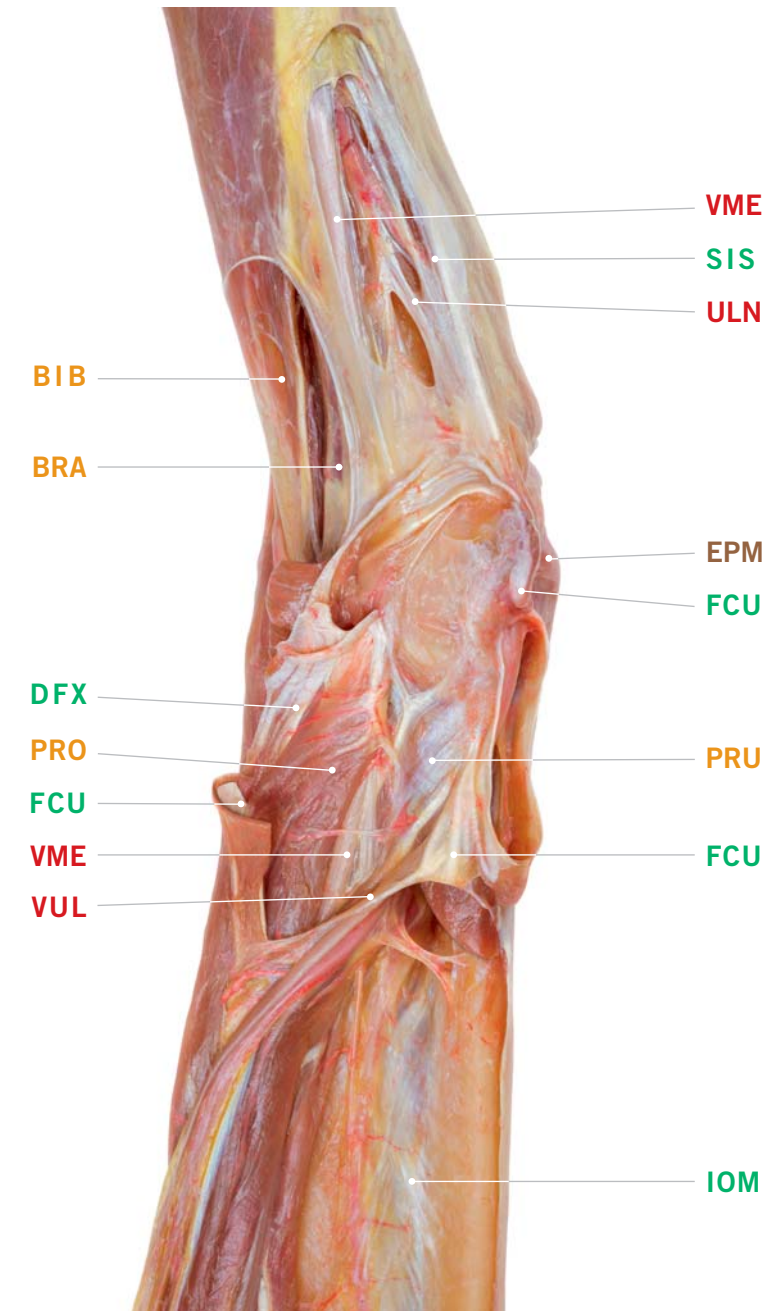


Dorsomedial view of the right elbow

The *deep fascia* of the arm has been partially removed, allowing visibility of the laterally located **M. brachialis BRA** and **M. biceps brachii BIB** reaching the *Fossa cubitalis* downwards. The **Sheath for N. medianus and A. comitans VME** is visible near the *Fossa cubitalis*, with the *A. brachialis* located slightly lateral and the perineum-enclosed **N. ulnaris ULN** medially.

At this point, the **ULN** passes posteriorly through the **Septum intermusculare brachii mediale (Struther) SIS**⁴². The **SIS** is attached to the **Epicondylus medialis humeri EPM**. The **M. flexor carpi ulnaris FCU** arises from an aponeurotic origin on the **EPM** and is reflected medially. This and the removal of the hand flexors, reveals the **Aponeurotic origin of forearm flexors DFX**. The **Sheath for N. medianus and Vasa ulnaria VUL** can be seen passing between the **M. pronator teres, Caput humerale PRO** and **Caput ulnare PRU** near the **Membrana interossea IOM**.



Subpectoral fascia of the thorax, anterior view

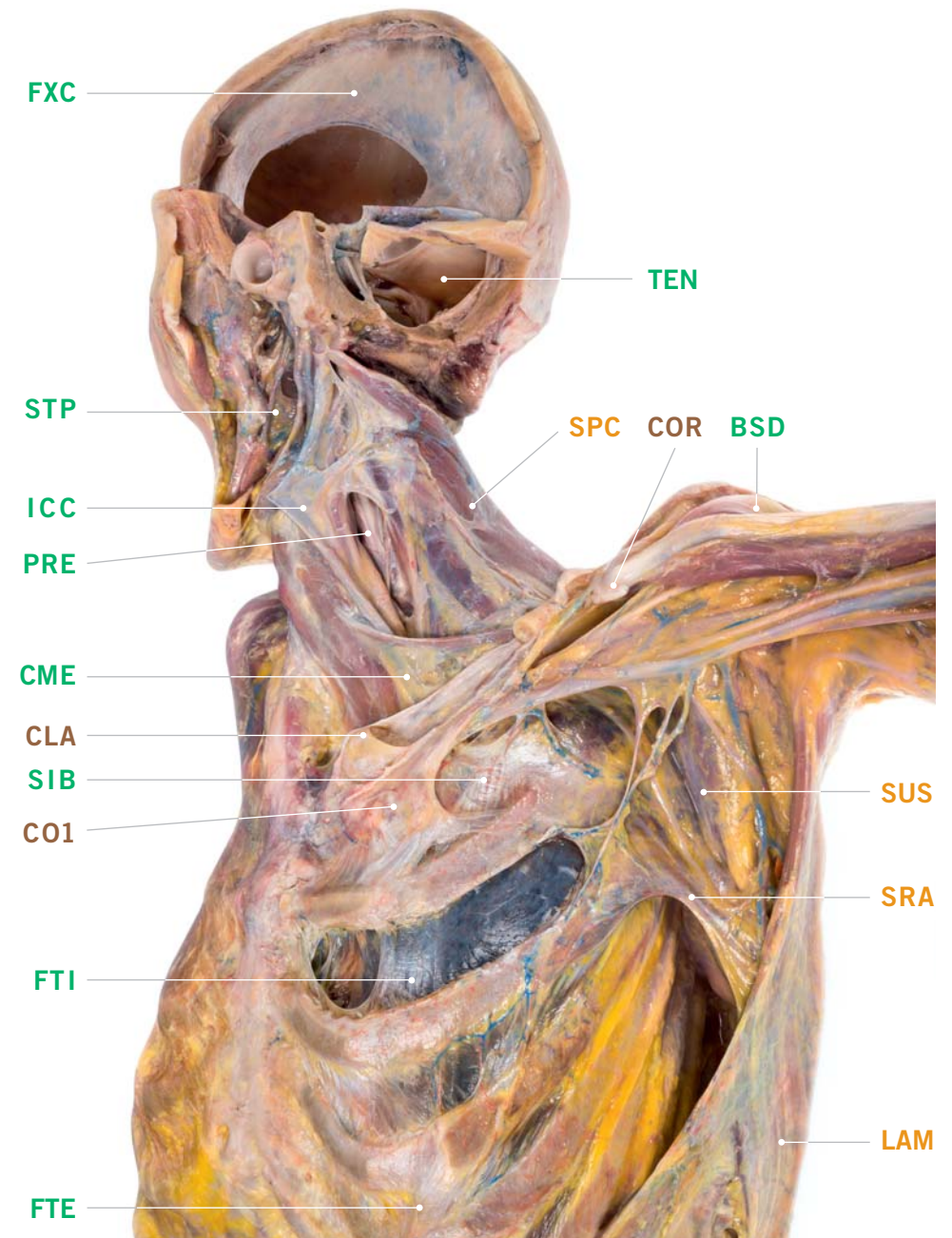
The head of the specimen has been turned to the right side, showing **Falx cerebri** **FXC** and **Tentorium cerebelli** **TEN**. Moving inferiorly, a window has been cut in both the **F. intercarotica** **ICC** and the **Lamina praetrachealis f. cervicalis** **CME** to demonstrate **Lamina praevertebralis f. cervicalis** **PRE**⁶⁴. The **F. stylopharyngea** **STP** is spanned between the *Mandibula* and the *Proc. styloideus*⁶⁵. Following the route of **M. splenius capitis** **SPC** inferiorly, the **Proc. coracoideus** **COR** is seen. Next to **COR**, the central part of the **Clavicula** **CLA** has been extracted, together with the lateral parts of *F. clavipectoralis*⁵⁰, in order to make **Costa prima** **CO1** and the underlying **Membrana suprapleuralis/Sibson's Fascia** **SIB** visible. Fibres from **CLA** and **COR** reach the *Cupula pleuris* from outside. The medial part of *F. clavipectoralis* extends very densely from **CO1** to the **COR**. This part is the *Membrana costocoracoidea*⁶⁶ contributing to *Cupula pleuris*.

The lateral part of **CLA** remains attached to **COR** by *Lig. coracoclaviculare, Pars conoidea et trapezoidea*⁴⁹. The *M. pectoralis minor* is cut to see the occurring gap for the passing *Plexus brachialis* with *A. et V. subclavia*. Note the vicinity of the *Cupula pleuris* to the subclavicular vessels. They, together with the plexus, pass distally in a common sheath, along the muscles from **COR**, the *Caput breve m. bicipitis brachii* and *M. coracobrachialis*.

On the inferior aspect, *M. pectoralis major* and *minor* and their respective fasciae as well as the intercostal muscles and fasciae between *Costa 2* and *Costa 3* have been cut. The **F. thoracica externa** **FTE** covers the thoracic cavity from the outside, the **F. thoracica interna** **FTI** from the inside, yet still on top of the *Pleura* as **SIB**. *Vasa thoracica interna* pass medially, near *Corpus sterni*, at the angle where the *Pleura parietalis* curves inside to be *Pleura mediastinalis*, forming the *Recessus costomediastinalis* there.

At the shoulder, large parts of *M. deltoideus* have been removed to show the **Subacromial/subdeltoideal bursa** **BSD** lying underneath⁵².

At the axilla, **M. subscapularis** **SUS** and remnants of **M. serratus anterior** **SRA** are distinguishable. A cushion between *Scapula* and thorax is built by **SUS** and **SRA**. Between **SUS** and **SRA**, a gliding space is seen, the *Subscapular Space* and below **SRA**, the *Serratus Anterior Space*⁵⁴ is visible. Both spaces form the *Scapulothoracic (para) Joint*. Lateroposteriorly, fibres of **M. latissimus dorsi** **LAM** form the posterior axillary fold.



Deep head and neck in anterior left view

Viscerocranium and Neurocranium are removed until the *Fossa cranii posterior* with the **Falx cerebelli FXL** is left as a remnant of *Dura mater*. The **Dens axis AXI** is seen at the occiput with the **Lig. alare LAE** and *Lig. apicis dentis* superiorly which is merged with **LAE**. The **Arcus atlantis** of **Atlas ATL** lies anteriorly, forming a part of the *Art. atlantoaxialis mediana*.

The left side was dissected deeper, while on the right side the prevertebral muscles remain, such as **M. longus capitis LCA**, together with the covering *Lamina praevertebralis f. cervicalis*. Even **M. scalenus anterior SLA** is obvious as a bridge for the **Sheath of Plexus brachialis and vessels VBR**.

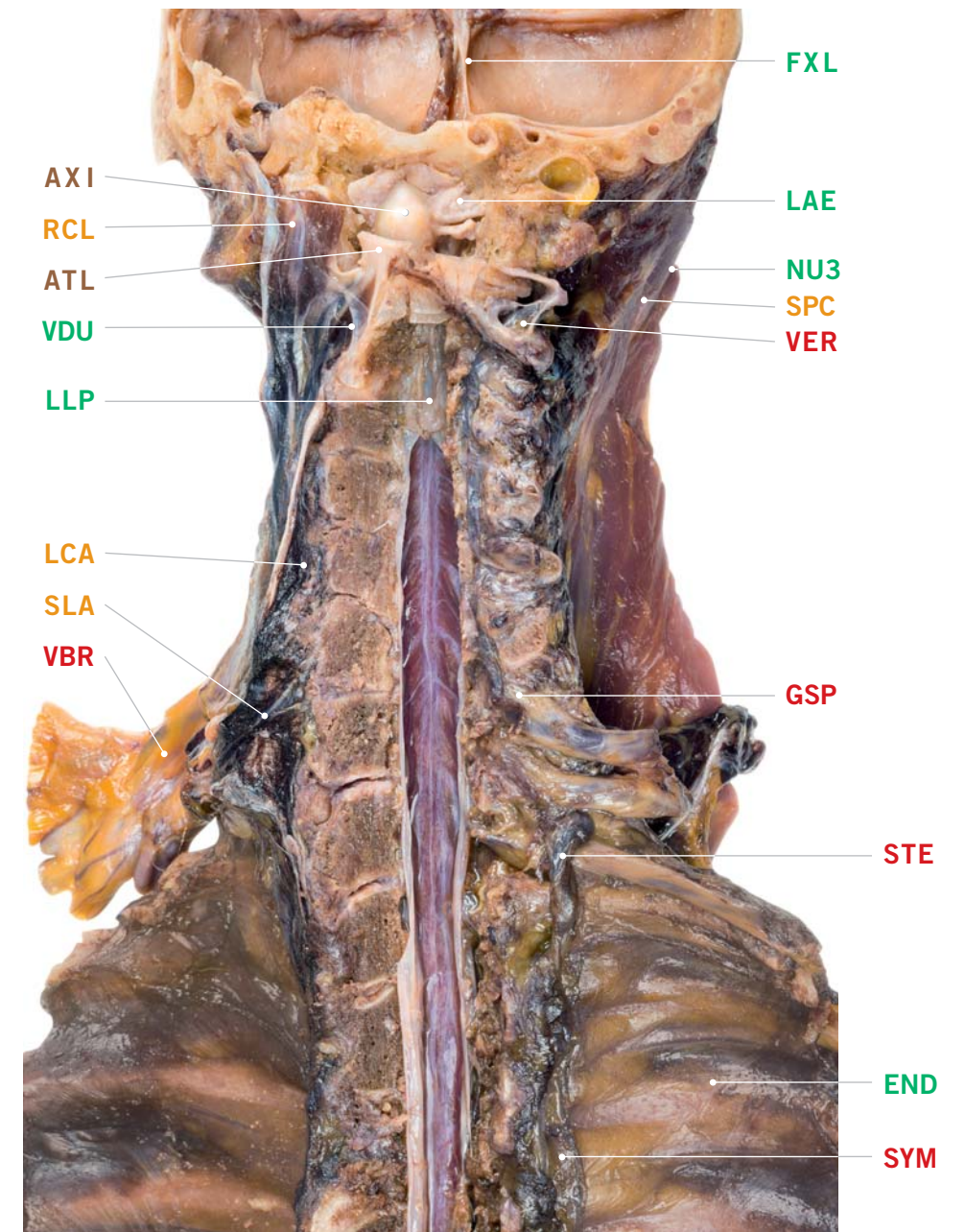
To reach the *Canalis vertebralis*, the vertebrae were cut sagittally. From the lateral view, the vertebrae are obviously covered anteriorly by the thinner *Lig. longitudinale anterius*, posteriorly by the thicker **Lig. longitudinale posterius LLP**, which envelops the inner anterior side of the vertebral canal. Superiorly, **LLP** remains. The *Dura mater* is opened in the next step to see the *Medulla spinalis*. From the medulla laterally, a **Ganglion spinale GSP** is revealed by removal of the *Vertebrae cervicales*. Anteriorly, **Vasa vertebrales VER** are near the *Vertebra cervicalis CV6* and cross superiorly over the *Nn. spinales* with the merged **GSP**. The *Pars atlantica* of **VER** passes *Foramen transversarium* of *Axis*, which remains in the dissection, to find *Massa lateralis atlantis*. After meandering there, **VER** is cut superiorly.

M. rectus capitis lateralis RCL inserts at *Massa lateralis atlantis*. **RCL** is anteriorly covered by the **Vertebroductal Ligament VDU**⁷⁶. Anteriorly of **VDU**, *M. rectus capitis anterior* remains. Posteriorly of **VDU**, the space for the short muscles of the head begins.

M. splenius capitis SPC covers this deepest posterior layer, divided by **Fascia nuchae, deep layer NU3**, which forms a fine white border between **RCL** and **SPC**. The **SPC** reaches the head inferiorly, together with the other visible remaining cervical muscles, such as *M. splenius cervicis*. They are crossed by **VBR**.

While on the right side of the inferior dissection the cervical part of **Truncus sympathicus SYM** is out of view, on the left side its thoracal part can be followed, covered by and merged with **F. endothoracica END**, embedded between *F. thoracica interna* and *Pleura parietalis*, which was removed. Doing so, the ribs as well as *Mm. intercostales interni* can be seen left, crossed by **END**.

Ggl. cervicothoracicum STE is seen at the *Capitulum costae* of *Costa prima*.

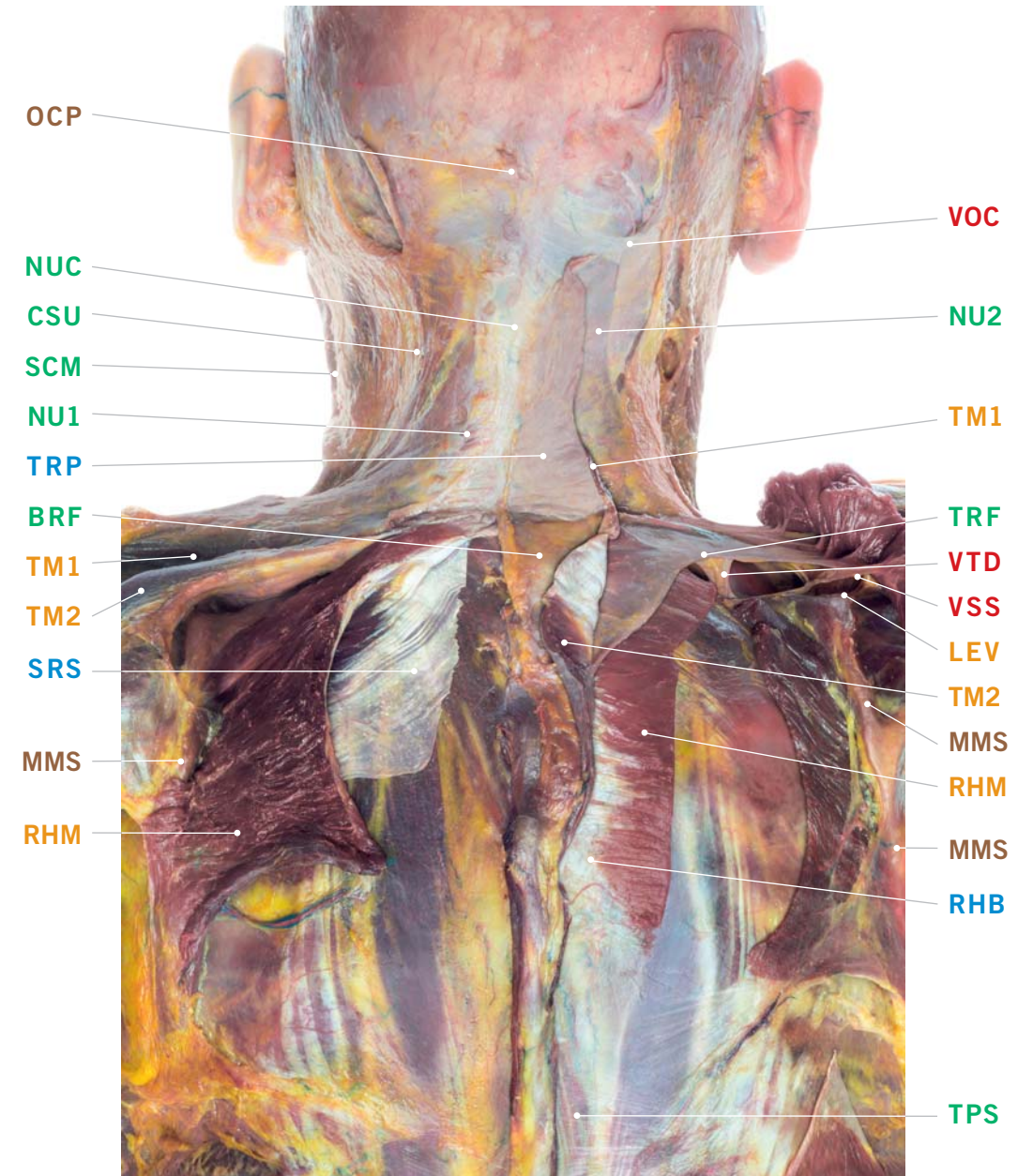


Neck from posterior

From the **Protuberantia occipitalis externa OCP** the **Lig. nuchae NUC** reaches inferiorly. **NUC** merges with **F. nuchae, superficial layer NU1** and **F. nuchae, middle layer NU2**. Both cover the **M. trapezius, upper part TM1**. The **Aponeurosis of the M. trapezius TRP** also contributes to **NUC**. From **NU1** to lateral the **F. cervicalis superficialis CSU** reaches the outer layer of **F. sternocleidomastoidea SCM**, a sheath of **CSU**. An arch from **NUC** to **CSU** forms a sheath for both the **A. occipitalis et N. occipitalis major VOC** which reach the occiput at the *Galea aponeurotica*⁴³, which is here partly removed. Lateral to **NU2** brown fat is visible, covered by **NU1**⁵⁷. This region refers to trigger point TrP1⁵¹.

The **M. trapezius, lower part TM2** likewise inserts to **NUC** via **TRP**. **Interscapular fat BRF** covers both. Below the merging of **TM1** and **TM2** an elastic **Subtrapeziusfascia TRF** reaches laterally. **TRF** becomes superficially visible in a fine line between **TM1** and **TM2** and ends at **TRP**.

TRF posteriorly crosses 1.: the **M. levator scapulae LEV**, 2.: the **Sheath for N. thoracodorsalis and vessels VTD** and 3. the **Sheath of the Vasa suprascapularis and N. suprascapularis VSS**. **TRF** forms a gliding lamella below **TRP** which covers both **M. rhomboideus major et minor RHM** together with the medial **Aponeurosis of M. rhomboideus major et minor RHB**. The muscles insert to **Margo medialis scapulae MMS**. We released **RHM** medially. By doing so, the **Aponeurosis of the M. serratus superior SRS** becomes visible, which covers the **F. thoracolumbalis, posterior layer, superficial lamina TPS**⁸¹.



View in the left greater pelvis with gut, inferior view, pancreas elevated

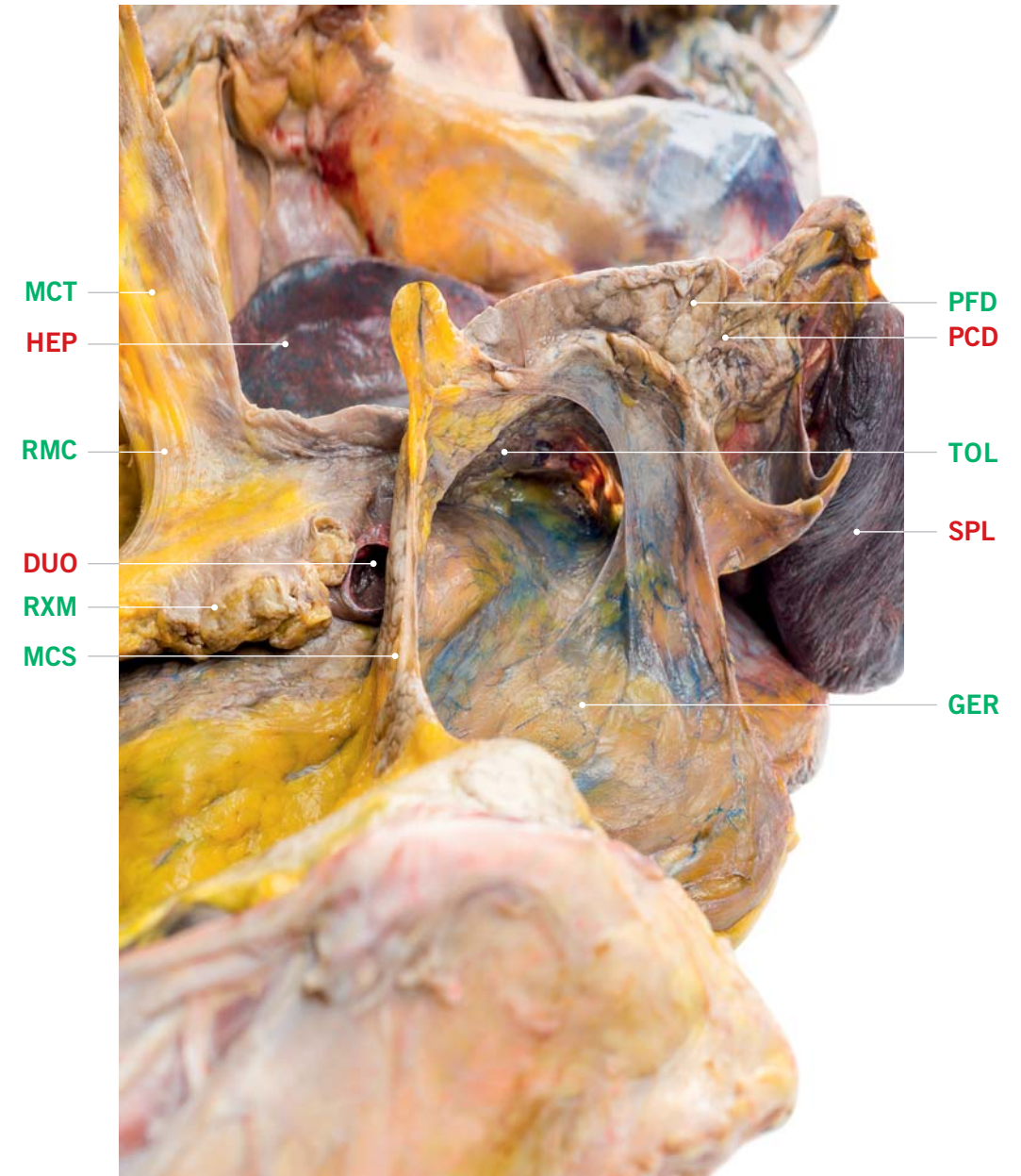
Mesocolon transversum MCT with **Radix mesocolica RMC** are elevated. The cut **Radix mesenterii RXM** adheres to **RMC** with **MCT**. The *Pancreas* is covered inside by both the inserting **RMC** and **RXM**.

Posteriorly, the *Flexura duodenojejunalis* of **Duodenum DUO** comes into view after cutting the *Jejunum*. Left of **DUO**, the *Plica paraduodenalis* is spanned anteriorly by sutures. **F. renalis Gerota GER** is revealed by removal of **Mesocolon sigmoideum MCS**. **Cauda pancreatis PCD** becomes visible after cutting **RMC** and parts of **MCT**. **PCD** reaches the region of the **Spleen SPL**.

The cut Meso with the **RMC** allows a posterior view, behind the posterior wall of the *Bursa omentalis*. We also use the term Meso for the fixed holding portions of the alimentary canal¹¹⁴. Posteriorly of **PCD**, the **fusing Fascia of Toldt TOL** is underlying this wall, re-enforcing **RMC**¹¹¹. **TOL** envelops both **DUO** and **PCD** from inferior, reaches the area behind both **PCD** and the still hidden *Corpus pancreatis* and ascends posteriorly, thinning. This postpancreatic part of **TOL**¹¹⁵ forms the posterior border of the *Bursa omentalis* as well as of the **MCT**.

However, the **PCD** is enveloped by another fine fascia, which directly continues onto **SPL**, covering it. This is referred to as **Fascia of Corpus and Cauda pancreatis PFD** a part of the the **TOL**. Dorsomedial to the **PFD** adherent parts of **MCS** arise. It is seen that neither **MCS**, nor **RMX** or **MCT** arise from **PCD**. **MCS** reaches posteriorly the **F. renalis Gerota GER**, which covers the left kidney and continues to **SPL** as *Lig. splenorenale*. However, **PFD** is apart from the latter and continues onto **PCD** to cover **SPL**. This is understandable, as **PFD**, **TOL**, *Caput pancreatis* and **SPL** all develop within and interact with the *posterior embryonal mesentery* or *Mesenterium dorsale*¹¹³, which remains connected by to *Corpus* and *Cauda pancreatis* via **PFD**.

The space behind of the posterior border of the *Bursa omentalis* and anterior of **GER** can be traced behind the stomach (not in view) to end at its *Cardia* when passing the *Diaphragma*, the contour of which is seen in the background of the picture. The space of the **Hepar HEP** remains apart from **MCS**.



Right Fossa poplitea with Pes anserinus superficialis et profundus

Superiorly, the **F. lata LAT** and underlying *Superficial Fascia* still remains. **LAT** continues distally to **F. cruris, Pars superficialis CRU**. In the opened *Fossa poplitea*, craniolateral the **Tendo of M. biceps femoris BCF** is seen. Craniomedially, **M. semimembranosus SEM** borders with **BCF** creating space for the **Sheath for N. tibialis and Vasa poplitea VPO**. **M. semitendinosus SET** continues medially. The **Tendo of M. gracilis GRA** is seen accompanying **SET** medially. More medial, **M. sartorius SAR** is seen reaching the area of **CRU** from anterior, together with superficial veins of *V. saphena magna*. The connection of those veins to the deeper layer is seen by the tension of the median **CRU**; one of these marked as **Dodd's vein via Fascia DOD**.

The *Pes anserinus (superficialis)* and its adherence to **CRU** can be demonstrated, by following **SAR**'s insertion at **CRU**, to its **Sartoriusfascia SAF**. **SET** continues to the **Tendo of M. semitendinosus STT**. **GRA**, already tendon-like, merges with **CRU**. However, the *Pes anserinus (superficialis)* is connected to the **Tibia TIB** differently, forming different spaces.

The tendon of **SEM** also forms a comparable structure, which is often called *Pes anserinus (profundus)*. Note here the marked **Boyd's vein BOY**. It comes via **CRU**, passing the connections of *Pes anserinus* to **TIB**, also reaching the anterior *V. saphena magna*¹³⁴.

Laterodistally, **VPO** becomes covered by **M. gastrocnemius, Caput mediale GCM** and **M. gastrocnemius, Caput laterale GCL**. The latter is covered by *V. saphena parva*. Hence, a connection of this vein is seen reaching superiorly.

In the region of *M. gastrocnemius*, other perforating veins are seen passing fascia. One of those veins reaches the **VPO** onto the distal **GCL**, perforating **CRU** as a **Cockett's vein CCK**. **GCM** and **GCL** respectively are beneath **CRU**, which is removed until the perforation of **CCK**. The **CCK** reaches *V. saphena parva* in the angle between **SEM** and **BCF**. Here, the *N. fibularis* is slightly visible in the fatty connectives. Another **CCK** is obvious medially of **GCM**, perforating the space beneath **SAF** and the thick medial **CRU**. This is a *Sherman's vein* reaching *V. saphena magna*¹³⁵ named paratibial perforator vein¹³⁴.

