# Head & Neck (Ashwani Sir)

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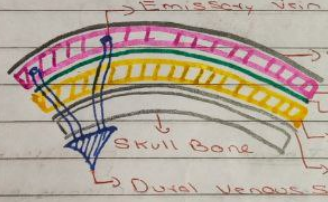
## # Scalp & Osteology

### ★ Scalp (5 layers)

S - Skin
C - Connective Tissue
A - Aponeurosis
L - Loose Areolar Tissue
P - Pericranium

→ Surgical layers of Scalp
↓
If we move scalp layer of head using fingers, these three move together (adherent)




→ Skin:- Thick, Hairy & Sweat Glands
↑ Sebaceous Glands → Sebaceous Cyst
Site for

- Sebaceous Cyst:- Sebaceous glands are blocked, which open close to hair follicle.
↓
Accumulate (secretion) under skin as can't come out

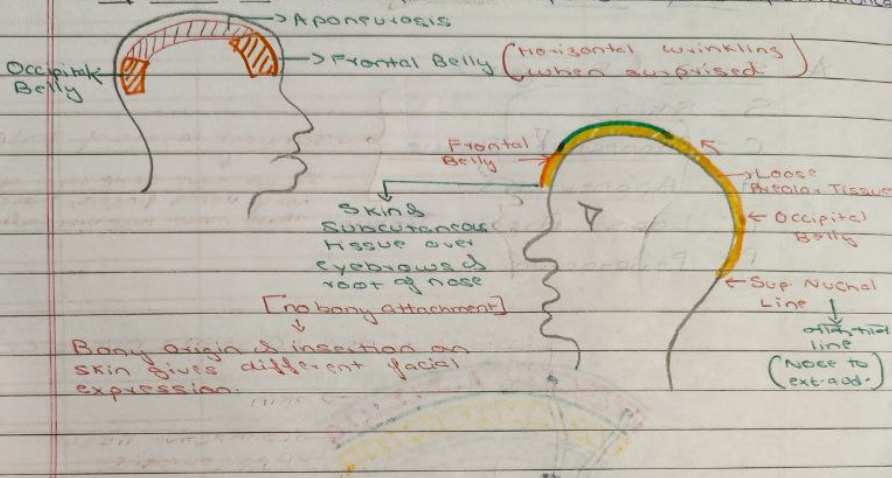
→ Connective Tissue:- Dense fibrous CT
- Bind Skin (1st layer) to Aponeurosis (III rd layer)
- Layer of Nerve & Blood Vessels

★ Clinical:- Vessels are adherent to dense CT. Hence, injury leads to profuse bleeding as BV can't retract
Dense CT holds the wall of BV.
- Hence if injury to scalp, press opposite → against bone itself.

2 bellies — Occipito-frontalis

2 bellies — Diff. to differentiate as close

→ **Aponeurosis:-** OR **Epicranial Apo.** OR **Galea Aponeurotica**
- on the cranium
- "Helmet"




→ **Loose Areolar Tissue** — Reflect from this
- Dangerous layer of scalp
- Cleavage layer/plane
- Responsible for safety valve hematoma
- 2nd layer to DVS
- Infection either direction
- Traversed by many emissary vein
  - No valves
  - Dangerous layer
  - Course appreciate here, space here

- Helpful too, say if pressure ↑ in DVS (DVS to II)
  - Skull can't expand

Clinical — not only due to direct injury to eye

→ **Black Eye:-** If head injury, blood accumulates in loose areolar tissue. Blood comes down, accumulates around eyeball. [Frontalis muscle no bony attachment]

→ Transverse wound will have more gape due to pull of occipito-frontalis muscle.

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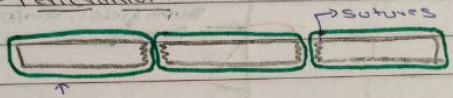
Safety Valve Hematoma :- If not fracture, skull can't expand. Bleeding compress brain

↳ Helpful in fracture of skull (Cranial vault)

↳ Tearing of dura & Pericranium. Intracranial Haemorrage communicate to loose areolar tissue.

↳ Therefore avoids cerebral compression

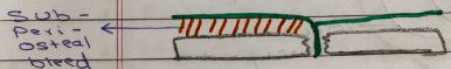
→ Pericranium




- Doesn't jump from bone to bone
- Goes through suture, communicates / continues as endocranium.

✱ Clinical

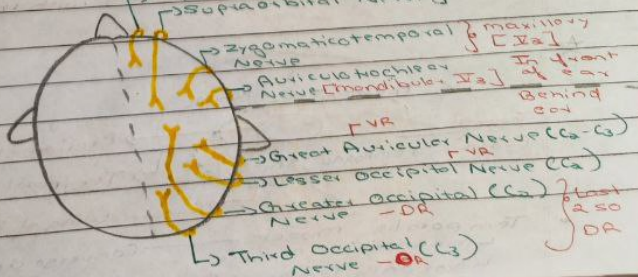
- Cephalohematoma




↳ Bounded by sutures ↳ Usually in Parietal Bone

↳ Bleeding take shape of bone

- Nerve Supply



- Left Common Carotid → direct branch from aorta

— Temporal Fascia ┌ Thickest in body
  └ Thick fascia
  └ over temporalis muscle
  └ Attach to zygomatic process

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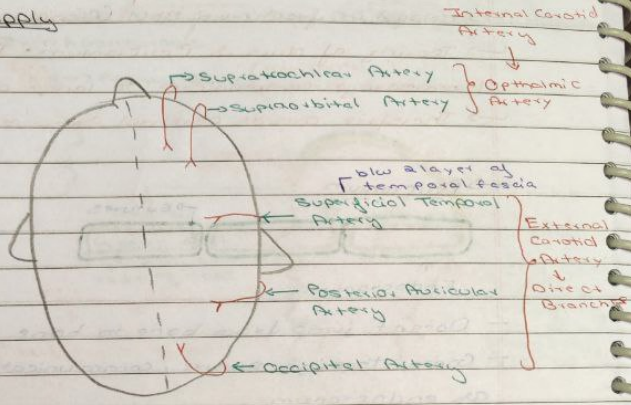
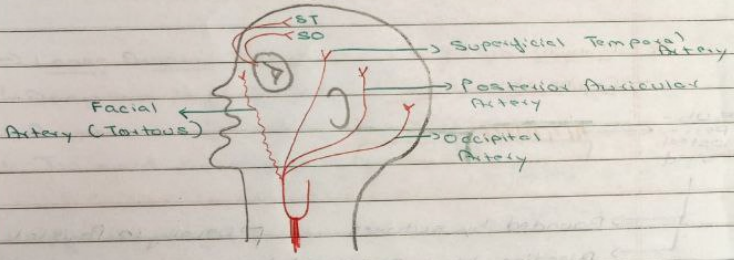
- Blood Supply

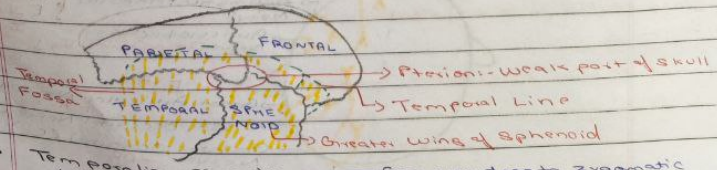



View from top →




★ Clinical: ┌ Craniotomy incision
→ If we want to open scalp, we open from top so the blood vessels remain intact with the flap.

★




- Temporalis muscle ——— Converge deep to zygomatic arch on to mandible
  └ mastication muscle
  └ Not only Temporal (P, F, S too)

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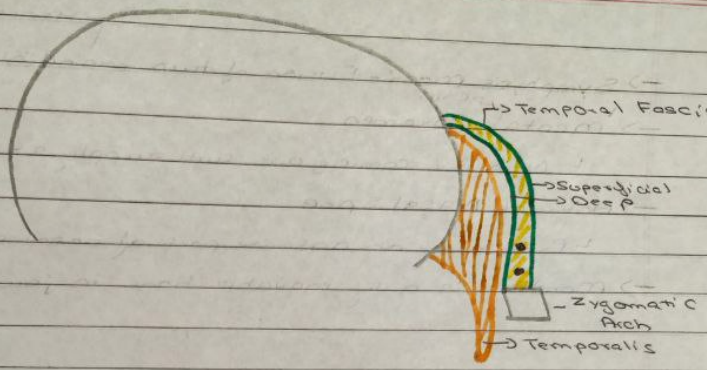



☆ Clinical:-

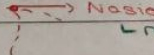
— Tympanoplasty:-

└ Repair of tympanic membrane

└ Graft usual taken from temporal fascia

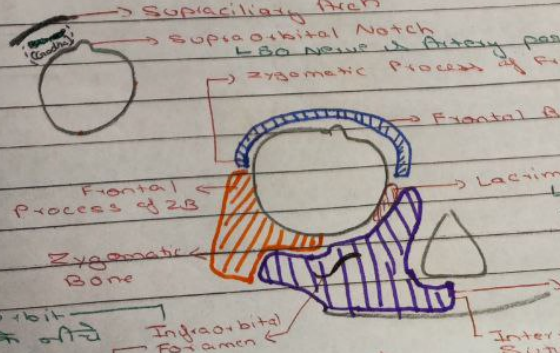
# FACE

- Frontal Eminence:- 'Bumps' on frontal bone (forehead)
- Internasal suture:- b/w nasal bone
- Fronto-nasal suture:- Separate frontal & nasal bone




└ Meeting point of internasal & fronto-nasal suture

- Glabella:- Where we put 'bindi'
- 



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-> Symphysis Menti - Fusion of two mandible ← Hence taken one
-> Mental Foramen ← chin
  ↳ N & BV coming out will supply skin of chin
-> Anterior Nasal Spine
  ↳ Prominence on anterior part of nasal aperture
-> Mandible is only movable bone in jaw