large, cup-shaped cavity located on the lateral side of the hip bone; formed by the junction of the ilium, pubis, and ischium portions of the hip bone

acromial end of the clavicle lateral end of the clavicle that articulates with the acromion of the scapula

acromial process acromion of the scapula

acromioclavicular joint articulation between the acromion of the scapula and the acromial end of the clavicle

acromion flattened bony process that extends laterally from the scapular spine to form the bony tip of the shoulder

adductor tubercle small, bony bump located on the superior aspect of the medial epicondyle of the femur

anatomical neck line on the humerus located around the outside margin of the humeral head

ankle joint joint that separates the leg and foot portions of the lower limb; formed by the articulations between the talus bone of the foot inferiorly, and the distal end of the tibia, medial malleolus of the tibia, and lateral malleolus of the fibula superiorly

anterior border of the tibia narrow, anterior margin of the tibia that extends inferiorly from the tibial tuberosity

anterior inferior iliac spine small, bony projection located on the anterior margin of the ilium, below the anterior superior iliac spine

anterior sacroiliac ligament strong ligament between the sacrum and the ilium portions of the hip bone that supports the anterior side of the sacroiliac joint

anterior superior iliac spine rounded, anterior end of the iliac crest

apical ectodermal ridge enlarged ridge of ectoderm at the distal end of a limb bud that stimulates growth and elongation of the limb

arcuate line of the ilium smooth ridge located at the inferior margin of the iliac fossa; forms the lateral portion of the pelvic brim

arm region of the upper limb located between the shoulder and elbow joints; contains the humerus bone

auricular surface of the ilium roughened area located on the posterior, medial side of the ilium of the hip bone; articulates with the auricular surface of the sacrum to form the sacroiliac joint

base of the metatarsal bone expanded, proximal end of each metatarsal bone

bicipital groove intertubercular groove; narrow groove located between the greater and lesser tubercles of the humerus

calcaneus heel bone; posterior, inferior tarsal bone that forms the heel of the foot

capitate from the lateral side, the third of the four distal carpal bones; articulates with the scaphoid and lunate proximally, the trapezoid laterally, the hamate medially, and primarily with the third metacarpal distally

capitulum knob-like bony structure located anteriorly on the lateral, distal end of the humerus

carpal bone one of the eight small bones that form the wrist and base of the hand; these are grouped as a proximal row consisting of (from lateral to medial) the scaphoid, lunate, triquetrum, and pisiform bones, and a distal row containing (from lateral to medial) the trapezium, trapezoid, capitate, and hamate bones

carpal tunnel passageway between the anterior forearm and hand formed by the carpal bones and flexor retinaculum

carpometacarpal joint articulation between one of the carpal bones in the distal row and a metacarpal bone of the hand

clavicle collarbone; elongated bone that articulates with the manubrium of the sternum medially and the acromion of the scapula laterally

coracoclavicular ligament strong band of connective tissue that anchors the coracoid process of the scapula to the lateral clavicle; provides important indirect support for the acromioclavicular joint

coracoid process short, hook-like process that projects anteriorly and laterally from the superior margin of the scapula

coronoid fossa depression on the anterior surface of the humerus above the trochlea; this space receives the coronoid process of the ulna when the elbow is maximally flexed

coronoid process of the ulna projecting bony lip located on the anterior, proximal ulna; forms the inferior margin of the trochlear notch

costoclavicular ligament band of connective tissue that unites the medial clavicle with the first rib

coxal bone hip bone

cuboid tarsal bone that articulates posteriorly with the calcaneus bone, medially with the lateral cuneiform bone, and anteriorly with the fourth and fifth metatarsal bones

deltoid tuberosity roughened, V-shaped region located laterally on the mid-shaft of the humerus

distal radioulnar joint articulation between the head of the ulna and the ulnar notch of the radius

distal tibiofibular joint articulation between the distal fibula and the fibular notch of the tibia

elbow joint joint located between the upper arm and forearm regions of the upper limb; formed by the articulations between the trochlea of the humerus and the trochlear notch of the ulna, and the capitulum of the humerus and the head of the radius

femur thigh bone; the single bone of the thigh

fibula thin, non-weight-bearing bone found on the lateral side of the leg

fibular notch wide groove on the lateral side of the distal tibia for articulation with the fibula at the distal tibiofibular joint

flexor retinaculum strong band of connective tissue at the anterior wrist that spans the top of the U-shaped grouping of the carpal bones to form the roof of the carpal tunnel

foot portion of the lower limb located distal to the ankle joint

forearm region of the upper limb located between the elbow and wrist joints; contains the radius and ulna bones

fossa (plural = fossae) shallow depression on the surface of a bone

fovea capitis minor indentation on the head of the femur that serves as the site of attachment for the ligament to the head of the femur

glenohumeral joint shoulder joint; formed by the articulation between the glenoid cavity of the scapula and the head of the humerus

glenoid cavity (also, glenoid fossa) shallow depression located on the lateral scapula, between the superior and lateral borders

gluteal tuberosity roughened area on the posterior side of the proximal femur, extending inferiorly from the base of the greater trochanter

greater pelvis (also, greater pelvic cavity or false pelvis) broad space above the pelvic brim defined laterally by the fan-like portion of the upper ilium

greater sciatic foramen pelvic opening formed by the greater sciatic notch of the hip bone, the sacrum, and the sacrospinous ligament

greater sciatic notch large, U-shaped indentation located on the posterior margin of the ilium, superior to the ischial spine

greater trochanter large, bony expansion of the femur that projects superiorly from the base of the femoral neck

greater tubercle enlarged prominence located on the lateral side of the proximal humerus

hallux big toe; digit 1 of the foot

hamate from the lateral side, the fourth of the four distal carpal bones; articulates with the lunate and triquetrum proximally, the fourth and fifth metacarpals distally, and the capitate laterally

hand region of the upper limb distal to the wrist joint

head of the femur rounded, proximal end of the femur that articulates with the acetabulum of the hip bone to form the hip joint

head of the fibula small, knob-like, proximal end of the fibula; articulates with the inferior aspect of the lateral condyle of the tibia

head of the humerus smooth, rounded region on the medial side of the proximal humerus; articulates with the glenoid fossa of the scapula to form the glenohumeral (shoulder) joint

head of the metatarsal bone expanded, distal end of each metatarsal bone

head of the radius disc-shaped structure that forms the proximal end of the radius; articulates with the capitulum of the humerus as part of the elbow joint, and with the radial notch of the ulna as part of the proximal radioulnar joint

head of the ulna small, rounded distal end of the ulna; articulates with the ulnar notch of the distal radius, forming the distal radioulnar joint

hip bone coxal bone; single bone that forms the pelvic girdle; consists of three areas, the ilium, ischium, and pubis

hip joint joint located at the proximal end of the lower limb; formed by the articulation between the acetabulum of the hip bone and the head of the femur

hook of the hamate bone bony extension located on the anterior side of the hamate carpal bone

humerus single bone of the upper arm

iliac crest curved, superior margin of the ilium

iliac fossa shallow depression found on the anterior and medial surfaces of the upper ilium

ilium superior portion of the hip bone

inferior angle of the scapula inferior corner of the scapula located where the medial and lateral borders meet

inferior pubic ramus narrow segment of bone that passes inferiorly and laterally from the pubic body; joins with the ischial ramus to form the ischiopubic ramus

infraglenoid tubercle small bump or roughened area located on the lateral border of the scapula, near the inferior margin of the glenoid cavity

infraspinous fossa broad depression located on the posterior scapula, inferior to the spine

intercondylar eminence irregular elevation on the superior end of the tibia, between the articulating surfaces of the medial and lateral condyles

intercondylar fossa deep depression on the posterior side of the distal femur that separates the medial and lateral condyles

intermediate cuneiform middle of the three cuneiform tarsal bones; articulates posteriorly with the navicular bone, medially with the medial cuneiform bone, laterally with the lateral cuneiform bone, and anteriorly with the second metatarsal bone

interosseous border of the fibula small ridge running down the medial side of the fibular shaft; for attachment of the interosseous membrane between the fibula and tibia

interosseous border of the radius narrow ridge located on the medial side of the radial shaft; for attachment of the interosseous membrane between the ulna and radius bones

interosseous border of the tibia small ridge running down the lateral side of the tibial shaft; for attachment of the interosseous membrane between the tibia and fibula

interosseous border of the ulna narrow ridge located on the lateral side of the ulnar shaft; for attachment of the interosseous membrane between the ulna and radius

interosseous membrane of the forearm sheet of dense connective tissue that unites the radius and ulna bones

interosseous membrane of the leg sheet of dense connective tissue that unites the shafts of the tibia and fibula bones

interphalangeal joint articulation between adjacent phalanx bones of the hand or foot digits

intertrochanteric crest short, prominent ridge running between the greater and lesser trochanters on the posterior side of the proximal femur

intertrochanteric line small ridge running between the greater and lesser trochanters on the anterior side of the proximal femur

intertubercular groove (sulcus) bicipital groove; narrow groove located between the greater and lesser tubercles of the humerus

ischial ramus bony extension projecting anteriorly and superiorly from the ischial tuberosity; joins with the inferior pubic ramus to form the ischiopubic ramus

ischial spine pointed, bony projection from the posterior margin of the ischium that separates the greater sciatic notch and lesser sciatic notch

ischial tuberosity large, roughened protuberance that forms the posteroinferior portion of the hip bone; weight-bearing region of the pelvis when sitting

ischiopubic ramus narrow extension of bone that connects the ischial tuberosity to the pubic body; formed by the junction of the ischial ramus and inferior pubic ramus

ischium posteroinferior portion of the hip bone

knee joint joint that separates the thigh and leg portions of the lower limb; formed by the articulations between the medial and lateral condyles of the femur, and the medial and lateral condyles of the tibia

lateral border of the scapula diagonally oriented lateral margin of the scapula

lateral condyle of the femur smooth, articulating surface that forms the distal and posterior sides of the lateral expansion of the distal femur

lateral condyle of the tibia lateral, expanded region of the proximal tibia that includes the smooth surface that articulates with the lateral condyle of the femur as part of the knee joint

lateral cuneiform most lateral of the three cuneiform tarsal bones; articulates posteriorly with the navicular bone, medially with the intermediate cuneiform bone, laterally with the cuboid bone, and anteriorly with the third metatarsal bone

lateral epicondyle of the femur roughened area of the femur located on the lateral side of the lateral condyle

lateral epicondyle of the humerus small projection located on the lateral side of the distal humerus

lateral malleolus expanded distal end of the fibula

lateral supracondylar ridge narrow, bony ridge located along the lateral side of the distal humerus, superior to the lateral epicondyle

leg portion of the lower limb located between the knee and ankle joints

lesser pelvis (also, lesser pelvic cavity or true pelvis) narrow space located within the pelvis, defined superiorly by the pelvic brim (pelvic inlet) and inferiorly by the pelvic outlet

lesser sciatic foramen pelvic opening formed by the lesser sciatic notch of the hip bone, the sacrospinous ligament, and the sacrotuberous ligament

lesser sciatic notch shallow indentation along the posterior margin of the ischium, inferior to the ischial spine

lesser trochanter small, bony projection on the medial side of the proximal femur, at the base of the femoral neck

lesser tubercle small, bony prominence located on anterior side of the proximal humerus

ligament of the head of the femur ligament that spans the acetabulum of the hip bone and the fovea

capitis of the femoral head
limb bud small elevation that appears on the lateral side of the embryo during the fourth or fifth week of development, which gives rise to an upper or lower limb
linea aspera longitudinally running bony ridge located in the middle third of the posterior femur
lunate from the lateral side, the second of the four proximal carpal bones; articulates with the radius proximally, the capitate and hamate distally, the scaphoid laterally, and the triquetrum medially
medial border of the scapula elongated, medial margin of the scapula
medial condyle of the femur smooth, articulating surface that forms the distal and posterior sides of the medial expansion of the distal femur
medial condyle of the tibia medial, expanded region of the proximal tibia that includes the smooth surface that articulates with the medial condyle of the femur as part of the knee joint
medial cuneiform most medial of the three cuneiform tarsal bones; articulates posteriorly with the navicular bone, laterally with the intermediate cuneiform bone, and anteriorly with the first and second metatarsal bones
medial epicondyle of the femur roughened area of the distal femur located on the medial side of the medial condyle
medial epicondyle of the humerus enlarged projection located on the medial side of the distal humerus
medial malleolus bony expansion located on the medial side of the distal tibia
metacarpal bone one of the five long bones that form the palm of the hand; numbered 1–5, starting on the lateral (thumb) side of the hand
metacarpophalangeal joint articulation between the distal end of a metacarpal bone of the hand and a proximal phalanx bone of the thumb or a finger
metatarsal bone one of the five elongated bones that forms the anterior half of the foot; numbered 1–5, starting on the medial side of the foot
metatarsophalangeal joint articulation between a metatarsal bone of the foot and the proximal phalanx bone of a toe
midcarpal joint articulation between the proximal and distal rows of the carpal bones; contributes to movements of the hand at the wrist
navicular tarsal bone that articulates posteriorly with the talus bone, laterally with the cuboid bone, and anteriorly with the medial, intermediate, and lateral cuneiform bones
neck of the femur narrowed region located inferior to the head of the femur
neck of the radius narrowed region immediately distal to the head of the radius
obturator foramen large opening located in the anterior hip bone, between the pubis and ischium regions
olecranon fossa large depression located on the posterior side of the distal humerus; this space receives the olecranon process of the ulna when the elbow is fully extended
olecranon process expanded posterior and superior portions of the proximal ulna; forms the bony tip of the elbow
patella kneecap; the largest sesamoid bone of the body; articulates with the distal femur
patellar surface smooth groove located on the anterior side of the distal femur, between the medial and lateral condyles; site of articulation for the patella
pectineal line narrow ridge located on the superior surface of the superior pubic ramus
pectoral girdle shoulder girdle; the set of bones, consisting of the scapula and clavicle, which attaches each upper limb to the axial skeleton
pelvic brim pelvic inlet; the dividing line between the greater and lesser pelvic regions; formed by the superior margin of the pubic symphysis, the pectineal lines of each pubis, the arcuate lines of each ilium, and the sacral promontory
pelvic girdle hip girdle; consists of a single hip bone, which attaches a lower limb to the sacrum of the axial skeleton
pelvic inlet pelvic brim
pelvic outlet inferior opening of the lesser pelvis; formed by the inferior margin of the pubic symphysis, right and left ischiopubic rami and sacrotuberous ligaments, and the tip of the coccyx
pelvis ring of bone consisting of the right and left hip bones, the sacrum, and the coccyx
phalanx bone of the foot (plural = phalanges) one of the 14 bones that form the toes; these include the proximal and distal phalanges of the big toe, and the proximal, middle, and distal phalanx bones of toes two through five
phalanx bone of the hand (plural = phalanges) one of the 14 bones that form the thumb and fingers; these include the proximal and distal phalanges of the thumb, and the proximal, middle, and distal phalanx bones of the fingers two through five
pisiform from the lateral side, the fourth of the four proximal carpal bones; articulates with the anterior surface of the triquetrum
pollex (also, thumb) digit 1 of the hand

posterior inferior iliac spine small, bony projection located at the inferior margin of the auricular surface on the posterior ilium
posterior sacroiliac ligament strong ligament spanning the sacrum and ilium of the hip bone that supports the posterior side of the sacroiliac joint
posterior superior iliac spine rounded, posterior end of the iliac crest
proximal radioulnar joint articulation formed by the radial notch of the ulna and the head of the radius
proximal tibiofibular joint articulation between the head of the fibula and the inferior aspect of the lateral condyle of the tibia
pubic arch bony structure formed by the pubic symphysis, and the bodies and inferior pubic rami of the right and left pubic bones
pubic body enlarged, medial portion of the pubis region of the hip bone
pubic symphysis joint formed by the articulation between the pubic bodies of the right and left hip bones
pubic tubercle small bump located on the superior aspect of the pubic body
pubis anterior portion of the hip bone
radial fossa small depression located on the anterior humerus above the capitulum; this space receives the head of the radius when the elbow is maximally flexed
radial notch of the ulna small, smooth area on the lateral side of the proximal ulna; articulates with the head of the radius as part of the proximal radioulnar joint
radial tuberosity oval-shaped, roughened protuberance located on the medial side of the proximal radius
radiocarpal joint wrist joint, located between the forearm and hand regions of the upper limb; articulation formed proximally by the distal end of the radius and the fibrocartilaginous pad that unites the distal radius and ulna bone, and distally by the scaphoid, lunate, and triquetrum carpal bones
radius bone located on the lateral side of the forearm
sacroiliac joint joint formed by the articulation between the auricular surfaces of the sacrum and ilium
sacrospinous ligament ligament that spans the sacrum to the ischial spine of the hip bone
sacrotuberous ligament ligament that spans the sacrum to the ischial tuberosity of the hip bone
scaphoid from the lateral side, the first of the four proximal carpal bones; articulates with the radius proximally, the trapezoid, trapezium, and capitate distally, and the lunate medially
scapula shoulder blade bone located on the posterior side of the shoulder
shaft of the femur cylindrically shaped region that forms the central portion of the femur
shaft of the fibula elongated, slender portion located between the expanded ends of the fibula
shaft of the humerus narrow, elongated, central region of the humerus
shaft of the radius narrow, elongated, central region of the radius
shaft of the tibia triangular-shaped, central portion of the tibia
shaft of the ulna narrow, elongated, central region of the ulna
soleal line small, diagonally running ridge located on the posterior side of the proximal tibia
spine of the scapula prominent ridge passing mediolaterally across the upper portion of the posterior scapular surface
sternal end of the clavicle medial end of the clavicle that articulates with the manubrium of the sternum
sternoclavicular joint articulation between the manubrium of the sternum and the sternal end of the clavicle; forms the only bony attachment between the pectoral girdle of the upper limb and the axial skeleton
styloid process of the radius pointed projection located on the lateral end of the distal radius
styloid process of the ulna short, bony projection located on the medial end of the distal ulna
subpubic angle inverted V-shape formed by the convergence of the right and left ischiopubic rami; this angle is greater than 80 degrees in females and less than 70 degrees in males
subscapular fossa broad depression located on the anterior (deep) surface of the scapula
superior angle of the scapula corner of the scapula between the superior and medial borders of the scapula
superior border of the scapula superior margin of the scapula
superior pubic ramus narrow segment of bone that passes laterally from the pubic body to join the ilium
supraglenoid tubercle small bump located at the superior margin of the glenoid cavity
suprascapular notch small notch located along the superior border of the scapula, medial to the coracoid process
supraspinous fossa narrow depression located on the posterior scapula, superior to the spine
surgical neck region of the humerus where the expanded, proximal end joins with the narrower shaft

sustentaculum tali bony ledge extending from the medial side of the calcaneus bone
talus tarsal bone that articulates superiorly with the tibia and fibula at the ankle joint; also articulates inferiorly with the calcaneus bone and anteriorly with the navicular bone
tarsal bone one of the seven bones that make up the posterior foot; includes the calcaneus, talus, navicular, cuboid, medial cuneiform, intermediate cuneiform, and lateral cuneiform bones
thigh portion of the lower limb located between the hip and knee joints
tibia shin bone; the large, weight-bearing bone located on the medial side of the leg
tibial tuberosity elevated area on the anterior surface of the proximal tibia
trapezium from the lateral side, the first of the four distal carpal bones; articulates with the scaphoid proximally, the first and second metacarpals distally, and the trapezoid medially
trapezoid from the lateral side, the second of the four distal carpal bones; articulates with the scaphoid proximally, the second metacarpal distally, the trapezium laterally, and the capitate medially
triquetrum from the lateral side, the third of the four proximal carpal bones; articulates with the lunate laterally, the hamate distally, and has a facet for the pisiform
trochlea pulley-shaped region located medially at the distal end of the humerus; articulates at the elbow with the trochlear notch of the ulna
trochlear notch large, C-shaped depression located on the anterior side of the proximal ulna; articulates at the elbow with the trochlea of the humerus
ulna bone located on the medial side of the forearm
ulnar notch of the radius shallow, smooth area located on the medial side of the distal radius; articulates with the head of the ulna at the distal radioulnar joint
ulnar tuberosity roughened area located on the anterior, proximal ulna inferior to the coronoid process

Chapter Review

8.1 The Pectoral Girdle

The pectoral girdle, consisting of the clavicle and the scapula, attaches each upper limb to the axial skeleton. The clavicle is an anterior bone whose sternal end articulates with the manubrium of the sternum at the sternoclavicular joint. The sternal end is also anchored to the first rib by the costoclavicular ligament. The acromial end of the clavicle articulates with the acromion of the scapula at the acromioclavicular joint. This end is also anchored to the coracoid process of the scapula by the coracoclavicular ligament, which provides indirect support for the acromioclavicular joint. The clavicle supports the scapula, transmits the weight and forces from the upper limb to the body trunk, and protects the underlying nerves and blood vessels.

The scapula lies on the posterior aspect of the pectoral girdle. It mediates the attachment of the upper limb to the clavicle, and contributes to the formation of the glenohumeral (shoulder) joint. This triangular bone has three sides called the medial, lateral, and superior borders. The suprascapular notch is located on the superior border. The scapula also has three corners, two of which are the superior and inferior angles. The third corner is occupied by the glenoid cavity. Posteriorly, the spine separates the supraspinous and infraspinous fossae, and then extends laterally as the acromion. The subscapular fossa is located on the anterior surface of the scapula. The coracoid process projects anteriorly, passing inferior to the lateral end of the clavicle.

8.2 Bones of the Upper Limb

Each upper limb is divided into three regions and contains a total of 30 bones. The upper arm is the region located between the shoulder and elbow joints. This area contains the humerus. The proximal humerus consists of the head, which articulates with the scapula at the glenohumeral joint, the greater and lesser tubercles separated by the intertubercular (bicipital) groove, and the anatomical and surgical necks. The humeral shaft has the roughened area of the deltoid tuberosity on its lateral side. The distal humerus is flattened, forming a lateral supracondylar ridge that terminates at the small lateral epicondyle. The medial side of the distal humerus has the large, medial epicondyle. The articulating surfaces of the distal humerus consist of the trochlea medially and the capitulum laterally. Depressions on the humerus that accommodate the forearm bones during bending (flexing) and straightening (extending) of the elbow include the coronoid fossa, the radial fossa, and the olecranon fossa.

The forearm is the region of the upper limb located between the elbow and wrist joints. This region contains two bones, the ulna medially and the radius on the lateral (thumb) side. The elbow joint is formed by the articulation between the trochlea of the humerus and the trochlear notch of the ulna, plus the articulation between the capitulum of the humerus and the head of the radius. The proximal radioulnar joint is the articulation between the head of the radius and the radial notch of the ulna. The proximal ulna also has the olecranon process, forming an expanded posterior region, and the coronoid process and ulnar tuberosity on its anterior aspect. On the proximal radius, the narrowed region below the head is the neck; distal to this is the radial tuberosity. The shaft portions of both the ulna and radius have an interosseous border, whereas the distal ends of each bone have a pointed styloid process. The distal radioulnar joint is found between the head of the ulna and the ulnar notch of the radius. The distal end of the radius articulates with the proximal carpal bones, but the ulna does not.

The base of the hand is formed by eight carpal bones. The carpal bones are united into two rows of bones. The proximal row contains (from lateral to medial) the scaphoid, lunate, triquetrum, and pisiform bones. The scaphoid, lunate, and triquetrum bones contribute to the formation of the radiocarpal joint. The distal row of carpal bones contains (from medial to lateral) the hamate, capitate, trapezoid, and trapezium bones ("So Long To Pinky, Here Comes The Thumb"). The anterior hamate has a prominent bony hook. The proximal and distal carpal rows articulate with each other at the midcarpal joint. The carpal bones, together with the flexor retinaculum, also form the carpal tunnel of the wrist.

The five metacarpal bones form the palm of the hand. The metacarpal bones are numbered 1–5, starting with the thumb side. The first metacarpal bone is freely mobile, but the other bones are united as a group. The digits are also numbered 1–5, with the thumb being number 1. The fingers and thumb contain a total of 14 phalanges (phalanx bones). The thumb contains a proximal and a distal phalanx, whereas the remaining digits each contain proximal, middle, and distal phalanges.

8.3 The Pelvic Girdle and Pelvis

The pelvic girdle, consisting of a hip bone, serves to attach a lower limb to the axial skeleton. The hip bone articulates posteriorly at the sacroiliac joint with the sacrum, which is part of the axial skeleton. The right and left hip bones converge anteriorly and articulate with each other at the pubic symphysis. The combination of the hip bone, the sacrum, and the coccyx forms the pelvis. The pelvis has a pronounced anterior tilt. The primary function of the pelvis is to support the upper body and transfer body weight to the lower limbs. It also serves as the site of attachment for multiple muscles.

The hip bone consists of three regions: the ilium, ischium, and pubis. The ilium forms the large, fan-like region of the hip bone. The superior margin of this area is the iliac crest. Located at either end of the iliac crest are the anterior superior and posterior superior iliac spines. Inferior to these are the anterior inferior and posterior inferior iliac spines. The auricular surface of the ilium articulates with the sacrum to form the sacroiliac joint. The medial surface of the upper ilium forms the iliac fossa, with the arcuate line marking the inferior limit of this area. The posterior margin of the ilium has the large greater sciatic notch.

The posterolateral portion of the hip bone is the ischium. It has the expanded ischial tuberosity, which supports body weight when sitting. The ischial ramus projects anteriorly and superiorly. The posterior margin of the ischium has the shallow lesser sciatic notch and the ischial spine, which separates the greater and lesser sciatic notches.

The pubis forms the anterior portion of the hip bone. The body of the pubis articulates with the pubis of the opposite hip bone at the pubic symphysis. The superior margin of the pubic body has the pubic tubercle. The pubis is joined to the ilium by the superior pubic ramus, the superior surface of which forms the pectineal line. The inferior pubic ramus projects inferiorly and laterally. The pubic arch is formed by the pubic symphysis, the bodies of the adjacent pubic bones, and the two inferior pubic rami. The inferior pubic ramus joins the ischial ramus to form the ischiopubic ramus. The subpubic angle is formed by the medial convergence of the right and left ischiopubic rami.

The lateral side of the hip bone has the cup-like acetabulum, which is part of the hip joint. The large anterior opening is the obturator foramen. The sacroiliac joint is supported by the anterior and posterior sacroiliac ligaments. The sacrum is also joined to the hip bone by the sacrospinous ligament, which attaches to the ischial spine, and the sacrotuberous ligament, which attaches to the ischial tuberosity. The sacrospinous and sacrotuberous ligaments contribute to the formation of the greater and lesser sciatic foramina.

The broad space of the upper pelvis is the greater pelvis, and the narrow, inferior space is the lesser pelvis. These areas are separated by the pelvic brim (pelvic inlet). The inferior opening of the pelvis is the pelvic outlet. Compared to the male, the female pelvis is wider to accommodate childbirth, has a larger subpubic angle, and a broader greater sciatic notch.

8.4 Bones of the Lower Limb

The lower limb is divided into three regions. These are the thigh, located between the hip and knee joints; the leg, located between the knee and ankle joints; and distal to the ankle, the foot. There are 30 bones in each lower limb. These are the femur, patella, tibia, fibula, seven tarsal bones, five metatarsal bones, and 14 phalanges.

The femur is the single bone of the thigh. Its rounded head articulates with the acetabulum of the hip bone to form the hip joint. The head has the fovea capitis for attachment of the ligament of the head of the femur. The narrow neck joins inferiorly with the greater and lesser trochanters. Passing between these bony expansions are the intertrochanteric line on the anterior femur and the larger intertrochanteric crest on the posterior femur. On the posterior shaft of the femur is the gluteal tuberosity proximally and the linea aspera in the mid-shaft region. The expanded distal end consists of three articulating surfaces: the medial and lateral condyles, and the patellar surface. The outside margins of the condyles are the medial and lateral epicondyles. The adductor tubercle is on the superior aspect of the medial epicondyle.

The patella is a sesamoid bone located within a muscle tendon. It articulates with the patellar surface on the anterior side of the distal femur, thereby protecting the muscle tendon from rubbing against the femur.

The leg contains the large tibia on the medial side and the slender fibula on the lateral side. The tibia bears the weight of the body, whereas the fibula does not bear weight. The interosseous border of each bone is the attachment site for the interosseous membrane of the leg, the connective tissue sheet that unites the tibia and fibula.

The proximal tibia consists of the expanded medial and lateral condyles, which articulate with the medial and lateral condyles of the femur to form the knee joint. Between the tibial condyles is the intercondylar eminence. On the anterior side of the proximal tibia is the tibial tuberosity, which is continuous inferiorly with the anterior border of the tibia. On the posterior side, the proximal tibia has the curved soleal line. The bony expansion on the medial side of the distal tibia is the medial malleolus. The groove on the lateral side of the distal tibia is the fibular notch.

The head of the fibula forms the proximal end and articulates with the underside of the lateral condyle of the tibia. The distal fibula articulates with the fibular notch of the tibia. The expanded distal end of the fibula is the lateral malleolus.

The posterior foot is formed by the seven tarsal bones. The talus articulates superiorly with the distal tibia, the medial malleolus of the tibia, and the lateral malleolus of the fibula to form the ankle joint. The talus articulates inferiorly with the calcaneus bone. The sustentaculum tali of the calcaneus helps to support the talus. Anterior to the talus is the navicular bone, and anterior to this are the medial, intermediate, and lateral cuneiform bones. The cuboid bone is anterior to the calcaneus.

The five metatarsal bones form the anterior foot. The base of these bones articulate with the cuboid or cuneiform bones. The metatarsal heads, at their distal ends, articulate with the proximal phalanges of the toes. The big toe (toe number 1) has proximal and distal phalanx bones. The remaining toes have proximal, middle, and distal phalanges.

8.5 Development of the Appendicular Skeleton

The bones of the appendicular skeleton arise from embryonic mesenchyme. Limb buds appear at the end of the fourth week. The apical ectodermal ridge, located at the end of the limb bud, stimulates growth and elongation of the limb. During the sixth week, the distal end of the limb bud becomes paddle-shaped, and selective cell death separates the developing fingers and toes. At the same time, mesenchyme within the limb bud begins to differentiate into hyaline cartilage, forming models for future bones. During the seventh week, the upper limbs rotate laterally and the lower limbs rotate medially, bringing the limbs into their final positions.

Endochondral ossification, the process that converts the hyaline cartilage model into bone, begins in most appendicular bones by the twelfth fetal week. This begins as a primary ossification center in the diaphysis, followed by the later appearance of one or more secondary ossifications centers in the regions of the epiphyses. Each secondary ossification center is separated from the primary ossification center by an epiphyseal plate. Continued growth of the epiphyseal plate cartilage provides for bone lengthening. Disappearance of the epiphyseal plate is followed by fusion of the bony components to form a single, adult bone.

The clavicle develops via intramembranous ossification, in which mesenchyme is converted directly into bone tissue. Ossification within the clavicle begins during the fifth week of development and continues until 25 years of age.

Interactive Link Questions

1. Watch this video (http://openstax.org/l/fractures) to see how fractures of the distal radius bone can affect the wrist joint. Explain the problems that may occur if a fracture of the distal radius involves the joint surface of the radiocarpal joint of the wrist.
2. Visit this site (http://openstax.org/l/handbone) to explore the bones and joints of the hand. What are the three arches of the hand, and what is the importance of these during the gripping of an object?
3. Watch this video (http://openstax.org/l/colles) to learn about a Colles fracture, a break of the distal radius, usually caused by falling onto an outstretched hand. When would surgery be required and how would the fracture be repaired in this case?
4. Watch this video (http://openstax.org/l/3Dpelvis) for a 3-D view of the pelvis and its associated ligaments. What is the large opening in the bony pelvis, located between the ischium and pubic regions, and what two parts of the pubis contribute to the formation of this opening?
5. Watch this video (http://openstax.org/l/midfemur) to view how a fracture of the mid-femur is surgically repaired. How are the two portions of the broken femur stabilized during surgical repair of a fractured femur?
6. Visit this site (http://openstax.org/l/kneesurgery) to watch a virtual knee replacement surgery. The prosthetic knee components must be properly aligned to function properly. How is this alignment ensured?
7. Use this tutorial (http://openstax.org/l/footbones) to review the bones of the foot. Which tarsal bones are in the proximal, intermediate, and distal groups?
8. View this link (http://openstax.org/l/bunion) to learn about a bunion, a localized swelling on the medial side of the foot, next to the first metatarsophalangeal joint, at the base of the big toe. What is a bunion and what type of shoe is most likely to cause this to develop?
9. Watch this animation (http://openstax.org/l/limbbuds) to follow the development and growth of the upper and lower limb buds. On what days of embryonic development do these events occur: (a) first appearance of the upper limb bud (limb ridge); (b) the flattening of the distal limb to form the handplate or footplate; and (c) the beginning of limb rotation?

Review Questions

10. Which part of the clavicle articulates with the manubrium?
    a. shaft
    b. sternal end
    c. acromial end
    d. coracoid process

11. A shoulder separation results from injury to the ________.
    a. glenohumeral joint
    b. costoclavicular joint
    c. acromioclavicular joint
    d. sternoclavicular joint

12. Which feature lies between the spine and superior border of the scapula?
    a. suprascapular notch
    b. glenoid cavity
    c. superior angle
    d. supraspinous fossa

13. What structure is an extension of the spine of the scapula?
    a. acromion
    b. coracoid process
    c. supraglenoid tubercle
    d. glenoid cavity

14. Name the short, hook-like bony process of the scapula that projects anteriorly.
    a. acromial process
    b. clavicle
    c. coracoid process
    d. glenoid fossa

15. How many bones are there in the upper limbs combined?
    a. 20
    b. 30
    c. 40
    d. 60

16. Which bony landmark is located on the lateral side of the proximal humerus?
a. greater tubercle
b. trochlea
c. lateral epicondyle
d. lesser tubercle

17. Which region of the humerus articulates with the radius as part of the elbow joint?
a. trochlea
b. styloid process
c. capitulum
d. olecranon process

18. Which is the lateral-most carpal bone of the proximal row?
a. trapezium
b. hamate
c. pisiform
d. scaphoid

19. The radius bone ________.
a. is found on the medial side of the forearm
b. has a head that articulates with the radial notch of the ulna
c. does not articulate with any of the carpal bones
d. has the radial tuberosity located near its distal end

20. How many bones fuse in adulthood to form the hip bone?
a. 2
b. 3
c. 4
d. 5

21. Which component forms the superior part of the hip bone?
a. ilium
b. pubis
c. ischium
d. sacrum

22. Which of the following supports body weight when sitting?
a. iliac crest
b. ischial tuberosity
c. ischiopubic ramus
d. pubic body

23. The ischial spine is found between which of the following structures?
a. inferior pubic ramus and ischial ramus
b. pectineal line and arcuate line
c. lesser sciatic notch and greater sciatic notch
d. anterior superior iliac spine and posterior superior iliac spine

24. The pelvis ________.
a. has a subpubic angle that is larger in females
b. consists of the two hip bones, but does not include the sacrum or coccyx
c. has an obturator foramen, an opening that is defined in part by the sacrospinous and sacrotuberous ligaments
d. has a space located inferior to the pelvic brim called the greater pelvis

25. Which bony landmark of the femur serves as a site for muscle attachments?
a. fovea capitis
b. lesser trochanter
c. head
d. medial condyle

26. What structure contributes to the knee joint?
a. lateral malleolus of the fibula
b. tibial tuberosity
c. medial condyle of the tibia
d. lateral epicondyle of the femur

27. Which tarsal bone articulates with the tibia and fibula?
a. calcaneus
b. cuboid
c. navicular
d. talus

28. What is the total number of bones found in the foot and toes?
a. 7
b. 14
c. 26
d. 30

29. The tibia ________.
a. has an expanded distal end called the lateral malleolus
b. is not a weight-bearing bone
c. is firmly anchored to the fibula by an interosseous membrane
d. can be palpated (felt) under the skin only at its proximal and distal ends

30. Which event takes place during the seventh week of development?
   a. appearance of the upper and lower limb buds
   b. flattening of the distal limb bud into a paddle shape
   c. the first appearance of hyaline cartilage models of future bones
   d. the rotation of the limbs

31. During endochondral ossification of a long bone, ________.
   a. a primary ossification center will develop within the epiphysis
   b. mesenchyme will differentiate directly into bone tissue
   c. growth of the epiphyseal plate will produce bone lengthening
   d. all epiphyseal plates will disappear before birth

32. The clavicle ________.
   a. develops via intramembranous ossification
   b. develops via endochondral ossification
   c. is the last bone of the body to begin ossification
   d. is fully ossified at the time of birth

Critical Thinking Questions

33. Describe the shape and palpable line formed by the clavicle and scapula.

34. Discuss two possible injuries of the pectoral girdle that may occur following a strong blow to the shoulder or a hard fall onto an outstretched hand.

35. Your friend runs out of gas and you have to help push their car. Discuss the sequence of bones and joints that convey the forces passing from your hand, through your upper limb and your pectoral girdle, and to your axial skeleton.

36. Name the bones in the wrist and hand, and describe or sketch out their locations and articulations.

37. Describe the articulations and ligaments that unite the four bones of the pelvis to each other.

38. Discuss the ways in which the female pelvis is adapted for childbirth.

39. Define the regions of the lower limb, name the bones found in each region, and describe the bony landmarks that articulate together to form the hip, knee, and ankle joints.

40. The talus bone of the foot receives the weight of the body from the tibia. The talus bone then distributes this weight toward the ground in two directions: one-half of the body weight is passed in a posterior direction and one-half of the weight is passed in an anterior direction. Describe the arrangement of the tarsal and metatarsal bones that are involved in both the posterior and anterior distribution of body weight.

41. How can a radiograph of a child’s femur be used to determine the approximate age of that child?

42. How does the development of the clavicle differ from the development of other appendicular skeleton bones?

CHAPTER 9
Joints

Figure 9.1 **Kayaking** Without joints, body movements would be impossible. (credit: Graham Richardson/flickr.com)

CHAPTER OBJECTIVES

After this chapter, you will be able to:

- Discuss both functional and structural classifications for body joints
- Describe the characteristic features for fibrous, cartilaginous, and synovial joints and give examples of each
- Define and identify the different body movements
- Discuss the structure of specific body joints and the movements allowed by each
- Explain the development of body joints

INTRODUCTION The adult human body has 206 bones, and with the exception of the hyoid bone in the neck, each bone is connected to at least one other bone. Joints are the location where bones come together. Many joints allow for movement between the bones. At these joints, the articulating surfaces of the adjacent bones can move smoothly against each other. However, the bones of other joints may be joined to each other by connective tissue or cartilage. These joints are designed for stability and provide for little or no movement. Importantly, joint stability and movement are related to each other. This means that stable joints allow for little or no mobility between the adjacent bones. Conversely, joints that provide the most movement between bones are the least stable. Understanding the relationship between joint structure and function will help to explain why particular types of joints are found in certain areas of the body.

The articulating surfaces of bones at stable types of joints, with little or no mobility, are strongly united to each other. For example, most of the joints of the skull are held together by fibrous connective tissue and do not allow for movement between the adjacent bones. This lack of mobility is important, because the skull bones serve to protect the brain. Similarly, other joints united by fibrous connective tissue allow for very little movement, which provides stability and weight-bearing support for the body. For example, the tibia and fibula of the leg are tightly united to give stability to the body when standing. At other joints, the bones are held together by cartilage, which permits limited movements between the bones. Thus, the joints of the vertebral column only allow for small movements between adjacent vertebrae, but when added together, these movements provide the flexibility that allows your body to twist, or bend to the front, back, or side. In contrast, at joints that allow for wide ranges of motion, the articulating surfaces of the bones are not directly united to each other. Instead, these surfaces are enclosed within a space filled with lubricating fluid, which allows the bones to move smoothly against each other. These joints provide greater mobility, but since the bones are free to move in relation to each other, the joint is less stable. Most of the joints between the bones of the appendicular skeleton are this freely moveable type of joint. These joints allow the muscles of the body to pull on a bone and thereby produce movement of that body region. Your ability to kick a soccer ball, pick up a fork, and dance the tango depend on mobility at these types of joints.

9.1 Classification of Joints

LEARNING OBJECTIVES

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

- Distinguish between the functional and structural classifications for joints
- Describe the three functional types of joints and give an example of each
- List the three types of diarthrodial joints

A **joint**, also called an **articulation**, is any place where adjacent bones or bone and cartilage come together (articulate with each other) to form a connection. Joints are classified both structurally and functionally. Structural classifications of joints take into account whether the adjacent bones are strongly anchored to each other by fibrous connective tissue or cartilage, or whether the adjacent bones articulate with each other within a fluid-filled space called a **joint cavity**. Functional classifications describe the degree of movement available between the bones, ranging from immobile, to slightly mobile, to freely moveable joints. The amount of movement available at a particular joint of the body is related to the functional requirements for that joint. Thus immobile or slightly moveable joints serve to protect internal organs, give stability to the body, and allow for limited body movement. In contrast, freely moveable joints allow for much more extensive movements of the body and limbs.

Structural Classification of Joints

The structural classification of joints is based on whether the articulating surfaces of the adjacent bones are directly connected by fibrous connective tissue or cartilage, or whether the articulating surfaces contact each other within a fluid-filled joint cavity. These differences serve to divide the joints of the body into three structural classifications. A **fibrous joint** is where the adjacent bones are united by fibrous connective tissue. At a **cartilaginous joint**, the bones are joined by hyaline cartilage or fibrocartilage. At a **synovial joint**, the articulating surfaces of the bones are not directly connected, but instead come into contact with each other within a joint cavity that is filled with a lubricating fluid. Synovial joints allow for free movement between the bones and are the most common joints of the body.

Functional Classification of Joints

The functional classification of joints is determined by the amount of mobility found between the adjacent bones. Joints are thus functionally classified as a synarthrosis or immobile joint, an amphiarthrosis or slightly moveable joint, or as a diarthrosis, which is a freely moveable joint (arthroun = “to fasten by a joint”). Depending on their location, fibrous joints may be functionally classified as a synarthrosis (immobile joint) or an amphiarthrosis (slightly mobile joint). Cartilaginous joints are also functionally classified as either a synarthrosis or an amphiarthrosis joint. All synovial joints are functionally classified as a diarthrosis joint.

Synarthrosis

An immobile or nearly immobile joint is called a **synarthrosis**. The immobile nature of these joints provide for a strong union between the articulating bones. This is important at locations where the bones provide protection for internal organs. Examples include sutures, the fibrous joints between the bones of the skull that surround and protect the brain (Figure 9.2), and the manubriosternal joint, the cartilaginous joint that unites the manubrium and body of the sternum for protection of the heart.

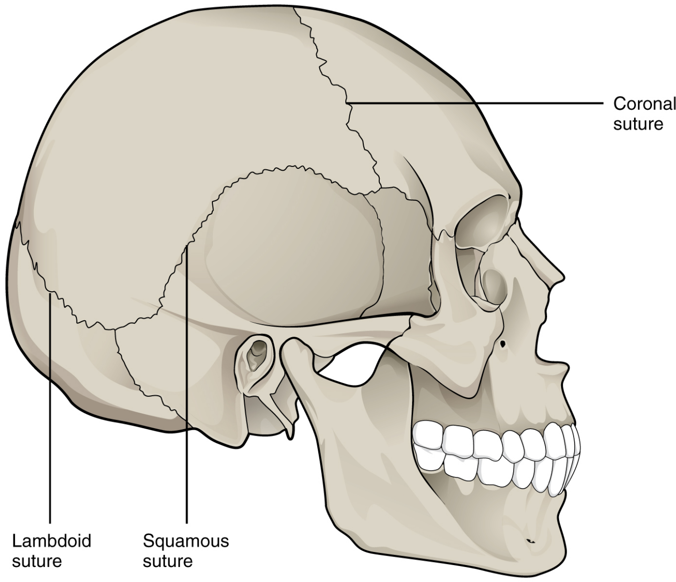


FIGURE 9.2 **Suture Joints of Skull** The suture joints of the skull are an example of a synarthrosis, an immobile or essentially immobile joint.

Amphiarthrosis

An **amphiarthrosis** is a joint that has limited mobility. An example of this type of joint is the cartilaginous joint that unites the bodies of adjacent vertebrae. Filling the gap between the vertebrae is a thick pad of fibrocartilage called an intervertebral disc (Figure 9.3). Each intervertebral disc strongly unites the vertebrae but still allows for a limited amount of movement between them. However, the small movements available between adjacent vertebrae can sum together along the length of the vertebral column to provide for large ranges of body movements.

Another example of an amphiarthrosis is the pubic symphysis of the pelvis. This is a cartilaginous joint in which the pubic regions of the right and left hip bones are strongly anchored to each other by fibrocartilage. This joint normally has very little mobility. The strength of the pubic symphysis is important in conferring weight-bearing stability to the pelvis.

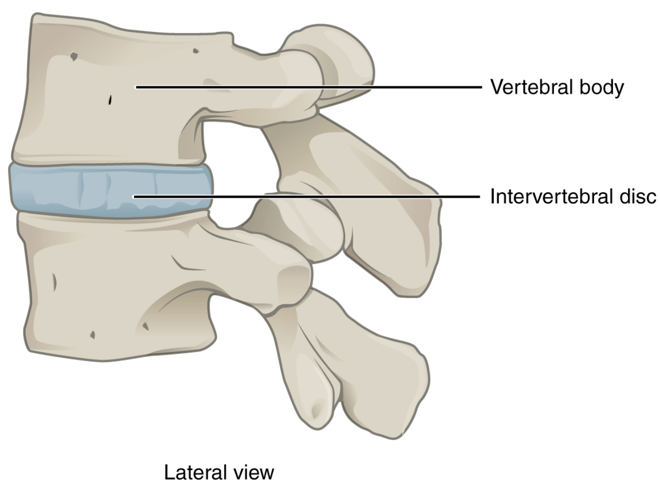


FIGURE 9.3 **Intervertebral Disc** An intervertebral disc unites the bodies of adjacent vertebrae within the vertebral column. Each disc allows for limited movement between the vertebrae and thus functionally forms an amphiarthrosis type of joint. Intervertebral discs are made of fibrocartilage and thereby structurally form a symphysis type of cartilaginous joint.

Diarthrosis

A freely mobile joint is classified as a **diarthrosis**. These types of joints include all synovial joints of the body, which provide the majority of body movements. Most diarthrotic joints are found in the appendicular skeleton and thus give the limbs a wide range of motion. These joints are divided into three categories, based on the number of axes of motion provided by each. An axis in anatomy is described as the movements in reference to the three anatomical planes: transverse, frontal, and sagittal. Thus, diarthroses are classified as uniaxial (for movement in one plane), biaxial (for movement in two planes), or multiaxial joints (for movement in all three anatomical planes).

A **uniaxial joint** only allows for a motion in a single plane (around a single axis). The elbow joint, which only allows for bending or straightening, is an example of a uniaxial joint. A **biaxial joint** allows for motions within two planes. An example of a biaxial joint is a metacarpophalangeal joint (knuckle joint) of the hand. The joint allows for movement along one axis to produce bending or straightening of the finger, and movement along a second axis, which allows for spreading of the fingers away from each other and bringing them together. A joint that allows for the several directions of movement is called a **multiaxial joint** (polyaxial or triaxial joint). This type of diarthrotic joint allows for movement along three axes (Figure 9.4). The shoulder and hip joints are multiaxial joints. They allow the upper or lower limb to move in an anterior-posterior direction and a medial-lateral direction. In addition, the limb can also be rotated around its long axis. This third movement results in rotation of the limb so that its anterior surface is moved either toward or away from the midline of the body.

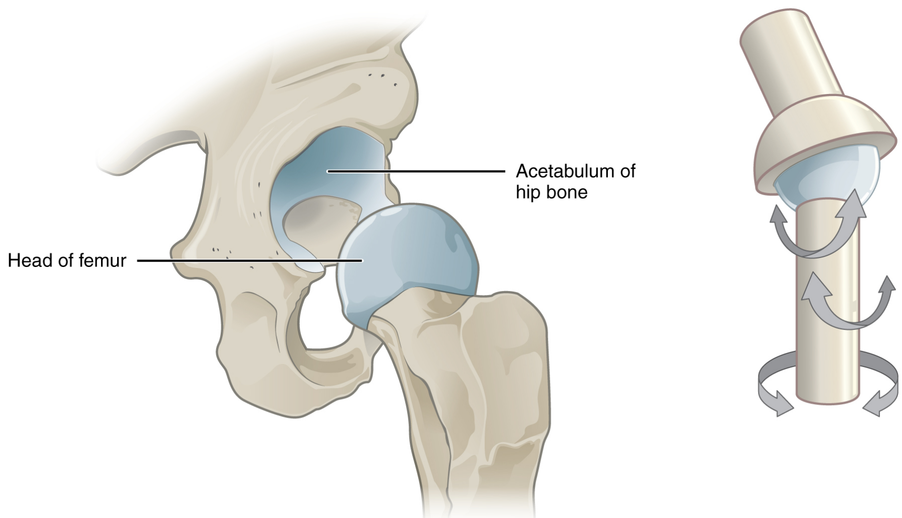


FIGURE 9.4 **Multiaxial Joint** A multiaxial joint, such as the hip joint, allows for three types of movement: anterior-posterior, medial-lateral, and rotational.

9.2 Fibrous Joints

LEARNING OBJECTIVES

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

- Describe the structural features of fibrous joints
- Distinguish between a suture, syndesmosis, and gomphosis
- Give an example of each type of fibrous joint

At a fibrous joint, the adjacent bones are directly connected to each other by fibrous connective tissue, and thus the bones do not have a joint cavity between them (Figure 9.5). The gap between the bones may be narrow or wide. There are three types of fibrous joints. A suture is the narrow fibrous joint found between most bones of the skull. At a syndesmosis joint, the bones are more widely separated but are held together by a narrow band of fibrous connective tissue called a **ligament** or a wide sheet of connective tissue called an interosseous membrane. This type of fibrous joint is found between the shaft regions of the long bones in the forearm and in the leg. Lastly, a gomphosis is the narrow fibrous joint between the roots of a tooth and the bony socket in the jaw into which the tooth fits.

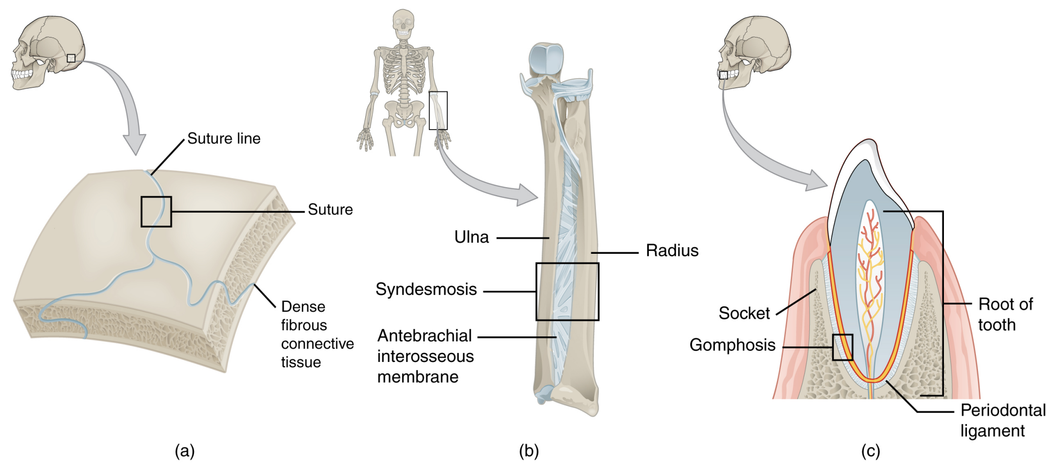


FIGURE 9.5 **Fibrous Joints** Fibrous joints form strong connections between bones. (a) Sutures join most bones of the skull. (b) An interosseous membrane forms a syndesmosis between the radius and ulna bones of the forearm. (c) A gomphosis is a specialized fibrous joint that anchors a tooth to its socket in the jaw.

Suture

All the bones of the skull, except for the mandible, are joined to each other by a fibrous joint called a **suture**. The fibrous connective tissue found at a suture ("to bind or sew") strongly unites the adjacent skull bones and thus helps to protect the brain and form the face. In adults, the skull bones are closely opposed and fibrous connective tissue fills the narrow gap between the bones. The suture is frequently convoluted, forming a tight union that prevents most movement between the bones. (See Figure 9.5**a**.) Thus, skull sutures are functionally classified as a synarthrosis, although some sutures may allow for slight movements between the cranial bones.

In newborns and infants, the areas of connective tissue between the bones are much wider, especially in those areas on the top and sides of the skull that will become the sagittal, coronal, squamous, and lambdoid sutures. These broad areas of connective tissue are called **fontanelles** (Figure 9.6). During birth, the fontanelles provide flexibility to the skull, allowing the bones to push closer together or to overlap slightly, thus aiding movement of the infant's head through the birth canal. After birth, these expanded regions of connective tissue allow for rapid growth of the skull and enlargement of the brain. The fontanelles greatly decrease in width during the first year after birth as the skull bones enlarge. When the connective tissue between the adjacent bones is reduced to a narrow layer, these fibrous joints are now called sutures. At some sutures, the connective tissue will ossify and be converted into bone, causing the adjacent bones to fuse to each other. This fusion between bones is called a **synostosis** ("joined by bone"). Examples of synostosis fusions between cranial bones are found both early and late in life. At the time of birth, the frontal and maxillary bones consist of right and left halves joined together by sutures, which disappear by the eighth year as the halves fuse together to form a single bone. Late in life, the sagittal, coronal, and lambdoid sutures of the skull will begin to ossify and fuse, causing the suture line to gradually disappear.

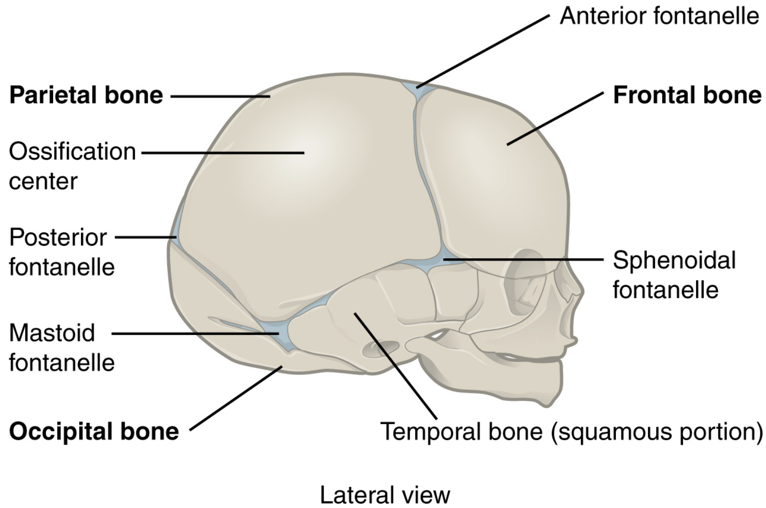


FIGURE 9.6 **The Newborn Skull** The fontanelles of a newborn's skull are broad areas of fibrous connective tissue that form fibrous joints between the bones of the skull.

Syndesmosis

A **syndesmosis** ("fastened with a band") is a type of fibrous joint in which two parallel bones are united to each other by fibrous connective tissue. The gap between the bones may be narrow, with the bones joined by ligaments, or the gap may be wide and filled in by a broad sheet of connective tissue called an **interosseous membrane**.

In the forearm, the wide gap between the shaft portions of the radius and ulna bones are strongly united by an interosseous membrane (see Figure 9.5**b**). Similarly, in the leg, the shafts of the tibia and fibula are also united by an interosseous membrane. In addition, at the distal tibiofibular joint, the articulating surfaces of the bones lack cartilage and the narrow gap between the bones is anchored by fibrous connective tissue and ligaments on both the anterior and posterior aspects of the joint. Together, the interosseous membrane and these ligaments form the tibiofibular syndesmosis.

The syndesmoses found in the forearm and leg serve to unite parallel bones and prevent their separation. However, a syndesmosis does not prevent all movement between the bones, and thus this type of fibrous joint is functionally classified as an amphiarthrosis. In the leg, the syndesmosis between the tibia and fibula strongly unites the bones, allows for little movement, and firmly locks the talus bone in place between the tibia and fibula at the ankle joint. This provides strength and stability to the leg and ankle, which are important during weight bearing. In the forearm, the interosseous membrane is flexible enough to allow for rotation of the radius bone during forearm movements. Thus in contrast to the stability provided by the tibiofibular syndesmosis, the flexibility of the antebrachial interosseous membrane allows for the much greater mobility of the forearm.

The interosseous membranes of the leg and forearm also provide areas for muscle attachment. Damage to a syndesmotic joint, which usually results from a fracture of the bone with an accompanying tear of the interosseous membrane, will produce pain, loss of stability of the bones, and may damage the muscles attached to the interosseous membrane. If the fracture site is not properly immobilized with a cast or splint, contractile activity by these muscles can cause improper alignment of the broken bones during healing.

Gomphosis

A **gomphosis** ("fastened with bolts") is the specialized fibrous joint that anchors the root of a tooth into its bony socket within the maxillary bone (upper jaw) or mandible bone (lower jaw) of the skull. A gomphosis is also known as a peg-and-socket joint. Spanning between the bony walls of the socket and the root of the tooth are numerous short bands of dense connective tissue, each of which is called a **periodontal ligament** (see Figure 9.5**c**). Due to the immobility of a gomphosis, this type of joint is functionally classified as a synarthrosis.

9.3 Cartilaginous Joints

LEARNING OBJECTIVES

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

- Describe the structural features of cartilaginous joints
- Distinguish between a synchondrosis and symphysis
- Give an example of each type of cartilaginous joint

As the name indicates, at a cartilaginous joint, the adjacent bones are united by cartilage, a tough but flexible type of connective tissue. These types of joints lack a joint cavity and involve bones that are joined together by either hyaline cartilage or fibrocartilage (Figure 9.7). There are two types of cartilaginous joints. A synchondrosis is a cartilaginous joint where the bones are joined by hyaline cartilage. Also classified as a synchondrosis are places where bone is united to a cartilage structure, such as between the anterior end of a rib and the costal cartilage of the thoracic cage. The second type of cartilaginous joint is a symphysis, where the bones are joined by fibrocartilage.

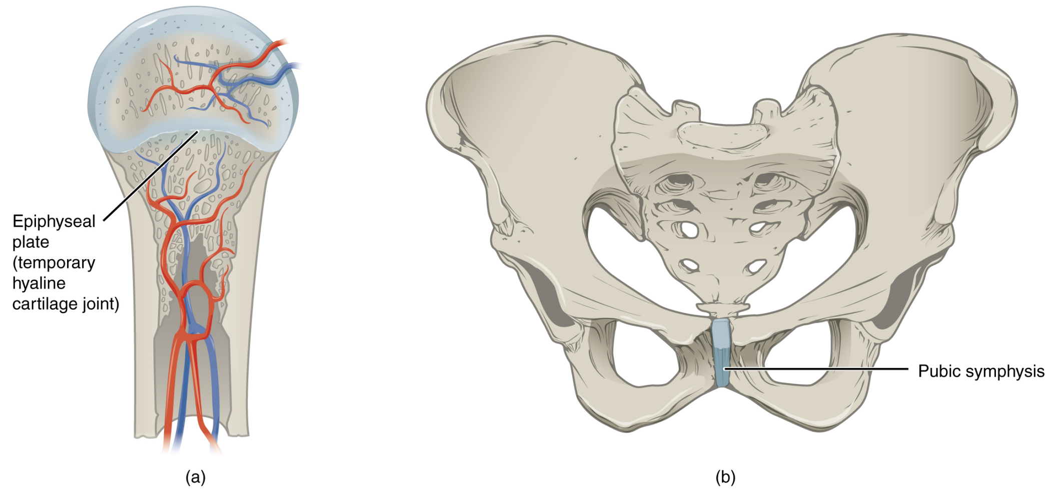


FIGURE 9.7 Cartilaginous Joints At cartilaginous joints, bones are united by hyaline cartilage to form a synchondrosis or by fibrocartilage to form a symphysis. (a) The hyaline cartilage of the epiphyseal plate (growth plate) forms a synchondrosis that unites the shaft (diaphysis) and end (epiphysis) of a long bone and allows the bone to grow in length. (b) The pubic portions of the right and left hip bones of the pelvis are joined together by fibrocartilage, forming the pubic symphysis.

Synchondrosis

A **synchondrosis** ("joined by cartilage") is a cartilaginous joint where bones are joined together by hyaline cartilage, or where bone is united to hyaline cartilage. A synchondrosis may be temporary or permanent. A temporary synchondrosis is the epiphyseal plate (growth plate) of a growing long bone. The epiphyseal plate is the region of growing hyaline cartilage that unites the diaphysis (shaft) of the bone to the epiphysis (end of the bone). Bone lengthening involves growth of the epiphyseal plate cartilage and its replacement by bone, which adds to the diaphysis. For many years during childhood growth, the rates of cartilage growth and bone formation are equal and thus the epiphyseal plate does not change in overall thickness as the bone lengthens. During the late teens and early 20s, growth of the cartilage slows and eventually stops. The epiphyseal plate is then completely replaced by bone, and the diaphysis and epiphysis portions of the bone fuse together to form a single adult bone. This fusion of the diaphysis and epiphysis is a synostosis. Once this occurs, bone lengthening ceases. For this reason, the epiphyseal plate is considered to be a temporary synchondrosis. Because cartilage is softer than bone tissue, injury to a growing long bone can damage the epiphyseal plate cartilage, thus stopping bone growth and preventing additional bone lengthening.

Growing layers of cartilage also form synchondroses that join together the ilium, ischium, and pubic portions of the hip bone during childhood and adolescence. When body growth stops, the cartilage disappears and is replaced by bone, forming synostoses and fusing the bony components together into the single hip bone of the adult. Similarly, synostoses unite the sacral vertebrae that fuse together to form the adult sacrum.

INTERACTIVE LINK

Visit this website (http://openstax.org/l/childhand) to view a radiograph (X-ray image) of a child's hand and wrist. The growing bones of child have an epiphyseal plate that forms a synchondrosis between the shaft and end of a long bone. Being less dense than bone, the area of epiphyseal cartilage is seen on this radiograph as the dark epiphyseal gaps located near the ends of the long bones, including the radius, ulna, metacarpal, and phalanx bones. Which of the bones in this image do not show an epiphyseal plate (epiphyseal gap)?

Examples of permanent synchondroses are found in the thoracic cage. One example is the first sternocostal joint, where the first rib is anchored to the manubrium by its costal cartilage. (The articulations of the remaining costal cartilages to the sternum are all synovial joints.) Additional synchondroses are formed where the anterior end of the other 11 ribs is joined to its costal cartilage. Unlike the temporary synchondroses of the epiphyseal plate, these permanent synchondroses retain their hyaline cartilage and thus do not ossify with age. Due to the lack of movement between the bone and cartilage, both temporary and permanent synchondroses are functionally classified as a synarthrosis.

Symphysis

A cartilaginous joint where the bones are joined by fibrocartilage is called a **symphysis** ("growing together"). Fibrocartilage is very strong because it contains numerous bundles of thick collagen fibers, thus giving it a much greater ability to resist pulling and bending forces when compared with hyaline cartilage. This gives symphyses the ability to strongly unite the adjacent bones, but can still allow for limited movement to occur. Thus, a symphysis is functionally classified as an amphiarthrosis.

The gap separating the bones at a symphysis may be narrow or wide. Examples in which the gap between the bones is narrow include the pubic symphysis and the manubriosternal joint. At the pubic symphysis, the pubic portions of the right and left hip bones of the pelvis are joined together by fibrocartilage across a narrow gap. Similarly, at the manubriosternal joint, fibrocartilage unites the manubrium and body portions of the sternum.

The intervertebral symphysis is a wide symphysis located between the bodies of adjacent vertebrae of the vertebral column. Here a thick pad of fibrocartilage called an intervertebral disc strongly unites the adjacent vertebrae by filling the gap between them. The width of the intervertebral symphysis is important because it allows for small movements between the adjacent vertebrae. In addition, the thick intervertebral disc provides cushioning between the vertebrae, which is important when carrying heavy objects or during high-impact activities such as running or jumping.

9.4 Synovial Joints

LEARNING OBJECTIVES

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

- Describe the structural features of a synovial joint
- Discuss the function of additional structures associated with synovial joints
- List the six types of synovial joints and give an example of each

Synovial joints are the most common type of joint in the body (Figure 9.8). A key structural characteristic for a synovial joint that is not seen at fibrous or cartilaginous joints is the presence of a joint cavity. This fluid-filled space is the site at which the articulating surfaces of the bones contact each other. Also unlike fibrous or cartilaginous joints, the articulating bone surfaces at a synovial joint are not directly connected to each other with fibrous connective tissue or cartilage. This gives the bones of a synovial joint the ability to move smoothly against each other, allowing for increased joint mobility.

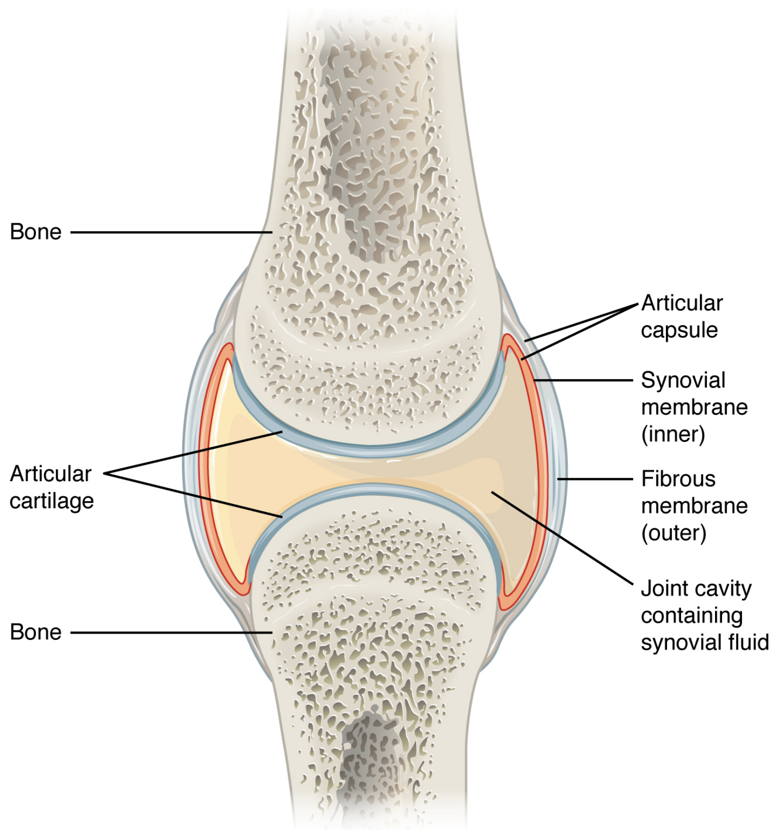


FIGURE 9.8 Synovial Joints Synovial joints allow for smooth movements between the adjacent bones. The joint is surrounded by an articular capsule that defines a joint cavity filled with synovial fluid. The articulating surfaces of the bones are covered by a thin layer of articular cartilage. Ligaments support the joint by holding the bones together and resisting excess or abnormal joint motions.

Structural Features of Synovial Joints

Synovial joints are characterized by the presence of a joint cavity. The walls of this space are formed by the **articular capsule**, a fibrous connective tissue structure that is attached to each bone just outside the area of the bone's articulating surface. The bones of the joint articulate with each other within the joint cavity.

Friction between the bones at a synovial joint is prevented by the presence of the **articular cartilage**, a thin layer of hyaline cartilage that covers the entire articulating surface of each bone. However, unlike at a cartilaginous joint, the articular cartilages of each bone are not continuous with each other. Instead, the articular cartilage acts like a Teflon® coating over the bone surface, allowing the articulating bones to move smoothly against each other without damaging the underlying bone tissue. Lining the inner surface of the articular capsule is a thin **synovial membrane**. The cells of this membrane secrete **synovial fluid** (synovia = "a thick fluid"), a thick, slimy fluid that provides lubrication to further reduce friction between the bones of the joint. This fluid also provides nourishment to the articular cartilage, which does not contain blood vessels. The ability of the bones to move smoothly against each other within the joint cavity, and the freedom of joint movement this provides, means that each synovial joint is functionally classified as a diarthrosis.

Outside of their articulating surfaces, the bones are connected together by ligaments, which are strong bands of fibrous connective tissue. These strengthen and support the joint by anchoring the bones together and preventing their separation. Ligaments allow for normal movements at a joint, but limit the range of these motions, thus preventing excessive or abnormal joint movements. Ligaments are classified based on their relationship to the fibrous articular capsule. An **extrinsic ligament** is located outside of the articular capsule, an **intrinsic ligament** is fused to or incorporated into the wall of the articular capsule, and an **intracapsular ligament** is located inside of the articular capsule.

At many synovial joints, additional support is provided by the muscles and their tendons that act across the joint. A **tendon** is the dense connective tissue structure that attaches a muscle to bone. As forces acting on a joint increase, the body will automatically increase the overall strength of contraction of the muscles crossing that joint, thus allowing the muscle and its tendon to serve as a "dynamic ligament" to resist forces and support the joint. This type of indirect support by muscles is very important at the shoulder joint, for example, where the ligaments are relatively weak.

Additional Structures Associated with Synovial Joints

A few synovial joints of the body have a fibrocartilage structure located between the articulating bones. This is called an **articular disc**, which is generally small and oval-shaped, or a **meniscus**, which is larger and C-shaped. These structures can serve several functions, depending on the specific joint. In some places, an articular disc may act to strongly unite the bones of the joint to each other. Examples of this include the articular discs found at the sternoclavicular joint or between the distal ends of the radius and ulna bones. At other synovial joints, the disc can provide shock absorption and cushioning between the bones, which is the function of each meniscus within the knee joint. Finally, an articular disc can serve to smooth the movements between the articulating bones, as seen at the temporomandibular joint. Some synovial joints also have a fat pad, which can serve as a cushion between the bones.

Additional structures located outside of a synovial joint serve to prevent friction between the bones of the joint and the overlying muscle tendons or skin. A **bursa** (plural = bursae) is a thin connective tissue sac filled with lubricating liquid. They are located in regions where skin, ligaments, muscles, or muscle tendons can rub against each other, usually near a body joint (Figure 9.9). Bursae reduce friction by separating the adjacent structures, preventing them from rubbing directly against each other. Bursae are classified by their location. A **subcutaneous bursa** is located between the skin and an underlying bone. It allows skin to move smoothly over the bone. Examples include the prepatellar bursa located over the kneecap and the olecranon bursa at the tip of the elbow. A **submuscular bursa** is found between a muscle and an underlying bone, or between adjacent muscles. These prevent rubbing of the muscle during movements. A large submuscular bursa, the trochanteric bursa, is found at the lateral hip, between the greater trochanter of the femur and the overlying gluteus maximus muscle. A **subtendinous bursa** is found between a tendon and a bone. Examples include the subacromial bursa that protects the tendon of shoulder muscle as it passes under the acromion of the scapula, and the suprapatellar bursa that separates the tendon of the large anterior thigh muscle from the distal femur just above the knee.

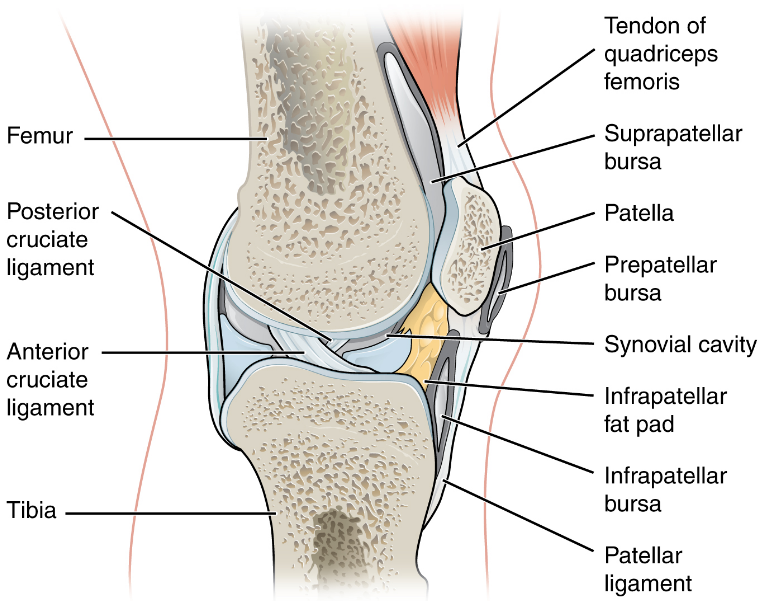


FIGURE 9.9 **Bursae** Bursae are fluid-filled sacs that serve to prevent friction between skin, muscle, or tendon and an underlying bone. Three major bursae and a fat pad are part of the complex joint that unites the femur and tibia of the leg.

A **tendon sheath** is similar in structure to a bursa, but smaller. It is a connective tissue sac that surrounds a muscle tendon at places where the tendon crosses a joint. It contains a lubricating fluid that allows for smooth motions of the tendon during muscle contraction and joint movements.

HOMEOSTATIC IMBALANCES

Bursitis

Bursitis is the inflammation of a bursa near a joint. This will cause pain, swelling, or tenderness of the bursa and surrounding area, and may also result in joint stiffness. Bursitis is most commonly associated with the bursae found at or near the shoulder, hip, knee, or elbow joints. At the shoulder, subacromial bursitis may occur in the bursa that separates the acromion of the scapula from the tendon of a shoulder muscle as it passes deep to the acromion. In the hip region, trochanteric bursitis can occur in the bursa that overlies the greater trochanter of the femur, just below the lateral side of the hip. Ischial bursitis occurs in the bursa that separates the skin from the ischial tuberosity of the pelvis, the bony structure that is weight bearing when sitting. At the knee, inflammation and swelling of the bursa located between the skin and patella bone is prepatellar bursitis ("housemaid's knee"), a condition more commonly seen today in roofers or floor and carpet installers who do not use knee pads. At the elbow, olecranon bursitis is inflammation of the bursa between the skin and olecranon process of the ulna. The olecranon forms the bony tip of the elbow, and bursitis here is also known as "student's elbow."

Bursitis can be either acute (lasting only a few days) or chronic. It can arise from muscle overuse, trauma, excessive or prolonged pressure on the skin, rheumatoid arthritis, gout, or infection of the joint. Repeated acute episodes of bursitis can result in a chronic condition. Treatments for the disorder include antibiotics if the bursitis is caused by an infection, or anti-inflammatory agents, such as nonsteroidal anti-inflammatory drugs (NSAIDs) or corticosteroids if the bursitis is due to trauma or overuse. Chronic bursitis may require that fluid be drained, but additional surgery is usually not required.

Types of Synovial Joints

Synovial joints are subdivided based on the shapes of the articulating surfaces of the bones that form each joint. The six types of synovial joints are pivot, hinge, condyloid, saddle, plane, and ball-and socket-joints (Figure 9.10).

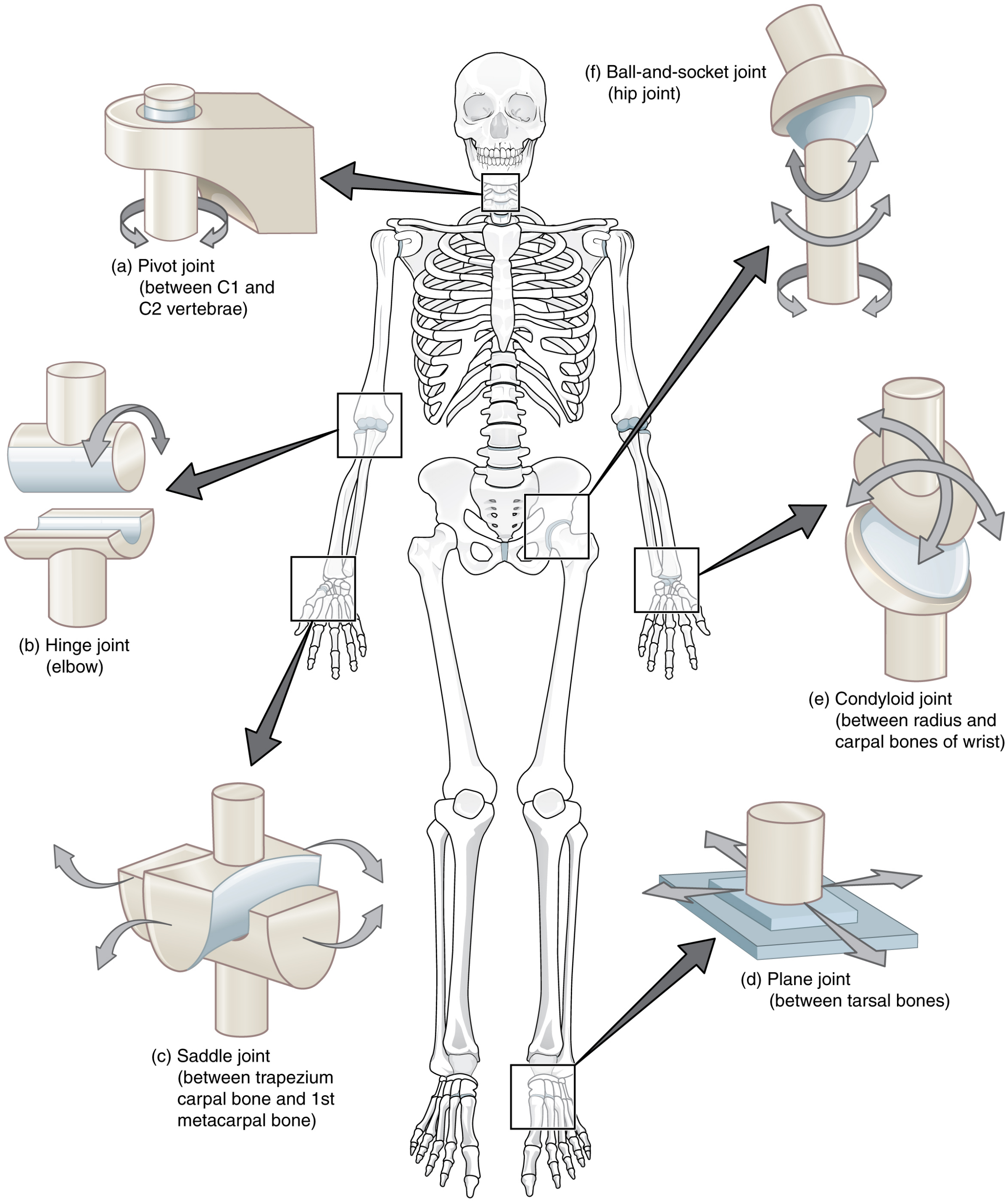


FIGURE 9.10 **Types of Synovial Joints** The six types of synovial joints allow the body to move in a variety of ways. (a) Pivot joints allow for rotation around an axis, such as between the first and second cervical vertebrae, which allows for side-to-side rotation of the head. (b) The hinge joint of the elbow works like a door hinge. (c) The articulation between the trapezium carpal bone and the first metacarpal bone at the base of the thumb is a saddle joint. (d) Plane joints, such as those between the tarsal bones of the foot, allow for limited gliding movements between bones. (e) The radiocarpal joint of the wrist is a condyloid joint. (f) The hip and shoulder joints are the only ball-and-socket joints of the body.

Pivot Joint

At a **pivot joint**, a rounded portion of a bone is enclosed within a ring formed partially by the articulation with another bone and partially by a ligament (see Figure 9.10**a**). The bone rotates within this ring. Since the rotation is around a single axis, pivot joints are functionally classified as a uniaxial diarthrosis type of joint. An example of a pivot joint is the atlantoaxial joint, found between the C1 (atlas) and C2 (axis) vertebrae. Here, the upward projecting dens of the axis articulates with the inner aspect of the atlas, where it is held in place by a ligament. Rotation at this joint allows you to turn your head from side to side. A second pivot joint is found at the **proximal radioulnar joint**. Here, the head of the radius is largely encircled by a ligament that holds it in place as it articulates with the radial notch of the ulna. Rotation of the radius allows for forearm movements.

Hinge Joint

In a **hinge joint**, the convex end of one bone articulates with the concave end of the adjoining bone (see Figure 9.10**b**). This type of joint allows only for bending and straightening motions along a single axis, and thus hinge joints are functionally classified as uniaxial joints. A good example is the elbow joint, with the articulation between the trochlea of the humerus and the trochlear notch of the ulna. Other hinge joints of the body include the knee, ankle, and interphalangeal joints between the phalanx bones of the fingers and toes.

Condyloid Joint

At a **condyloid joint** (ellipsoid joint), the shallow depression at the end of one bone articulates with a rounded structure from an adjacent bone or bones (see Figure 9.10**e**). The knuckle (metacarpophalangeal) joints of the hand between the distal end of a metacarpal bone and the proximal phalanx bone are condyloid joints. Another example is the radiocarpal joint of the wrist, between the shallow depression at the distal end of the radius bone and the rounded scaphoid, lunate, and triquetrum carpal bones. In this case, the articulation area has a more oval (elliptical) shape. Functionally, condyloid joints are biaxial joints that allow for two planes of movement. One movement involves the bending and straightening of the fingers or the anterior-posterior movements of the hand. The second movement is a side-to-side movement, which allows you to spread your fingers apart and bring them together, or to move your hand in a medial-going or lateral-going direction.

Saddle Joint

At a **saddle joint**, both of the articulating surfaces for the bones have a saddle shape, which is concave in one direction and convex in the other (see Figure 9.10**c**). This allows the two bones to fit together like a rider sitting on a saddle. Saddle joints are functionally classified as biaxial joints. The primary example is the first carpometacarpal joint, between the trapezium (a carpal bone) and the first metacarpal bone at the base of the thumb. This joint provides the thumb the ability to move away from the palm of the hand along two planes. Thus, the thumb can move within the same plane as the palm of the hand, or it can jut out anteriorly, perpendicular to the palm. This movement of the first carpometacarpal joint is what gives humans their distinctive “opposable” thumbs. The sternoclavicular joint is also classified as a saddle joint.

Plane Joint

At a **plane joint** (gliding joint), the articulating surfaces of the bones are flat or slightly curved and of approximately the same size, which allows the bones to slide against each other (see Figure 9.10**d**). The motion at this type of joint is usually small and tightly constrained by surrounding ligaments. Based only on their shape, plane joints can allow multiple movements, including rotation. Thus plane joints can be functionally classified as a multiaxial joint. However, not all of these movements are available to every plane joint due to limitations placed on it by ligaments or neighboring bones. Thus, depending upon the specific joint of the body, a plane joint may exhibit only a single type of movement or several movements. Plane joints are found between the carpal bones (intercarpal joints) of the wrist or tarsal bones (intertarsal joints) of the foot, between the clavicle and acromion of the scapula (acromioclavicular joint), and between the superior and inferior articular processes of adjacent vertebrae (zygapophysial joints).

Ball-and-Socket Joint

The joint with the greatest range of motion is the **ball-and-socket joint**. At these joints, the rounded head of one bone (the ball) fits into the concave articulation (the socket) of the adjacent bone (see Figure 9.10**f**). The hip joint and the glenohumeral (shoulder) joint are the only ball-and-socket joints of the body. At the hip joint, the head of the femur articulates with the acetabulum of the hip bone, and at the shoulder joint, the head of the humerus articulates with the glenoid cavity of the scapula.

Ball-and-socket joints are classified functionally as multiaxial joints. The femur and the humerus are able to move in both anterior-posterior and medial-lateral directions and they can also rotate around their long axis. The shallow socket formed by the glenoid cavity allows the shoulder joint an extensive range of motion. In contrast, the deep socket of the acetabulum and the strong supporting ligaments of the hip joint serve to constrain movements of the femur, reflecting the need for stability and weight-bearing ability at the hip.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/synjoints) to see an animation of synovial joints in action. Synovial joints are places where bones articulate with each other inside of a joint cavity. The different types of synovial joints are the ball-and-socket joint (shoulder joint), hinge joint (knee), pivot joint (atlantoaxial joint, between C1 and C2 vertebrae of the neck), condyloid joint (radiocarpal joint of the wrist), saddle joint (first carpometacarpal joint, between the trapezium carpal bone and the first metacarpal bone, at the base of the thumb), and plane joint (facet joints of vertebral column, between superior and inferior articular processes). Which type of synovial joint allows for the widest range of motion?

Aging and the...

Joints

Arthritis is a common disorder of synovial joints that involves inflammation of the joint. This often results in significant joint pain, along with swelling, stiffness, and reduced joint mobility. There are more than 100 different forms of arthritis. Arthritis may arise from aging, damage to the articular cartilage, autoimmune diseases, bacterial or viral infections, or unknown (probably genetic) causes.

The most common type of arthritis is osteoarthritis, which is associated with aging and “wear and tear” of the articular cartilage (Figure 9.11). Risk factors that may lead to osteoarthritis later in life include injury to a joint; jobs that involve physical labor; sports with running, twisting, or throwing actions; and being overweight. These factors put stress on the articular cartilage that covers the surfaces of bones at synovial joints, causing the cartilage to gradually become thinner. As the articular cartilage layer wears down, more pressure is placed on the bones. The joint responds by increasing production of the lubricating synovial fluid, but this can lead to swelling of the joint cavity, causing pain and joint stiffness as the articular capsule is stretched. The bone tissue underlying the damaged articular cartilage also responds by thickening, producing irregularities and causing the articulating surface of the bone to become rough or bumpy. Joint movement then results in pain and inflammation. In its early stages, symptoms of osteoarthritis may be reduced by mild activity that “warms up” the joint, but the symptoms may worsen following exercise. In individuals with more advanced osteoarthritis, the affected joints can become more painful and therefore are difficult to use effectively, resulting in increased immobility. There is no cure for osteoarthritis, but several treatments can help alleviate the pain. Treatments may include lifestyle changes, such as weight loss and low-impact exercise, and over-the-counter or prescription medications that help to alleviate the pain and inflammation. For severe cases, joint replacement surgery (arthroplasty) may be required.

Joint replacement is a very invasive procedure, so other treatments are always tried before surgery. However arthroplasty can provide relief from chronic pain and can enhance mobility within a few months following the surgery. This type of surgery involves replacing the articular surfaces of the bones with prosthesis (artificial components). For example, in hip arthroplasty, the worn or damaged parts of the hip joint, including the head and neck of the femur and the acetabulum of the pelvis, are removed and replaced with artificial joint components. The replacement head for the femur consists of a rounded ball attached to the end of a shaft that is inserted inside the diaphysis of the femur. The acetabulum of the pelvis is reshaped and a replacement socket is fitted into its place. The parts, which are always built in advance of the surgery, are sometimes custom made to produce the best possible fit for a patient.

Gout is a form of arthritis that results from the deposition of uric acid crystals within a body joint. Usually only one or a few joints are affected, such as the big toe, knee, or ankle. The attack may only last a few days, but may return to the same or another joint. Gout occurs when the body makes too much uric acid or the kidneys do not properly excrete it. A diet with excessive fructose has been implicated in raising the chances of a susceptible individual developing gout.

Other forms of arthritis are associated with various autoimmune diseases, bacterial infections of the joint, or unknown genetic causes. Autoimmune diseases, including rheumatoid arthritis, scleroderma, or systemic lupus erythematosus, produce arthritis because the immune system of the body attacks the body joints. In rheumatoid arthritis, the joint capsule and synovial membrane become inflamed. As the disease progresses, the articular cartilage is severely damaged or destroyed, resulting in joint deformation, loss of movement, and severe disability. The most commonly involved joints are the hands, feet, and cervical spine, with corresponding joints on both sides of the body usually affected, though not always to the same extent. Rheumatoid arthritis is also associated with lung fibrosis, vasculitis (inflammation of blood vessels), coronary heart disease, and premature mortality. With no known cure, treatments are aimed at alleviating symptoms. Exercise, anti-inflammatory and pain medications, various specific disease-modifying anti-rheumatic drugs, or surgery are used to treat rheumatoid arthritis.

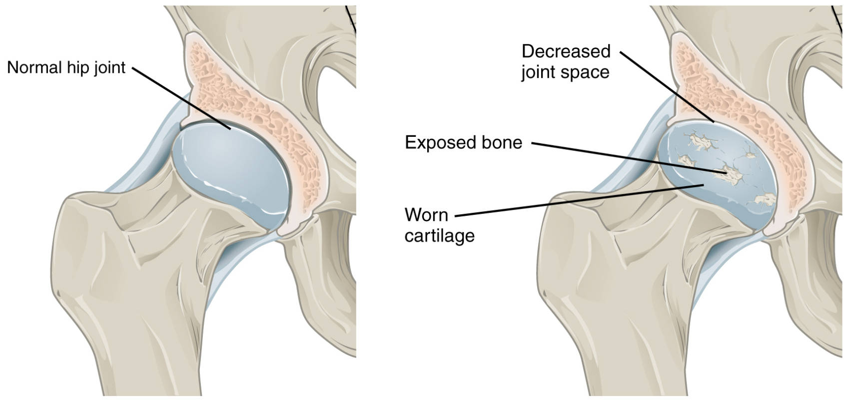


FIGURE 9.11 **Osteoarthritis** Osteoarthritis of a synovial joint results from aging or prolonged joint wear and tear. These cause erosion and loss of the articular cartilage covering the surfaces of the bones, resulting in inflammation that causes joint stiffness and pain.

INTERACTIVE LINK

Visit this website (http://openstax.org/l/gout) to learn about a patient who arrives at the hospital with joint pain and weakness in his legs. What caused this patient's weakness?

INTERACTIVE LINK

Watch this animation (http://openstax.org/l/hipreplace) to observe hip replacement surgery (total hip arthroplasty), which can be used to alleviate the pain and loss of joint mobility associated with osteoarthritis of the hip joint. What is the most common cause of hip disability?

INTERACTIVE LINK

Watch this video (http://openstax.org/l/rheuarthritis) to learn about the symptoms and treatments for rheumatoid arthritis. Which system of the body malfunctions in rheumatoid arthritis and what does this cause?

9.5 Types of Body Movements

LEARNING OBJECTIVES

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

- Define the different types of body movements
- Identify the joints that allow for these motions

Synovial joints allow the body a tremendous range of movements. Each movement at a synovial joint results from the contraction or relaxation of the muscles that are attached to the bones on either side of the articulation. The type of movement that can be produced at a synovial joint is determined by its structural type. While the ball-and-socket joint gives the greatest range of movement at an individual joint, in other regions of the body, several joints may work together to produce a particular movement. Overall, each type of synovial joint is necessary to provide the body with its great flexibility and mobility. There are many types of movement that can occur at synovial joints (Table 9.1). Movement types are generally paired, with one being the opposite of the other. Body movements are always described in relation to the anatomical position of the body: upright stance, with upper limbs to the side of body and palms facing forward. Refer to Figure 9.12 as you go through this section.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/anatomical) to learn about anatomical motions. What motions involve increasing or decreasing the angle of the foot at the ankle?

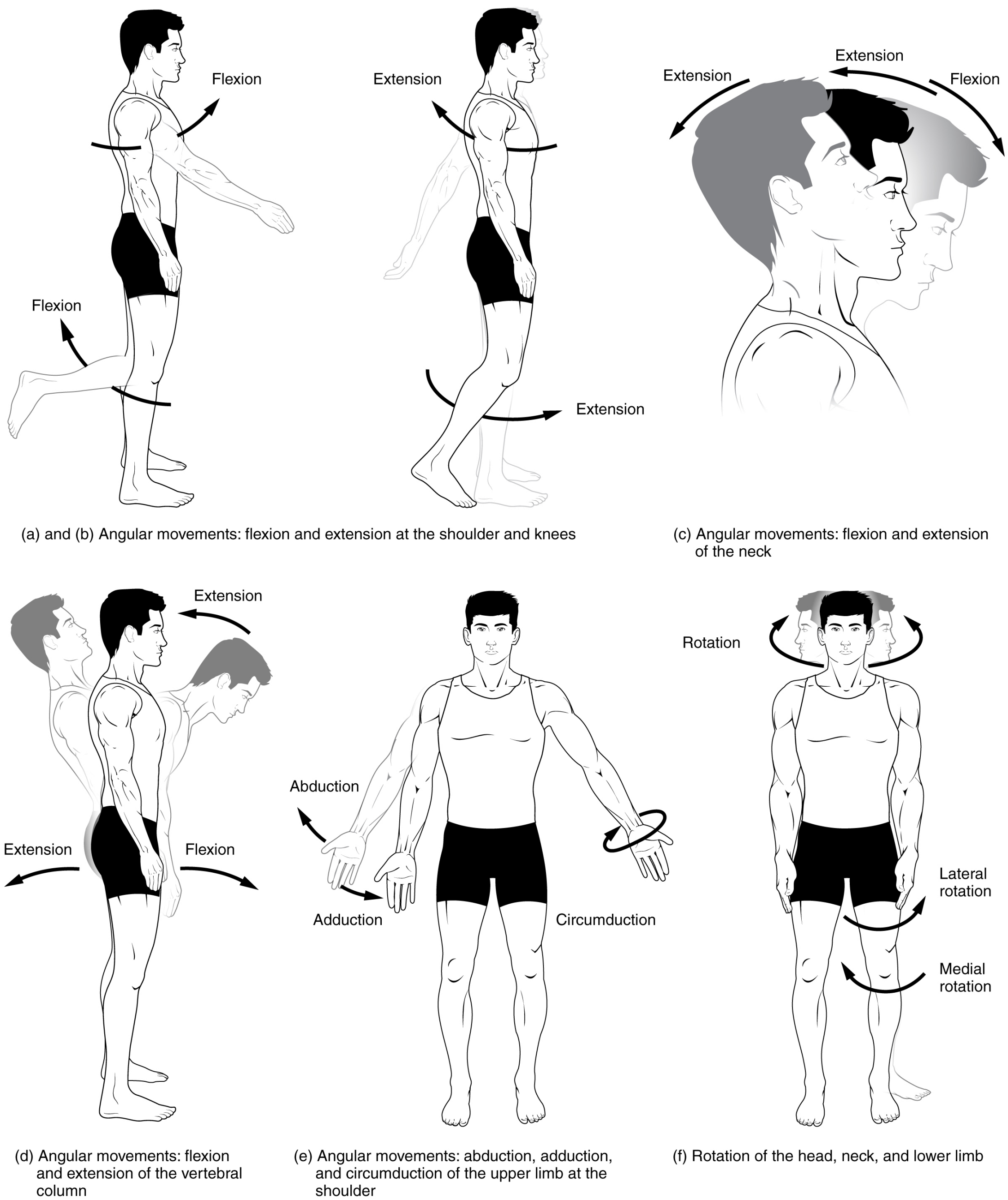


FIGURE 9.12 **Movements of the Body, Part 1** Synovial joints give the body many ways in which to move. (a)–(b) Flexion and extension motions are in the sagittal (anterior–posterior) plane of motion. These movements take place at the shoulder, hip, elbow, knee, wrist, metacarpophalangeal, metatarsophalangeal, and interphalangeal joints. (c)–(d) Anterior bending of the head or vertebral column is flexion, while any posterior-going movement is extension. (e) Abduction and adduction are motions of the limbs, hand, fingers, or toes in the coronal (medial–lateral) plane of movement. Moving the limb or hand laterally away from the body, or spreading the fingers or toes, is abduction. Adduction brings the limb or hand toward or across the midline of the body, or brings the fingers or toes together. Circumduction is the movement of the limb, hand, or fingers in a circular pattern, using the sequential combination of flexion, adduction, extension, and abduction motions. Adduction/abduction and circumduction take place at the shoulder, hip, wrist, metacarpophalangeal, and metatarsophalangeal joints. (f) Turning of the head side to side or twisting of the body is rotation. Medial and lateral rotation of the upper limb at the shoulder or lower limb at the hip involves turning the anterior surface of the limb toward the midline of the body (medial or

internal rotation) or away from the midline (lateral or external rotation).

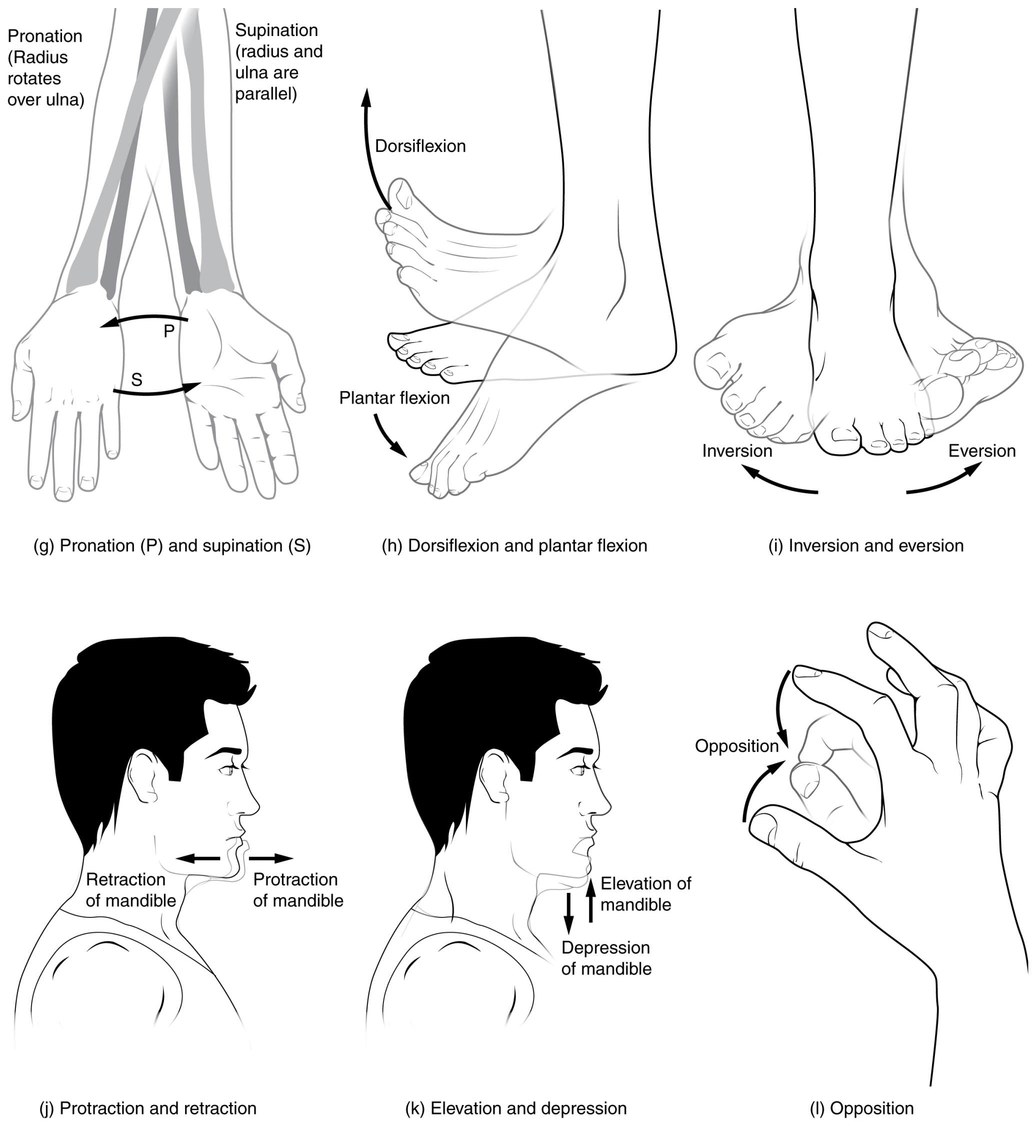


FIGURE 9.13 **Movements of the Body, Part 2** (g) Supination of the forearm turns the hand to the palm forward position in which the radius and ulna are parallel, while forearm pronation turns the hand to the palm backward position in which the radius crosses over the ulna to form an "X." (h) Dorsiflexion of the foot at the ankle joint moves the top of the foot toward the leg, while plantar flexion lifts the heel and points the toes. (i) Eversion of the foot moves the bottom (sole) of the foot away from the midline of the body, while foot inversion faces the sole toward the midline. (j) Protraction of the mandible pushes the chin forward, and retraction pulls the chin back. (k) Depression of the mandible opens the mouth, while elevation closes it. (l) Opposition of the thumb brings the tip of the thumb into contact with the tip of the fingers of the same hand and reposition brings the thumb back next to the index finger.

Flexion and Extension

Flexion and **extension** are typically movements that take place within the sagittal plane and involve anterior or posterior movements of the neck, trunk, or limbs. For the vertebral column, flexion (anterior flexion) is an anterior (forward) bending of the neck or trunk, while extension involves a posterior-directed motion, such as straightening from a flexed position or bending backward. **Lateral flexion** of the vertebral column occurs in the coronal plane and is defined as the bending of the neck or trunk toward the right or left side. These movements of the vertebral column involve both the symphysis joint formed by each intervertebral disc, as well as the plane type of synovial joint formed between the inferior articular processes of one vertebra and the superior articular processes of the next lower vertebra.

In the limbs, flexion decreases the angle between the bones (bending of the joint), while extension increases the angle and straightens the joint. For the upper limb, all anterior-going motions are flexion and all posterior-going motions are extension. These include anterior-posterior movements of the arm at the shoulder, the forearm at the elbow, the hand at the wrist, and the fingers at the metacarpophalangeal and interphalangeal joints. For the thumb, extension moves the thumb away from the palm of the hand, within the same plane as the palm, while flexion brings the thumb back against the index finger or into the palm. These motions take place at the first carpometacarpal joint. In the lower limb, bringing the thigh forward and upward is flexion at the hip joint, while any posterior-going motion of the thigh is extension. Note that extension of the thigh beyond the anatomical (standing) position is greatly limited by the ligaments that support the hip joint. Knee flexion is the bending of the knee to bring the foot toward the posterior thigh, and extension is the straightening of the knee. Flexion and extension movements are seen at the hinge, condyloid, saddle, and ball-and-socket joints of the limbs (see Figure 9.12**a-d**).

Hyperextension is the abnormal or excessive extension of a joint beyond its normal range of motion, thus resulting in injury. Similarly, **hyperflexion** is excessive flexion at a joint. Hyperextension injuries are common at hinge joints such as the knee or elbow. In cases of "whiplash" in which the head is suddenly moved backward and then forward, a patient may experience both hyperextension and hyperflexion of the cervical region.

Abduction and Adduction

Abduction and **adduction** motions occur within the coronal plane and involve medial-lateral motions of the limbs, fingers, toes, or thumb. Abduction moves the limb laterally away from the midline of the body, while adduction is the opposing movement that brings the limb toward the body or across the midline. For example, abduction is raising the arm at the shoulder joint, moving it laterally away from the body, while adduction brings the arm down to the side of the body. Similarly, abduction and adduction at the wrist moves the hand away from or toward the midline of the body. Spreading the fingers or toes apart is also abduction, while bringing the fingers or toes together is adduction. For the thumb, abduction is the anterior movement that brings the thumb to a 90° perpendicular position, pointing straight out from the palm. Adduction moves the thumb back to the anatomical position, next to the index finger. Abduction and adduction movements are seen at condyloid, saddle, and ball-and-socket joints (see Figure 9.12**e**).

Circumduction

Circumduction is the movement of a body region in a circular manner, in which one end of the body region being moved stays relatively stationary while the other end describes a circle. It involves the sequential combination of flexion, adduction, extension, and abduction at a joint. This type of motion is found at biaxial condyloid and saddle joints, and at multiaxial ball-and-sockets joints (see Figure 9.12**e**).

Rotation

Rotation can occur within the vertebral column, at a pivot joint, or at a ball-and-socket joint. Rotation of the neck or body is the twisting movement produced by the summation of the small rotational movements available between adjacent vertebrae. At a pivot joint, one bone rotates in relation to another bone. This is a uniaxial joint, and thus rotation is the only motion allowed at a pivot joint. For example, at the atlantoaxial joint, the first cervical (C1) vertebra (atlas) rotates around the dens, the upward projection from the second cervical (C2) vertebra (axis). This allows the head to rotate from side to side as when shaking the head "no." The proximal radioulnar joint is a pivot joint formed by the head of the radius and its articulation with the ulna. This joint allows for the radius to rotate along its length during pronation and supination movements of the forearm.

Rotation can also occur at the ball-and-socket joints of the shoulder and hip. Here, the humerus and femur rotate around their long axis, which moves the anterior surface of the arm or thigh either toward or away from the midline of the body. Movement that brings the anterior surface of the limb toward the midline of the body is called **medial (internal) rotation**. Conversely, rotation of the limb so that the anterior surface moves away from the midline is **lateral (external) rotation** (see Figure 9.12**f**). Be sure to distinguish medial and lateral rotation, which can only occur at the multiaxial shoulder and hip joints, from circumduction, which can occur at either biaxial or multiaxial joints.

Supination and Pronation

Supination and pronation are movements of the forearm. In the anatomical position, the upper limb is held next to the body with the palm facing forward. This is the **supinated position** of the forearm. In this position, the radius and ulna are parallel to each other. When the palm of the hand faces backward, the forearm is in the **pronated position**, and the radius and ulna form an X-shape.

Supination and pronation are the movements of the forearm that go between these two positions. **Pronation** is the motion that moves the forearm from the supinated (anatomical) position to the pronated (palm backward) position. This motion is produced by rotation of the radius at the proximal radioulnar joint, accompanied by movement of the radius at the distal radioulnar joint. The proximal radioulnar joint is a pivot joint that allows for rotation of the head of the radius. Because of the slight curvature of the shaft of the radius, this rotation causes the distal end of the radius to cross over the distal ulna at the distal radioulnar joint. This crossing over brings the radius and ulna into an X-shape position. **Supination** is the opposite motion, in which rotation of the radius returns the bones to their parallel positions and moves the palm to the anterior facing (supinated) position. It helps to remember that supination is the motion you use when scooping up soup with a spoon (see Figure 9.13**g**).

Dorsiflexion and Plantar Flexion

Dorsiflexion and **plantar flexion** are movements at the ankle joint, which is a hinge joint. Lifting the front of the foot, so that the top of the foot moves toward the anterior leg is dorsiflexion, while lifting the heel of the foot from the ground or pointing the toes downward is plantar flexion. These are the only movements available at the ankle joint (see Figure 9.13**h**).

Inversion and Eversion

Inversion and eversion are complex movements that involve the multiple plane joints among the tarsal bones of the posterior foot (intertarsal joints) and thus are not motions that take place at the ankle joint. **Inversion** is the turning of the foot to angle the bottom of the foot toward the midline, while **eversion** turns the bottom of the foot away from the midline. The foot has a greater range of inversion than eversion motion. These are important motions that help to stabilize the foot when walking or running on an uneven surface and aid in the quick side-to-side changes in direction used during active sports such as basketball, racquetball, or soccer (see Figure 9.13**i**).

Protraction and Retraction

Protraction and **retraction** are anterior-posterior movements of the scapula or mandible. Protraction of the scapula occurs when the shoulder is moved forward, as when pushing against something or throwing a ball. Retraction is the opposite motion, with the scapula being pulled posteriorly and medially, toward the vertebral column. For the mandible, protraction occurs when the lower jaw is pushed forward, to stick out the chin, while retraction pulls the lower jaw backward. (See Figure 9.13**j**.)

Depression and Elevation

Depression and **elevation** are downward and upward movements of the scapula or mandible. The upward movement of the scapula and shoulder is elevation, while a downward movement is depression. These movements are used to shrug your shoulders. Similarly, elevation of the mandible is the upward movement of the lower jaw used to close the mouth or bite on something, and depression is the downward movement that produces opening of the mouth (see Figure 9.13**k**).

Excursion

Excursion is the side to side movement of the mandible. **Lateral excursion** moves the mandible away from the midline, toward either the right or left side. **Medial excursion** returns the mandible to its resting position at the midline.

Superior Rotation and Inferior Rotation

Superior and inferior rotation are movements of the scapula and are defined by the direction of movement of the glenoid cavity. These motions involve rotation of the scapula around a point inferior to the scapular spine and are produced by combinations of muscles acting on the scapula. During **superior rotation**, the glenoid cavity moves upward as the medial end of the scapular spine moves downward. This is a very important motion that contributes to upper limb abduction. Without superior rotation of the scapula, the greater tubercle of the humerus would hit the acromion of the scapula, thus preventing any abduction of the arm above shoulder height. Superior rotation of the scapula is thus required for full abduction of the upper limb. Superior rotation is also used without arm abduction when carrying a heavy load with your hand or on your shoulder. You can feel this rotation when you pick up a load, such as a heavy book bag and carry it on only one shoulder. To increase its weight-bearing support for the bag, the shoulder lifts as the scapula superiorly rotates. **Inferior rotation** occurs during limb adduction and involves the downward motion of the glenoid cavity with upward movement of the medial end of the scapular spine.

Opposition and Reposition

Opposition is the thumb movement that brings the tip of the thumb in contact with the tip of a finger. This movement is produced at the first carpometacarpal joint, which is a saddle joint formed between the trapezium carpal bone and the first metacarpal bone. Thumb opposition is produced by a combination of flexion and abduction of the thumb at this joint. Returning the thumb to its anatomical position next to the index finger is called **reposition** (see Figure 9.13**l**).

Movements of the Joints

Type of Joint	Movement	Example
Pivot	Uniaxial joint; allows rotational movement	Atlantoaxial joint (C1–C2 vertebrae articulation); proximal radioulnar joint
Hinge	Uniaxial joint; allows flexion/extension movements	Knee; elbow; ankle; interphalangeal joints of fingers and toes
Condyloid	Biaxial joint; allows flexion/extension, abduction/adduction, and circumduction movements	Metacarpophalangeal (knuckle) joints of fingers; radiocarpal joint of wrist; metatarsophalangeal joints for toes
Saddle	Biaxial joint; allows flexion/extension, abduction/adduction, and circumduction movements	First carpometacarpal joint of the thumb; sternoclavicular joint
Plane	Multiaxial joint; allows inversion and eversion of foot, or flexion, extension, and lateral flexion of the vertebral column	Intertarsal joints of foot; superior-inferior articular process articulations between vertebrae
Ball-and-socket	Multiaxial joint; allows flexion/extension, abduction/adduction, circumduction, and medial/lateral rotation movements	Shoulder and hip joints

TABLE 9.1

9.6 Anatomy of Selected Synovial Joints

LEARNING OBJECTIVES

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

- Describe the bones that articulate together to form selected synovial joints
- Discuss the movements available at each joint
- Describe the structures that support and prevent excess movements at each joint

Each synovial joint of the body is specialized to perform certain movements. The movements that are allowed are determined by the structural classification for each joint. For example, a multiaxial ball-and-socket joint has much more mobility than a uniaxial hinge joint. However, the ligaments and muscles that support a joint may place restrictions on the total range of motion available. Thus, the ball-and-socket joint of the shoulder has little in the way of ligament support, which gives the shoulder a very large range of motion. In contrast, movements at the hip joint are restricted by strong ligaments, which reduce its range of motion but confer stability during standing and weight bearing.

This section will examine the anatomy of selected synovial joints of the body. Anatomical names for most joints are derived from the names of the bones that articulate at that joint, although some joints, such as the elbow, hip, and knee joints are exceptions to this general naming scheme.

Articulations of the Vertebral Column

In addition to being held together by the intervertebral discs, adjacent vertebrae also articulate with each other at synovial joints formed between the superior and inferior articular processes called **zygapophysial joints** (facet joints) (see Figure 9.3). These are plane joints that provide for only limited motions between the vertebrae. The orientation of the articular processes at these joints varies in different regions of the vertebral column and serves to determine the types of motions available in each vertebral region. The cervical and lumbar regions have the greatest ranges of motions.

In the neck, the articular processes of cervical vertebrae are flattened and generally face upward or downward. This orientation provides the cervical vertebral column with extensive ranges of motion for flexion, extension, lateral flexion, and rotation. In the thoracic region, the downward projecting and overlapping spinous processes, along with the attached thoracic cage, greatly limit flexion, extension, and lateral flexion. However, the flattened and vertically positioned thoracic articular processes allow for the greatest range of rotation within the vertebral column. The lumbar region allows for considerable extension, flexion, and lateral flexion, but the orientation of the articular processes largely prohibits rotation.

The articulations formed between the skull, the atlas (C1 vertebra), and the axis (C2 vertebra) differ from the articulations in other vertebral areas and play important roles in movement of the head. The **atlanto-occipital joint** is formed by the articulations between the superior articular processes of the atlas and the occipital condyles on the base of the skull. This articulation has a pronounced U-shaped curvature, oriented along the anterior-posterior axis. This allows the skull to rock forward and backward, producing flexion and extension of the head. This moves the head up and down, as when shaking your head "yes."

The **atlantoaxial joint**, between the atlas and axis, consists of three articulations. The paired superior articular processes of the axis articulate with the inferior articular processes of the atlas. These articulating surfaces are relatively flat and oriented horizontally. The third articulation is the pivot joint formed between the dens, which projects upward from the body of the axis, and the inner aspect of the anterior arch of the atlas (Figure 9.14). A strong ligament passes posterior to the dens to hold it in position against the anterior arch. These articulations allow the atlas to rotate on top of the axis, moving the head toward the right or left, as when shaking your head "no."

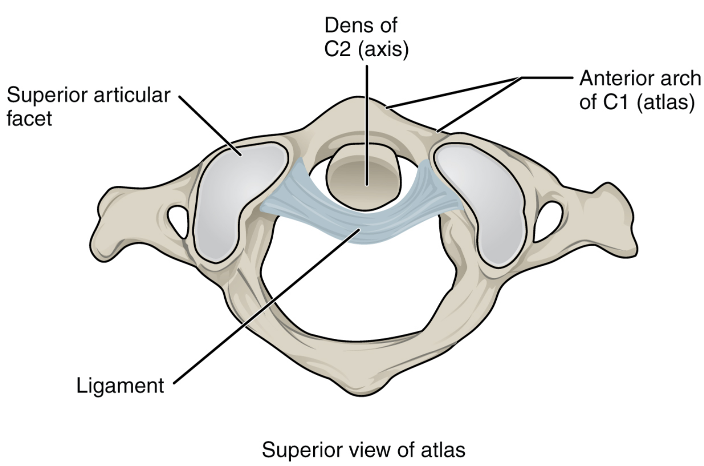


FIGURE 9.14 **Atlantoaxial Joint** The atlantoaxial joint is a pivot type of joint between the dens portion of the axis (C2 vertebra) and the anterior arch of the atlas (C1 vertebra), with the dens held in place by a ligament.

Temporomandibular Joint

The **temporomandibular joint (TMJ)** is the joint that allows for opening (mandibular depression) and closing (mandibular elevation) of the mouth, as well as side-to-side and protraction/retraction motions of the lower jaw.

This joint involves the articulation between the mandibular fossa and articular tubercle of the temporal bone, with the condyle (head) of the mandible. Located between these bony structures, filling the gap between the skull and mandible, is a flexible articular disc (Figure 9.15). This disc serves to smooth the movements between the temporal bone and mandibular condyle.

Movement at the TMJ during opening and closing of the mouth involves both gliding and hinge motions of the mandible. With the mouth closed, the mandibular condyle and articular disc are located within the mandibular fossa of the temporal bone. During opening of the mouth, the mandible hinges downward and at the same time is pulled anteriorly, causing both the condyle and the articular disc to glide forward from the mandibular fossa onto the downward projecting articular tubercle. The net result is a forward and downward motion of the condyle and mandibular depression. The temporomandibular joint is supported by an extrinsic ligament that anchors the mandible to the skull. This ligament spans the distance between the base of the skull and the lingula on the medial side of the mandibular ramus.

Dislocation of the TMJ may occur when opening the mouth too wide (such as when taking a large bite) or following a blow to the jaw, resulting in the mandibular condyle moving beyond (anterior to) the articular tubercle. In this case, the individual would not be able to close their mouth. Temporomandibular joint disorder is a painful condition that may arise due to arthritis, wearing of the articular cartilage covering the bony surfaces of the joint, muscle fatigue from overuse or grinding of the teeth, damage to the articular disc within the joint, or jaw injury. Temporomandibular joint disorders can also cause headache, difficulty chewing, or even the inability to move the jaw (lock jaw). Pharmacologic agents for pain or other therapies, including bite guards, are used as treatments.

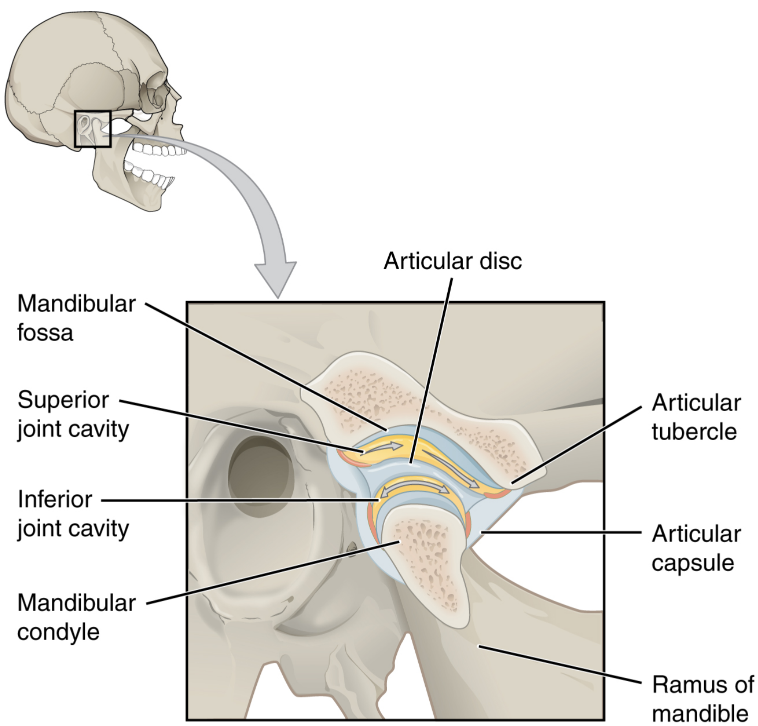


FIGURE 9.15 **Temporomandibular Joint** The temporomandibular joint is the articulation between the temporal bone of the skull and the condyle of the mandible, with an articular disc located between these bones. During depression of the mandible (opening of the mouth), the mandibular condyle moves both forward and hinges downward as it travels from the mandibular fossa onto the articular tubercle.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/TMJ) to learn about TMJ. Opening of the mouth requires the combination of two motions at the temporomandibular joint, an anterior gliding motion of the articular disc and mandible and the downward hinging of the mandible. What is the initial movement of the mandible during opening and how much mouth opening does this produce?

Shoulder Joint

The shoulder joint is called the **glenohumeral joint**. This is a ball-and-socket joint formed by the articulation between the head of the humerus and the glenoid cavity of the scapula (Figure 9.16). This joint has the largest range of motion of any joint in the body. However, this freedom of movement is due to the lack of structural support and thus the enhanced mobility is offset by a loss of stability.

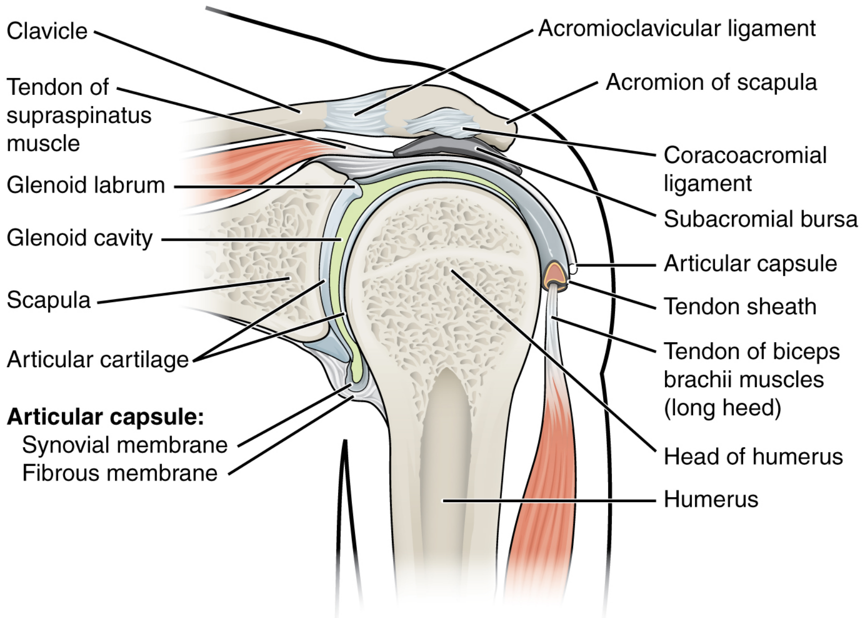


FIGURE 9.16 **Glenohumeral Joint** The glenohumeral (shoulder) joint is a ball-and-socket joint that provides the widest range of motions. It has a loose articular capsule and is supported by ligaments and the rotator cuff muscles.

The large range of motions at the shoulder joint is provided by the articulation of the large, rounded humeral head with the small and shallow glenoid cavity, which is only about one third of the size of the humeral head. The socket formed by the glenoid cavity is deepened slightly by a small lip of fibrocartilage called the **glenoid labrum**, which extends around the outer margin of the cavity. The articular capsule that surrounds the glenohumeral joint is relatively thin and loose to allow for large motions of the upper limb. Some structural support for the joint is provided by thickenings of the articular capsule wall that form weak intrinsic ligaments. These include the **coracohumeral ligament**, running from the coracoid process of the scapula to the anterior humerus, and three ligaments, each called a **glenohumeral ligament**, located on the anterior side of the articular capsule. These ligaments help to strengthen the superior and anterior capsule walls.

However, the primary support for the shoulder joint is provided by muscles crossing the joint, particularly the four rotator cuff muscles. These muscles (supraspinatus, infraspinatus, teres minor, and subscapularis) arise from the scapula and attach to the greater or lesser tubercles of the humerus. As these muscles cross the shoulder joint, their tendons encircle the head of the humerus and become fused to the anterior, superior, and posterior walls of the articular capsule. The thickening of the capsule formed by the fusion of these four muscle tendons is called the **rotator cuff**. Two bursae, the **subacromial bursa** and the **subscapular bursa**, help to prevent friction between the rotator cuff muscle tendons and the scapula as these tendons cross the glenohumeral joint. In addition to their individual actions of moving the upper limb, the rotator cuff muscles also serve to hold the head of the humerus in position within the glenoid cavity. By constantly adjusting their strength of contraction to resist forces acting on the shoulder, these muscles serve as “dynamic ligaments” and thus provide the primary structural support for the glenohumeral joint.

Injuries to the shoulder joint are common. Repetitive use of the upper limb, particularly in abduction such as during throwing, swimming, or racquet sports, may lead to acute or chronic inflammation of the bursa or muscle tendons, a tear of the glenoid labrum, or degeneration or tears of the rotator cuff. Because the humeral head is strongly supported by muscles and ligaments around its anterior, superior, and posterior aspects, most dislocations of the humerus occur in an inferior direction. This can occur when force is applied to the humerus when the upper limb is fully abducted, as when diving to catch a baseball and landing on your hand or elbow. Inflammatory responses to any shoulder injury can lead to the formation of scar tissue between the articular capsule and surrounding structures, thus reducing shoulder mobility, a condition called adhesive capsulitis (“frozen shoulder”).

INTERACTIVE LINK

Watch this video (http://openstax.org/l/shoulderjoint1) for a tutorial on the anatomy of the shoulder joint. What movements are available at the shoulder joint?

INTERACTIVE LINK

Watch this video (http://openstax.org/l/shoulderjoint2) to learn more about the anatomy of the shoulder joint, including bones, joints, muscles, nerves, and blood vessels. What is the shape of the glenoid labrum in cross-section, and what is the importance of this shape?

Elbow Joint

The **elbow joint** is a uniaxial hinge joint formed by the **humeroulnar joint**, the articulation between the trochlea of the humerus and the trochlear notch of the ulna. Also associated with the elbow are the **humeroradial joint** and the proximal radioulnar joint. All three of these joints are enclosed within a single articular capsule (Figure 9.17).

The articular capsule of the elbow is thin on its anterior and posterior aspects, but is thickened along its outside margins by strong intrinsic ligaments. These ligaments prevent side-to-side movements and hyperextension. On the medial side is the triangular **ulnar collateral ligament**. This arises from the medial epicondyle of the humerus and attaches to the medial side of the proximal ulna. The strongest part of this ligament is the anterior portion, which resists hyperextension of the elbow. The ulnar collateral ligament may be injured by frequent, forceful extensions of the forearm, as is seen in baseball pitchers. Reconstructive surgical repair of this ligament is referred to as Tommy John surgery, named for the former major league pitcher who was the first person to have this treatment.

The lateral side of the elbow is supported by the **radial collateral ligament**. This arises from the lateral epicondyle of the humerus and then blends into the lateral side of the annular ligament. The **annular ligament** encircles the head of the radius. This ligament supports the head of the radius as it articulates with the radial notch of the ulna at the proximal radioulnar joint. This is a pivot joint that allows for rotation of the radius during supination and pronation of the forearm.

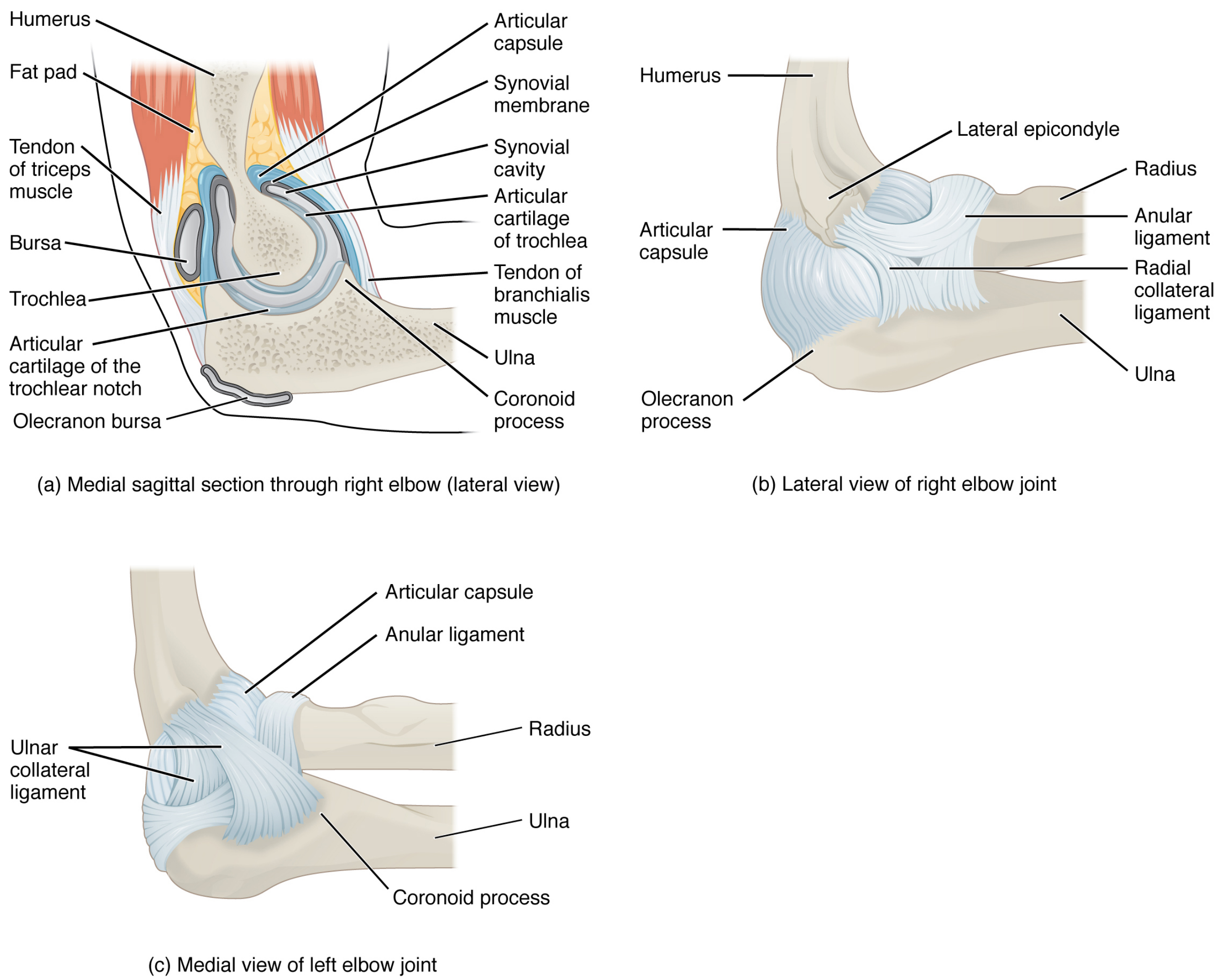


FIGURE 9.17 **Elbow Joint** (a) The elbow is a hinge joint that allows only for flexion and extension of the forearm. (b) It is supported by the ulnar and radial collateral ligaments. (c) The annular ligament supports the head of the radius at the proximal radioulnar joint, the pivot joint that allows for rotation of the radius.

INTERACTIVE LINK

Watch this animation (http://openstax.org/l/elbowjoint1) to learn more about the anatomy of the elbow joint. Which structures provide the main stability for the elbow?

INTERACTIVE LINK

Watch this video (http://openstax.org/l/elbowjoint2) to learn more about the anatomy of the elbow joint, including bones, joints, muscles, nerves, and blood vessels. What are the functions of the articular cartilage?

Hip Joint

The hip joint is a multiaxial ball-and-socket joint between the head of the femur and the acetabulum of the hip bone (Figure 9.18). The hip carries the weight of the body and thus requires strength and stability during standing and walking. For these reasons, its range of motion is more limited than at the shoulder joint.

The acetabulum is the socket portion of the hip joint. This space is deep and has a large articulation area for the femoral head, thus giving stability and weight bearing ability to the joint. The acetabulum is further deepened by the **acetabular labrum**, a fibrocartilage lip attached to the outer margin of the acetabulum. The surrounding articular capsule is strong, with several thickened areas forming intrinsic ligaments. These ligaments arise from the hip bone, at the margins of the acetabulum, and attach to the femur at the base of the neck. The ligaments are the **iliofemoral ligament**, **pubofemoral ligament**, and **ischiofemoral ligament**, all of which spiral around the head and neck of the femur. The ligaments are tightened by extension at the hip, thus pulling the head of the femur tightly into the acetabulum when in the upright, standing position. Very little additional extension of the thigh is permitted beyond this vertical position. These ligaments thus stabilize the hip joint and allow you to maintain an upright standing position with only minimal muscle contraction. Inside of the articular capsule, the **ligament of the head of the femur** (ligamentum teres) spans between the acetabulum and femoral head. This intracapsular ligament is normally slack and does not provide any significant joint support, but it does provide a pathway for an important artery that supplies the head of the femur.

The hip is prone to osteoarthritis, and thus was the first joint for which a replacement prosthesis was developed. A common injury in elderly individuals, particularly those with weakened bones due to osteoporosis, is a “broken hip,” which is actually a fracture of the femoral neck. This may result from a fall, or it may cause the fall. This can happen as one lower limb is taking a step and all of the body weight is placed on the other limb, causing the femoral neck to break and producing a fall. Any accompanying disruption of the blood supply to the femoral neck or head can lead to necrosis of these areas, resulting in bone and cartilage death. Femoral fractures usually require surgical treatment, after which the patient will need mobility assistance for a prolonged period, either from family members or in a long-term care facility. Consequentially, the associated health care costs of “broken hips” are substantial. In addition, hip fractures are associated with increased rates of morbidity (incidences of disease) and mortality (death). Surgery for a hip fracture followed by prolonged bed rest may lead to life-threatening complications, including pneumonia, infection of pressure ulcers (bedsores), and thrombophlebitis (deep vein thrombosis; blood clot formation) that can result in a pulmonary embolism (blood clot within the lung).

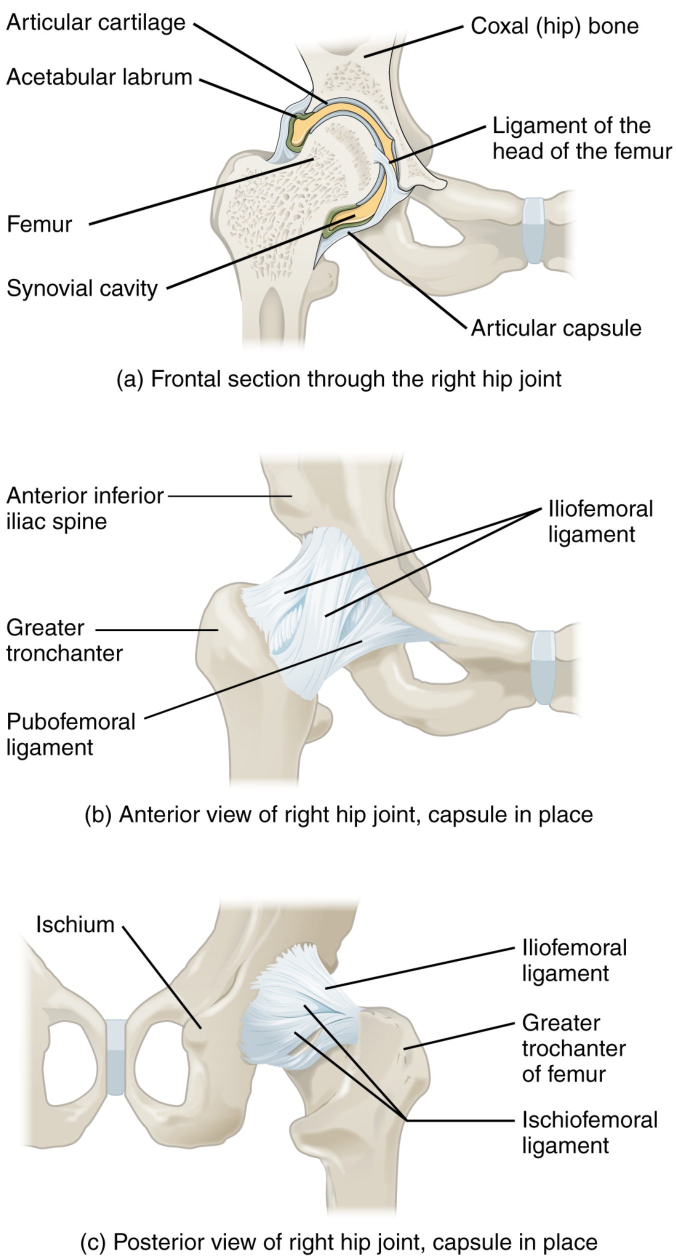


FIGURE 9.18 **Hip Joint** (a) The ball-and-socket joint of the hip is a multiaxial joint that provides both stability and a wide range of motion. (b–c) When standing, the supporting ligaments are tight, pulling the head of the femur into the acetabulum.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/hipjoint1) for a tutorial on the anatomy of the hip joint. What is a possible consequence following a fracture of the femoral neck within the capsule of the hip joint?

INTERACTIVE LINK

Watch this video (http://openstax.org/l/hipjoint2) to learn more about the anatomy of the hip joint, including bones, joints, muscles, nerves, and blood vessels. Where is the articular cartilage thickest within the hip joint?

Knee Joint

The knee joint is the largest joint of the body (Figure 9.19). It actually consists of three articulations. The **femoropatellar joint** is found between the patella and the distal femur. The **medial tibiofemoral joint** and **lateral tibiofemoral joint** are located between the medial and lateral condyles of the femur and the medial and lateral condyles of the tibia. All of these articulations are enclosed within a single articular capsule. The knee functions as a hinge joint, allowing flexion and extension of the leg. This action is generated by both rolling and gliding motions of the femur on the tibia. In addition, some rotation of the leg is available when the knee is flexed, but not when extended. The knee is well constructed for weight bearing in its extended position, but is vulnerable to injuries associated with hyperextension, twisting, or blows to the medial or lateral side of the joint, particularly while weight bearing.

At the femoropatellar joint, the patella slides vertically within a groove on the distal femur. The patella is a sesamoid bone incorporated into the tendon of the quadriceps femoris muscle, the large muscle of the anterior thigh. The patella serves to protect the quadriceps tendon from friction against the distal femur. Continuing from the patella to the anterior tibia just below the knee is the **patellar ligament**. Acting via the patella and patellar ligament, the quadriceps femoris is a powerful muscle that acts to extend the leg at the knee. It also serves as a “dynamic ligament” to provide very important support and stabilization for the knee joint.

The medial and lateral tibiofemoral joints are the articulations between the rounded condyles of the femur and the relatively flat condyles of the tibia. During flexion and extension motions, the condyles of the femur both roll and glide over the surfaces of the tibia. The rolling action produces flexion or extension, while the gliding action serves to maintain the femoral condyles centered over the tibial condyles, thus ensuring maximal bony, weight-bearing support for the femur in all knee positions. As the knee comes into full extension, the femur undergoes a slight medial rotation in relation to tibia. The rotation results because the lateral condyle of the femur is slightly smaller than the medial condyle. Thus, the lateral condyle finishes its rolling motion first, followed by the medial condyle. The resulting small medial rotation of the femur serves to “lock” the knee into its fully extended and most stable position. Flexion of the knee is initiated by a slight lateral rotation of the femur on the tibia, which “unlocks” the knee. This lateral rotation motion is produced by the popliteus muscle of the posterior leg.

Located between the articulating surfaces of the femur and tibia are two articular discs, the **medial meniscus** and **lateral meniscus** (see Figure 9.19**b**). Each is a C-shaped fibrocartilage structure that is thin along its inside margin and thick along the outer margin. They are attached to their tibial condyles, but do not attach to the femur. While both menisci are free to move during knee motions, the medial meniscus shows less movement because it is anchored at its outer margin to the articular capsule and tibial collateral ligament. The menisci provide padding between the bones and help to fill the gap between the round femoral condyles and flattened tibial condyles. Some areas of each meniscus lack an arterial blood supply and thus these areas heal poorly if damaged.

The knee joint has multiple ligaments that provide support, particularly in the extended position (see Figure 9.19**c**). Outside of the articular capsule, located at the sides of the knee, are two extrinsic ligaments. The **fibular collateral ligament** (lateral collateral ligament) is on the lateral side and spans from the lateral epicondyle of the femur to the head of the fibula. The **tibial collateral ligament** (medial collateral ligament) of the medial knee runs from the medial epicondyle of the femur to the medial tibia. As it crosses the knee, the tibial collateral ligament is firmly attached on its deep side to the articular capsule and to the medial meniscus, an important factor when considering knee injuries. In the fully extended knee position, both collateral ligaments are taut (tight), thus serving to stabilize and support the extended knee and preventing side-to-side or rotational motions between the femur and tibia.

The articular capsule of the posterior knee is thickened by intrinsic ligaments that help to resist knee hyperextension. Inside the knee are two intracapsular ligaments, the **anterior cruciate ligament** and **posterior cruciate ligament**. These ligaments are anchored inferiorly to the tibia at the intercondylar eminence, the roughened area between the tibial condyles. The cruciate ligaments are named for whether they are attached anteriorly or posteriorly to this tibial region. Each ligament runs diagonally upward to attach to the inner aspect of a femoral condyle. The cruciate ligaments are named for the X-shape formed as they pass each other (cruciate means “cross”). The posterior cruciate ligament is the stronger ligament. It serves to support the knee when it is flexed and weight bearing, as when walking downhill. In this position, the posterior cruciate ligament prevents the femur from sliding anteriorly off the top of the tibia. The anterior cruciate ligament becomes tight when the knee is extended, and thus resists hyperextension.

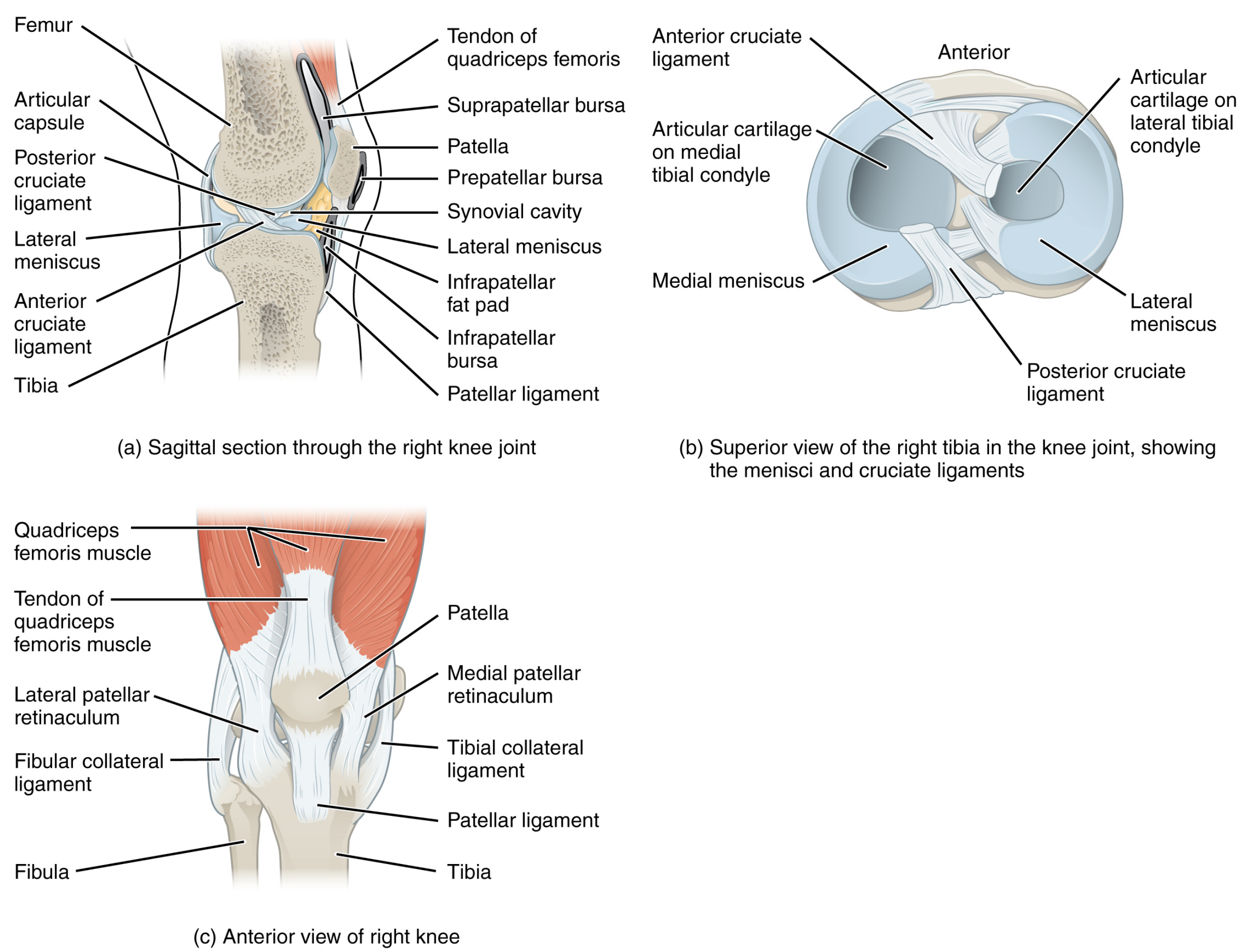


FIGURE 9.19 **Knee Joint** (a) The knee joint is the largest joint of the body. (b)–(c) It is supported by the tibial and fibular collateral ligaments located on the sides of the knee outside of the articular capsule, and the anterior and posterior cruciate ligaments found inside the capsule. The medial and lateral menisci provide padding and support between the femoral condyles and tibial condyles.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/flexext) to learn more about the flexion and extension of the knee, as the femur both rolls and glides on the tibia to maintain stable contact between the bones in all knee positions. The patella glides along a groove on the anterior side of the distal femur. The collateral ligaments on the sides of the knee become tight in the fully extended position to help stabilize the knee. The posterior cruciate ligament supports the knee when flexed and the anterior cruciate ligament becomes tight when the knee comes into full extension to resist hyperextension. What are the ligaments that support the knee joint?

INTERACTIVE LINK

Watch this video (http://openstax.org/l/kneejoint1) to learn more about the anatomy of the knee joint, including bones, joints, muscles, nerves, and blood vessels. Which ligament of the knee keeps the tibia from sliding too far forward in relation to the femur and which ligament keeps the tibia from sliding too far backward?

Disorders of the...

Joints

Injuries to the knee are common. Since this joint is primarily supported by muscles and ligaments, injuries to any of these structures will result in pain or knee instability. Injury to the posterior cruciate ligament occurs when the knee is flexed and the tibia is driven posteriorly, such as falling and landing on the tibial tuberosity or hitting the tibia on the dashboard when not wearing a seatbelt during an automobile accident. More commonly, injuries occur when forces are applied to the extended knee, particularly when the foot is planted and unable to move. Anterior cruciate ligament injuries can result with a forceful blow to the anterior knee, producing hyperextension, or when a runner makes a quick change of direction that produces both twisting and hyperextension of the knee.

A worse combination of injuries can occur with a hit to the lateral side of the extended knee (Figure 9.20). A moderate blow to the lateral knee will cause the medial side of the joint to open, resulting in stretching or damage to the tibial collateral ligament. Because the medial meniscus is attached to the tibial collateral ligament, a stronger blow can tear the ligament and also damage the medial meniscus. This is one reason that the medial meniscus is 20 times more likely to be injured than the lateral meniscus. A powerful blow to the lateral knee produces a “terrible triad” injury, in which there is a sequential injury to the tibial collateral ligament, medial meniscus, and anterior cruciate ligament.

Arthroscopic surgery has greatly improved the surgical treatment of knee injuries and reduced subsequent recovery times. This procedure involves a small incision and the insertion into the joint of an arthroscope, a pencil-thin instrument that allows for visualization of the joint interior. Small surgical instruments are also inserted via additional incisions. These tools allow a surgeon to remove or repair a torn meniscus or to reconstruct a ruptured cruciate ligament. The current method for anterior cruciate ligament replacement involves using a portion of the patellar ligament. Holes are drilled into the cruciate ligament attachment points on the tibia and femur, and the patellar ligament graft, with small areas of attached bone still intact at each end, is inserted into these holes. The bone-to-bone sites at each end of the graft heal rapidly and strongly, thus enabling a rapid recovery.

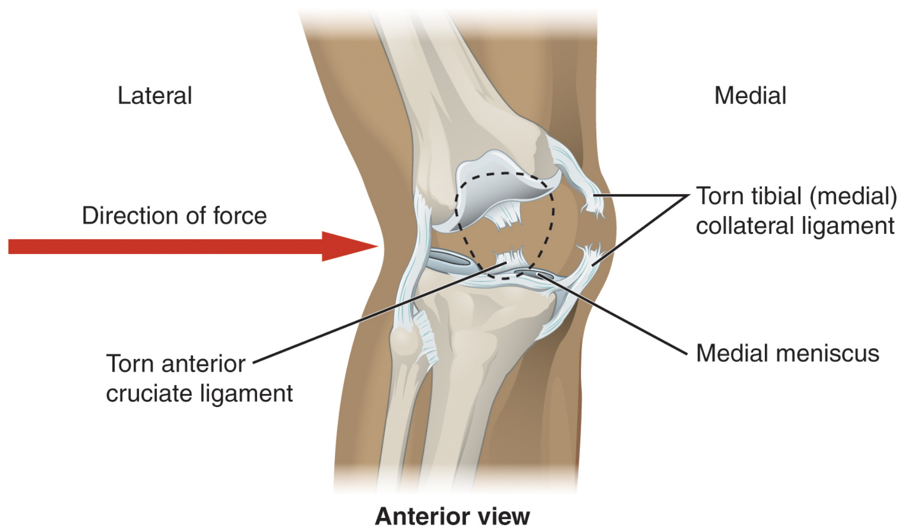


FIGURE 9.20 **Knee Injury** A strong blow to the lateral side of the extended knee will cause three injuries, in sequence: tearing of the tibial collateral ligament, damage to the medial meniscus, and rupture of the anterior cruciate ligament.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/kneeinjury) to learn more about different knee injuries and diagnostic testing of the knee. What are the most common causes of anterior cruciate ligament injury?

Ankle and Foot Joints

The ankle is formed by the **talocrural joint** (Figure 9.21). It consists of the articulations between the talus bone of the foot and the distal ends of the tibia and fibula of the leg (crural = “leg”). The superior aspect of the talus bone is square-shaped and has three areas of articulation. The top of the talus articulates with the inferior tibia. This is the portion of the ankle joint that carries the body weight between the leg and foot. The sides of the talus are firmly held in position by the articulations with the medial malleolus of the tibia and the lateral malleolus of the fibula, which prevent any side-to-side motion of the talus. The ankle is thus a uniaxial hinge joint that allows only for dorsiflexion and plantar flexion of the foot.

Additional joints between the tarsal bones of the posterior foot allow for the movements of foot inversion and eversion. Most important for these movements is the **subtalar joint**, located between the talus and calcaneus bones. The joints between the talus and navicular bones and the calcaneus and cuboid bones are also important contributors to these movements. All of the joints between tarsal bones are plane joints. Together, the small motions that take place at these joints all contribute to the production of inversion and eversion foot motions.

Like the hinge joints of the elbow and knee, the talocrural joint of the ankle is supported by several strong ligaments located on the sides of the joint. These ligaments extend from the medial malleolus of the tibia or lateral malleolus of the fibula and anchor to the talus and calcaneus bones. Since they are located on the sides of the ankle joint, they allow for dorsiflexion and plantar flexion of the foot. They also prevent abnormal side-to-side and twisting movements of the talus and calcaneus bones during eversion and inversion of the foot. On the medial side is the broad **deltoid ligament**. The deltoid ligament supports the ankle joint and also resists excessive eversion of the foot. The lateral side of the ankle has several smaller ligaments. These include the **anterior talofibular ligament** and the **posterior talofibular ligament**, both of which span between the talus bone and the lateral malleolus of the fibula, and the **calcaneofibular ligament**, located between the calcaneus bone and fibula. These ligaments support the ankle and also resist excess inversion of the foot.

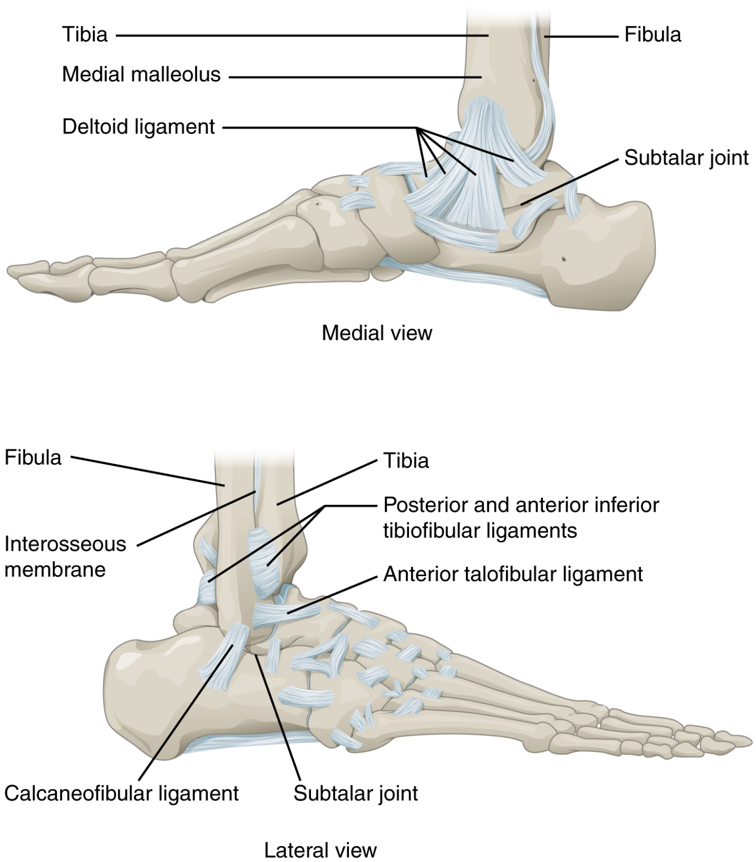


FIGURE 9.21 **Ankle Joint** The talocrural (ankle) joint is a uniaxial hinge joint that only allows for dorsiflexion or plantar flexion of the foot. Movements at the subtalar joint, between the talus and calcaneus bones, combined with motions at other intertarsal joints, enables eversion/inversion movements of the foot. Ligaments that unite the medial or lateral malleolus with the talus and calcaneus bones serve to support the talocrural joint and to resist excess eversion or inversion of the foot.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/anklejoint1) for a tutorial on the anatomy of the ankle joint. What are the three ligaments found on the lateral side of the ankle joint?

INTERACTIVE LINK

Watch this [video (http://openstax.org/l/anklejoint2)](http://openstax.org/l/anklejoint2) to learn more about the anatomy of the ankle joint, including bones, joints, muscles, nerves, and blood vessels. Which type of joint used in woodworking does the ankle joint resemble?

Disorders of the...

Joints

The ankle is the most frequently injured joint in the body, with the most common injury being an inversion ankle sprain. A sprain is the stretching or tearing of the supporting ligaments. Excess inversion causes the talus bone to tilt laterally, thus damaging the ligaments on the lateral side of the ankle. The anterior talofibular ligament is most commonly injured, followed by the calcaneofibular ligament. In severe inversion injuries, the forceful lateral movement of the talus not only ruptures the lateral ankle ligaments, but also fractures the distal fibula.

Less common are eversion sprains of the ankle, which involve stretching of the deltoid ligament on the medial side of the ankle. Forcible eversion of the foot, for example, with an awkward landing from a jump or when a football player has a foot planted and is hit on the lateral ankle, can result in a Pott's fracture and dislocation of the ankle joint. In this injury, the very strong deltoid ligament does not tear, but instead shears off the medial malleolus of the tibia. This frees the talus, which moves laterally and fractures the distal fibula. In extreme cases, the posterior margin of the tibia may also be sheared off.

Above the ankle, the distal ends of the tibia and fibula are united by a strong syndesmosis formed by the interosseous membrane and ligaments at the distal tibiofibular joint. These connections prevent separation between the distal ends of the tibia and fibula and maintain the talus locked into position between the medial malleolus and lateral malleolus. Injuries that produce a lateral twisting of the leg on top of the planted foot can result in stretching or tearing of the tibiofibular ligaments, producing a syndesmotic ankle sprain or "high ankle sprain."

Most ankle sprains can be treated using the RICE technique: Rest, Ice, Compression, and Elevation. Reducing joint mobility using a brace or cast may be required for a period of time. More severe injuries involving ligament tears or bone fractures may require surgery.

INTERACTIVE LINK

Watch this [video (http://openstax.org/l/anklejoint3)](http://openstax.org/l/anklejoint3) to learn more about the ligaments of the ankle joint, ankle sprains, and treatment. During an inversion ankle sprain injury, all three ligaments that resist excessive inversion of the foot may be injured. What is the sequence in which these three ligaments are injured?

9.7 Development of Joints

LEARNING OBJECTIVES

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

- Describe the two processes by which mesenchyme can give rise to bone
- Discuss the process by which joints of the limbs are formed

Joints form during embryonic development in conjunction with the formation and growth of the associated bones. The embryonic tissue that gives rise to all bones, cartilages, and connective tissues of the body is called mesenchyme. In the head, mesenchyme will accumulate at those areas that will become the bones that form the top and sides of the skull. The mesenchyme in these areas will develop directly into bone through the process of intramembranous ossification, in which mesenchymal cells differentiate into bone-producing cells that then generate bone tissue. The mesenchyme between the areas of bone production will become the fibrous connective tissue that fills the spaces between the developing bones. Initially, the connective tissue-filled gaps between the bones are wide, and are called fontanelles. After birth, as the skull bones grow and enlarge, the gaps between them decrease in width and the fontanelles are reduced to suture joints in which the bones are united by a narrow layer of fibrous connective tissue.

The bones that form the base and facial regions of the skull develop through the process of endochondral ossification. In this process, mesenchyme accumulates and differentiates into hyaline cartilage, which forms a model of the future bone. The hyaline cartilage model is then gradually, over a period of many years, displaced by bone. The mesenchyme between these developing bones becomes the fibrous connective tissue of the suture joints between the bones in these regions of the skull.

A similar process of endochondral ossification gives rises to the bones and joints of the limbs. The limbs initially develop as small limb buds that appear on the sides of the embryo around the end of the fourth week of development. Starting during the sixth week, as each limb bud continues to grow and elongate, areas of mesenchyme within the bud begin to differentiate into the hyaline cartilage that will form models for of each of the future bones. The synovial joints will form between the adjacent cartilage models, in an area called the **joint interzone**. Cells at the center of this interzone region undergo cell death to form the joint cavity, while surrounding mesenchyme cells will form the articular capsule and supporting ligaments. The process of endochondral ossification, which converts the cartilage models into bone, begins by the twelfth week of embryonic development. At birth, ossification of much of the bone has occurred, but the hyaline cartilage of the epiphyseal plate will remain throughout childhood and adolescence to allow for bone lengthening. Hyaline cartilage is also retained as the articular cartilage that covers the surfaces of the bones at synovial joints.

Key Terms

abduction movement in the coronal plane that moves a limb laterally away from the body; spreading of the fingers

acetabular labrum lip of fibrocartilage that surrounds outer margin of the acetabulum on the hip bone

adduction movement in the coronal plane that moves a limb medially toward or across the midline of the body; bringing fingers together

amphiarthrosis slightly mobile joint

annular ligament intrinsic ligament of the elbow articular capsule that surrounds and supports the head of the radius at the proximal radioulnar joint

anterior cruciate ligament intracapsular ligament of the knee; extends from anterior, superior surface of the tibia to the inner aspect of the lateral condyle of the femur; resists hyperextension of knee

anterior talofibular ligament intrinsic ligament located on the lateral side of the ankle joint, between talus bone and lateral malleolus of fibula; supports talus at the talocrural joint and resists excess inversion of the foot

articular capsule connective tissue structure that encloses the joint cavity of a synovial joint

articular cartilage thin layer of hyaline cartilage that covers the articulating surfaces of bones at a synovial joint

articular disc meniscus; a fibrocartilage structure found between the bones of some synovial joints; provides padding or smooths movements between the bones; strongly unites the bones together

articulation joint of the body

atlanto-occipital joint articulation between the occipital condyles of the skull and the superior articular processes of the atlas (C1 vertebra)

atlantoaxial joint series of three articulations between the atlas (C1) vertebra and the axis (C2) vertebra, consisting of the joints between the inferior articular processes of C1 and the superior articular processes of C2, and the articulation between the dens of C2 and the anterior arch of C1

ball-and-socket joint synovial joint formed between the spherical end of one bone (the ball) that fits into the depression of a second bone (the socket); found at the hip and shoulder joints; functionally classified as a multiaxial joint

biaxial joint type of diarthrosis; a joint that allows for movements within two planes (two axes)

bursa connective tissue sac containing lubricating fluid that prevents friction between adjacent structures, such as skin and bone, tendons and bone, or between muscles

calcaneofibular ligament intrinsic ligament located on the lateral side of the ankle joint, between the calcaneus bone and lateral malleolus of the fibula; supports the talus bone at the ankle joint and resists excess inversion of the foot

cartilaginous joint joint at which the bones are united by hyaline cartilage (synchondrosis) or fibrocartilage (symphysis)

circumduction circular motion of the arm, thigh, hand, thumb, or finger that is produced by the sequential combination of flexion, abduction, extension, and adduction

condyloid joint synovial joint in which the shallow depression at the end of one bone receives a rounded end from a second bone or a rounded structure formed by two bones; found at the metacarpophalangeal joints of the fingers or the radiocarpal joint of the wrist; functionally classified as a biaxial joint

coracohumeral ligament intrinsic ligament of the shoulder joint; runs from the coracoid process of the scapula to the anterior humerus

deltoid ligament broad intrinsic ligament located on the medial side of the ankle joint; supports the talus at the talocrural joint and resists excess eversion of the foot

depression downward (inferior) motion of the scapula or mandible

diarthrosis freely mobile joint

dorsiflexion movement at the ankle that brings the top of the foot toward the anterior leg

elbow joint humeroulnar joint

elevation upward (superior) motion of the scapula or mandible

eversion foot movement involving the intertarsal joints of the foot in which the bottom of the foot is turned laterally, away from the midline

extension movement in the sagittal plane that increases the angle of a joint (straightens the joint); motion involving posterior bending of the vertebral column or returning to the upright position from a flexed position

extrinsic ligament ligament located outside of the articular capsule of a synovial joint

femoropatellar joint portion of the knee joint consisting of the articulation between the distal femur and the patella

fibrous joint joint where the articulating areas of the adjacent bones are connected by fibrous connective tissue

fibular collateral ligament extrinsic ligament of the knee joint that spans from the lateral epicondyle of the femur to the head of the fibula; resists hyperextension and rotation of the extended knee

flexion movement in the sagittal plane that decreases the angle of a joint (bends the joint); motion involving anterior bending of the vertebral column

fontanelles expanded areas of fibrous connective tissue that separate the braincase bones of the skull prior to birth and during the first year after birth

glenohumeral joint shoulder joint; articulation between the glenoid cavity of the scapula and head of the humerus; multiaxial ball-and-socket joint that allows for flexion/extension, abduction/adduction, circumduction, and medial/lateral rotation of the humerus

glenohumeral ligament one of the three intrinsic ligaments of the shoulder joint that strengthen the anterior articular capsule

glenoid labrum lip of fibrocartilage located around the outside margin of the glenoid cavity of the scapula

gomphosis type of fibrous joint in which the root of a tooth is anchored into its bony jaw socket by strong periodontal ligaments

hinge joint synovial joint at which the convex surface of one bone articulates with the concave surface of a second bone; includes the elbow, knee, ankle, and interphalangeal joints; functionally classified as a uniaxial joint

humeroradial joint articulation between the capitulum of the humerus and head of the radius

humeroulnar joint articulation between the trochlea of humerus and the trochlear notch of the ulna; uniaxial hinge joint that allows for flexion/extension of the forearm

hyperextension excessive extension of joint, beyond the normal range of movement

hyperflexion excessive flexion of joint, beyond the normal range of movement

iliofemoral ligament intrinsic ligament spanning from the ilium of the hip bone to the femur, on the superior-anterior aspect of the hip joint

inferior rotation movement of the scapula during upper limb adduction in which the glenoid cavity of the scapula moves in a downward direction as the medial end of the scapular spine moves in an upward direction

interosseous membrane wide sheet of fibrous connective tissue that fills the gap between two parallel bones, forming a syndesmosis; found between the radius and ulna of the forearm and between the tibia and fibula of the leg

intracapsular ligament ligament that is located within the articular capsule of a synovial joint

intrinsic ligament ligament that is fused to or incorporated into the wall of the articular capsule of a synovial joint

inversion foot movement involving the intertarsal joints of the foot in which the bottom of the foot is turned toward the midline

ischiofemoral ligament intrinsic ligament spanning from the ischium of the hip bone to the femur, on the posterior aspect of the hip joint

joint site at which two or more bones or bone and cartilage come together (articulate)

joint cavity space enclosed by the articular capsule of a synovial joint that is filled with synovial fluid and contains the articulating surfaces of the adjacent bones

joint interzone site within a growing embryonic limb bud that will become a synovial joint

lateral (external) rotation movement of the arm at the shoulder joint or the thigh at the hip joint that moves the anterior surface of the limb away from the midline of the body

lateral excursion side-to-side movement of the mandible away from the midline, toward either the right or left side

lateral flexion bending of the neck or body toward the right or left side

lateral meniscus C-shaped fibrocartilage articular disc located at the knee, between the lateral condyle of the femur and the lateral condyle of the tibia

lateral tibiofemoral joint portion of the knee consisting of the articulation between the lateral condyle of the tibia and the lateral condyle of the femur; allows for flexion/extension at the knee

ligament strong band of dense connective tissue spanning between bones

ligament of the head of the femur intracapsular ligament that runs from the acetabulum of the hip bone to the head of the femur

medial (internal) rotation movement of the arm at the shoulder joint or the thigh at the hip joint that brings the anterior surface of the limb toward the midline of the body

medial excursion side-to-side movement that returns the mandible to the midline

medial meniscus C-shaped fibrocartilage articular disc located at the knee, between the medial condyle of the femur and medial condyle of the tibia

medial tibiofemoral joint portion of the knee consisting of the articulation between the medial condyle of the tibia and the medial condyle of the femur; allows for flexion/extension at the knee

meniscus articular disc
multiaxial joint type of diarthrosis; a joint that allows for movements within three planes (three axes)
opposition thumb movement that brings the tip of the thumb in contact with the tip of a finger
patellar ligament ligament spanning from the patella to the anterior tibia; serves as the final attachment for the quadriceps femoris muscle
periodontal ligament band of dense connective tissue that anchors the root of a tooth into the bony jaw socket
pivot joint synovial joint at which the rounded portion of a bone rotates within a ring formed by a ligament and an articulating bone; functionally classified as uniaxial joint
plane joint synovial joint formed between the flattened articulating surfaces of adjacent bones; functionally classified as a multiaxial joint
plantar flexion foot movement at the ankle in which the heel is lifted off of the ground
posterior cruciate ligament intracapsular ligament of the knee; extends from the posterior, superior surface of the tibia to the inner aspect of the medial condyle of the femur; prevents anterior displacement of the femur when the knee is flexed and weight bearing
posterior talofibular ligament intrinsic ligament located on the lateral side of the ankle joint, between the talus bone and lateral malleolus of the fibula; supports the talus at the talocrural joint and resists excess inversion of the foot
pronated position forearm position in which the palm faces backward
pronation forearm motion that moves the palm of the hand from the palm forward to the palm backward position
protraction anterior motion of the scapula or mandible
proximal radioulnar joint articulation between head of radius and radial notch of ulna; uniaxial pivot joint that allows for rotation of radius during pronation/ supination of forearm
pubofemoral ligament intrinsic ligament spanning from the pubis of the hip bone to the femur, on the anterior-inferior aspect of the hip joint
radial collateral ligament intrinsic ligament on the lateral side of the elbow joint; runs from the lateral epicondyle of humerus to merge with the annular ligament
reposition movement of the thumb from opposition back to the anatomical position (next to index finger)
retraction posterior motion of the scapula or mandible
rotation movement of a bone around a central axis (atlantoaxial joint) or around its long axis (proximal radioulnar joint; shoulder or hip joint); twisting of the vertebral column resulting from the summation of small motions between adjacent vertebrae
rotator cuff strong connective tissue structure formed by the fusion of four rotator cuff muscle tendons to the articular capsule of the shoulder joint; surrounds and supports superior, anterior, lateral, and posterior sides of the humeral head
saddle joint synovial joint in which the articulating ends of both bones are convex and concave in shape, such as at the first carpometacarpal joint at the base of the thumb; functionally classified as a biaxial joint
subacromial bursa bursa that protects the supraspinatus muscle tendon and superior end of the humerus from rubbing against the acromion of the scapula
subcutaneous bursa bursa that prevents friction between skin and an underlying bone
submuscular bursa bursa that prevents friction between bone and a muscle or between adjacent muscles
subscapular bursa bursa that prevents rubbing of the subscapularis muscle tendon against the scapula
subtalar joint articulation between the talus and calcaneus bones of the foot; allows motions that contribute to inversion/eversion of the foot
subtendinous bursa bursa that prevents friction between bone and a muscle tendon
superior rotation movement of the scapula during upper limb abduction in which the glenoid cavity of the scapula moves in an upward direction as the medial end of the scapular spine moves in a downward direction
supinated position forearm position in which the palm faces anteriorly (anatomical position)
supination forearm motion that moves the palm of the hand from the palm backward to the palm forward position
suture fibrous joint that connects the bones of the skull (except the mandible); an immobile joint (synarthrosis)
symphysis type of cartilaginous joint where the bones are joined by fibrocartilage
synarthrosis immobile or nearly immobile joint
synchondrosis type of cartilaginous joint where the bones are joined by hyaline cartilage
syndesmosis type of fibrous joint in which two separated, parallel bones are connected by an

interosseous membrane

synostosis site at which adjacent bones or bony components have fused together

synovial fluid thick, lubricating fluid that fills the interior of a synovial joint

synovial joint joint at which the articulating surfaces of the bones are located within a joint cavity formed by an articular capsule

synovial membrane thin layer that lines the inner surface of the joint cavity at a synovial joint; produces the synovial fluid

talocrural joint ankle joint; articulation between the talus bone of the foot and medial malleolus of the tibia, distal tibia, and lateral malleolus of the fibula; a uniaxial hinge joint that allows only for dorsiflexion and plantar flexion of the foot

temporomandibular joint (TMJ) articulation between the condyle of the mandible and the mandibular fossa and articular tubercle of the temporal bone of the skull; allows for depression/elevation (opening/closing of mouth), protraction/retraction, and side-to-side motions of the mandible

tendon dense connective tissue structure that anchors a muscle to bone

tendon sheath connective tissue that surrounds a tendon at places where the tendon crosses a joint; contains a lubricating fluid to prevent friction and allow smooth movements of the tendon

tibial collateral ligament extrinsic ligament of knee joint that spans from the medial epicondyle of the femur to the medial tibia; resists hyperextension and rotation of extended knee

ulnar collateral ligament intrinsic ligament on the medial side of the elbow joint; spans from the medial epicondyle of the humerus to the medial ulna

uniaxial joint type of diarthrosis; joint that allows for motion within only one plane (one axis)

zygapophysial joints facet joints; plane joints between the superior and inferior articular processes of adjacent vertebrae that provide for only limited motions between the vertebrae

Chapter Review

9.1 Classification of Joints

Structural classifications of the body joints are based on how the bones are held together and articulate with each other. At fibrous joints, the adjacent bones are directly united to each other by fibrous connective tissue. Similarly, at a cartilaginous joint, the adjacent bones are united by cartilage. In contrast, at a synovial joint, the articulating bone surfaces are not directly united to each other, but come together within a fluid-filled joint cavity.

The functional classification of body joints is based on the degree of movement found at each joint. A synarthrosis is a joint that is essentially immobile. This type of joint provides for a strong connection between the adjacent bones, which serves to protect internal structures such as the brain or heart. Examples include the fibrous joints of the skull sutures and the cartilaginous manubriosternal joint. A joint that allows for limited movement is an amphiarthrosis. An example is the pubic symphysis of the pelvis, the cartilaginous joint that strongly unites the right and left hip bones of the pelvis. The cartilaginous joints in which vertebrae are united by intervertebral discs provide for small movements between the adjacent vertebrae and are also an amphiarthrosis type of joint. Thus, based on their movement ability, both fibrous and cartilaginous joints are functionally classified as a synarthrosis or amphiarthrosis.

The most common type of joint is the diarthrosis, which is a freely moveable joint. All synovial joints are functionally classified as diarthroses. A uniaxial diarthrosis, such as the elbow, is a joint that only allows for movement within a single anatomical plane. Joints that allow for movements in two planes are biaxial joints, such as the metacarpophalangeal joints of the fingers. A multiaxial joint, such as the shoulder or hip joint, allows for three planes of motions.

9.2 Fibrous Joints

Fibrous joints are where adjacent bones are strongly united by fibrous connective tissue. The gap filled by connective tissue may be narrow or wide. The three types of fibrous joints are sutures, gomphoses, and syndesmoses. A suture is the narrow fibrous joint that unites most bones of the skull. At a gomphosis, the root of a tooth is anchored across a narrow gap by periodontal ligaments to the walls of its socket in the bony jaw. A syndesmosis is the type of fibrous joint found between parallel bones. The gap between the bones may be wide and filled with a fibrous interosseous membrane, or it may narrow with ligaments spanning between the bones. Syndesmoses are found between the bones of the forearm (radius and ulna) and the leg (tibia and fibula). Fibrous joints strongly unite adjacent bones and thus serve to provide protection for internal organs, strength to body regions, or weight-bearing stability.

9.3 Cartilaginous Joints

There are two types of cartilaginous joints. A synchondrosis is formed when the adjacent bones are united by hyaline cartilage. A temporary synchondrosis is formed by the epiphyseal plate of a growing long bone, which is lost when the epiphyseal plate ossifies as the bone reaches maturity. The synchondrosis is thus replaced by a synostosis. Permanent synchondroses that do not ossify are found at the first sternocostal joint and between the anterior ends of the bony ribs and the junction with their costal cartilage. A symphysis is where the bones are joined by fibrocartilage and the gap between the bones may be narrow or wide. A narrow symphysis is found at the manubriosternal joint and at the pubic symphysis. A wide symphysis is the intervertebral symphysis in which the bodies of adjacent vertebrae are united by an intervertebral disc.

9.4 Synovial Joints

Synovial joints are the most common type of joints in the body. They are characterized by the presence of a joint cavity, inside of which the bones of the joint articulate with each other. The articulating surfaces of the bones at a synovial joint are not directly connected to each other by connective tissue or cartilage, which allows the bones to move freely against each other. The walls of the joint cavity are formed by the articular capsule. Friction between the bones is reduced by a thin layer of articular cartilage covering the surfaces of the bones, and by a lubricating synovial fluid, which is secreted by the synovial membrane.

Synovial joints are strengthened by the presence of ligaments, which hold the bones together and resist excessive or abnormal movements of the joint. Ligaments are classified as extrinsic ligaments if they are located outside of the articular capsule, intrinsic ligaments if they are fused to the wall of the articular capsule, or intracapsular ligaments if they are located inside the articular capsule. Some synovial joints also have an articular disc (meniscus), which can provide padding between the bones, smooth their movements, or strongly join the bones together to strengthen the joint. Muscles and their tendons acting across a joint can also increase their contractile strength when needed, thus providing indirect support for the joint.

Bursae contain a lubricating fluid that serves to reduce friction between structures. Subcutaneous bursae prevent friction between the skin and an underlying bone, submuscular bursae protect muscles from rubbing against a bone or another muscle, and a subtendinous bursa prevents friction between bone and a muscle tendon. Tendon sheaths contain a lubricating fluid and surround tendons to allow for smooth movement of the tendon as it crosses a joint.

Based on the shape of the articulating bone surfaces and the types of movement allowed, synovial joints are classified into six types. At a pivot joint, one bone is held within a ring by a ligament and its articulation with a second bone. Pivot joints only allow for rotation around a single axis. These are found at the articulation between the C1 (atlas) and the dens of the C2 (axis) vertebrae, which provides the side-to-side rotation of the head, or at the proximal radioulnar joint between the head of the radius and the radial notch of the ulna, which allows for rotation of the radius during forearm movements. Hinge joints, such as at the elbow, knee, ankle, or interphalangeal joints between phalanx bones of the fingers and toes, allow only for bending and straightening of the joint. Pivot and hinge joints are functionally classified as uniaxial joints.

Condyloid joints are found where the shallow depression of one bone receives a rounded bony area formed by one or two bones. Condyloid joints are found at the base of the fingers (metacarpophalangeal joints) and at the wrist (radiocarpal joint). At a saddle joint, the articulating bones fit together like a rider and a saddle. An example is the first carpometacarpal joint located at the base of the thumb. Both condyloid and saddle joints are functionally classified as biaxial joints.

Plane joints are formed between the small, flattened surfaces of adjacent bones. These joints allow the bones to slide or rotate against each other, but the range of motion is usually slight and tightly limited by ligaments or surrounding bones. This type of joint is found between the articular processes of adjacent vertebrae, at the acromioclavicular joint, or at the intercarpal joints of the hand and intertarsal joints of the foot. Ball-and-socket joints, in which the rounded head of a bone fits into a large depression or socket, are found at the shoulder and hip joints. Both plane and ball-and-sockets joints are classified functionally as multiaxial joints. However, ball-and-socket joints allow for large movements, while the motions between bones at a plane joint are small.

9.5 Types of Body Movements

The variety of movements provided by the different types of synovial joints allows for a large range of body motions and gives you tremendous mobility. These movements allow you to flex or extend your body or limbs, medially rotate and adduct your arms and flex your elbows to hold a heavy object against your chest, raise your arms above your head, rotate or shake your head, and bend to touch the toes (with or without bending your knees).

Each of the different structural types of synovial joints also allow for specific motions. The atlantoaxial pivot joint provides side-to-side rotation of the head, while the proximal radioulnar articulation allows for rotation of the radius during pronation and supination of the forearm. Hinge joints, such as at the knee and elbow, allow only for flexion and extension. Similarly, the hinge joint of the ankle only allows for dorsiflexion and plantar flexion of the foot.

Condyloid and saddle joints are biaxial. These allow for flexion and extension, and abduction and adduction. The sequential combination of flexion, adduction, extension, and abduction produces circumduction. Multiaxial plane joints provide for only small motions, but these can add together over several adjacent joints to produce body movement, such as inversion and eversion of the foot. Similarly, plane joints allow for flexion, extension, and lateral flexion movements of the vertebral column. The multiaxial ball and socket joints allow for flexion-extension, abduction-adduction, and circumduction. In addition, these also allow for medial (internal) and lateral (external) rotation. Ball-and-socket joints have the greatest range of motion of all synovial joints.

9.6 Anatomy of Selected Synovial Joints

Although synovial joints share many common features, each joint of the body is specialized for certain movements and activities. The joints of the upper limb provide for large ranges of motion, which give the upper limb great mobility, thus enabling actions such as the throwing of a ball or typing on a keyboard. The joints of the lower limb are more robust, giving them greater strength and the stability needed to support the body weight during running, jumping, or kicking activities.

The joints of the vertebral column include the symphysis joints formed by each intervertebral disc and the plane synovial joints between the superior and inferior articular processes of adjacent vertebrae. Each of these joints provide for limited motions, but these sum together to produce flexion, extension, lateral flexion, and rotation of the neck and body. The range of motions available in each region of the vertebral column varies, with all of these motions available in the cervical region. Only rotation is allowed in the thoracic region, while the lumbar region has considerable extension, flexion, and lateral flexion, but rotation is prevented. The atlanto-occipital joint allows for flexion and extension of the head, while the atlantoaxial joint is a pivot joint that provides for rotation of the head.

The temporomandibular joint is the articulation between the condyle of the mandible and the mandibular fossa and articular tubercle of the skull temporal bone. An articular disc is located between the bony components of this joint. A combination of gliding and hinge motions of the mandibular condyle allows for elevation/depression, protraction/retraction, and side-to-side motions of the lower jaw.

The glenohumeral (shoulder) joint is a multiaxial ball-and-socket joint that provides flexion/extension, abduction/adduction, circumduction, and medial/lateral rotation of the humerus. The head of the humerus articulates with the glenoid cavity of the scapula. The glenoid labrum extends around the margin of the glenoid cavity. Intrinsic ligaments, including the coracohumeral ligament and glenohumeral ligaments, provide some support for the shoulder joint. However, the primary support comes from muscles crossing the joint whose tendons form the rotator cuff. These muscle tendons are protected from friction against the scapula by the subacromial bursa and subscapular bursa.

The elbow is a uniaxial hinge joint that allows for flexion/extension of the forearm. It includes the humeroulnar joint and the humeroradial joint. The medial elbow is supported by the ulnar collateral ligament and the radial collateral ligament supports the lateral side. These ligaments prevent side-to-side movements and resist hyperextension of the elbow. The proximal radioulnar joint is a pivot joint that allows for rotation of the radius during pronation/supination of the forearm. The annular ligament surrounds the head of the radius to hold it in place at this joint.

The hip joint is a ball-and-socket joint whose motions are more restricted than at the shoulder to provide greater stability during weight bearing. The hip joint is the articulation between the head of the femur and the acetabulum of the hip bone. The acetabulum is deepened by the acetabular labrum. The iliofemoral, pubofemoral, and ischiofemoral ligaments strongly support the hip joint in the upright, standing position. The ligament of the head of the femur provides little support but carries an important artery that supplies the femur.

The knee includes three articulations. The femoropatellar joint is between the patella and distal femur. The patella, a sesamoid bone incorporated into the tendon of the quadriceps femoris muscle of the anterior thigh, serves to protect this tendon from rubbing against the distal femur during knee movements. The medial and lateral tibiofemoral joints, between the condyles of the femur and condyles of the tibia, are modified hinge joints that allow for knee extension and flexion. During these movements, the condyles of the femur both roll and glide over the surface of the tibia. As the knee comes into full extension, a slight medial rotation of the femur serves to “lock” the knee into its most stable, weight-bearing position. The reverse motion, a small lateral rotation of the femur, is required to initiate knee flexion. When the knee is flexed, some rotation of the leg is available.

Two extrinsic ligaments, the tibial collateral ligament on the medial side and the fibular collateral ligament on the lateral side, serve to resist hyperextension or rotation of the extended knee joint. Two intracapsular ligaments, the anterior cruciate ligament and posterior cruciate ligament, span between the tibia and the inner aspects of the femoral condyles. The anterior cruciate ligament resists hyperextension of the knee, while the posterior cruciate ligament prevents anterior sliding of the femur, thus supporting the knee when it is flexed and weight bearing. The medial and lateral menisci, located between the femoral and tibial condyles, are articular discs that provide padding and improve the fit between the bones.

The talocrural joint forms the ankle. It consists of the articulation between the talus bone and the medial malleolus of the tibia, the distal end of the tibia, and the lateral malleolus of the fibula. This is a uniaxial hinge joint that allows only dorsiflexion and plantar flexion of the foot. Gliding motions at the subtalar and intertarsal joints of the foot allow for inversion/eversion of the foot. The ankle joint is supported on the medial side by the deltoid ligament, which prevents side-to-side motions of the talus at the talocrural joint and resists excessive eversion of the foot. The lateral ankle is supported by the anterior and posterior talofibular ligaments and the calcaneofibular ligament. These support the ankle joint and also resist excess inversion of the foot. An inversion ankle sprain, a common injury, will result in injury to one or more of these lateral ankle ligaments.

9.7 Development of Joints

During embryonic growth, bones and joints develop from mesenchyme, an embryonic tissue that gives rise to bone, cartilage, and fibrous connective tissues. In the skull, the bones develop either directly from mesenchyme through the process of intramembranous ossification, or indirectly through endochondral ossification, which initially forms a hyaline cartilage model of the future bone, which is later converted into bone. In both cases, the mesenchyme between the developing bones differentiates into fibrous connective tissue that will unite the skull bones at suture joints. In the limbs, mesenchyme accumulations within the growing limb bud will become a hyaline cartilage model for each of the limb bones. A joint interzone will develop between these areas of cartilage. Mesenchyme cells at the margins of the interzone will give rise to the articular capsule, while cell death at the center forms the space that will become the joint cavity of the future synovial joint. The hyaline cartilage model of each limb bone will eventually be converted into bone via the process of endochondral ossification. However, hyaline cartilage will remain, covering the ends of the adult bone as the articular cartilage.

Interactive Link Questions

1. Go to this website (http://openstax.org/l/childhand) to view a radiograph (X-ray image) of a child’s hand and wrist. The growing bones of child have an epiphyseal plate that forms a synchondrosis between the shaft and end of a long bone. Being less dense than bone, the area of epiphyseal cartilage is seen on this radiograph as the dark epiphyseal gaps located near the ends of the long bones, including the radius, ulna, metacarpal, and phalanx bones. Which of the bones in this image do not show an epiphyseal plate (epiphyseal gap)?

2. Watch this video (http://openstax.org/l/synjoints) to see an animation of synovial joints in action. Synovial joints are places where bones articulate with each other inside of a joint cavity. The different types of synovial joints are the ball-and-socket joint (shoulder joint), hinge joint (knee), pivot joint (atlantoaxial joint, between C1 and C2 vertebrae of the neck), condyloid joint (radiocarpal joint of the wrist), saddle joint (first carpometacarpal joint, between the trapezium carpal bone and the first metacarpal bone, at the base of the thumb), and plane joint (facet joints of vertebral column, between superior and inferior articular processes). Which type of synovial joint allows for the widest ranges of motion?

3. Visit this website (http://openstax.org/l/gout) to read about a patient who arrives at the hospital with joint pain and weakness in his legs. What caused this patient's weakness?
4. Watch this animation (http://openstax.org/l/hipreplace) to observe hip replacement surgery (total hip arthroplasty), which can be used to alleviate the pain and loss of joint mobility associated with osteoarthritis of the hip joint. What is the most common cause of hip disability?
5. Watch this video (http://openstax.org/l/rheuarthritis) to learn about the symptoms and treatments for rheumatoid arthritis. Which system of the body malfunctions in rheumatoid arthritis and what does this cause?
6. Watch this video (http://openstax.org/l/anatomical) to learn about anatomical motions. What motions involve increasing or decreasing the angle of the foot at the ankle?
7. Watch this video (http://openstax.org/l/TMJ) to learn about TMJ. Opening of the mouth requires the combination of two motions at the temporomandibular joint, an anterior gliding motion of the articular disc and mandible and the downward hinging of the mandible. What is the initial movement of the mandible during opening and how much mouth opening does this produce?
8. Watch this video (http://openstax.org/l/shoulderjoint1) for a tutorial on the anatomy of the shoulder joint. What movements are available at the shoulder joint?
9. Watch this video (http://openstax.org/l/shoulderjoint2) to learn about the anatomy of the shoulder joint, including bones, joints, muscles, nerves, and blood vessels. What is the shape of the glenoid labrum in cross-section, and what is the importance of this shape?
10. Watch this animation (http://openstax.org/l/elbowjoint1) to learn more about the anatomy of the elbow joint. What structures provide the main stability for the elbow?
11. Watch this video (http://openstax.org/l/elbowjoint2) to learn more about the anatomy of the elbow joint, including bones, joints, muscles, nerves, and blood vessels. What are the functions of the articular cartilage?
12. Watch this video (http://openstax.org/l/hipjoint1) for a tutorial on the anatomy of the hip joint. What is a possible consequence following a fracture of the femoral neck within the capsule of the hip joint?
13. Watch this video (http://openstax.org/l/hipjoint2) to learn more about the anatomy of the hip joint, including bones, joints, muscles, nerves, and blood vessels. Where is the articular cartilage thickest within the hip joint?
14. Watch this video (http://openstax.org/l/flexext) to learn more about the flexion and extension of the knee, as the femur both rolls and glides on the tibia to maintain stable contact between the bones in all knee positions. The patella glides along a groove on the anterior side of the distal femur. The collateral ligaments on the sides of the knee become tight in the fully extended position to help stabilize the knee. The posterior cruciate ligament supports the knee when flexed and the anterior cruciate ligament becomes tight when the knee comes into full extension to resist hyperextension. What are the ligaments that support the knee joint?
15. Watch this video (http://openstax.org/l/kneejoint1) to learn more about the anatomy of the knee joint, including bones, joints, muscles, nerves, and blood vessels. Which ligament of the knee keeps the tibia from sliding too far forward in relation to the femur and which ligament keeps the tibia from sliding too far backward?
16. Watch this video (http://openstax.org/l/kneeinjury) to learn more about different knee injuries and diagnostic testing of the knee. What are the most causes of anterior cruciate ligament injury?
17. Watch this video (http://openstax.org/l/anklejoint1) for a tutorial on the anatomy of the ankle joint. What are the three ligaments found on the lateral side of the ankle joint?
18. Watch this video (http://openstax.org/l/anklejoint2) to learn more about the anatomy of the ankle joint, including bones, joints, muscles, nerves, and blood vessels. The ankle joint resembles what type of joint used in woodworking?
19. Watch this video (http://openstax.org/l/anklejoint3) to learn about the ligaments of the ankle joint, ankle sprains, and treatment. During an inversion ankle sprain injury, all three ligaments that resist excessive inversion of the foot may be injured. What is the sequence in which these three ligaments are injured?

Review Questions

20. The joint between adjacent vertebrae that includes an invertebral disc is classified as which type of joint?
   a. diarthrosis
   b. multiaxial
   c. amphiarthrosis
   d. synarthrosis

21. Which of these joints is classified as a synarthrosis?
   a. the pubic symphysis
   b. the manubriosternal joint
   c. an invertebral disc
   d. the shoulder joint

22. Which of these joints is classified as a biaxial diarthrosis?
   a. the metacarpophalangeal joint
   b. the hip joint
   c. the elbow joint
   d. the pubic symphysis

23. Synovial joints ________.
   a. may be functionally classified as a synarthrosis
   b. are joints where the bones are connected to each other by hyaline cartilage
   c. may be functionally classified as an amphiarthrosis
   d. are joints where the bones articulate with each other within a fluid-filled joint cavity

24. Which type of fibrous joint connects the tibia and fibula?
   a. syndesmosis
   b. symphysis
   c. suture
   d. gomphosis

25. An example of a wide fibrous joint is ________.
   a. the interosseous membrane of the forearm
   b. a gomphosis
   c. a suture joint
   d. a synostosis

26. A gomphosis ________.
   a. is formed by an interosseous membrane
   b. connects the tibia and fibula bones of the leg
   c. contains a joint cavity
   d. anchors a tooth to the jaw

27. A syndesmosis is ________.
   a. a narrow fibrous joint
   b. the type of joint that unites bones of the skull
   c. a fibrous joint that unites parallel bones
   d. the type of joint that anchors the teeth in the jaws

28. A cartilaginous joint ________.
   a. has a joint cavity
   b. is called a symphysis when the bones are united by fibrocartilage
   c. anchors the teeth to the jaws
   d. is formed by a wide sheet of fibrous connective tissue

29. A synchondrosis is ________.
   a. found at the pubic symphysis
   b. where bones are connected together with fibrocartilage
   c. a type of fibrous joint
   d. found at the first sternocostal joint of the thoracic cage

30. Which of the following are joined by a symphysis?
   a. adjacent vertebrae
   b. the first rib and the sternum
   c. the end and shaft of a long bone
   d. the radius and ulna bones

31. The epiphyseal plate of a growing long bone in a child is classified as a ________.
   a. synchondrosis
   b. synostosis
   c. symphysis
   d. syndesmosis

32. Which type of joint provides the greatest range of motion?
   a. ball-and-socket
   b. hinge
   c. condyloid
   d. plane

33. Which type of joint allows for only uniaxial movement?
   a. saddle joint
   b. hinge joint
   c. condyloid joint
   d. ball-and-socket joint

34. Which of the following is a type of synovial joint?
   a. a synostosis
   b. a suture
   c. a plane joint
   d. a synchondrosis

35. A bursa ________.

a. surrounds a tendon at the point where the tendon crosses a joint
b. secretes the lubricating fluid for a synovial joint
c. prevents friction between skin and bone, or a muscle tendon and bone
d. is the strong band of connective tissue that holds bones together at a synovial joint

36. At synovial joints, ________.

a. the articulating ends of the bones are directly connected by fibrous connective tissue
b. the ends of the bones are enclosed within a space called a subcutaneous bursa
c. intrinsic ligaments are located entirely inside of the articular capsule
d. the joint cavity is filled with a thick, lubricating fluid

37. At a synovial joint, the synovial membrane ________.

a. forms the fibrous connective walls of the joint cavity
b. is the layer of cartilage that covers the articulating surfaces of the bones
c. forms the intracapsular ligaments
d. secretes the lubricating synovial fluid

38. Condyloid joints ________.

a. are a type of ball-and-socket joint
b. include the radiocarpal joint
c. are a uniaxial diarthrosis joint
d. are found at the proximal radioulnar joint

39. A meniscus is ________.

a. a fibrocartilage pad that provides padding between bones
b. a fluid-filled space that prevents friction between a muscle tendon and underlying bone
c. the articular cartilage that covers the ends of a bone at a synovial joint
d. the lubricating fluid within a synovial joint

40. The joints between the articular processes of adjacent vertebrae can contribute to which movement?

a. lateral flexion
b. circumduction
c. dorsiflexion
d. abduction

41. Which motion moves the bottom of the foot away from the midline of the body?

a. elevation
b. dorsiflexion
c. eversion
d. plantar flexion

42. Movement of a body region in a circular movement at a condyloid joint is what type of motion?

a. rotation
b. elevation
c. abduction
d. circumduction

43. Supination is the motion that moves the ________.

a. hand from the palm backward position to the palm forward position
b. foot so that the bottom of the foot faces the midline of the body
c. hand from the palm forward position to the palm backward position
d. scapula in an upward direction

44. Movement at the shoulder joint that moves the upper limb laterally away from the body is called ________.

a. elevation
b. eversion
c. abduction
d. lateral rotation

45. The primary support for the glenohumeral joint is provided by the ________.

a. coracohumeral ligament
b. glenoid labrum
c. rotator cuff muscles
d. subacromial bursa

46. The proximal radioulnar joint ________.

a. is supported by the annular ligament
b. contains an articular disc that strongly unites the bones
c. is supported by the ulnar collateral ligament
d. is a hinge joint that allows for flexion/extension of the forearm

47. Which statement is true concerning the knee joint?
   a. The lateral meniscus is an intrinsic ligament located on the lateral side of the knee joint.
   b. Hyperextension is resisted by the posterior cruciate ligament.
   c. The anterior cruciate ligament supports the knee when it is flexed and weight bearing.
   d. The medial meniscus is attached to the tibial collateral ligament.

48. The ankle joint ________.
   a. is also called the subtalar joint
   b. allows for gliding movements that produce inversion/eversion of the foot
   c. is a uniaxial hinge joint
   d. is supported by the tibial collateral ligament on the lateral side

49. Which region of the vertebral column has the *greatest* range of motion for rotation?
   a. cervical
   b. thoracic
   c. lumbar
   d. sacral

50. Intramembranous ossification ________.
   a. gives rise to the bones of the limbs
   b. produces the bones of the top and sides of the skull
   c. produces the bones of the face and base of the skull
   d. involves the conversion of a hyaline cartilage model into bone

51. Synovial joints ________.
   a. are derived from fontanelles
   b. are produced by intramembranous ossification
   c. develop at an interzone site
   d. are produced by endochondral ossification

52. Endochondral ossification is ________.
   a. the process that replaces hyaline cartilage with bone tissue
   b. the process by which mesenchyme differentiates directly into bone tissue
   c. completed before birth
   d. the process that gives rise to the joint interzone and future joint cavity

Critical Thinking Questions

53. Define how joints are classified based on function. Describe and give an example for each functional type of joint.

54. Explain the reasons for why joints differ in their degree of mobility.

55. Distinguish between a narrow and wide fibrous joint and give an example of each.

56. The periodontal ligaments are made of collagen fibers and are responsible for connecting the roots of the teeth to the jaws. Describe how scurvy, a disease that inhibits collagen production, can affect the teeth.

57. Describe the two types of cartilaginous joints and give examples of each.

58. Both functional and structural classifications can be used to describe an individual joint. Define the first sternocostal joint and the pubic symphysis using both functional and structural characteristics.

59. Describe the characteristic structures found at all synovial joints.

60. Describe the structures that provide direct and indirect support for a synovial joint.

61. Briefly define the types of joint movements available at a ball-and-socket joint.

62. Discuss the joints involved and movements required for you to cross your arms together in front of your chest.

63. Discuss the structures that contribute to support of the shoulder joint.

64. Describe the sequence of injuries that may occur if the extended, weight-bearing knee receives a very strong blow to the lateral side of the knee.

65. Describe how synovial joints develop within the embryonic limb.

66. Differentiate between endochondral and intramembranous ossification.

CHAPTER 10
Muscle Tissue

Figure 10.1 **Tennis Player** Athletes rely on toned skeletal muscles to supply the force required for movement. (credit: Emmanuel Huybrechts/flickr)

CHAPTER OBJECTIVES

After studying this chapter, you will be able to:

- Explain the organization of muscle tissue
- Describe the function and structure of skeletal, cardiac muscle, and smooth muscle
- Explain how muscles work with tendons to move the body
- Describe how muscles contract and relax
- Define the process of muscle metabolism
- Explain how the nervous system controls muscle tension
- Relate the connections between exercise and muscle performance
- Explain the development and regeneration of muscle tissue

INTRODUCTION When most people think of muscles, they think of the muscles that are visible just under the skin, particularly of the limbs. These are skeletal muscles, so-named because most of them move the skeleton. But there are two other types of muscle in the body, with distinctly different jobs. Cardiac muscle, found in the heart, is concerned with pumping blood through the circulatory system. Smooth muscle is concerned with various involuntary movements, such as having one’s hair stand on end when cold or frightened, or moving food through the digestive system. This chapter will examine the structure and function of these three types of muscles.

10.1 Overview of Muscle Tissues

LEARNING OBJECTIVES

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

- Describe the different types of muscle
- Explain contractibility and extensibility

Muscle is one of the four primary tissue types of the body, and the body contains three types of muscle tissue: skeletal muscle, cardiac muscle, and smooth muscle (Figure 10.2). All three muscle tissues have some properties in common; they all exhibit a quality called **excitability** as their plasma membranes can change their electrical states (from polarized to depolarized) and send an electrical wave called an action potential along the entire length of the membrane. While the nervous system can influence the excitability of cardiac and smooth muscle to some degree, skeletal muscle completely depends on signaling from the nervous system to work properly. On the other hand, both cardiac muscle and smooth muscle can respond to other stimuli, such as hormones and local stimuli.

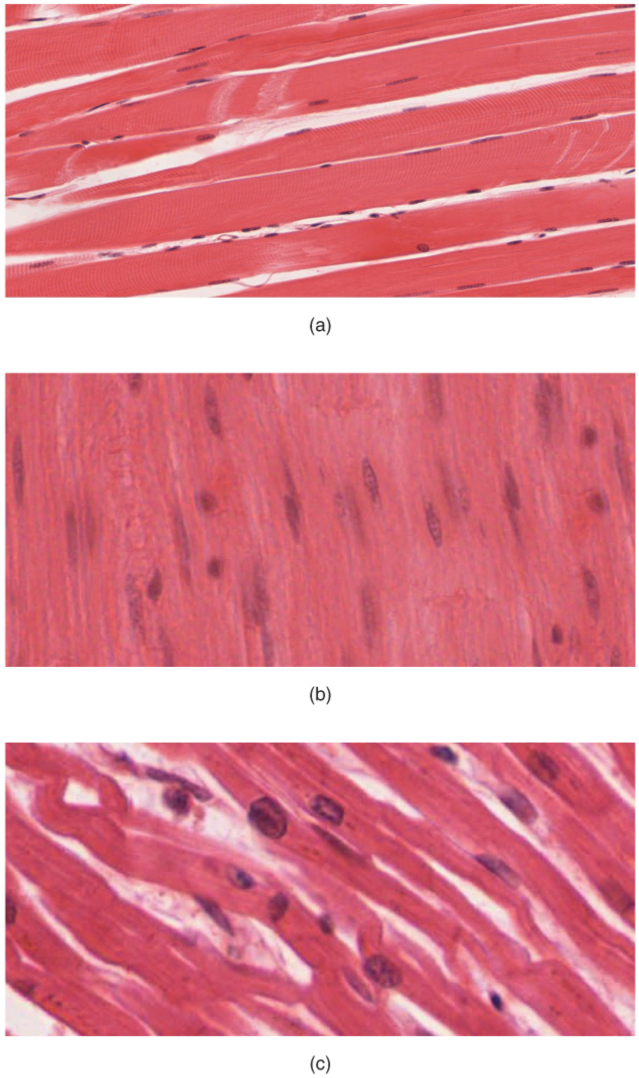


FIGURE 10.2 **The Three Types of Muscle Tissue** The body contains three types of muscle tissue: (a) skeletal muscle, (b) smooth muscle, and (c) cardiac muscle. (Micrographs provided by the Regents of University of Michigan Medical School © 2012)

The muscles all begin the actual process of contracting (shortening) when a protein called actin is pulled by a protein called myosin. This occurs in striated muscle (skeletal and cardiac) after specific binding sites on the actin have been exposed in response to the interaction between calcium ions (Ca^{++}) and proteins (troponin and tropomyosin) that "shield" the actin-binding sites. Ca^{++} also is required for the contraction of smooth muscle, although its role is different: here Ca^{++} activates enzymes, which in turn activate myosin heads. All muscles require adenosine triphosphate (ATP) to continue the process of contracting, and they all relax when the Ca^{++} is removed and the actin-binding sites are re-shielded.

A muscle can return to its original length when relaxed due to a quality of muscle tissue called **elasticity**. It can recoil back to its original length due to elastic fibers. Muscle tissue also has the quality of **extensibility**; it can stretch or extend. **Contractility** allows muscle tissue to pull on its attachment points and shorten with force.

Differences among the three muscle types include the microscopic organization of their contractile proteins—actin and myosin. The actin and myosin proteins are arranged very regularly in the cytoplasm of individual muscle cells (referred to as fibers) in both skeletal muscle and cardiac muscle, which creates a pattern, or stripes, called striations. The striations are visible with a light microscope under high magnification (see Figure 10.2). **Skeletal**

muscle fibers are multinucleated structures that compose the skeletal muscle. **Cardiac muscle** fibers each have one to two nuclei and are physically and electrically connected to each other so that the entire heart contracts as one unit (called a syncytium).

Because the actin and myosin are not arranged in such regular fashion in **smooth muscle**, the cytoplasm of a smooth muscle fiber (which has only a single nucleus) has a uniform, nonstriated appearance (resulting in the name smooth muscle). However, the less organized appearance of smooth muscle should not be interpreted as less efficient. Smooth muscle in the walls of arteries is a critical component that regulates blood pressure necessary to push blood through the circulatory system; and smooth muscle in the skin, visceral organs, and internal passageways is essential for moving all materials through the body.

10.2 Skeletal Muscle

LEARNING OBJECTIVES

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

- Describe the layers of connective tissues packaging skeletal muscle
- Explain how muscles work with tendons to move the body
- Identify areas of the skeletal muscle fibers
- Describe excitation-contraction coupling

The best-known feature of skeletal muscle is its ability to contract and cause movement. Skeletal muscles act not only to produce movement but also to stop movement, such as resisting gravity to maintain posture. Small, constant adjustments of the skeletal muscles are needed to hold a body upright or balanced in any position. Muscles also prevent excess movement of the bones and joints, maintaining skeletal stability and preventing skeletal structure damage or deformation. Joints can become misaligned or dislocated entirely by pulling on the associated bones; muscles work to keep joints stable. Skeletal muscles are located throughout the body at the openings of internal tracts to control the movement of various substances. These muscles allow functions, such as swallowing, urination, and defecation, to be under voluntary control. Skeletal muscles also protect internal organs (particularly abdominal and pelvic organs) by acting as an external barrier or shield to external trauma and by supporting the weight of the organs.

Skeletal muscles contribute to the maintenance of homeostasis in the body by generating heat. Muscle contraction requires energy, and when ATP is broken down, heat is produced. This heat is very noticeable during exercise, when sustained muscle movement causes body temperature to rise, and in cases of extreme cold, when shivering produces random skeletal muscle contractions to generate heat.

Each skeletal muscle is an organ that consists of various integrated tissues. These tissues include the skeletal muscle fibers, blood vessels, nerve fibers, and connective tissue. Each skeletal muscle has three layers of connective tissue (called “mysia”) that enclose it and provide structure to the muscle as a whole, and also compartmentalize the muscle fibers within the muscle (Figure 10.3). Each muscle is wrapped in a sheath of dense, irregular connective tissue called the **epimysium**, which allows a muscle to contract and move powerfully while maintaining its structural integrity. The epimysium also separates muscle from other tissues and organs in the area, allowing the muscle to move independently.

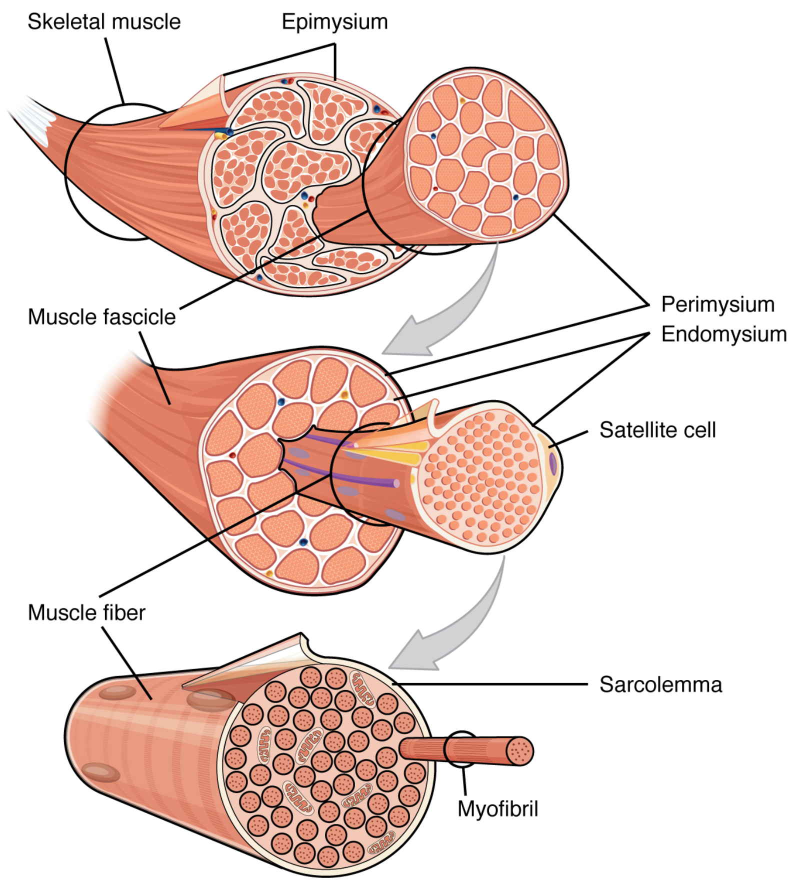


FIGURE 10.3 **The Three Connective Tissue Layers** Bundles of muscle fibers, called fascicles, are covered by the perimysium. Muscle fibers are covered by the endomysium.

Inside each skeletal muscle, muscle fibers are organized into individual bundles, each called a **fascicle**, by a middle layer of connective tissue called the **perimysium**. This fascicular organization is common in muscles of the limbs; it allows the nervous system to trigger a specific movement of a muscle by activating a subset of muscle fibers within a bundle, or fascicle of the muscle. Inside each fascicle, each muscle fiber is encased in a thin connective tissue layer of collagen and reticular fibers called the **endomysium**. The endomysium contains the extracellular fluid and nutrients to support the muscle fiber. These nutrients are supplied via blood to the muscle tissue.

In skeletal muscles that work with tendons to pull on bones, the collagen in the three tissue layers (the mysia) intertwines with the collagen of a tendon. At the other end of the tendon, it fuses with the periosteum coating the bone. The tension created by contraction of the muscle fibers is then transferred though the mysia, to the tendon, and then to the periosteum to pull on the bone for movement of the skeleton. In other places, the mysia may fuse with a broad, tendon-like sheet called an **aponeurosis**, or to fascia, the connective tissue between skin and bones. The broad sheet of connective tissue in the lower back that the latissimus dorsi muscles (the "lats") fuse into is an example of an aponeurosis.

Every skeletal muscle is also richly supplied by blood vessels for nourishment, oxygen delivery, and waste removal. In addition, every muscle fiber in a skeletal muscle is supplied by the axon branch of a somatic motor neuron, which signals the fiber to contract. Unlike cardiac and smooth muscle, the only way to functionally contract a skeletal muscle is through signaling from the nervous system.

Skeletal Muscle Fibers

Because skeletal muscle cells are long and cylindrical, they are commonly referred to as muscle fibers. Skeletal muscle fibers can be quite large for human cells, with diameters up to 100 μm and lengths up to 30 cm (11.8 in) in the Sartorius of the upper leg. During early development, embryonic myoblasts, each with its own nucleus, fuse with up to hundreds of other myoblasts to form the multinucleated skeletal muscle fibers. Multiple nuclei mean multiple copies of genes, permitting the production of the large amounts of proteins and enzymes needed for muscle contraction.

Some other terminology associated with muscle fibers is rooted in the Greek *sarco*, which means “flesh.” The plasma membrane of muscle fibers is called the **sarcolemma**, the cytoplasm is referred to as **sarcoplasm**, and the specialized smooth endoplasmic reticulum, which stores, releases, and retrieves calcium ions (Ca^{++}) is called the **sarcoplasmic reticulum (SR)** (Figure 10.4). As will soon be described, the functional unit of a skeletal muscle fiber is the sarcomere, a highly organized arrangement of the contractile myofilaments **actin** (thin filament) and **myosin** (thick filament), along with other support proteins.

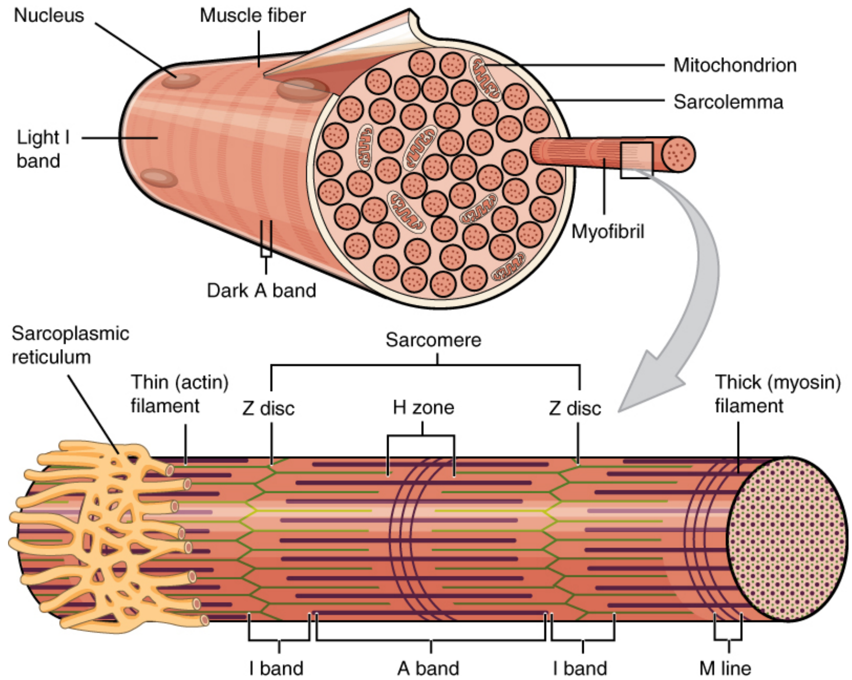


FIGURE 10.4 **Muscle Fiber** A skeletal muscle fiber is surrounded by a plasma membrane called the sarcolemma, which contains sarcoplasm, the cytoplasm of muscle cells. A muscle fiber is composed of many fibrils, which give the cell its striated appearance.

The Sarcomere

The striated appearance of skeletal muscle fibers is due to the arrangement of the myofilaments of actin and myosin in sequential order from one end of the muscle fiber to the other. Each packet of these microfilaments and their regulatory proteins, **troponin** and **tropomyosin** (along with other proteins) is called a **sarcomere**.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/micromacro) to learn more about macro- and microstructures of skeletal muscles. (a) What are the names of the “junction points” between sarcomeres? (b) What are the names of the “subunits” within the myofibrils that run the length of skeletal muscle fibers? (c) What is the “double strand of pearls” described in the video? (d) What gives a skeletal muscle fiber its striated appearance?

The sarcomere is the functional unit of the muscle fiber. The sarcomere itself is bundled within the myofibril that runs the entire length of the muscle fiber and attaches to the sarcolemma at its end. As myofibrils contract, the entire muscle cell contracts. Because myofibrils are only approximately 1.2 μm in diameter, hundreds to thousands (each with thousands of sarcomeres) can be found inside one muscle fiber. Each sarcomere is approximately 2 μm in length with a three-dimensional cylinder-like arrangement and is bordered by structures called Z-discs (also called Z-lines, because pictures are two-dimensional), to which the actin myofilaments are anchored (Figure 10.5). Because the actin and its troponin-tropomyosin complex (projecting from the Z-discs toward the center of the sarcomere) form strands that are thinner than the myosin, it is called the **thin filament** of the sarcomere. Likewise, because the myosin strands and their multiple heads (projecting from the center of the sarcomere, toward but not all to way to, the Z-discs) have more mass and are thicker, they are called the **thick filament** of the sarcomere.

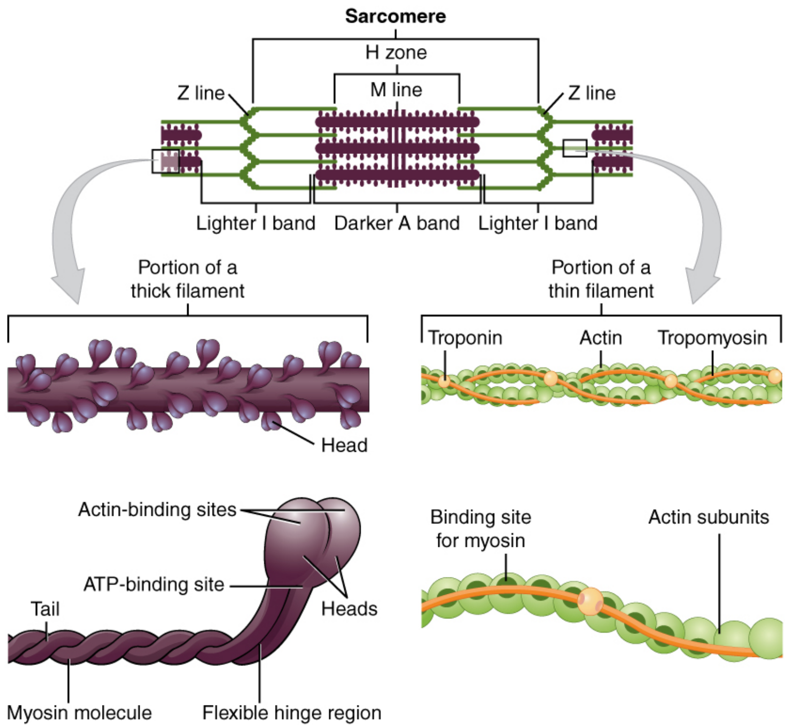


FIGURE 10.5 **The Sarcomere** The sarcomere, the region from one Z-line to the next Z-line, is the functional unit of a skeletal muscle fiber.

The Neuromuscular Junction

Another specialization of the skeletal muscle is the site where a motor neuron's terminal meets the muscle fiber—called the **neuromuscular junction (NMJ)**. This is where the muscle fiber first responds to signaling by the motor neuron. Every skeletal muscle fiber in every skeletal muscle is innervated by a motor neuron at the NMJ. Excitation signals from the neuron are the only way to functionally activate the fiber to contract.

INTERACTIVE LINK

Every skeletal muscle fiber is supplied by a motor neuron at the NMJ. Watch this video (http://openstax.org/l/skelmuscfiber) to learn more about what happens at the NMJ. (a) What is the definition of a motor unit? (b) What is the structural and functional difference between a large motor unit and a small motor unit? (c) Can you give an example of each? (d) Why is the neurotransmitter acetylcholine degraded after binding to its receptor?

Excitation-Contraction Coupling

All living cells have membrane potentials, or electrical gradients across their membranes. The inside of the membrane is usually around -60 to -90 mV, relative to the outside. This is referred to as a cell's membrane potential. Neurons and muscle cells can use their membrane potentials to generate electrical signals. They do this by controlling the movement of charged particles, called ions, across their membranes to create electrical currents. This is achieved by opening and closing specialized proteins in the membrane called ion channels. Although the currents generated by ions moving through these channel proteins are very small, they form the basis of both neural signaling and muscle contraction.

Both neurons and skeletal muscle cells are electrically excitable, meaning that they are able to generate action potentials. An action potential is a special type of electrical signal that can travel along a cell membrane as a wave. This allows a signal to be transmitted quickly and faithfully over long distances.

Although the term **excitation-contraction coupling** confuses or scares some students, it comes down to this: for a skeletal muscle fiber to contract, its membrane must first be "excited"—in other words, it must be stimulated to fire an action potential. The muscle fiber action potential, which sweeps along the sarcolemma as a wave, is "coupled" to the actual contraction through the release of calcium ions (Ca^{++}) from the SR. Once released, the Ca^{++} interacts with the shielding proteins, forcing them to move aside so that the actin-binding sites are available for attachment by myosin heads. The myosin then pulls the actin filaments toward the center, shortening the muscle fiber.

In skeletal muscle, this sequence begins with signals from the somatic motor division of the nervous system. In other words, the “excitation” step in skeletal muscles is always triggered by signaling from the nervous system (Figure 10.6).

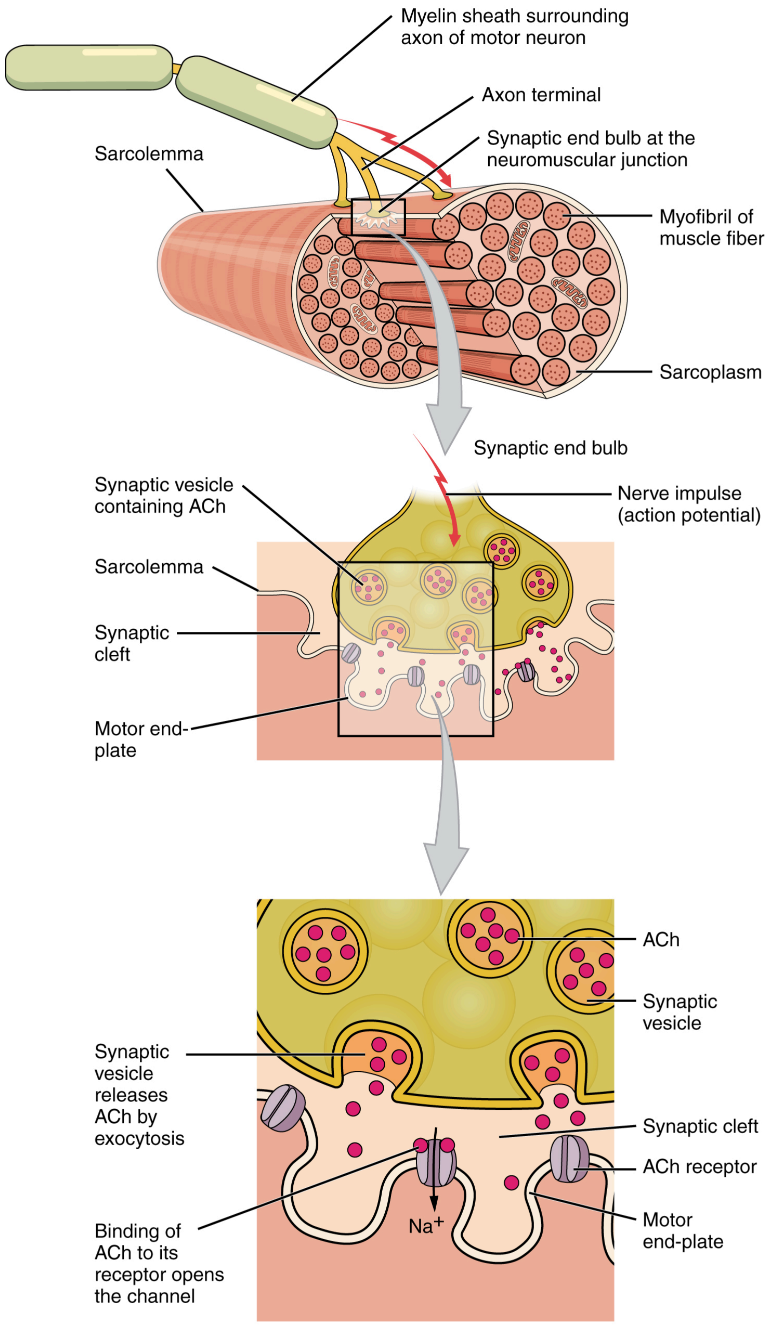


FIGURE 10.6 **Motor End-Plate and Innervation** At the NMJ, the axon terminal releases ACh. The motor end-plate is the location of the ACh-receptors in the muscle fiber sarcolemma. When ACh molecules are released, they diffuse across a minute space called the synaptic cleft and bind to the receptors.

The motor neurons that tell the skeletal muscle fibers to contract originate in the spinal cord, with a smaller number located in the brainstem for activation of skeletal muscles of the face, head, and neck. These neurons have long processes, called axons, which are specialized to transmit action potentials long distances— in this case, all the way from the spinal cord to the muscle itself (which may be up to three feet away). The axons of multiple neurons bundle together to form nerves, like wires bundled together in a cable.

Signaling begins when a neuronal **action potential** travels along the axon of a motor neuron, and then along the individual branches to terminate at the NMJ. At the NMJ, the axon terminal releases a chemical messenger, or **neurotransmitter**, called **acetylcholine (ACh)**. The ACh molecules diffuse across a minute space called the **synaptic cleft** and bind to ACh receptors located within the **motor end-plate** of the sarcolemma on the other side of the synapse. Once ACh binds, a channel in the ACh receptor opens and positively charged ions can pass through into the muscle fiber, causing it to **depolarize**, meaning that the membrane potential of the muscle fiber becomes less negative (closer to zero.)

As the membrane depolarizes, another set of ion channels called **voltage-gated sodium channels** are triggered to open. Sodium ions enter the muscle fiber, and an action potential rapidly spreads (or “fires”) along the entire membrane to initiate excitation-contraction coupling.

Things happen very quickly in the world of excitable membranes (just think about how quickly you can snap your fingers as soon as you decide to do it). Immediately following depolarization of the membrane, it repolarizes, re-establishing the negative membrane potential. Meanwhile, the ACh in the synaptic cleft is degraded by the enzyme acetylcholinesterase (AChE) so that the ACh cannot rebind to a receptor and reopen its channel, which would cause unwanted extended muscle excitation and contraction.

Propagation of an action potential along the sarcolemma is the excitation portion of excitation-contraction coupling. Recall that this excitation actually triggers the release of calcium ions (Ca^{++}) from its storage in the cell’s SR. For the action potential to reach the membrane of the SR, there are periodic invaginations in the sarcolemma, called **T-tubules** (“T” stands for “transverse”). You will recall that the diameter of a muscle fiber can be up to 100 μm, so these T-tubules ensure that the membrane can get close to the SR in the sarcoplasm. The arrangement of a T-tubule with the membranes of SR on either side is called a **triad** (Figure 10.7). The triad surrounds the cylindrical structure called a **myofibril**, which contains actin and myosin.

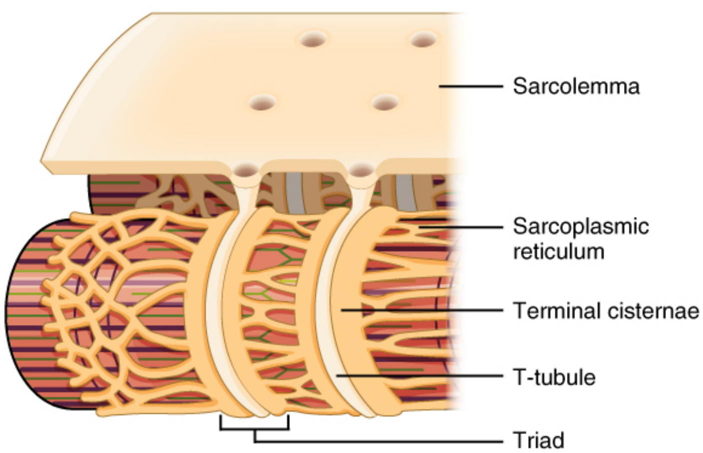


FIGURE 10.7 **The T-tubule** Narrow T-tubules permit the conduction of electrical impulses. The SR functions to regulate intracellular levels of calcium. Two terminal cisternae (where enlarged SR connects to the T-tubule) and one T-tubule comprise a triad—a “threesome” of membranes, with those of SR on two sides and the T-tubule sandwiched between them.

The T-tubules carry the action potential into the interior of the cell, which triggers the opening of calcium channels in the membrane of the adjacent SR, causing Ca^{++} to diffuse out of the SR and into the sarcoplasm. It is the arrival of Ca^{++} in the sarcoplasm that initiates contraction of the muscle fiber by its contractile units, or sarcomeres.

10.3 Muscle Fiber Contraction and Relaxation

LEARNING OBJECTIVES

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

- Describe the components involved in a muscle contraction
- Explain how muscles contract and relax
- Describe the sliding filament model of muscle contraction

The sequence of events that result in the contraction of an individual muscle fiber begins with a signal—the neurotransmitter, ACh—from the motor neuron innervating that fiber. The local membrane of the fiber will depolarize as positively charged sodium ions (Na^+) enter, triggering an action potential that spreads to the rest of the membrane which will depolarize, including the T-tubules. This triggers the release of calcium ions (Ca^{++}) from storage in the sarcoplasmic reticulum (SR). The Ca^{++} then initiates contraction, which is sustained by ATP (Figure 10.8). As long as Ca^{++} ions remain in the sarcoplasm to bind to troponin, which keeps the actin-binding sites "unshielded," and as long as ATP is available to drive the cross-bridge cycling and the pulling of actin strands by myosin, the muscle fiber will continue to shorten to an anatomical limit.

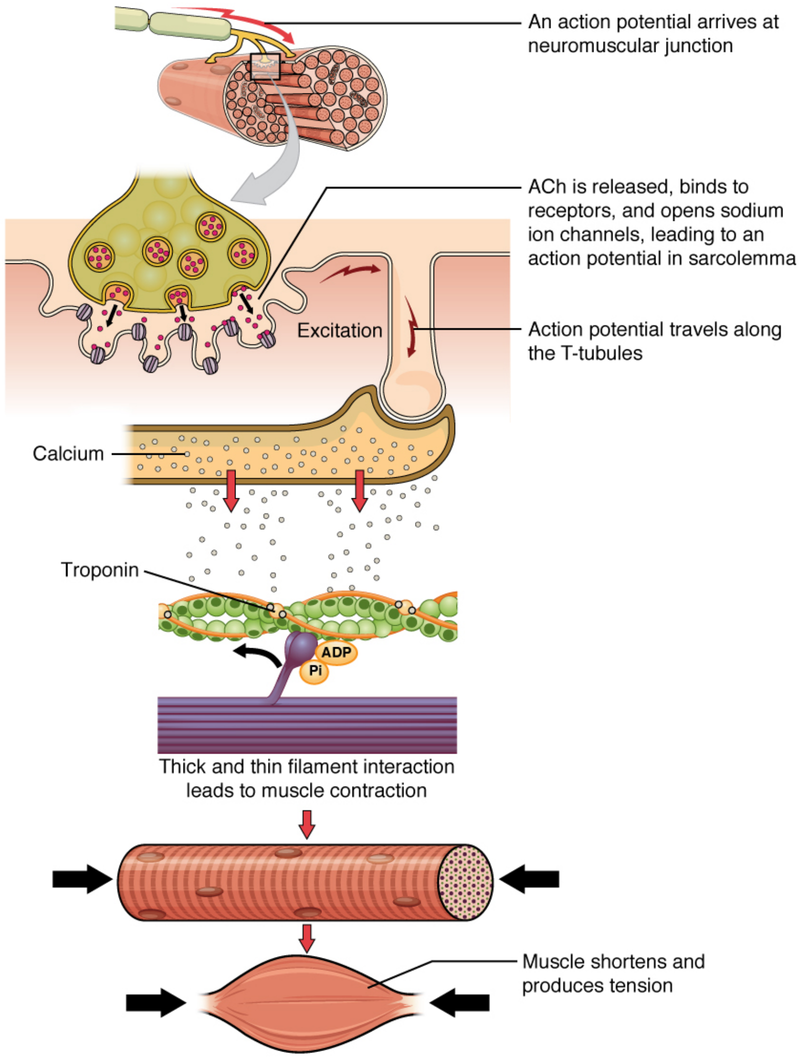


FIGURE 10.8 **Contraction of a Muscle Fiber** A cross-bridge forms between actin and the myosin heads triggering contraction. As long as Ca^{++} ions remain in the sarcoplasm to bind to troponin, and as long as ATP is available, the muscle fiber will continue to shorten.

Muscle contraction usually stops when signaling from the motor neuron ends, which repolarizes the sarcolemma and T-tubules, and closes the voltage-gated calcium channels in the SR. Ca^{++} ions are then pumped back into the SR, which causes the tropomyosin to reshield (or re-cover) the binding sites on the actin strands. A muscle also can stop contracting when it runs out of ATP and becomes fatigued (Figure 10.9).

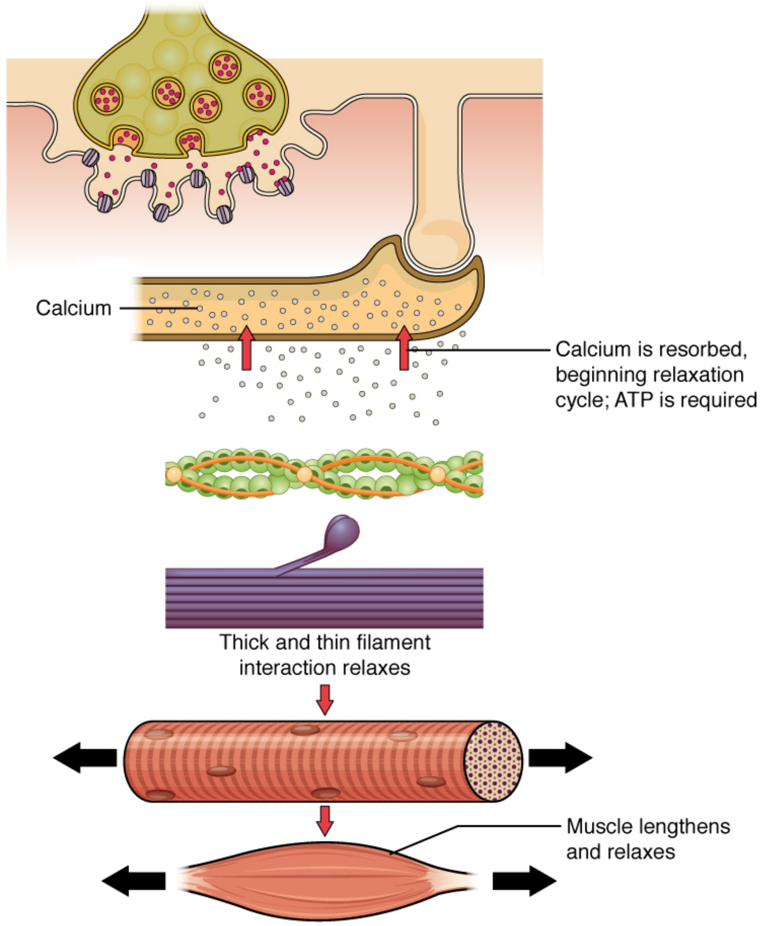


FIGURE 10.9 **Relaxation of a Muscle Fiber** Ca^{++} ions are pumped back into the SR, which causes the tropomyosin to reshield the binding sites on the actin strands. A muscle may also stop contracting when it runs out of ATP and becomes fatigued.

INTERACTIVE LINK

The release of calcium ions initiates muscle contractions. Watch this video (http://openstax.org/l/calciumrole) to learn more about the role of calcium. (a) What are "T-tubules" and what is their role? (b) Please describe how actin-binding sites are made available for cross-bridging with myosin heads during contraction.

The molecular events of muscle fiber shortening occur within the fiber's sarcomeres (see Figure 10.10). The contraction of a striated muscle fiber occurs as the sarcomeres, linearly arranged within myofibrils, shorten as myosin heads pull on the actin filaments.

The region where thick and thin filaments overlap has a dense appearance, as there is little space between the filaments. This zone where thin and thick filaments overlap is very important to muscle contraction, as it is the site where filament movement starts. Thin filaments, anchored at their ends by the Z-discs, do not extend completely into the central region that only contains thick filaments, anchored at their bases at a spot called the M-line. A myofibril is composed of many sarcomeres running along its length; thus, myofibrils and muscle cells contract as the sarcomeres contract.

The Sliding Filament Model of Contraction

When signaled by a motor neuron, a skeletal muscle fiber contracts as the thin filaments are pulled and then slide past the thick filaments within the fiber's sarcomeres. This process is known as the sliding filament model of muscle contraction (Figure 10.10). The sliding can only occur when myosin-binding sites on the actin filaments are exposed by a series of steps that begins with Ca^{++} entry into the sarcoplasm.

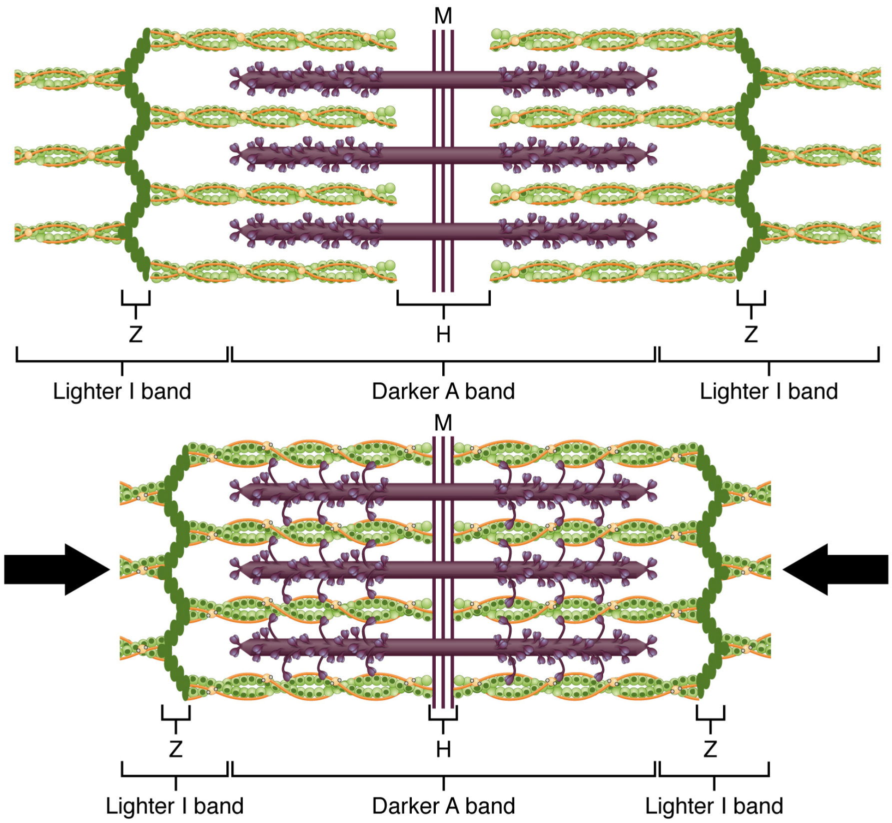


FIGURE 10.10 **The Sliding Filament Model of Muscle Contraction** When a sarcomere contracts, the Z lines move closer together, and the I band becomes smaller. The A band stays the same width. At full contraction, the thin and thick filaments overlap completely.

Tropomyosin is a protein that winds around the chains of the actin filament and covers the myosin-binding sites to prevent actin from binding to myosin. Tropomyosin binds to troponin to form a troponin-tropomyosin complex. The troponin-tropomyosin complex prevents the myosin “heads” from binding to the active sites on the actin microfilaments. Troponin also has a binding site for Ca^{++} ions.

To initiate muscle contraction, tropomyosin has to expose the myosin-binding site on an actin filament to allow cross-bridge formation between the actin and myosin microfilaments. The first step in the process of contraction is for Ca^{++} to bind to troponin so that tropomyosin can slide away from the binding sites on the actin strands. This allows the myosin heads to bind to these exposed binding sites and form cross-bridges. The thin filaments are then pulled by the myosin heads to slide past the thick filaments toward the center of the sarcomere. But each head can only pull a very short distance before it has reached its limit and must be “re-cocked” before it can pull again, a step that requires ATP.

ATP and Muscle Contraction

For thin filaments to continue to slide past thick filaments during muscle contraction, myosin heads must pull the actin at the binding sites, detach, re-cock, attach to more binding sites, pull, detach, re-cock, etc. This repeated movement is known as the cross-bridge cycle. This motion of the myosin heads is similar to the oars when an individual rows a boat: The paddle of the oars (the myosin heads) pull, are lifted from the water (detach), repositioned (re-cocked) and then immersed again to pull (Figure 10.11). Each cycle requires energy, and the action of the myosin heads in the sarcomeres repetitively pulling on the thin filaments also requires energy, which is provided by ATP.

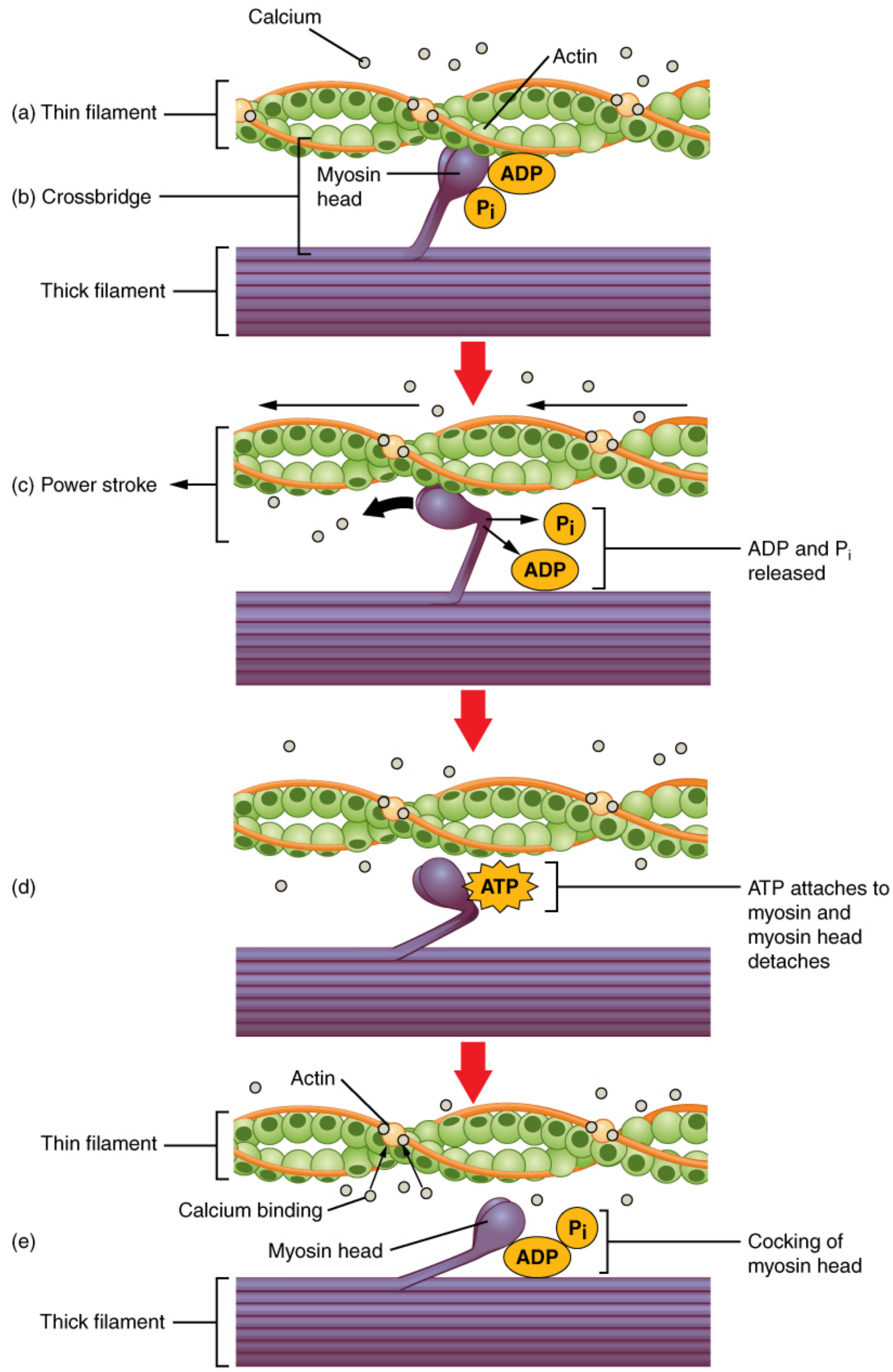


FIGURE 10.11 Skeletal Muscle Contraction (a) The active site on actin is exposed as calcium binds to troponin. (b) The myosin head is attracted to actin, and myosin binds actin at its actin-binding site, forming the cross-bridge. (c) During the power stroke, the phosphate generated in the previous contraction cycle is released. This results in the myosin head pivoting toward the center of the sarcomere, after which the attached ADP and phosphate group are released. (d) A new molecule of ATP attaches to the myosin head, causing the cross-bridge to detach. (e) The myosin head hydrolyzes ATP to ADP and phosphate, which returns the myosin to the cocked position.

Cross-bridge formation occurs when the myosin head attaches to the actin while adenosine diphosphate (ADP) and inorganic phosphate (P_i) are still bound to myosin (Figure 10.11**a,b**). P_i is then released, causing myosin to form a stronger attachment to the actin, after which the myosin head moves toward the M-line, pulling the actin along with it. As actin is pulled, the filaments move approximately 10 nm toward the M-line. This movement is called the **power stroke**, as movement of the thin filament occurs at this step (Figure 10.11**c**). In the absence of ATP, the myosin head will not detach from actin.

One part of the myosin head attaches to the binding site on the actin, but the head has another binding site for ATP.

ATP binding causes the myosin head to detach from the actin (Figure 10.11**d**). After this occurs, ATP is converted to ADP and P_i by the intrinsic **ATPase** activity of myosin. The energy released during ATP hydrolysis changes the angle of the myosin head into a cocked position (Figure 10.11**e**). The myosin head is now in position for further movement.

When the myosin head is cocked, myosin is in a high-energy configuration. This energy is expended as the myosin head moves through the power stroke, and at the end of the power stroke, the myosin head is in a low-energy position. After the power stroke, ADP is released; however, the formed cross-bridge is still in place, and actin and myosin are bound together. As long as ATP is available, it readily attaches to myosin, the cross-bridge cycle can recur, and muscle contraction can continue.

Note that each thick filament of roughly 300 myosin molecules has multiple myosin heads, and many cross-bridges form and break continuously during muscle contraction. Multiply this by all of the sarcomeres in one myofibril, all the myofibrils in one muscle fiber, and all of the muscle fibers in one skeletal muscle, and you can understand why so much energy (ATP) is needed to keep skeletal muscles working. In fact, it is the loss of ATP that results in the rigor mortis observed soon after someone dies. With no further ATP production possible, there is no ATP available for myosin heads to detach from the actin-binding sites, so the cross-bridges stay in place, causing the rigidity in the skeletal muscles.

Sources of ATP

ATP supplies the energy for muscle contraction to take place. In addition to its direct role in the cross-bridge cycle, ATP also provides the energy for the active-transport Ca^{++} pumps in the SR. Muscle contraction does not occur without sufficient amounts of ATP. The amount of ATP stored in muscle is very low, only sufficient to power a few seconds worth of contractions. As it is broken down, ATP must therefore be regenerated and replaced quickly to allow for sustained contraction. There are three mechanisms by which ATP can be regenerated in muscle cells: creatine phosphate metabolism, anaerobic glycolysis, and aerobic respiration.

Creatine phosphate is a molecule that can store energy in its phosphate bonds. In a resting muscle, excess ATP transfers its energy to creatine, producing ADP and creatine phosphate. This acts as an energy reserve that can be used to quickly create more ATP. When the muscle starts to contract and needs energy, creatine phosphate transfers its phosphate back to ADP to form ATP and creatine. This reaction is catalyzed by the enzyme creatine kinase and occurs very quickly; thus, creatine phosphate-derived ATP powers the first few seconds of muscle contraction. However, creatine phosphate can only provide approximately 15 seconds worth of energy, at which point another energy source has to be used (Figure 10.12).

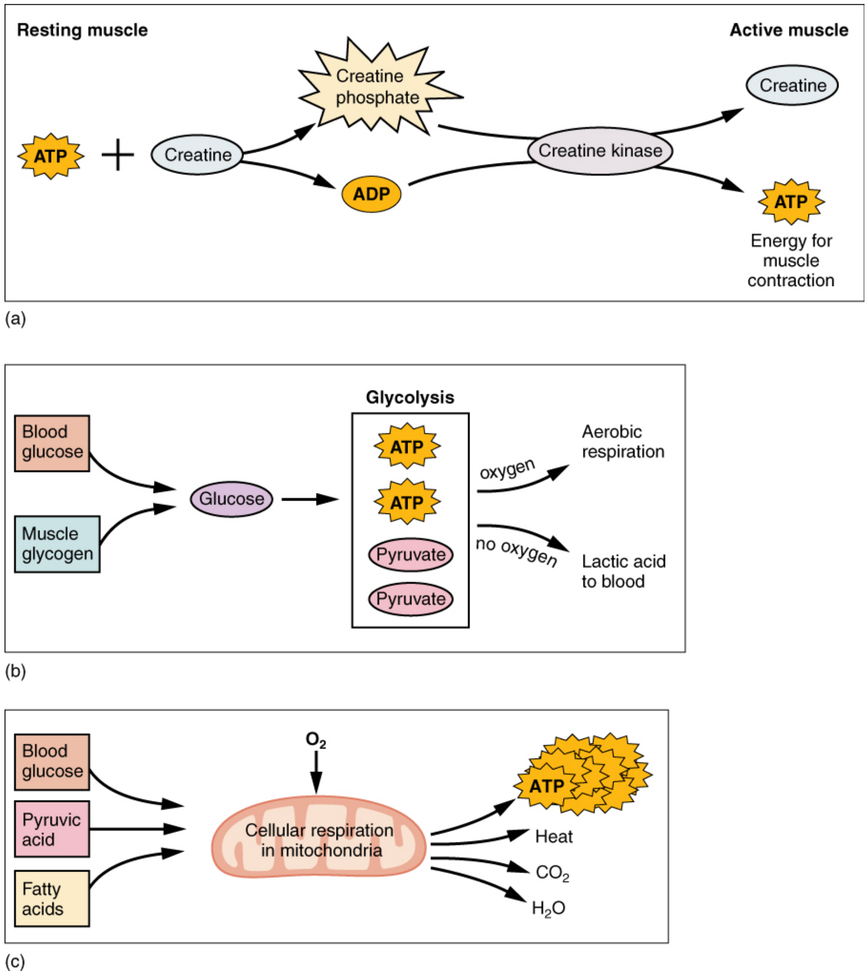


FIGURE 10.12 **Muscle Metabolism** (a) Some ATP is stored in a resting muscle. As contraction starts, it is used up in seconds. More ATP is generated from creatine phosphate for about 15 seconds. (b) Each glucose molecule produces two ATP and two molecules of pyruvic acid, which can be used in aerobic respiration or converted to lactic acid. If oxygen is not available, pyruvic acid is converted to lactic acid, which may contribute to muscle fatigue. This occurs during strenuous exercise when high amounts of energy are needed but oxygen cannot be sufficiently delivered to muscle. (c) Aerobic respiration is the breakdown of glucose in the presence of oxygen (O_2) to produce carbon dioxide, water, and ATP. Approximately 95 percent of the ATP required for resting or moderately active muscles is provided by aerobic respiration, which takes place in mitochondria.

As the ATP produced by creatine phosphate is depleted, muscles turn to glycolysis as an ATP source. **Glycolysis** is an anaerobic (non-oxygen-dependent) process that breaks down glucose (sugar) to produce ATP; however, glycolysis cannot generate ATP as quickly as creatine phosphate. Thus, the switch to glycolysis results in a slower rate of ATP availability to the muscle. The sugar used in glycolysis can be provided by blood glucose or by metabolizing glycogen that is stored in the muscle. The breakdown of one glucose molecule produces two ATP and two molecules of **pyruvic acid**, which can be used in aerobic respiration or when oxygen levels are low, converted to lactic acid (Figure 10.12**b**).

If oxygen is available, pyruvic acid is used in aerobic respiration. However, if oxygen is not available, pyruvic acid is converted to **lactic acid**, which may contribute to muscle fatigue. This conversion allows the recycling of the enzyme NAD^+ from NADH, which is needed for glycolysis to continue. This occurs during strenuous exercise when high amounts of energy are needed but oxygen cannot be sufficiently delivered to muscle. Glycolysis itself cannot be sustained for very long (approximately 1 minute of muscle activity), but it is useful in facilitating short bursts of high-intensity output. This is because glycolysis does not utilize glucose very efficiently, producing a net gain of two ATPs per molecule of glucose, and the end product of lactic acid, which may contribute to muscle fatigue as it accumulates.

Aerobic respiration is the breakdown of glucose or other nutrients in the presence of oxygen (O_2) to produce carbon dioxide, water, and ATP. Approximately 95 percent of the ATP required for resting or moderately active muscles is provided by aerobic respiration, which takes place in mitochondria. The inputs for aerobic respiration include glucose circulating in the bloodstream, pyruvic acid, and fatty acids. Aerobic respiration is much more efficient than anaerobic glycolysis, producing approximately 36 ATPs per molecule of glucose versus four from glycolysis. However, aerobic respiration cannot be sustained without a steady supply of O_2 to the skeletal muscle and is much slower (Figure 10.12**c**). To compensate, muscles store small amount of excess oxygen in proteins call myoglobin, allowing for more efficient muscle contractions and less fatigue. Aerobic training also increases the efficiency of the circulatory system so that O_2 can be supplied to the muscles for longer periods of time.

Muscle fatigue occurs when a muscle can no longer contract in response to signals from the nervous system. The exact causes of muscle fatigue are not fully known, although certain factors have been correlated with the decreased muscle contraction that occurs during fatigue. ATP is needed for normal muscle contraction, and as ATP reserves are reduced, muscle function may decline. This may be more of a factor in brief, intense muscle output rather than sustained, lower intensity efforts. Lactic acid buildup may lower intracellular pH, affecting enzyme and protein activity. Imbalances in Na^+ and K^+ levels as a result of membrane depolarization may disrupt Ca^{++} flow out of the SR. Long periods of sustained exercise may damage the SR and the sarcolemma, resulting in impaired Ca^{++} regulation.

Intense muscle activity results in an **oxygen debt**, which is the amount of oxygen needed to compensate for ATP produced without oxygen during muscle contraction. Oxygen is required to restore ATP and creatine phosphate levels, convert lactic acid to pyruvic acid, and, in the liver, to convert lactic acid into glucose or glycogen. Other systems used during exercise also require oxygen, and all of these combined processes result in the increased breathing rate that occurs after exercise. Until the oxygen debt has been met, oxygen intake is elevated, even after exercise has stopped.

Relaxation of a Skeletal Muscle

Relaxing skeletal muscle fibers, and ultimately, the skeletal muscle, begins with the motor neuron, which stops releasing its chemical signal, ACh, into the synapse at the NMJ. The muscle fiber will repolarize, which closes the gates in the SR where Ca^{++} was being released. ATP-driven pumps will move Ca^{++} out of the sarcoplasm back into the SR. This results in the “reshielding” of the actin-binding sites on the thin filaments. Without the ability to form cross-bridges between the thin and thick filaments, the muscle fiber loses its tension and relaxes.

Muscle Strength

The number of skeletal muscle fibers in a given muscle is genetically determined and does not change. Muscle strength is directly related to the amount of myofibrils and sarcomeres within each fiber. Factors, such as hormones and stress (and artificial anabolic steroids), acting on the muscle can increase the production of sarcomeres and myofibrils within the muscle fibers, a change called hypertrophy, which results in the increased mass and bulk in a skeletal muscle. Likewise, decreased use of a skeletal muscle results in atrophy, where the number of sarcomeres and myofibrils disappear (but not the number of muscle fibers). It is common for a limb in a cast to show atrophied muscles when the cast is removed, and certain diseases, such as polio, show atrophied muscles.

Disorders of the...

Muscular System

Duchenne muscular dystrophy (DMD) is a progressive weakening of the skeletal muscles. It is one of several diseases collectively referred to as “muscular dystrophy.” DMD is caused by a lack of the protein dystrophin, which helps the thin filaments of myofibrils bind to the sarcolemma. Without sufficient dystrophin, muscle contractions cause the sarcolemma to tear, causing an influx of Ca^{++}, leading to cellular damage and muscle fiber degradation. Over time, as muscle damage accumulates, muscle mass is lost, and greater functional impairments develop.

DMD is an inherited disorder caused by an abnormal X chromosome. It primarily affects males, and it is usually diagnosed in early childhood. DMD usually first appears as difficulty with balance and motion, and then progresses to an inability to walk. It continues progressing upward in the body from the lower extremities to the upper body, where it affects the muscles responsible for breathing and circulation. It ultimately causes death due to respiratory failure, and those afflicted do not usually live past their 20s.

Because DMD is caused by a mutation in the gene that codes for dystrophin, it was thought that introducing healthy myoblasts into patients might be an effective treatment. Myoblasts are the embryonic cells responsible for muscle development, and ideally, they would carry healthy genes that could produce the dystrophin needed for normal muscle contraction. This approach has been largely unsuccessful in humans. A recent approach has involved attempting to boost the muscle's production of utrophin, a protein similar to dystrophin that may be able to assume the role of dystrophin and prevent cellular damage from occurring.

10.4 Nervous System Control of Muscle Tension

LEARNING OBJECTIVES

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

- Explain concentric, isotonic, and eccentric contractions
- Describe the length-tension relationship
- Describe the three phases of a muscle twitch
- Define wave summation, tetanus, and treppe

To move an object, referred to as load, the sarcomeres in the muscle fibers of the skeletal muscle must shorten. The force generated by the contraction of the muscle (or shortening of the sarcomeres) is called **muscle tension**. However, muscle tension also is generated when the muscle is contracting against a load that does not move, resulting in two main types of skeletal muscle contractions: isotonic contractions and isometric contractions.

In **isotonic contractions**, where the tension in the muscle stays constant, a load is moved as the length of the muscle changes (shortens). There are two types of isotonic contractions: concentric and eccentric. A **concentric contraction** involves the muscle shortening to move a load. An example of this is the biceps brachii muscle contracting when a hand weight is brought upward with increasing muscle tension. As the biceps brachii contract, the angle of the elbow joint decreases as the forearm is brought toward the body. Here, the biceps brachii contracts as sarcomeres in its muscle fibers are shortening and cross-bridges form; the myosin heads pull the actin. An **eccentric contraction** occurs as the muscle tension diminishes and the muscle lengthens. In this case, the hand weight is lowered in a slow and controlled manner as the amount of cross-bridges being activated by nervous system stimulation decreases. In this case, as tension is released from the biceps brachii, the angle of the elbow joint increases. Eccentric contractions are also used for movement and balance of the body.

An **isometric contraction** occurs as the muscle produces tension without changing the angle of a skeletal joint. Isometric contractions involve sarcomere shortening and increasing muscle tension, but do not move a load, as the force produced cannot overcome the resistance provided by the load. For example, if one attempts to lift a hand weight that is too heavy, there will be sarcomere activation and shortening to a point, and ever-increasing muscle tension, but no change in the angle of the elbow joint. In everyday living, isometric contractions are active in maintaining posture and maintaining bone and joint stability. However, holding your head in an upright position occurs not because the muscles cannot move the head, but because the goal is to remain stationary and not produce movement. Most actions of the body are the result of a combination of isotonic and isometric contractions working together to produce a wide range of outcomes (Figure 10.13).

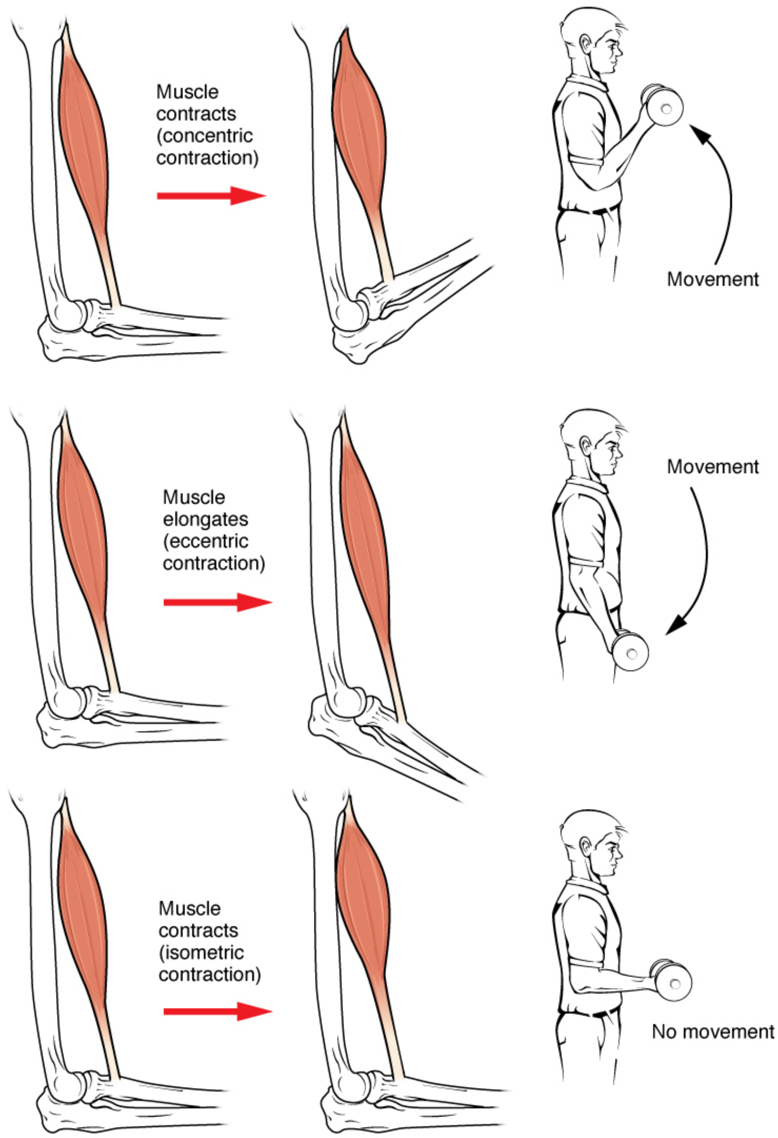


FIGURE 10.13 **Types of Muscle Contractions** During isotonic contractions, muscle length changes to move a load. During isometric contractions, muscle length does not change because the load exceeds the tension the muscle can generate.

All of these muscle activities are under the exquisite control of the nervous system. Neural control regulates concentric, eccentric and isometric contractions, muscle fiber recruitment, and muscle tone. A crucial aspect of nervous system control of skeletal muscles is the role of motor units.

Motor Units

As you have learned, every skeletal muscle fiber must be innervated by the axon terminal of a motor neuron in order to contract. Each muscle fiber is innervated by only one motor neuron. The actual group of muscle fibers in a muscle innervated by a single motor neuron is called a **motor unit**. The size of a motor unit is variable depending on the nature of the muscle.

A small motor unit is an arrangement where a single motor neuron supplies a small number of muscle fibers in a muscle. Small motor units permit very fine motor control of the muscle. The best example in humans is the small motor units of the extraocular eye muscles that move the eyeballs. There are thousands of muscle fibers in each muscle, but every six or so fibers are supplied by a single motor neuron, as the axons branch to form synaptic connections at their individual NMJs. This allows for exquisite control of eye movements so that both eyes can quickly focus on the same object. Small motor units are also involved in the many fine movements of the fingers and thumb of the hand for grasping, texting, etc.

A large motor unit is an arrangement where a single motor neuron supplies a large number of muscle fibers in a muscle. Large motor units are concerned with simple, or “gross,” movements, such as powerfully extending the knee joint. The best example is the large motor units of the thigh muscles or back muscles, where a single motor neuron will supply thousands of muscle fibers in a muscle, as its axon splits into thousands of branches.

There is a wide range of motor units within many skeletal muscles, which gives the nervous system a wide range of control over the muscle. The small motor units in the muscle will have smaller, lower-threshold motor neurons that are more excitable, firing first to their skeletal muscle fibers, which also tend to be the smallest. Activation of these smaller motor units, results in a relatively small degree of contractile strength (tension) generated in the muscle. As more strength is needed, larger motor units, with bigger, higher-threshold motor neurons are enlisted to activate larger muscle fibers. This increasing activation of motor units produces an increase in muscle contraction known as **recruitment**. As more motor units are recruited, the muscle contraction grows progressively stronger. In some muscles, the largest motor units may generate a contractile force of 50 times more than the smallest motor units in the muscle. This allows a feather to be picked up using the biceps brachii arm muscle with minimal force, and a heavy weight to be lifted by the same muscle by recruiting the largest motor units.

When necessary, the maximal number of motor units in a muscle can be recruited simultaneously, producing the maximum force of contraction for that muscle, but this cannot last for very long because of the energy requirements to sustain the contraction. To prevent complete muscle fatigue, motor units are generally not all simultaneously active, but instead some motor units rest while others are active, which allows for longer muscle contractions. The nervous system uses recruitment as a mechanism to efficiently utilize a skeletal muscle.

The Length-Tension Range of a Sarcomere

When a skeletal muscle fiber contracts, myosin heads attach to actin to form cross-bridges followed by the thin filaments sliding over the thick filaments as the heads pull the actin, and this results in sarcomere shortening, creating the tension of the muscle contraction. The cross-bridges can only form where thin and thick filaments already overlap, so that the length of the sarcomere has a direct influence on the force generated when the sarcomere shortens. This is called the length-tension relationship.

The ideal length of a sarcomere to produce maximal tension occurs at 80 percent to 120 percent of its resting length, with 100 percent being the state where the medial edges of the thin filaments are just at the most-medial myosin heads of the thick filaments (Figure 10.14). This length maximizes the overlap of actin-binding sites and myosin heads. If a sarcomere is stretched past this ideal length (beyond 120 percent), thick and thin filaments do not overlap sufficiently, which results in less tension produced. If a sarcomere is shortened beyond 80 percent, the zone of overlap is reduced with the thin filaments jutting beyond the last of the myosin heads and shrinks the H zone, which is normally composed of myosin tails. Eventually, there is nowhere else for the thin filaments to go and the amount of tension is diminished. If the muscle is stretched to the point where thick and thin filaments do not overlap at all, no cross-bridges can be formed, and no tension is produced in that sarcomere. This amount of stretching does not usually occur, as accessory proteins and connective tissue oppose extreme stretching.

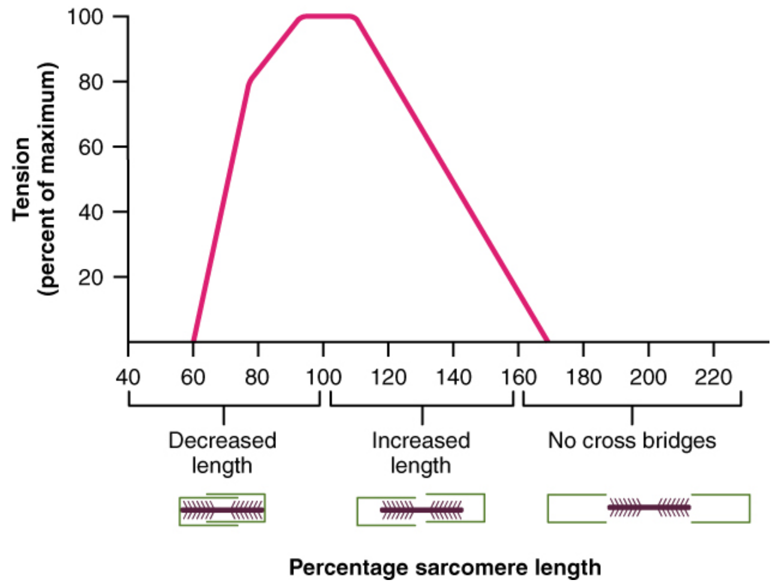


FIGURE 10.14 **The Ideal Length of a Sarcomere** Sarcomeres produce maximal tension when thick and thin filaments overlap between about 80 percent to 120 percent.

The Frequency of Motor Neuron Stimulation

A single action potential from a motor neuron will produce a single contraction in the muscle fibers of its motor unit. This isolated contraction is called a **twitch**. A twitch can last for a few milliseconds or 100 milliseconds, depending on the muscle type. The tension produced by a single twitch can be measured by a **myogram**, an instrument that measures the amount of tension produced over time (Figure 10.15). Each twitch undergoes three phases. The first phase is the **latent period**, during which the action potential is being propagated along the sarcolemma and Ca^{++} ions are released from the SR. This is the phase during which excitation and contraction are being coupled but contraction has yet to occur. The **contraction phase** occurs next. The Ca^{++} ions in the sarcoplasm have bound to troponin, tropomyosin has shifted away from actin-binding sites, cross-bridges have formed, and sarcomeres are actively shortening to the point of peak tension. The last phase is the **relaxation phase**, when tension decreases as contraction stops. Ca^{++} ions are pumped out of the sarcoplasm into the SR, and cross-bridge cycling stops, returning the muscle fibers to their resting state.

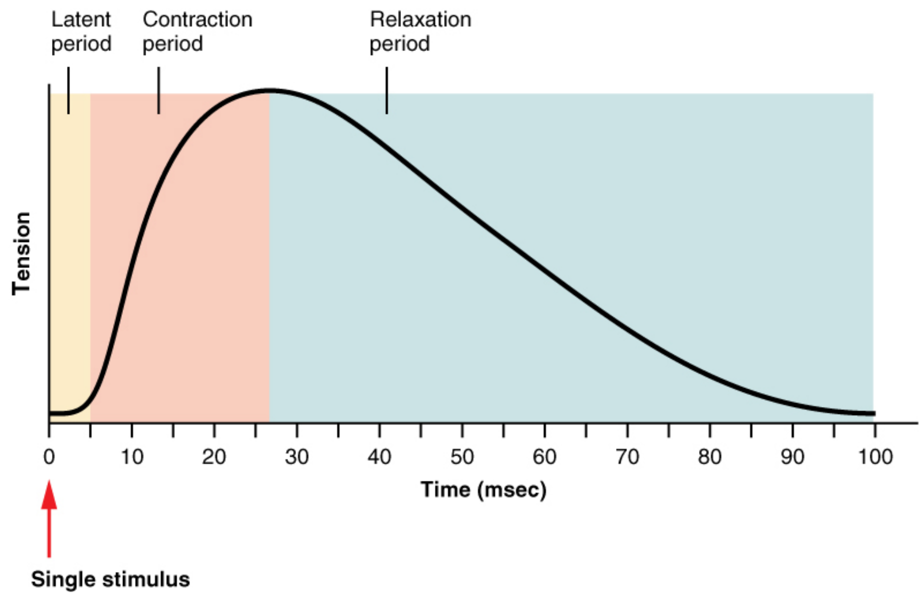


FIGURE 10.15 **A Myogram of a Muscle Twitch** A single muscle twitch has a latent period, a contraction phase when tension increases, and a relaxation phase when tension decreases. During the latent period, the action potential is being propagated along the sarcolemma. During the contraction phase, Ca^{++} ions in the sarcoplasm bind to troponin, tropomyosin moves from actin-binding sites, cross-bridges form, and sarcomeres shorten. During the relaxation phase, tension decreases as Ca^{++} ions are pumped out of the sarcoplasm and cross-bridge cycling stops.

Although a person can experience a muscle "twitch," a single twitch does not produce any significant muscle activity in a living body. A series of action potentials to the muscle fibers is necessary to produce a muscle contraction that can produce work. Normal muscle contraction is more sustained, and it can be modified by input from the nervous system to produce varying amounts of force; this is called a **graded muscle response**. The frequency of action potentials (nerve impulses) from a motor neuron and the number of motor neurons transmitting action potentials both affect the tension produced in skeletal muscle.

The rate at which a motor neuron fires action potentials affects the tension produced in the skeletal muscle. If the fibers are stimulated while a previous twitch is still occurring, the second twitch will be stronger. This response is called **wave summation**, because the excitation-contraction coupling effects of successive motor neuron signaling is summed, or added together (Figure 10.16**a**). At the molecular level, summation occurs because the second stimulus triggers the release of more Ca^{++} ions, which become available to activate additional sarcomeres while the muscle is still contracting from the first stimulus. Summation results in greater contraction of the motor unit.

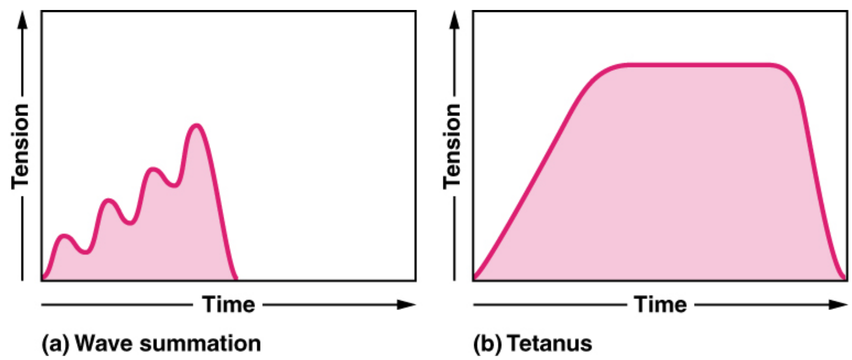


FIGURE 10.16 **Wave Summation and Tetanus** (a) The excitation-contraction coupling effects of successive motor neuron signaling is added together which is referred to as wave summation. The bottom of each wave, the end of the relaxation phase, represents the point of stimulus. (b) When the stimulus frequency is so high that the relaxation phase disappears completely, the contractions become continuous; this is called tetanus.

If the frequency of motor neuron signaling increases, summation and subsequent muscle tension in the motor unit continues to rise until it reaches a peak point. The tension at this point is about three to four times greater than the tension of a single twitch, a state referred to as incomplete tetanus. During incomplete tetanus, the muscle goes through quick cycles of contraction with a short relaxation phase for each. If the stimulus frequency is so high that the relaxation phase disappears completely, contractions become continuous in a process called complete **tetanus** (Figure 10.16**b**).

During tetanus, the concentration of Ca^{++} ions in the sarcoplasm allows virtually all of the sarcomeres to form cross-bridges and shorten, so that a contraction can continue uninterrupted (until the muscle fatigues and can no longer produce tension).

Treppe

When a skeletal muscle has been dormant for an extended period and then activated to contract, with all other things being equal, the initial contractions generate about one-half the force of later contractions. The muscle tension increases in a graded manner that to some looks like a set of stairs. This tension increase is called **treppe**, a condition where muscle contractions become more efficient. It's also known as the "staircase effect" (Figure 10.17).

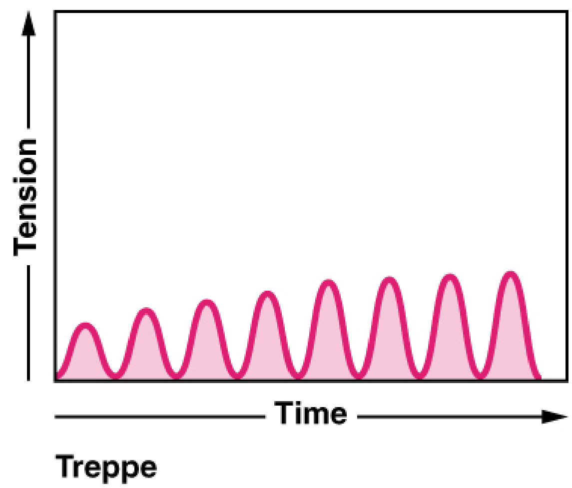


FIGURE 10.17 **Treppe** When muscle tension increases in a graded manner that looks like a set of stairs, it is called treppe. The bottom of each wave represents the point of stimulus.

It is believed that treppe results from a higher concentration of Ca^{++} in the sarcoplasm resulting from the steady stream of signals from the motor neuron. It can only be maintained with adequate ATP.

Muscle Tone

Skeletal muscles are rarely completely relaxed, or flaccid. Even if a muscle is not producing movement, it is contracted a small amount to maintain its contractile proteins and produce **muscle tone**. The tension produced by muscle tone allows muscles to continually stabilize joints and maintain posture.

Muscle tone is accomplished by a complex interaction between the nervous system and skeletal muscles that results in the activation of a few motor units at a time, most likely in a cyclical manner. In this manner, muscles never fatigue completely, as some motor units can recover while others are active.

The absence of the low-level contractions that lead to muscle tone is referred to as **hypotonia**, and can result from damage to parts of the central nervous system (CNS), such as the cerebellum, or from loss of innervations to a skeletal muscle, as in poliomyelitis. Hypotonic muscles have a flaccid appearance and display functional impairments, such as weak reflexes. Conversely, excessive muscle tone is referred to as **hypertonia**, accompanied by hyperreflexia (excessive reflex responses), often the result of damage to upper motor neurons in the CNS. Hypertonia can present with muscle rigidity (as seen in Parkinson’s disease) or spasticity, a phasic change in muscle tone, where a limb will “snap” back from passive stretching (as seen in some strokes).

10.5 Types of Muscle Fibers

LEARNING OBJECTIVES

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

- Describe the types of skeletal muscle fibers
- Explain fast and slow muscle fibers

Two criteria to consider when classifying the types of muscle fibers are how fast some fibers contract relative to others, and how fibers produce ATP. Using these criteria, there are three main types of skeletal muscle fibers. **Slow oxidative (SO)** fibers contract relatively slowly and use aerobic respiration (oxygen and glucose) to produce ATP. **Fast oxidative (FO)** fibers have fast contractions and primarily use aerobic respiration, but because they may switch to anaerobic respiration (glycolysis), can fatigue more quickly than SO fibers. Lastly, **fast glycolytic (FG)** fibers have fast contractions and primarily use anaerobic glycolysis. The FG fibers fatigue more quickly than the others. Most skeletal muscles in a human contain(s) all three types, although in varying proportions.

The speed of contraction is dependent on how quickly myosin’s ATPase hydrolyzes ATP to produce cross-bridge action. Fast fibers hydrolyze ATP approximately twice as quickly as slow fibers, resulting in much quicker cross-bridge cycling (which pulls the thin filaments toward the center of the sarcomeres at a faster rate). The primary metabolic pathway used by a muscle fiber determines whether the fiber is classified as oxidative or glycolytic. If a fiber primarily produces ATP through aerobic pathways it is oxidative. More ATP can be produced during each metabolic cycle, making the fiber more resistant to fatigue. Glycolytic fibers primarily create ATP through anaerobic glycolysis, which produces less ATP per cycle. As a result, glycolytic fibers fatigue at a quicker rate.

The oxidative fibers contain many more mitochondria than the glycolytic fibers, because aerobic metabolism, which uses oxygen (O_2) in the metabolic pathway, occurs in the mitochondria. The SO fibers possess a large number of mitochondria and are capable of contracting for longer periods because of the large amount of ATP they can produce, but they have a relatively small diameter and do not produce a large amount of tension. SO fibers are extensively supplied with blood capillaries to supply O_2 from the red blood cells in the bloodstream. The SO fibers also possess myoglobin, an O_2-carrying molecule similar to O_2-carrying hemoglobin in the red blood cells. The myoglobin stores some of the needed O_2 within the fibers themselves (and gives SO fibers their red color). All of these features allow SO fibers to produce large quantities of ATP, which can sustain muscle activity without fatiguing for long periods of time.

The fact that SO fibers can function for long periods without fatiguing makes them useful in maintaining posture, producing isometric contractions, stabilizing bones and joints, and making small movements that happen often but do not require large amounts of energy. They do not produce high tension, and thus they are not used for powerful, fast movements that require high amounts of energy and rapid cross-bridge cycling.

FO fibers are sometimes called intermediate fibers because they possess characteristics that are intermediate between fast fibers and slow fibers. They produce ATP relatively quickly, more quickly than SO fibers, and thus can produce relatively high amounts of tension. They are oxidative because they produce ATP aerobically, possess high amounts of mitochondria, and do not fatigue quickly. However, FO fibers do not possess significant myoglobin, giving them a lighter color than the red SO fibers. FO fibers are used primarily for movements, such as walking, that require more energy than postural control but less energy than an explosive movement, such as sprinting. FO fibers are useful for this type of movement because they produce more tension than SO fibers but they are more fatigue-resistant than FG fibers.

FG fibers primarily use anaerobic glycolysis as their ATP source. They have a large diameter and possess high amounts of glycogen, which is used in glycolysis to generate ATP quickly to produce high levels of tension. Because they do not primarily use aerobic metabolism, they do not possess substantial numbers of mitochondria or significant amounts of myoglobin and therefore have a white color. FG fibers are used to produce rapid, forceful contractions to make quick, powerful movements. These fibers fatigue quickly, permitting them to only be used for short periods. Most muscles possess a mixture of each fiber type. The predominant fiber type in a muscle is determined by the primary function of the muscle.

10.6 Exercise and Muscle Performance

LEARNING OBJECTIVES

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

- Describe hypertrophy and atrophy
- Explain how resistance exercise builds muscle
- Explain how performance-enhancing substances affect muscle

Physical training alters the appearance of skeletal muscles and can produce changes in muscle performance. Conversely, a lack of use can result in decreased performance and muscle appearance. Although muscle cells can change in size, new cells are not formed when muscles grow. Instead, structural proteins are added to muscle fibers in a process called **hypertrophy**, so cell diameter increases. The reverse, when structural proteins are lost and muscle mass decreases, is called **atrophy**. Age-related muscle atrophy is called **sarcopenia**. Cellular components of muscles can also undergo changes in response to changes in muscle use.

Endurance Exercise

Slow fibers are predominantly used in endurance exercises that require little force but involve numerous repetitions. The aerobic metabolism used by slow-twitch fibers allows them to maintain contractions over long periods. Endurance training modifies these slow fibers to make them even more efficient by producing more mitochondria to enable more aerobic metabolism and more ATP production. Endurance exercise can also increase the amount of myoglobin in a cell, as increased aerobic respiration increases the need for oxygen. Myoglobin is found in the sarcoplasm and acts as an oxygen storage supply for the mitochondria.

The training can trigger the formation of more extensive capillary networks around the fiber, a process called **angiogenesis**, to supply oxygen and remove metabolic waste. To allow these capillary networks to supply the deep portions of the muscle, muscle mass does not greatly increase in order to maintain a smaller area for the diffusion of nutrients and gases. All of these cellular changes result in the ability to sustain low levels of muscle contractions for greater periods without fatiguing.

The proportion of SO muscle fibers in muscle determines the suitability of that muscle for endurance, and may benefit those participating in endurance activities. Postural muscles have a large number of SO fibers and relatively few FO and FG fibers, to keep the back straight (Figure 10.18). Endurance athletes, like marathon-runners also would benefit from a larger proportion of SO fibers, but it is unclear if the most-successful marathoners are those with naturally high numbers of SO fibers, or whether the most successful marathon runners develop high numbers of SO fibers with repetitive training. Endurance training can result in overuse injuries such as stress fractures and joint and tendon inflammation.

FIGURE 10.18 **Marathoners** Long-distance runners have a large number of SO fibers and relatively few FO and FG fibers. (credit: "Tseo2"/Wikimedia Commons)

Resistance Exercise

Resistance exercises, as opposed to endurance exercise, require large amounts of FG fibers to produce short, powerful movements that are not repeated over long periods. The high rates of ATP hydrolysis and cross-bridge formation in FG fibers result in powerful muscle contractions. Muscles used for power have a higher ratio of FG to SO/FO fibers, and trained athletes possess even higher levels of FG fibers in their muscles. Resistance exercise affects muscles by increasing the formation of myofibrils, thereby increasing the thickness of muscle fibers. This added structure causes hypertrophy, or the enlargement of muscles, exemplified by the large skeletal muscles seen in body builders and other athletes (Figure 10.19). Because this muscular enlargement is achieved by the addition of structural proteins, athletes trying to build muscle mass often ingest large amounts of protein.

FIGURE 10.19 **Hypertrophy** Body builders have a large number of FG fibers and relatively few FO and SO fibers. (credit: Lin Mei/flickr)

Except for the hypertrophy that follows an increase in the number of sarcomeres and myofibrils in a skeletal muscle, the cellular changes observed during endurance training do not usually occur with resistance training. There is usually no significant increase in mitochondria or capillary density. However, resistance training does increase the development of connective tissue, which adds to the overall mass of the muscle and helps to contain muscles as they produce increasingly powerful contractions. Tendons also become stronger to prevent tendon damage, as the force produced by muscles is transferred to tendons that attach the muscle to bone.

For effective strength training, the intensity of the exercise must continually be increased. For instance, continued weight lifting without increasing the weight of the load does not increase muscle size. To produce ever-greater results, the weights lifted must become increasingly heavier, making it more difficult for muscles to move the load. The muscle then adapts to this heavier load, and an even heavier load must be used if even greater muscle mass is desired.

If done improperly, resistance training can lead to overuse injuries of the muscle, tendon, or bone. These injuries can occur if the load is too heavy or if the muscles are not given sufficient time between workouts to recover or if joints are not aligned properly during the exercises. Cellular damage to muscle fibers that occurs after intense exercise includes damage to the sarcolemma and myofibrils. This muscle damage contributes to the feeling of soreness after strenuous exercise, but muscles gain mass as this damage is repaired, and additional structural proteins are added to replace the damaged ones. Overworking skeletal muscles can also lead to tendon damage and even skeletal damage if the load is too great for the muscles to bear.

Performance-Enhancing Substances

Some athletes attempt to boost their performance by using various agents that may enhance muscle performance. Anabolic steroids are one of the more widely known agents used to boost muscle mass and increase power output. Anabolic steroids are a form of testosterone, a male sex hormone that stimulates muscle formation, leading to increased muscle mass.

Endurance athletes may also try to boost the availability of oxygen to muscles to increase aerobic respiration by using substances such as erythropoietin (EPO), a hormone normally produced in the kidneys, which triggers the production of red blood cells. The extra oxygen carried by these blood cells can then be used by muscles for aerobic respiration. Human growth hormone (hGH) is another supplement, and although it can facilitate building muscle mass, its main role is to promote the healing of muscle and other tissues after strenuous exercise. Increased hGH may allow for faster recovery after muscle damage, reducing the rest required after exercise, and allowing for more sustained high-level performance.

Although performance-enhancing substances often do improve performance, most are banned by governing bodies in sports and are illegal for nonmedical purposes. Their use to enhance performance raises ethical issues of cheating because they give users an unfair advantage over nonusers. A greater concern, however, is that their use carries serious health risks. The side effects of these substances are often significant, nonreversible, and in some cases fatal. The physiological strain caused by these substances is often greater than what the body can handle, leading to effects that are unpredictable and dangerous. Anabolic steroid use has been linked to infertility, aggressive behavior, cardiovascular disease, and brain cancer.

Similarly, some athletes have used creatine to increase power output. Creatine phosphate provides quick bursts of ATP to muscles in the initial stages of contraction. Increasing the amount of creatine available to cells is thought to produce more ATP and therefore increase explosive power output, although its effectiveness as a supplement has been questioned.

Everyday Connection

Aging and Muscle Tissue

Although atrophy due to disuse can often be reversed with exercise, muscle atrophy with age, referred to as sarcopenia, is irreversible. This is a primary reason why even highly trained athletes succumb to declining performance with age. This decline is noticeable in athletes whose sports require strength and powerful movements, such as sprinting, whereas the effects of age are less noticeable in endurance athletes such as marathon runners or long-distance cyclists. As muscles age, muscle fibers die, and they are replaced by connective tissue and adipose tissue (Figure 10.20). Because those tissues cannot contract and generate force as muscle can, muscles lose the ability to produce powerful contractions. The decline in muscle mass causes a loss of strength, including the strength required for posture and mobility. This may be caused by a reduction in FG fibers that hydrolyze ATP quickly to produce short, powerful contractions. Muscles in older people sometimes possess greater numbers of SO fibers, which are responsible for longer contractions and do not produce powerful movements. There may also be a reduction in the size of motor units, resulting in fewer fibers being stimulated and less muscle tension being produced.

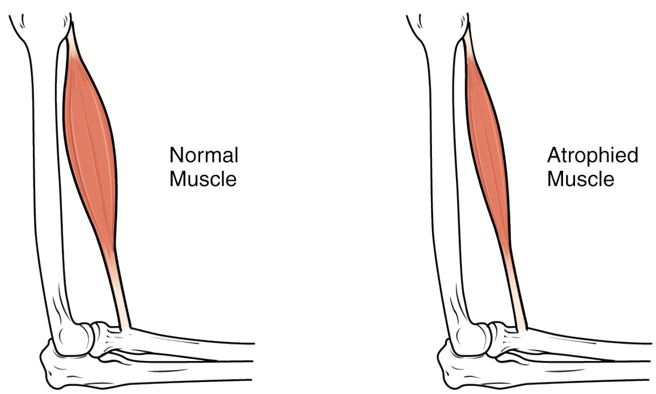


FIGURE 10.20 **Atrophy** Muscle mass is reduced as muscles atrophy with disuse.

Sarcopenia can be delayed to some extent by exercise, as training adds structural proteins and causes cellular changes that can offset the effects of atrophy. Increased exercise can produce greater numbers of cellular mitochondria, increase capillary density, and increase the mass and strength of connective tissue. The effects of age-related atrophy are especially pronounced in people who are sedentary, as the loss of muscle cells is displayed as functional impairments such as trouble with locomotion, balance, and posture. This can lead to a decrease in quality of life and medical problems, such as joint problems because the muscles that stabilize bones and joints are weakened. Problems with locomotion and balance can also cause various injuries due to falls.

10.7 Cardiac Muscle Tissue

LEARNING OBJECTIVES

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

- Describe intercalated discs and gap junctions
- Describe a desmosome

Cardiac muscle tissue is only found in the heart. Highly coordinated contractions of cardiac muscle pump blood into the vessels of the circulatory system. Similar to skeletal muscle, cardiac muscle is striated and organized into sarcomeres, possessing the same banding organization as skeletal muscle (Figure 10.21). However, cardiac muscle fibers are shorter than skeletal muscle fibers and usually contain only one nucleus, which is located in the central region of the cell. Cardiac muscle fibers also possess many mitochondria and myoglobin, as ATP is produced primarily through aerobic metabolism. Cardiac muscle fibers cells also are extensively branched and are connected to one another at their ends by intercalated discs. An **intercalated disc** allows the cardiac muscle cells to contract in a wave-like pattern so that the heart can work as a pump.

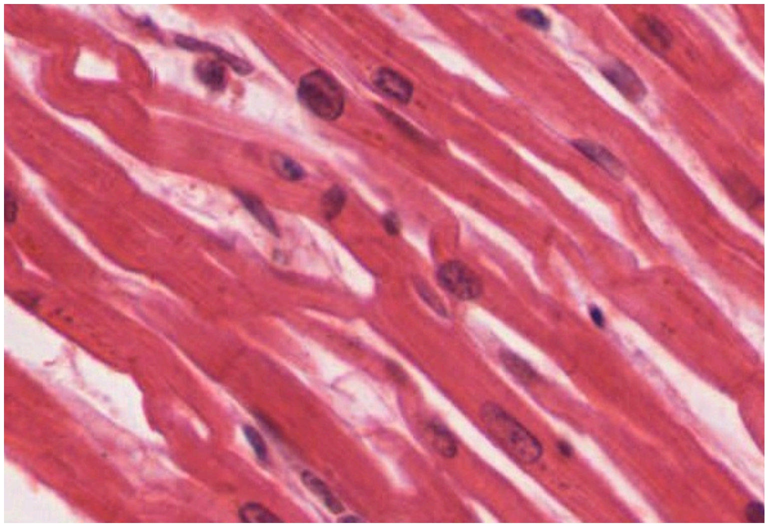


FIGURE 10.21 **Cardiac Muscle Tissue** Cardiac muscle tissue is only found in the heart. LM × 1600. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

INTERACTIVE LINK

View the University of Michigan WebScope (http://openstax.org/l/cardmuscleMG) to explore the tissue sample in greater detail.

Intercalated discs are part of the sarcolemma and contain two structures important in cardiac muscle contraction: gap junctions and desmosomes. A gap junction forms channels between adjacent cardiac muscle fibers that allow the depolarizing current produced by cations to flow from one cardiac muscle cell to the next. This joining is called electric coupling, and in cardiac muscle it allows the quick transmission of action potentials and the coordinated contraction of the entire heart. This network of electrically connected cardiac muscle cells creates a functional unit of contraction called a syncytium. The remainder of the intercalated disc is composed of desmosomes. A **desmosome** is a cell structure that anchors the ends of cardiac muscle fibers together so the cells do not pull apart during the stress of individual fibers contracting (Figure 10.22).

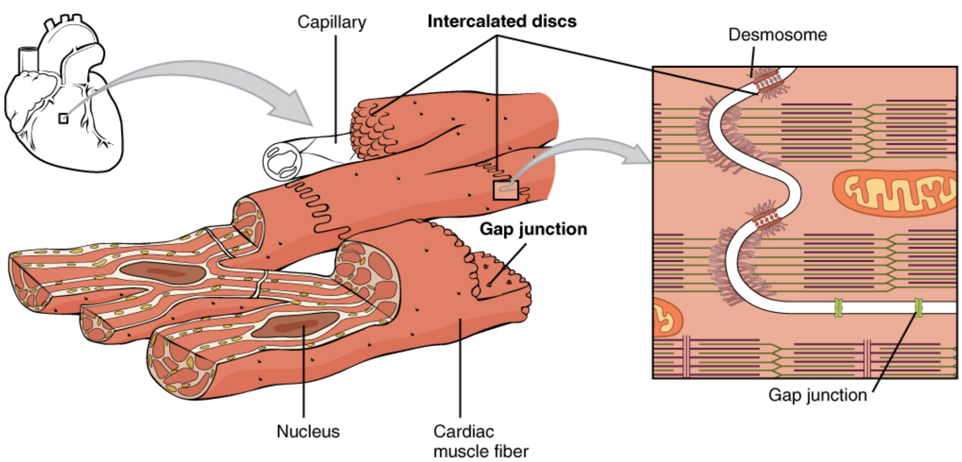


FIGURE 10.22 **Cardiac Muscle** Intercalated discs are part of the cardiac muscle sarcolemma and they contain gap junctions and desmosomes.

Contractions of the heart (heartbeats) are controlled by specialized cardiac muscle cells called pacemaker cells that directly control heart rate. Although cardiac muscle cannot be consciously controlled, the pacemaker cells respond to signals from the autonomic nervous system (ANS) to speed up or slow down the heart rate. The pacemaker cells can also respond to various hormones that modulate heart rate to control blood pressure.

The wave of contraction that allows the heart to work as a unit, called a functional syncytium, begins with the pacemaker cells. This group of cells is self-excitable and able to depolarize to threshold and fire action potentials on their own, a feature called **autorhythmicity**; they do this at set intervals which determine heart rate. Because they are connected with gap junctions to surrounding muscle fibers and the specialized fibers of the heart's conduction system, the pacemaker cells are able to transfer the depolarization to the other cardiac muscle fibers in a manner that allows the heart to contract in a coordinated manner.

Another feature of cardiac muscle is its relatively long action potentials in its fibers, having a sustained depolarization "plateau." The plateau is produced by Ca^{++} entry though voltage-gated calcium channels in the sarcolemma of cardiac muscle fibers. This sustained depolarization (and Ca^{++} entry) provides for a longer contraction than is produced by an action potential in skeletal muscle. Unlike skeletal muscle, a large percentage of the Ca^{++} that initiates contraction in cardiac muscles comes from outside the cell rather than from the SR.

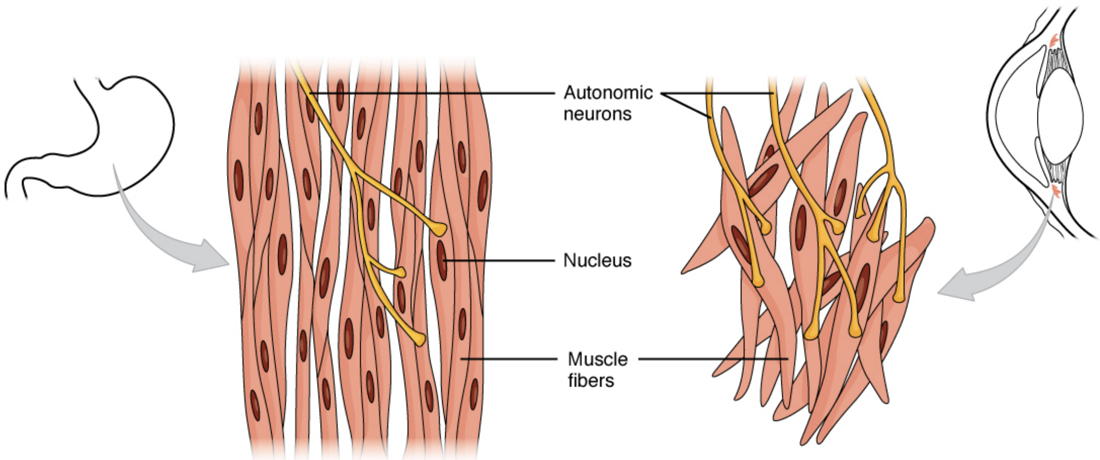
10.8 Smooth Muscle

LEARNING OBJECTIVES

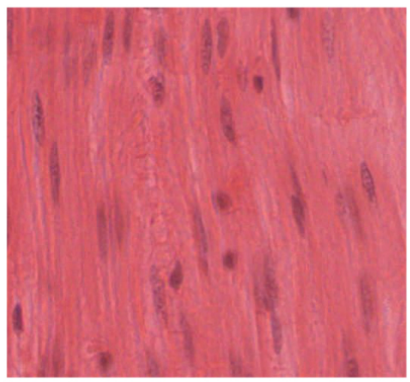
By the end of this section, you will be able to:

- Describe a dense body
- Explain how smooth muscle works with internal organs and passageways through the body
- Explain how smooth muscles differ from skeletal and cardiac muscles
- Explain the difference between single-unit and multi-unit smooth muscle

Smooth muscle (so-named because the cells do not have striations) is present in the walls of hollow organs like the urinary bladder, uterus, stomach, intestines, and in the walls of passageways, such as the arteries and veins of the circulatory system, and the tracts of the respiratory, urinary, and reproductive systems (Figure 10.23**ab**). Smooth muscle is also present in the eyes, where it functions to change the size of the iris and alter the shape of the lens; and in the skin where it causes hair to stand erect in response to cold temperature or fear.



(a)



(b)

FIGURE 10.23 **Smooth Muscle Tissue** Smooth muscle tissue is found around organs in the digestive, respiratory, reproductive tracts and the iris of the eye. LM × 1600. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

INTERACTIVE LINK

View the University of Michigan WebScope (http://openstax.org/l/smoothmuscMG) to explore the tissue sample in greater detail.

Smooth muscle fibers are spindle-shaped (wide in the middle and tapered at both ends, somewhat like a football) and have a single nucleus; they range from about 30 to 200 μm (thousands of times shorter than skeletal muscle fibers), and they produce their own connective tissue, endomysium. Although they do not have striations and sarcomeres, smooth muscle fibers do have actin and myosin contractile proteins, and thick and thin filaments. These thin filaments are anchored by dense bodies. A **dense body** is analogous to the Z-discs of skeletal and cardiac muscle fibers and is fastened to the sarcolemma. Calcium ions are supplied by the SR in the fibers and by sequestration from the extracellular fluid through membrane indentations called calveoli.

Because smooth muscle cells do not contain troponin, cross-bridge formation is not regulated by the troponin-tropomyosin complex but instead by the regulatory protein **calmodulin**. In a smooth muscle fiber, external Ca^{++} ions passing through opened calcium channels in the sarcolemma, and additional Ca^{++} released from SR, bind to calmodulin. The Ca^{++}-calmodulin complex then activates an enzyme called myosin (light chain) kinase, which, in turn, activates the myosin heads by phosphorylating them (converting ATP to ADP and P_i, with the P_i attaching to the head). The heads can then attach to actin-binding sites and pull on the thin filaments. The thin filaments also are anchored to the dense bodies; the structures invested in the inner membrane of the sarcolemma (at adherens junctions) that also have cord-like intermediate filaments attached to them. When the thin filaments slide past the thick filaments, they pull on the dense bodies, structures tethered to the sarcolemma, which then pull on the intermediate filaments networks throughout the sarcoplasm. This arrangement causes the entire muscle fiber to contract in a manner whereby the ends are pulled toward the center, causing the midsection to bulge in a corkscrew motion (Figure 10.24).

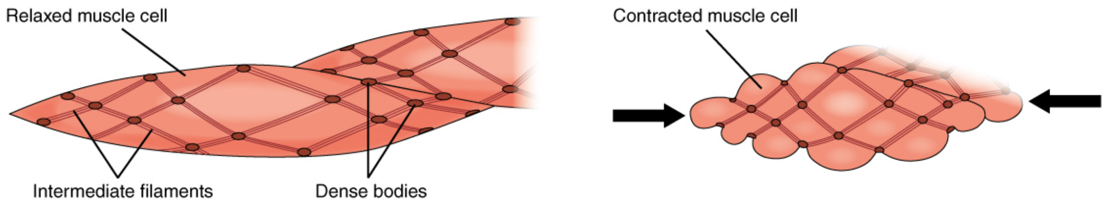


FIGURE 10.24 **Muscle Contraction** The dense bodies and intermediate filaments are networked through the sarcoplasm, which cause the muscle fiber to contract.

Although smooth muscle contraction relies on the presence of Ca^{++} ions, smooth muscle fibers have a much smaller diameter than skeletal muscle cells. T-tubules are not required to reach the interior of the cell and therefore not necessary to transmit an action potential deep into the fiber. Smooth muscle fibers have a limited calcium-storing SR but have calcium channels in the sarcolemma (similar to cardiac muscle fibers) that open during the action potential along the sarcolemma. The influx of extracellular Ca^{++} ions, which diffuse into the sarcoplasm to reach the calmodulin, accounts for most of the Ca^{++} that triggers contraction of a smooth muscle cell.

Muscle contraction continues until ATP-dependent calcium pumps actively transport Ca^{++} ions back into the SR and out of the cell. However, a low concentration of calcium remains in the sarcoplasm to maintain muscle tone. This remaining calcium keeps the muscle slightly contracted, which is important in certain tracts and around blood vessels.

Because most smooth muscles must function for long periods without rest, their power output is relatively low, but contractions can continue without using large amounts of energy. Some smooth muscle can also maintain contractions even as Ca^{++} is removed and myosin kinase is inactivated/dephosphorylated. This can happen as a subset of cross-bridges between myosin heads and actin, called **latch-bridges**, keep the thick and thin filaments linked together for a prolonged period, and without the need for ATP. This allows for the maintaining of muscle "tone" in smooth muscle that lines arterioles and other visceral organs with very little energy expenditure.

Smooth muscle is not under voluntary control; thus, it is called involuntary muscle. The triggers for smooth muscle contraction include hormones, neural stimulation by the ANS, and local factors. In certain locations, such as the walls of visceral organs, stretching the muscle can trigger its contraction (the stress-relaxation response).

Axons of neurons in the ANS do not form the highly organized NMJs with smooth muscle, as seen between motor neurons and skeletal muscle fibers. Instead, there is a series of neurotransmitter-filled bulges called varicosities as an axon courses through smooth muscle, loosely forming motor units (Figure 10.25). A **varicosity** releases neurotransmitters into the synaptic cleft. Also, visceral muscle in the walls of the hollow organs (except the heart) contains pacesetter cells. A **pacesetter cell** can spontaneously trigger action potentials and contractions in the muscle.

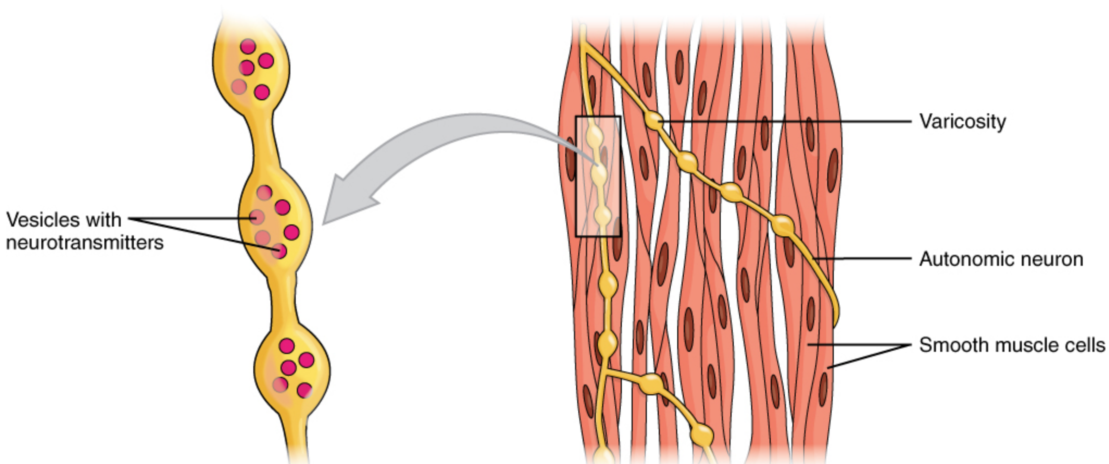


FIGURE 10.25 **Motor Units** A series of axon-like swelling, called varicosities or "boutons," from autonomic neurons form motor units through the smooth muscle.

Smooth muscle is organized in two ways: as single-unit smooth muscle, which is much more common; and as multiunit smooth muscle. The two types have different locations in the body and have different characteristics. Single-unit muscle has its muscle fibers joined by gap junctions so that the muscle contracts as a single unit. This type of smooth muscle is found in the walls of all visceral organs except the heart (which has cardiac muscle in its walls), and so it is commonly called **visceral muscle**. Because the muscle fibers are not constrained by the organization and stretchability limits of sarcomeres, visceral smooth muscle has a **stress-relaxation response**. This means that as the muscle of a hollow organ is stretched when it fills, the mechanical stress of the stretching will trigger contraction, but this is immediately followed by relaxation so that the organ does not empty its contents prematurely. This is important for hollow organs, such as the stomach or urinary bladder, which continuously expand as they fill. The smooth muscle around these organs also can maintain a muscle tone when the organ empties and shrinks, a feature that prevents “flabbiness” in the empty organ. In general, visceral smooth muscle produces slow, steady contractions that allow substances, such as food in the digestive tract, to move through the body.

Multiunit smooth muscle cells rarely possess gap junctions, and thus are not electrically coupled. As a result, contraction does not spread from one cell to the next, but is instead confined to the cell that was originally stimulated. Stimuli for multiunit smooth muscles come from autonomic nerves or hormones but not from stretching. This type of tissue is found around large blood vessels, in the respiratory airways, and in the eyes.

Hyperplasia in Smooth Muscle

Similar to skeletal and cardiac muscle cells, smooth muscle can undergo hypertrophy to increase in size. Unlike other muscle, smooth muscle can also divide to produce more cells, a process called **hyperplasia**. This can most evidently be observed in the uterus at puberty, which responds to increased estrogen levels by producing more uterine smooth muscle fibers, and greatly increases the size of the myometrium.

10.9 Development and Regeneration of Muscle Tissue

LEARNING OBJECTIVES

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

- Describe the function of satellite cells
- Define fibrosis
- Explain which muscle has the greatest regeneration ability

Most muscle tissue of the body arises from embryonic mesoderm. Paraxial mesodermal cells adjacent to the neural tube form blocks of cells called **somites**. Skeletal muscles, excluding those of the head and limbs, develop from mesodermal somites, whereas skeletal muscle in the head and limbs develop from general mesoderm. Somites give rise to myoblasts. A **myoblast** is a muscle-forming stem cell that migrates to different regions in the body and then fuse(s) to form a syncytium, or **myotube**. As a myotube is formed from many different myoblast cells, it contains many nuclei, but has a continuous cytoplasm. This is why skeletal muscle cells are multinucleate, as the nucleus of each contributing myoblast remains intact in the mature skeletal muscle cell. However, cardiac and smooth muscle cells are not multinucleate because the myoblasts that form their cells do not fuse.

Gap junctions develop in the cardiac and single-unit smooth muscle in the early stages of development. In skeletal muscles, ACh receptors are initially present along most of the surface of the myoblasts, but spinal nerve innervation causes the release of growth factors that stimulate the formation of motor end-plates and NMJs. As neurons become active, electrical signals that are sent through the muscle influence the distribution of slow and fast fibers in the muscle.

Although the number of muscle cells is set during development, satellite cells help to repair skeletal muscle cells. A **satellite cell** is similar to a myoblast because it is a type of stem cell; however, satellite cells are incorporated into muscle cells and facilitate the protein synthesis required for repair and growth. These cells are located outside the sarcolemma and are stimulated to grow and fuse with muscle cells by growth factors that are released by muscle fibers under certain forms of stress. Satellite cells can regenerate muscle fibers to a very limited extent, but they primarily help to repair damage in living cells. If a cell is damaged to a greater extent than can be repaired by satellite cells, the muscle fibers are replaced by scar tissue in a process called **fibrosis**. Because scar tissue cannot contract, muscle that has sustained significant damage loses strength and cannot produce the same amount of power or endurance as it could before being damaged.

Smooth muscle tissue can regenerate from a type of stem cell called a **pericyte**, which is found in some small blood vessels. Pericytes allow smooth muscle cells to regenerate and repair much more readily than skeletal and cardiac muscle tissue. Similar to skeletal muscle tissue, cardiac muscle does not regenerate to a great extent. Dead cardiac muscle tissue is replaced by scar tissue, which cannot contract. As scar tissue accumulates, the heart loses its ability to pump because of the loss of contractile power. However, some minor regeneration may occur due to stem cells found in the blood that occasionally enter cardiac tissue.

CAREER CONNECTION

Physical Therapist

As muscle cells die, they are not regenerated but instead are replaced by connective tissue and adipose tissue, which do not possess the contractile abilities of muscle tissue. Muscles atrophy when they are not used, and over time if atrophy is prolonged, muscle cells die. It is therefore important that those who are susceptible to muscle atrophy exercise to maintain muscle function and prevent the complete loss of muscle tissue. In extreme cases, when movement is not possible, electrical stimulation can be introduced to a muscle from an external source. This acts as a substitute for endogenous neural stimulation, stimulating the muscle to contract and preventing the loss of proteins that occurs with a lack of use.

Physiotherapists work with patients to maintain muscles. They are trained to target muscles susceptible to atrophy, and to prescribe and monitor exercises designed to stimulate those muscles. There are various causes of atrophy, including mechanical injury, disease, and age. After breaking a limb or undergoing surgery, muscle use is impaired and can lead to disuse atrophy. If the muscles are not exercised, this atrophy can lead to long-term muscle weakness. A stroke can also cause muscle impairment by interrupting neural stimulation to certain muscles. Without neural inputs, these muscles do not contract and thus begin to lose structural proteins. Exercising these muscles can help to restore muscle function and minimize functional impairments. Age-related muscle loss is also a target of physical therapy, as exercise can reduce the effects of age-related atrophy and improve muscle function.

The goal of a physiotherapist is to improve physical functioning and reduce functional impairments; this is achieved by understanding the cause of muscle impairment and assessing the capabilities of a patient, after which a program to enhance these capabilities is designed. Some factors that are assessed include strength, balance, and endurance, which are continually monitored as exercises are introduced to track improvements in muscle function. Physiotherapists can also instruct patients on the proper use of equipment, such as crutches, and assess whether someone has sufficient strength to use the equipment and when they can function without it.

Key Terms

acetylcholine (ACh) neurotransmitter that binds at a motor end-plate to trigger depolarization

actin protein that makes up most of the thin myofilaments in a sarcomere muscle fiber

action potential change in voltage of a cell membrane in response to a stimulus that results in transmission of an electrical signal; unique to neurons and muscle fibers

aerobic respiration production of ATP in the presence of oxygen

angiogenesis formation of blood capillary networks

aponeurosis broad, tendon-like sheet of connective tissue that attaches a skeletal muscle to another skeletal muscle or to a bone

ATPase enzyme that hydrolyzes ATP to ADP

atrophy loss of structural proteins from muscle fibers

autorhythmicity heart's ability to control its own contractions

calmodulin regulatory protein that facilitates contraction in smooth muscles

cardiac muscle striated muscle found in the heart; joined to one another at intercalated discs and under the regulation of pacemaker cells, which contract as one unit to pump blood through the circulatory system. Cardiac muscle is under involuntary control.

concentric contraction muscle contraction that shortens the muscle to move a load

contractility ability to shorten (contract) forcibly

contraction phase twitch contraction phase when tension increases

creatine phosphate phosphagen used to store energy from ATP and transfer it to muscle

dense body sarcoplasmic structure that attaches to the sarcolemma and shortens the muscle as thin filaments slide past thick filaments

depolarize to reduce the voltage difference between the inside and outside of a cell's plasma membrane (the sarcolemma for a muscle fiber), making the inside less negative than at rest

desmosome cell structure that anchors the ends of cardiac muscle fibers to allow contraction to occur

eccentric contraction muscle contraction that lengthens the muscle as the tension is diminished

elasticity ability to stretch and rebound

endomysium loose, and well-hydrated connective tissue covering each muscle fiber in a skeletal muscle

epimysium outer layer of connective tissue around a skeletal muscle

excitability ability to undergo neural stimulation

excitation-contraction coupling sequence of events from motor neuron signaling to a skeletal muscle fiber to contraction of the fiber's sarcomeres

extensibility ability to lengthen (extend)

fascicle bundle of muscle fibers within a skeletal muscle

fast glycolytic (FG) muscle fiber that primarily uses anaerobic glycolysis

fast oxidative (FO) intermediate muscle fiber that is between slow oxidative and fast glycolytic fibers

fibrosis replacement of muscle fibers by scar tissue

glycolysis anaerobic breakdown of glucose to ATP

graded muscle response modification of contraction strength

hyperplasia process in which one cell splits to produce new cells

hypertonia abnormally high muscle tone

hypertrophy addition of structural proteins to muscle fibers

hypotonia abnormally low muscle tone caused by the absence of low-level contractions

intercalated disc part of the sarcolemma that connects cardiac tissue, and contains gap junctions and desmosomes

isometric contraction muscle contraction that occurs with no change in muscle length

isotonic contraction muscle contraction that involves changes in muscle length

lactic acid product of anaerobic glycolysis

latch-bridges subset of a cross-bridge in which actin and myosin remain locked together

latent period the time when a twitch does not produce contraction

motor end-plate sarcolemma of muscle fiber at the neuromuscular junction, with receptors for the neurotransmitter acetylcholine

motor unit motor neuron and the group of muscle fibers it innervates

muscle tension force generated by the contraction of the muscle; tension generated during isotonic contractions and isometric contractions

muscle tone low levels of muscle contraction that occur when a muscle is not producing movement

myoblast muscle-forming stem cell

myofibril long, cylindrical organelle that runs parallel within the muscle fiber and contains the sarcomeres

myogram instrument used to measure twitch tension

myosin protein that makes up most of the thick cylindrical myofilament within a sarcomere muscle fiber

myotube fusion of many myoblast cells

neuromuscular junction (NMJ) synapse between the axon terminal of a motor neuron and the section of the membrane of a muscle fiber with receptors for the acetylcholine released by the terminal

neurotransmitter signaling chemical released by nerve terminals that bind to and activate receptors on target cells

oxygen debt amount of oxygen needed to compensate for ATP produced without oxygen during muscle contraction

pacesetter cell cell that triggers action potentials in smooth muscle

pericyte stem cell that regenerates smooth muscle cells

perimysium connective tissue that bundles skeletal muscle fibers into fascicles within a skeletal muscle

power stroke action of myosin pulling actin inward (toward the M line)

pyruvic acid product of glycolysis that can be used in aerobic respiration or converted to lactic acid

recruitment increase in the number of motor units involved in contraction

relaxation phase period after twitch contraction when tension decreases

sarcolemma plasma membrane of a skeletal muscle fiber

sarcomere longitudinally, repeating functional unit of skeletal muscle, with all of the contractile and associated proteins involved in contraction

sarcopenia age-related muscle atrophy

sarcoplasm cytoplasm of a muscle cell

sarcoplasmic reticulum (SR) specialized smooth endoplasmic reticulum, which stores, releases, and retrieves Ca^{++}

satellite cell stem cell that helps to repair muscle cells

skeletal muscle striated, multinucleated muscle that requires signaling from the nervous system to trigger contraction; most skeletal muscles are referred to as voluntary muscles that move bones and produce movement

slow oxidative (SO) muscle fiber that primarily uses aerobic respiration

smooth muscle nonstriated, mononucleated muscle in the skin that is associated with hair follicles; assists in moving materials in the walls of internal organs, blood vessels, and internal passageways

somites blocks of paraxial mesoderm cells

stress-relaxation response relaxation of smooth muscle tissue after being stretched

synaptic cleft space between a nerve (axon) terminal and a motor end-plate

T-tubule projection of the sarcolemma into the interior of the cell

tetanus a continuous fused contraction

thick filament the thick myosin strands and their multiple heads projecting from the center of the sarcomere toward, but not all to way to, the Z-discs

thin filament thin strands of actin and its troponin-tropomyosin complex projecting from the Z-discs toward the center of the sarcomere

treppe stepwise increase in contraction tension

triad the grouping of one T-tubule and two terminal cisternae

tropomyosin regulatory protein that covers myosin-binding sites to prevent actin from binding to myosin

troponin regulatory protein that binds to actin, tropomyosin, and calcium

twitch single contraction produced by one action potential

varicosity enlargement of neurons that release neurotransmitters into synaptic clefts

visceral muscle smooth muscle found in the walls of visceral organs

voltage-gated sodium channels membrane proteins that open sodium channels in response to a sufficient voltage change, and initiate and transmit the action potential as Na^{+} enters through the channel

wave summation addition of successive neural stimuli to produce greater contraction

Chapter Review

10.1 Overview of Muscle Tissues

Muscle is the tissue in animals that allows for active movement of the body or materials within the body. There are three types of muscle tissue: skeletal muscle, cardiac muscle, and smooth muscle. Most of the body's skeletal muscle produces movement by acting on the skeleton. Cardiac muscle is found in the wall of the heart and pumps blood through the circulatory system.

Smooth muscle is found in the skin, where it is associated with hair follicles; it also is found in the walls of internal organs, blood vessels, and internal passageways, where it assists in moving materials.

10.2 Skeletal Muscle

Skeletal muscles contain connective tissue, blood vessels, and nerves. There are three layers of connective tissue: epimysium, perimysium, and endomysium. Skeletal muscle fibers are organized into groups called fascicles. Blood vessels and nerves enter the connective tissue and branch in the cell. Muscles attach to bones directly or through tendons or aponeuroses. Skeletal muscles maintain posture, stabilize bones and joints, control internal movement, and generate heat.

Skeletal muscle fibers are long, multinucleated cells. The membrane of the cell is the sarcolemma; the cytoplasm of the cell is the sarcoplasm. The sarcoplasmic reticulum (SR) is a form of endoplasmic reticulum. Muscle fibers are composed of myofibrils. The striations are created by the organization of actin and myosin resulting in the banding pattern of myofibrils.

10.3 Muscle Fiber Contraction and Relaxation

A sarcomere is the smallest contractile portion of a muscle. Myofibrils are composed of thick and thin filaments. Thick filaments are composed of the protein myosin; thin filaments are composed of the protein actin. Troponin and tropomyosin are regulatory proteins.

Muscle contraction is described by the sliding filament model of contraction. ACh is the neurotransmitter that binds at the neuromuscular junction (NMJ) to trigger depolarization, and an action potential travels along the sarcolemma to trigger calcium release from SR. The actin sites are exposed after Ca^{++} enters the sarcoplasm from its SR storage to activate the troponin-tropomyosin complex so that the tropomyosin shifts away from the sites. The cross-bridging of myosin heads docking into actin-binding sites is followed by the “power stroke”—the sliding of the thin filaments by thick filaments. The power strokes are powered by ATP. Ultimately, the sarcomeres, myofibrils, and muscle fibers shorten to produce movement.

10.4 Nervous System Control of Muscle Tension

The number of cross-bridges formed between actin and myosin determines the amount of tension produced by a muscle. The length of a sarcomere is optimal when the zone of overlap between thin and thick filaments is greatest. Muscles that are stretched or compressed too greatly do not produce maximal amounts of power. A motor unit is formed by a motor neuron and all of the muscle fibers that are innervated by that same motor neuron. A single contraction is called a twitch. A muscle twitch has a latent period, a contraction phase, and a relaxation phase. A graded muscle response allows variation in muscle tension. Summation occurs as successive stimuli are added together to produce a stronger muscle contraction. Tetanus is the fusion of contractions to produce a continuous contraction. Increasing the number of motor neurons involved increases the amount of motor units activated in a muscle, which is called recruitment. Muscle tone is the constant low-level contractions that allow for posture and stability.

10.5 Types of Muscle Fibers

ATP provides the energy for muscle contraction. The three mechanisms for ATP regeneration are creatine phosphate, anaerobic glycolysis, and aerobic metabolism. Creatine phosphate provides about the first 15 seconds of ATP at the beginning of muscle contraction. Anaerobic glycolysis produces small amounts of ATP in the absence of oxygen for a short period. Aerobic metabolism utilizes oxygen to produce much more ATP, allowing a muscle to work for longer periods. Muscle fatigue, which has many contributing factors, occurs when muscle can no longer contract. An oxygen debt is created as a result of muscle use. The three types of muscle fiber are slow oxidative (SO), fast oxidative (FO) and fast glycolytic (FG). SO fibers use aerobic metabolism to produce low power contractions over long periods and are slow to fatigue. FO fibers use aerobic metabolism to produce ATP but produce higher tension contractions than SO fibers. FG fibers use anaerobic metabolism to produce powerful, high-tension contractions but fatigue quickly.

10.6 Exercise and Muscle Performance

Hypertrophy is an increase in muscle mass due to the addition of structural proteins. The opposite of hypertrophy is atrophy, the loss of muscle mass due to the breakdown of structural proteins. Endurance exercise causes an increase in cellular mitochondria, myoglobin, and capillary networks in SO fibers. Endurance athletes have a high level of SO fibers relative to the other fiber types. Resistance exercise causes hypertrophy. Power-producing muscles have a higher number of FG fibers than of slow fibers. Strenuous exercise causes muscle cell damage that requires time to heal. Some athletes use performance-enhancing substances to enhance muscle performance. Muscle atrophy due to age is called sarcopenia and occurs as muscle fibers die and are replaced by connective and adipose tissue.

10.7 Cardiac Muscle Tissue

Cardiac muscle is striated muscle that is present only in the heart. Cardiac muscle fibers have a single nucleus, are branched, and joined to one another by intercalated discs that contain gap junctions for depolarization between cells and desmosomes to hold the fibers together when the heart contracts. Contraction in each cardiac muscle fiber is triggered by Ca^{++} ions in a similar manner as skeletal muscle, but here the Ca^{++} ions come from SR and through voltage-gated calcium channels in the sarcolemma. Pacemaker cells stimulate the spontaneous contraction of cardiac muscle as a functional unit, called a syncytium.

10.8 Smooth Muscle

Smooth muscle is found throughout the body around various organs and tracts. Smooth muscle cells have a single nucleus, and are spindle-shaped. Smooth muscle cells can undergo hyperplasia, mitotically dividing to produce new cells. The smooth cells are nonstriated, but their sarcoplasm is filled with actin and myosin, along with dense bodies in the sarcolemma to anchor the thin filaments and a network of intermediate filaments involved in pulling the sarcolemma toward the fiber's middle, shortening it in the process. Ca^{++} ions trigger contraction when they are released from SR and enter through opened voltage-gated calcium channels. Smooth muscle contraction is initiated when the Ca^{++} binds to intracellular calmodulin, which then activates an enzyme called myosin kinase that phosphorylates myosin heads so they can form the cross-bridges with actin and then pull on the thin filaments. Smooth muscle can be stimulated by pacesetter cells, by the autonomic nervous system, by hormones, spontaneously, or by stretching. The fibers in some smooth muscle have latch-bridges, cross-bridges that cycle slowly without the need for ATP; these muscles can maintain low-level contractions for long periods. Single-unit smooth muscle tissue contains gap junctions to synchronize membrane depolarization and contractions so that the muscle contracts as a single unit. Single-unit smooth muscle in the walls of the viscera, called visceral muscle, has a stress-relaxation response that permits muscle to stretch, contract, and relax as the organ expands. Multiunit smooth muscle cells do not possess gap junctions, and contraction does not spread from one cell to the next.

10.9 Development and Regeneration of Muscle Tissue

Muscle tissue arises from embryonic mesoderm. Somites give rise to myoblasts and fuse to form a myotube. The nucleus of each contributing myoblast remains intact in the mature skeletal muscle cell, resulting in a mature, multinucleate cell. Satellite cells help to repair skeletal muscle cells. Smooth muscle tissue can regenerate from stem cells called pericytes, whereas dead cardiac muscle tissue is replaced by scar tissue. Aging causes muscle mass to decrease and be replaced by noncontractile connective tissue and adipose tissue.

Interactive Link Questions

1. Watch this video (http://openstax.org/l/micromacro) to learn more about macro- and microstructures of skeletal muscles. (a) What are the names of the "junction points" between sarcomeres? (b) What are the names of the "subunits" within the myofibrils that run the length of skeletal muscle fibers? (c) What is the "double strand of pearls" described in the video? (d) What gives a skeletal muscle fiber its striated appearance?

2. Every skeletal muscle fiber is supplied by a motor neuron at the NMJ. Watch this video (http://openstax.org/l/skelmuscfiber) to learn more about what happens at the neuromuscular junction. (a) What is the definition of a motor unit? (b) What is the structural and functional difference between a large motor unit and a small motor unit? Can you give an example of each? (c) Why is the neurotransmitter acetylcholine degraded after binding to its receptor?

3. The release of calcium ions initiates muscle contractions. Watch this video (http://openstax.org/l/calciumrole) to learn more about the role of calcium. (a) What are "T-tubules" and what is their role? (b) Please also describe how actin-binding sites are made available for cross-bridging with myosin heads during contraction.

Review Questions

4. Muscle that has a striped appearance is described as being ________.
  a. elastic
  b. nonstriated
  c. excitable
  d. striated

5. Which element is important in directly triggering contraction?
  a. sodium (Na^+)
  b. calcium (Ca^{++})
  c. potassium (K^+)
  d. chloride (Cl^-)

6. Which of the following properties is *not* common to all three muscle tissues?
  a. excitability
  b. the need for ATP
  c. at rest, uses shielding proteins to cover actin-binding sites
  d. elasticity

7. The correct order for the smallest to the largest unit of organization in muscle tissue is ________.
  a. fascicle, filament, muscle fiber, myofibril
  b. filament, myofibril, muscle fiber, fascicle
  c. muscle fiber, fascicle, filament, myofibril
  d. myofibril, muscle fiber, filament, fascicle

8. Depolarization of the sarcolemma means ________.
  a. the inside of the membrane has become less negative as sodium ions accumulate
  b. the outside of the membrane has become less negative as sodium ions accumulate
  c. the inside of the membrane has become more negative as sodium ions accumulate
  d. the sarcolemma has completely lost any electrical charge

9. In relaxed muscle, the myosin-binding site on actin is blocked by ________.
  a. titin
  b. troponin
  c. myoglobin
  d. tropomyosin

10. According to the sliding filament model, binding sites on actin open when ________.
  a. creatine phosphate levels rise
  b. ATP levels rise
  c. acetylcholine levels rise
  d. calcium ion levels rise

11. The cell membrane of a muscle fiber is called ________.
  a. myofibril
  b. sarcolemma
  c. sarcoplasm
  d. myofilament

12. Muscle relaxation occurs when ________.
  a. calcium ions are actively transported out of the sarcoplasmic reticulum
  b. calcium ions diffuse out of the sarcoplasmic reticulum
  c. calcium ions are actively transported into the sarcoplasmic reticulum
  d. calcium ions diffuse into the sarcoplasmic reticulum

13. During muscle contraction, the cross-bridge detaches when ________.
  a. the myosin head binds to an ADP molecule
  b. the myosin head binds to an ATP molecule
  c. calcium ions bind to troponin
  d. calcium ions bind to actin

14. Thin and thick filaments are organized into functional units called ________.
  a. myofibrils
  b. myofilaments
  c. T-tubules
  d. sarcomeres

15. During which phase of a twitch in a muscle fiber is tension the greatest?
  a. resting phase
  b. repolarization phase
  c. contraction phase
  d. relaxation phase

16. Muscle fatigue is caused by ________.
  a. buildup of ATP and lactic acid levels
  b. exhaustion of energy reserves and buildup of lactic acid levels
  c. buildup of ATP and pyruvic acid levels
  d. exhaustion of energy reserves and buildup of pyruvic acid levels

17. A sprinter would experience muscle fatigue sooner than a marathon runner due to ________.
  a. anaerobic metabolism in the muscles of the sprinter
  b. anaerobic metabolism in the muscles of the marathon runner
  c. aerobic metabolism in the muscles of the sprinter
  d. glycolysis in the muscles of the marathon runner

18. What aspect of creatine phosphate allows it to supply energy to muscles?
  a. ATPase activity
  b. phosphate bonds
  c. carbon bonds
  d. hydrogen bonds

19. Drug X blocks ATP regeneration from ADP and phosphate. How will muscle cells respond to this drug?
  a. by absorbing ATP from the bloodstream
  b. by using ADP as an energy source
  c. by using glycogen as an energy source
  d. none of the above

20. The muscles of a professional sprinter are most likely to have ________.
  a. 80 percent fast-twitch muscle fibers and 20 percent slow-twitch muscle fibers
  b. 20 percent fast-twitch muscle fibers and 80 percent slow-twitch muscle fibers
  c. 50 percent fast-twitch muscle fibers and 50 percent slow-twitch muscle fibers
  d. 40 percent fast-twitch muscle fibers and 60 percent slow-twitch muscle fibers

21. The muscles of a professional marathon runner are most likely to have ________.
  a. 80 percent fast-twitch muscle fibers and 20 percent slow-twitch muscle fibers
  b. 20 percent fast-twitch muscle fibers and 80 percent slow-twitch muscle fibers
  c. 50 percent fast-twitch muscle fibers and 50 percent slow-twitch muscle fibers
  d. 40 percent fast-twitch muscle fibers and 60 percent slow-twitch muscle fibers

22. Which of the following statements is *true*?
  a. Fast fibers have a small diameter.
  b. Fast fibers contain loosely packed myofibrils.
  c. Fast fibers have large glycogen reserves.
  d. Fast fibers have many mitochondria.

23. Which of the following statements is *false*?
  a. Slow fibers have a small network of capillaries.
  b. Slow fibers contain the pigment myoglobin.
  c. Slow fibers contain a large number of mitochondria.
  d. Slow fibers contract for extended periods.

24. Cardiac muscles differ from skeletal muscles in that they ________.
  a. are striated
  b. utilize aerobic metabolism
  c. contain myofibrils
  d. contain intercalated discs

25. If cardiac muscle cells were prevented from undergoing aerobic metabolism, they ultimately would ________.
  a. undergo glycolysis
  b. synthesize ATP
  c. stop contracting
  d. start contracting

26. Smooth muscles differ from skeletal and cardiac muscles in that they ________.
  a. lack myofibrils
  b. are under voluntary control
  c. lack myosin
  d. lack actin

27. Which of the following statements describes smooth muscle cells?
  a. They are resistant to fatigue.
  b. They have a rapid onset of contractions.
  c. They cannot exhibit tetanus.
  d. They primarily use anaerobic metabolism.

28. From which embryonic cell type does muscle tissue develop?
  a. ganglion cells
  b. myotube cells
  c. myoblast cells
  d. satellite cells

29. Which cell type helps to repair injured muscle fibers?
  a. ganglion cells
  b. myotube cells
  c. myoblast cells
  d. satellite cells

Critical Thinking Questions

30. Why is elasticity an important quality of muscle tissue?
31. What would happen to skeletal muscle if the epimysium were destroyed?
32. Describe how tendons facilitate body movement.
33. What are the five primary functions of skeletal muscle?
34. What are the opposite roles of voltage-gated sodium channels and voltage-gated potassium channels?
35. How would muscle contractions be affected if skeletal muscle fibers did not have T-tubules?
36. What causes the striated appearance of skeletal muscle tissue?
37. How would muscle contractions be affected if ATP was completely depleted in a muscle fiber?
38. Why does a motor unit of the eye have few muscle fibers compared to a motor unit of the leg?
39. What factors contribute to the amount of tension produced in an individual muscle fiber?
40. Why do muscle cells use creatine phosphate instead of glycolysis to supply ATP for the first few seconds of muscle contraction?
41. Is aerobic respiration more or less efficient than glycolysis? Explain your answer.
42. What changes occur at the cellular level in response to endurance training?
43. What changes occur at the cellular level in response to resistance training?
44. What would be the drawback of cardiac contractions being the same duration as skeletal muscle contractions?
45. How are cardiac muscle cells similar to and different from skeletal muscle cells?
46. Why can smooth muscles contract over a wider range of resting lengths than skeletal and cardiac muscle?
47. Describe the differences between single-unit smooth muscle and multiunit smooth muscle.
48. Why is muscle that has sustained significant damage unable to produce the same amount of power as it could before being damaged?
49. Which muscle type(s) (skeletal, smooth, or cardiac) can regenerate new muscle cells/fibers? Explain your answer.

CHAPTER 11
The Muscular System

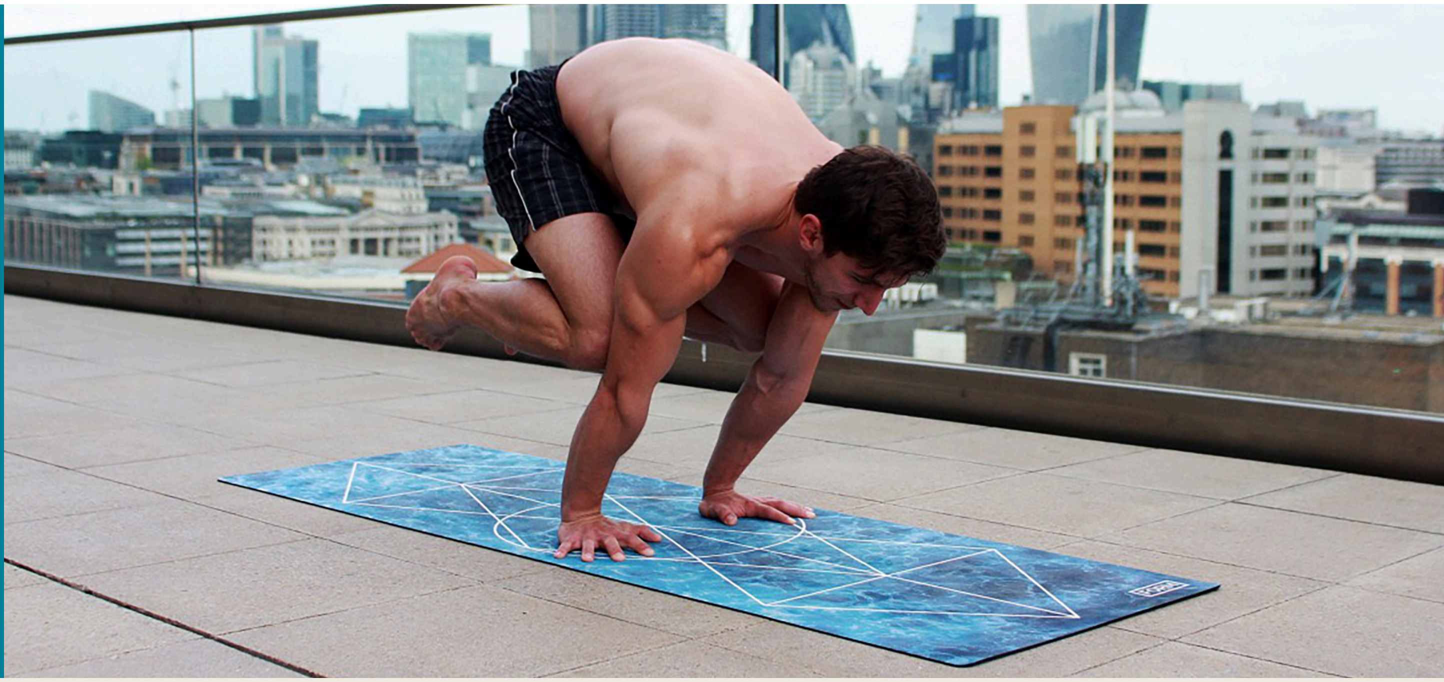


Figure 11.1 **A Body in Motion** The muscular system allows us to move, flex and contort our bodies. Practicing yoga, as pictured here, is a good example of the voluntary use of the muscular system. (credit: Dmitry Yanchylenko)

CHAPTER OBJECTIVES

After studying this chapter, you will be able to:

- Describe the actions and roles of agonists and antagonists
- Explain the structure and organization of muscle fascicles and their role in generating force
- Explain the criteria used to name skeletal muscles
- Identify the skeletal muscles and their actions on the skeleton and soft tissues of the body
- Identify the origins and insertions of skeletal muscles and the prime movements

INTRODUCTION Think about the things that you do each day—talking, walking, sitting, standing, and running—all of these activities require movement of particular skeletal muscles. Skeletal muscles are even used during sleep. The diaphragm is a sheet of skeletal muscle that has to contract and relax for you to breathe day and night. If you recall from your study of the skeletal system and joints, body movement occurs around the joints in the body. The focus of this chapter is on skeletal muscle organization. The system to name skeletal muscles will be explained; in some cases, the muscle is named by its shape, and in other cases it is named by its location or attachments to the skeleton. If you understand the meaning of the name of the muscle, often it will help you remember its location and/or what it does. This chapter also will describe how skeletal muscles are arranged to accomplish movement, and how other muscles may assist, or be arranged on the skeleton to resist or carry out the opposite movement. The actions of the skeletal muscles will be covered in a regional manner, working from the head down to the toes.

11.1 Interactions of Skeletal Muscles, Their Fascicle Arrangement, and Their Lever Systems

LEARNING OBJECTIVES

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

- Compare and contrast agonist and antagonist muscles
- Describe how fascicles are arranged within a skeletal muscle
- Explain the major events of a skeletal muscle contraction within a muscle in generating force

To move the skeleton, the tension created by the contraction of the fibers in most skeletal muscles is transferred to the tendons. The tendons are strong bands of dense, regular connective tissue that connect muscles to bones. The bone connection is why this muscle tissue is called skeletal muscle.

Interactions of Skeletal Muscles in the Body

To pull on a bone, that is, to change the angle at its synovial joint, which essentially moves the skeleton, a skeletal muscle must also be attached to a fixed part of the skeleton. The moveable end of the muscle that attaches to the bone being pulled is called the muscle's **insertion**, and the end of the muscle attached to a fixed (stabilized) bone is called the **origin**. During forearm **flexion**—bending the elbow—the brachioradialis assists the brachialis.

Although a number of muscles may be involved in an action, the principal muscle involved is called the **prime mover**, or **agonist**. To lift a cup, a muscle called the biceps brachii is actually the prime mover; however, because it can be assisted by the brachialis, the brachialis is called a **synergist** in this action (Figure 11.2). A synergist can also be a **fixator** that stabilizes the bone that is the attachment for the prime mover's origin.

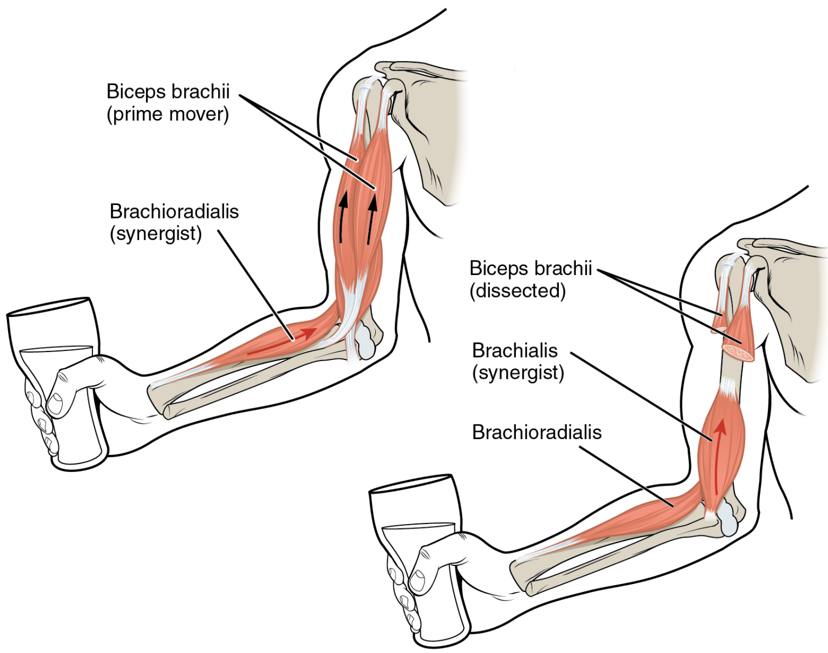


FIGURE 11.2 **Prime Movers and Synergists** The biceps brachii flex the lower arm. The brachoradialis, in the forearm, and brachialis, located deep to the biceps in the upper arm, are both synergists that aid in this motion.

A muscle with the opposite action of the prime mover is called an **antagonist**. Antagonists play two important roles in muscle function: (1) they maintain body or limb position, such as holding the arm out or standing erect; and (2) they control rapid movement, as in shadow boxing without landing a punch or the ability to check the motion of a limb.

For example, to extend the knee, a group of four muscles called the quadriceps femoris in the anterior compartment of the thigh are activated (and would be called the agonists of knee extension). However, to flex the knee joint, an opposite or antagonistic set of muscles called the hamstrings is activated.

As you can see, these terms would also be reversed for the opposing action. If you consider the first action as the knee bending, the hamstrings would be called the agonists and the quadriceps femoris would then be called the antagonists. See Table 11.1 for a list of some agonists and antagonists.

Agonist and Antagonist Skeletal Muscle Pairs

Agonist	Antagonist	Movement
Biceps brachii: in the anterior compartment of the arm	Triceps brachii: in the posterior compartment of the arm	The biceps brachii flexes the forearm, whereas the triceps brachii extends it.
Hamstrings: group of three muscles in the posterior compartment of the thigh	Quadriceps femoris: group of four muscles in the anterior compartment of the thigh	The hamstrings flex the leg, whereas the quadriceps femoris extend it.
Flexor digitorum superficialis and flexor digitorum profundus: in the anterior compartment of the forearm	Extensor digitorum: in the posterior compartment of the forearm	The flexor digitorum superficialis and flexor digitorum profundus flex the fingers and the hand at the wrist, whereas the extensor digitorum extends the fingers and the hand at the wrist.

TABLE 11.1

There are also skeletal muscles that do not pull against the skeleton for movements. For example, there are the muscles that produce facial expressions. The insertions and origins of facial muscles are in the skin, so that certain individual muscles contract to form a smile or frown, form sounds or words, and raise the eyebrows. There also are skeletal muscles in the tongue, and the external urinary and anal sphincters that allow for voluntary regulation of urination and defecation, respectively. In addition, the diaphragm contracts and relaxes to change the volume of the pleural cavities but it does not move the skeleton to do this.

Everyday Connection

Exercise and Stretching

When exercising, it is important to first warm up the muscles. Stretching pulls on the muscle fibers and it also results in an increased blood flow to the muscles being worked. Without a proper warm-up, it is possible that you may either damage some of the muscle fibers or pull a tendon. A pulled tendon, regardless of location, results in pain, swelling, and diminished function; if it is moderate to severe, the injury could immobilize you for an extended period.

Recall the discussion about muscles crossing joints to create movement. Most of the joints you use during exercise are synovial joints, which have synovial fluid in the joint space between two bones. Exercise and stretching may also have a beneficial effect on synovial joints. Synovial fluid is a thin, but viscous film with the consistency of egg whites. When you first get up and start moving, your joints feel stiff for a number of reasons. After proper stretching and warm-up, the synovial fluid may become less viscous, allowing for better joint function.

Patterns of Fascicle Organization

Skeletal muscle is enclosed in connective tissue scaffolding at three levels. Each muscle fiber (cell) is covered by endomysium and the entire muscle is covered by epimysium. When a group of muscle fibers is “bundled” as a unit within the whole muscle by an additional covering of a connective tissue called perimysium, that bundled group of muscle fibers is called a **fascicle**. Fascicle arrangement by perimysia is correlated to the force generated by a muscle; it also affects the range of motion of the muscle. Based on the patterns of fascicle arrangement, skeletal muscles can be classified in several ways. What follows are the most common fascicle arrangements.

Parallel muscles have fascicles that are arranged in the same direction as the long axis of the muscle (Figure 11.3). The majority of skeletal muscles in the body have this type of organization. Some parallel muscles are flat sheets that expand at the ends to make broad attachments. Other parallel muscles are rotund with tendons at one or both ends. Muscles that seem to be plump have a large mass of tissue located in the middle of the muscle, between the insertion and the origin, which is known as the central body. A more common name for this muscle is **belly**. When a muscle contracts, the contractile fibers shorten it to an even larger bulge. For example, extend and then flex your biceps brachii muscle; the large, middle section is the belly (Figure 11.4). When a parallel muscle has a central, large belly that is spindle-shaped, meaning it tapers as it extends to its origin and insertion, it sometimes is called **fusiform**.

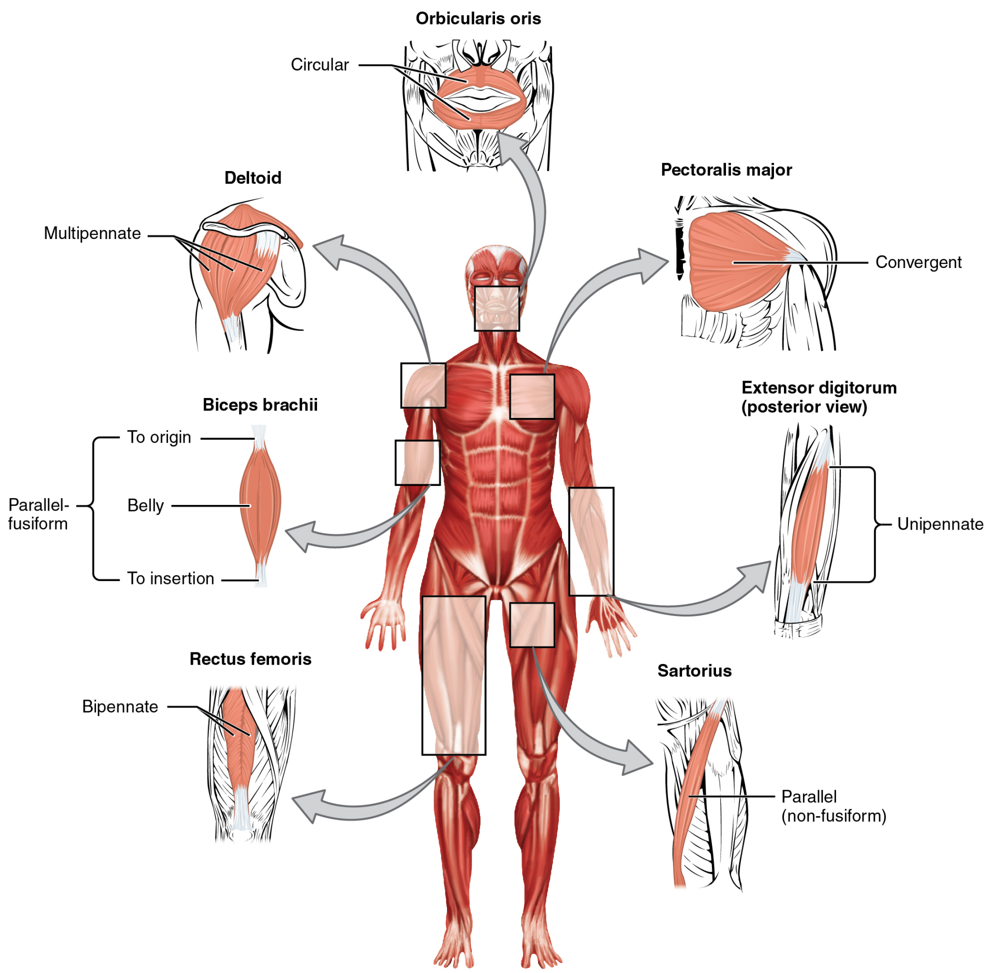


FIGURE 11.3 **Muscle Shapes and Fiber Alignment** The skeletal muscles of the body typically come in seven different general shapes.

FIGURE 11.4 **Biceps Brachii Muscle Contraction** The large mass at the center of a muscle is called the belly. Tendons emerge from both ends of the belly and connect the muscle to the bones, allowing the skeleton to move. The tendons of the bicep connect to the upper arm and the forearm. (credit: Victoria Garcia)

Circular muscles are also called sphincters (see Figure 11.3). When they relax, the sphincters' concentrically arranged bundles of muscle fibers increase the size of the opening, and when they contract, the size of the opening shrinks to the point of closure. The orbicularis oris muscle is a circular muscle that goes around the mouth. When it contracts, the oral opening becomes smaller, as when puckering the lips for whistling. Another example is the orbicularis oculi, one of which surrounds each eye. Consider, for example, the names of the two orbicularis muscles (orbicularis oris and oribicularis oculi), where part of the first name of both muscles is the same. The first part of orbicularis, orb (orb = "circular"), is a reference to a round or circular structure; it may also make one think of orbit, such as the moon's path around the earth. The word oris (oris = "oral") refers to the oral cavity, or the mouth. The word oculi (ocular = "eye") refers to the eye.

There are other muscles throughout the body named by their shape or location. The deltoid is a large, triangular-shaped muscle that covers the shoulder. It is so-named because the Greek letter delta looks like a triangle. The rectus abdominis (rector = "straight") is the straight muscle in the anterior wall of the abdomen, while the rectus femoris is the straight muscle in the anterior compartment of the thigh.

When a muscle has a widespread expansion over a sizable area, but then the fascicles come to a single, common attachment point, the muscle is called **convergent**. The attachment point for a convergent muscle could be a tendon, an aponeurosis (a flat, broad tendon), or a raphe (a very slender tendon). The large muscle on the chest, the pectoralis major, is an example of a convergent muscle because it converges on the greater tubercle of the humerus via a tendon. The temporalis muscle of the cranium is another.

Pennate muscles (penna = "feathers") blend into a tendon that runs through the central region of the muscle for its whole length, somewhat like the quill of a feather with the muscle arranged similar to the feathers. Due to this design, the muscle fibers in a pennate muscle can only pull at an angle, and as a result, contracting pennate muscles do not move their tendons very far. However, because a pennate muscle generally can hold more muscle fibers within it, it can produce relatively more tension for its size. There are three subtypes of pennate muscles.

In a **unipennate** muscle, the fascicles are located on one side of the tendon. The extensor digitorum of the forearm is an example of a unipennate muscle. A **bipennate** muscle has fascicles on both sides of the tendon. In some pennate muscles, the muscle fibers wrap around the tendon, sometimes forming individual fascicles in the process. This arrangement is referred to as **multipennate**. A common example is the deltoid muscle of the shoulder, which covers the shoulder but has a single tendon that inserts on the deltoid tuberosity of the humerus.

Because of fascicles, a portion of a multipennate muscle like the deltoid can be stimulated by the nervous system to change the direction of the pull. For example, when the deltoid muscle contracts, the arm abducts (moves away from midline in the sagittal plane), but when only the anterior fascicle is stimulated, the arm will **abduct** and flex (move anteriorly at the shoulder joint).

The Lever System of Muscle and Bone Interactions

Skeletal muscles do not work by themselves. Muscles are arranged in pairs based on their functions. For muscles attached to the bones of the skeleton, the connection determines the force, speed, and range of movement. These characteristics depend on each other and can explain the general organization of the muscular and skeletal systems.

The skeleton and muscles act together to move the body. Have you ever used the back of a hammer to remove a nail from wood? The handle acts as a lever and the head of the hammer acts as a fulcrum, the fixed point that the force is applied to when you pull back or push down on the handle. The effort applied to this system is the pulling or pushing on the handle to remove the nail, which is the load, or "resistance" to the movement of the handle in the system. Our musculoskeletal system works in a similar manner, with bones being stiff levers and the articular endings of the bones—encased in synovial joints—acting as fulcrums. The load would be an object being lifted or any resistance to a movement (your head is a load when you are lifting it), and the effort, or applied force, comes from contracting skeletal muscle.

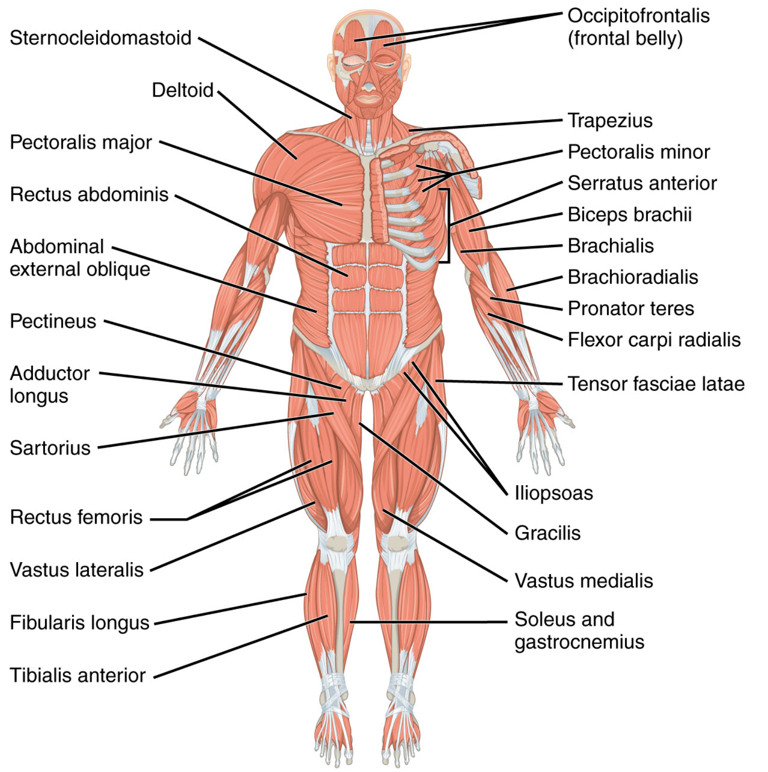
11.2 Naming Skeletal Muscles

LEARNING OBJECTIVES

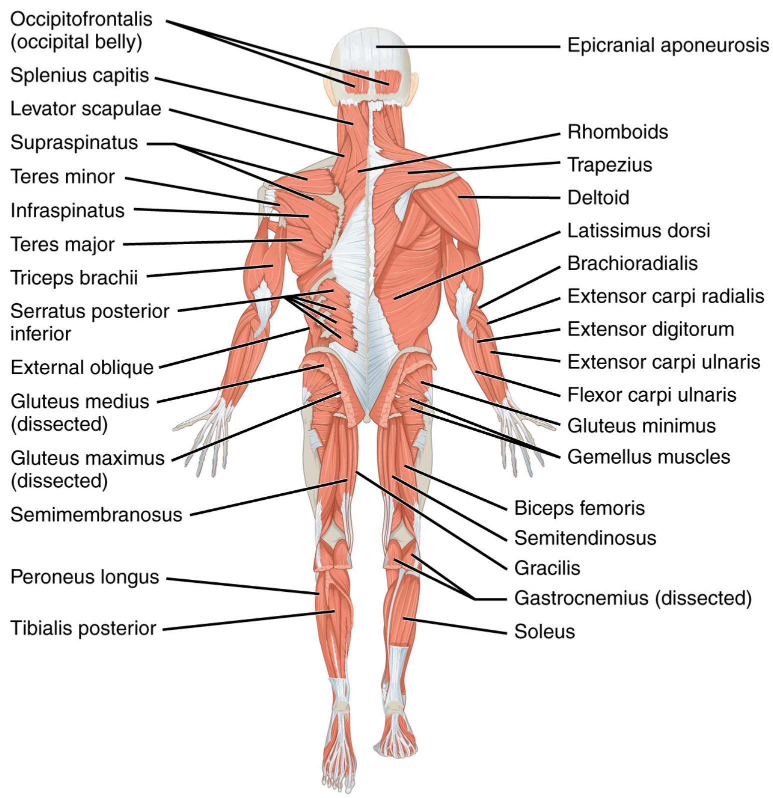
By the end of this section, you will be able to:

- Describe the criteria used to name skeletal muscles
- Explain how understanding the muscle names helps describe shapes, location, and actions of various muscles

The Greeks and Romans conducted the first studies done on the human body in Western culture. The educated class of subsequent societies studied Latin and Greek, and therefore the early pioneers of anatomy continued to apply Latin and Greek terminology or roots when they named the skeletal muscles. The large number of muscles in the body and unfamiliar words can make learning the names of the muscles in the body seem daunting, but understanding the etymology can help. Etymology is the study of how the root of a particular word entered a language and how the use of the word evolved over time. Taking the time to learn the root of the words is crucial to understanding the vocabulary of anatomy and physiology. When you understand the names of muscles it will help you remember where the muscles are located and what they do (Figure 11.5, Figure 11.6, and Table 11.2). Pronunciation of words and terms will take a bit of time to master, but after you have some basic information; the correct names and pronunciations will become easier.



Major muscles of the body.
Right side: superficial; left side: deep (anterior view)



Major muscles of the body.
Right side: superficial; left side: deep (posterior view)

FIGURE 11.5 Overview of the Muscular System On the anterior and posterior views of the muscular system above, superficial muscles (those at the surface) are shown on the right side of the body while deep muscles (those underneath the superficial muscles) are shown on the left half of the body. For the legs, superficial muscles are shown in the anterior view while the posterior view shows both superficial and deep muscles.

Example	Word	Latin Root 1	Latin Root 2	Meaning	Translation
abductor digiti minimi	abductor	ab = away from	duct = to move	a muscle that moves away from	A muscle that moves the little finger or toe away
	digiti	digitus = digit		refers to a finger or toe	
	minimi	minimus = mini, tiny		little	
adductor digiti minimi	adductor	ad = to, toward	duct = to move	a muscle that moves towards	A muscle that moves the little finger or toe toward
	digiti	digitus = digit		refers to a finger or toe	
	minimi	minimus = mini, tiny		little	

FIGURE 11.6 **Understanding a Muscle Name from the Latin**

Mnemonic Device for Latin Roots

Example	Latin or Greek Translation	Mnemonic Device
ad	to; toward	ADvance toward your goal
ab	away from	n/a
sub	under	SUBmarines move under water.
ductor	something that moves	A conDUCTOR makes a train move.
anti	against	If you are antisocial, you are against engaging in social activities.
epi	on top of	n/a
apo	to the side of	n/a
longissimus	longest	“Longissimus” is longer than the word “long.”
longus	long	long
brevis	short	brief
maximus	large	max
medius	medium	“Medius” and “medium” both begin with “med.”
minimus	tiny; little	mini
rectus	straight	To RECTify a situation is to straighten it out.
multi	many	If something is MULTIcolored, it has many colors.
uni	one	A UNIcorn has one horn.

TABLE 11.2

Example	Latin or Greek Translation	Mnemonic Device
bi/di	two	If a ring is DIcast, it is made of two metals.
tri	three	TRIple the amount of money is three times as much.
quad	four	QUADruplets are four children born at one birth.
externus	outside	EXternal
internus	inside	INternal

TABLE 11.2

Anatomists name the skeletal muscles according to a number of criteria, each of which describes the muscle in some way. These include naming the muscle after its shape, its size compared to other muscles in the area, its location in the body or the location of its attachments to the skeleton, how many origins it has, or its action.

The skeletal muscle's anatomical location or its relationship to a particular bone often determines its name. For example, the frontalis muscle is located on top of the frontal bone of the skull. Similarly, the shapes of some muscles are very distinctive and the names, such as orbicularis, reflect the shape. For the buttocks, the size of the muscles influences the names: gluteus **maximus** (largest), gluteus **medius** (medium), and the gluteus **minimus** (smallest). Names were given to indicate length—**brevis** (short), **longus** (long)—and to identify position relative to the midline: **lateralis** (to the outside away from the midline), and **medialis** (toward the midline). The direction of the muscle fibers and fascicles are used to describe muscles relative to the midline, such as the **rectus** (straight) abdominis, or the **oblique** (at an angle) muscles of the abdomen.

Some muscle names indicate the number of muscles in a group. One example of this is the quadriceps, a group of four muscles located on the anterior (front) thigh. Other muscle names can provide information as to how many origins a particular muscle has, such as the biceps brachii. The prefix **bi** indicates that the muscle has two origins and **tri** indicates three origins.

The location of a muscle's attachment can also appear in its name. When the name of a muscle is based on the attachments, the origin is always named first. For instance, the sternocleidomastoid muscle of the neck has a dual origin on the sternum (sterno) and clavicle (cleido), and it inserts on the mastoid process of the temporal bone. The last feature by which to name a muscle is its action. When muscles are named for the movement they produce, one can find action words in their name. Some examples are **flexor** (decreases the angle at the joint), **extensor** (increases the angle at the joint), **abductor** (moves the bone away from the midline), or **adductor** (moves the bone toward the midline).

11.3 Axial Muscles of the Head, Neck, and Back

LEARNING OBJECTIVES

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

- Identify the axial muscles of the face, head, and neck
- Identify the movement and function of the face, head, and neck muscles

The skeletal muscles are divided into **axial** (muscles of the trunk and head) and **appendicular** (muscles of the arms and legs) categories. This system reflects the bones of the skeleton system, which are also arranged in this manner. The axial muscles are grouped based on location, function, or both. Some of the axial muscles may seem to blur the boundaries because they cross over to the appendicular skeleton. The first grouping of the axial muscles you will review includes the muscles of the head and neck, then you will review the muscles of the vertebral column, and finally you will review the oblique and rectus muscles.

Muscles That Create Facial Expression

The origins of the muscles of facial expression are on the surface of the skull (remember, the origin of a muscle does not move). The insertions of these muscles have fibers intertwined with connective tissue and the dermis of the skin. Because the muscles insert in the skin rather than on bone, when they contract, the skin moves to create facial expression (Figure 11.7).

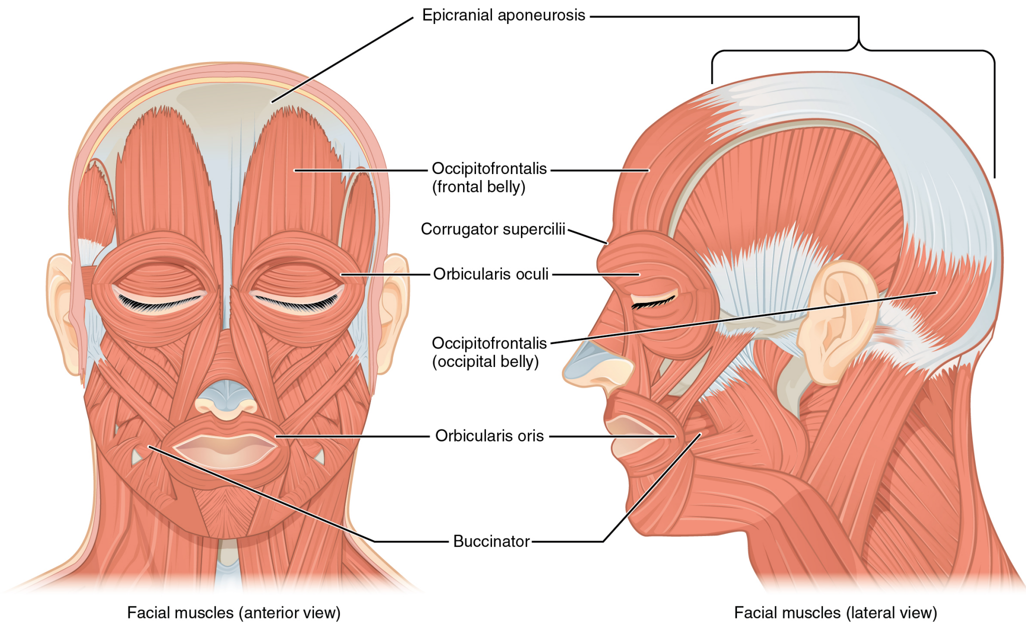


FIGURE 11.7 Muscles of Facial Expression Many of the muscles of facial expression insert into the skin surrounding the eyelids, nose and mouth, producing facial expressions by moving the skin rather than bones.

The **orbicularis oris** is a circular muscle that moves the lips, and the **orbicularis oculi** is a circular muscle that closes the eye. The **occipitofrontalis** muscle moves up the scalp and eyebrows. The muscle has a frontal belly and an occipital (near the occipital bone on the posterior part of the skull) belly. In other words, there is a muscle on the forehead (**frontalis**) and one on the back of the head (**occipitalis**), but there is no muscle across the top of the head. Instead, the two bellies are connected by a broad tendon called the **epicranial aponeurosis**, or galea aponeurosis (galea = “helmet”). The physicians originally studying human anatomy thought the skull looked like a helmet.

A large portion of the face is composed of the **buccinator** muscle, which compresses the cheek. This muscle allows you to whistle, blow, and suck; and it contributes to the action of chewing. There are several small facial muscles, one of which is the **corrugator supercilii**, which is the prime mover of the eyebrows. Place your finger on your eyebrows at the point of the bridge of the nose. Raise your eyebrows as if you were surprised and lower your eyebrows as if you were frowning. With these movements, you can feel the action of the corrugator supercilii. Additional muscles of facial expression are presented in Figure 11.8.

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Brow					
Raising eyebrows (e.g., showing surprise)	Skin of scalp	Anterior	Occipito-frontalis, frontal belly	Epicraneal aponeurosis	Underneath skin of forehead
Tensing and retracting scalp	Skin of scalp	Posterior	Occipito-frontalis, occipital belly	Occipital bone; mastoid process (temporal bone)	Epicraneal aponeurosis
Lowering eyebrows (e.g., scowling, frowning)	Skin underneath eyebrows	Inferior	Corrugator supercilii	Frontal bone	Skin underneath eyebrow
Nose					
Flaring nostrils	Nasal cartilage (pushes nostrils open when cartilage is compressed)	Inferior compression; posterior compression	Nasalis	Maxilla	Nasal bone
Mouth					
Raising upper lip	Upper lip	Elevation	Levator labii superioris	Maxilla	Underneath skin at corners of the mouth; orbicularis oris
Lowering lower lip	Lower lip	Depression	Depressor labii inferioris	Mandible	Underneath skin of lower lip
Opening mouth and sliding lower jaw left and right	Lower jaw	Depression, lateral	Depressor angulus oris	Mandible	Underneath skin at corners of mouth
Smiling	Corners of mouth	Lateral elevation	Zygomaticus major	Zygomatic bone	Underneath skin at corners of mouth (dimple area); orbicularis oris
Shaping of lips (as during speech)	Lips	Multiple	Orbicularis oris	Tissue surrounding lips	Underneath skin at corners of the mouth
Lateral movement of cheeks (e.g., sucking on a straw; also used to compress air in mouth while blowing)	Cheeks	Lateral	Buccinator	Maxilla, mandible; sphenoid bone (via pterygomandibular raphae)	Orbicularis oris
Pursing of lips by straightening them laterally	Corners of mouth	Lateral	Risorius	Fascia of parotid salivary gland	Underneath skin at corners of the mouth
Protrusion of lower lip (e.g., pouting expression)	Lower lip and skin of chin	Protraction	Mentalis	Mandible	Underneath skin of chin

FIGURE 11.8 **Muscles in Facial Expression**

Muscles That Move the Eyes

The movement of the eyeball is under the control of the **extrinsic eye muscles**, which originate outside the eye and insert onto the outer surface of the white of the eye. These muscles are located inside the eye socket and cannot be seen on any part of the visible eyeball (Figure 11.9 and Table 11.3). If you have ever been to a doctor who held up a finger and asked you to follow it up, down, and to both sides, the doctor is checking to make sure your eye muscles are acting in a coordinated pattern.

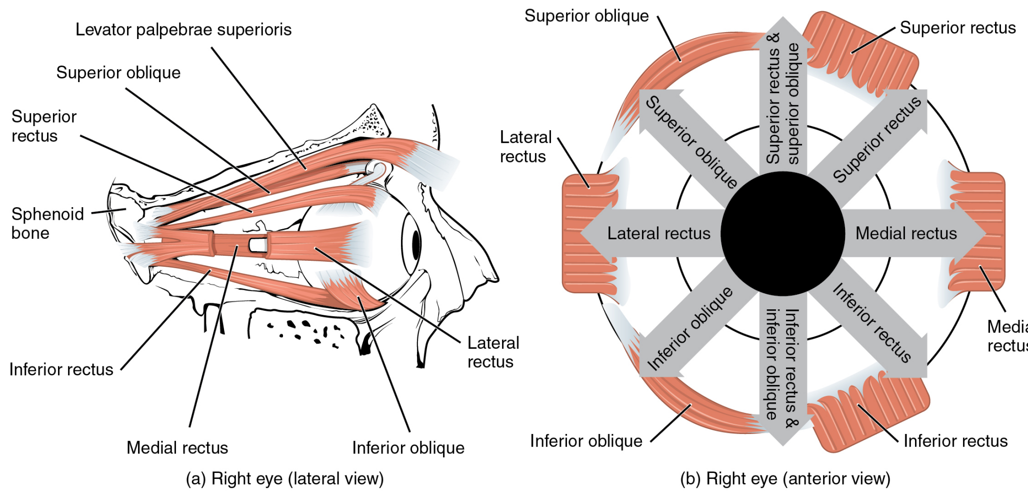


FIGURE 11.9 Muscles of the Eyes (a) The extrinsic eye muscles originate outside of the eye on the skull. (b) Each muscle inserts onto the eyeball.

Muscles of the Eyes

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Moves eyes up and toward nose; rotates eyes from 1 o'clock to 3 o'clock	Eyeballs	Superior (elevates); medial (adducts)	Superior rectus	Common tendinous ring (ring attaches to optic foramen)	Superior surface of eyeball
Moves eyes down and toward nose; rotates eyes from 6 o'clock to 3 o'clock	Eyeballs	Inferior (depresses); medial (adducts)	Inferior rectus	Common tendinous ring (ring attaches to optic foramen)	Inferior surface of eyeball
Moves eyes away from nose	Eyeballs	Lateral (abducts)	Lateral rectus	Common tendinous ring (ring attaches to optic foramen)	Lateral surface of eyeball
Moves eyes toward nose	Eyeballs	Medial (adducts)	Medial rectus	Common tendinous ring (ring attaches to optic foramen)	Medial surface of eyeball
Moves eyes up and away from nose; rotates eyeball from 12 o'clock to 9 o'clock	Eyeballs	Superior (elevates); lateral (abducts)	Inferior oblique	Floor of orbit (maxilla)	Surface of eyeball between inferior rectus and lateral rectus

TABLE 11.3

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Moves eyes down and away from nose; rotates eyeball from 6 o'clock to 9 o'clock	Eyeballs	Inferior (depress); lateral (abducts)	Superior oblique	Sphenoid bone	Surface of eyeball between superior rectus and lateral rectus
Opens eyes	Upper eyelid	Superior (elevates)	Levator palpabrae superioris	Roof of orbit (sphenoid bone)	Skin of upper eyelids
Closes eyelids	Eyelid skin	Compression along superior–inferior axis	Orbicularis oculi	Medial bones composing the orbit	Circumference of orbit

TABLE 11.3

Muscles That Move the Lower Jaw

In anatomical terminology, chewing is called **mastication**. Muscles involved in chewing must be able to exert enough pressure to bite through and then chew food before it is swallowed (Figure 11.10 and Table 11.4). The **masseter** muscle is the main muscle used for chewing because it elevates the mandible (lower jaw) to close the mouth, and it is assisted by the **temporalis** muscle, which retracts the mandible. You can feel the temporalis move by putting your fingers to your temple as you chew.

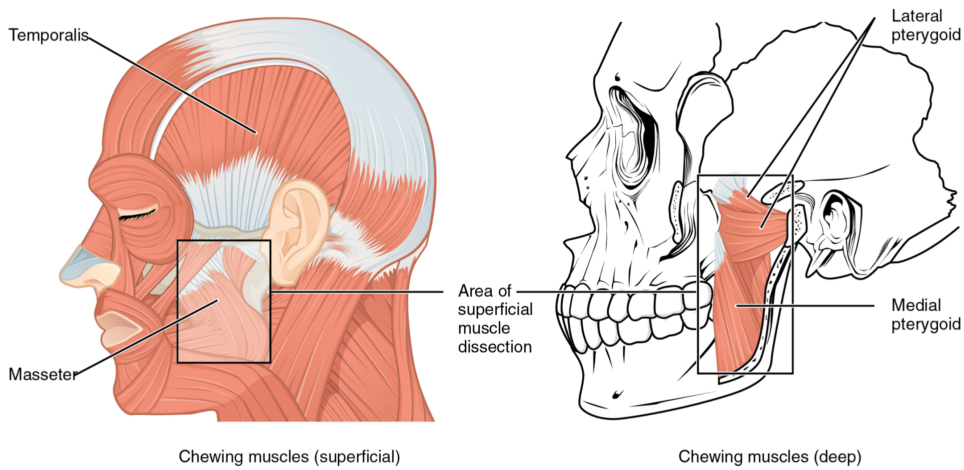


FIGURE 11.10 **Muscles That Move the Lower Jaw** The muscles that move the lower jaw are typically located within the cheek and originate from processes in the skull. This provides the jaw muscles with the large amount of leverage needed for chewing.

Muscles of the Lower Jaw

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Closes mouth; aids chewing	Mandible	Superior (elevates)	Masseter	Maxilla arch; zygomatic arch (for masseter)	Mandible
Closes mouth; pulls lower jaw in under upper jaw	Mandible	Superior (elevates); posterior (retracts)	Temporalis	Temporal bone	Mandible
Opens mouth; pushes lower jaw out under upper jaw; moves lower jaw side-to-side	Mandible	Inferior (depresses); posterior (protracts); lateral (abducts); medial (adducts)	Lateral pterygoid	Pterygoid process of sphenoid bone	Mandible
Closes mouth; pushes lower jaw out under upper jaw; moves lower jaw side-to-side	Mandible	Superior (elevates); posterior (protracts); lateral (abducts); medial (adducts)	Medial pterygoid	Sphenoid bone; maxilla	Mandible; temporo-mandibular joint

TABLE 11.4

Although the masseter and temporalis are responsible for elevating and closing the jaw to break food into digestible pieces, the **medial pterygoid** and **lateral pterygoid** muscles provide assistance in chewing and moving food within the mouth.

Muscles That Move the Tongue

Although the tongue is obviously important for tasting food, it is also necessary for mastication, **deglutition** (swallowing), and speech (Figure 11.11 and Figure 11.12). Because it is so moveable, the tongue facilitates complex speech patterns and sounds.

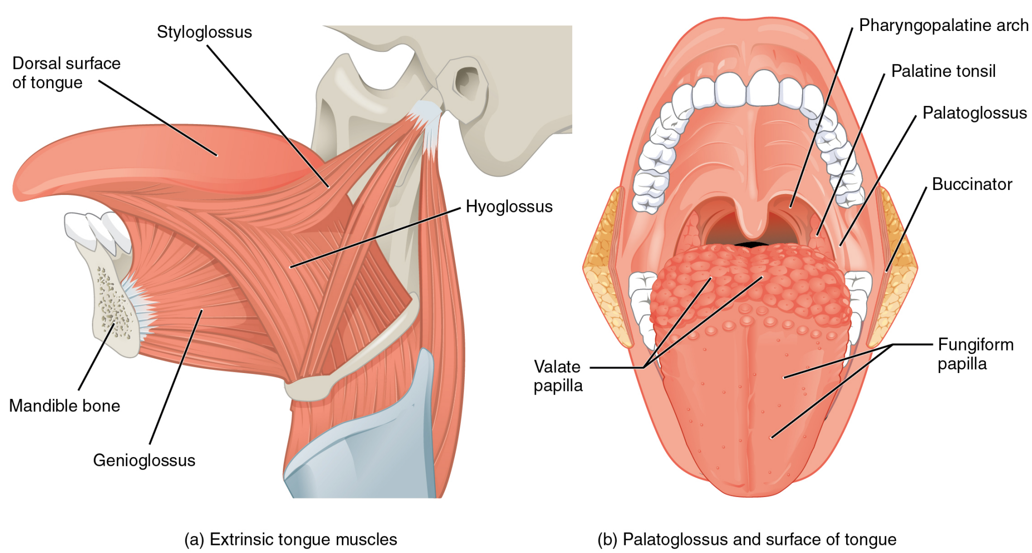


FIGURE 11.11 **Muscles that Move the Tongue**

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Tongue					
Moves tongue down; sticks tongue out of mouth	Tongue	Inferior (depresses); anterior (protracts)	Genioglossus	Mandible	Tongue undersurface; hyoid bone
Moves tongue up; retracts tongue back into mouth	Tongue	Superior (elevates); posterior (retracts)	Styloglossus	Temporal bone (styloid process)	Tongue undersurface and sides
Flattens tongue	Tongue	Inferior (depresses)	Hyoglossus	Hyoid bone	Sides of tongue
Bulges tongue	Tongue	Superior (elevation)	Palatoglossus	Soft palate	Side of tongue
Swallowing and speaking					
Raises the hyoid bone in a way that also raises the larynx, allowing the epiglottis to cover the glottis during deglutition; also assists in opening the mouth by depressing the mandible	Hyoid bone; larynx	Superior (elevates)	Digastric	Mandible; temporal bone	Hyoid bone
Raises and retracts the hyoid bone in a way that elongates the oral cavity during deglutition	Hyoid bone	Superior (elevates); posterior (retracts)	Stylohyoid	Temporal bone (styloid process)	Hyoid bone
Raises hyoid bone in a way that presses tongue against the roof of the mouth, pushing food back into the pharynx during deglutition	Hyoid bone	Superior (elevates)	Mylohyoid	Mandible	Hyoid bone; median raphe
Raises and moves hyoid bone forward, widening pharynx during deglutition	Hyoid bone	Superior (elevates); anterior (protracts)	Geniohyoid	Mandible	Hyoid bone
Retracts hyoid bone and moves it down during later phases of deglutition	Hyoid bone	Inferior (depresses); posterior (retracts)	Omohyoid	Scapula	Hyoid bone
Depresses the hyoid bone during swallowing and speaking	Hyoid bone	Inferior (depresses)	Sternohyoid	Clavicle	Hyoid bone
Shrinks distance between thyroid cartilage and hyoid bone, allowing production of high-pitch vocalizations	Hyoid bone; thyroid cartilage	Hyoid bone: inferior (depresses); thyroid cartilage: superior (elevates)	Thyrohyoid	Thyroid cartilage	Hyoid bone
Depresses larynx, thyroid cartilage, and hyoid bone to create different vocal tones	Larynx; thyroid cartilage; hyoid bone	Inferior (depresses)	Sternothyroid	Sternum	Thyroid cartilage
Rotates and tilts head to he side; tilts head forward	Skull; cervical vertebrae	Individually: medial rotation; lateral flexion; bilaterally: anterior (flexes)	Sternocleid-omastoid; semispinalis capitis	Sternum; clavicle	Temporal bone (mastoid process); occipital bone
Rotates and tilts head to the side; tilts head backwards	Skull; cervical vertebrae	Individually: lateral rotation; lateral flexion; bilaterally: anterior (flexes)	Splenius capitis; longissimus capitis		

FIGURE 11.12 **Muscles for Tongue Movement, Swallowing, and Speech**

Tongue muscles can be extrinsic or intrinsic. Extrinsic tongue muscles insert into the tongue from outside origins, and the intrinsic tongue muscles insert into the tongue from origins within it. The extrinsic muscles move the whole tongue in different directions, whereas the intrinsic muscles allow the tongue to change its shape (such as, curling the tongue in a loop or flattening it).

The extrinsic muscles all include the word root glossus (glossus = “tongue”), and the muscle names are derived from where the muscle originates. The **genioglossus** (genio = “chin”) originates on the mandible and allows the tongue to move downward and forward. The **styloglossus** originates on the styloid bone, and allows upward and backward motion. The **palatoglossus** originates on the soft palate to elevate the back of the tongue, and the **hyoglossus** originates on the hyoid bone to move the tongue downward and flatten it.

Everyday Connection

Anesthesia and the Tongue Muscles

Before surgery, a patient must be made ready for general anesthesia. The normal homeostatic controls of the body are put “on hold” so that the patient can be prepped for surgery. Control of respiration must be switched from the patient’s homeostatic control to the control of the anesthesiologist. The drugs used for anesthesia relax a majority of the body’s muscles.

Among the muscles affected during general anesthesia are those that are necessary for breathing and moving the tongue. Under anesthesia, the tongue can relax and partially or fully block the airway, and the muscles of respiration may not move the diaphragm or chest wall. To avoid possible complications, the safest procedure to use on a patient is called endotracheal intubation. Placing a tube into the trachea allows the doctors to maintain a patient’s (open) airway to the lungs and seal the airway off from the oropharynx. Post-surgery, the anesthesiologist gradually changes the mixture of the gases that keep the patient unconscious, and when the muscles of respiration begin to function, the tube is removed. It still takes about 30 minutes for a patient to wake up, and for breathing muscles to regain control of respiration. After surgery, most people have a sore or scratchy throat for a few days.

Muscles of the Anterior Neck

The muscles of the anterior neck assist in deglutition (swallowing) and speech by controlling the positions of the larynx (voice box), and the hyoid bone, a horseshoe-shaped bone that functions as a solid foundation on which the tongue can move. The muscles of the neck are categorized according to their position relative to the hyoid bone (Figure 11.13). **Suprahyoid muscles** are superior to it, and the **infrahyoid muscles** are located inferiorly.

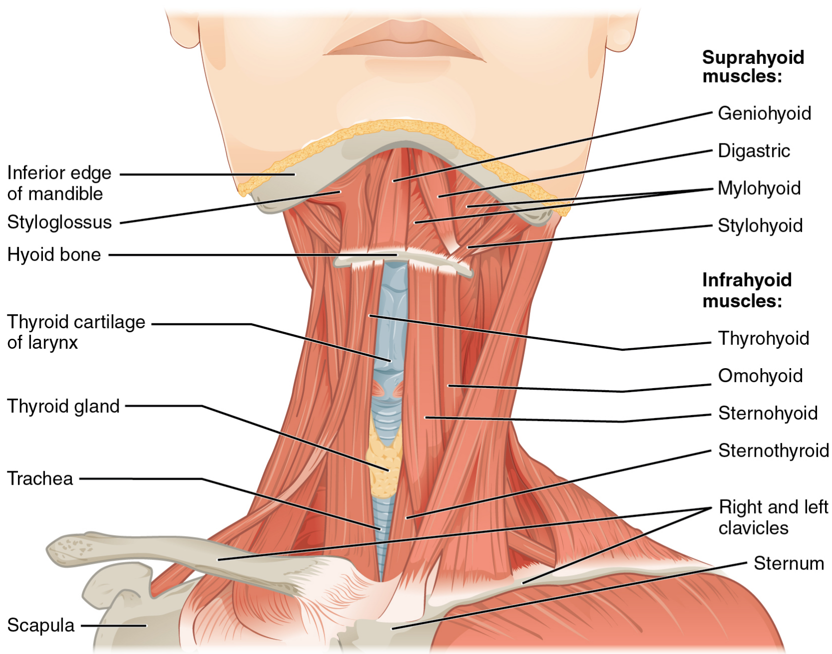


FIGURE 11.13 **Muscles of the Anterior Neck** The anterior muscles of the neck facilitate swallowing and speech. The suprahyoid muscles originate from above the hyoid bone in the chin region. The infrahyoid muscles originate below the hyoid bone in the lower neck.

The suprahyoid muscles raise the hyoid bone, the floor of the mouth, and the larynx during deglutition. These include the **digastric** muscle, which has anterior and posterior bellies that work to elevate the hyoid bone and larynx when one swallows; it also depresses the mandible. The **stylohyoid** muscle moves the hyoid bone posteriorly, elevating the larynx, and the **mylohyoid** muscle lifts it and helps press the tongue to the top of the mouth. The **geniohyoid** depresses the mandible in addition to raising and pulling the hyoid bone anteriorly.

The strap-like infrahyoid muscles generally depress the hyoid bone and control the position of the larynx. The **omohyoid** muscle, which has superior and inferior bellies, depresses the hyoid bone in conjunction with the **sternohyoid** and **thyrohyoid** muscles. The thyrohyoid muscle also elevates the larynx's thyroid cartilage, whereas the **sternothyroid** depresses it to create different tones of voice.

Muscles That Move the Head

The head, attached to the top of the vertebral column, is balanced, moved, and rotated by the neck muscles (Table 11.5). When these muscles act unilaterally, the head rotates. When they contract bilaterally, the head flexes or extends. The major muscle that laterally flexes and rotates the head is the **sternocleidomastoid**. In addition, both muscles working together are the flexors of the head. Place your fingers on both sides of the neck and turn your head to the left and to the right. You will feel the movement originate there. This muscle divides the neck into anterior and posterior triangles when viewed from the side (Figure 11.14).

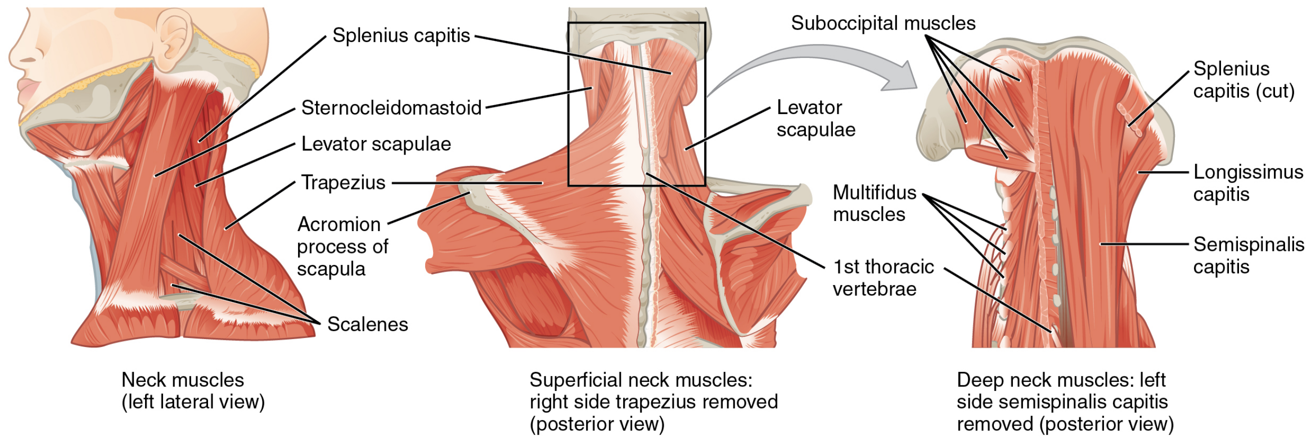


FIGURE 11.14 **Posterior and Lateral Views of the Neck** The superficial and deep muscles of the neck are responsible for moving the head, cervical vertebrae, and scapulas.

Muscles That Move the Head

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Rotates and tilts head to the side; tilts head forward	Skull; vertebrae	Individually: rotates head to opposite side; bilaterally: flexion	Sternocleidomastoid	Sternum; clavicle	Temporal bone (mastoid process); occipital bone
Rotates and tilts head backward	Skull; vertebrae	Individually: laterally flexes and rotates head to same side; bilaterally: extension	Semispinalis capitis	Transverse and articular processes of cervical and thoracic vertebra	Occipital bone

TABLE 11.5

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Rotates and tilts head to the side; tilts head backward	Skull; vertebrae	Individually: laterally flexes and rotates head to same side; bilaterally: extension	Splenius capitis	Spinous processes of cervical and thoracic vertebra	Temporal bone (mastoid process); occipital bone
Rotates and tilts head to the side; tilts head backward	Skull; vertebrae	Individually: laterally flexes and rotates head to same side; bilaterally: extension	Longissimus capitis	Transverse and articular processes of cervical and thoracic vertebra	Temporal bone (mastoid process)

TABLE 11.5

Muscles of the Posterior Neck and the Back

The posterior muscles of the neck are primarily concerned with head movements, like extension. The back muscles stabilize and move the vertebral column, and are grouped according to the lengths and direction of the fascicles.

The **splenius** muscles originate at the midline and run laterally and superiorly to their insertions. From the sides and the back of the neck, the **splenius capitis** inserts onto the head region, and the **splenius cervicis** extends onto the cervical region. These muscles can extend the head, laterally flex it, and rotate it (Figure 11.15).

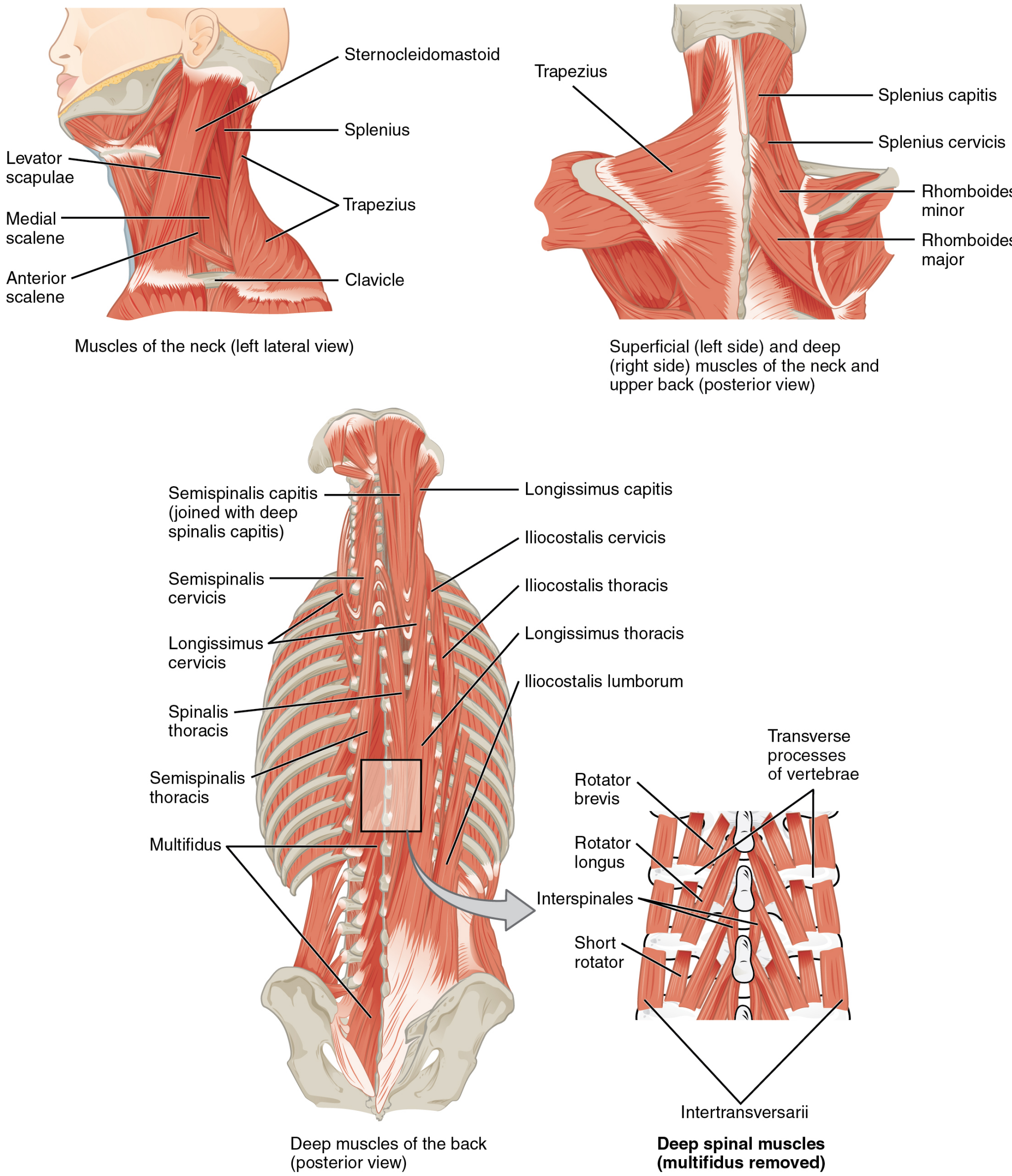


FIGURE 11.15 **Muscles of the Neck and Back** The large, complex muscles of the neck and back move the head, shoulders, and vertebral column.

The **erector spinae group** forms the majority of the muscle mass of the back and it is the primary extensor of the vertebral column. It controls flexion, lateral flexion, and rotation of the vertebral column, and maintains the lumbar curve. The erector spinae comprises the iliocostalis (laterally placed) group, the longissimus (intermediately placed) group, and the spinalis (medially placed) group.

The **iliocostalis group** includes the **iliocostalis cervicis**, associated with the cervical region; the **iliocostalis thoracis**, associated with the thoracic region; and the **iliocostalis lumborum**, associated with the lumbar region. The three muscles of the **longissimus group** are the **longissimus capitis**, associated with the head region; the **longissimus cervicis**, associated with the cervical region; and the **longissimus thoracis**, associated with the thoracic region. The third group, the **spinalis group**, comprises the **spinalis capitis** (head region), the **spinalis cervicis** (cervical region), and the **spinalis thoracis** (thoracic region).

The **transversospinales** muscles run from the transverse processes to the spinous processes of the vertebrae. Similar to the erector spinae muscles, the semispinalis muscles in this group are named for the areas of the body with which they are associated. The semispinalis muscles include the **semispinalis capitis**, the **semispinalis cervicis**, and the **semispinalis thoracis**. The **multifidus** muscle of the lumbar region helps extend and laterally flex the vertebral column.

Important in the stabilization of the vertebral column is the **segmental muscle group**, which includes the interspinales and intertransversarii muscles. These muscles bring together the spinous and transverse processes of each consecutive vertebra. Finally, the **scalene muscles** work together to flex, laterally flex, and rotate the head. They also contribute to deep inhalation. The scalene muscles include the **anterior scalene** muscle (anterior to the middle scalene), the **middle scalene** muscle (the longest, intermediate between the anterior and posterior scalenes), and the **posterior scalene** muscle (the smallest, posterior to the middle scalene).

11.4 Axial Muscles of the Abdominal Wall, and Thorax

LEARNING OBJECTIVES

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

- Identify the intrinsic skeletal muscles of the back and neck, and the skeletal muscles of the abdominal wall and thorax
- Identify the movement and function of the intrinsic skeletal muscles of the back and neck, and the skeletal muscles of the abdominal wall and thorax

It is a complex job to balance the body on two feet and walk upright. The muscles of the vertebral column, thorax, and abdominal wall extend, flex, and stabilize different parts of the body's trunk. The deep muscles of the core of the body help maintain posture as well as carry out other functions. The brain sends out electrical impulses to these various muscle groups to control posture by alternate contraction and relaxation. This is necessary so that no single muscle group becomes fatigued too quickly. If any one group fails to function, body posture will be compromised.

Muscles of the Abdomen

There are four pairs of abdominal muscles that cover the anterior and lateral abdominal region and meet at the anterior midline. These muscles of the anterolateral abdominal wall can be divided into four groups: the external obliques, the internal obliques, the transversus abdominis, and the rectus abdominis (Figure 11.16 and Table 11.6).

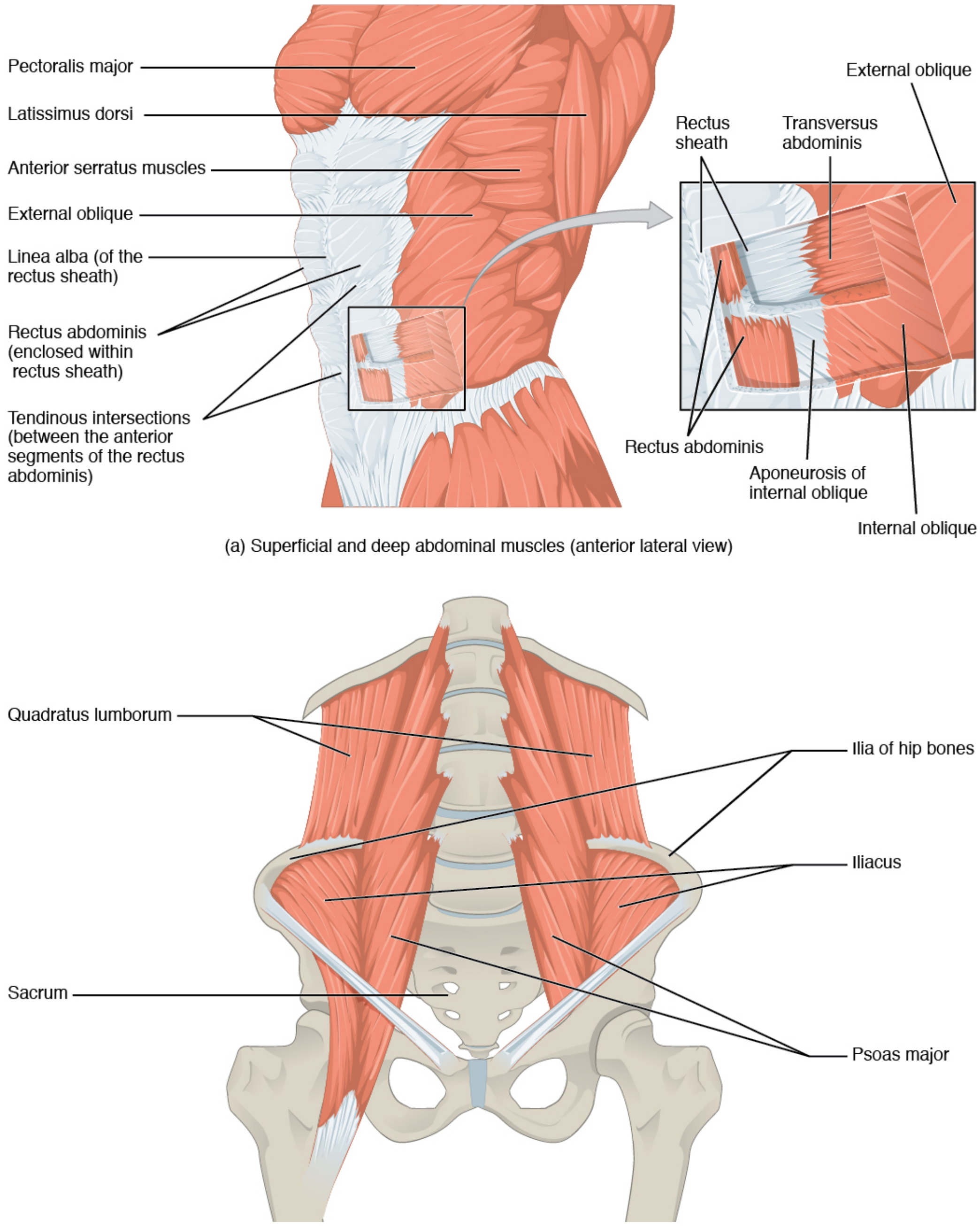


FIGURE 11.16 Muscles of the Abdomen (a) The anterior abdominal muscles include the medially located rectus abdominis, which is covered by a sheet of connective tissue called the rectus sheath. On the flanks of the body, medial to the rectus abdominis, the abdominal wall is composed of three layers. The external oblique muscles form the superficial layer, while the internal oblique muscles form the middle layer, and the transversus abdominis forms the deepest layer. (b) The muscles of the lower back move the lumbar spine but also assist in femur movements.

Muscles of the Abdomen

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Twisting at waist; also bending to the side	Vertebral column	Supination; lateral flexion	External obliques; internal obliques	Ribs 5–12; ilium	Ribs 7–10; linea alba; ilium
Squeezing abdomen during forceful exhalations, defecation, urination, and childbirth	Abdominal cavity	Compression	Transversus abdominis	Ilium; ribs 5–10	Sternum; linea alba; pubis
Sitting up	Vertebral column	Flexion	Rectus abdominis	Pubis	Sternum; ribs 5 and 7
Bending to the side	Vertebral column	Lateral flexion	Quadratus lumborum	Ilium; ribs 5–10	Rib 12; vertebrae L1–L4

TABLE 11.6

There are three flat skeletal muscles in the antero-lateral wall of the abdomen. The **external oblique**, closest to the surface, extend inferiorly and medially, in the direction of sliding one's four fingers into pants pockets. Perpendicular to it is the intermediate **internal oblique**, extending superiorly and medially, the direction the thumbs usually go when the other fingers are in the pants pocket. The deep muscle, the **transversus abdominis**, is arranged transversely around the abdomen, similar to the front of a belt on a pair of pants. This arrangement of three bands of muscles in different orientations allows various movements and rotations of the trunk. The three layers of muscle also help to protect the internal abdominal organs in an area where there is no bone.

The **linea alba** is a white, fibrous band that is made of the bilateral **rectus sheaths** that join at the anterior midline of the body. These enclose the **rectus abdominis** muscles (a pair of long, linear muscles, commonly called the "sit-up" muscles) that originate at the pubic crest and symphysis, and extend the length of the body's trunk. Each muscle is segmented by three transverse bands of collagen fibers called the **tendinous intersections**. This results in the look of "six-pack abs," as each segment hypertrophies on individuals at the gym who do many sit-ups.

The posterior abdominal wall is formed by the lumbar vertebrae, parts of the ilia of the hip bones, psoas major and iliacus muscles, and **quadratus lumborum** muscle. This part of the core plays a key role in stabilizing the rest of the body and maintaining posture.

CAREER CONNECTION

Physical Therapists

Those who have a muscle or joint injury will most likely be sent to a physical therapist (PT) after seeing their regular doctor. PTs have a master's degree or doctorate, and are highly trained experts in the mechanics of body movements. Many PTs also specialize in sports injuries.

If you injured your shoulder while you were kayaking, the first thing a physical therapist would do during your first visit is to assess the functionality of the joint. The range of motion of a particular joint refers to the normal movements the joint performs. The PT will ask you to abduct and adduct, circumduct, and flex and extend the arm. The PT will note the shoulder's degree of function, and based on the assessment of the injury, will create an appropriate physical therapy plan.

The first step in physical therapy will probably be applying a heat pack to the injured site, which acts much like a warm-up to draw blood to the area, to enhance healing. You will be instructed to do a series of exercises to continue the therapy at home, followed by icing, to decrease inflammation and swelling, which will continue for several weeks. When physical therapy is complete, the PT will do an exit exam and send a detailed report on the improved range of motion and return of normal limb function to your doctor. Gradually, as the injury heals, the shoulder will begin to function correctly. A PT works closely with patients to help them get back to their normal level of physical activity.

Muscles of the Thorax

The muscles of the chest serve to facilitate breathing by changing the size of the thoracic cavity (Table 11.7). When you inhale, your chest rises because the cavity expands. Alternately, when you exhale, your chest falls because the thoracic cavity decreases in size.

Muscles of the Thorax

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Inhalation; exhalation	Thoracic cavity	Compression; expansion	Diaphragm	Sternum; ribs 6–12; lumbar vertebrae	Central tendon
Inhalation;exhalation	Ribs	Elevation (expands thoracic cavity)	External intercostals	Rib superior to each intercostal muscle	Rib inferior to each intercostal muscle
Forced exhalation	Ribs	Movement along superior/inferior axis to bring ribs closer together	Internal intercostals	Rib inferior to each intercostal muscle	Rib superior to each intercostal muscle

TABLE 11.7

The Diaphragm

The change in volume of the thoracic cavity during breathing is due to the alternate contraction and relaxation of the **diaphragm** (Figure 11.17). It separates the thoracic and abdominal cavities, and is dome-shaped at rest. The superior surface of the diaphragm is convex, creating the elevated floor of the thoracic cavity. The inferior surface is concave, creating the curved roof of the abdominal cavity.

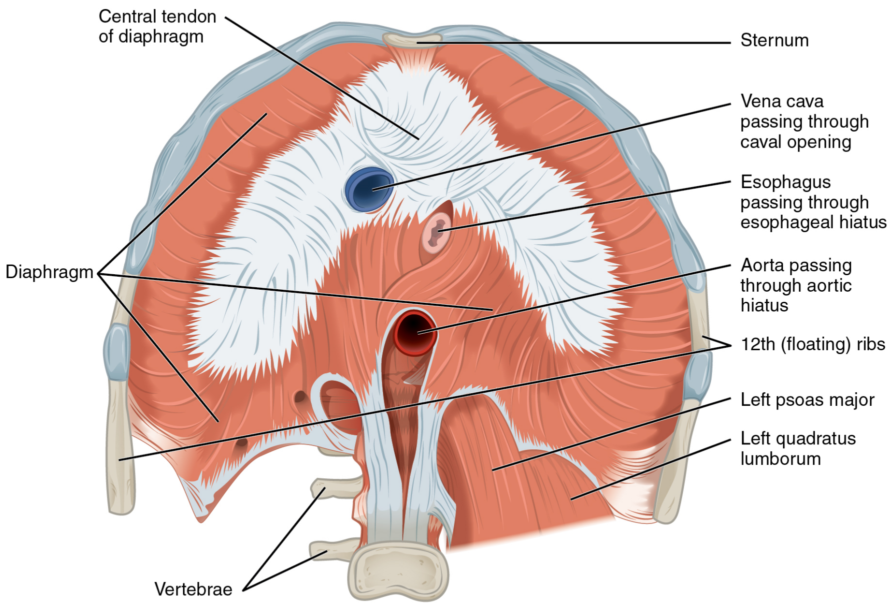


FIGURE 11.17 **Muscles of the Diaphragm** The diaphragm separates the thoracic and abdominal cavities.

Defecating, urination, and even childbirth involve cooperation between the diaphragm and abdominal muscles (this cooperation is referred to as the “Valsalva maneuver”). You hold your breath by a steady contraction of the diaphragm; this stabilizes the volume and pressure of the peritoneal cavity. When the abdominal muscles contract, the pressure cannot push the diaphragm up, so it increases pressure on the intestinal tract (defecation), urinary tract (urination), or reproductive tract (childbirth).

The inferior surface of the pericardial sac and the inferior surfaces of the pleural membranes (parietal pleura) fuse onto the central tendon of the diaphragm. To the sides of the tendon are the skeletal muscle portions of the diaphragm, which insert into the tendon while having a number of origins including the xiphoid process of the sternum anteriorly, the inferior six ribs and their cartilages laterally, and the lumbar vertebrae and 12th ribs posteriorly.

The diaphragm also includes three openings for the passage of structures between the thorax and the abdomen. The inferior vena cava passes through the **caval opening**, and the esophagus and attached nerves pass through the esophageal hiatus. The aorta, thoracic duct, and azygous vein pass through the aortic hiatus of the posterior diaphragm.

The Intercostal Muscles

There are three sets of muscles, called **intercostal muscles**, which span each of the intercostal spaces. The principal role of the intercostal muscles is to assist in breathing by changing the dimensions of the rib cage (Figure 11.18).

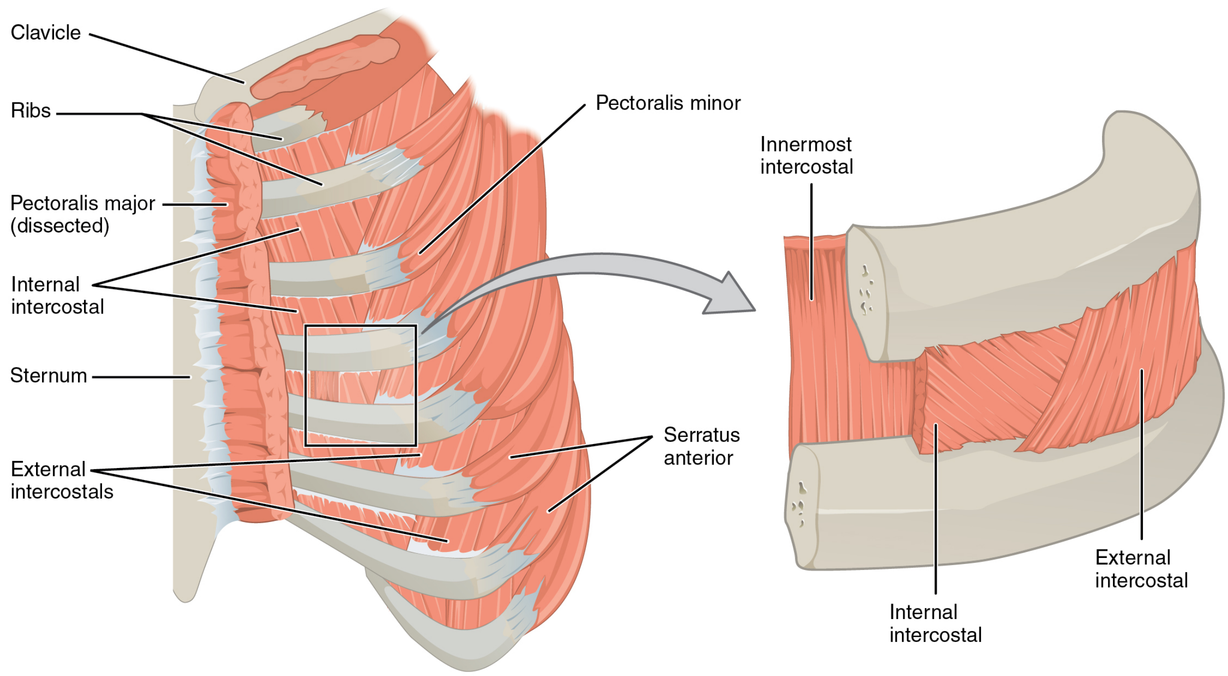


FIGURE 11.18 **Intercostal Muscles** The external intercostals are located laterally on the sides of the body. The internal intercostals are located medially near the sternum. The innermost intercostals are located deep to both the internal and external intercostals.

The 11 pairs of superficial **external intercostal** muscles aid in inspiration of air during breathing because when they contract, they raise the rib cage, which expands it. The 11 pairs of **internal intercostal** muscles, just under the externals, are used for expiration because they draw the ribs together to constrict the rib cage. The **innermost intercostal** muscles are the deepest, and they act as synergists for the action of the internal intercostals.

Muscles of the Pelvic Floor and Perineum

The pelvic floor is a muscular sheet that defines the inferior portion of the pelvic cavity. The **pelvic diaphragm**, spanning anteriorly to posteriorly from the pubis to the coccyx, comprises the levator ani and the ischiococcygeus. Its openings include the anal canal and urethra, and the vagina in females.

The large **levator ani** consists of two skeletal muscles, the **pubococcygeus** and the **iliococcygeus** (Figure 11.19). The levator ani is considered the most important muscle of the pelvic floor because it supports the pelvic viscera. It resists the pressure produced by contraction of the abdominal muscles so that the pressure is applied to the colon to aid in defecation and to the uterus to aid in childbirth (assisted by the **ischiococcygeus**, which pulls the coccyx anteriorly). This muscle also creates skeletal muscle sphincters at the urethra and anus.

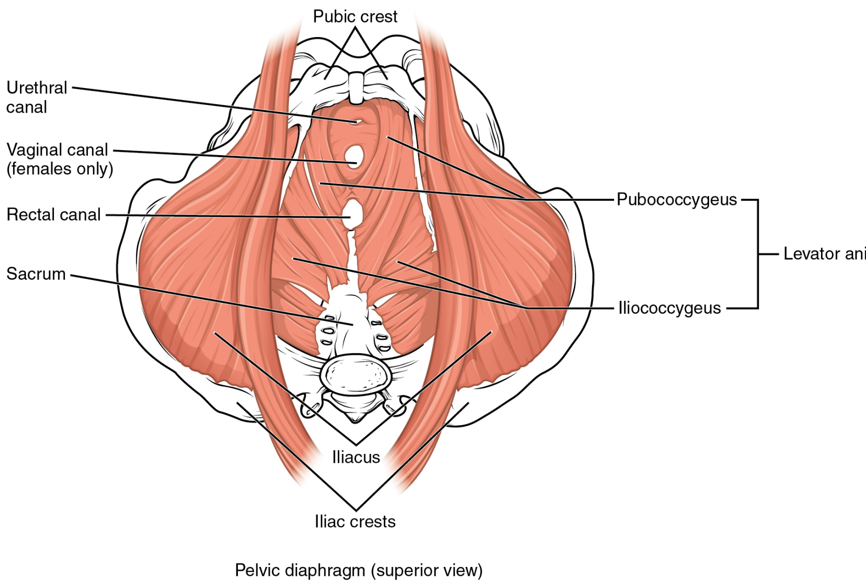


FIGURE 11.19 **Muscles of the Pelvic Floor** The pelvic floor muscles support the pelvic organs, resist intra-abdominal pressure, and work as sphincters for the urethra, rectum, and vagina.

The **perineum** is the diamond-shaped space between the pubic symphysis (anteriorly), the coccyx (posteriorly), and the ischial tuberosities (laterally), lying just inferior to the pelvic diaphragm (levator ani and coccygeus). Divided transversely into triangles, the anterior is the **urogenital triangle**, which includes the external genitals. The posterior is the **anal triangle**, which contains the anus (Figure 11.20). The perineum is also divided into superficial and deep layers with some of the muscles common to people of any sex (Figure 11.21). Females also have the **compressor urethrae** and the **sphincter urethrovaginalis**, which function to close the vagina. In males, there is the **deep transverse perineal** muscle that plays a role in ejaculation.

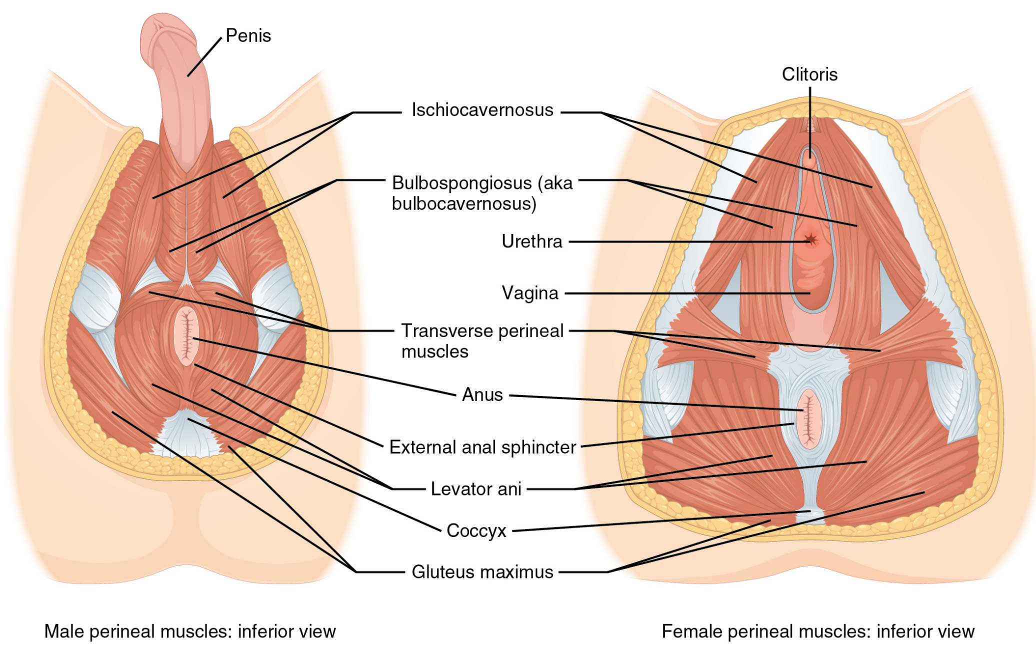


FIGURE 11.20 **Muscles of the Perineum** The perineum muscles play roles in urination in both sexes, ejaculation in males, and vaginal contraction in females.

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Defecation; urination; birth; coughing	Abdominal cavity	Superior (resists pressure during abdominal compression)	Levator ani pubococcygeus; levator ani iliococcygeus	Pubis; ischium	Urethra; anal canal; perineal body; coccyx
Superficial muscles					
None—supports perineal body maintaining anus at center of perineum	Perineal body	None	Superficial transverse perineal	Ischium	Perineal body
Involuntary response that compresses urethra when excreting urine in both sexes or while ejaculating in males; also aids in erection of penis in males	Urethra	Compression	Bulbospongiosus	Perineal body	Perineal membrane; corpus spongiosum of penis; deep fascia of penis; clitoris in female
Compresses veins to maintain erection of penis in males; erection of clitoris in females	Veins of penis and clitoris	Compression	Ischiocavernosus	Ischium; ischial rami; pubic rami	Pubic symphysis; corpus cavernosum of penis in male; clitoris of female
Deep muscles					
Voluntarily compresses urethra during urination	Urethra	Compression	External urethral sphincter	Ischial rami; pubic rami	Male: median raphe; female: vaginal wall
Closes anus	Anus	Sphincter	External anal sphincter	Anoccoccygeal ligament	Perineal body

FIGURE 11.21 Muscles of the Perineum Common to All Humans

11.5 Muscles of the Pectoral Girdle and Upper Limbs

LEARNING OBJECTIVES

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

- Identify the muscles of the pectoral girdle and upper limbs
- Identify the movement and function of the pectoral girdle and upper limbs

Muscles of the shoulder and upper limb can be divided into four groups: muscles that stabilize and position the pectoral girdle, muscles that move the arm, muscles that move the forearm, and muscles that move the wrists, hands, and fingers. The **pectoral girdle**, or shoulder girdle, consists of the lateral ends of the clavicle and scapula, along with the proximal end of the humerus, and the muscles covering these three bones to stabilize the shoulder joint. The girdle creates a base from which the head of the humerus, in its ball-and-socket joint with the glenoid fossa of the scapula, can move the arm in multiple directions.

Muscles That Position the Pectoral Girdle

Muscles that position the pectoral girdle are located either on the anterior thorax or on the posterior thorax (Figure 11.22 and Table 11.8). The anterior muscles include the **subclavius**, **pectoralis minor**, and **serratus anterior**. The posterior muscles include the **trapezius**, **rhomboid major**, and **rhomboid minor**. When the rhomboids are contracted, your scapula moves medially, which can pull the shoulder and upper limb posteriorly.

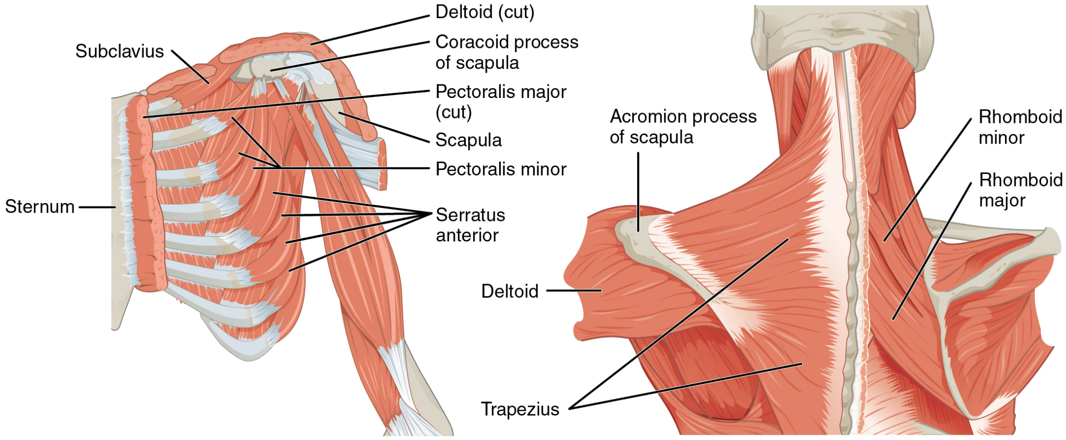


FIGURE 11.22 **Muscles That Position the Pectoral Girdle** The muscles that stabilize the pectoral girdle make it a steady base on which other muscles can move the arm. Note that the pectoralis major and deltoid, which move the humerus, are cut here to show the deeper positioning muscles.

Muscles that Position the Pectoral Girdle

Position in the thorax	Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Anterior thorax	Stabilizes clavicle during movement by depressing it	Clavicle	Depression	Subclavius	First rib	Inferior surface of clavicle
Anterior thorax	Rotates shoulder anteriorly (throwing motion); assists with inhalation	Scapula; ribs	Scapula: depresses; ribs: elevates	Pectoralis minor	Anterior surfaces of certain ribs (2–4 or 3–5)	Coracoid process of scapula
Anterior thorax	Moves arm from side of body to front of body; assists with inhalation	Scapula; ribs	Scapula: protracts; ribs: elevates	Serratus anterior	Muscle slips from certain ribs (1–8 or 1–9)	Anterior surface of vertebral border of scapula
Posterior thorax	Elevates shoulders (shrugging); pulls shoulder blades together; tilts head backwards	Scapula; cervical spine	Scapula: rotests inferiorly, retracts, elevates, and depresses; spine: extends	Trapezius	Skull; vertebral column	Acromion and spine of scapula; clavicle

TABLE 11.8

Position in the thorax	Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Posterior thorax	Stabilizes scapula during pectoral girdle movement	Scapula	Retracts; rotates inferiorly	Rhomboid major	Thoracic vertebrae (T2–T5)	Medial border of scapula
Posterior thorax	Stabilizes scapula during pectoral girdle movement	Scapula	Retracts; rotates inferiorly	Rhomboid minor	Cervical and thoracic vertebrae (C7 and T1)	Medial border of scapula

TABLE 11.8

Muscles That Move the Humerus

Similar to the muscles that position the pectoral girdle, muscles that cross the shoulder joint and move the humerus bone of the arm include both axial and scapular muscles (Figure 11.23 and Figure 11.24). The two axial muscles are the pectoralis major and the latissimus dorsi. The **pectoralis major** is thick and fan-shaped, covering much of the superior portion of the anterior thorax. The broad, triangular **latissimus dorsi** is located on the inferior part of the back, where it inserts into a thick connective tissue sheath called an aponeurosis.

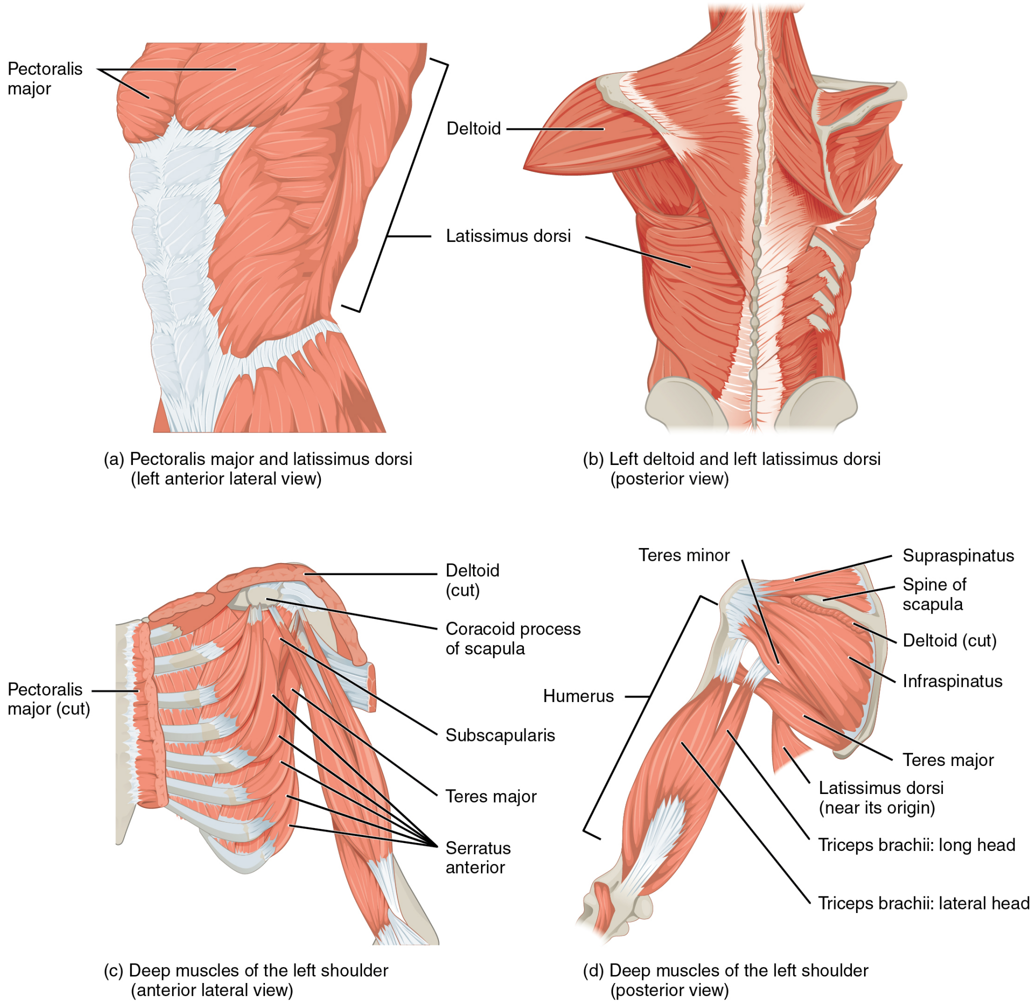


FIGURE 11.23 **Muscles That Move the Humerus** (a, c) The muscles that move the humerus anteriorly are generally located on the anterior side of the body and originate from the sternum (e.g., pectoralis major) or the anterior side of the scapula (e.g., subscapularis). (b) The muscles that move the humerus superiorly generally originate from the superior surfaces of the scapula and/or the clavicle (e.g., deltoids). The muscles that move the humerus inferiorly generally originate from middle or lower back (e.g., latissiumus dorsi). (d) The muscles that move the humerus posteriorly are generally located on the posterior side of the body and insert into the scapula (e.g., infraspinatus).

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Axial muscles					
Brings elbows together; moves elbow up (as during an uppercut punch)	Humerus	Flexion; adduction; medial rotation	Pectoralis major	Clavicle; sternum; cartilage of certain ribs (1–6 or 1–7); aponeurosis of external oblique muscle	Greater tubercle of humerus
Moves elbow back (as in elbowing someone standing behind you); spreads elbows apart	Humerus; scapula	Humerus: extension, adduction, and medial rotation; scapula: depression	Latissimus dorsi	Thoracic vertebrae (T7–T12); lumbar vertebrae; lower ribs (9–12); iliac crest	Intertubercular sulcus of humerus
Scapular muscles					
Lifts arms at shoulder	Humerus	Abduction; flexion; extension; medial and lateral rotation	Deltoid	Trapezius; clavicle; acromion; spine of scapula	Deltoid tuberosity of humerus
Assists pectoralis major in bringing elbows together and stabilizes shoulder joint during movement of the pectoral girdle	Humerus	Medial rotation	Subscapularis	Subscapular fossa of scapula	Lesser tubercle of humerus
Rotates elbow outwards, as during a tennis swing	Humerus	Abduction	Supraspinatus	Supraspinous fossa of scapula	Greater tubercle of humerus
Rotates elbow outwards, as during a tennis swing	Humerus	Extension; adduction	Infraspinatus	Infraspinous fossa of scapula	Greater tubercle of humerus
Assists with medial rotation at the shoulder	Humerus	Extension; adduction	Teres major	Posterior surface of scapula	Intertubercular sulcus of humerus
Assists infraspinatus in rotating elbow outwards	Humerus	Extension; adduction	Teres minor	Lateral border of dorsal scapular surface	Greater tubercle of humerus
Moves elbow up and across body, as when putting hand on chest	Humerus	Flexion; adduction	Coracobra chialis	Coracoid process of scapula	Medial surface of humerus shaft

FIGURE 11.24 Muscles That Move the Humerus

The rest of the shoulder muscles originate on the scapula. The anatomical and ligamental structure of the shoulder joint and the arrangements of the muscles covering it, allows the arm to carry out different types of movements. The **deltoid**, the thick muscle that creates the rounded lines of the shoulder is the major abductor of the arm, but it also facilitates flexing and medial rotation, as well as extension and lateral rotation. The **subscapularis** originates on the anterior scapula and medially rotates the arm. Named for their locations, the **supraspinatus** (superior to the spine of the scapula) and the **infraspinatus** (inferior to the spine of the scapula) abduct the arm, and laterally rotate the arm, respectively. The thick and flat **teres major** is inferior to the teres minor and extends the arm, and assists in adduction and medial rotation of it. The long **teres minor** laterally rotates and extends the arm. Finally, the **coracobrachialis** flexes and adducts the arm.

The tendons of the deep subscapularis, supraspinatus, infraspinatus, and teres minor connect the scapula to the humerus, forming the **rotator cuff** (musculotendinous cuff), the circle of tendons around the shoulder joint. When baseball pitchers undergo shoulder surgery it is usually on the rotator cuff, which becomes pinched and inflamed, and may tear away from the bone due to the repetitive motion of bring the arm overhead to throw a fast pitch.

Muscles That Move the Forearm

The forearm, made of the radius and ulna bones, has four main types of action at the hinge of the elbow joint:

flexion, extension, pronation, and supination. The forearm flexors include the biceps brachii, brachialis, and brachioradialis. The extensors are the **triceps brachii** and **anconeus**. The pronators are the **pronator teres** and the **pronator quadratus**, and the **supinator** is the only one that turns the forearm anteriorly. When the forearm faces anteriorly, it is supinated. When the forearm faces posteriorly, it is pronated.

The biceps brachii, brachialis, and brachioradialis flex the forearm. The two-headed **biceps brachii** crosses the shoulder and elbow joints to flex the forearm, also taking part in supinating the forearm at the radioulnar joints and flexing the arm at the shoulder joint. Deep to the biceps brachii, the **brachialis** provides additional power in flexing the forearm. Finally, the **brachioradialis** can flex the forearm quickly or help lift a load slowly. These muscles and their associated blood vessels and nerves form the **anterior compartment of the arm** (anterior flexor compartment of the arm) (Figure 11.25 and Figure 11.26).

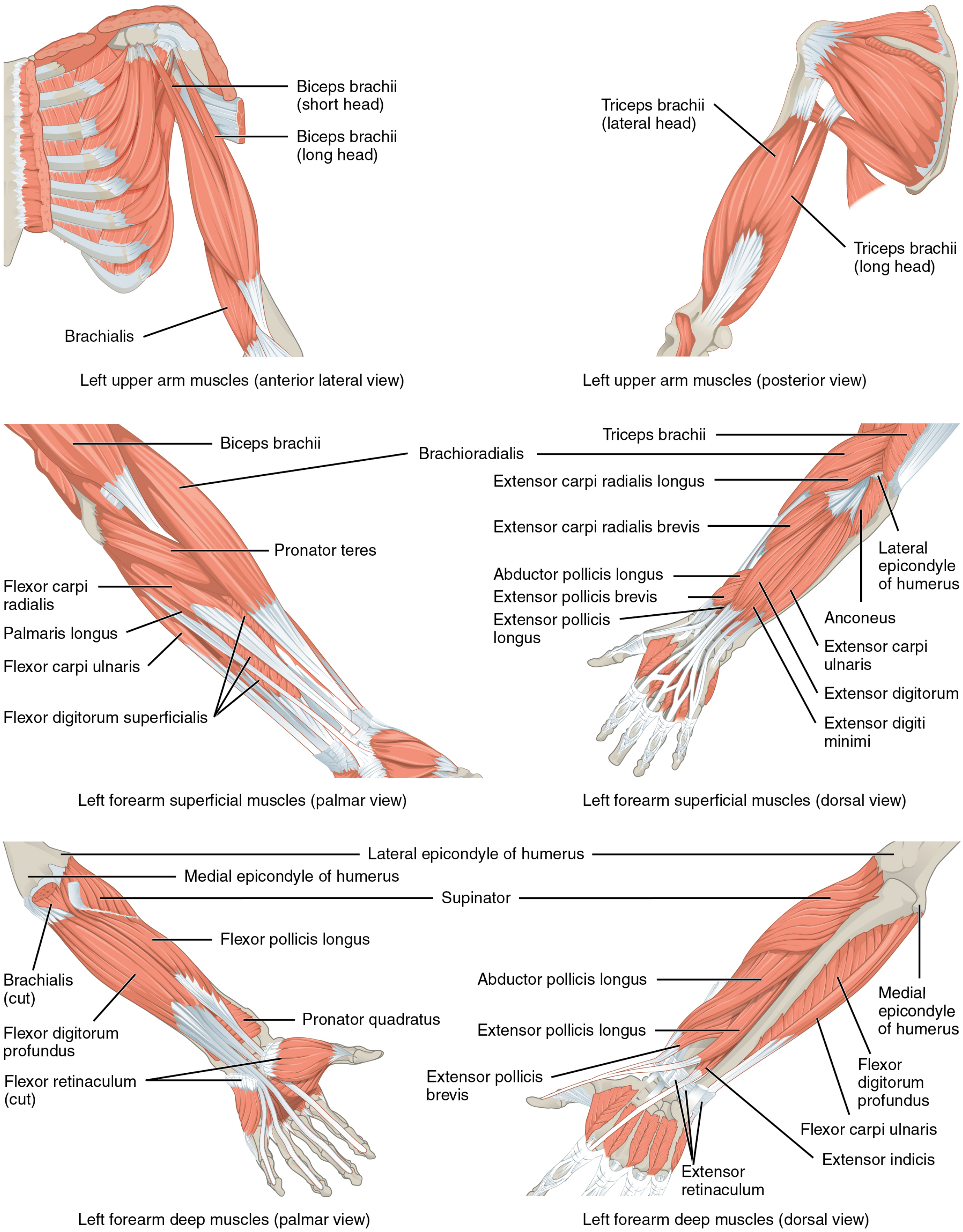


FIGURE 11.25 **Muscles That Move the Forearm** The muscles originating in the upper arm flex, extend, pronate, and supinate the forearm. The muscles originating in the forearm move the wrists, hands, and fingers.

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Anterior muscles (flexion)					
Performs a bicep curl; also allows palm of hand to point toward body while flexing	Forearm	Flexion; supination	Biceps brachii	Coracoid process; tubercle above glenoid cavity	Radial tuberosity
	Forearm	Flexion	Brachialis	Front of distal humerus	Coronoid process of ulna
Assists and stabilizes elbow during bicep-curl motion	Forearm	Flexion	Brachioradialis	Lateral supracondylar ridge at distal end of humerus	Base of styloid process of radius
Posterior muscles (extension)					
Extends forearm, as during a punch	Forearm	Extension	Triceps brachii	Infraglenoid tubercle of scapula; posterior shaft of humerus; posterior humeral shaft distal to radial groove	Olecranon process of ulna
Assists in extending forearm; also allows forearm to extend away from body	Forearm	Extension; abduction	Anconeus	Lateral epicondyle of humerus	Lateral aspect of olecranon process of ulna
Anterior muscles (pronation)					
Turns hand palm-down	Forearm	Pronation	Pronator teres	Medial epicondyle of humerus; coronoid process of ulna	Lateral radius
Assists in turning hand palm-down	Forearm	Pronation	Pronator quadratus	Distal portion of anterior ulnar shaft	Distal surface of anterior radius
Posterior muscles (supination)					
Turns hand palm-up	Forearm	Supination	Supinator	Lateral epicondyle of humerus; proximal ulna	Proximal end of radius

FIGURE 11.26 Muscles That Move the Forearm

Muscles That Move the Wrist, Hand, and Fingers

Wrist, hand, and finger movements are facilitated by two groups of muscles. The forearm is the origin of the **extrinsic muscles of the hand**. The palm is the origin of the intrinsic muscles of the hand.

Muscles of the Arm That Move the Wrists, Hands, and Fingers

The muscles in the **anterior compartment of the forearm** (anterior flexor compartment of the forearm) originate on the humerus and insert onto different parts of the hand. These make up the bulk of the forearm. From lateral to medial, the **superficial anterior compartment of the forearm** includes the **flexor carpi radialis**, **palmaris longus**, **flexor carpi ulnaris**, and **flexor digitorum superficialis**. The flexor digitorum superficialis flexes the hand as well as the digits at the knuckles, which allows for rapid finger movements, as in typing or playing a musical instrument (see Figure 11.27 and Table 11.9). However, poor ergonomics can irritate the tendons of these muscles as they slide back and forth with the carpal tunnel of the anterior wrist and pinch the median nerve, which also travels through the tunnel, causing Carpal Tunnel Syndrome. The **deep anterior compartment** produces flexion and bends fingers to make a fist. These are the **flexor pollicis longus** and the **flexor digitorum profundus**.

The muscles in the **superficial posterior compartment of the forearm** (superficial posterior extensor compartment of the forearm) originate on the humerus. These are the **extensor radialis longus**, **extensor carpi radialis brevis**, **extensor digitorum**, **extensor digiti minimi**, and the **extensor carpi ulnaris**.

The muscles of the **deep posterior compartment of the forearm** (deep posterior extensor compartment of the forearm) originate on the radius and ulna. These include the **abductor pollicis longus**, **extensor pollicis brevis**,

extensor pollicis longus, and **extensor indicis** (see Figure 11.27).

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Superficial anterior compartment of forearm					
Bends wrist toward body; tilts hand to side away from body	Wrist; hand	Flexion; abduction	Flexor carpi radialis	Medial epicondyle of humerus	Base of second and third metacarpals
Assists in bending hand up toward shoulder	Wrist	Flexion	Palmaris longus	Medial epicondyle of humerus	Palmar aponeurosis; skin and fascia of palm
Assists in bending hand up toward shoulder; tilts hand to side away from body; stabilizes wrist	Wrist; hand	Flexion, adduction	Flexor carpi ulnaris	Medial epicondyle of humerus; olecranon process; posterior surface of ulna	Pisiform, hamate bones, and base of fifth metacarpal
Bends fingers to make a fist	Wrist; fingers 2–5	Flexion	Flexor digitorum superficialis	Medial epicondyle of humerus; coronoid process of ulna; shaft of radius	Middle phalanges of fingers 2–5
Deep anterior compartment of forearm					
Bends tip of thumb	Thumb	Flexion	Flexor pollicis longus	Anterior surface of radius; interosseous membrane	Distal phalanx of thumb
Bends fingers to make a fist; also bends wrist toward body	Wrist; fingers	Flexion	Flexor digitorum profundus	Coronoid process; anteromedial surface of ulna; interosseous membrane	Distal phalanges of fingers 2–5
Superficial posterior compartment of forearm					
Straightens wrist away from body; tilts hand to side away from body	Wrist	Extension; abduction	Extensor radialis longus	Lateral supracondylar ridge of humerus	Base of second metacarpal
Assists extensor radialis longus in extending and abducting wrist; also stabilizes hand during finger flexion.	Wrist	Extension, abduction	Extensor carpi radialis brevis	Lateral epicondyle of humerus	Base of third metacarpal
Opens fingers and moves them sideways away from the body	Wrist; fingers	Extension; abduction	Extensor digitorum	Lateral epicondyle of humerus	Extensor expansions; distal phalanges of fingers
Extends little finger	Little finger	Extension	Extensor digiti minimi	Lateral epicondyle of humerus	Extensor expansion; distal phalanx of finger 5
Straightens wrist away from body; tilts hand to side toward body	Wrist	Extension; adduction	Extensor carpi ulnaris	Lateral epicondyle of humerus; posterior border of ulna	Base of fifth metacarpal
Deep posterior compartment of forearm					
Moves thumb sideways toward body; extends thumb; moves hand sideways toward body	Wrist; thumb	Thumb: abduction, extension; wrist: abduction	Abductor pollicis longus	Posterior surface of radius and ulna; interosseous membrane	Base of first metacarpal; trapezium
Extends thumb	Thumb	Extension	Extensor pollicis brevis	Dorsal shaft of radius and ulna; interosseous membrane	Base of proximal phalanx of thumb
Extends thumb	Thumb	Extension	Extensor pollicis longus	Dorsal shaft of radius and ulna; interosseous membrane	Base of distal phalanx of thumb
Extends index finger; straightens wrist away from body	Wrist; index finger	Extension	Extensor indicis	Posterior surface of distal ulna; interosseous membrane	Tendon of extensor digitorum of index finger

FIGURE 11.27 **Muscles That Move the Wrist, Hands, and Forearm**

The tendons of the forearm muscles attach to the wrist and extend into the hand. Fibrous bands called **retinacula** sheath the tendons at the wrist. The **flexor retinaculum** extends over the palmar surface of the hand while the **extensor retinaculum** extends over the dorsal surface of the hand.

Intrinsic Muscles of the Hand

The **intrinsic muscles of the hand** both originate and insert within it (Figure 11.28). These muscles allow your fingers to also make precise movements for actions, such as typing or writing. These muscles are divided into three groups. The **thenar** muscles are on the radial aspect of the palm. The **hypothenar** muscles are on the medial aspect of the palm, and the **intermediate** muscles are midpalmar.

The thenar muscles include the **abductor pollicis brevis**, **opponens pollicis**, **flexor pollicis brevis**, and the **adductor pollicis**. These muscles form the **thenar eminence**, the rounded contour of the base of the thumb, and all act on the thumb. The movements of the thumb play an integral role in most precise movements of the hand.

The hypothenar muscles include the **abductor digiti minimi**, **flexor digiti minimi brevis**, and the **opponens digiti minimi**. These muscles form the **hypothenar eminence**, the rounded contour of the little finger, and as such, they all act on the little finger. Finally, the intermediate muscles act on all the fingers and include the **lumbrical**, the **palmar interossei**, and the **dorsal interossei**.

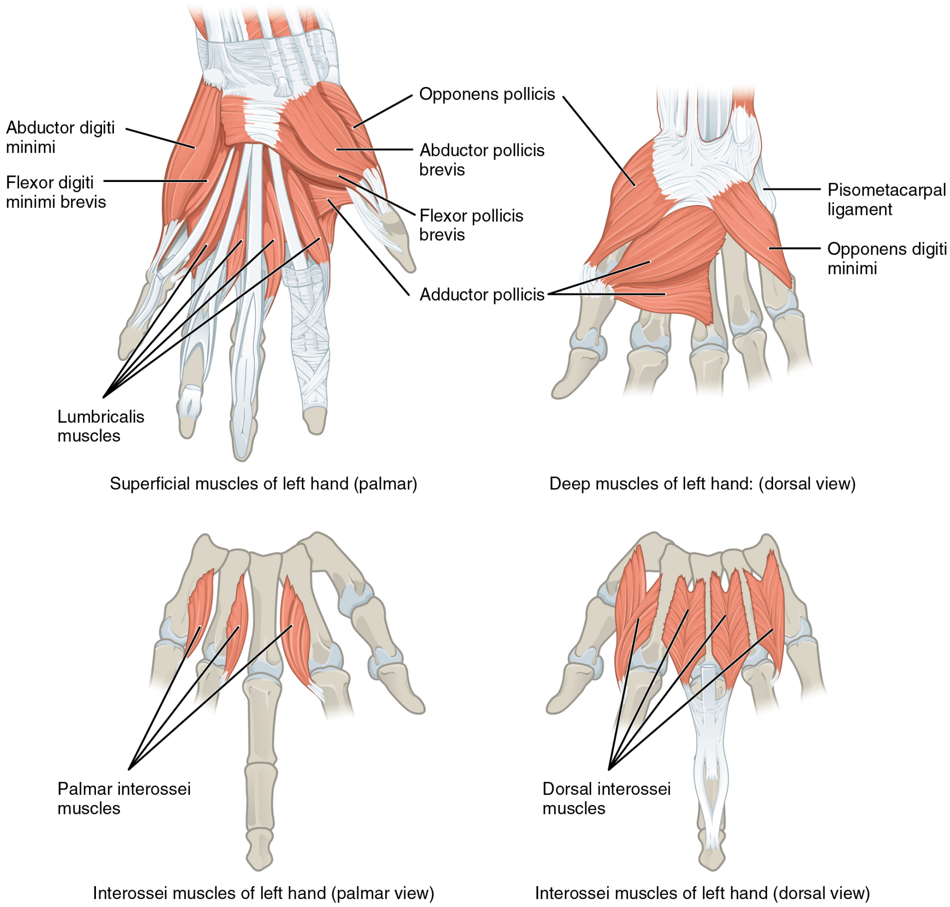


FIGURE 11.28 **Intrinsic Muscles of the Hand** The intrinsic muscles of the hand both originate and insert within the hand. These muscles provide the fine motor control of the fingers by flexing, extending, abducting, and adducting the more distal finger and thumb segments.

Intrinsic Muscles of the Hand

Muscle	Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Thenar muscles	Moves thumb toward body	Thumb	Abduction	Abductor pollicis brevis	Flexor retinaculum; and nearby carpals	Lateral base of proximal phalanx of thumb
Thenar muscles	Moves thumb across palm to touch other fingers	Thumb	Opposition	Opponens pollicis	Flexor retinaculum; trapezium	Anterior of first metacarpal
Thenar muscles	Flexes thumb	Thumb	Flexion	Flexor pollicis brevis	Flexor retinaculum; trapezium	Lateral base of proximal phalanx of thumb
Thenar muscles	Moves thumb away from body	Thumb	Adduction	Adductor pollicis	Capitate bone; bases of metacarpals 2–4; front of metacarpal 3	Medial base of proximal phalanx of thumb
Hypothenar muscles	Moves little finger toward body	Little finger	Abduction	Abductor digiti minimi	Pisiform bone	Medial side of proximal phalanx of little finger
Hypothenar muscles	Flexes little finger	Little finger	Flexion	Flexor digiti minimi brevis	Hamate bone; flexor retinaculum	Medial side of proximal phalanx of little finger
Hypothenar muscles	Moves little finger across palm to touch thumb	Little finger	Opposition	Opponens digiti minimi	Hamate bone; flexor retinaculum	Medial side of fifth metacarpal
Intermediate muscles	Flexes each finger at metacarpo-phalangeal joints; extends each finger at interphalangeal joints	Fingers	Flexion	Lumbricals	Palm (lateral sides of tendons in flexor digitorum profundus)	Fingers 2–5 (lateral edges of extensional expansions on first phalanges)

TABLE 11.9

Muscle	Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Intermediate muscles	Adducts and flexes each finger at metacarpo-phalangeal joints; extends each finger at interphalangeal joints	Fingers	Adduction; flexion; extension	Palmar interossei	Side of each metacarpal that faces metacarpal 3 (absent from metacarpal 3)	Extensor expansion on first phalanx of each finger (except finger 3) on side facing finger 3
Intermediate muscles	Abducts and flexes the three middle fingers at metacarpo-phalangeal joints; extends the three middle fingers at interphalangeal joints	Fingers	Abduction; flexion; extension	Dorsal interossei	Sides of metacarpals	Both sides of finger 3; for each other finger, extensor expansion over first phalanx on side opposite finger 3

TABLE 11.9

11.6 Appendicular Muscles of the Pelvic Girdle and Lower Limbs

LEARNING OBJECTIVES

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

- Identify the appendicular muscles of the pelvic girdle and lower limb
- Identify the movement and function of the pelvic girdle and lower limb

The appendicular muscles of the lower body position and stabilize the **pelvic girdle**, which serves as a foundation for the lower limbs. Comparatively, there is much more movement at the pectoral girdle than at the pelvic girdle. There is very little movement of the pelvic girdle because of its connection with the sacrum at the base of the axial skeleton. The pelvic girdle is less range of motion because it was designed to stabilize and support the body.

Muscles of the Thigh

What would happen if the pelvic girdle, which attaches the lower limbs to the torso, were capable of the same range of motion as the pectoral girdle? For one thing, walking would expend more energy if the heads of the femurs were not secured in the acetabula of the pelvis. The body’s center of gravity is in the area of the pelvis. If the center of gravity were not to remain fixed, standing up would be difficult as well. Therefore, what the leg muscles lack in range of motion and versatility, they make up for in size and power, facilitating the body’s stabilization, posture, and movement.

Gluteal Region Muscles That Move the Femur

Most muscles that insert on the femur (the thigh bone) and move it, originate on the pelvic girdle. The **psoas major** and **iliacus** make up the **iliopsoas group**. Some of the largest and most powerful muscles in the body are the gluteal muscles or **gluteal group**. The **gluteus maximus** is the largest; deep to the gluteus maximus is the **gluteus medius**, and deep to the gluteus medius is the **gluteus minimus**, the smallest of the trio (Figure 11.29 and Figure 11.30).

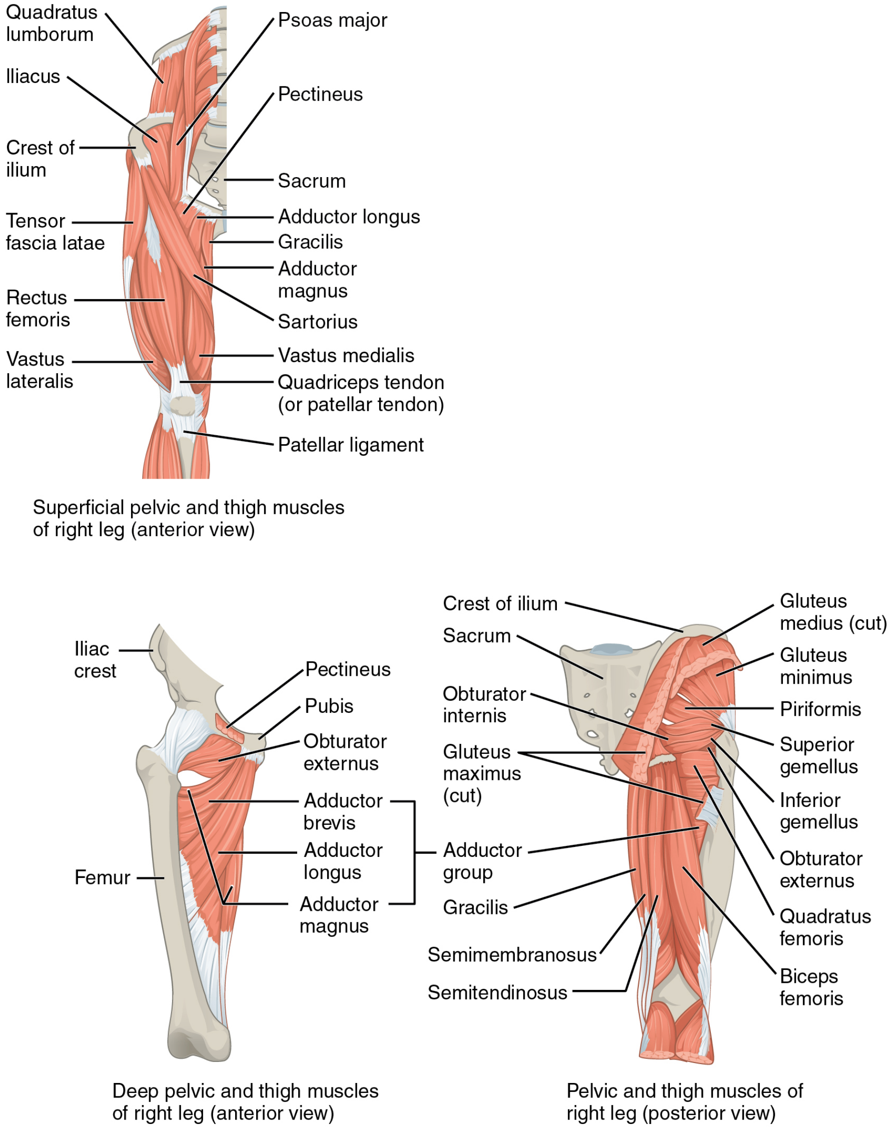


FIGURE 11.29 Hip and Thigh Muscles The large and powerful muscles of the hip that move the femur generally originate on the pelvic girdle and insert into the femur. The muscles that move the lower leg typically originate on the femur and insert into the bones of the knee joint. The anterior muscles of the femur extend the lower leg but also aid in flexing the thigh. The posterior muscles of the femur flex the lower leg but also aid in extending the thigh. A combination of gluteal and thigh muscles also adduct, abduct, and rotate the thigh and lower leg.

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Iliopsoas group					
Raises knee at hip, as if performing a knee attack; assists lateral rotators in twisting thigh (and lower leg) outward; assists with bending over, maintaining posture	Femur	Thigh: flexion and lateral rotation; torso: flexion	Psoas major	Lumbar vertebrae (L1–L5); thoracic vertebra (T12)	Lesser trochanter of femur
Raises knee at hip, as if performing a knee attack; assists lateral rotators in twisting thigh (and lower leg) outward; assists with bending over, maintaining posture	Femur	Thigh: flexion and lateral rotation; torso: flexion	Iliacus	Iliac fossa; iliac crest; lateral sacrum	Lesser trochanter of femur
Gluteal group					
Lowers knee and moves thigh back, as when getting ready to kick a ball	Femur	Extension	Gluteus maximus	Dorsal ilium; sacrum; coccyx	Gluteal tuberosity of femur; iliotibial tract
Opens thighs, as when doing a split	Femur	Abduction	Gluteus medius	Lateral surface of ilium	Greater trochanter of femur
Brings the thighs back together	Femur	Abduction	Gluteus minimus	External surface of ilium	Greater trochanter of femur
Assists with raising knee at hip and opening thighs; maintains posture by stabilizing the iliotibial track, which connects to the knee	Femur	Flexion; abduction	Tensor fascia lata	Anterior aspect of iliac crest; anterior superior iliac spine	Iliotibial tract
Lateral rotators					
Twists thigh (and lower leg) outward; maintains posture by stabilizing hip joint	Femur	Lateral rotation	Piriformis	Anterolateral surface of sacrum	Greater trochanter of femur
Twists thigh (and lower leg) outward; maintains posture by stabilizing hip joint	Femur	Lateral rotation	Obutrator internus	Inner surface of obturator membrane; greater sciatic notch; margins of obturator foramen	Greater trochanter in front of piriformis
Twists thigh (and lower leg) outward; maintains posture by stabilizing hip joint	Femur	Lateral rotation	Obutrator externus	Outer surfaces of obturator membrane, pubic, and ischium; margins of obturator foramen	Trochanteric fossa of posterior femur
Twists thigh (and lower leg) outward; maintains posture by stabilizing hip joint	Femur	Lateral rotation	Superior gemellus	Ischial spine	Greater trochanter of femur
Twists thigh (and lower leg) outward; maintains posture by stabilizing hip joint	Femur	Lateral rotation	Inferior gemellus	Ischial tuberosity	Greater trochanter of femur
Twists thigh (and lower leg) outward; maintains posture by stabilizing hip joint	Femur	Lateral rotation	Quadratus femoris	Ischial tuberosity	Trochanteric crest of femur
Adductors					
Brings the thighs back together; assists with raising the knee	Femur	Adduction; flexion	Adductor longus	Pubis near pubic symphysis	Linea aspera
Brings the thighs back together; assists with raising the knee	Femur	Adduction; flexion	Adductor brevis	Body of pubis; inferior ramus of pubis	Linea aspera above adductor longus
Brings the thighs back together; assists with raising the knee and moving the thigh back	Femur	Adduction; flexion; extension	Adductor magnus	Ischial rami; pubic rami; ischial tuberosity	Linea aspera; adductor tubercle of femur
Opens thighs; assists with raising the knee and turning the thigh (and lower leg) inward	Femur	Adduction; flexion; medial rotation	Pectineus	Pectineal line of pubis	Lesser trochanter to linea aspera of posterior aspect of femur

FIGURE 11.30 **Gluteal Region Muscles That Move the Femur**

The **tensor fascia latae** is a thick, squarish muscle in the superior aspect of the lateral thigh. It acts as a synergist of the gluteus medius and iliopsoas in flexing and abducting the thigh. It also helps stabilize the lateral aspect of the knee by pulling on the **iliotibial tract** (band), making it taut. Deep to the gluteus maximus, the **piriformis**, **obturator internus**, **obturator externus**, **superior gemellus**, **inferior gemellus**, and **quadratus femoris** laterally rotate the femur at the hip.

The **adductor longus**, **adductor brevis**, and **adductor magnus** can both medially and laterally rotate the thigh depending on the placement of the foot. The adductor longus flexes the thigh, whereas the adductor magnus extends it. The **pectineus** adducts and flexes the femur at the hip as well. The pectineus is located in the **femoral triangle**, which is formed at the junction between the hip and the leg and also includes the femoral nerve, the femoral artery, the femoral vein, and the deep inguinal lymph nodes.

Thigh Muscles That Move the Femur, Tibia, and Fibula

Deep fascia in the thigh separates it into medial, anterior, and posterior compartments (see Figure 11.29 and Figure 11.31). The muscles in the **medial compartment of the thigh** are responsible for adducting the femur at the hip. Along with the adductor longus, adductor brevis, adductor magnus, and pectineus, the strap-like **gracilis** adducts the thigh in addition to flexing the leg at the knee.

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Medial compartment of thigh					
Moves back of lower legs up toward buttocks, as when kneeling; assists in opening thighs	Femur; tibia/fibula	Tibia/fibula: flexion; thigh: adduction	Gracilis	Inferior ramus; body of pubis; ischial ramus	Medial surface of tibia
Anterior compartment of thigh: Quadriceps femoris group					
Moves lower leg out in front of body, as when kicking; assists in raising the knee	Femur; tibia/fibula	Tibia/fibula: extension; thigh: flexion	Rectus femoris	Anterior inferior iliac spine; superior margin of acetabulum	Patella; tibial tuberosity
Moves lower leg out in front of body, as when kicking	Tibia/fibula	Extension	Vastus lateralis	Greater trochanter; intertrochanteric line; linea aspera	Patella; tibial tuberosity
Moves lower leg out in front of body, as when kicking	Tibia/fibula	Extension	Vastus medialis	Linea aspera; intertrochanteric line	Patella; tibial tuberosity
Moves lower leg out in front of body, as when kicking	Tibia/fibula	Extension	Vastus intermedius	Proximal femur shaft	Patella; tibial tuberosity
Moves back of lower legs up and back toward the buttocks, as when kneeling; assists in moving thigh diagonally upward and outward as when mounting a bike	Femur; tibia/fibula	Tibia: flexion; thigh: flexion, abduction, lateral rotation	Sartorius	Anterior superior iliac spine	Medial aspect of proximal tibia
Posterior compartment of thigh: Hamstring group					
Moves back of lower legs up and back toward the buttocks, as when kneeling; moves thigh down and back; twists the thigh (and lower leg) outward	Femur; tibia/fibula	Tibia/fibula: flexion; thigh: extension, lateral rotation	Biceps femoris	Ischial tuberosity; linea aspera; distal femur	Head of fibula; lateral condyle of tibia
Moves back of lower legs up toward buttocks, as when kneeling; moves thigh down and back; twists the thigh (and lower leg) inward	Femur; tibia/fibula	Tibia/fibula: flexion; thigh: extension, medial rotation	Semitendinosus	Ischial tuberosity	Upper tibial shaft
Moves back of lower legs up and back toward the buttocks as when kneeling; moves thigh down and back; twists the thigh (and lower leg) inward	Femur; tibia/fibula	Tibia/fibula: flexion; thigh: extension, medial rotation	Semi-membranosus	Ischial tuberosity	Medial condyle of tibia; lateral condyle of femur

FIGURE 11.31 Thigh Muscles That Move the Femur, Tibia, and Fibula

The muscles of the **anterior compartment of the thigh** flex the thigh and extend the leg. This compartment contains the **quadriceps femoris group**, which actually comprises four muscles that extend and stabilize the knee. The **rectus femoris** is on the anterior aspect of the thigh, the **vastus lateralis** is on the lateral aspect of the thigh, the **vastus medialis** is on the medial aspect of the thigh, and the **vastus intermedius** is between the vastus lateralis and vastus medialis and deep to the rectus femoris. The tendon common to all four is the **quadriceps tendon** (patellar tendon), which inserts into the patella and continues below it as the **patellar ligament**. The patellar ligament attaches to the tibial tuberosity. In addition to the quadriceps femoris, the **sartorius** is a band-like muscle that extends from the anterior superior iliac spine to the medial side of the proximal tibia. This versatile muscle flexes the leg at the knee and flexes, abducts, and laterally rotates the leg at the hip. This muscle allows us to sit cross-legged.

The **posterior compartment of the thigh** includes muscles that flex the leg and extend the thigh. The three long muscles on the back of the knee are the **hamstring group**, which flexes the knee. These are the **biceps femoris**, **semitendinosus**, and **semimembranosus**. The tendons of these muscles form the **popliteal fossa**, the diamond-shaped space at the back of the knee.

Muscles That Move the Feet and Toes

Similar to the thigh muscles, the muscles of the leg are divided by deep fascia into compartments, although the leg has three: anterior, lateral, and posterior (Figure 11.32 and Figure 11.33).

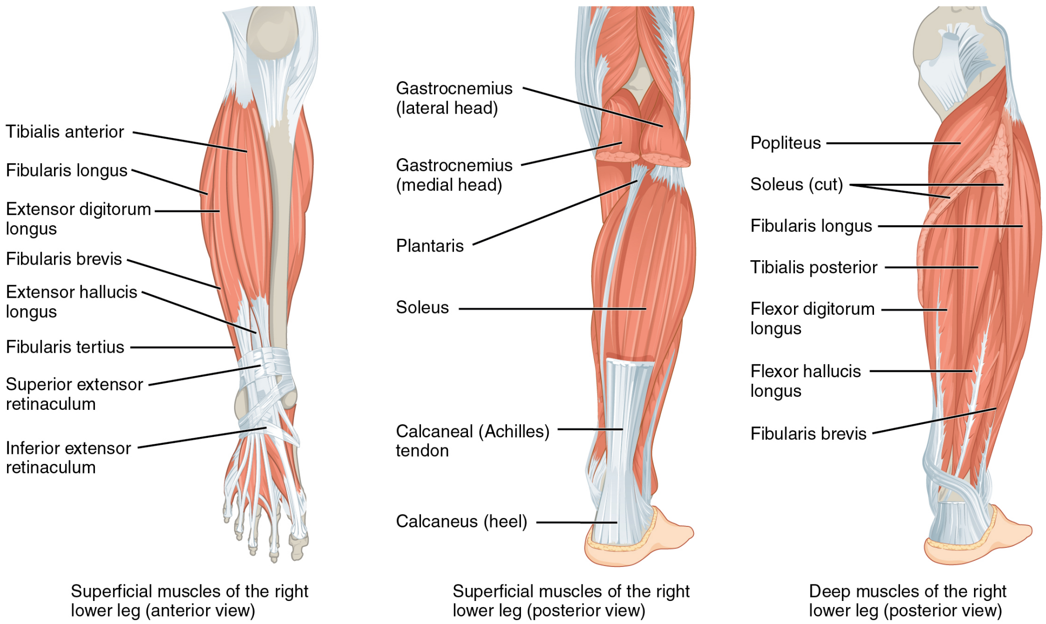


FIGURE 11.32 **Muscles of the Lower Leg** The muscles of the anterior compartment of the lower leg are generally responsible for dorsiflexion, and the muscles of the posterior compartment of the lower leg are generally responsible for plantar flexion. The lateral and medial muscles in both compartments invert, evert, and rotate the foot.

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Anterior compartment of leg					
Raises the sole of the foot off the ground, as when preparing to foot-tap; bends the inside of the foot upwards, as when catching your balance while falling laterally toward the opposite side as the balancing foot	Foot	Dorsiflexion; inversion	Tibialis anterior	Lateral condyle and upper tibial shaft; interosseous membrane	Interior surface of medial cuneiform; First metatarsal bone
Raises the sole of the foot off the ground, as when preparing to foot-tap; extends the big toe	Foot; big toe	Foot: dorsiflexion; big toe: extension	Extensor hallucis longus	Anteromedial fibula shaft; interosseous membrane	Distal phalanx of big toe
Raises the sole of the foot off the ground, as when preparing to foot-tap; extends toes	Foot; toes 2–5	Foot: dorsiflexion; toes: extension	Extensor digitorum longus	Lateral condyle of tibia; proximal portion of fibula; interosseous membrane	Middle and distal phalanges of toes 2–5
Lateral compartment of leg					
Lowers the sole of the foot to the ground, as when foot-tapping or jumping; bends the inside of the foot downwards, as when catching your balance while falling laterally toward the same side as the balancing foot	Foot	Plantar flexion and eversion	Fibularis longus	Upper portion of lateral fibula	First metatarsal; medial cuneiform
Lowers the sole of the foot to the ground, as when foot-tapping or jumping; bends the inside of the foot downward, as when catching your balance while falling laterally toward the same side as the balancing foot	Foot	Plantar flexion and eversion	Fibularis (peroneus) brevis	Distal fibula shaft	Proximal end of fifth metatarsal
Posterior compartment of leg: Superficial muscles					
Lowers the sole of the foot to the ground, as when foot-tapping or jumping; assists in moving the back of the lower legs up and back toward the buttocks	Foot; tibia/ fibula	Foot: plantar flexion; tibia/fibula: flexion	Gastrocnemius	Medial and lateral condyles of femur	Posterior calcaneus
Lowers the sole of the foot to the ground, as when foot-tapping or jumping; maintains posture while walking	Foot	Plantar flexion	Soleus	Superior tibia; fibula; interosseous membrane	Posterior calcaneus
Lowers the sole of the foot to the ground, as when foot-tapping or jumping; assists in moving the back of the lower legs up and back toward the buttocks	Foot; tibia/ fibula	Foot: plantar flexion; tibia/fibula: flexion	Plantaris	Posterior femur above lateral condyle	Calcaneus or calcaneus tendon
Lowers the sole of the foot to the ground, as when foot-tapping or jumping	Foot	Plantar flexion	Tibialis posterior	Superior tibia and fibula; interosseous membrane	Several tarsals and metatarsals 2–4
Posterior compartment of leg: Deep muscles					
Moves the back of the lower legs up and back toward the buttocks; assists in rotation of the leg at the knee and thigh	Tibia/ fibula	Tibia/fibula: flexion thigh and lower leg: medial and lateral rotation	Popliteus	Lateral condyle of femur; lateral meniscus	Proximal tibia
Lowers the sole of the foot to the ground, as when foot-tapping or jumping; bends the inside of the foot upward and flexes toes	Foot; toes 2–5	Foot: plantar flexion and inversion toes: flexion	Flexor digitorum longus	Posterior tibia	Distal phalanges of toes 2–5
Flexes the big toe	Big toe; foot	Big toe: flexion foot: plantar flexion	Flexor hallucis longus	Midshaft of fibula; interosseous membrane	Distal phalanx of big toe

FIGURE 11.33 **Muscles That Move the Feet and Toes**

The muscles in the **anterior compartment of the leg**: the **tibialis anterior**, a long and thick muscle on the lateral surface of the tibia, the **extensor hallucis longus**, deep under it, and the **extensor digitorum longus**, lateral to it, all contribute to raising the front of the foot when they contract. The **fibularis tertius**, a small muscle that originates on the anterior surface of the fibula, is associated with the extensor digitorum longus and sometimes fused to it, but is not present in all people. Thick bands of connective tissue called the **superior extensor retinaculum** (transverse ligament of the ankle) and the **inferior extensor retinaculum**, hold the tendons of these muscles in place during dorsiflexion.

The **lateral compartment of the leg** includes two muscles: the **fibularis longus** (peroneus longus) and the **fibularis brevis** (peroneus brevis). The superficial muscles in the **posterior compartment of the leg** all insert onto the **calcaneal tendon** (Achilles tendon), a strong tendon that inserts into the calcaneal bone of the ankle. The muscles in this compartment are large and strong and keep humans upright. The most superficial and visible muscle of the calf is the **gastrocnemius**. Deep to the gastrocnemius is the wide, flat **soleus**. The **plantaris** runs obliquely between the two; some people may have two of these muscles, whereas no plantaris is observed in about seven percent of other cadaver dissections. The plantaris tendon is a desirable substitute for the fascia lata in hernia repair, tendon transplants, and repair of ligaments. There are four deep muscles in the posterior compartment of the leg as well: the **popliteus**, **flexor digitorum longus**, **flexor hallucis longus**, and **tibialis posterior**.

The foot also has intrinsic muscles, which originate and insert within it (similar to the intrinsic muscles of the hand). These muscles primarily provide support for the foot and its arch, and contribute to movements of the toes (Figure 11.34 and Figure 11.35). The principal support for the longitudinal arch of the foot is a deep fascia called **plantar aponeurosis**, which runs from the calcaneus bone to the toes (inflammation of this tissue is the cause of "plantar fasciitis," which can affect runners. The intrinsic muscles of the foot consist of two groups. The **dorsal group** includes only one muscle, the **extensor digitorum brevis**. The second group is the **plantar group**, which consists of four layers, starting with the most superficial.

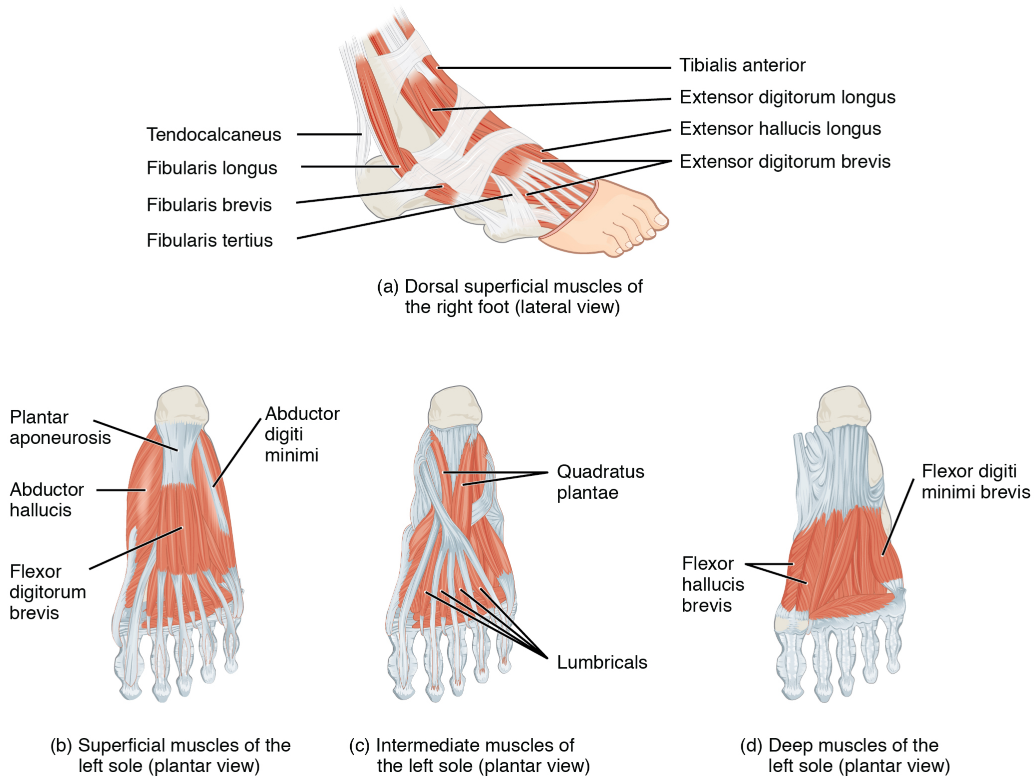


FIGURE 11.34 **Intrinsic Muscles of the Foot** The muscles along the dorsal side of the foot (a) generally extend the toes while the muscles of the plantar side of the foot (b, c, d) generally flex the toes. The plantar muscles exist in three layers, providing the foot the strength to counterbalance the weight of the body. In this diagram, these three layers are shown from a plantar view beginning with the bottom-most layer just under the plantar skin of the foot (b) and ending with the top-most layer (d) located just inferior to the foot and toe bones.

Movement	Target	Target motion direction	Prime mover	Origin	Insertion
Dorsal group					
Extends toes 2–5	Toes 2–5	Extension	Extensor digitorum brevis	Calcaneus; extensor retinaculum	Base of proximal phalanx of big toe; extensor expansions on toes 2–5
Plantar group (layer 1)					
Abducts and flexes big toe	Big toe	Adduction; flexion	Abductor hallucis	Calcaneal tuberosity; flexor retinaculum	Proximal phalanx of big toe
Flexes toes 2–4	Middle toes	Flexion	Flexor digitorum brevis	Calcaneal tuberosity	Middle phalanx of toes 2–4
Abducts and flexes small toe	Toe 5	Abduction; flexion	Abductor digiti minimi	Calcaneal tuberosity	Proximal phalanx of little toe
Plantar group (layer 2)					
Assists in flexing toes 2–5	Toes 2–5	Flexion	Quadratus plantae	Medial and lateral sides of calcaneus	Tendon of flexor digitorum longus
Extends toes 2–5 at the interphalangeal joints; flexes the small toes at the metatarsophalangeal joints	Toes 2–5	Extension; flexion	Lumbricals	Tendons of flexor digitorum longus	Medial side of proximal phalanx of toes 2–5
Plantar group (layer 3)					
Flexes big toe	Big toe	Flexion	Flexor hallucis brevis	Lateral cuneiform; cuboid bones	Base of proximal phalanx of big toe
Adducts and flexes big toe	Big toe	Adduction; flexion	Adductor hallucis	Bases of metatarsals 2–4; fibularis longus tendon sheath; ligament across metatarsophalangeal joints	Base of proximal phalanx of big toe
Flexes small toe	Little toe	Flexion	Flexor digiti minimi brevis	Base of metatarsal 5; tendon sheath of fibularis longus	Base of proximal phalanx of little toe
Plantar group (layer 4)					
Abducts and flexes middle toes at metatarsophalangeal joints; extends middle toes at interphalangeal joints	Middle toes	Abduction; flexion; extension	Dorsal interossei	Sides of metatarsals	Both sides of toe 2; for each other toe, extensor expansion over first phalanx on side opposite toe 2
Abducts toes 3–5; flexes proximal phalanges and extends distal phalanges	Small toes	Abduction; flexion; extension	Plantar interossei	Side of each metatarsal that faces metatarsal 2 (absent from metatarsal 2)	Extensor expansion on first phalanx of each toe (except to 2) on side facing toe 2

FIGURE 11.35 Intrinsic Muscles in the Foot

Key Terms

abduct move away from midline in the sagittal plane

abductor moves the bone away from the midline

abductor digiti minimi muscle that abducts the little finger

abductor pollicis brevis muscle that abducts the thumb

abductor pollicis longus muscle that inserts into the first metacarpal

adductor moves the bone toward the midline

adductor brevis muscle that adducts and medially rotates the thigh

adductor longus muscle that adducts, medially rotates, and flexes the thigh

adductor magnus muscle with an anterior fascicle that adducts, medially rotates and flexes the thigh, and a posterior fascicle that assists in thigh extension

adductor pollicis muscle that adducts the thumb

agonist (also, prime mover) muscle whose contraction is responsible for producing a particular motion

anal triangle posterior triangle of the perineum that includes the anus

anconeus small muscle on the lateral posterior elbow that extends the forearm

antagonist muscle that opposes the action of an agonist

anterior compartment of the arm (anterior flexor compartment of the arm) the biceps brachii, brachialis, brachioradialis, and their associated blood vessels and nerves

anterior compartment of the forearm (anterior flexor compartment of the forearm) deep and superficial muscles that originate on the humerus and insert into the hand

anterior compartment of the leg region that includes muscles that dorsiflex the foot

anterior compartment of the thigh region that includes muscles that flex the thigh and extend the leg

anterior scalene a muscle anterior to the middle scalene

appendicular of the arms and legs

axial of the trunk and head

belly bulky central body of a muscle

bi two

biceps brachii two-headed muscle that crosses the shoulder and elbow joints to flex the forearm while assisting in supinating it and flexing the arm at the shoulder

biceps femoris hamstring muscle

bipennate pennate muscle that has fascicles that are located on both sides of the tendon

brachialis muscle deep to the biceps brachii that provides power in flexing the forearm.

brachioradialis muscle that can flex the forearm quickly or help lift a load slowly

brevis short

buccinator muscle that compresses the cheek

calcaneal tendon (also, Achilles tendon) strong tendon that inserts into the calcaneal bone of the ankle

caval opening opening in the diaphragm that allows the inferior vena cava to pass through; foramen for the vena cava

circular (also, sphincter) fascicles that are concentrically arranged around an opening

compressor urethrae deep perineal muscle in females

convergent fascicles that extend over a broad area and converge on a common attachment site

coracobrachialis muscle that flexes and adducts the arm

corrugator supercilii prime mover of the eyebrows

deep anterior compartment flexor pollicis longus, flexor digitorum profundus, and their associated blood vessels and nerves

deep posterior compartment of the forearm (deep posterior extensor compartment of the forearm) the abductor pollicis longus, extensor pollicis brevis, extensor pollicis longus, extensor indicis, and their associated blood vessels and nerves

deep transverse perineal deep perineal muscle in males

deglutition swallowing

deltoid shoulder muscle that abducts the arm as well as flexes and medially rotates it, and extends and laterally rotates it

diaphragm skeletal muscle that separates the thoracic and abdominal cavities and is dome-shaped at rest

digastric muscle that has anterior and posterior bellies and elevates the hyoid bone and larynx when one swallows; it also depresses the mandible

dorsal group region that includes the extensor digitorum brevis

dorsal interossei muscles that abduct and flex the three middle fingers at the metacarpophalangeal joints and extend them at the interphalangeal joints

epicranial aponeurosis (also, galea aponeurosis) flat broad tendon that connects the frontalis and occipitalis

erector spinae group large muscle mass of the back; primary extensor of the vertebral column

extensor muscle that increases the angle at the joint
extensor carpi radialis brevis muscle that extends and abducts the hand at the wrist
extensor carpi ulnaris muscle that extends and adducts the hand
extensor digiti minimi muscle that extends the little finger
extensor digitorum muscle that extends the hand at the wrist and the phalanges
extensor digitorum brevis muscle that extends the toes
extensor digitorum longus muscle that is lateral to the tibialis anterior
extensor hallucis longus muscle that is partly deep to the tibialis anterior and extensor digitorum longus
extensor indicis muscle that inserts onto the tendon of the extensor digitorum of the index finger
extensor pollicis brevis muscle that inserts onto the base of the proximal phalanx of the thumb
extensor pollicis longus muscle that inserts onto the base of the distal phalanx of the thumb
extensor radialis longus muscle that extends and abducts the hand at the wrist
extensor retinaculum band of connective tissue that extends over the dorsal surface of the hand
external intercostal superficial intercostal muscles that raise the rib cage
external oblique superficial abdominal muscle with fascicles that extend inferiorly and medially
extrinsic eye muscles originate outside the eye and insert onto the outer surface of the white of the eye, and create eyeball movement
extrinsic muscles of the hand muscles that move the wrists, hands, and fingers and originate on the arm
fascicle muscle fibers bundled by perimysium into a unit
femoral triangle region formed at the junction between the hip and the leg and includes the pectineus, femoral nerve, femoral artery, femoral vein, and deep inguinal lymph nodes
fibularis brevis (also, peroneus brevis) muscle that plantar flexes the foot at the ankle and everts it at the intertarsal joints
fibularis longus (also, peroneus longus) muscle that plantar flexes the foot at the ankle and everts it at the intertarsal joints
fibularis tertius small muscle that is associated with the extensor digitorum longus
fixator synergist that assists an agonist by preventing or reducing movement at another joint, thereby stabilizing the origin of the agonist
flexion movement that decreases the angle of a joint
flexor muscle that decreases the angle at the joint
flexor carpi radialis muscle that flexes and abducts the hand at the wrist
flexor carpi ulnaris muscle that flexes and adducts the hand at the wrist
flexor digiti minimi brevis muscle that flexes the little finger
flexor digitorum longus muscle that flexes the four small toes
flexor digitorum profundus muscle that flexes the phalanges of the fingers and the hand at the wrist
flexor digitorum superficialis muscle that flexes the hand and the digits
flexor hallucis longus muscle that flexes the big toe
flexor pollicis brevis muscle that flexes the thumb
flexor pollicis longus muscle that flexes the distal phalanx of the thumb
flexor retinaculum band of connective tissue that extends over the palmar surface of the hand
frontalis front part of the occipitofrontalis muscle
fusiform muscle that has fascicles that are spindle-shaped to create large bellies
gastrocnemius most superficial muscle of the calf
genioglossus muscle that originates on the mandible and allows the tongue to move downward and forward
geniohyoid muscle that depresses the mandible, and raises and pulls the hyoid bone anteriorly
gluteal group muscle group that extends, flexes, rotates, adducts, and abducts the femur
gluteus maximus largest of the gluteus muscles that extends the femur
gluteus medius muscle deep to the gluteus maximus that abducts the femur at the hip
gluteus minimus smallest of the gluteal muscles and deep to the gluteus medius
gracilis muscle that adducts the thigh and flexes the leg at the knee
hamstring group three long muscles on the back of the leg
hyoglossus muscle that originates on the hyoid bone to move the tongue downward and flatten it
hypothenar group of muscles on the medial aspect of the palm
hypothenar eminence rounded contour of muscle at the base of the little finger
iliacus muscle that, along with the psoas major, makes up the iliopsoas
iliococcygeus muscle that makes up the levator ani along with the pubococcygeus
iliocostalis cervicis muscle of the iliocostalis group associated with the cervical region
iliocostalis group laterally placed muscles of the

erector spinae
iliocostalis lumborum muscle of the iliocostalis group associated with the lumbar region
iliocostalis thoracis muscle of the iliocostalis group associated with the thoracic region
iliopsoas group muscle group consisting of iliacus and psoas major muscles, that flexes the thigh at the hip, rotates it laterally, and flexes the trunk of the body onto the hip
iliotibial tract muscle that inserts onto the tibia; made up of the gluteus maximus and connective tissues of the tensor fasciae latae
inferior extensor retinaculum cruciate ligament of the ankle
inferior gemellus muscle deep to the gluteus maximus on the lateral surface of the thigh that laterally rotates the femur at the hip
infrahyoid muscles anterior neck muscles that are attached to, and inferior to the hyoid bone
infraspinatus muscle that laterally rotates the arm
innermost intercostal the deepest intercostal muscles that draw the ribs together
insertion end of a skeletal muscle that is attached to the structure (usually a bone) that is moved when the muscle contracts
intercostal muscles muscles that span the spaces between the ribs
intermediate group of midpalmar muscles
internal intercostal muscles the intermediate intercostal muscles that draw the ribs together
internal oblique flat, intermediate abdominal muscle with fascicles that run perpendicular to those of the external oblique
intrinsic muscles of the hand muscles that move the wrists, hands, and fingers and originate in the palm
ischiococcygeus muscle that assists the levator ani and pulls the coccyx anteriorly
lateral compartment of the leg region that includes the fibularis (peroneus) longus and the fibularis (peroneus) brevis and their associated blood vessels and nerves
lateral pterygoid muscle that moves the mandible from side to side
lateralis to the outside
latissimus dorsi broad, triangular axial muscle located on the inferior part of the back
levator ani pelvic muscle that resists intra-abdominal pressure and supports the pelvic viscera
linea alba white, fibrous band that runs along the midline of the trunk
longissimus capitis muscle of the longissimus group associated with the head region
longissimus cervicis muscle of the longissimus group associated with the cervical region
longissimus group intermediately placed muscles of the erector spinae
longissimus thoracis muscle of the longissimus group associated with the thoracic region
longus long
lumbrical muscle that flexes each finger at the metacarpophalangeal joints and extend each finger at the interphalangeal joints
masseter main muscle for chewing that elevates the mandible to close the mouth
mastication chewing
maximus largest
medial compartment of the thigh a region that includes the adductor longus, adductor brevis, adductor magnus, pectineus, gracilis, and their associated blood vessels and nerves
medial pterygoid muscle that moves the mandible from side to side
medialis to the inside
medius medium
middle scalene longest scalene muscle, located between the anterior and posterior scalenes
minimus smallest
multifidus muscle of the lumbar region that helps extend and laterally flex the vertebral column
multipennate pennate muscle that has a tendon branching within it
mylohyoid muscle that lifts the hyoid bone and helps press the tongue to the top of the mouth
oblique at an angle
obturator externus muscle deep to the gluteus maximus on the lateral surface of the thigh that laterally rotates the femur at the hip
obturator internus muscle deep to the gluteus maximus on the lateral surface of the thigh that laterally rotates the femur at the hip
occipitalis posterior part of the occipitofrontalis muscle
occipitofrontalis muscle that makes up the scalp with a frontal belly and an occipital belly
omohyoid muscle that has superior and inferior bellies and depresses the hyoid bone
opponens digiti minimi muscle that brings the little finger across the palm to meet the thumb
opponens pollicis muscle that moves the thumb across the palm to meet another finger
orbicularis oculi circular muscle that closes the eye
orbicularis oris circular muscle that moves the lips
origin end of a skeletal muscle that is attached to another structure (usually a bone) in a fixed position
palatoglossus muscle that originates on the soft palate to elevate the back of the tongue

palmar interossei muscles that abduct and flex each finger at the metacarpophalangeal joints and extend each finger at the interphalangeal joints
palmaris longus muscle that provides weak flexion of the hand at the wrist
parallel fascicles that extend in the same direction as the long axis of the muscle
patellar ligament extension of the quadriceps tendon below the patella
pectineus muscle that abducts and flexes the femur at the hip
pectoral girdle shoulder girdle, made up of the clavicle and scapula
pectoralis major thick, fan-shaped axial muscle that covers much of the superior thorax
pectoralis minor muscle that moves the scapula and assists in inhalation
pelvic diaphragm muscular sheet that comprises the levator ani and the ischiococcygeus
pelvic girdle hips, a foundation for the lower limb
pennate fascicles that are arranged differently based on their angles to the tendon
perineum diamond-shaped region between the pubic symphysis, coccyx, and ischial tuberosities
piriformis muscle deep to the gluteus maximus on the lateral surface of the thigh that laterally rotates the femur at the hip
plantar aponeurosis muscle that supports the longitudinal arch of the foot
plantar group four-layered group of intrinsic foot muscles
plantaris muscle that runs obliquely between the gastrocnemius and the soleus
popliteal fossa diamond-shaped space at the back of the knee
popliteus muscle that flexes the leg at the knee and creates the floor of the popliteal fossa
posterior compartment of the leg region that includes the superficial gastrocnemius, soleus, and plantaris, and the deep popliteus, flexor digitorum longus, flexor hallucis longus, and tibialis posterior
posterior compartment of the thigh region that includes muscles that flex the leg and extend the thigh
posterior scalene smallest scalene muscle, located posterior to the middle scalene
prime mover (also, agonist) principle muscle involved in an action
pronator quadratus pronator that originates on the ulna and inserts on the radius
pronator teres pronator that originates on the humerus and inserts on the radius
psoas major muscle that, along with the iliacus, makes up the iliopsoas
pubococcygeus muscle that makes up the levator ani along with the iliococcygeus
quadratus femoris muscle deep to the gluteus maximus on the lateral surface of the thigh that laterally rotates the femur at the hip
quadratus lumborum posterior part of the abdominal wall that helps with posture and stabilization of the body
quadriceps femoris group four muscles, that extend and stabilize the knee
quadriceps tendon (also, patellar tendon) tendon common to all four quadriceps muscles, inserts into the patella
rectus straight
rectus abdominis long, linear muscle that extends along the middle of the trunk
rectus femoris quadricep muscle on the anterior aspect of the thigh
rectus sheaths tissue that makes up the linea alba
retinacula fibrous bands that sheath the tendons at the wrist
rhomboid major muscle that attaches the vertebral border of the scapula to the spinous process of the thoracic vertebrae
rhomboid minor muscle that attaches the vertebral border of the scapula to the spinous process of the thoracic vertebrae
rotator cuff (also, musculotendinous cuff) the circle of tendons around the shoulder joint
sartorius band-like muscle that flexes, abducts, and laterally rotates the leg at the hip
scalene muscles flex, laterally flex, and rotate the head; contribute to deep inhalation
segmental muscle group interspinales and intertransversarii muscles that bring together the spinous and transverse processes of each consecutive vertebra
semimembranosus hamstring muscle
semispinalis capitis transversospinales muscle associated with the head region
semispinalis cervicis transversospinales muscle associated with the cervical region
semispinalis thoracis transversospinales muscle associated with the thoracic region
semitendinosus hamstring muscle
serratus anterior large and flat muscle that originates on the ribs and inserts onto the scapula
soleus wide, flat muscle deep to the gastrocnemius
sphincter urethrovaginalis deep perineal muscle in females
spinalis capitis muscle of the spinalis group associated with the head region

spinalis cervicis muscle of the spinalis group associated with the cervical region
spinalis group medially placed muscles of the erector spinae
spinalis thoracis muscle of the spinalis group associated with the thoracic region
splenius posterior neck muscles; includes the splenius capitis and splenius cervicis
splenius capitis neck muscle that inserts into the head region
splenius cervicis neck muscle that inserts into the cervical region
sternocleidomastoid major muscle that laterally flexes and rotates the head
sternohyoid muscle that depresses the hyoid bone
sternothyroid muscle that depresses the larynx's thyroid cartilage
styloglossus muscle that originates on the styloid bone, and allows upward and backward motion of the tongue
stylohyoid muscle that elevates the hyoid bone posteriorly
subclavius muscle that stabilizes the clavicle during movement
subscapularis muscle that originates on the anterior scapula and medially rotates the arm
superficial anterior compartment of the forearm flexor carpi radialis, palmaris longus, flexor carpi ulnaris, flexor digitorum superficialis, and their associated blood vessels and nerves
superficial posterior compartment of the forearm extensor radialis longus, extensor carpi radialis brevis, extensor digitorum, extensor digiti minimi, extensor carpi ulnaris, and their associated blood vessels and nerves
superior extensor retinaculum transverse ligament of the ankle
superior gemellus muscle deep to the gluteus maximus on the lateral surface of the thigh that laterally rotates the femur at the hip
supinator muscle that moves the palm and forearm anteriorly
suprahyoid muscles neck muscles that are superior to the hyoid bone
supraspinatus muscle that abducts the arm
synergist muscle whose contraction helps a prime mover in an action
temporalis muscle that retracts the mandible
tendinous intersections three transverse bands of collagen fibers that divide the rectus abdominis into segments
tensor fascia lata muscle that flexes and abducts the thigh
teres major muscle that extends the arm and assists in adduction and medial rotation of it
teres minor muscle that laterally rotates and extends the arm
thenar group of muscles on the lateral aspect of the palm
thenar eminence rounded contour of muscle at the base of the thumb
thyrohyoid muscle that depresses the hyoid bone and elevates the larynx's thyroid cartilage
tibialis anterior muscle located on the lateral surface of the tibia
tibialis posterior muscle that plantar flexes and inverts the foot
transversospinales muscles that originate at the transverse processes and insert at the spinous processes of the vertebrae
transversus abdominis deep layer of the abdomen that has fascicles arranged transversely around the abdomen
trapezius muscle that stabilizes the upper part of the back
tri three
triceps brachii three-headed muscle that extends the forearm
unipennate pennate muscle that has fascicles located on one side of the tendon
urogenital triangle anterior triangle of the perineum that includes the external genitals
vastus intermedius quadricep muscle that is between the vastus lateralis and vastus medialis and is deep to the rectus femoris
vastus lateralis quadricep muscle on the lateral aspect of the thigh
vastus medialis quadricep muscle on the medial aspect of the thigh

Chapter Review

11.1 Interactions of Skeletal Muscles, Their Fascicle Arrangement, and Their Lever Systems

Skeletal muscles each have an origin and an insertion. The end of the muscle that attaches to the bone being pulled is called the muscle's insertion and the end of the muscle attached to a fixed, or stabilized, bone is called the origin. The muscle primarily responsible for a movement is called the prime mover, and muscles that assist in this action are called synergists. A synergist that makes the insertion site more stable is called a fixator. Meanwhile, a muscle with the opposite action of the prime mover is called an antagonist. Several factors contribute to the force generated by a skeletal muscle. One is the arrangement of the fascicles in the skeletal muscle. Fascicles can be parallel, circular, convergent, pennate, fusiform, or triangular. Each arrangement has its own range of motion and ability to do work.

11.2 Naming Skeletal Muscles

Muscle names are based on many characteristics. The location of a muscle in the body is important. Some muscles are named based on their size and location, such as the gluteal muscles of the buttocks. Other muscle names can indicate the location in the body or bones with which the muscle is associated, such as the tibialis anterior. The shapes of some muscles are distinctive; for example, the direction of the muscle fibers is used to describe muscles of the body midline. The origin and/or insertion can also be features used to name a muscle; examples are the biceps brachii, triceps brachii, and the pectoralis major.

11.3 Axial Muscles of the Head, Neck, and Back

Muscles are either axial muscles or appendicular. The axial muscles are grouped based on location, function, or both. Some axial muscles cross over to the appendicular skeleton. The muscles of the head and neck are all axial. The muscles in the face create facial expression by inserting into the skin rather than onto bone. Muscles that move the eyeballs are extrinsic, meaning they originate outside of the eye and insert onto it. Tongue muscles are both extrinsic and intrinsic. The genioglossus depresses the tongue and moves it anteriorly; the styloglossus lifts the tongue and retracts it; the palatoglossus elevates the back of the tongue; and the hyoglossus depresses and flattens it. The muscles of the anterior neck facilitate swallowing and speech, stabilize the hyoid bone and position the larynx. The muscles of the neck stabilize and move the head. The sternocleidomastoid divides the neck into anterior and posterior triangles.

The muscles of the back and neck that move the vertebral column are complex, overlapping, and can be divided into five groups. The splenius group includes the splenius capitis and the splenius cervicis. The erector spinae has three subgroups. The iliocostalis group includes the iliocostalis cervicis, the iliocostalis thoracis, and the iliocostalis lumborum. The longissimus group includes the longissimus capitis, the longissimus cervicis, and the longissimus thoracis. The spinalis group includes the spinalis capitis, the spinalis cervicis, and the spinalis thoracis. The transversospinales include the semispinalis capitis, semispinalis cervicis, semispinalis thoracis, multifidus, and rotatores. The segmental muscles include the interspinales and intertransversarii. Finally, the scalenes include the anterior scalene, middle scalene, and posterior scalene.

11.4 Axial Muscles of the Abdominal Wall, and Thorax

Made of skin, fascia, and four pairs of muscle, the anterior abdominal wall protects the organs located in the abdomen and moves the vertebral column. These muscles include the rectus abdominis, which extends through the entire length of the trunk, the external oblique, the internal oblique, and the transversus abdominis. The quadratus lumborum forms the posterior abdominal wall.

The muscles of the thorax play a large role in breathing, especially the dome-shaped diaphragm. When it contracts and flattens, the volume inside the pleural cavities increases, which decreases the pressure within them. As a result, air will flow into the lungs. The external and internal intercostal muscles span the space between the ribs and help change the shape of the rib cage and the volume-pressure ratio inside the pleural cavities during inspiration and expiration.

The perineum muscles play roles in urination in both sexes, ejaculation in males, and vaginal contraction in females. The pelvic floor muscles support the pelvic organs, resist intra-abdominal pressure, and work as sphincters for the urethra, rectum, and vagina.

11.5 Muscles of the Pectoral Girdle and Upper Limbs

The clavicle and scapula make up the pectoral girdle, which provides a stable origin for the muscles that move the humerus. The muscles that position and stabilize the pectoral girdle are located on the thorax. The anterior thoracic muscles are the subclavius, pectoralis minor, and the serratus anterior. The posterior thoracic muscles are the trapezius, levator scapulae, rhomboid major, and rhomboid minor. Nine muscles cross the shoulder joint to move the humerus. The ones that originate on the axial skeleton are the pectoralis major and the latissimus dorsi. The deltoid, subscapularis, supraspinatus, infraspinatus, teres major, teres minor, and coracobrachialis originate on the scapula.

The forearm flexors include the biceps brachii, brachialis, and brachioradialis. The extensors are the triceps brachii and anconeus. The pronators are the pronator teres and the pronator quadratus. The supinator is the only one that turns the forearm anteriorly.

The extrinsic muscles of the hands originate along the forearm and insert into the hand in order to facilitate crude movements of the wrists, hands, and fingers. The superficial anterior compartment of the forearm produces flexion. These muscles are the flexor carpi radialis, palmaris longus, flexor carpi ulnaris, and the flexor digitorum superficialis. The deep anterior compartment produces flexion as well. These are the flexor pollicis longus and the flexor digitorum profundus. The rest of the compartments produce extension. The extensor carpi radialis longus, extensor carpi radialis brevis, extensor digitorum, extensor digiti minimi, and extensor carpi ulnaris are the muscles found in the superficial posterior compartment. The deep posterior compartment includes the abductor longus, extensor pollicis brevis, extensor pollicis longus, and the extensor indicis.

Finally, the intrinsic muscles of the hands allow our fingers to make precise movements, such as typing and writing. They both originate and insert within the hand. The thenar muscles, which are located on the lateral part of the palm, are the abductor pollicis brevis, opponens pollicis, flexor pollicis brevis, and adductor pollicis. The hypothenar muscles, which are located on the medial part of the palm, are the abductor digiti minimi, flexor digiti minimi brevis, and opponens digiti minimi. The intermediate muscles, located in the middle of the palm, are the lumbricals, palmar interossei, and dorsal interossei.

11.6 Appendicular Muscles of the Pelvic Girdle and Lower Limbs

The pelvic girdle attaches the legs to the axial skeleton. The hip joint is where the pelvic girdle and the leg come together. The hip is joined to the pelvic girdle by many muscles. In the gluteal region, the psoas major and iliacus form the iliopsoas. The large and strong gluteus maximus, gluteus medius, and gluteus minimus extend and abduct the femur. Along with the gluteus maximus, the tensor fascia lata muscle forms the iliotibial tract. The lateral rotators of the femur at the hip are the piriformis, obturator internus, obturator externus, superior gemellus, inferior gemellus, and quadratus femoris. On the medial part of the thigh, the adductor longus, adductor brevis, and adductor magnus adduct the thigh and medially rotate it. The pectineus muscle adducts and flexes the femur at the hip.

The thigh muscles that move the femur, tibia, and fibula are divided into medial, anterior, and posterior compartments. The medial compartment includes the adductors, pectineus, and the gracilis. The anterior compartment comprises the quadriceps femoris, quadriceps tendon, patellar ligament, and the sartorius. The quadriceps femoris is made of four muscles: the rectus femoris, the vastus lateralis, the vastus medius, and the vastus intermedius, which together extend the knee. The posterior compartment of the thigh includes the hamstrings: the biceps femoris, semitendinosus, and the semimembranosus, which all flex the knee.

The muscles of the leg that move the foot and toes are divided into anterior, lateral, superficial- and deep-posterior compartments. The anterior compartment includes the tibialis anterior, the extensor hallucis longus, the extensor digitorum longus, and the fibularis (peroneus) tertius. The lateral compartment houses the fibularis (peroneus) longus and the fibularis (peroneus) brevis. The superficial posterior compartment has the gastrocnemius, soleus, and plantaris; and the deep posterior compartment has the popliteus, tibialis posterior, flexor digitorum longus, and flexor hallucis longus.

Review Questions

1. Which of the following is unique to the muscles of facial expression?
   a. They all originate from the scalp musculature.
   b. They insert onto the cartilage found around the face.
   c. They only insert onto the facial bones.
   d. They insert into the skin.

2. Which of the following helps an agonist work?
   a. a synergist
   b. a fixator
   c. an insertion
   d. an antagonist

3. Which of the following statements is correct about what happens during flexion?
   a. The angle between bones is increased.
   b. The angle between bones is decreased.
   c. The bone moves away from the body.
   d. The bone moves toward the center of the body.

4. Which is moved the *least* during muscle contraction?
   a. the origin
   b. the insertion
   c. the ligaments
   d. the joints

5. Which muscle has a convergent pattern of fascicles?
   a. biceps brachii
   b. gluteus maximus
   c. pectoralis major
   d. rectus femoris

6. A muscle that has a pattern of fascicles running along the long axis of the muscle has which of the following fascicle arrangements?
   a. circular
   b. pennate
   c. parallel
   d. rectus

7. Which arrangement *best* describes a bipennate muscle?
   a. The muscle fibers feed in on an angle to a long tendon from both sides.
   b. The muscle fibers feed in on an angle to a long tendon from all directions.
   c. The muscle fibers feed in on an angle to a long tendon from one side.
   d. The muscle fibers on one side of a tendon feed into it at a certain angle and muscle fibers on the other side of the tendon feed into it at the opposite angle.

8. The location of a muscle's insertion and origin can determine ________.
   a. action
   b. the force of contraction
   c. muscle name
   d. the load a muscle can carry

9. Where is the temporalis muscle located?
   a. on the forehead
   b. in the neck
   c. on the side of the head
   d. on the chin

10. Which muscle name does *not* make sense?
   a. extensor digitorum
   b. gluteus minimus
   c. biceps femoris
   d. extensor minimus longus

11. Which of the following terms would be used in the name of a muscle that moves the leg away from the body?
   a. flexor
   b. adductor
   c. extensor
   d. abductor

12. Which of the following is a prime mover in head flexion?
   a. occipitofrontalis
   b. corrugator supercilii
   c. sternocleidomastoid
   d. masseter

13. Where is the inferior oblique muscle located?
   a. in the abdomen
   b. in the eye socket
   c. in the anterior neck
   d. in the face

14. What is the action of the masseter?
   a. swallowing
   b. chewing
   c. moving the lips
   d. closing the eye

15. The names of the extrinsic tongue muscles commonly end in ________.
   a. -glottis
   b. -glossus
   c. -gluteus
   d. -hyoid

16. What is the function of the erector spinae?
   a. movement of the arms
   b. stabilization of the pelvic girdle
   c. postural support
   d. rotating of the vertebral column

17. Which of the following abdominal muscles is not a part of the anterior abdominal wall?
   a. quadratus lumborum
   b. rectus abdominis
   c. interior oblique
   d. exterior oblique

18. Which muscle pair plays a role in respiration?
    a. intertransversarii, interspinales
    b. semispinalis cervicis, semispinalis thoracis
    c. trapezius, rhomboids
    d. diaphragm, scalene
19. What is the linea alba?
    a. a small muscle that helps with compression of the abdominal organs
    b. a long tendon that runs down the middle of the rectus abdominis
    c. a long band of collagen fibers that connects the hip to the knee
    d. another name for the tendinous inscription
20. The rhomboid major and minor muscles are deep to the ________.
    a. rectus abdominis
    b. scalene muscles
    c. trapezius
    d. ligamentum nuchae
21. Which muscle extends the forearm?
    a. biceps brachii
    b. triceps brachii
    c. brachialis
    d. deltoid
22. What is the origin of the wrist flexors?
    a. the lateral epicondyle of the humerus
    b. the medial epicondyle of the humerus
    c. the carpal bones of the wrist
    d. the deltoid tuberosity of the humerus
23. Which muscles stabilize the pectoral girdle?
    a. axial and scapular
    b. axial
    c. appendicular
    d. axial and appendicular
24. The large muscle group that attaches the leg to the pelvic girdle and produces extension of the hip joint is the ________ group.
    a. gluteal
    b. obturator
    c. adductor
    d. abductor
25. Which muscle produces movement that allows you to cross your legs?
    a. the gluteus maximus
    b. the piriformis
    c. the gracilis
    d. the sartorius
26. What is the largest muscle in the lower leg?
    a. soleus
    b. gastrocnemius
    c. tibialis anterior
    d. tibialis posterior
27. The vastus intermedius muscle is deep to which of the following muscles?
    a. biceps femoris
    b. rectus femoris
    c. vastus medialis
    d. vastus lateralis

Critical Thinking Questions

28. What effect does fascicle arrangement have on a muscle's action?
29. Movements of the body occur at joints. Describe how muscles are arranged around the joints of the body.
30. Explain how a synergist assists an agonist by being a fixator.
31. Describe the different criteria that contribute to how skeletal muscles are named.
32. Explain the difference between axial and appendicular muscles.
33. Describe the muscles of the anterior neck.
34. Why are the muscles of the face different from typical skeletal muscle?
35. Describe the fascicle arrangement in the muscles of the abdominal wall. How do they relate to each other?
36. What are some similarities and differences between the diaphragm and the pelvic diaphragm?
37. The tendons of which muscles form the rotator cuff? Why is the rotator cuff important?
38. List the general muscle groups of the shoulders and upper limbs as well as their subgroups.
39. Which muscles form the hamstrings? How do they function together?
40. Which muscles form the quadriceps? How do they function together?

CHAPTER 12
The Nervous System and Nervous Tissue

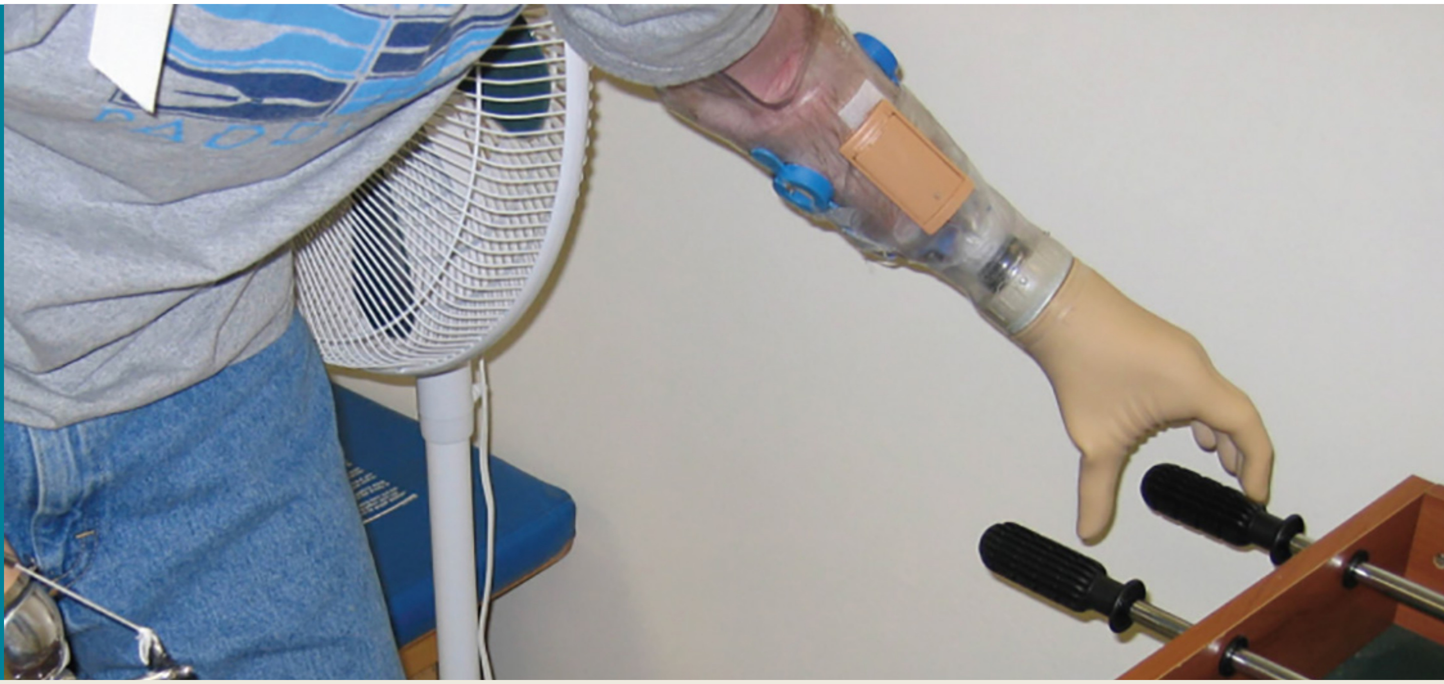


Figure 12.1 **Robotic Arms Playing Foosball** As the neural circuitry of the nervous system has become more fully understood and robotics more sophisticated, it is now possible to integrate technology with the body and restore abilities following traumatic events. At some point in the future, will this type of technology lead to the ability to augment our nervous systems? (credit: U.S. Army/Wikimedia Commons)

CHAPTER OBJECTIVES

After studying this chapter, you will be able to:

- Name the major divisions of the nervous system, both anatomical and functional
- Describe the functional and structural differences between gray matter and white matter structures
- Name the parts of the multipolar neuron in order of polarity
- List the types of glial cells and assign each to the proper division of the nervous system, along with their function(s)
- Distinguish the major functions of the nervous system: sensation, integration, and response
- Describe the components of the membrane that establish the resting membrane potential
- Describe the changes that occur to the membrane that result in the action potential
- Explain the differences between types of graded potentials
- Categorize the major neurotransmitters by chemical type and effect

INTRODUCTION The nervous system is a very complex organ system. In Peter D. Kramer's book *Listening to Prozac*, a pharmaceutical researcher is quoted as saying, "If the human brain were simple enough for us to understand, we would be too simple to understand it" (1994). That quote is from the early 1990s; in the two decades since, progress has continued at an amazing rate within the scientific disciplines of neuroscience. It is an interesting conundrum to consider that the complexity of the nervous system may be too complex for it (that is, for us) to completely unravel. But our current level of understanding is probably nowhere close to that limit.

One easy way to begin to understand the structure of the nervous system is to start with the large divisions and work through to a more in-depth understanding. In other chapters, the finer details of the nervous system will be explained, but first looking at an overview of the system will allow you to begin to understand how its parts work together. The focus of this chapter is on nervous (neural) tissue, both its structure and its function. But before you learn about that, you will see a big picture of the system—actually, a few big pictures.

12.1 Basic Structure and Function of the Nervous System

LEARNING OBJECTIVES

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

- Identify the anatomical and functional divisions of the nervous system
- Relate the functional and structural differences between gray matter and white matter structures of the nervous system to the structure of neurons
- List the basic functions of the nervous system

The picture you have in your mind of the nervous system probably includes the **brain**, the nervous tissue contained within the cranium, and the **spinal cord**, the extension of nervous tissue within the vertebral column. That suggests it is made of two organs—and you may not even think of the spinal cord as an organ—but the nervous system is a very complex structure. Within the brain, many different and separate regions are responsible for many different and separate functions. It is as if the nervous system is composed of many organs that all look similar and can only be differentiated using tools such as the microscope or electrophysiology. In comparison, it is easy to see that the stomach is different than the esophagus or the liver, so you can imagine the digestive system as a collection of specific organs.

The Central and Peripheral Nervous Systems

The nervous system can be divided into two major regions: the central and peripheral nervous systems. The **central nervous system (CNS)** is the brain and spinal cord, and the **peripheral nervous system (PNS)** is everything else (Figure 12.2). The brain is contained within the cranial cavity of the skull, and the spinal cord is contained within the vertebral cavity of the vertebral column. It is a bit of an oversimplification to say that the CNS is what is inside these two cavities and the peripheral nervous system is outside of them, but that is one way to start to think about it. In actuality, there are some elements of the peripheral nervous system that are within the cranial or vertebral cavities. The peripheral nervous system is so named because it is on the periphery—meaning beyond the brain and spinal cord. Depending on different aspects of the nervous system, the dividing line between central and peripheral is not necessarily universal.

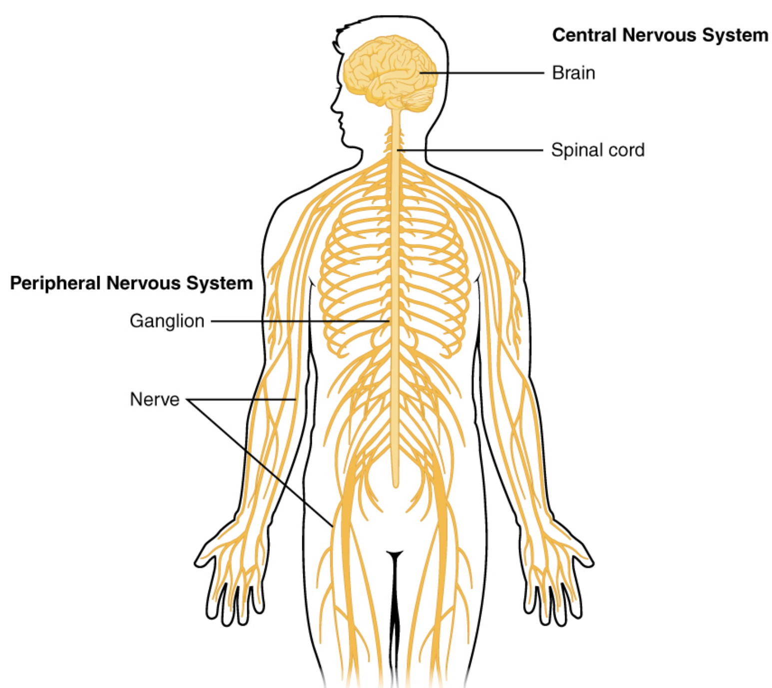


FIGURE 12.2 **Central and Peripheral Nervous System** The structures of the PNS are referred to as ganglia and nerves, which can be seen as distinct structures. The equivalent structures in the CNS are not obvious from this overall perspective and are best examined in prepared tissue under the microscope.

Nervous tissue, present in both the CNS and PNS, contains two basic types of cells: neurons and glial cells. A **glial cell** is one of a variety of cells that provide a framework of tissue that supports the neurons and their activities. The

neuron is the more functionally important of the two, in terms of the communicative function of the nervous system. To describe the functional divisions of the nervous system, it is important to understand the structure of a neuron. Neurons are cells and therefore have a **soma**, or cell body, but they also have extensions of the cell; each extension is generally referred to as a **process**. There is one important process that every neuron has called an **axon**, which is the fiber that connects a neuron with its target. Another type of process that branches off from the soma is the **dendrite**. Dendrites are responsible for receiving most of the input from other neurons. Looking at nervous tissue, there are regions that predominantly contain cell bodies and regions that are largely composed of just axons. These two regions within nervous system structures are often referred to as **gray matter** (the regions with many cell bodies and dendrites) or **white matter** (the regions with many axons). Figure 12.3 demonstrates the appearance of these regions in the brain and spinal cord. The colors ascribed to these regions are what would be seen in "fresh," or unstained, nervous tissue. Gray matter is not necessarily gray. It can be pinkish because of blood content, or even slightly tan, depending on how long the tissue has been preserved. But white matter is white because axons are insulated by a lipid-rich substance called **myelin**. Lipids can appear as white ("fatty") material, much like the fat on a raw piece of chicken or beef. Actually, gray matter may have that color ascribed to it because next to the white matter, it is just darker—hence, gray.

The distinction between gray matter and white matter is most often applied to central nervous tissue, which has large regions that can be seen with the unaided eye. When looking at peripheral structures, often a microscope is used and the tissue is stained with artificial colors. That is not to say that central nervous tissue cannot be stained and viewed under a microscope, but unstained tissue is most likely from the CNS—for example, a frontal section of the brain or cross section of the spinal cord.

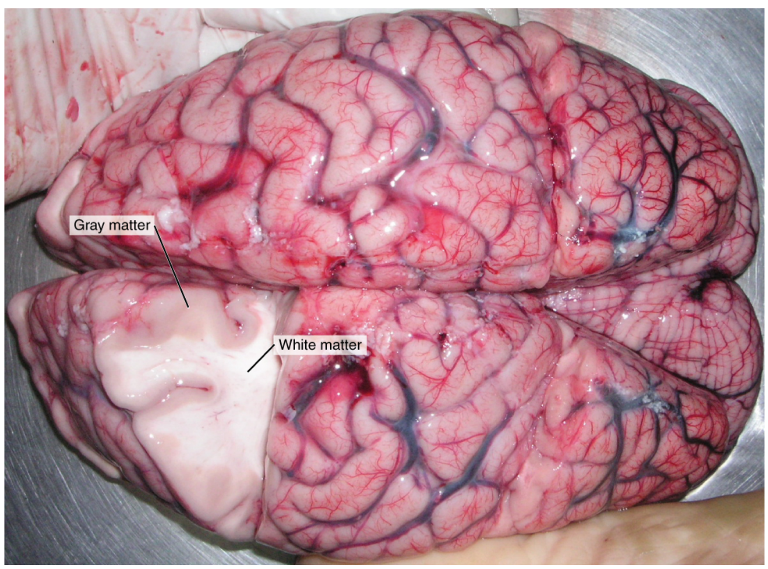


FIGURE 12.3 **Gray Matter and White Matter** A brain removed during an autopsy, with a partial section removed, shows white matter surrounded by gray matter. Gray matter makes up the outer cortex of the brain. (credit: modification of work by "Suseno"/Wikimedia Commons)

Regardless of the appearance of stained or unstained tissue, the cell bodies of neurons or axons can be located in discrete anatomical structures that need to be named. Those names are specific to whether the structure is central or peripheral. A localized collection of neuron cell bodies in the CNS is referred to as a **nucleus**. In the PNS, a cluster of neuron cell bodies is referred to as a **ganglion**. Figure 12.4 indicates how the term nucleus has a few different meanings within anatomy and physiology. It is the center of an atom, where protons and neutrons are found; it is the center of a cell, where the DNA is found; and it is a center of some function in the CNS. There is also a potentially confusing use of the word ganglion (plural = ganglia) that has a historical explanation. In the central nervous system, there is a group of nuclei that are connected together and were once called the basal ganglia before "ganglion" became accepted as a description for a peripheral structure. Some sources refer to this group of nuclei as the "basal nuclei" to avoid confusion.

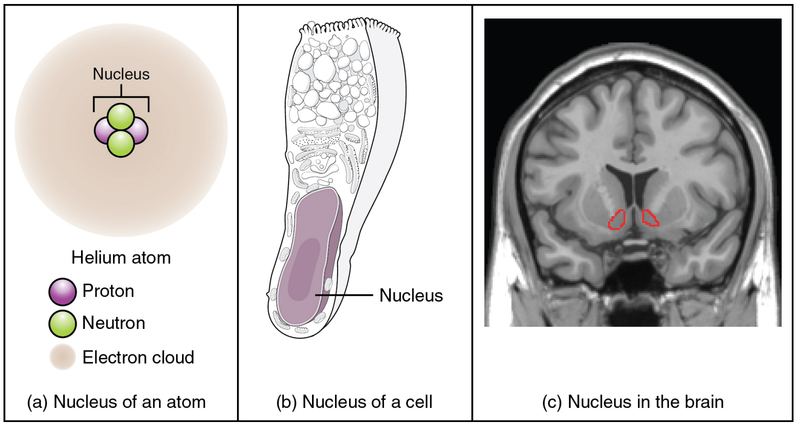


FIGURE 12.4 **What Is a Nucleus?** (a) The nucleus of an atom contains its protons and neutrons. (b) The nucleus of a cell is the organelle that contains DNA. (c) A nucleus in the CNS is a localized center of function with the cell bodies of several neurons, shown here circled in red. (credit c: "Was a bee"/Wikimedia Commons)

Terminology applied to bundles of axons also differs depending on location. A bundle of axons, or fibers, found in the CNS is called a **tract** whereas the same thing in the PNS would be called a **nerve**. There is an important point to make about these terms, which is that they can both be used to refer to the same bundle of axons. When those axons are in the PNS, the term is nerve, but if they are CNS, the term is tract. The most obvious example of this is the axons that project from the retina into the brain. Those axons are called the optic nerve as they leave the eye, but when they are inside the cranium, they are referred to as the optic tract. There is a specific place where the name changes, which is the optic chiasm, but they are still the same axons (Figure 12.5). A similar situation outside of science can be described for some roads. Imagine a road called "Broad Street" in a town called "Anyville." The road leaves Anyville and goes to the next town over, called "Hometown." When the road crosses the line between the two towns and is in Hometown, its name changes to "Main Street." That is the idea behind the naming of the retinal axons. In the PNS, they are called the optic nerve, and in the CNS, they are the optic tract. Table 12.1 helps to clarify which of these terms apply to the central or peripheral nervous systems.

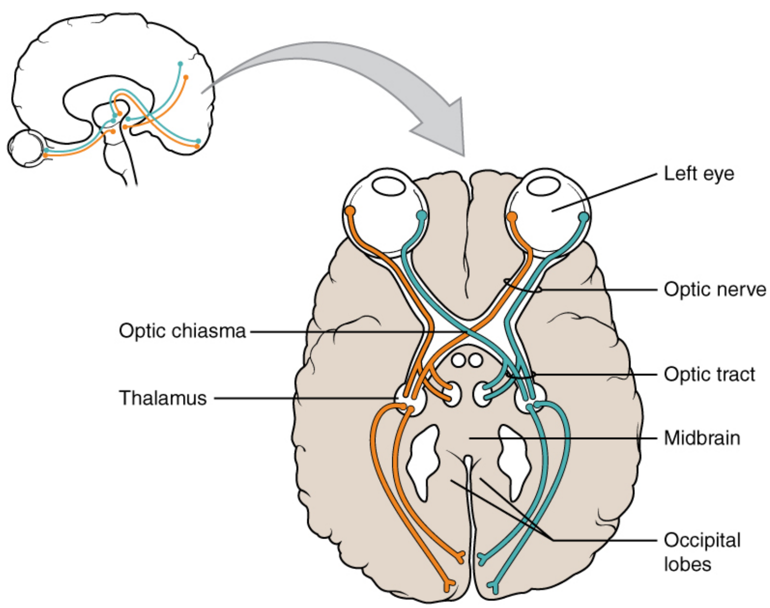


FIGURE 12.5 **Optic Nerve Versus Optic Tract** This drawing of the connections of the eye to the brain shows the optic nerve extending from the eye to the chiasm, where the structure continues as the optic tract. The same axons extend from the eye to the brain through these two bundles of fibers, but the chiasm represents the border between peripheral and central.

INTERACTIVE LINK

In 2003, the Nobel Prize in Physiology or Medicine was awarded to Paul C. Lauterbur and Sir Peter Mansfield for discoveries related to magnetic resonance imaging (MRI). This is a tool to see the structures of the body (not just the nervous system) that depends on magnetic fields associated with certain atomic nuclei. The utility of this technique in the nervous system is that fat tissue and water appear as different shades between black and white. Because white matter is fatty (from myelin) and gray matter is not, they can be easily distinguished in MRI images. Try this PhET simulation (http://openstax.org/l/nobel_2) that demonstrates the use of this technology and compares it with other types of imaging technologies. Also, the results from an MRI session are compared with images obtained from X-ray or computed tomography. How do the imaging techniques shown in this game indicate the separation of white and gray matter compared with the freshly dissected tissue shown earlier?

Structures of the CNS and PNS

	CNS	PNS
Group of Neuron Cell Bodies (i.e., gray matter)	Nucleus	Ganglion
Bundle of Axons (i.e., white matter)	Tract	Nerve

TABLE 12.1

Functional Divisions of the Nervous System

The nervous system can also be divided on the basis of its functions, but anatomical divisions and functional divisions are different. The CNS and the PNS both contribute to the same functions, but those functions can be attributed to different regions of the brain (such as the cerebral cortex or the hypothalamus) or to different ganglia in the periphery. The problem with trying to fit functional differences into anatomical divisions is that sometimes the same structure can be part of several functions. For example, the optic nerve carries signals from the retina that are either used for the conscious perception of visual stimuli, which takes place in the cerebral cortex, or for the reflexive responses of smooth muscle tissue that are processed through the hypothalamus.

There are two ways to consider how the nervous system is divided functionally. First, the basic functions of the nervous system are sensation, integration, and response. Secondly, control of the body can be somatic or autonomic—divisions that are largely defined by the structures that are involved in the response. There is also a region of the peripheral nervous system that is called the enteric nervous system that is responsible for a specific set of the functions within the realm of autonomic control related to gastrointestinal functions.

Basic Functions

The nervous system is involved in receiving information about the environment around us (sensation) and generating responses to that information (motor responses). The nervous system can be divided into regions that are responsible for **sensation** (sensory functions) and for the **response** (motor functions). But there is a third function that needs to be included. Sensory input needs to be integrated with other sensations, as well as with memories, emotional state, or learning (cognition). Some regions of the nervous system are termed **integration** or association areas. The process of integration combines sensory perceptions and higher cognitive functions such as memories, learning, and emotion to produce a response.

Sensation. The first major function of the nervous system is sensation—receiving information about the environment to gain input about what is happening outside the body (or, sometimes, within the body). The sensory functions of the nervous system register the presence of a change from homeostasis or a particular event in the environment, known as a **stimulus**. The senses we think of most are the “big five”: taste, smell, touch, sight, and hearing. The stimuli for taste and smell are both chemical substances (molecules, compounds, ions, etc.), touch is physical or mechanical stimuli that interact with the skin, sight is light stimuli, and hearing is the perception of sound, which is a physical stimulus similar to some aspects of touch. There are actually more senses than just those, but that list represents the major senses. Those five are all senses that receive stimuli from the outside world, and of which there is conscious perception. Additional sensory stimuli might be from the internal environment (inside the body), such as the stretch of an organ wall or the concentration of certain ions in the blood.

Response. The nervous system produces a response on the basis of the stimuli perceived by sensory structures. An obvious response would be the movement of muscles, such as withdrawing a hand from a hot stove, but there are broader uses of the term. The nervous system can cause the contraction of all three types of muscle tissue. For example, skeletal muscle contracts to move the skeleton, cardiac muscle is influenced as heart rate increases during exercise, and smooth muscle contracts as the digestive system moves food along the digestive tract. Responses also include the neural control of glands in the body as well, such as the production and secretion of sweat by the eccrine and merocrine sweat glands found in the skin to lower body temperature.

Responses can be divided into those that are voluntary or conscious (contraction of skeletal muscle) and those that are involuntary (contraction of smooth muscles, regulation of cardiac muscle, activation of glands). Voluntary responses are governed by the somatic nervous system and involuntary responses are governed by the autonomic nervous system, which are discussed in the next section.

Integration. Stimuli that are received by sensory structures are communicated to the nervous system where that information is processed. This is called integration. Stimuli are compared with, or integrated with, other stimuli, memories of previous stimuli, or the state of a person at a particular time. This leads to the specific response that will be generated. Seeing a baseball pitched to a batter will not automatically cause the batter to swing. The trajectory of the ball and its speed will need to be considered. Maybe the count is three balls and one strike, and the batter wants to let this pitch go by in the hope of getting a walk to first base. Or maybe the batter's team is so far ahead, it would be fun to just swing away.

Controlling the Body

The nervous system can be divided into two parts mostly on the basis of a functional difference in responses. The **somatic nervous system (SNS)** is responsible for conscious perception and voluntary motor responses. Voluntary motor response means the contraction of skeletal muscle, but those contractions are not always voluntary in the sense that you have to want to perform them. Some somatic motor responses are reflexes, and often happen without a conscious decision to perform them. If your friend jumps out from behind a corner and yells "Boo!" you will be startled and you might scream or leap back. You didn't decide to do that, and you may not have wanted to give your friend a reason to laugh at your expense, but it is a reflex involving skeletal muscle contractions. Other motor responses become automatic (in other words, unconscious) as a person learns motor skills (referred to as "habit learning" or "procedural memory").

The **autonomic nervous system (ANS)** is responsible for involuntary control of the body, usually for the sake of homeostasis (regulation of the internal environment). Sensory input for autonomic functions can be from sensory structures tuned to external or internal environmental stimuli. The motor output extends to smooth and cardiac muscle as well as glandular tissue. The role of the autonomic system is to regulate the organ systems of the body, which usually means to control homeostasis. Sweat glands, for example, are controlled by the autonomic system. When you are hot, sweating helps cool your body down. That is a homeostatic mechanism. But when you are nervous, you might start sweating also. That is not homeostatic, it is the physiological response to an emotional state.

There is another division of the nervous system that describes functional responses. The **enteric nervous system (ENS)** is responsible for controlling the smooth muscle and glandular tissue in your digestive system. It is a large part of the PNS, and is not dependent on the CNS. It is sometimes valid, however, to consider the enteric system to be a part of the autonomic system because the neural structures that make up the enteric system are a component of the autonomic output that regulates digestion. There are some differences between the two, but for our purposes here there will be a good bit of overlap. See Figure 12.6 for examples of where these divisions of the nervous system can be found.

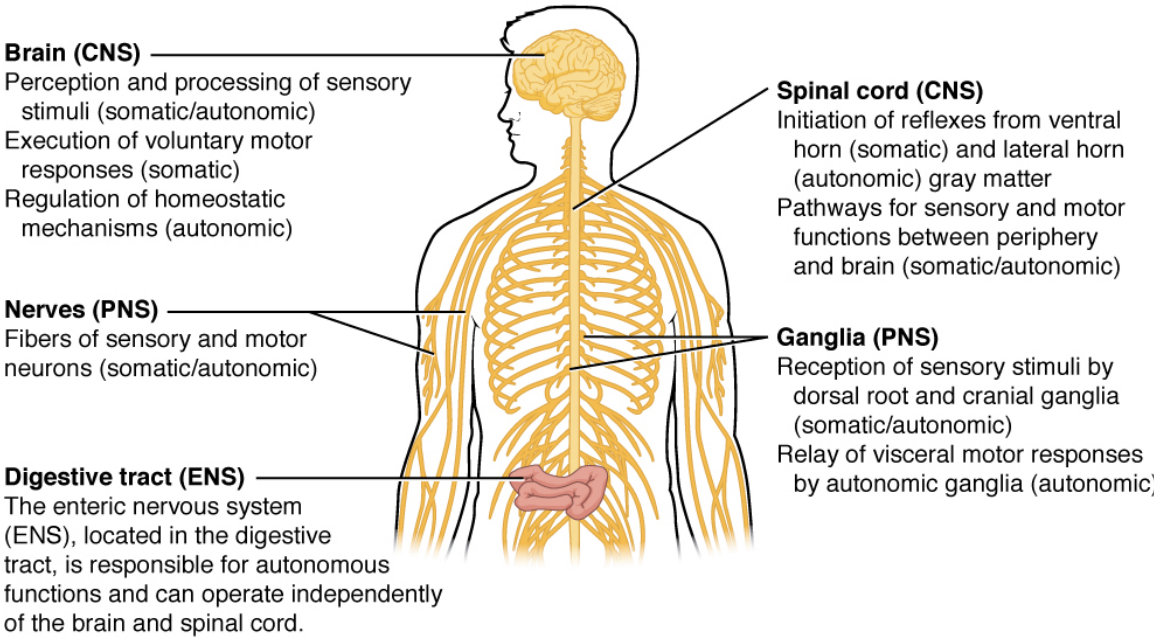


FIGURE 12.6 **Somatic, Autonomic, and Enteric Structures of the Nervous System** Somatic structures include the spinal nerves, both motor and sensory fibers, as well as the sensory ganglia (posterior root ganglia and cranial nerve ganglia). Autonomic structures are found in the nerves also, but include the sympathetic and parasympathetic ganglia. The enteric nervous system includes the nervous tissue within the organs of the digestive tract.

INTERACTIVE LINK

Visit this site (http://openstax.org/l/troublewstairs) to read about a woman that notices that her daughter is having trouble walking up the stairs. This leads to the discovery of a hereditary condition that affects the brain and spinal cord. The electromyography and MRI tests indicated deficiencies in the spinal cord and cerebellum, both of which are responsible for controlling coordinated movements. To what functional division of the nervous system would these structures belong?

Everyday Connection

How Much of Your Brain Do You Use?

Have you ever heard the claim that humans only use 10 percent of their brains? Maybe you have seen an advertisement on a website saying that there is a secret to unlocking the full potential of your mind—as if there were 90 percent of your brain sitting idle, just waiting for you to use it. If you see an ad like that, don’t click. It isn’t true.

An easy way to see how much of the brain a person uses is to take measurements of brain activity while performing a task. An example of this kind of measurement is functional magnetic resonance imaging (fMRI), which generates a map of the most active areas and can be generated and presented in three dimensions (Figure 12.7). This procedure is different from the standard MRI technique because it is measuring changes in the tissue in time with an experimental condition or event.

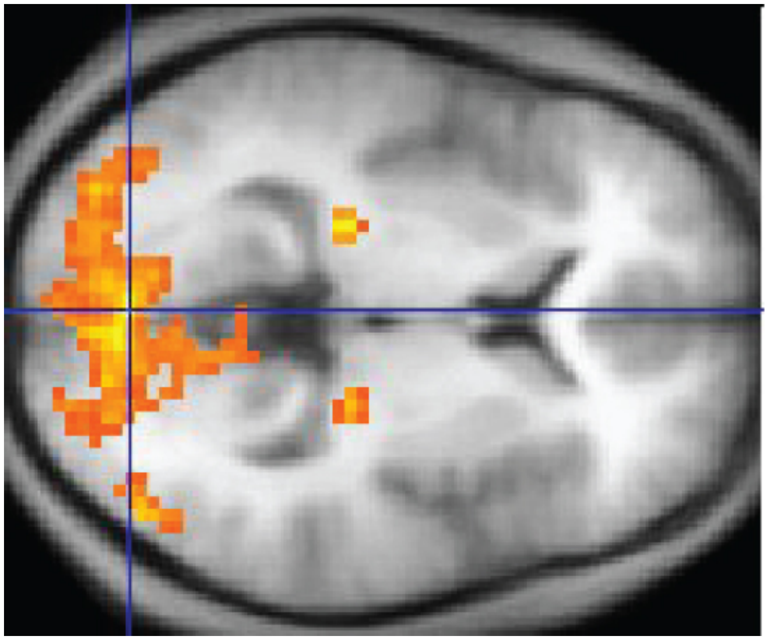


FIGURE 12.7 **fMRI** This fMRI shows activation of the visual cortex in response to visual stimuli. (credit: "Superborsuk"/Wikimedia Commons)

The underlying assumption is that active nervous tissue will have greater blood flow. By having the subject perform a visual task, activity all over the brain can be measured. Consider this possible experiment: the subject is told to look at a screen with a black dot in the middle (a fixation point). A photograph of a face is projected on the screen away from the center. The subject has to look at the photograph and decipher what it is. The subject has been instructed to push a button if the photograph is of someone they recognize. The photograph might be of a celebrity, so the subject would press the button, or it might be of a random person unknown to the subject, so the subject would not press the button.

In this task, visual sensory areas would be active, integrating areas would be active, motor areas responsible for moving the eyes would be active, and motor areas for pressing the button with a finger would be active. Those areas are distributed all around the brain and the fMRI images would show activity in more than just 10 percent of the brain (some evidence suggests that about 80 percent of the brain is using energy—based on blood flow to the tissue—during well-defined tasks similar to the one suggested above). This task does not even include all of the functions the brain performs. There is no language response, the body is mostly lying still in the MRI machine, and it does not consider the autonomic functions that would be ongoing in the background.

12.2 Nervous Tissue

LEARNING OBJECTIVES

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

- Describe the basic structure of a neuron
- Identify the different types of neurons on the basis of polarity
- List the glial cells of the CNS and describe their function
- List the glial cells of the PNS and describe their function

Nervous tissue is composed of two types of cells, neurons and glial cells. Neurons are the primary type of cell that most anyone associates with the nervous system. They are responsible for the computation and communication that the nervous system provides. They are electrically active and release chemical signals to target cells. Glial cells, or glia, are known to play a supporting role for nervous tissue. Ongoing research pursues an expanded role that glial cells might play in signaling, but neurons are still considered the basis of this function. Neurons are important, but without glial support they would not be able to perform their function.

Neurons

Neurons are the cells considered to be the basis of nervous tissue. They are responsible for the electrical signals that communicate information about sensations, and that produce movements in response to those stimuli, along with inducing thought processes within the brain. An important part of the function of neurons is in their structure, or shape. The three-dimensional shape of these cells makes the immense numbers of connections within the nervous system possible.

Parts of a Neuron

As you learned in the first section, the main part of a neuron is the cell body, which is also known as the soma (soma = "body"). The cell body contains the nucleus and most of the major organelles. But what makes neurons special is that they have many extensions of their cell membranes, which are generally referred to as processes. Neurons are usually described as having one, and only one, axon—a fiber that emerges from the cell body and projects to target cells. That single axon can branch repeatedly to communicate with many target cells. It is the axon that propagates the nerve impulse, which is communicated to one or more cells. The other processes of the neuron are dendrites, which receive information from other neurons at specialized areas of contact called **synapses**. The dendrites are usually highly branched processes, providing locations for other neurons to communicate with the cell body. Information flows through a neuron from the dendrites, across the cell body, and down the axon. This gives the neuron a polarity—meaning that information flows in this one direction. Figure 12.8 shows the relationship of these parts to one another.

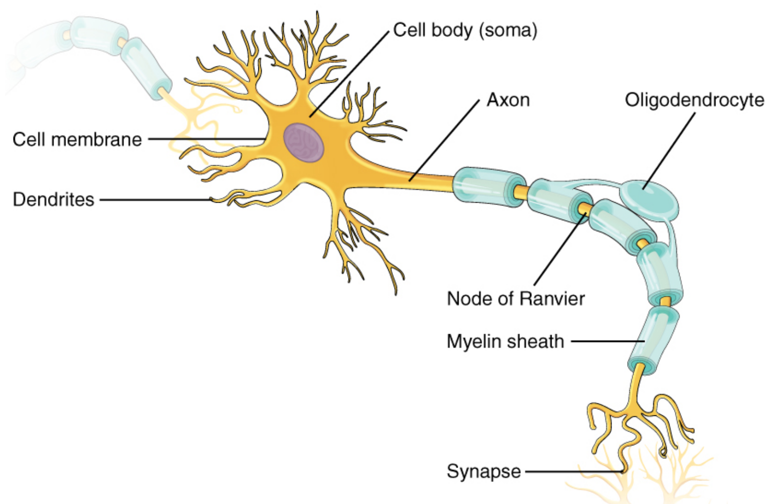


FIGURE 12.8 **Parts of a Neuron** The major parts of the neuron are labeled on a multipolar neuron from the CNS.

Where the axon emerges from the cell body, there is a special region referred to as the **axon hillock**. This is a tapering of the cell body toward the axon fiber. Within the axon hillock, the cytoplasm changes to a solution of limited components called **axoplasm**. Because the axon hillock represents the beginning of the axon, it is also referred to as the **initial segment**.

Many axons are wrapped by an insulating substance called myelin, which is actually made from glial cells. Myelin acts as insulation much like the plastic or rubber that is used to insulate electrical wires. A key difference between myelin and the insulation on a wire is that there are gaps in the myelin covering of an axon. Each gap is called a **node of Ranvier** and is important to the way that electrical signals travel down the axon. The length of the axon between each gap, which is wrapped in myelin, is referred to as an **axon segment**. At the end of the axon is the **axon terminal**, where there are usually several branches extending toward the target cell, each of which ends in an enlargement called a **synaptic end bulb**. These bulbs are what make the connection with the target cell at the synapse.

Types of Neurons

There are many neurons in the nervous system—a number in the trillions. And there are many different types of neurons. They can be classified by many different criteria. The first way to classify them is by the number of processes attached to the cell body. Using the standard model of neurons, one of these processes is the axon, and the rest are dendrites. Because information flows through the neuron from dendrites or cell bodies toward the axon, these names are based on the neuron's polarity (Figure 12.9).

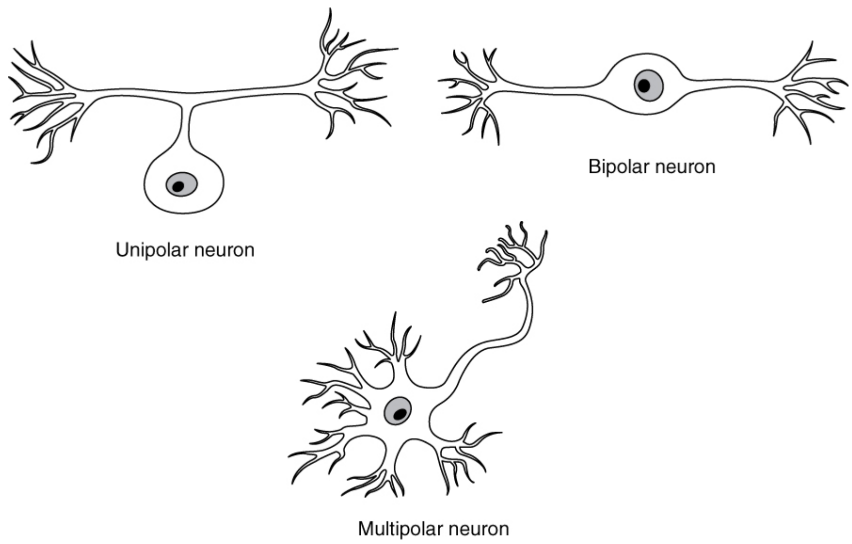


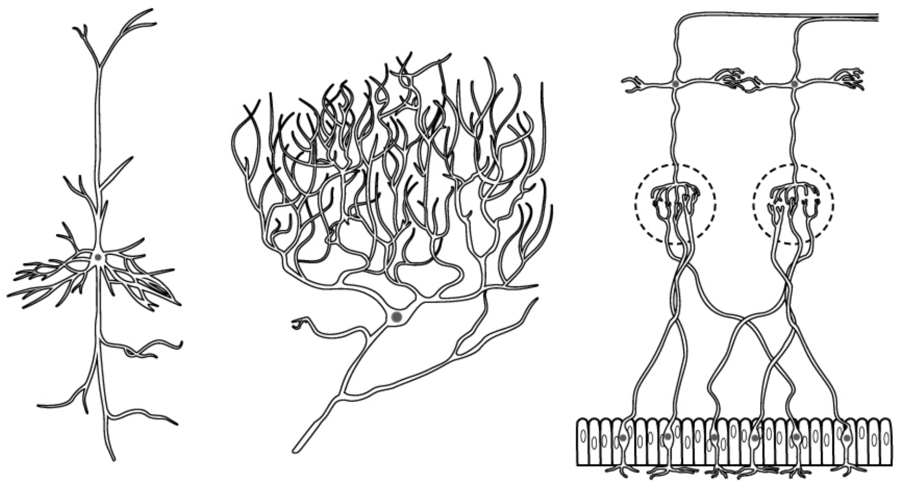
FIGURE 12.9 **Neuron Classification by Shape** Unipolar cells have one process that includes both the axon and dendrite. Bipolar cells have two processes, the axon and a dendrite. Multipolar cells have more than two processes, the axon and two or more dendrites.

Unipolar cells have only one process emerging from the cell. True unipolar cells are only found in invertebrate animals, so the unipolar cells in humans are more appropriately called "pseudo-unipolar" cells. Invertebrate unipolar cells do not have dendrites. Human unipolar cells have an axon that emerges from the cell body, but it splits so that the axon can extend along a very long distance. At one end of the axon are dendrites, and at the other end, the axon forms synaptic connections with a target. Unipolar cells are exclusively sensory neurons and have two unique characteristics. First, their dendrites are receiving sensory information, sometimes directly from the stimulus itself. Secondly, the cell bodies of unipolar neurons are always found in ganglia. Sensory reception is a peripheral function (those dendrites are in the periphery, perhaps in the skin) so the cell body is in the periphery, though closer to the CNS in a ganglion. The axon projects from the dendrite endings, past the cell body in a ganglion, and into the central nervous system.

Bipolar cells have two processes, which extend from each end of the cell body, opposite to each other. One is the axon and one the dendrite. Bipolar cells are not very common. They are found mainly in the olfactory epithelium (where smell stimuli are sensed), and as part of the retina.

Multipolar neurons are all of the neurons that are not unipolar or bipolar. They have one axon and two or more dendrites (usually many more). With the exception of the unipolar sensory ganglion cells, and the two specific bipolar cells mentioned above, all other neurons are multipolar. Some cutting edge research suggests that certain neurons in the CNS do not conform to the standard model of "one, and only one" axon. Some sources describe a fourth type of neuron, called an anaxonic neuron. The name suggests that it has no axon (an- = "without"), but this is not accurate. Anaxonic neurons are very small, and if you look through a microscope at the standard resolution used in histology (approximately 400X to 1000X total magnification), you will not be able to distinguish any process specifically as an axon or a dendrite. Any of those processes can function as an axon depending on the conditions at any given time. Nevertheless, even if they cannot be easily seen, and one specific process is definitively the axon, these neurons have multiple processes and are therefore multipolar.

Neurons can also be classified on the basis of where they are found, who found them, what they do, or even what chemicals they use to communicate with each other. Some neurons referred to in this section on the nervous system are named on the basis of those sorts of classifications (Figure 12.10). For example, a multipolar neuron that has a very important role to play in a part of the brain called the cerebellum is known as a Purkinje (commonly pronounced per-KIN-gee) cell. It is named after the anatomist who discovered it (Jan Evangelista Purkinje, 1787–1869).



(a) Pyramidal cell of the cerebral cortex (b) Purkinje cell of the cerebellar cortex (c) Olfactory cells in the olfactory epithelium and olfactory bulbs

FIGURE 12.10 **Other Neuron Classifications** Three examples of neurons that are classified on the basis of other criteria. (a) The pyramidal cell is a multipolar cell with a cell body that is shaped something like a pyramid. (b) The Purkinje cell in the cerebellum was named after the scientist who originally described it. (c) Olfactory neurons are named for the functional group with which they belong.

Glial Cells

Glial cells, or neuroglia or simply glia, are the other type of cell found in nervous tissue. They are considered to be supporting cells, and many functions are directed at helping neurons complete their function for communication. The name glia comes from the Greek word that means "glue," and was coined by the German pathologist Rudolph Virchow, who wrote in 1856: "This connective substance, which is in the brain, the spinal cord, and the special sense nerves, is a kind of glue (neuroglia) in which the nervous elements are planted." Today, research into nervous tissue has shown that there are many deeper roles that these cells play. And research may find much more about them in the future.

There are six types of glial cells. Four of them are found in the CNS and two are found in the PNS. Table 12.2 outlines some common characteristics and functions.

Glial Cell Types by Location and Basic Function

CNS glia	PNS glia	Basic function
Astrocyte	Satellite cell	Support
Oligodendrocyte	Schwann cell	Insulation, myelination
Microglia	-	Immune surveillance and phagocytosis
Ependymal cell	-	Creating CSF

TABLE 12.2

Glial Cells of the CNS

One cell providing support to neurons of the CNS is the **astrocyte**, so named because it appears to be star-shaped under the microscope (astro- = "star"). Astrocytes have many processes extending from their main cell body (not axons or dendrites like neurons, just cell extensions). Those processes extend to interact with neurons, blood vessels, or the connective tissue covering the CNS that is called the pia mater (Figure 12.11). Generally, they are supporting cells for the neurons in the central nervous system. Some ways in which they support neurons in the central nervous system are by maintaining the concentration of chemicals in the extracellular space, removing excess signaling molecules, reacting to tissue damage, and contributing to the **blood-brain barrier (BBB)**. The blood-brain barrier is a physiological barrier that keeps many substances that circulate in the rest of the body from getting into the central nervous system, restricting what can cross from circulating blood into the CNS. Nutrient molecules, such as glucose or amino acids, can pass through the BBB, but other molecules cannot. This actually causes problems with drug delivery to the CNS. Pharmaceutical companies are challenged to design drugs that can cross the BBB as well as have an effect on the nervous system.

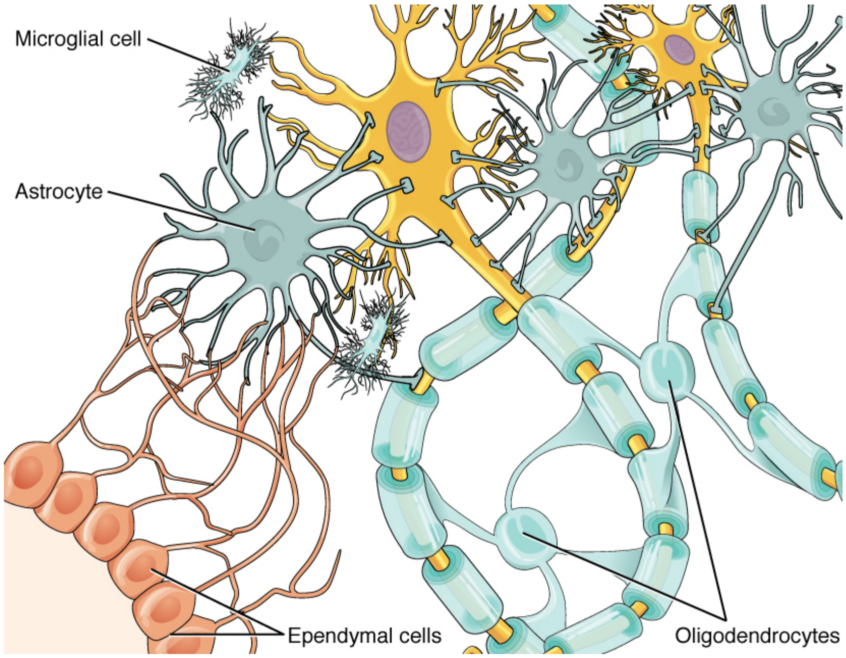


FIGURE 12.11 **Glial Cells of the CNS** The CNS has astrocytes, oligodendrocytes, microglia, and ependymal cells that support the neurons of the CNS in several ways.

Like a few other parts of the body, the brain has a privileged blood supply. Very little can pass through by diffusion. Most substances that cross the wall of a blood vessel into the CNS must do so through an active transport process. Because of this, only specific types of molecules can enter the CNS. Glucose—the primary energy source—is allowed, as are amino acids. Water and some other small particles, like gases and ions, can enter. But most everything else cannot, including white blood cells, which are one of the body's main lines of defense. While this barrier protects the CNS from exposure to toxic or pathogenic substances, it also keeps out the cells that could protect the brain and spinal cord from disease and damage. The BBB also makes it harder for pharmaceuticals to be developed that can affect the nervous system. Aside from finding efficacious substances, the means of delivery is also crucial.

Also found in CNS tissue is the **oligodendrocyte**, sometimes called just "oligo," which is the glial cell type that insulates axons in the CNS. The name means "cell of a few branches" (oligo- = "few"; dendro- = "branches"; -cyte = "cell"). There are a few processes that extend from the cell body. Each one reaches out and surrounds an axon to insulate it in myelin. One oligodendrocyte will provide the myelin for multiple axon segments, either for the same axon or for separate axons. The function of myelin will be discussed below.

Microglia are, as the name implies, smaller than most of the other glial cells. Ongoing research into these cells, although not entirely conclusive, suggests that they may originate as white blood cells, called macrophages, that become part of the CNS during early development. While their origin is not conclusively determined, their function is related to what macrophages do in the rest of the body. When macrophages encounter diseased or damaged cells in the rest of the body, they ingest and digest those cells or the pathogens that cause disease. Microglia are the cells in the CNS that can do this in normal, healthy tissue, and they are therefore also referred to as CNS-resident macrophages.

The **ependymal cell** is a glial cell that filters blood to make **cerebrospinal fluid (CSF)**, the fluid that circulates through the CNS. Because of the privileged blood supply inherent in the BBB, the extracellular space in nervous tissue does not easily exchange components with the blood. Ependymal cells line each **ventricle**, one of four central cavities that are remnants of the hollow center of the neural tube formed during the embryonic development of the brain. The **choroid plexus** is a specialized structure in the ventricles where ependymal cells come in contact with blood vessels and filter and absorb components of the blood to produce cerebrospinal fluid. Because of this, ependymal cells can be considered a component of the BBB, or a place where the BBB breaks down. These glial cells appear similar to epithelial cells, making a single layer of cells with little intracellular space and tight connections between adjacent cells. They also have cilia on their apical surface to help move the CSF through the ventricular space. The relationship of these glial cells to the structure of the CNS is seen in Figure 12.11.

Glial Cells of the PNS

One of the two types of glial cells found in the PNS is the **satellite cell**. Satellite cells are found in sensory and autonomic ganglia, where they surround the cell bodies of neurons. This accounts for the name, based on their appearance under the microscope. They provide support, performing similar functions in the periphery as astrocytes do in the CNS—except, of course, for establishing the BBB.

The second type of glial cell is the **Schwann cell**, which insulate axons with myelin in the periphery. Schwann cells are different than oligodendrocytes, in that a Schwann cell wraps around a portion of only one axon segment and no others. Oligodendrocytes have processes that reach out to multiple axon segments, whereas the entire Schwann cell surrounds just one axon segment. The nucleus and cytoplasm of the Schwann cell are on the edge of the myelin sheath. The relationship of these two types of glial cells to ganglia and nerves in the PNS is seen in Figure 12.12.

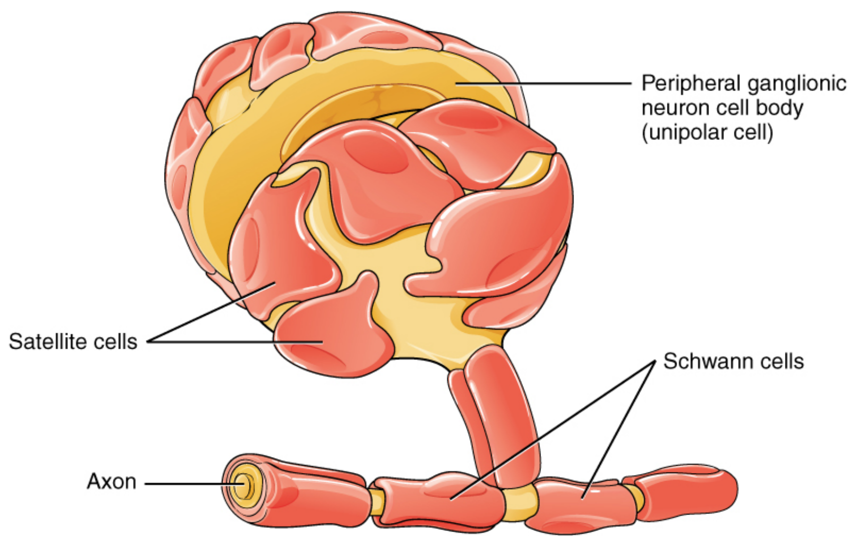


FIGURE 12.12 **Glial Cells of the PNS** The PNS has satellite cells and Schwann cells.

Myelin

The insulation for axons in the nervous system is provided by glial cells, oligodendrocytes in the CNS, and Schwann cells in the PNS. Whereas the manner in which either cell is associated with the axon segment, or segments, that it insulates is different, the means of myelinating an axon segment is mostly the same in the two situations. Myelin is a lipid-rich sheath that surrounds the axon and by doing so creates a **myelin sheath** that facilitates the transmission of electrical signals along the axon. The lipids are essentially the phospholipids of the glial cell membrane. Myelin, however, is more than just the membrane of the glial cell. It also includes important proteins that are integral to that membrane. Some of the proteins help to hold the layers of the glial cell membrane closely together.

The appearance of the myelin sheath can be thought of as similar to the pastry wrapped around a hot dog for "pigs in a blanket" or a similar food. The glial cell is wrapped around the axon several times with little to no cytoplasm between the glial cell layers. For oligodendrocytes, the rest of the cell is separate from the myelin sheath as a cell process extends back toward the cell body. A few other processes provide the same insulation for other axon segments in the area. For Schwann cells, the outermost layer of the cell membrane contains cytoplasm and the nucleus of the cell as a bulge on one side of the myelin sheath. During development, the glial cell is loosely or incompletely wrapped around the axon (Figure 12.13**a**). The edges of this loose enclosure extend toward each other, and one end tucks under the other. The inner edge wraps around the axon, creating several layers, and the other edge closes around the outside so that the axon is completely enclosed.

Myelin sheaths can extend for one or two millimeters, depending on the diameter of the axon. Axon diameters can be as small as 1 to 20 micrometers. Because a micrometer is 1/1000 of a millimeter, this means that the length of a myelin sheath can be 100–1000 times the diameter of the axon. Figure 12.8, Figure 12.11, and Figure 12.12 show the myelin sheath surrounding an axon segment, but are not to scale. If the myelin sheath were drawn to scale, the neuron would have to be immense—possibly covering an entire wall of the room in which you are sitting.

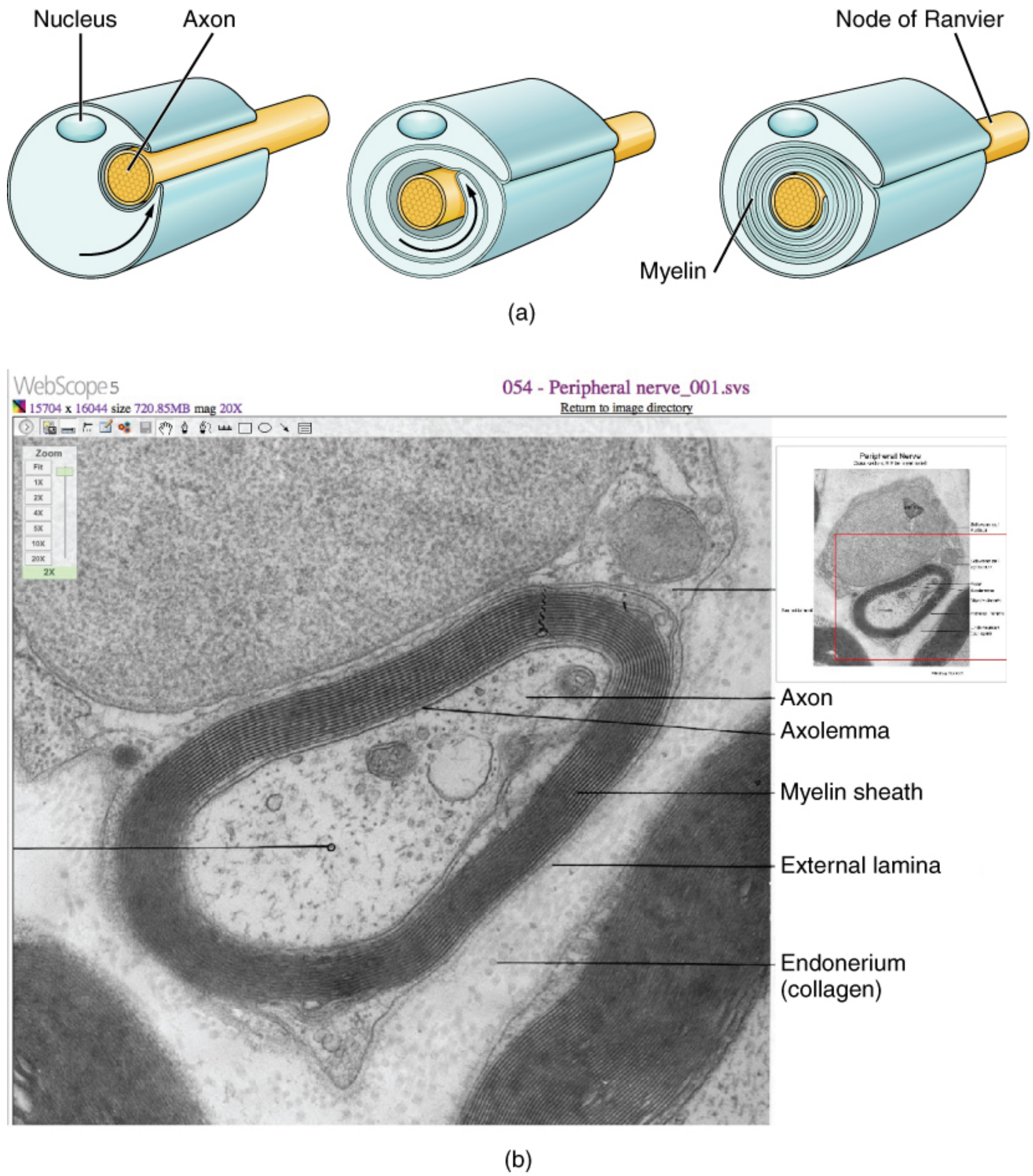


FIGURE 12.13 **The Process of Myelination** Myelinating glia wrap several layers of cell membrane around the cell membrane of an axon segment. A single Schwann cell insulates a segment of a peripheral nerve, whereas in the CNS, an oligodendrocyte may provide insulation for a few separate axon segments. EM × 1,460,000. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

Disorders of the...

Nervous Tissue

Several diseases can result from the demyelination of axons. The causes of these diseases are not the same; some have genetic causes, some are caused by pathogens, and others are the result of autoimmune disorders. Though the causes are varied, the results are largely similar. The myelin insulation of axons is compromised, making electrical signaling slower.

Multiple sclerosis (MS) is one such disease. It is an example of an autoimmune disease. The antibodies produced by lymphocytes (a type of white blood cell) mark myelin as something that should not be in the body. This causes inflammation and the destruction of the myelin in the central nervous system. As the insulation around the axons is destroyed by the disease, scarring becomes obvious. This is where the name of the disease comes from; sclerosis means hardening of tissue, which is what a scar is. Multiple scars are found in the white matter of the brain and spinal cord. The symptoms of MS include both somatic and autonomic deficits. Control of the musculature is compromised, as is control of organs such as the bladder.

Guillain-Barré (pronounced gee-YAN bah-RAY) syndrome is an example of a demyelinating disease of the peripheral nervous system. It is also the result of an autoimmune reaction, but the inflammation is in peripheral nerves. Sensory symptoms or motor deficits are common, and autonomic failures can lead to changes in the heart rhythm or a drop in blood pressure, especially when standing, which causes dizziness.

12.3 The Function of Nervous Tissue

LEARNING OBJECTIVES

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

- Distinguish the major functions of the nervous system: sensation, integration, and response
- List the sequence of events in a simple sensory receptor–motor response pathway

Having looked at the components of nervous tissue, and the basic anatomy of the nervous system, next comes an understanding of how nervous tissue is capable of communicating within the nervous system. Before getting to the nuts and bolts of how this works, an illustration of how the components come together will be helpful. An example is summarized in Figure 12.14.

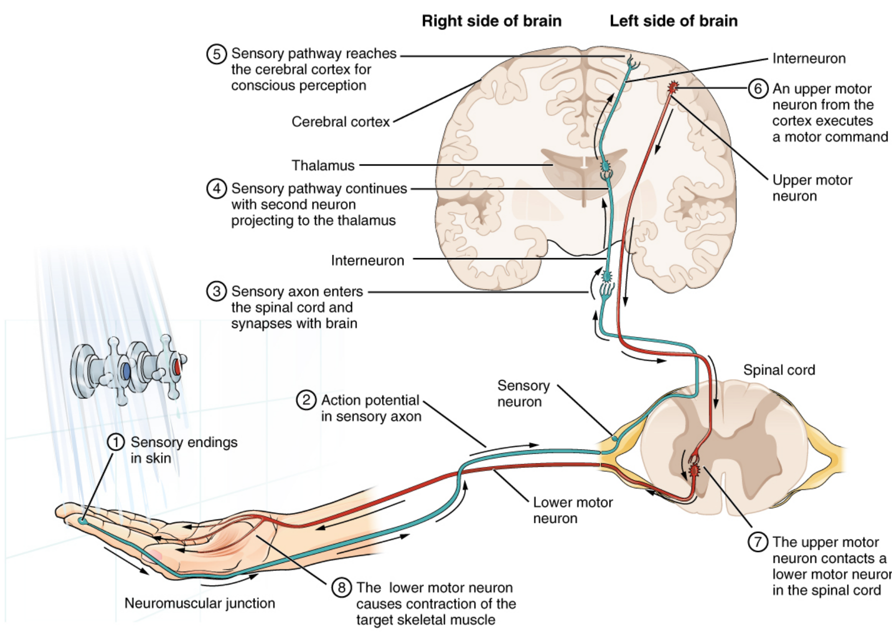


FIGURE 12.14 **Testing the Water** (1) The sensory neuron has endings in the skin that sense a stimulus such as water temperature. The strength of the signal that starts here is dependent on the strength of the stimulus. (2) The graded potential from the sensory endings, if strong enough, will initiate an action potential at the initial segment of the axon (which is immediately adjacent to the sensory endings in the skin). (3) The axon of the peripheral sensory neuron enters the spinal cord and contacts another neuron in the gray matter. The contact is a synapse where another graded potential is caused by the release of a chemical signal from the axon terminals. (4) An action potential is initiated at the initial segment of this neuron and travels up the sensory pathway to a region of the brain called the thalamus. Another synapse passes the information along to the next neuron. (5) The sensory pathway ends when the signal reaches the cerebral cortex. (6) After integration with neurons in other parts of the cerebral cortex, a motor command is sent from the precentral gyrus of the frontal cortex. (7) The upper motor neuron sends an action potential down to the spinal cord. The target of the upper motor neuron is the dendrites of the lower motor neuron in the gray matter of the spinal cord. (8) The axon of the lower motor neuron emerges from the spinal cord in a nerve and connects to a muscle through a neuromuscular junction to cause contraction of the target muscle.

Imagine you are about to take a shower in the morning before going to school. You have turned on the faucet to start the water as you prepare to get in the shower. After a few minutes, you expect the water to be a temperature that will be comfortable to enter. So you put your hand out into the spray of water. What happens next depends on how your nervous system interacts with the stimulus of the water temperature and what you do in response to that stimulus.

Found in the skin of your fingers or toes is a type of sensory receptor that is sensitive to temperature, called a **thermoreceptor**. When you place your hand under the shower (Figure 12.15), the cell membrane of the thermoreceptors changes its electrical state (voltage). The amount of change is dependent on the strength of the stimulus (how hot the water is). This is called a **graded potential**. If the stimulus is strong, the voltage of the cell membrane will change enough to generate an electrical signal that will travel down the axon. You have learned about this type of signaling before, with respect to the interaction of nerves and muscles at the neuromuscular junction. The voltage at which such a signal is generated is called the **threshold**, and the resulting electrical signal is called an **action potential**. In this example, the action potential travels—a process known as **propagation**—along the axon from the axon hillock to the axon terminals and into the synaptic end bulbs. When this signal reaches the end bulbs, it causes the release of a signaling molecule called a **neurotransmitter**.

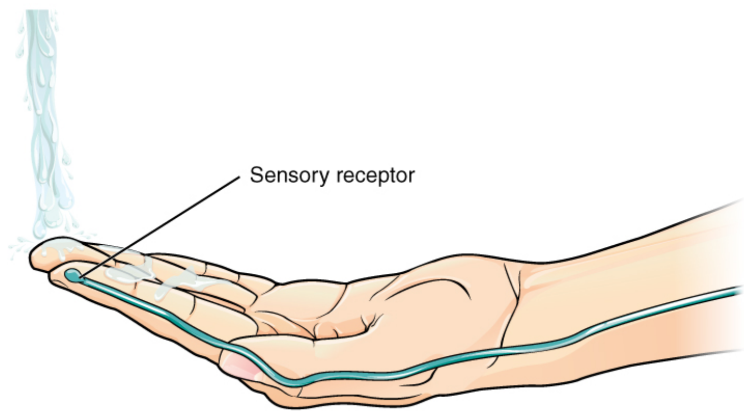


FIGURE 12.15 **The Sensory Input** Receptors in the skin sense the temperature of the water.

The neurotransmitter diffuses across the short distance of the synapse and binds to a receptor protein of the target neuron. When the molecular signal binds to the receptor, the cell membrane of the target neuron changes its electrical state and a new graded potential begins. If that graded potential is strong enough to reach threshold, the second neuron generates an action potential at its axon hillock. The target of this neuron is another neuron in the **thalamus** of the brain, the part of the CNS that acts as a relay for sensory information. At another synapse, neurotransmitter is released and binds to its receptor. The thalamus then sends the sensory information to the **cerebral cortex**, the outermost layer of gray matter in the brain, where conscious perception of that water temperature begins.

Within the cerebral cortex, information is processed among many neurons, integrating the stimulus of the water temperature with other sensory stimuli, with your emotional state (you just aren't ready to wake up; the bed is calling to you), memories (perhaps of the lab notes you have to study before a quiz). Finally, a plan is developed about what to do, whether that is to turn the temperature up, turn the whole shower off and go back to bed, or step into the shower. To do any of these things, the cerebral cortex has to send a command out to your body to move muscles (Figure 12.16).

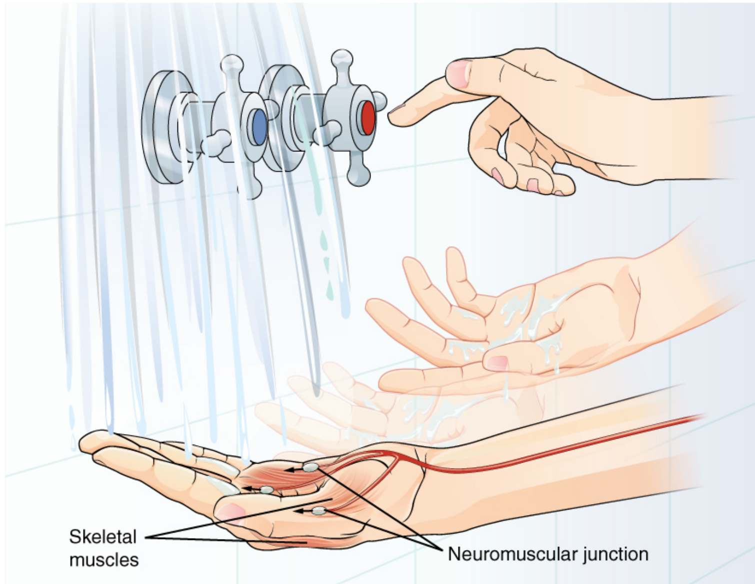


FIGURE 12.16 **The Motor Response** On the basis of the sensory input and the integration in the CNS, a motor response is formulated and executed.

A region of the cortex is specialized for sending signals down to the spinal cord for movement. The **upper motor neuron** is in this region, called the **precentral gyrus of the frontal cortex**, which has an axon that extends all the way down the spinal cord. At the level of the spinal cord at which this axon makes a synapse, a graded potential occurs in the cell membrane of a **lower motor neuron**. This second motor neuron is responsible for causing muscle fibers to contract. In the manner described in the chapter on muscle tissue, an action potential travels along the motor neuron axon into the periphery. The axon terminates on muscle fibers at the neuromuscular junction. Acetylcholine is released at this specialized synapse, which causes the muscle action potential to begin, following a large potential known as an end plate potential. When the lower motor neuron excites the muscle fiber, it contracts. All of this occurs in a fraction of a second, but this story is the basis of how the nervous system functions.

CAREER CONNECTION

Neurophysiologist

Understanding how the nervous system works could be a driving force in your career. Studying neurophysiology is a very rewarding path to follow. It means that there is a lot of work to do, but the rewards are worth the effort.

The career path of a research scientist can be straightforward: college, graduate school, postdoctoral research, academic research position at a university. A Bachelor's degree in science will get you started, and for neurophysiology that might be in biology, psychology, computer science, engineering, or neuroscience. But the real specialization comes in graduate school. There are many different programs out there to study the nervous system, not just neuroscience itself. Most graduate programs are doctoral, meaning that a Master's degree is not part of the work. These are usually considered five-year programs, with the first two years dedicated to course work and finding a research mentor, and the last three years dedicated to finding a research topic and pursuing that with a near single-mindedness. The research will usually result in a few publications in scientific journals, which will make up the bulk of a doctoral dissertation. After graduating with a Ph.D., researchers will go on to find specialized work called a postdoctoral fellowship within established labs. In this position, a researcher starts to establish their own research career with the hopes of finding an academic position at a research university.

Other options are available if you are interested in how the nervous system works. Especially for neurophysiology, a medical degree might be more suitable so you can learn about the clinical applications of neurophysiology and possibly work with human subjects. An academic career is not a necessity. Biotechnology firms are eager to find motivated scientists ready to tackle the tough questions about how the nervous system works so that therapeutic chemicals can be tested on some of the most challenging disorders such as Alzheimer's disease or Parkinson's disease, or spinal cord injury.

Others with a medical degree and a specialization in neuroscience go on to work directly with patients, diagnosing and treating mental disorders. You can do this as a psychiatrist, a neuropsychologist, a neuroscience nurse, or a neurodiagnostic technician, among other possible career paths.

12.4 The Action Potential

LEARNING OBJECTIVES

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

- Describe the components of the membrane that establish the resting membrane potential
- Describe the changes that occur to the membrane that result in the action potential

The functions of the nervous system—sensation, integration, and response—depend on the functions of the neurons underlying these pathways. To understand how neurons are able to communicate, it is necessary to describe the role of an **excitable membrane** in generating these signals. The basis of this communication is the action potential, which demonstrates how changes in the membrane can constitute a signal. Looking at the way these signals work in more variable circumstances involves a look at graded potentials, which will be covered in the next section.

Electrically Active Cell Membranes

Most cells in the body make use of charged particles, ions, to build up a charge across the cell membrane. Previously, this was shown to be a part of how muscle cells work. For skeletal muscles to contract, based on excitation–contraction coupling, requires input from a neuron. Both of the cells make use of the cell membrane to regulate ion movement between the extracellular fluid and cytosol.

As you learned in the chapter on cells, the cell membrane is primarily responsible for regulating what can cross the membrane and what stays on only one side. The cell membrane is a phospholipid bilayer, so only substances that can pass directly through the hydrophobic core can diffuse through unaided. Charged particles, which are hydrophilic by definition, cannot pass through the cell membrane without assistance (Figure 12.17). Transmembrane proteins, specifically channel proteins, make this possible. Several passive transport channels, as well as active transport pumps, are necessary to generate a transmembrane potential and an action potential. Of special interest is the carrier protein referred to as the sodium/potassium pump that moves sodium ions (Na^+) out of a cell and potassium ions (K^+) into a cell, thus regulating ion concentration on both sides of the cell membrane.

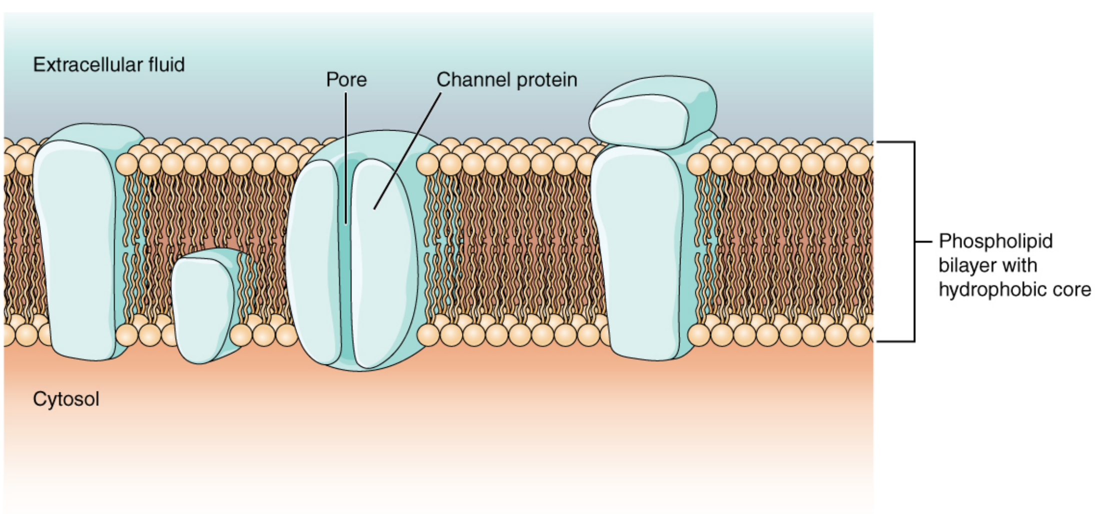


FIGURE 12.17 **Cell Membrane and Transmembrane Proteins** The cell membrane is composed of a phospholipid bilayer and has many transmembrane proteins, including different types of channel proteins that serve as ion channels.

The sodium/potassium pump requires energy in the form of adenosine triphosphate (ATP), so it is also referred to as an ATPase. As was explained in the cell chapter, the concentration of Na^+ is higher outside the cell than inside, and the concentration of K^+ is higher inside the cell than outside. That means that this pump is moving the ions against the concentration gradients for sodium and potassium, which is why it requires energy. In fact, the pump basically maintains those concentration gradients.

Ion channels are pores that allow specific charged particles to cross the membrane in response to an existing concentration gradient. Proteins are capable of spanning the cell membrane, including its hydrophobic core, and can interact with the charge of ions because of the varied properties of amino acids found within specific domains or regions of the protein channel. Hydrophobic amino acids are found in the domains that are apposed to the hydrocarbon tails of the phospholipids. Hydrophilic amino acids are exposed to the fluid environments of the extracellular fluid and cytosol. Additionally, the ions will interact with the hydrophilic amino acids, which will be selective for the charge of the ion. Channels for cations (positive ions) will have negatively charged side chains in the pore. Channels for anions (negative ions) will have positively charged side chains in the pore. This is called **electrochemical exclusion**, meaning that the channel pore is charge-specific.

Ion channels can also be specified by the diameter of the pore. The distance between the amino acids will be specific for the diameter of the ion when it dissociates from the water molecules surrounding it. Because of the surrounding water molecules, larger pores are not ideal for smaller ions because the water molecules will interact, by hydrogen bonds, more readily than the amino acid side chains. This is called **size exclusion**. Some ion channels are selective for charge but not necessarily for size, and thus are called a **nonspecific channel**. These nonspecific channels allow cations—particularly Na^+, K^+, and Ca^{2+}—to cross the membrane, but exclude anions.

Ion channels do not always freely allow ions to diffuse across the membrane. Some are opened by certain events, meaning the channels are **gated**. So another way that channels can be categorized is on the basis of how they are gated. Although these classes of ion channels are found primarily in the cells of nervous or muscular tissue, they also can be found in the cells of epithelial and connective tissues.

A **ligand-gated channel** opens because a signaling molecule, a ligand, binds to the extracellular region of the channel. This type of channel is also known as an **ionotropic receptor** because when the ligand, known as a neurotransmitter in the nervous system, binds to the protein, ions cross the membrane changing its charge (Figure 12.18).

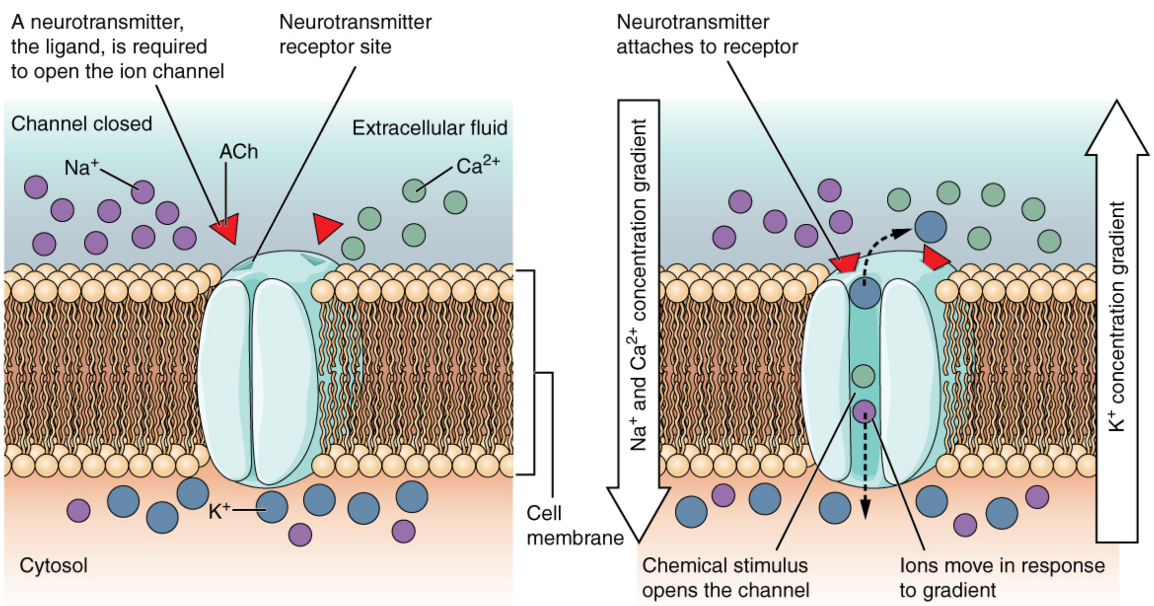


FIGURE 12.18 **Ligand-Gated Channels** When the ligand, in this case the neurotransmitter acetylcholine, binds to a specific location on the extracellular surface of the channel protein, the pore opens to allow select ions through. The ions, in this case, are cations of sodium, calcium, and potassium.

A **mechanically gated channel** opens because of a physical distortion of the cell membrane. Many channels associated with the sense of touch (somatosensation) are mechanically gated. For example, as pressure is applied to the skin, these channels open and allow ions to enter the cell. Similar to this type of channel would be the channel that opens on the basis of temperature changes, as in testing the water in the shower (Figure 12.19).

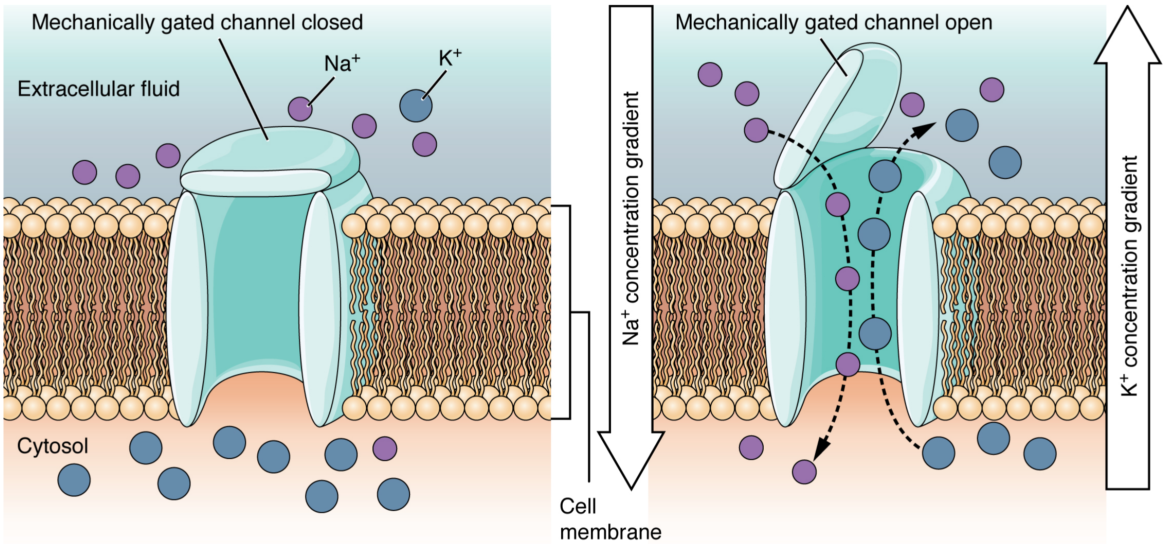


FIGURE 12.19 **Mechanically Gated Channels** When a mechanical change occurs in the surrounding tissue, such as pressure or touch, the channel is physically opened. Thermoreceptors work on a similar principle. When the local tissue temperature changes, the protein reacts by physically opening the channel.

A **voltage-gated channel** is a channel that responds to changes in the electrical properties of the membrane in which it is embedded. Normally, the inner portion of the membrane is at a negative voltage. When that voltage becomes less negative, the channel begins to allow ions to cross the membrane (Figure 12.20).

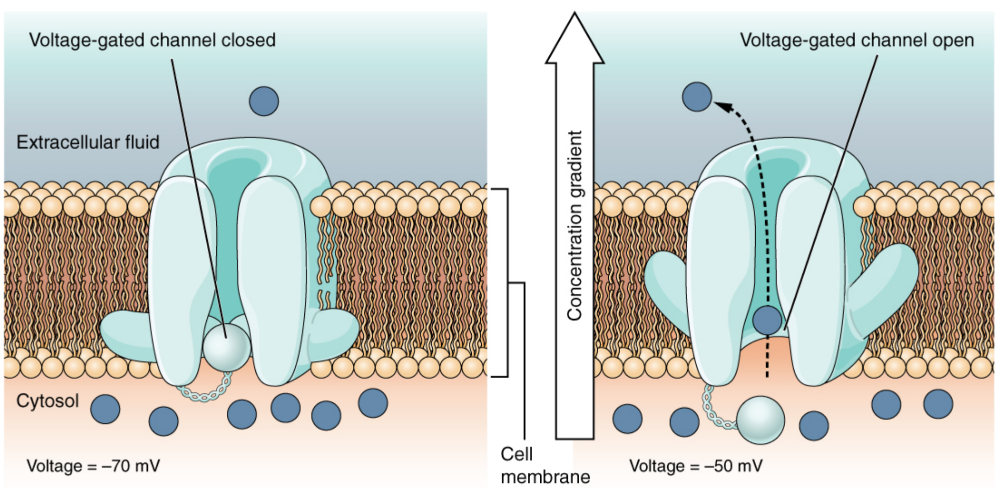


FIGURE 12.20 **Voltage-Gated Channels** Voltage-gated channels open when the transmembrane voltage changes around them. Amino acids in the structure of the protein are sensitive to charge and cause the pore to open to the selected ion.

A **leakage channel** is randomly gated, meaning that it opens and closes at random, hence the reference to leaking. There is no actual event that opens the channel; instead, it has an intrinsic rate of switching between the open and closed states. Leakage channels contribute to the resting transmembrane voltage of the excitable membrane (Figure 12.21).

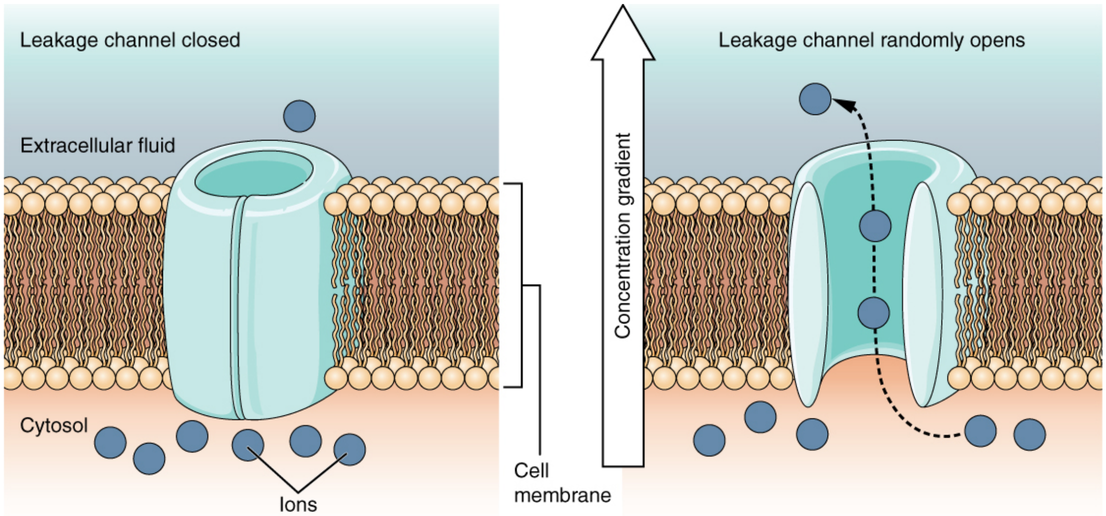


FIGURE 12.21 **Leakage Channels** In certain situations, ions need to move across the membrane randomly. The particular electrical properties of certain cells are modified by the presence of this type of channel.

The Membrane Potential

The electrical state of the cell membrane can have several variations. These are all variations in the **membrane potential**. A potential is a distribution of charge across the cell membrane, measured in millivolts (mV). The standard is to compare the inside of the cell relative to the outside, so the membrane potential is a value representing the charge on the intracellular side of the membrane based on the outside being zero, relatively speaking (Figure 12.22).

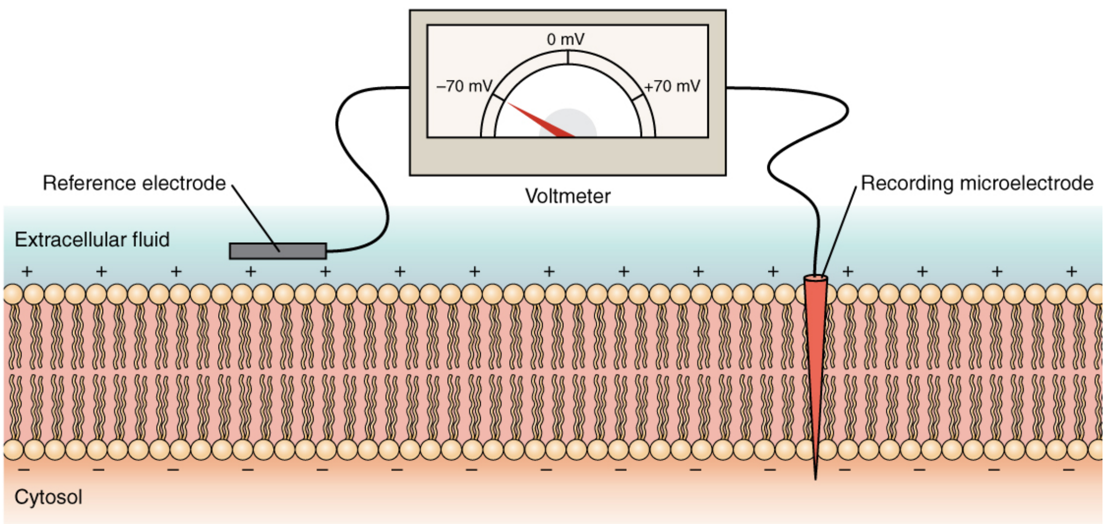


FIGURE 12.22 **Measuring Charge across a Membrane with a Voltmeter** A recording electrode is inserted into the cell and a reference electrode is outside the cell. By comparing the charge measured by these two electrodes, the transmembrane voltage is determined. It is conventional to express that value for the cytosol relative to the outside.

The concentration of ions in extracellular and intracellular fluids is largely balanced, with a net neutral charge. However, a slight difference in charge occurs right at the membrane surface, both internally and externally. It is the difference in this very limited region that has all the power in neurons (and muscle cells) to generate electrical signals, including action potentials.

Before these electrical signals can be described, the resting state of the membrane must be explained. When the cell is at rest, and the ion channels are closed (except for leakage channels which randomly open), ions are distributed across the membrane in a very predictable way. The concentration of Na^+ outside the cell is 10 times greater than the concentration inside. Also, the concentration of K^+ inside the cell is greater than outside. The cytosol contains a high concentration of anions, in the form of phosphate ions and negatively charged proteins.

Large anions are a component of the inner cell membrane, including specialized phospholipids and proteins associated with the inner leaflet of the membrane (leaflet is a term used for one side of the lipid bilayer membrane). The negative charge is localized in the large anions.

With the ions distributed across the membrane at these concentrations, the difference in charge is measured at -70 mV, the value described as the **resting membrane potential**. The exact value measured for the resting membrane potential varies between cells, but -70 mV is most commonly used as this value. This voltage would actually be much lower except for the contributions of some important proteins in the membrane. Leakage channels allow Na^+ to slowly move into the cell or K^+ to slowly move out, and the Na^+/K^+ pump restores them. This may appear to be a waste of energy, but each has a role in maintaining the membrane potential.

The Action Potential

Resting membrane potential describes the steady state of the cell, which is a dynamic process that is balanced by ion leakage and ion pumping. Without any outside influence, it will not change. To get an electrical signal started, the membrane potential has to change.

This starts with a channel opening for Na^+ in the membrane. Because the concentration of Na^+ is higher outside the cell than inside the cell by a factor of 10, ions will rush into the cell that are driven largely by the concentration gradient. Because sodium is a positively charged ion, it will change the relative voltage immediately inside the cell relative to immediately outside. The resting potential is the state of the membrane at a voltage of -70 mV, so the sodium cation entering the cell will cause it to become less negative. This is known as **depolarization**, meaning the membrane potential moves toward zero.

The concentration gradient for Na^+ is so strong that it will continue to enter the cell even after the membrane potential has become zero, so that the voltage immediately around the pore begins to become positive. The electrical gradient also plays a role, as negative proteins below the membrane attract the sodium ion. The membrane potential will reach +30 mV by the time sodium has entered the cell.

As the membrane potential reaches +30 mV, other voltage-gated channels are opening in the membrane. These channels are specific for the potassium ion. A concentration gradient acts on K^+, as well. As K^+ starts to leave the cell, taking a positive charge with it, the membrane potential begins to move back toward its resting voltage. This is called **repolarization**, meaning that the membrane voltage moves back toward the -70 mV value of the resting membrane potential.

Repolarization returns the membrane potential to the -70 mV value that indicates the resting potential, but it actually overshoots that value. Potassium ions reach equilibrium when the membrane voltage is below -70 mV, so a period of hyperpolarization occurs while the K^+ channels are open. Those K^+ channels are slightly delayed in closing, accounting for this short overshoot.

What has been described here is the action potential, which is presented as a graph of voltage over time in Figure 12.23. It is the electrical signal that nervous tissue generates for communication. The change in the membrane voltage from -70 mV at rest to +30 mV at the end of depolarization is a 100 mV change. That can also be written as a 0.1 V change. To put that value in perspective, think about a battery. An AA battery that you might find in a television remote has a voltage of 1.5 V, or a 9 V battery (the rectangular battery with two posts on one end) is, obviously, 9 V. The change seen in the action potential is one or two orders of magnitude less than the charge in these batteries. In fact, the membrane potential can be described as a battery. A charge is stored across the membrane that can be released under the correct conditions. A battery in your remote has stored a charge that is "released" when you push a button.

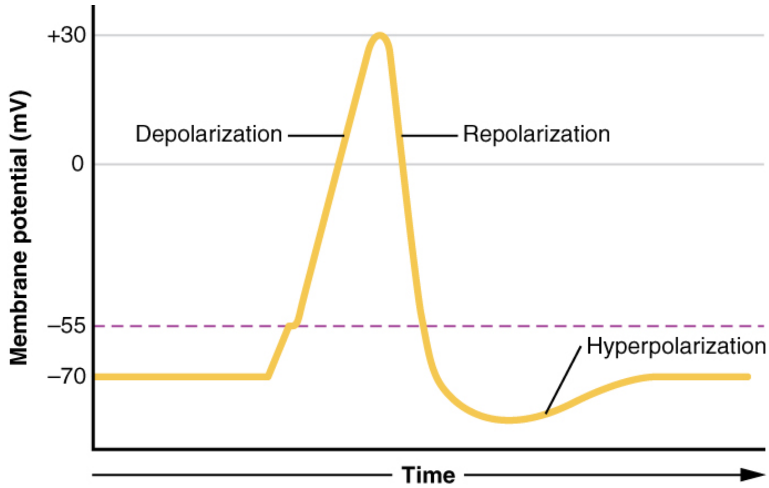


FIGURE 12.23 **Graph of Action Potential** Plotting voltage measured across the cell membrane against time, the action potential begins with depolarization, followed by repolarization, which goes past the resting potential into hyperpolarization, and finally the membrane returns to rest.

INTERACTIVE LINK

What happens across the membrane of an electrically active cell is a dynamic process that is hard to visualize with static images or through text descriptions. View this animation (http://openstax.org/l/dynamic1) to learn more about this process. What is the difference between the driving force for Na^+ and K^+? And what is similar about the movement of these two ions?

The question is, now, what initiates the action potential? The description above conveniently glosses over that point. But it is vital to understanding what is happening. The membrane potential will stay at the resting voltage until something changes. The description above just says that a Na^+ channel opens. Now, to say “a channel opens” does not mean that one individual transmembrane protein changes. Instead, it means that one kind of channel opens. There are a few different types of channels that allow Na^+ to cross the membrane. A ligand-gated Na^+ channel will open when a neurotransmitter binds to it and a mechanically gated Na^+ channel will open when a physical stimulus affects a sensory receptor (like pressure applied to the skin compresses a touch receptor). Whether it is a neurotransmitter binding to its receptor protein or a sensory stimulus activating a sensory receptor cell, some stimulus gets the process started. Sodium starts to enter the cell and the membrane becomes less negative.

A third type of channel that is an important part of depolarization in the action potential is the voltage-gated Na^+ channel. The channels that start depolarizing the membrane because of a stimulus help the cell to depolarize from -70 mV to -55 mV. Once the membrane reaches that voltage, the voltage-gated Na^+ channels open. This is what is known as the threshold. Any depolarization that does not change the membrane potential to -55 mV or higher will not reach threshold and thus will not result in an action potential. Also, any stimulus that depolarizes the membrane to -55 mV or beyond will cause a large number of channels to open and an action potential will be initiated.

Because of the threshold, the action potential can be likened to a digital event—it either happens or it does not. If the threshold is not reached, then no action potential occurs. If depolarization reaches -55 mV, then the action potential continues and runs all the way to +30 mV, at which K^+ causes repolarization, including the hyperpolarizing overshoot. Also, those changes are the same for every action potential, which means that once the threshold is reached, the exact same thing happens. A stronger stimulus, which might depolarize the membrane well past threshold, will not make a “bigger” action potential. Action potentials are “all or none.” Either the membrane reaches the threshold and everything occurs as described above, or the membrane does not reach the threshold and nothing else happens. All action potentials peak at the same voltage (+30 mV), so one action potential is not bigger than another. Stronger stimuli will initiate multiple action potentials more quickly, but the individual signals are not bigger. Thus, for example, you will not feel a greater sensation of pain, or have a stronger muscle contraction, because of the size of the action potential because they are not different sizes.

As we have seen, the depolarization and repolarization of an action potential are dependent on two types of channels (the voltage-gated Na^+ channel and the voltage-gated K^+ channel). The voltage-gated Na^+ channel actually has two gates. One is the **activation gate**, which opens when the membrane potential crosses -55 mV. The other gate is the **inactivation gate**, which closes after a specific period of time—on the order of a fraction of a millisecond. When a cell is at rest, the activation gate is closed and the inactivation gate is open. However, when the threshold is reached, the activation gate opens, allowing Na^+ to rush into the cell. Timed with the peak of depolarization, the inactivation gate closes. During repolarization, no more sodium can enter the cell. When the membrane potential passes -55 mV again, the activation gate closes. After that, the inactivation gate re-opens, making the channel ready to start the whole process over again.

The voltage-gated K^+ channel has only one gate, which is sensitive to a membrane voltage of -50 mV. However, it does not open as quickly as the voltage-gated Na^+ channel does. It might take a fraction of a millisecond for the channel to open once that voltage has been reached. The timing of this coincides exactly with when the Na^+ flow peaks, so voltage-gated K^+ channels open just as the voltage-gated Na^+ channels are being inactivated. As the membrane potential repolarizes and the voltage passes -50 mV again, the channel closes—again, with a little delay. Potassium continues to leave the cell for a short while and the membrane potential becomes more negative, resulting in the hyperpolarizing overshoot. Then the channel closes again and the membrane can return to the resting potential because of the ongoing activity of the non-gated channels and the Na^+/K^+ pump.

All of this takes place within approximately 2 milliseconds (Figure 12.24). While an action potential is in progress, another one cannot be initiated. That effect is referred to as the **refractory period**. There are two phases of the refractory period: the **absolute refractory period** and the **relative refractory period**. During the absolute phase, another action potential will not start. This is because of the inactivation gate of the voltage-gated Na^+ channel. Once that channel is back to its resting conformation (less than -55 mV), a new action potential could be started, but only by a stronger stimulus than the one that initiated the current action potential. This is because of the flow of K^+ out of the cell. Because that ion is rushing out, any Na^+ that tries to enter will not depolarize the cell, but will only keep the cell from hyperpolarizing.

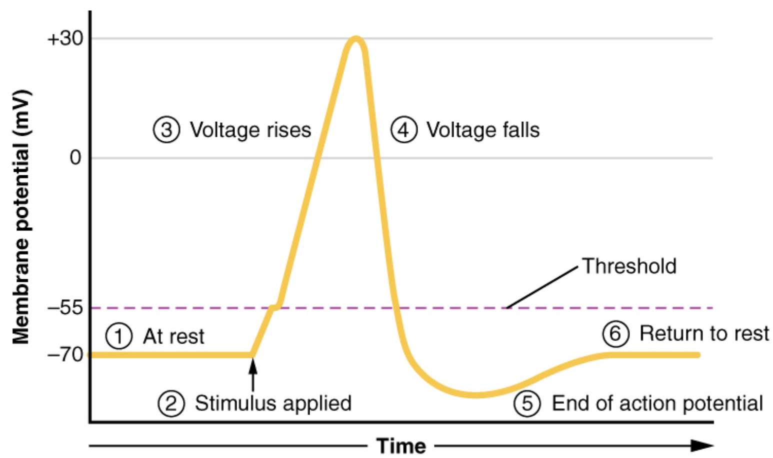


FIGURE 12.24 **Stages of an Action Potential** Plotting voltage measured across the cell membrane against time, the events of the action potential can be related to specific changes in the membrane voltage. (1) At rest, the membrane voltage is -70 mV. (2) The membrane begins to depolarize when an external stimulus is applied. (3) The membrane voltage begins a rapid rise toward +30 mV. (4) The membrane voltage starts to return to a negative value. (5) Repolarization continues past the resting membrane voltage, resulting in hyperpolarization. (6) The membrane voltage returns to the resting value shortly after hyperpolarization.

Propagation of the Action Potential

The action potential is initiated at the beginning of the axon, at what is called the initial segment. There is a high density of voltage-gated Na^+ channels so that rapid depolarization can take place here. Going down the length of the axon, the action potential is propagated because more voltage-gated Na^+ channels are opened as the depolarization spreads. This spreading occurs because Na^+ enters through the channel and moves along the inside of the cell membrane. As the Na^+ moves, or flows, a short distance along the cell membrane, its positive charge depolarizes a little more of the cell membrane. As that depolarization spreads, new voltage-gated Na^+ channels open and more ions rush into the cell, spreading the depolarization a little farther.

Because voltage-gated Na^+ channels are inactivated at the peak of the depolarization, they cannot be opened again for a brief time—the absolute refractory period. Because of this, depolarization spreading back toward previously opened channels has no effect. The action potential must propagate toward the axon terminals; as a result, the polarity of the neuron is maintained, as mentioned above.

Propagation, as described above, applies to unmyelinated axons. When myelination is present, the action potential propagates differently. Sodium ions that enter the cell at the initial segment start to spread along the length of the axon segment, but there are no voltage-gated Na^+ channels until the first node of Ranvier. Because there is not constant opening of these channels along the axon segment, the depolarization spreads at an optimal speed. The distance between nodes is the optimal distance to keep the membrane still depolarized above threshold at the next node. As Na^+ spreads along the inside of the membrane of the axon segment, the charge starts to dissipate. If the node were any farther down the axon, that depolarization would have fallen off too much for voltage-gated Na^+ channels to be activated at the next node of Ranvier. If the nodes were any closer together, the speed of propagation would be slower.

Propagation along an unmyelinated axon is referred to as **continuous conduction**; along the length of a myelinated axon, it is **saltatory conduction**. Continuous conduction is slow because there are always voltage-gated Na^+ channels opening, and more and more Na^+ is rushing into the cell. Saltatory conduction is faster because the action potential basically jumps from one node to the next (saltare = “to leap”), and the new influx of Na^+ renews the depolarized membrane. Along with the myelination of the axon, the diameter of the axon can influence the speed of conduction. Much as water runs faster in a wide river than in a narrow creek, Na^+-based depolarization spreads faster down a wide axon than down a narrow one. This concept is known as **resistance** and is generally true for electrical wires or plumbing, just as it is true for axons, although the specific conditions are different at the scales of electrons or ions versus water in a river.

HOMEOSTATIC IMBALANCES

Potassium Concentration

Glial cells, especially astrocytes, are responsible for maintaining the chemical environment of the CNS tissue. The concentrations of ions in the extracellular fluid are the basis for how the membrane potential is established and changes in electrochemical signaling. If the balance of ions is upset, drastic outcomes are possible.

Normally the concentration of K^+ is higher inside the neuron than outside. After the repolarizing phase of the action potential, K^+ leakage channels and the Na^+/K^+ pump ensure that the ions return to their original locations. Following a stroke or other ischemic event, extracellular K^+ levels are elevated. The astrocytes in the area are equipped to clear excess K^+ to aid the pump. But when the level is far out of balance, the effects can be irreversible.

Astrocytes can become reactive in cases such as these, which impairs their ability to maintain the local chemical environment. The glial cells enlarge and their processes swell. They lose their K^+ buffering ability and the function of the pump is affected, or even reversed. One of the early signs of cell disease is this "leaking" of sodium ions into the body cells. This sodium/potassium imbalance negatively affects the internal chemistry of cells, preventing them from functioning normally.

INTERACTIVE LINK

Visit this site (http://openstax.org/l/neurolab) to see a virtual neurophysiology lab, and to observe electrophysiological processes in the nervous system, where scientists directly measure the electrical signals produced by neurons. Often, the action potentials occur so rapidly that watching a screen to see them occur is not helpful. A speaker is powered by the signals recorded from a neuron and it “pops” each time the neuron fires an action potential. These action potentials are firing so fast that it sounds like static on the radio. Electrophysiologists can recognize the patterns within that static to understand what is happening. Why is the leech model used for measuring the electrical activity of neurons instead of using humans?

12.5 Communication Between Neurons

LEARNING OBJECTIVES

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

- Explain the differences between the types of graded potentials
- Categorize the major neurotransmitters by chemical type and effect

The electrical changes taking place within a neuron, as described in the previous section, are similar to a light switch being turned on. A stimulus starts the depolarization, but the action potential runs on its own once a threshold has been reached. The question is now, “What flips the light switch on?” Temporary changes to the cell membrane voltage can result from neurons receiving information from the environment, or from the action of one neuron on another. These special types of potentials influence a neuron and determine whether an action potential will occur or not. Many of these transient signals originate at the synapse.

Graded Potentials

Local changes in the membrane potential are called graded potentials and are usually associated with the dendrites of a neuron. The amount of change in the membrane potential is determined by the size of the stimulus that causes it. In the example of testing the temperature of the shower, slightly warm water would only initiate a small change in a thermoreceptor, whereas hot water would cause a large amount of change in the membrane potential.

Graded potentials can be of two sorts, either they are depolarizing or hyperpolarizing (Figure 12.25). For a membrane at the resting potential, a graded potential represents a change in that voltage either above -70 mV or below -70 mV. Depolarizing graded potentials are often the result of Na^+ or Ca^{2+} entering the cell. Both of these ions have higher concentrations outside the cell than inside; because they have a positive charge, they will move into the cell causing it to become less negative relative to the outside. Hyperpolarizing graded potentials can be caused by K^+ leaving the cell or Cl^- entering the cell. If a positive charge moves out of a cell, the cell becomes more negative; if a negative charge enters the cell, the same thing happens.

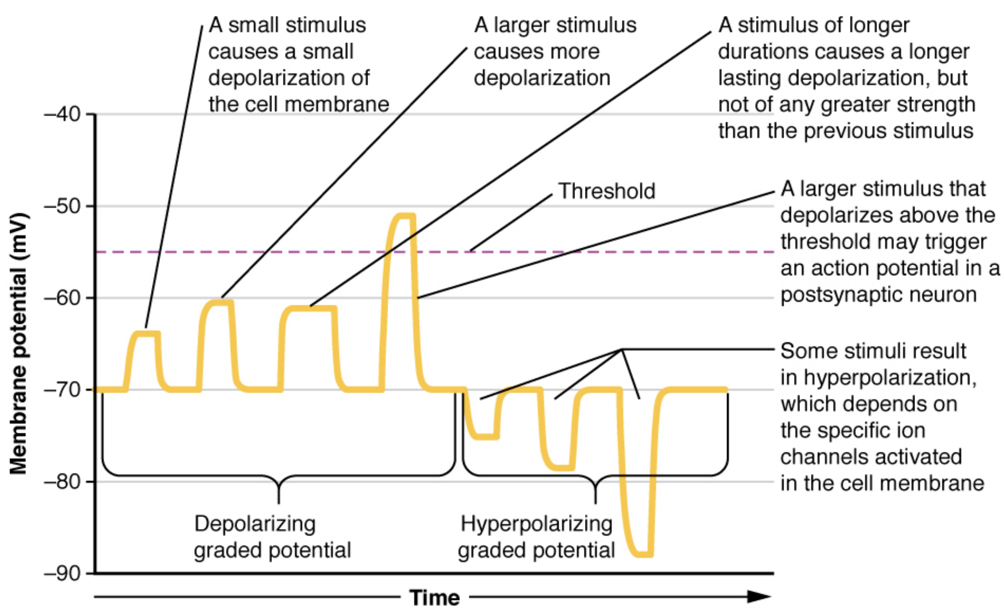


FIGURE 12.25 **Graded Potentials** Graded potentials are temporary changes in the membrane voltage, the characteristics of which depend on the size of the stimulus. Some types of stimuli cause depolarization of the membrane, whereas others cause hyperpolarization. It depends on the specific ion channels that are activated in the cell membrane.

Types of Graded Potentials

For the unipolar cells of sensory neurons—both those with free nerve endings and those within encapsulations—graded potentials develop in the dendrites that influence the generation of an action potential in the axon of the same cell. This is called a **generator potential**. For other sensory receptor cells, such as taste cells or photoreceptors of the retina, graded potentials in their membranes result in the release of neurotransmitters at synapses with sensory neurons. This is called a **receptor potential**.

A **postsynaptic potential (PSP)** is the graded potential in the dendrites of a neuron that is receiving synapses from other cells. Postsynaptic potentials can be depolarizing or hyperpolarizing. Depolarization in a postsynaptic potential is called an **excitatory postsynaptic potential (EPSP)** because it causes the membrane potential to move toward threshold. Hyperpolarization in a postsynaptic potential is an **inhibitory postsynaptic potential (IPSP)** because it causes the membrane potential to move away from threshold.

Summation

All types of graded potentials will result in small changes of either depolarization or hyperpolarization in the voltage of a membrane. These changes can lead to the neuron reaching threshold if the changes add together, or **summate**. The combined effects of different types of graded potentials are illustrated in Figure 12.26. If the total change in voltage in the membrane is a positive 15 mV, meaning that the membrane depolarizes from -70 mV to -55 mV, then the graded potentials will result in the membrane reaching threshold.

For receptor potentials, threshold is not a factor because the change in membrane potential for receptor cells directly causes neurotransmitter release. However, generator potentials can initiate action potentials in the sensory neuron axon, and postsynaptic potentials can initiate an action potential in the axon of other neurons. Graded potentials summate at a specific location at the beginning of the axon to initiate the action potential, namely the initial segment. For sensory neurons, which do not have a cell body between the dendrites and the axon, the initial segment is directly adjacent to the dendritic endings. For all other neurons, the axon hillock is essentially the initial segment of the axon, and it is where summation takes place. These locations have a high density of voltage-gated Na^+ channels that initiate the depolarizing phase of the action potential.

Summation can be spatial or temporal, meaning it can be the result of multiple graded potentials at different locations on the neuron, or all at the same place but separated in time. **Spatial summation** is related to associating the activity of multiple inputs to a neuron with each other. **Temporal summation** is the relationship of multiple action potentials from a single cell resulting in a significant change in the membrane potential. Spatial and temporal summation can act together, as well.

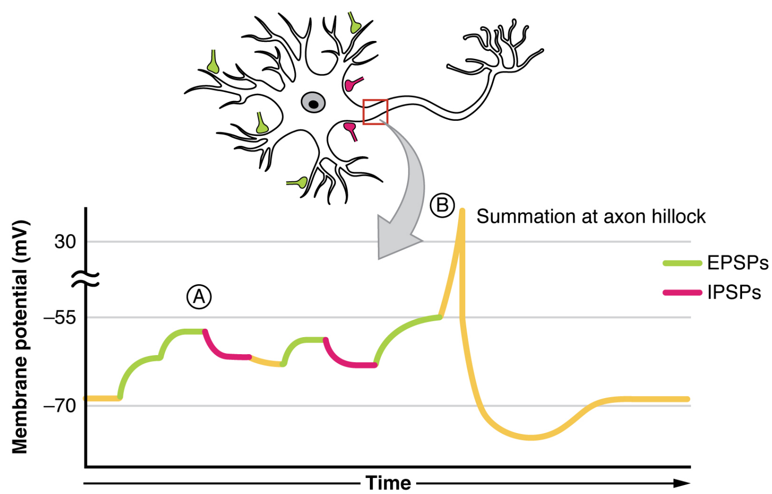


FIGURE 12.26 **Postsynaptic Potential Summation** The result of summation of postsynaptic potentials is the overall change in the membrane potential. At point A, several different excitatory postsynaptic potentials add up to a large depolarization. At point B, a mix of excitatory and inhibitory postsynaptic potentials result in a different end result for the membrane potential.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/summation) to learn about summation. The process of converting electrical signals to chemical signals and back requires subtle changes that can result in transient increases or decreases in membrane voltage. To cause a lasting change in the target cell, multiple signals are usually added together, or summated. Does spatial summation have to happen all at once, or can the separate signals arrive on the postsynaptic neuron at slightly different times? Explain your answer.

Synapses

There are two types of connections between electrically active cells, chemical synapses and electrical synapses. In a **chemical synapse**, a chemical signal—namely, a neurotransmitter—is released from one cell and it affects the other cell. In an **electrical synapse**, there is a direct connection between the two cells so that ions can pass directly from one cell to the next. If one cell is depolarized in an electrical synapse, the joined cell also depolarizes because the ions pass between the cells. Chemical synapses involve the transmission of chemical information from one cell to the next. This section will concentrate on the chemical type of synapse.

An example of a chemical synapse is the neuromuscular junction (NMJ) described in the chapter on muscle tissue. In the nervous system, there are many more synapses that are essentially the same as the NMJ. All synapses have common characteristics, which can be summarized in this list:

- presynaptic element
- neurotransmitter (packaged in vesicles)
- synaptic cleft
- receptor proteins
- postsynaptic element
- neurotransmitter elimination or re-uptake

For the NMJ, these characteristics are as follows: the presynaptic element is the motor neuron's axon terminals, the neurotransmitter is acetylcholine, the synaptic cleft is the space between the cells where the neurotransmitter diffuses, the receptor protein is the nicotinic acetylcholine receptor, the postsynaptic element is the sarcolemma of the muscle cell, and the neurotransmitter is eliminated by acetylcholinesterase. Other synapses are similar to this, and the specifics are different, but they all contain the same characteristics.

Neurotransmitter Release

When an action potential reaches the axon terminals, voltage-gated Ca^{2+} channels in the membrane of the synaptic end bulb open. The concentration of Ca^{2+} increases inside the end bulb, and the Ca^{2+} ion associates with proteins in the outer surface of neurotransmitter vesicles. The Ca^{2+} facilitates the merging of the vesicle with the presynaptic membrane so that the neurotransmitter is released through exocytosis into the small gap between the cells, known as the **synaptic cleft**.

Once in the synaptic cleft, the neurotransmitter diffuses the short distance to the postsynaptic membrane and can interact with neurotransmitter receptors. Receptors are specific for the neurotransmitter, and the two fit together like a key and lock. One neurotransmitter binds to its receptor and will not bind to receptors for other neurotransmitters, making the binding a specific chemical event (Figure 12.27).

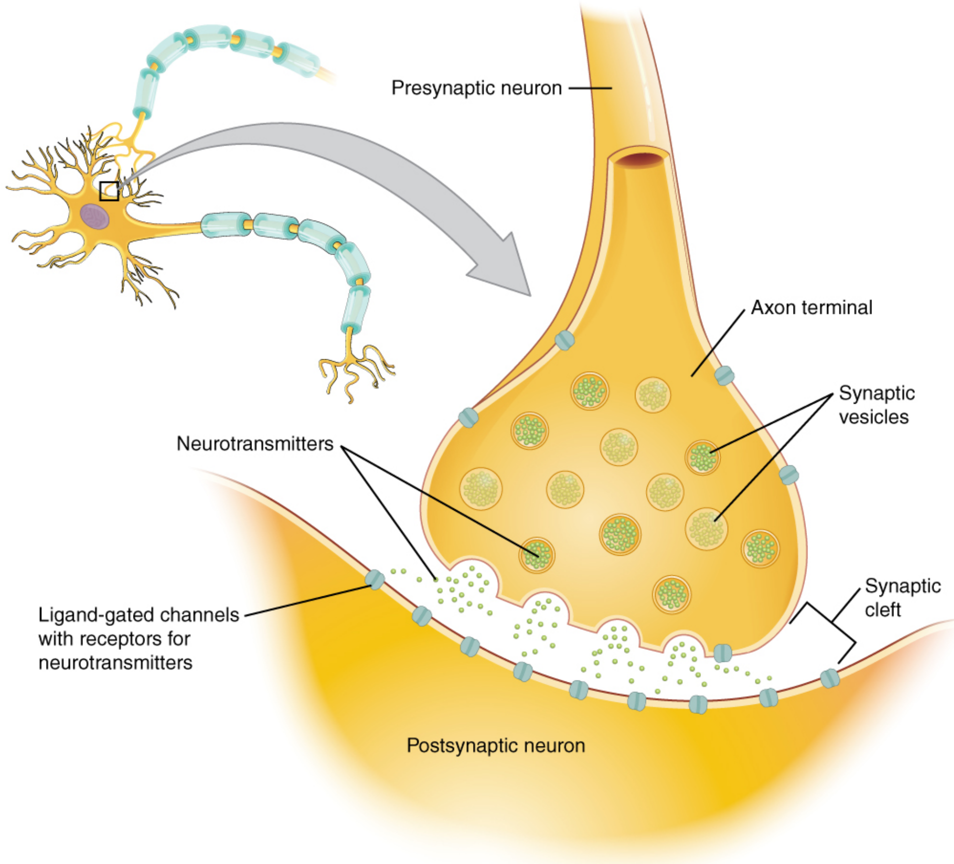


FIGURE 12.27 **The Synapse** The synapse is a connection between a neuron and its target cell (which is not necessarily a neuron). The presynaptic element is the synaptic end bulb of the axon where Ca^{2+} enters the bulb to cause vesicle fusion and neurotransmitter release. The neurotransmitter diffuses across the synaptic cleft to bind to its receptor. The neurotransmitter is cleared from the synapse either by enzymatic degradation, neuronal reuptake, or glial reuptake.

Neurotransmitter Systems

There are several systems of neurotransmitters that are found at various synapses in the nervous system. These groups refer to the chemicals that are the neurotransmitters, and within the groups are specific systems.

The first group, which is a neurotransmitter system of its own, is the **cholinergic system**. It is the system based on acetylcholine. This includes the NMJ as an example of a cholinergic synapse, but cholinergic synapses are found in other parts of the nervous system. They are in the autonomic nervous system, as well as distributed throughout the brain.

The cholinergic system has two types of receptors, the **nicotinic receptor** is found in the NMJ as well as other synapses. There is also an acetylcholine receptor known as the **muscarinic receptor**. Both of these receptors are named for drugs that interact with the receptor in addition to acetylcholine. Nicotine will bind to the nicotinic receptor and activate it similar to acetylcholine. Muscarine, a product of certain mushrooms, will bind to the muscarinic receptor. However, nicotine will not bind to the muscarinic receptor and muscarine will not bind to the nicotinic receptor.

Another group of neurotransmitters are amino acids. This includes glutamate (Glu), GABA (gamma-aminobutyric acid, a derivative of glutamate), and glycine (Gly). These amino acids have an amino group and a carboxyl group in their chemical structures. Glutamate is one of the 20 amino acids that are used to make proteins. Each amino acid neurotransmitter would be part of its own system, namely the glutamatergic, GABAergic, and glycinergic systems. They each have their own receptors and do not interact with each other. Amino acid neurotransmitters are eliminated from the synapse by reuptake. A pump in the cell membrane of the presynaptic element, or sometimes a neighboring glial cell, will clear the amino acid from the synaptic cleft so that it can be recycled, repackaged in vesicles, and released again.

Another class of neurotransmitter is the **biogenic amine**, a group of neurotransmitters that are enzymatically made from amino acids. They have amino groups in them, but no longer have carboxyl groups and are therefore no longer classified as amino acids. Serotonin is made from tryptophan. It is the basis of the serotonergic system, which has its own specific receptors. Serotonin is transported back into the presynaptic cell for repackaging.

Other biogenic amines are made from tyrosine, and include dopamine, norepinephrine, and epinephrine. Dopamine is part of its own system, the dopaminergic system, which has dopamine receptors. Dopamine is removed from the synapse by transport proteins in the presynaptic cell membrane. Norepinephrine and epinephrine belong to the adrenergic neurotransmitter system. The two molecules are very similar and bind to the same receptors, which are referred to as alpha and beta receptors. Norepinephrine and epinephrine are also transported back into the presynaptic cell. The chemical epinephrine (epi- = "on"; "-nephrine" = kidney) is also known as adrenaline (renal = "kidney"), and norepinephrine is sometimes referred to as noradrenaline. The adrenal gland produces epinephrine and norepinephrine to be released into the blood stream as hormones.

A **neuropeptide** is a neurotransmitter molecule made up of chains of amino acids connected by peptide bonds. This is what a protein is, but the term protein implies a certain length to the molecule. Some neuropeptides are quite short, such as met-enkephalin, which is five amino acids long. Others are long, such as beta-endorphin, which is 31 amino acids long. Neuropeptides are often released at synapses in combination with another neurotransmitter, and they often act as hormones in other systems of the body, such as vasoactive intestinal peptide (VIP) or substance P.

The effect of a neurotransmitter on the postsynaptic element is entirely dependent on the receptor protein. First, if there is no receptor protein in the membrane of the postsynaptic element, then the neurotransmitter has no effect. The depolarizing or hyperpolarizing effect is also dependent on the receptor. When acetylcholine binds to the nicotinic receptor, the postsynaptic cell is depolarized. This is because the receptor is a cation channel and positively charged Na^+ will rush into the cell. However, when acetylcholine binds to the muscarinic receptor, of which there are several variants, it might cause depolarization or hyperpolarization of the target cell.

The amino acid neurotransmitters, glutamate, glycine, and GABA, are almost exclusively associated with just one effect. Glutamate is considered an excitatory amino acid, but only because Glu receptors in the adult cause depolarization of the postsynaptic cell. Glycine and GABA are considered inhibitory amino acids, again because their receptors cause hyperpolarization.

The biogenic amines have mixed effects. For example, the dopamine receptors that are classified as D1 receptors are excitatory whereas D2-type receptors are inhibitory. Biogenic amine receptors and neuropeptide receptors can have even more complex effects because some may not directly affect the membrane potential, but rather have an effect on gene transcription or other metabolic processes in the neuron. The characteristics of the various neurotransmitter systems presented in this section are organized in Table 12.3.

The important thing to remember about neurotransmitters, and signaling chemicals in general, is that the effect is entirely dependent on the receptor. Neurotransmitters bind to one of two classes of receptors at the cell surface, ionotropic or metabotropic (Figure 12.28). Ionotropic receptors are ligand-gated ion channels, such as the nicotinic receptor for acetylcholine or the glycine receptor. A **metabotropic receptor** involves a complex of proteins that result in metabolic changes within the cell. The receptor complex includes the transmembrane receptor protein, a G protein, and an effector protein. The neurotransmitter, referred to as the first messenger, binds to the receptor protein on the extracellular surface of the cell, and the intracellular side of the protein initiates activity of the G protein. The **G protein** is a guanosine triphosphate (GTP) hydrolase that physically moves from the receptor protein to the effector protein to activate the latter. An **effector protein** is an enzyme that catalyzes the generation of a new molecule, which acts as the intracellular mediator of the signal that binds to the receptor. This intracellular mediator is called the second messenger.

Different receptors use different second messengers. Two common examples of second messengers are cyclic adenosine monophosphate (cAMP) and inositol triphosphate (IP_3). The enzyme adenylate cyclase (an example of an effector protein) makes cAMP, and phospholipase C is the enzyme that makes IP_3. Second messengers, after they are produced by the effector protein, cause metabolic changes within the cell. These changes are most likely the activation of other enzymes in the cell. In neurons, they often modify ion channels, either opening or closing them. These enzymes can also cause changes in the cell, such as the activation of genes in the nucleus, and therefore the increased synthesis of proteins. In neurons, these kinds of changes are often the basis of stronger connections between cells at the synapse and may be the basis of learning and memory.

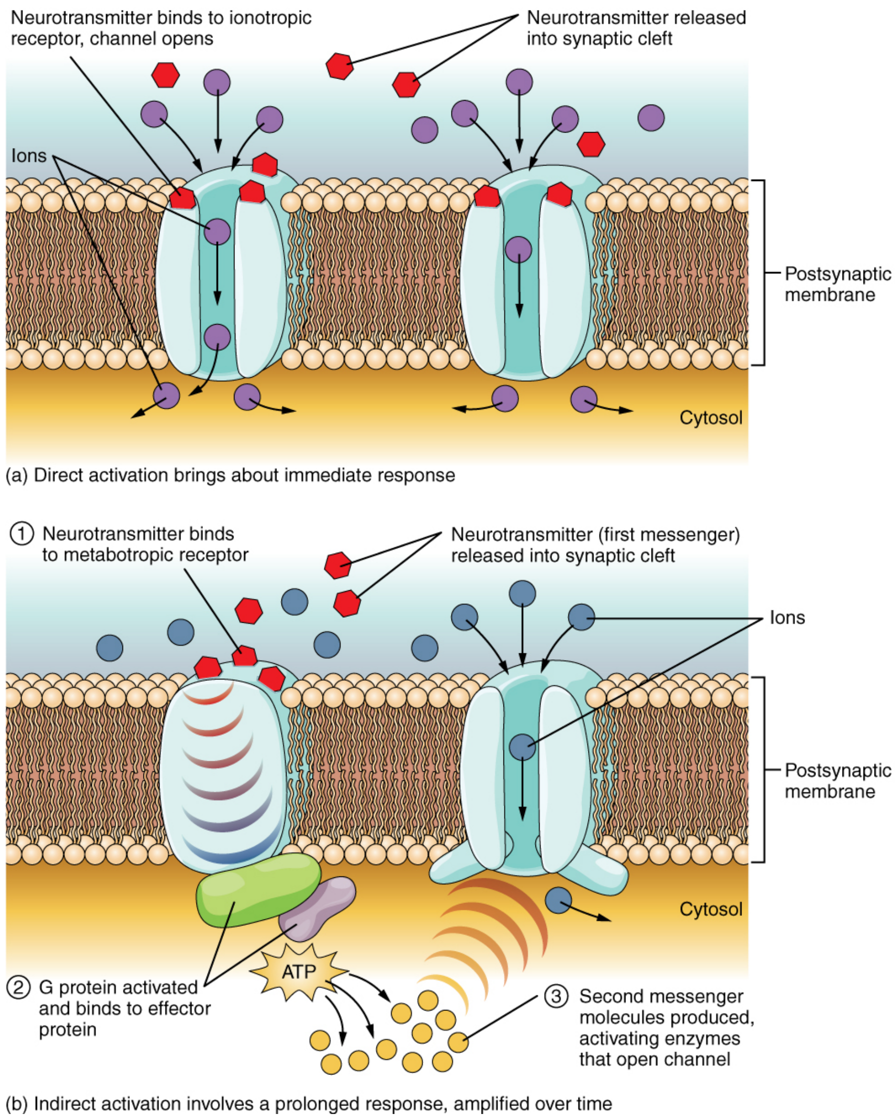


FIGURE 12.28 **Receptor Types** (a) An ionotropic receptor is a channel that opens when the neurotransmitter binds to it. (b) A metabotropic receptor is a complex that causes metabolic changes in the cell when the neurotransmitter binds to it (1). After binding, the G protein hydrolyzes ATP and moves to the effector protein (2). When the G protein contacts the effector protein, the latter is activated. In the case shown, the effector protein then acts on ATP to generate a second messenger, cAMP (3). The second messenger can then go on to cause changes in the neuron, such as opening or closing ion channels, metabolic changes, and changes in gene transcription.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/neurotrans) to learn about the release of a neurotransmitter. The action potential reaches the end of the axon, called the axon terminal, and a chemical signal is released to tell the target cell to do something—either to initiate a new action potential, or to suppress that activity. In a very short space, the electrical signal of the action potential is changed into the chemical signal of a neurotransmitter and then back to electrical changes in the target cell membrane. What is the importance of voltage-gated calcium channels in the release of neurotransmitters?

Characteristics of Neurotransmitter Systems

System	Cholinergic	Amino acids	Biogenic amines	Neuropeptides
Neurotransmitters	Acetylcholine	Glutamate, glycine, GABA	Serotonin (5-HT), dopamine, norepinephrine, (epinephrine)	Met-enkephalin, beta-endorphin, VIP, Substance P, etc.
Receptors	Nicotinic and muscarinic receptors	Glu receptors, gly receptors, GABA receptors	5-HT receptors, D1 and D2 receptors, α-adrenergic and β-adrenergic receptors	Receptors are too numerous to list, but are specific to the peptides.
Elimination	Degradation by acetylcholinesterase	Reuptake by neurons or glia	Reuptake by neurons	Degradation by enzymes called peptidases
Postsynaptic effect	Nicotinic receptor causes depolarization. Muscarinic receptors can cause both depolarization or hyperpolarization depending on the subtype.	Glu receptors cause depolarization. Gly and GABA receptors cause hyperpolarization.	Depolarization or hyperpolarization depends on the specific receptor. For example, D1 receptors cause depolarization and D2 receptors cause hyperpolarization.	Depolarization or hyperpolarization depends on the specific receptor.

TABLE 12.3

Disorders of the...

Nervous System

The underlying cause of some neurodegenerative diseases, such as Alzheimer's and Parkinson's, appears to be related to proteins—specifically, to proteins behaving badly. One of the strongest theories of what causes Alzheimer's disease is based on the accumulation of beta-amyloid plaques, dense conglomerations of a protein that is not functioning correctly. Parkinson's disease is linked to an increase in a protein known as alpha-synuclein that is toxic to the cells of the substantia nigra nucleus in the midbrain.

For proteins to function correctly, they are dependent on their three-dimensional shape. The linear sequence of amino acids folds into a three-dimensional shape that is based on the interactions between and among those amino acids. When the folding is disturbed, and proteins take on a different shape, they stop functioning correctly. But the disease is not necessarily the result of functional loss of these proteins; rather, these altered proteins start to accumulate and may become toxic. For example, in Alzheimer's, the hallmark of the disease is the accumulation of these amyloid plaques in the cerebral cortex. The term coined to describe this sort of disease is "proteopathy" and it includes other diseases. Creutzfeld-Jacob disease, the human variant of the prion disease known as mad cow disease in the bovine, also involves the accumulation of amyloid plaques, similar to Alzheimer's. Diseases of other organ systems can fall into this group as well, such as cystic fibrosis or type 2 diabetes. Recognizing the relationship between these diseases has suggested new therapeutic possibilities. Interfering with the accumulation of the proteins, and possibly as early as their original production within the cell, may unlock new ways to alleviate these devastating diseases.

Key Terms

absolute refractory period time during an action period when another action potential cannot be generated because the voltage-gated Na^+ channel is inactivated

action potential change in voltage of a cell membrane in response to a stimulus that results in transmission of an electrical signal; unique to neurons and muscle fibers

activation gate part of the voltage-gated Na^+ channel that opens when the membrane voltage reaches threshold

astrocyte glial cell type of the CNS that provides support for neurons and maintains the blood-brain barrier

autonomic nervous system (ANS) functional division of the nervous system that is responsible for homeostatic reflexes that coordinate control of cardiac and smooth muscle, as well as glandular tissue

axon single process of the neuron that carries an electrical signal (action potential) away from the cell body toward a target cell

axon hillock tapering of the neuron cell body that gives rise to the axon

axon segment single stretch of the axon insulated by myelin and bounded by nodes of Ranvier at either end (except for the first, which is after the initial segment, and the last, which is followed by the axon terminal)

axon terminal end of the axon, where there are usually several branches extending toward the target cell

axoplasm cytoplasm of an axon, which is different in composition than the cytoplasm of the neuronal cell body

biogenic amine class of neurotransmitters that are enzymatically derived from amino acids but no longer contain a carboxyl group

bipolar shape of a neuron with two processes extending from the neuron cell body—the axon and one dendrite

blood-brain barrier (BBB) physiological barrier between the circulatory system and the central nervous system that establishes a privileged blood supply, restricting the flow of substances into the CNS

brain the large organ of the central nervous system composed of white and gray matter, contained within the cranium and continuous with the spinal cord

central nervous system (CNS) anatomical division of the nervous system located within the cranial and vertebral cavities, namely the brain and spinal cord

cerebral cortex outermost layer of gray matter in the brain, where conscious perception takes place

cerebrospinal fluid (CSF) circulatory medium within the CNS that is produced by ependymal cells in the choroid plexus filtering the blood

chemical synapse connection between two neurons, or between a neuron and its target, where a neurotransmitter diffuses across a very short distance

cholinergic system neurotransmitter system of acetylcholine, which includes its receptors and the enzyme acetylcholinesterase

choroid plexus specialized structure containing ependymal cells that line blood capillaries and filter blood to produce CSF in the four ventricles of the brain

continuous conduction slow propagation of an action potential along an unmyelinated axon owing to voltage-gated Na^+ channels located along the entire length of the cell membrane

dendrite one of many branchlike processes that extends from the neuron cell body and functions as a contact for incoming signals (synapses) from other neurons or sensory cells

depolarization change in a cell membrane potential from rest toward zero

effector protein enzyme that catalyzes the generation of a new molecule, which acts as the intracellular mediator of the signal that binds to the receptor

electrical synapse connection between two neurons, or any two electrically active cells, where ions flow directly through channels spanning their adjacent cell membranes

electrochemical exclusion principle of selectively allowing ions through a channel on the basis of their charge

enteric nervous system (ENS) neural tissue associated with the digestive system that is responsible for nervous control through autonomic connections

ependymal cell glial cell type in the CNS responsible for producing cerebrospinal fluid

excitable membrane cell membrane that regulates the movement of ions so that an electrical signal can be generated

excitatory postsynaptic potential (EPSP) graded potential in the postsynaptic membrane that is the result of depolarization and makes an action potential more likely to occur

G protein guanosine triphosphate (GTP) hydrolase that physically moves from the receptor protein to the effector protein to activate the latter

ganglion localized collection of neuron cell bodies in the peripheral nervous system

gated property of a channel that determines how it opens under specific conditions, such as voltage change or physical deformation

generator potential graded potential from dendrites of a unipolar cell which generates the action potential in the initial segment of that cell's axon

glial cell one of the various types of neural tissue cells responsible for maintenance of the tissue, and largely responsible for supporting neurons

graded potential change in the membrane potential that varies in size, depending on the size of the stimulus that elicits it

gray matter regions of the nervous system containing cell bodies of neurons with few or no myelinated axons; actually may be more pink or tan in color, but called gray in contrast to white matter

inactivation gate part of a voltage-gated Na^+ channel that closes when the membrane potential reaches +30 mV

inhibitory postsynaptic potential (IPSP) graded potential in the postsynaptic membrane that is the result of hyperpolarization and makes an action potential less likely to occur

initial segment first part of the axon as it emerges from the axon hillock, where the electrical signals known as action potentials are generated

integration nervous system function that combines sensory perceptions and higher cognitive functions (memories, learning, emotion, etc.) to produce a response

ionotropic receptor neurotransmitter receptor that acts as an ion channel gate, and opens by the binding of the neurotransmitter

leakage channel ion channel that opens randomly and is not gated to a specific event, also known as a non-gated channel

ligand-gated channels another name for an ionotropic receptor for which a neurotransmitter is the ligand

lower motor neuron second neuron in the motor command pathway that is directly connected to the skeletal muscle

mechanically gated channel ion channel that opens when a physical event directly affects the structure of the protein

membrane potential distribution of charge across the cell membrane, based on the charges of ions

metabotropic receptor neurotransmitter receptor that involves a complex of proteins that cause metabolic changes in a cell

microglia glial cell type in the CNS that serves as the resident component of the immune system

multipolar shape of a neuron that has multiple processes—the axon and two or more dendrites

muscarinic receptor type of acetylcholine receptor protein that is characterized by also binding to muscarine and is a metabotropic receptor

myelin lipid-rich insulating substance surrounding the axons of many neurons, allowing for faster transmission of electrical signals

myelin sheath lipid-rich layer of insulation that surrounds an axon, formed by oligodendrocytes in the CNS and Schwann cells in the PNS; facilitates the transmission of electrical signals

nerve cord-like bundle of axons located in the peripheral nervous system that transmits sensory input and response output to and from the central nervous system

neuron neural tissue cell that is primarily responsible for generating and propagating electrical signals into, within, and out of the nervous system

neuropeptide neurotransmitter type that includes protein molecules and shorter chains of amino acids

neurotransmitter chemical signal that is released from the synaptic end bulb of a neuron to cause a change in the target cell

nicotinic receptor type of acetylcholine receptor protein that is characterized by also binding to nicotine and is an ionotropic receptor

node of Ranvier gap between two myelinated regions of an axon, allowing for strengthening of the electrical signal as it propagates down the axon

nonspecific channel channel that is not specific to one ion over another, such as a nonspecific cation channel that allows any positively charged ion across the membrane

nucleus in the nervous system, a localized collection of neuron cell bodies that are functionally related; a "center" of neural function

oligodendrocyte glial cell type in the CNS that provides the myelin insulation for axons in tracts

peripheral nervous system (PNS) anatomical division of the nervous system that is largely outside the cranial and vertebral cavities, namely all parts except the brain and spinal cord

postsynaptic potential (PSP) graded potential in the postsynaptic membrane caused by the binding of neurotransmitter to protein receptors

precentral gyrus of the frontal cortex region of the cerebral cortex responsible for generating motor commands, where the upper motor neuron cell body is located

process in cells, an extension of a cell body; in the case of neurons, this includes the axon and dendrites

propagation movement of an action potential along the length of an axon

receptor potential graded potential in a specialized sensory cell that directly causes the release of neurotransmitter without an intervening action potential

refractory period time after the initiation of an action potential when another action potential cannot be generated

relative refractory period time during the refractory period when a new action potential can only be initiated by a stronger stimulus than the current action potential because voltage-gated K^+ channels are not closed

repolarization return of the membrane potential to its normally negative voltage at the end of the action potential

resistance property of an axon that relates to the ability of particles to diffuse through the cytoplasm; this is inversely proportional to the fiber diameter

response nervous system function that causes a target tissue (muscle or gland) to produce an event as a consequence to stimuli

resting membrane potential the difference in voltage measured across a cell membrane under steady-state conditions, typically -70 mV

saltatory conduction quick propagation of the action potential along a myelinated axon owing to voltage-gated Na^+ channels being present only at the nodes of Ranvier

satellite cell glial cell type in the PNS that provides support for neurons in the ganglia

Schwann cell glial cell type in the PNS that provides the myelin insulation for axons in nerves

sensation nervous system function that receives information from the environment and translates it into the electrical signals of nervous tissue

size exclusion principle of selectively allowing ions through a channel on the basis of their relative size

soma in neurons, that portion of the cell that contains the nucleus; the cell body, as opposed to the cell processes (axons and dendrites)

somatic nervous system (SNS) functional division of the nervous system that is concerned with conscious perception, voluntary movement, and skeletal muscle reflexes

spatial summation combination of graded potentials across the neuronal cell membrane caused by signals from separate presynaptic elements that add up to initiate an action potential

spinal cord organ of the central nervous system found within the vertebral cavity and connected with the periphery through spinal nerves; mediates reflex behaviors

stimulus an event in the external or internal environment that registers as activity in a sensory neuron

summate to add together, as in the cumulative change in postsynaptic potentials toward reaching threshold in the membrane, either across a span of the membrane or over a certain amount of time

synapse narrow junction across which a chemical signal passes from neuron to the next, initiating a new electrical signal in the target cell

synaptic cleft small gap between cells in a chemical synapse where neurotransmitter diffuses from the presynaptic element to the postsynaptic element

synaptic end bulb swelling at the end of an axon where neurotransmitter molecules are released onto a target cell across a synapse

temporal summation combination of graded potentials at the same location on a neuron resulting in a strong signal from one input

thalamus region of the central nervous system that acts as a relay for sensory pathways

thermoreceptor type of sensory receptor capable of transducing temperature stimuli into neural action potentials

threshold membrane voltage at which an action potential is initiated

tract bundle of axons in the central nervous system having the same function and point of origin

unipolar shape of a neuron which has only one process that includes both the axon and dendrite

upper motor neuron first neuron in the motor command pathway with its cell body in the cerebral cortex that synapses on the lower motor neuron in the spinal cord

ventricle central cavity within the brain where CSF is produced and circulates

voltage-gated channel ion channel that opens because of a change in the charge distributed across the membrane where it is located

white matter regions of the nervous system containing mostly myelinated axons, making the tissue appear white because of the high lipid content of myelin

Chapter Review

12.1 Basic Structure and Function of the Nervous System

The nervous system can be separated into divisions on the basis of anatomy and physiology. The anatomical divisions are the central and peripheral nervous systems. The CNS is the brain and spinal cord. The PNS is everything else. Functionally, the nervous system can be divided into those regions that are responsible for sensation, those that are responsible for integration, and those that are responsible for generating responses. All of these functional areas are found in both the central and peripheral anatomy.

Considering the anatomical regions of the nervous system, there are specific names for the structures within each division. A localized collection of neuron cell bodies is referred to as a nucleus in the CNS and as a ganglion in the PNS. A bundle of axons is referred to as a tract in the CNS and as a nerve in the PNS. Whereas nuclei and ganglia are specifically in the central or peripheral divisions, axons can cross the boundary between the two. A single axon can be part of a nerve and a tract. The name for that specific structure depends on its location.

Nervous tissue can also be described as gray matter and white matter on the basis of its appearance in unstained tissue. These descriptions are more often used in the CNS. Gray matter is where nuclei are found and white matter is where tracts are found. In the PNS, ganglia are basically gray matter and nerves are white matter.

The nervous system can also be divided on the basis of how it controls the body. The somatic nervous system (SNS) is responsible for functions that result in moving skeletal muscles. Any sensory or integrative functions that result in the movement of skeletal muscle would be considered somatic. The autonomic nervous system (ANS) is responsible for functions that affect cardiac or smooth muscle tissue, or that cause glands to produce their secretions. Autonomic functions are distributed between central and peripheral regions of the nervous system. The sensations that lead to autonomic functions can be the same sensations that are part of initiating somatic responses. Somatic and autonomic integrative functions may overlap as well.

A special division of the nervous system is the enteric nervous system, which is responsible for controlling the digestive organs. Parts of the autonomic nervous system overlap with the enteric nervous system. The enteric nervous system is exclusively found in the periphery because it is the nervous tissue in the organs of the digestive system.

12.2 Nervous Tissue

Nervous tissue contains two major cell types, neurons and glial cells. Neurons are the cells responsible for communication through electrical signals. Glial cells are supporting cells, maintaining the environment around the neurons.

Neurons are polarized cells, based on the flow of electrical signals along their membrane. Signals are received at the dendrites, are passed along the cell body, and propagate along the axon towards the target, which may be another neuron, muscle tissue, or a gland. Many axons are insulated by a lipid-rich substance called myelin. Specific types of glial cells provide this insulation.

Several types of glial cells are found in the nervous system, and they can be categorized by the anatomical division in which they are found. In the CNS, astrocytes, oligodendrocytes, microglia, and ependymal cells are found. Astrocytes are important for maintaining the chemical environment around the neuron and are crucial for regulating the blood-brain barrier. Oligodendrocytes are the myelinating glia in the CNS. Microglia act as phagocytes and play a role in immune surveillance. Ependymal cells are responsible for filtering the blood to produce cerebrospinal fluid, which is a circulatory fluid that performs some of the functions of blood in the brain and spinal cord because of the BBB. In the PNS, satellite cells are supporting cells for the neurons, and Schwann cells insulate peripheral axons.

12.3 The Function of Nervous Tissue

Sensation starts with the activation of a sensory ending, such as the thermoreceptor in the skin sensing the temperature of the water. The sensory endings in the skin initiate an electrical signal that travels along the sensory axon within a nerve into the spinal cord, where it synapses with a neuron in the gray matter of the spinal cord. The temperature information represented in that electrical signal is passed to the next neuron by a chemical signal that diffuses across the small gap of the synapse and initiates a new electrical signal in the target cell. That signal travels through the sensory pathway to the brain, passing through the thalamus, where conscious perception of the water temperature is made possible by the cerebral cortex. Following integration of that information with other cognitive processes and sensory information, the brain sends a command back down to the spinal cord to initiate a motor response by controlling a skeletal muscle. The motor pathway is composed of two cells, the upper motor neuron and the lower motor neuron. The upper motor neuron has its cell body in the cerebral cortex and synapses on a cell in the gray matter of the spinal cord. The lower motor neuron is that cell in the gray matter of the spinal cord and its axon extends into the periphery where it synapses with a skeletal muscle in a neuromuscular junction.

12.4 The Action Potential

The nervous system is characterized by electrical signals that are sent from one area to another. Whether those areas are close or very far apart, the signal must travel along an axon. The basis of the electrical signal is the controlled distribution of ions across the membrane. Transmembrane ion channels regulate when ions can move in or out of the cell, so that a precise signal is generated. This signal is the action potential which has a very characteristic shape based on voltage changes across the membrane in a given time period.

The membrane is normally at rest with established Na^+ and K^+ concentrations on either side. A stimulus will start the depolarization of the membrane, and voltage-gated channels will result in further depolarization followed by repolarization of the membrane. A slight overshoot of hyperpolarization marks the end of the action potential. While an action potential is in progress, another cannot be generated under the same conditions. While the voltage-gated Na^+ channel is inactivated, absolutely no action potentials can be generated. Once that channel has returned to its resting state, a new action potential is possible, but it must be started by a relatively stronger stimulus to overcome the K^+ leaving the cell.

The action potential travels down the axon as voltage-gated ion channels are opened by the spreading depolarization. In unmyelinated axons, this happens in a continuous fashion because there are voltage-gated channels throughout the membrane. In myelinated axons, propagation is described as saltatory because voltage-gated channels are only found at the nodes of Ranvier and the electrical events seem to “jump” from one node to the next. Saltatory conduction is faster than continuous conduction, meaning that myelinated axons propagate their signals faster. The diameter of the axon also makes a difference as ions diffusing within the cell have less resistance in a wider space.

12.5 Communication Between Neurons

The basis of the electrical signal within a neuron is the action potential that propagates down the axon. For a neuron to generate an action potential, it needs to receive input from another source, either another neuron or a sensory stimulus. That input will result in opening ion channels in the neuron, resulting in a graded potential based on the strength of the stimulus. Graded potentials can be depolarizing or hyperpolarizing and can summate to affect the probability of the neuron reaching threshold.

Graded potentials can be the result of sensory stimuli. If the sensory stimulus is received by the dendrites of a unipolar sensory neuron, such as the sensory neuron ending in the skin, the graded potential is called a generator potential because it can directly generate the action potential in the initial segment of the axon. If the sensory stimulus is received by a specialized sensory receptor cell, the graded potential is called a receptor potential. Graded potentials produced by interactions between neurons at synapses are called postsynaptic potentials (PSPs). A depolarizing graded potential at a synapse is called an excitatory PSP, and a hyperpolarizing graded potential at a synapse is called an inhibitory PSP.

Synapses are the contacts between neurons, which can either be chemical or electrical in nature. Chemical synapses are far more common. At a chemical synapse, neurotransmitter is released from the presynaptic element and diffuses across the synaptic cleft. The neurotransmitter binds to a receptor protein and causes a change in the postsynaptic membrane (the PSP). The neurotransmitter must be inactivated or removed from the synaptic cleft so that the stimulus is limited in time.

The particular characteristics of a synapse vary based on the neurotransmitter system produced by that neuron. The cholinergic system is found at the neuromuscular junction and in certain places within the nervous system. Amino acids, such as glutamate, glycine, and gamma-aminobutyric acid (GABA) are used as neurotransmitters. Other neurotransmitters are the result of amino acids being enzymatically changed, as in the biogenic amines, or being covalently bonded together, as in the neuropeptides.

Interactive Link Questions

1. In 2003, the Nobel Prize in Physiology or Medicine was awarded to Paul C. Lauterbur and Sir Peter Mansfield for discoveries related to magnetic resonance imaging (MRI). This is a tool to see the structures of the body (not just the nervous system) that depends on magnetic fields associated with certain atomic nuclei. The utility of this technique in the nervous system is that fat tissue and water appear as different shades between black and white. Because white matter is fatty (from myelin) and gray matter is not, they can be easily distinguished in MRI images. Visit the Nobel Prize website (http://openstax.org/l/nobel_2) to play an interactive game that demonstrates the use of this technology and compares it with other types of imaging technologies. Also, the results from an MRI session are compared with images obtained from x-ray or computed tomography. How do the imaging techniques shown in this game indicate the separation of white and gray matter compared with the freshly dissected tissue shown earlier?
2. Visit this site (http://openstax.org/l/troublewstairs) to read about a woman that notices that her daughter is having trouble walking up the stairs. This leads to the discovery of a hereditary condition that affects the brain and spinal cord. The electromyography and MRI tests indicated deficiencies in the spinal cord and cerebellum, both of which are responsible for controlling coordinated movements. To what functional division of the nervous system would these structures belong?
3. The neurons are dynamic cells with the ability to make a vast number of connections and to respond incredibly quickly to stimuli and to initiate movements based on those stimuli. They are the focus of intense research as failures in physiology can lead to devastating illnesses. Why are neurons only found in animals? Why wouldn’t they be helpful for plants or microorganisms?
4. View the University of Michigan Webscope (http://openstax.org/l/nervefiber) to see an electron micrograph of a cross-section of a myelinated nerve fiber. The axon contains microtubules and neurofilaments, bounded by a plasma membrane known as the axolemma. Outside the plasma membrane of the axon is the myelin sheath, which is composed of the tightly wrapped plasma membrane of a Schwann cell. What aspects of the cells in this image react with the stain that makes them the deep, dark, black color, such as the multiple layers that are the myelin sheath?
5. What happens across the membrane of an electrically active cell is a dynamic process that is hard to visualize with static images or through text descriptions. View this animation (http://openstax.org/l/dynamic1) to really understand the process. What is the difference between the driving force for Na^+ and K^+? And what is similar about the movement of these two ions?
6. Visit this site (http://openstax.org/l/neurolab) to see a virtual neurophysiology lab, and to observe electrophysiological processes in the nervous system, where scientists directly measure the electrical signals produced by neurons. Often, the action potentials occur so rapidly that watching a screen to see them occur is not helpful. A speaker is powered by the signals recorded from a neuron and it “pops” each time the neuron fires an action potential. These action potentials are firing so fast that it sounds like static on the radio. Electrophysiologists can recognize the patterns within that static to understand what is happening. Why is the leech model used for measuring the electrical activity of neurons instead of using humans?
7. Watch this video (http://openstax.org/l/summation) to learn about summation. The process of converting electrical signals to chemical signals and back requires subtle changes that can result in transient increases or decreases in membrane voltage. To cause a lasting change in the target cell, multiple signals are usually added together, or summated. Does spatial summation have to happen all at once, or can the separate signals arrive on the postsynaptic neuron at slightly different times? Explain your answer.
8. Watch this video (http://openstax.org/l/neurotrans) to learn about the release of a neurotransmitter. The action potential reaches the end of the axon, called the axon terminal, and a chemical signal is released to tell the target cell to do something, either initiate a new action potential, or to suppress that activity. In a very short space, the electrical signal of the action potential is changed into the chemical signal of a neurotransmitter, and then back to electrical changes in the target cell membrane. What is the importance of voltage-gated calcium channels in the release of neurotransmitters?

Review Questions

9. Which of the following cavities contains a component of the central nervous system?
   a. abdominal
   b. pelvic
   c. cranial
   d. thoracic

10. Which structure predominates in the white matter of the brain?
   a. myelinated axons
   b. neuronal cell bodies
   c. ganglia of the parasympathetic nerves
   d. bundles of dendrites from the enteric nervous system

11. Which part of a neuron transmits an electrical signal to a target cell?
   a. dendrites
   b. soma
   c. cell body
   d. axon

12. Which term describes a bundle of axons in the peripheral nervous system?
   a. nucleus
   b. ganglion
   c. tract
   d. nerve

13. Which functional division of the nervous system would be responsible for the physiological changes seen during exercise (e.g., increased heart rate and sweating)?
   a. somatic
   b. autonomic
   c. enteric
   d. central

14. What type of glial cell provides myelin for the axons in a tract?
   a. oligodendrocyte
   b. astrocyte
   c. Schwann cell
   d. satellite cell

15. Which part of a neuron contains the nucleus?
   a. dendrite
   b. soma
   c. axon
   d. synaptic end bulb

16. Which of the following substances is least able to cross the blood-brain barrier?
   a. water
   b. sodium ions
   c. glucose
   d. white blood cells

17. What type of glial cell is the resident macrophage behind the blood-brain barrier?
   a. microglia
   b. astrocyte
   c. Schwann cell
   d. satellite cell

18. What two types of macromolecules are the main components of myelin?
   a. carbohydrates and lipids
   b. proteins and nucleic acids
   c. lipids and proteins
   d. carbohydrates and nucleic acids

19. If a thermoreceptor is sensitive to temperature sensations, what would a chemoreceptor be sensitive to?
   a. light
   b. sound
   c. molecules
   d. vibration

20. Which of these locations is where the greatest level of integration is taking place in the example of testing the temperature of the shower?
   a. skeletal muscle
   b. spinal cord
   c. thalamus
   d. cerebral cortex

21. How long does all the signaling through the sensory pathway, within the central nervous system, and through the motor command pathway take?
   a. 1 to 2 minutes
   b. 1 to 2 seconds
   c. fraction of a second
   d. varies with graded potential

22. What is the target of an upper motor neuron?
   a. cerebral cortex
   b. lower motor neuron
   c. skeletal muscle
   d. thalamus

23. What ion enters a neuron causing depolarization of the cell membrane?
a. sodium
b. chloride
c. potassium
d. phosphate

24. Voltage-gated Na^+ channels open upon reaching what state?
a. resting potential
b. threshold
c. repolarization
d. overshoot

25. What does a ligand-gated channel require in order to open?
a. increase in concentration of Na^+ ions
b. binding of a neurotransmitter
c. increase in concentration of K^+ ions
d. depolarization of the membrane

26. What does a mechanically gated channel respond to?
a. physical stimulus
b. chemical stimulus
c. increase in resistance
d. decrease in resistance

27. Which of the following voltages would most likely be measured during the relative refractory period?
a. +30 mV
b. 0 mV
c. -45 mV
d. -80 mv

28. Which of the following is probably going to propagate an action potential fastest?
a. a thin, unmyelinated axon
b. a thin, myelinated axon
c. a thick, unmyelinated axon
d. a thick, myelinated axon

29. How much of a change in the membrane potential is necessary for the summation of postsynaptic potentials to result in an action potential being generated?
a. +30 mV
b. +15 mV
c. +10 mV
d. -15 mV

30. A channel opens on a postsynaptic membrane that causes a negative ion to enter the cell. What type of graded potential is this?
a. depolarizing
b. repolarizing
c. hyperpolarizing
d. non-polarizing

31. What neurotransmitter is released at the neuromuscular junction?
a. norepinephrine
b. serotonin
c. dopamine
d. acetylcholine

32. What type of receptor requires an effector protein to initiate a signal?
a. biogenic amine
b. ionotropic receptor
c. cholinergic system
d. metabotropic receptor

33. Which of the following neurotransmitters is associated with inhibition exclusively?
a. GABA
b. acetylcholine
c. glutamate
d. norepinephrine

Critical Thinking Questions

34. What responses are generated by the nervous system when you run on a treadmill? Include an example of each type of tissue that is under nervous system control.

35. When eating food, what anatomical and functional divisions of the nervous system are involved in the perceptual experience?

36. Multiple sclerosis is a demyelinating disease affecting the central nervous system. What type of cell would be the most likely target of this disease? Why?

37. Which type of neuron, based on its shape, is best suited for relaying information directly from one neuron to another? Explain why.

38. Sensory fibers, or pathways, are referred to as “afferent.” Motor fibers, or pathways, are referred to as “efferent.” What can you infer about the meaning of these two terms (afferent and efferent) in a structural or anatomical context?

39. If a person has a motor disorder and cannot move their arm voluntarily, but their muscles have tone, which motor neuron—upper or lower—is probably affected? Explain why.

40. What does it mean for an action potential to be an "all or none" event?

41. The conscious perception of pain is often delayed because of the time it takes for the sensations to reach the cerebral cortex. Why would this be the case based on propagation of the axon potential?

42. If a postsynaptic cell has synapses from five different cells, and three cause EPSPs and two of them cause IPSPs, give an example of a series of depolarizations and hyperpolarizations that would result in the neuron reaching threshold.

43. Why is the receptor the important element determining the effect a neurotransmitter has on a target cell?

CHAPTER 13
Anatomy of the Nervous System

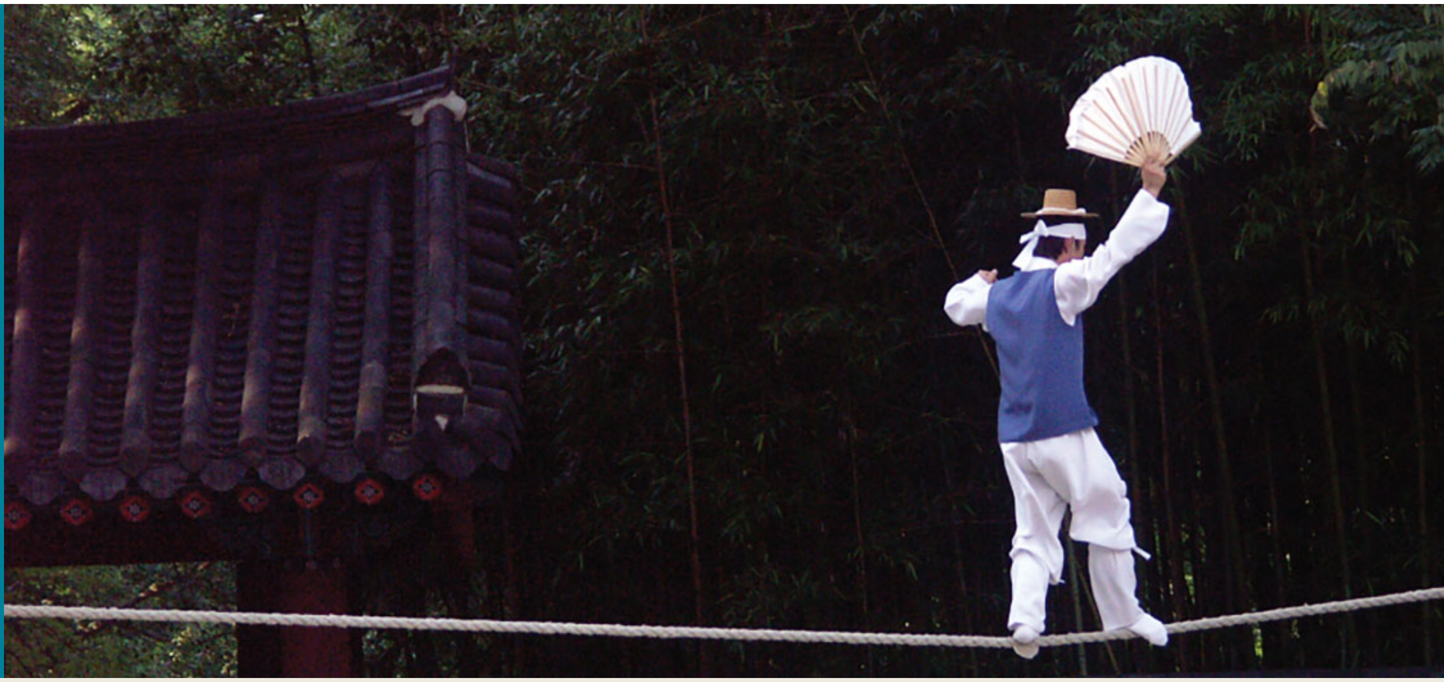


Figure 13.1 **Human Nervous System** The ability to balance like an acrobat combines functions throughout the nervous system. The central and peripheral divisions coordinate control of the body using the senses of balance, body position, and touch on the soles of the feet. (credit: Rhett Sutphin)

CHAPTER OBJECTIVES

After studying this chapter, you will be able to:

- Relate the developmental processes of the embryonic nervous system to the adult structures
- Name the major regions of the adult nervous system
- Locate regions of the cerebral cortex on the basis of anatomical landmarks common to all human brains
- Describe the regions of the spinal cord in cross-section
- List the cranial nerves in order of anatomical location and provide the central and peripheral connections
- List the spinal nerves by vertebral region and by which nerve plexus each supplies

INTRODUCTION The nervous system is responsible for controlling much of the body, both through somatic (voluntary) and autonomic (involuntary) functions. The structures of the nervous system must be described in detail to understand how many of these functions are possible. There is a physiological concept known as localization of function that states that certain structures are specifically responsible for prescribed functions. It is an underlying concept in all of anatomy and physiology, but the nervous system illustrates the concept very well.

Fresh, unstained nervous tissue can be described as gray or white matter, and within those two types of tissue it can be very hard to see any detail. However, as specific regions and structures have been described, they were related to specific functions. Understanding these structures and the functions they perform requires a detailed description of the anatomy of the nervous system, delving deep into what the central and peripheral structures are.

The place to start this study of the nervous system is the beginning of the individual human life, within the womb. The embryonic development of the nervous system allows for a simple framework on which progressively more complicated structures can be built. With this framework in place, a thorough investigation of the nervous system is possible.

13.1 The Embryologic Perspective

LEARNING OBJECTIVES

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

- Describe the growth and differentiation of the neural tube
- Relate the different stages of development to the adult structures of the central nervous system
- Explain the expansion of the ventricular system of the adult brain from the central canal of the neural tube
- Describe the connections of the diencephalon and cerebellum on the basis of patterns of embryonic development

The brain is a complex organ composed of gray parts and white matter, which can be hard to distinguish. Starting from an embryologic perspective allows you to understand more easily how the parts relate to each other. The embryonic nervous system begins as a very simple structure—essentially just a straight line, which then gets increasingly complex. Looking at the development of the nervous system with a couple of early snapshots makes it easier to understand the whole complex system.

Many structures that appear to be adjacent in the adult brain are not connected, and the connections that exist may seem arbitrary. But there is an underlying order to the system that comes from how different parts develop. By following the developmental pattern, it is possible to learn what the major regions of the nervous system are.

The Neural Tube

To begin, a sperm cell and an egg cell fuse to become a fertilized egg. The fertilized egg cell, or zygote, starts dividing to generate the cells that make up an entire organism. Sixteen days after fertilization, the developing embryo's cells belong to one of three germ layers that give rise to the different tissues in the body. The endoderm, or inner tissue, is responsible for generating the lining tissues of various spaces within the body, such as the mucosae of the digestive and respiratory systems. The mesoderm, or middle tissue, gives rise to most of the muscle and connective tissues. Finally the ectoderm, or outer tissue, develops into the integumentary system (the skin) and the nervous system. It is probably not difficult to see that the outer tissue of the embryo becomes the outer covering of the body. But how is it responsible for the nervous system?

As the embryo develops, a portion of the ectoderm differentiates into a specialized region of neuroectoderm, which is the precursor for the tissue of the nervous system. Molecular signals induce cells in this region to differentiate into the neuroepithelium, forming a **neural plate**. The cells then begin to change shape, causing the tissue to buckle and fold inward (Figure 13.2). A **neural groove** forms, visible as a line along the dorsal surface of the embryo. The ridge-like edge on either side of the neural groove is referred as the **neural fold**. As the neural folds come together and converge, the underlying structure forms into a tube just beneath the ectoderm called the **neural tube**. Cells from the neural folds then separate from the ectoderm to form a cluster of cells referred to as the **neural crest**, which runs lateral to the neural tube. The neural crest migrates away from the nascent, or embryonic, central nervous system (CNS) that will form along the neural groove and develops into several parts of the peripheral nervous system (PNS), including the enteric nervous tissue. Many tissues that are not part of the nervous system also arise from the neural crest, such as craniofacial cartilage and bone, and melanocytes.

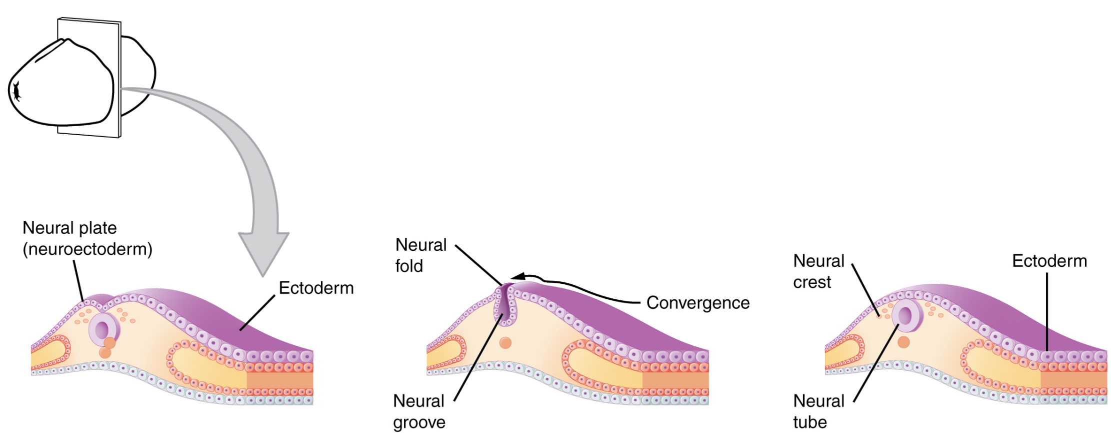


FIGURE 13.2 **Early Embryonic Development of Nervous System** The neuroectoderm begins to fold inward to form the neural groove.

As the two sides of the neural groove converge, they form the neural tube, which lies beneath the ectoderm. The anterior end of the neural tube will develop into the brain, and the posterior portion will become the spinal cord. The neural crest develops into peripheral structures.

At this point, the early nervous system is a simple, hollow tube. It runs from the anterior end of the embryo to the posterior end. Beginning at 25 days, the anterior end develops into the brain, and the posterior portion becomes the spinal cord. This is the most basic arrangement of tissue in the nervous system, and it gives rise to the more complex structures by the fourth week of development.

Primary Vesicles

As the anterior end of the neural tube starts to develop into the brain, it undergoes a couple of enlargements; the result is the production of sac-like vesicles. Similar to a child's balloon animal, the long, straight neural tube begins to take on a new shape. Three vesicles form at the first stage, which are called **primary vesicles**. These vesicles are given names that are based on Greek words, the main root word being *enkephalon*, which means "brain" (en- = "inside"; kephalon = "head"). The prefix to each generally corresponds to its position along the length of the developing nervous system.

The **prosencephalon** (pros- = "in front") is the forward-most vesicle, and the term can be loosely translated to mean **forebrain**. The **mesencephalon** (mes- = "middle") is the next vesicle, which can be called the **midbrain**. The third vesicle at this stage is the **rhombencephalon**. The first part of this word is also the root of the word rhombus, which is a geometrical figure with four sides of equal length (a square is a rhombus with 90° angles). Whereas prosencephalon and mesencephalon translate into the English words forebrain and midbrain, there is not a word for "four-sided-figure-brain." However, the third vesicle can be called the **hindbrain**. One way of thinking about how the brain is arranged is to use these three regions—forebrain, midbrain, and hindbrain—which are based on the primary vesicle stage of development (Figure 13.3**a**).

Secondary Vesicles

The brain continues to develop, and the vesicles differentiate further (see Figure 13.3**b**). The three primary vesicles become five **secondary vesicles**. The prosencephalon enlarges into two new vesicles called the **telencephalon** and the **diencephalon**. The telecephalon will become the cerebrum. The diencephalon gives rise to several adult structures; two that will be important are the thalamus and the hypothalamus. In the embryonic diencephalon, a structure known as the eye cup develops, which will eventually become the retina, the nervous tissue of the eye called the retina. This is a rare example of nervous tissue developing as part of the CNS structures in the embryo, but becoming a peripheral structure in the fully formed nervous system.

The mesencephalon does not differentiate into any finer divisions. The midbrain is an established region of the brain at the primary vesicle stage of development and remains that way. The rest of the brain develops around it and constitutes a large percentage of the mass of the brain. Dividing the brain into forebrain, midbrain, and hindbrain is useful in considering its developmental pattern, but the midbrain is a small proportion of the entire brain, relatively speaking.

The rhombencephalon develops into the **metencephalon** and **myelencephalon**. The metencephalon corresponds to the adult structure known as the pons and also gives rise to the cerebellum. The cerebellum (from the Latin meaning "little brain") accounts for about 10 percent of the mass of the brain and is an important structure in itself. The most significant connection between the cerebellum and the rest of the brain is at the pons, because the pons and cerebellum develop out of the same vesicle. The myelencephalon corresponds to the adult structure known as the medulla oblongata. The structures that come from the mesencephalon and rhombencephalon, except for the cerebellum, are collectively considered the **brain stem**, which specifically includes the midbrain, pons, and medulla.

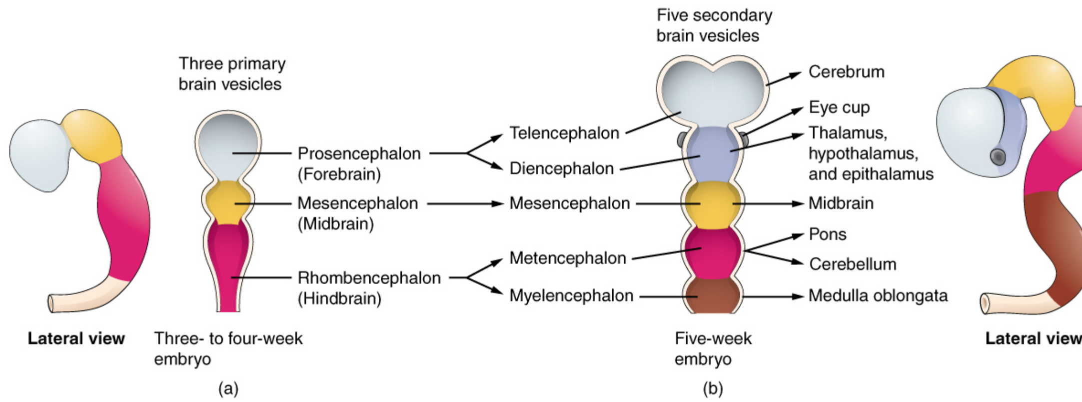


FIGURE 13.3 **Primary and Secondary Vesicle Stages of Development** The embryonic brain develops complexity through enlargements of the neural tube called vesicles; (a) The primary vesicle stage has three regions, and (b) the secondary vesicle stage has five regions.

INTERACTIVE LINK

Watch this animation (http://openstax.org/l/braindevel) to examine the development of the brain, starting with the neural tube. As the anterior end of the neural tube develops, it enlarges into the primary vesicles that establish the forebrain, midbrain, and hindbrain. Those structures continue to develop throughout the rest of embryonic development and into adolescence. They are the basis of the structure of the fully developed adult brain. How would you describe the difference in the relative sizes of the three regions of the brain when comparing the early (25th embryonic day) brain and the adult brain?

Spinal Cord Development

While the brain is developing from the anterior neural tube, the spinal cord is developing from the posterior neural tube. However, its structure does not differ from the basic layout of the neural tube. It is a long, straight cord with a small, hollow space down the center. The neural tube is defined in terms of its anterior versus posterior portions, but it also has a dorsal–ventral dimension. As the neural tube separates from the rest of the ectoderm, the side closest to the surface is dorsal, and the deeper side is ventral.

As the spinal cord develops, the cells making up the wall of the neural tube proliferate and differentiate into the neurons and glia of the spinal cord. The dorsal tissues will be associated with sensory functions, and the ventral tissues will be associated with motor functions.

Relating Embryonic Development to the Adult Brain

Embryonic development can help in understanding the structure of the adult brain because it establishes a framework on which more complex structures can be built. First, the neural tube establishes the anterior–posterior dimension of the nervous system, which is called the **neuraxis**. The embryonic nervous system in mammals can be said to have a standard arrangement. Humans (and other primates, to some degree) make this complicated by standing up and walking on two legs. The anterior–posterior dimension of the neuraxis overlays the superior–inferior dimension of the body. However, there is a major curve between the brain stem and forebrain, which is called the **cephalic flexure**. Because of this, the neuraxis starts in an inferior position—the end of the spinal cord—and ends in an anterior position, the front of the cerebrum. If this is confusing, just imagine a four-legged animal standing up on two legs. Without the flexure in the brain stem, and at the top of the neck, that animal would be looking straight up instead of straight in front (Figure 13.4).

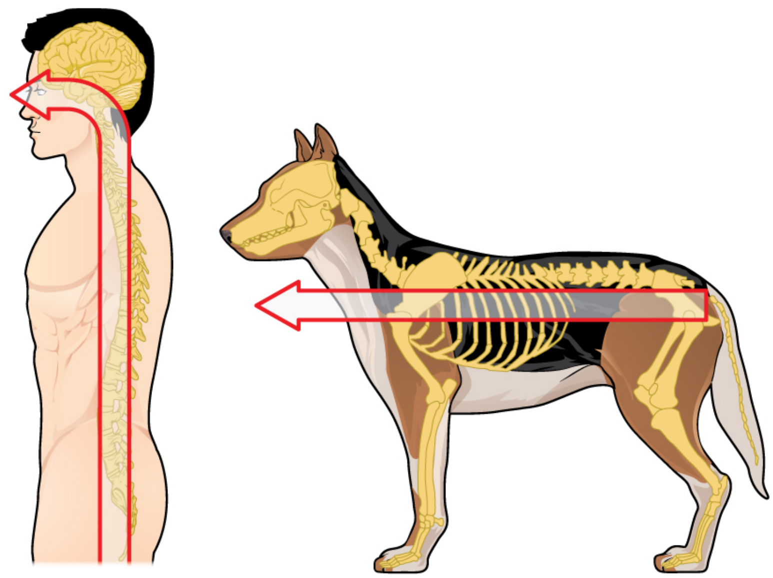


FIGURE 13.4 **Human Neuraxis** The mammalian nervous system is arranged with the neural tube running along an anterior to posterior axis, from nose to tail for a four-legged animal like a dog. Humans, as two-legged animals, have a bend in the neuraxis between the brain stem and the diencephalon, along with a bend in the neck, so that the eyes and the face are oriented forward.

In summary, the primary vesicles help to establish the basic regions of the nervous system: forebrain, midbrain, and hindbrain. These divisions are useful in certain situations, but they are not equivalent regions. The midbrain is small compared with the hindbrain and particularly the forebrain. The secondary vesicles go on to establish the major regions of the adult nervous system that will be followed in this text. The telencephalon is the cerebrum, which is the major portion of the human brain. The diencephalon continues to be referred to by this Greek name, because there is no better term for it (dia- = "through"). The diencephalon is between the cerebrum and the rest of the nervous system and can be described as the region through which all projections have to pass between the cerebrum and everything else. The brain stem includes the midbrain, pons, and medulla, which correspond to the mesencephalon, metencephalon, and myelencephalon. The cerebellum, being a large portion of the brain, is considered a separate region. Table 13.1 connects the different stages of development to the adult structures of the CNS.

One other benefit of considering embryonic development is that certain connections are more obvious because of how these adult structures are related. The retina, which began as part of the diencephalon, is primarily connected to the diencephalon. The eyes are just inferior to the anterior-most part of the cerebrum, but the optic nerve extends back to the thalamus as the optic tract, with branches into a region of the hypothalamus. There is also a connection of the optic tract to the midbrain, but the mesencephalon is adjacent to the diencephalon, so that is not difficult to imagine. The cerebellum originates out of the metencephalon, and its largest white matter connection is to the pons, also from the metencephalon. There are connections between the cerebellum and both the medulla and midbrain, which are adjacent structures in the secondary vesicle stage of development. In the adult brain, the cerebellum seems close to the cerebrum, but there is no direct connection between them.

Another aspect of the adult CNS structures that relates to embryonic development is the ventricles—open spaces within the CNS where cerebrospinal fluid circulates. They are the remnant of the hollow center of the neural tube. The four ventricles and the tubular spaces associated with them can be linked back to the hollow center of the embryonic brain (see Table 13.1).

Stages of Embryonic Development

Neural tube	Primary vesicle stage	Secondary vesicle stage	Adult structures	Ventricles
Anterior neural tube	Prosencephalon	Telencephalon	Cerebrum	Lateral ventricles
Anterior neural tube	Prosencephalon	Diencephalon	Diencephalon	Third ventricle
Anterior neural tube	Mesencephalon	Mesencephalon	Midbrain	Cerebral aqueduct
Anterior neural tube	Rhombencephalon	Metencephalon	Pons cerebellum	Fourth ventricle
Anterior neural tube	Rhombencephalon	Myelencephalon	Medulla	Fourth ventricle
Posterior neural tube			Spinal cord	Central canal

TABLE 13.1

Disorders of the...

Nervous System

Early formation of the nervous system depends on the formation of the neural tube. A groove forms along the dorsal surface of the embryo, which becomes deeper until its edges meet and close off to form the tube. If this fails to happen, especially in the posterior region where the spinal cord forms, a developmental defect called spina bifida occurs. The closing of the neural tube is important for more than just the proper formation of the nervous system. The surrounding tissues are dependent on the correct development of the tube. The connective tissues surrounding the CNS can be involved as well.

There are three classes of this disorder: occulta, meningocele, and myelomeningocele (Figure 13.5). The first type, spina bifida occulta, is the mildest because the vertebral bones do not fully surround the spinal cord, but the spinal cord itself is not affected. No functional differences may be noticed, which is what the word occulta means; it is hidden spina bifida. The other two types both involve the formation of a cyst—a fluid-filled sac of the connective tissues that cover the spinal cord called the meninges. “Meningocele” means that the meninges protrude through the spinal column but nerves may not be involved and few symptoms are present, though complications may arise later in life. “Myelomeningocele” means that the meninges protrude and spinal nerves are involved, and therefore severe neurological symptoms can be present.

Often surgery to close the opening or to remove the cyst is necessary. The earlier that surgery can be performed, the better the chances of controlling or limiting further damage or infection at the opening. For many children with meningocele, surgery will alleviate the pain, although they may experience some functional loss. Because the myelomeningocele form of spina bifida involves more extensive damage to the nervous tissue, neurological damage may persist, but symptoms can often be handled. Complications of the spinal cord may present later in life, but overall life expectancy is not reduced.

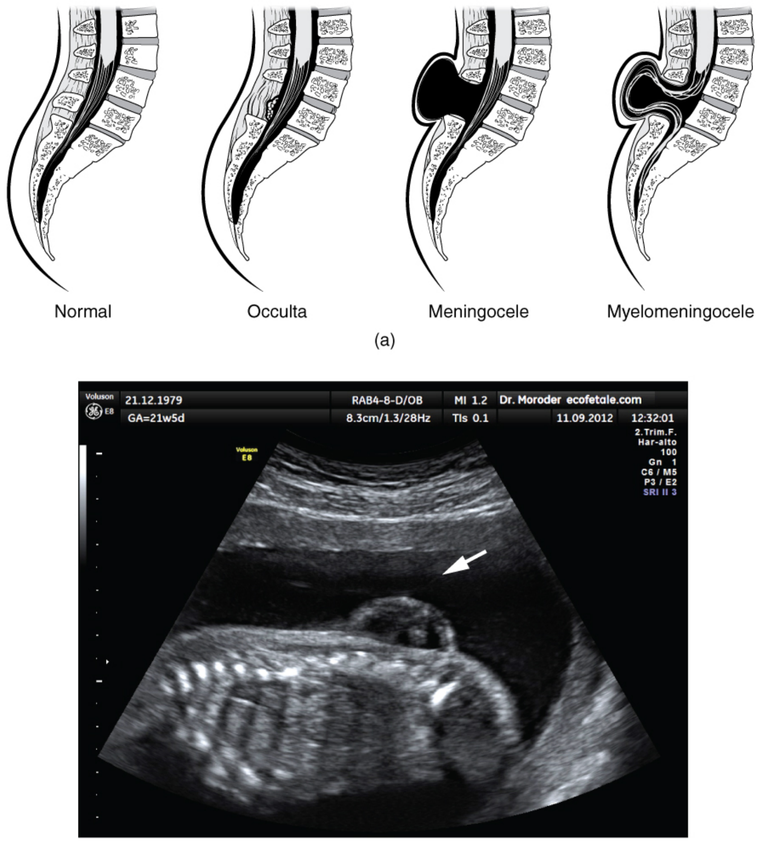


FIGURE 13.5 **Spinal Bifida** (a) Spina bifida is a birth defect of the spinal cord caused when the neural tube does not completely close, but the rest of development continues. The result is the emergence of meninges and neural tissue through the vertebral column. (b) Fetal myelomeningocele is evident in this ultrasound taken at 21 weeks.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/whitematter) to learn about the white matter in the cerebrum that develops during childhood and adolescence. This is a composite of MRI images taken of the brains of people from 5 years of age through 20 years of age, demonstrating how the cerebrum changes. As the color changes to blue, the ratio of gray matter to white matter changes. The caption for the video describes it as “less gray matter,” which is another way of saying “more white matter.” If the brain does not finish developing until approximately 20 years of age, can teenagers be held responsible for behaving badly?

13.2 The Central Nervous System

LEARNING OBJECTIVES

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

- Name the major regions of the adult brain
- Describe the connections between the cerebrum and brain stem through the diencephalon, and from those regions into the spinal cord
- Recognize the complex connections within the subcortical structures of the basal nuclei
- Explain the arrangement of gray and white matter in the spinal cord

The brain and the spinal cord are the central nervous system, and they represent the main organs of the nervous system. The spinal cord is a single structure, whereas the adult brain is described in terms of four major regions: the cerebrum, the diencephalon, the brain stem, and the cerebellum. A person’s conscious experiences are based on neural activity in the brain. The regulation of homeostasis is governed by a specialized region in the brain. The coordination of reflexes depends on the integration of sensory and motor pathways in the spinal cord.

The Cerebrum

The iconic gray mantle of the human brain, which appears to make up most of the mass of the brain, is the **cerebrum** (Figure 13.6). The wrinkled portion is the **cerebral cortex**, and the rest of the structure is beneath that outer covering. There is a large separation between the two sides of the cerebrum called the **longitudinal fissure**. It separates the cerebrum into two distinct halves, a right and left **cerebral hemisphere**. Deep within the cerebrum, the white matter of the **corpus callosum** provides the major pathway for communication between the two hemispheres of the cerebral cortex.

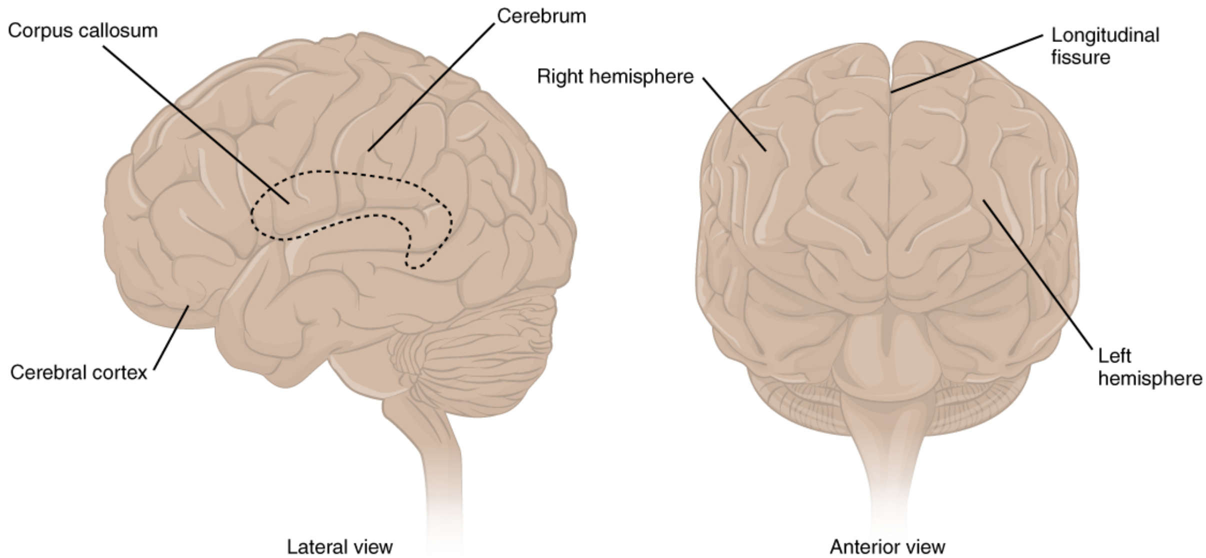


FIGURE 13.6 **The Cerebrum** The cerebrum is a large component of the CNS in humans, and the most obvious aspect of it is the folded surface called the cerebral cortex.

Many of the higher neurological functions, such as memory, emotion, and consciousness, are the result of cerebral function. The complexity of the cerebrum is different across vertebrate species. The cerebrum of the most primitive vertebrates is not much more than the connection for the sense of smell. In mammals, the cerebrum comprises the outer gray matter that is the cortex (from the Latin word meaning “bark of a tree”) and several deep nuclei that belong to three important functional groups. The **basal nuclei** are responsible for cognitive processing, the most important function being that associated with planning movements. The **basal forebrain** contains nuclei that are important in learning and memory. The **limbic cortex** is the region of the cerebral cortex that is part of the **limbic system**, a collection of structures involved in emotion, memory, and behavior.

Cerebral Cortex

The cerebrum is covered by a continuous layer of gray matter that wraps around either side of the forebrain—the cerebral cortex. This thin, extensive region of wrinkled gray matter is responsible for the higher functions of the nervous system. A **gyrus** (plural = gyri) is the ridge of one of those wrinkles, and a **sulcus** (plural = sulci) is the groove between two gyri. The pattern of these folds of tissue indicates specific regions of the cerebral cortex.

The head is limited by the size of the birth canal, and the brain must fit inside the cranial cavity of the skull. Extensive folding in the cerebral cortex enables more gray matter to fit into this limited space. If the gray matter of the cortex were peeled off of the cerebrum and laid out flat, its surface area would be roughly equal to one square meter.

The folding of the cortex maximizes the amount of gray matter in the cranial cavity. During embryonic development, as the telencephalon expands within the skull, the brain goes through a regular course of growth that results in everyone’s brain having a similar pattern of folds. The surface of the brain can be mapped on the basis of the locations of large gyri and sulci. Using these landmarks, the cortex can be separated into four major regions, or lobes (Figure 13.7). The **lateral sulcus** that separates the **temporal lobe** from the other regions is one such landmark. Superior to the lateral sulcus are the **parietal lobe** and **frontal lobe**, which are separated from each other by the **central sulcus**. The posterior region of the cortex is the **occipital lobe**, which has no obvious anatomical border between it and the parietal or temporal lobes on the lateral surface of the brain. From the medial surface, an obvious landmark separating the parietal and occipital lobes is called the **parieto-occipital sulcus**. The fact that there is no obvious anatomical border between these lobes is consistent with the functions of these regions being interrelated.

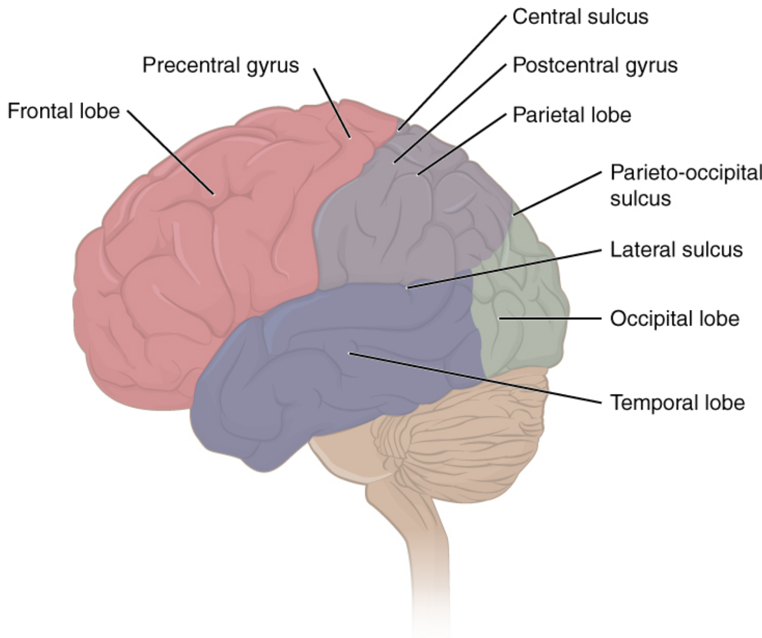


FIGURE 13.7 **Lobes of the Cerebral Cortex** The cerebral cortex is divided into four lobes. Extensive folding increases the surface area available for cerebral functions.

Different regions of the cerebral cortex can be associated with particular functions, a concept known as localization of function. In the early 1900s, a German neuroscientist named Korbinian Brodmann performed an extensive study of the microscopic anatomy—the cytoarchitecture—of the cerebral cortex and divided the cortex into 52 separate regions on the basis of the histology of the cortex. His work resulted in a system of classification known as **Brodmann's areas**, which is still used today to describe the anatomical distinctions within the cortex (Figure 13.8). The results from Brodmann's work on the anatomy align very well with the functional differences within the cortex. Areas 17 and 18 in the occipital lobe are responsible for primary visual perception. That visual information is complex, so it is processed in the temporal and parietal lobes as well.

The temporal lobe is associated with primary auditory sensation, known as Brodmann's areas 41 and 42 in the superior temporal lobe. Because regions of the temporal lobe are part of the limbic system, memory is an important function associated with that lobe. Memory is essentially a sensory function; memories are recalled sensations such as the smell of Mom's baking or the sound of a barking dog. Even memories of movement are really the memory of sensory feedback from those movements, such as stretching muscles or the movement of the skin around a joint. Structures in the temporal lobe are responsible for establishing long-term memory, but the ultimate location of those memories is usually in the region in which the sensory perception was processed.

The main sensation associated with the parietal lobe is **somatosensation**, meaning the general sensations associated with the body. Posterior to the central sulcus is the **postcentral gyrus**, the primary somatosensory cortex, which is identified as Brodmann's areas 1, 2, and 3. All of the tactile senses are processed in this area, including touch, pressure, tickle, pain, itch, and vibration, as well as more general senses of the body such as **proprioception** and **kinesthesia**, which are the senses of body position and movement, respectively.

Anterior to the central sulcus is the frontal lobe, which is primarily associated with motor functions. The **precentral gyrus** is the primary motor cortex. Cells from this region of the cerebral cortex are the upper motor neurons that instruct cells in the spinal cord to move skeletal muscles. Anterior to this region are a few areas that are associated with planned movements. The **premotor area** is responsible for thinking of a movement to be made. The **frontal eye fields** are important in eliciting eye movements and in attending to visual stimuli. **Broca's area** is responsible for the production of language, or controlling movements responsible for speech; in the vast majority of people, it is located only on the left side. Anterior to these regions is the **prefrontal lobe**, which serves cognitive functions that can be the basis of personality, short-term memory, and consciousness. The prefrontal lobotomy is an outdated mode of treatment for personality disorders (psychiatric conditions) that profoundly affected the personality of the patient.

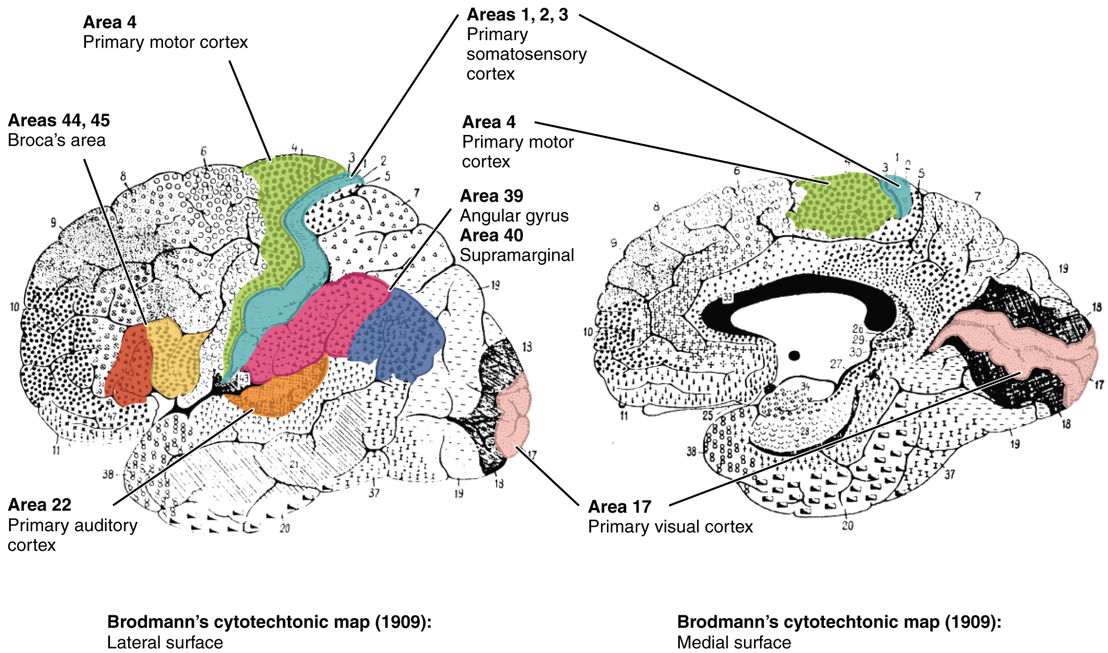


FIGURE 13.8 **Brodmann's Areas of the Cerebral Cortex** Brodmann mapping of functionally distinct regions of the cortex was based on its cytoarchitecture at a microscopic level.

Subcortical structures

Beneath the cerebral cortex are sets of nuclei known as **subcortical nuclei** that augment cortical processes. The nuclei of the basal forebrain serve as the primary location for acetylcholine production, which modulates the overall activity of the cortex, possibly leading to greater attention to sensory stimuli. Alzheimer's disease is associated with a loss of neurons in the basal forebrain. The **hippocampus** and **amygdala** are medial-lobe structures that, along with the adjacent cortex, are involved in long-term memory formation and emotional responses. The basal nuclei are a set of nuclei in the cerebrum responsible for comparing cortical processing with the general state of activity in the nervous system to influence the likelihood of movement taking place. For example, while a student is sitting in a classroom listening to a lecture, the basal nuclei will keep the urge to jump up and scream from actually happening. (The basal nuclei are also referred to as the basal ganglia, although that is potentially confusing because the term ganglia is typically used for peripheral structures.)

The major structures of the basal nuclei that control movement are the **caudate**, **putamen**, and **globus pallidus**, which are located deep in the cerebrum. The caudate is a long nucleus that follows the basic C-shape of the cerebrum from the frontal lobe, through the parietal and occipital lobes, into the temporal lobe. The putamen is mostly deep in the anterior regions of the frontal and parietal lobes. Together, the caudate and putamen are called the **striatum**. The globus pallidus is a layered nucleus that lies just medial to the putamen; they are called the lenticular nuclei because they look like curved pieces fitting together like lenses. The globus pallidus has two subdivisions, the external and internal segments, which are lateral and medial, respectively. These nuclei are depicted in a frontal section of the brain in Figure 13.9.

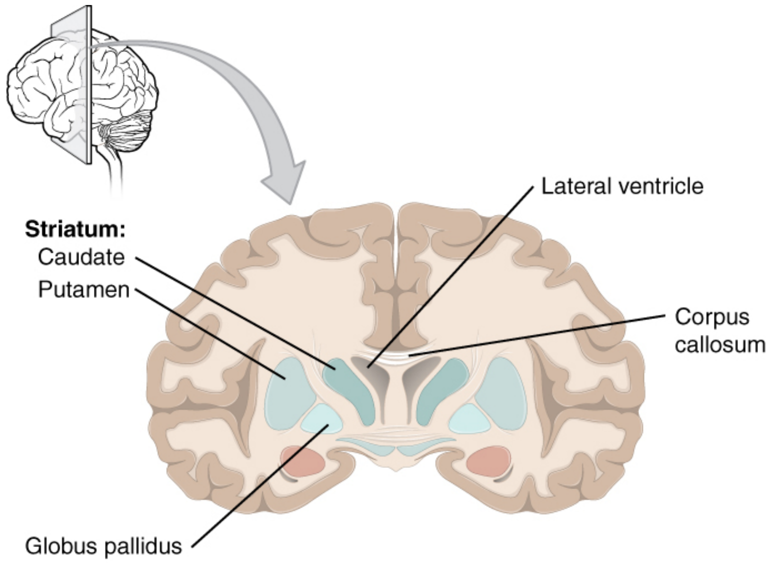


FIGURE 13.9 **Frontal Section of Cerebral Cortex and Basal Nuclei** The major components of the basal nuclei, shown in a frontal section of the brain, are the caudate (just lateral to the lateral ventricle), the putamen (inferior to the caudate and separated by the large white-matter structure called the internal capsule), and the globus pallidus (medial to the putamen).

The basal nuclei in the cerebrum are connected with a few more nuclei in the brain stem that together act as a functional group that forms a motor pathway. Two streams of information processing take place in the basal nuclei. All input to the basal nuclei is from the cortex into the striatum (Figure 13.10). The **direct pathway** is the projection of axons from the striatum to the globus pallidus internal segment (GPi) and the **substantia nigra pars reticulata** (SNr). The GPi/SNr then projects to the thalamus, which projects back to the cortex. The **indirect pathway** is the projection of axons from the striatum to the globus pallidus external segment (GPe), then to the subthalamic nucleus (STN), and finally to GPi/SNr. The two streams both target the GPi/SNr, but one has a direct projection and the other goes through a few intervening nuclei. The direct pathway causes the **disinhibition** of the thalamus (inhibition of one cell on a target cell that then inhibits the first cell), whereas the indirect pathway causes, or reinforces, the normal inhibition of the thalamus. The thalamus then can either excite the cortex (as a result of the direct pathway) or fail to excite the cortex (as a result of the indirect pathway).

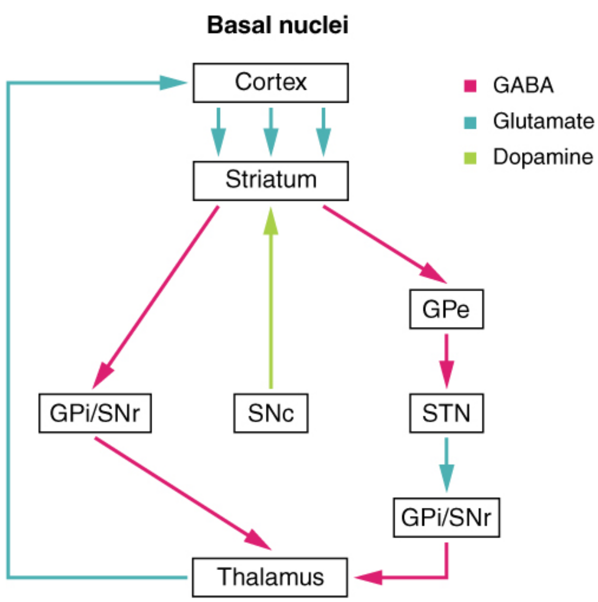


FIGURE 13.10 **Connections of Basal Nuclei** Input to the basal nuclei is from the cerebral cortex, which is an excitatory connection releasing glutamate as a neurotransmitter. This input is to the striatum, or the caudate and putamen. In the direct pathway, the striatum projects to the internal segment of the globus pallidus and the substantia nigra pars reticulata (GPi/SNr). This is an inhibitory pathway, in which GABA is released at the synapse, and the target cells are hyperpolarized and less likely to fire. The output from the basal nuclei is to the thalamus, which is an inhibitory projection using GABA. The diagram also includes the substantia nigra compacta (SNc), globus pallidus

external segment (GPe), and subthalamic nucleus (STN).

The switch between the two pathways is the **substantia nigra pars compacta**, which projects to the striatum and releases the neurotransmitter dopamine. Dopamine receptors are either excitatory (D1-type receptors) or inhibitory (D2-type receptors). The direct pathway is activated by dopamine, and the indirect pathway is inhibited by dopamine. When the substantia nigra pars compacta is firing, it signals to the basal nuclei that the body is in an active state, and movement will be more likely. When the substantia nigra pars compacta is silent, the body is in a passive state, and movement is inhibited. To illustrate this situation, while a student is sitting listening to a lecture, the substantia nigra pars compacta would be silent and the student less likely to get up and walk around. Likewise, while the professor is lecturing, and walking around at the front of the classroom, the professor's substantia nigra pars compacta would be active, in keeping with their activity level.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/basalnuclei1) to learn about the basal nuclei (also known as the basal ganglia), which have two pathways that process information within the cerebrum. As shown in this video, the direct pathway is the shorter pathway through the system that results in increased activity in the cerebral cortex and increased motor activity. The direct pathway is described as resulting in "disinhibition" of the thalamus. What does disinhibition mean? What are the two neurons doing individually to cause this?

INTERACTIVE LINK

Watch this video (http://openstax.org/l/basalnuclei2) to learn about the basal nuclei (also known as the basal ganglia), which have two pathways that process information within the cerebrum. As shown in this video, the indirect pathway is the longer pathway through the system that results in decreased activity in the cerebral cortex, and therefore less motor activity. The indirect pathway has an extra couple of connections in it, including disinhibition of the subthalamic nucleus. What is the end result on the thalamus, and therefore on movement initiated by the cerebral cortex?

Everyday Connection

The Myth of Left Brain/Right Brain

There is a persistent myth that people are "right-brained" or "left-brained," which is an oversimplification of an important concept about the cerebral hemispheres. There is some lateralization of function, in which the left side of the brain is devoted to language function and the right side is devoted to spatial and nonverbal reasoning. Whereas these functions are predominantly associated with those sides of the brain, there is no monopoly by either side on these functions. Many pervasive functions, such as language, are distributed globally around the cerebrum.

Some of the support for this misconception has come from studies of split brains. A drastic way to deal with a rare and devastating neurological condition (intractable epilepsy) is to separate the two hemispheres of the brain. After sectioning the corpus callosum, a split-brained patient will have trouble producing verbal responses on the basis of sensory information processed on the right side of the cerebrum, leading to the idea that the left side is responsible for language function.

However, there are well-documented cases of language functions lost from damage to the right side of the brain. The deficits seen in damage to the left side of the brain are classified as aphasia, a loss of speech function; damage on the right side can affect the use of language. Right-side damage can result in a loss of ability to understand figurative aspects of speech, such as jokes, irony, or metaphors. Nonverbal aspects of speech can be affected by damage to the right side, such as facial expression or body language, and right-side damage can lead to a "flat affect" in speech, or a loss of emotional expression in speech—sounding like a robot when talking.

The Diencephalon

The diencephalon is the one region of the adult brain that retains its name from embryologic development. The etymology of the word diencephalon translates to "through brain." It is the connection between the cerebrum and the rest of the nervous system, with one exception. The rest of the brain, the spinal cord, and the PNS all send information to the cerebrum through the diencephalon. Output from the cerebrum passes through the diencephalon. The single exception is the system associated with **olfaction**, or the sense of smell, which connects directly with the cerebrum. In the earliest vertebrate species, the cerebrum was not much more than olfactory bulbs that received peripheral information about the chemical environment (to call it smell in these organisms is imprecise because they lived in the ocean).

The diencephalon is deep beneath the cerebrum and constitutes the walls of the third ventricle. The diencephalon can be described as any region of the brain with "thalamus" in its name. The two major regions of the diencephalon are the thalamus itself and the hypothalamus (Figure 13.11). There are other structures, such as the **epithalamus**, which contains the pineal gland, or the **subthalamus**, which includes the subthalamic nucleus that is part of the basal nuclei.

Thalamus

The **thalamus** is a collection of nuclei that relay information between the cerebral cortex and the periphery, spinal cord, or brain stem. All sensory information, except for the sense of smell, passes through the thalamus before processing by the cortex. Axons from the peripheral sensory organs, or intermediate nuclei, synapse in the thalamus, and thalamic neurons project directly to the cerebrum. It is a requisite synapse in any sensory pathway, except for olfaction. The thalamus does not just pass the information on, it also processes that information. For example, the portion of the thalamus that receives visual information will influence what visual stimuli are important, or what receives attention.

The cerebrum also sends information down to the thalamus, which usually communicates motor commands. This involves interactions with the cerebellum and other nuclei in the brain stem. The cerebrum interacts with the basal nuclei, which involves connections with the thalamus. The primary output of the basal nuclei is to the thalamus, which relays that output to the cerebral cortex. The cortex also sends information to the thalamus that will then influence the effects of the basal nuclei.

Hypothalamus

Inferior and slightly anterior to the thalamus is the **hypothalamus**, the other major region of the diencephalon. The hypothalamus is a collection of nuclei that are largely involved in regulating homeostasis. The hypothalamus is the executive region in charge of the autonomic nervous system and the endocrine system through its regulation of the anterior pituitary gland. Other parts of the hypothalamus are involved in memory and emotion as part of the limbic system.

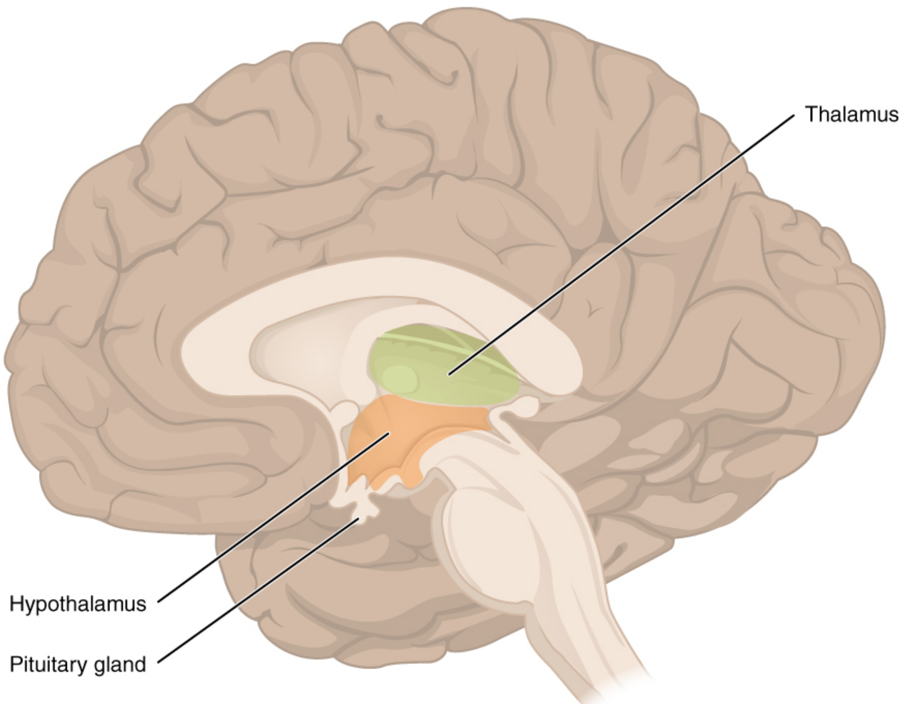


FIGURE 13.11 **The Diencephalon** The diencephalon is composed primarily of the thalamus and hypothalamus, which together define the walls of the third ventricle. The thalami are two elongated, ovoid structures on either side of the midline that make contact in the middle. The hypothalamus is inferior and anterior to the thalamus, culminating in a sharp angle to which the pituitary gland is attached.

Brain Stem

The midbrain and hindbrain (composed of the pons and the medulla) are collectively referred to as the brain stem (Figure 13.12). The structure emerges from the ventral surface of the forebrain as a tapering cone that connects the brain to the spinal cord. Attached to the brain stem, but considered a separate region of the adult brain, is the cerebellum. The midbrain coordinates sensory representations of the visual, auditory, and somatosensory perceptual spaces. The pons is the main connection with the cerebellum. The pons and the medulla regulate several crucial functions, including the cardiovascular and respiratory systems and rates.

The cranial nerves connect through the brain stem and provide the brain with the sensory input and motor output associated with the head and neck, including most of the special senses. The major ascending and descending pathways between the spinal cord and brain, specifically the cerebrum, pass through the brain stem.

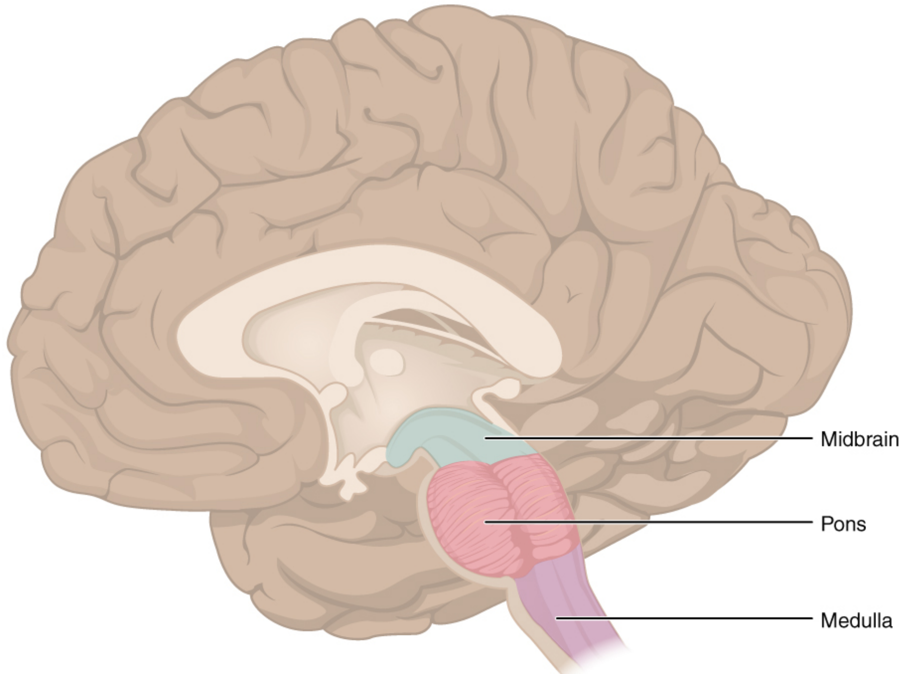


FIGURE 13.12 **The Brain Stem** The brain stem comprises three regions: the midbrain, the pons, and the medulla.

Midbrain

One of the original regions of the embryonic brain, the midbrain is a small region between the thalamus and pons. It is separated into the **tectum** and **tegmentum**, from the Latin words for roof and floor, respectively. The cerebral aqueduct passes through the center of the midbrain, such that these regions are the roof and floor of that canal.

The tectum is composed of four bumps known as the colliculi (singular = colliculus), which means “little hill” in Latin. The **inferior colliculus** is the inferior pair of these enlargements and is part of the auditory brain stem pathway. Neurons of the inferior colliculus project to the thalamus, which then sends auditory information to the cerebrum for the conscious perception of sound. The **superior colliculus** is the superior pair and combines sensory information about visual space, auditory space, and somatosensory space. Activity in the superior colliculus is related to orienting the eyes to a sound or touch stimulus. If you are walking along the sidewalk on campus and you hear chirping, the superior colliculus coordinates that information with your awareness of the visual location of the tree right above you. That is the correlation of auditory and visual maps. If you suddenly feel something wet fall on your head, your superior colliculus integrates that with the auditory and visual maps and you know that the chirping bird just relieved itself on you. You want to look up to see the culprit, but do not.

The tegmentum is continuous with the gray matter of the rest of the brain stem. Throughout the midbrain, pons, and medulla, the tegmentum contains the nuclei that receive and send information through the cranial nerves, as well as regions that regulate important functions such as those of the cardiovascular and respiratory systems.

Pons

The word pons comes from the Latin word for bridge. It is visible on the anterior surface of the brain stem as the thick bundle of white matter attached to the cerebellum. The pons is the main connection between the cerebellum and the brain stem. The bridge-like white matter is only the anterior surface of the pons; the gray matter beneath that is a continuation of the tegmentum from the midbrain. Gray matter in the tegmentum region of the pons contains neurons receiving descending input from the forebrain that is sent to the cerebellum.

Medulla

The medulla is the region known as the myelencephalon in the embryonic brain. The initial portion of the name, “myel,” refers to the significant white matter found in this region—especially on its exterior, which is continuous with the white matter of the spinal cord. The tegmentum of the midbrain and pons continues into the medulla because this gray matter is responsible for processing cranial nerve information. A diffuse region of gray matter throughout the brain stem, known as the **reticular formation**, is related to sleep and wakefulness, such as general brain activity and attention.

The Cerebellum

The **cerebellum**, as the name suggests, is the "little brain." It is covered in gyri and sulci like the cerebrum, and looks like a miniature version of that part of the brain (Figure 13.13). The cerebellum is largely responsible for comparing information from the cerebrum with sensory feedback from the periphery through the spinal cord. It accounts for approximately 10 percent of the mass of the brain.

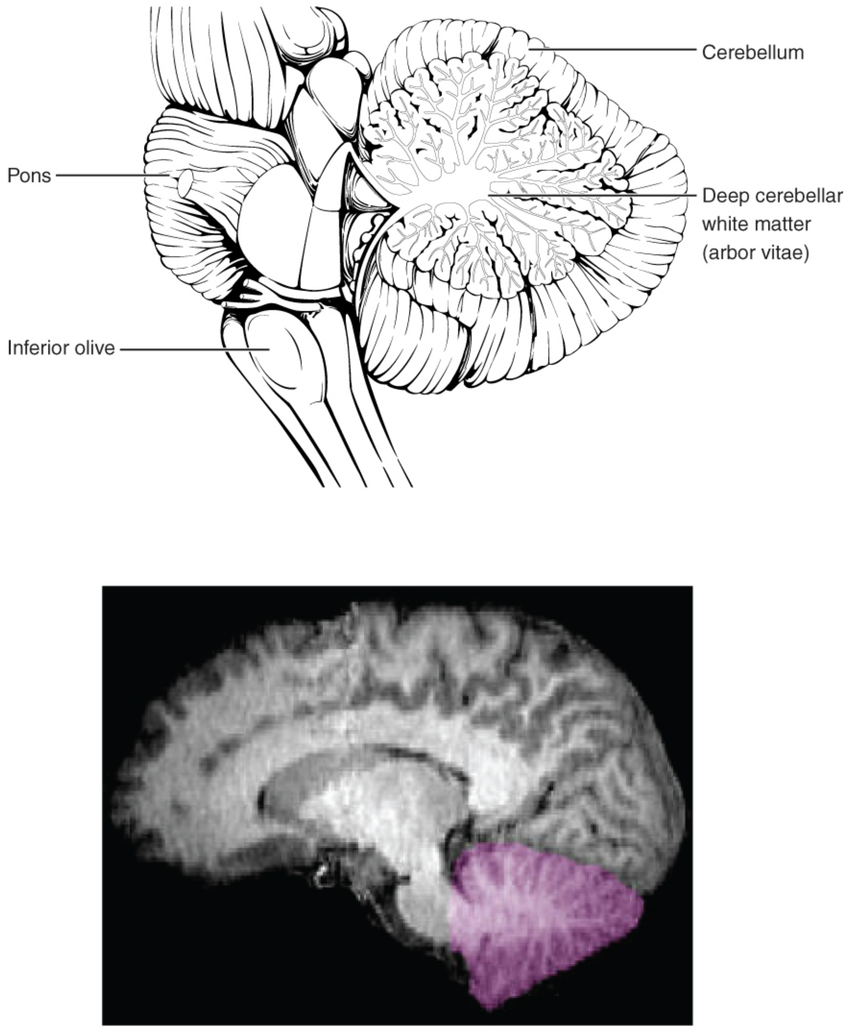


FIGURE 13.13 **The Cerebellum** The cerebellum is situated on the posterior surface of the brain stem. Descending input from the cerebellum enters through the large white matter structure of the pons. Ascending input from the periphery and spinal cord enters through the fibers of the inferior olive. Output goes to the midbrain, which sends a descending signal to the spinal cord.

Descending fibers from the cerebrum have branches that connect to neurons in the pons. Those neurons project into the cerebellum, providing a copy of motor commands sent to the spinal cord. Sensory information from the periphery, which enters through spinal or cranial nerves, is copied to a nucleus in the medulla known as the **inferior olive**. Fibers from this nucleus enter the cerebellum and are compared with the descending commands from the cerebrum. If the primary motor cortex of the frontal lobe sends a command down to the spinal cord to initiate walking, a copy of that instruction is sent to the cerebellum. Sensory feedback from the muscles and joints, proprioceptive information about the movements of walking, and sensations of balance are sent to the cerebellum through the inferior olive and the cerebellum compares them. If walking is not coordinated, perhaps because the ground is uneven or a strong wind is blowing, then the cerebellum sends out a corrective command to compensate for the difference between the original cortical command and the sensory feedback. The output of the cerebellum is into the midbrain, which then sends a descending input to the spinal cord to correct the messages going to skeletal muscles.

The Spinal Cord

The description of the CNS is concentrated on the structures of the brain, but the spinal cord is another major organ of the system. Whereas the brain develops out of expansions of the neural tube into primary and then secondary vesicles, the spinal cord maintains the tube structure and is only specialized into certain regions. As the spinal cord continues to develop in the newborn, anatomical features mark its surface. The anterior midline is marked by the **anterior median fissure**, and the posterior midline is marked by the **posterior median sulcus**. Axons enter the posterior side through the **dorsal (posterior) nerve root**, which marks the **posterolateral sulcus** on either side. The axons emerging from the anterior side do so through the **ventral (anterior) nerve root**. Note that it is common to see the terms dorsal (dorsal = “back”) and ventral (ventral = “belly”) used interchangeably with posterior and anterior, particularly in reference to nerves and the structures of the spinal cord. You should learn to be comfortable with both.

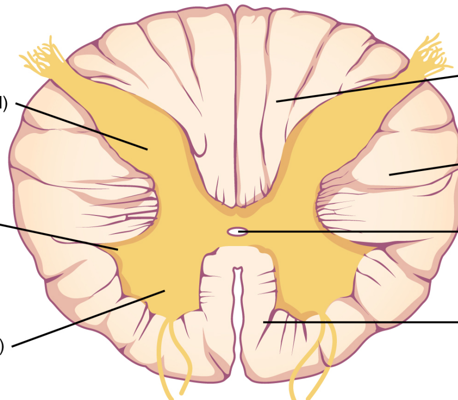
On the whole, the posterior regions are responsible for sensory functions and the anterior regions are associated with motor functions. This comes from the initial development of the spinal cord, which is divided into the **basal plate** and the **alar plate**. The basal plate is closest to the ventral midline of the neural tube, which will become the anterior face of the spinal cord and gives rise to motor neurons. The alar plate is on the dorsal side of the neural tube and gives rise to neurons that will receive sensory input from the periphery.

The length of the spinal cord is divided into regions that correspond to the regions of the vertebral column. The name of a spinal cord region corresponds to the level at which spinal nerves pass through the intervertebral foramina. Immediately adjacent to the brain stem is the cervical region, followed by the thoracic, then the lumbar, and finally the sacral region. The spinal cord is not the full length of the vertebral column because the spinal cord does not grow significantly longer after the first or second year, but the skeleton continues to grow. The nerves that emerge from the spinal cord pass through the intervertebral foramina at the respective levels. As the vertebral column grows, these nerves grow with it and result in a long bundle of nerves that resembles a horse’s tail and is named the **cauda equina**. The sacral spinal cord is at the level of the upper lumbar vertebral bones. The spinal nerves extend from their various levels to the proper level of the vertebral column.

Gray Horns

In cross-section, the gray matter of the spinal cord has the appearance of an ink-blot test, with the spread of the gray matter on one side replicated on the other—a shape reminiscent of a bulbous capital “H.” As shown in Figure 13.14, the gray matter is subdivided into regions that are referred to as horns. The **posterior horn** is responsible for sensory processing. The **anterior horn** sends out motor signals to the skeletal muscles. The **lateral horn**, which is only found in the thoracic, upper lumbar, and sacral regions, contains cell bodies of motor neurons of the autonomic nervous system.

Some of the largest neurons of the spinal cord are the multipolar motor neurons in the anterior horn. The fibers that cause contraction of skeletal muscles are the axons of these neurons. The motor neuron that causes contraction of the big toe, for example, is located in the sacral spinal cord. The axon that has to reach all the way to the belly of that muscle may be a meter in length. The neuronal cell body that maintains that long fiber must be quite large, possibly several hundred micrometers in diameter, making it one of the largest cells in the body.



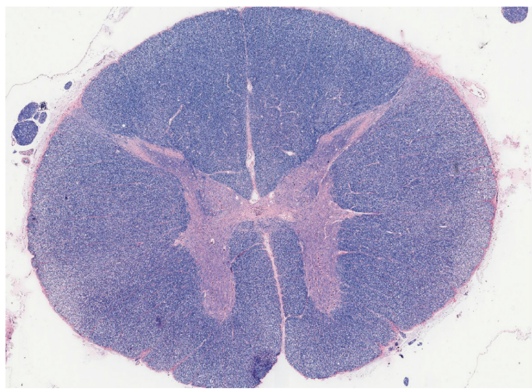


FIGURE 13.14 **Cross-section of Spinal Cord** The cross-section of a thoracic spinal cord segment shows the posterior, anterior, and lateral horns of gray matter, as well as the posterior, anterior, and lateral columns of white matter. LM × 40. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

White Columns

Just as the gray matter is separated into horns, the white matter of the spinal cord is separated into columns. **Ascending tracts** of nervous system fibers in these columns carry sensory information up to the brain, whereas **descending tracts** carry motor commands from the brain. Looking at the spinal cord longitudinally, the columns extend along its length as continuous bands of white matter. Between the two posterior horns of gray matter are the **posterior columns**. Between the two anterior horns, and bounded by the axons of motor neurons emerging from that gray matter area, are the **anterior columns**. The white matter on either side of the spinal cord, between the posterior horn and the axons of the anterior horn neurons, are the **lateral columns**. The posterior columns are composed of axons of ascending tracts. The anterior and lateral columns are composed of many different groups of axons of both ascending and descending tracts—the latter carrying motor commands down from the brain to the spinal cord to control output to the periphery.

INTERACTIVE LINK

Watch this video (http://openstax.org/l/graymatter) to learn about the gray matter of the spinal cord that receives input from fibers of the dorsal (posterior) root and sends information out through the fibers of the ventral (anterior) root. As discussed in this video, these connections represent the interactions of the CNS with peripheral structures for both sensory and motor functions. The cervical and lumbar spinal cords have enlargements as a result of larger populations of neurons. What are these enlargements responsible for?

Disorders of the...

Basal Nuclei

Parkinson's disease is a disorder of the basal nuclei, specifically of the substantia nigra, that demonstrates the effects of the direct and indirect pathways. Parkinson's disease is the result of neurons in the substantia nigra pars compacta dying. These neurons release dopamine into the striatum. Without that modulatory influence, the basal nuclei are stuck in the indirect pathway, without the direct pathway being activated. The direct pathway is responsible for increasing cortical movement commands. The increased activity of the indirect pathway results in the hypokinetic disorder of Parkinson's disease.

Parkinson's disease is neurodegenerative, meaning that neurons die that cannot be replaced, so there is no cure for the disorder. Treatments for Parkinson's disease are aimed at increasing dopamine levels in the striatum. Currently, the most common way of doing that is by providing the amino acid L-DOPA, which is a precursor to the neurotransmitter dopamine and can cross the blood-brain barrier. With levels of the precursor elevated, the remaining cells of the substantia nigra pars compacta can make more neurotransmitter and have a greater effect. Unfortunately, the patient will become less responsive to L-DOPA treatment as time progresses, and it can cause increased dopamine levels elsewhere in the brain, which are associated with psychosis or schizophrenia.

INTERACTIVE LINK

Visit this site (http://openstax.org/l/parkinsons) for a thorough explanation of Parkinson's disease.

INTERACTIVE LINK

Compared with the nearest evolutionary relative, the chimpanzee, the human has a brain that is huge. At a point in the past, a common ancestor gave rise to the two species of humans and chimpanzees. That evolutionary history is long and is still an area of intense study. But something happened to increase the size of the human brain relative to the chimpanzee. Read this article (http://openstax.org/l/hugebrain) in which the author explores the current understanding of why this happened.

According to one hypothesis about the expansion of brain size, what tissue might have been sacrificed so energy was available to grow our larger brain? Based on what you know about that tissue and nervous tissue, why would there be a trade-off between them in terms of energy use?

13.3 Circulation and the Central Nervous System

LEARNING OBJECTIVES

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

- Describe the vessels that supply the CNS with blood
- Name the components of the ventricular system and the regions of the brain in which each is located
- Explain the production of cerebrospinal fluid and its flow through the ventricles
- Explain how a disruption in circulation would result in a stroke

The CNS is crucial to the operation of the body, and any compromise in the brain and spinal cord can lead to severe difficulties. The CNS has a privileged blood supply, as suggested by the blood-brain barrier. The function of the tissue in the CNS is crucial to the survival of the organism, so the contents of the blood cannot simply pass into the central nervous tissue. To protect this region from the toxins and pathogens that may be traveling through the blood stream, there is strict control over what can move out of the general systems and into the brain and spinal cord. Because of this privilege, the CNS needs specialized structures for the maintenance of circulation. This begins with a unique arrangement of blood vessels carrying fresh blood into the CNS. Beyond the supply of blood, the CNS filters that blood into cerebrospinal fluid (CSF), which is then circulated through the cavities of the brain and spinal cord called ventricles.

Blood Supply to the Brain

A lack of oxygen to the CNS can be devastating, and the cardiovascular system has specific regulatory reflexes to ensure that the blood supply is not interrupted. There are multiple routes for blood to get into the CNS, with specializations to protect that blood supply and to maximize the ability of the brain to get an uninterrupted perfusion.

Arterial Supply

The major artery carrying recently oxygenated blood away from the heart is the aorta. The very first branches off the aorta supply the heart with nutrients and oxygen. The next branches give rise to the **common carotid arteries**, which further branch into the **internal carotid arteries**. The external carotid arteries supply blood to the tissues on the surface of the cranium. The bases of the common carotids contain stretch receptors that immediately respond to the drop in blood pressure upon standing. The **orthostatic reflex** is a reaction to this change in body position, so that blood pressure is maintained against the increasing effect of gravity (orthostatic means “standing up”). Heart rate increases—a reflex of the sympathetic division of the autonomic nervous system—and this raises blood pressure.

The internal carotid artery enters the cranium through the **carotid canal** in the temporal bone. A second set of vessels that supply the CNS are the **vertebral arteries**, which are protected as they pass through the neck region by the transverse foramina of the cervical vertebrae. The vertebral arteries enter the cranium through the **foramen magnum** of the occipital bone. Branches off the left and right vertebral arteries merge into the **anterior spinal artery** supplying the anterior aspect of the spinal cord, found along the anterior median fissure. The two vertebral arteries then merge into the **basilar artery**, which gives rise to branches to the brain stem and cerebellum. The left and right internal carotid arteries and branches of the basilar artery all become the **circle of Willis**, a confluence of arteries that can maintain perfusion of the brain even if narrowing or a blockage limits flow through one part (Figure 13.15).

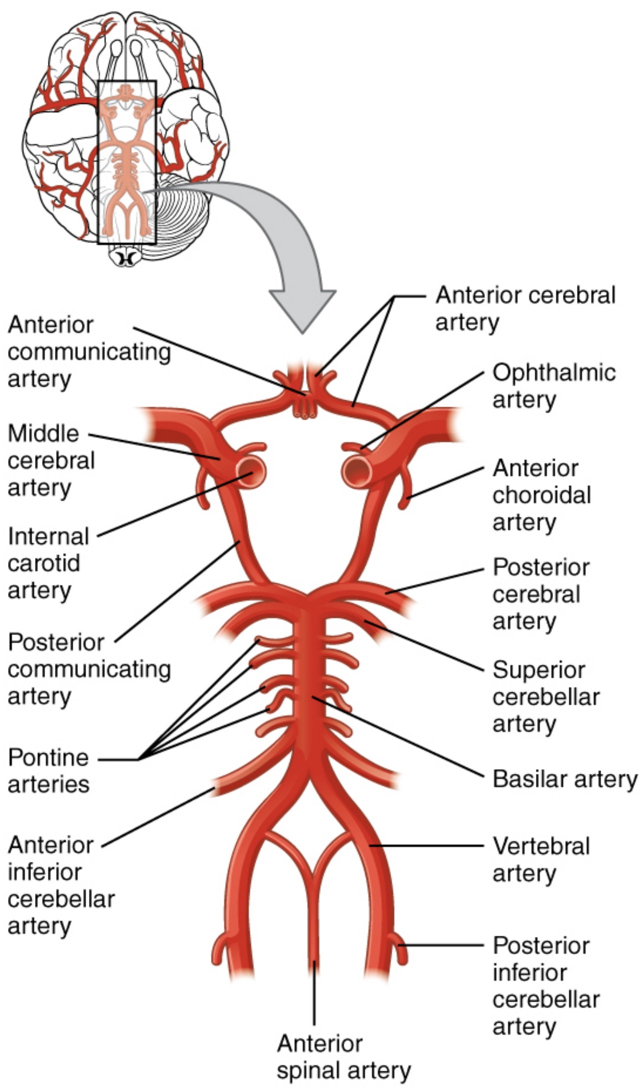


FIGURE 13.15 **Circle of Willis** The blood supply to the brain enters through the internal carotid arteries and the vertebral arteries, eventually giving rise to the circle of Willis.