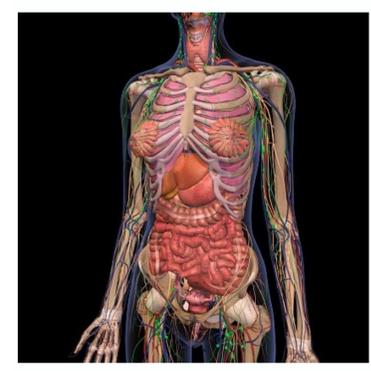


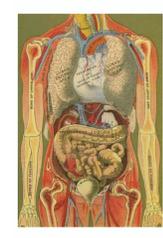
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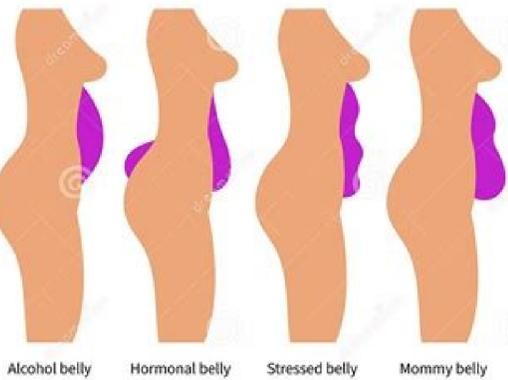




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Parts of lower abdomen in female. Parts of the stomach female. Where is the abdomen in a female.

Human Anatomy Medically Reviewed by Sabrina Felson, MD on July 09, 2020 © 2014 WebMD, LLC. All rights reserved. The abdomen (commonly called the belly) is the body space between the thorax (chest) and pelvis. The diaphragm forms the upper surface of the abdomen. At the level of the pelvic bones, the abdomen ends and the pelvis begins. The abdomen contains all the digestive organs, including the stomach, small and large intestines, pancreas, liver, and gallbladder. These organs are held together loosely by connecting tissues (mesentery) that allow them to expand and to slide against each other. The abdomen also contains the kidneys and spleen. Many important blood vessels travel through the abdomen, including the aorta, inferior vena cava, and dozens of their smaller branches. In the front, the abdomen is protected by a thin, tough layer of tissue called fascia. In front of the fascia are the abdominal muscles and skin. In the rear of the abdomen are the back muscles and spine. Peritonitis: Inflammation of the covering of the abdominal structures, causing abdominal wall rigidity and severe pain. Usually, this is due to a ruptured or infected abdominal organ. Acute abdomen: A medical phrase doctors use to suggest that peritonitis or some other emergency is present and surgery is likely needed. Appendicitis: Inflammation of the appendix, in the lower right colon. Usually, an inflamed appendix must be removed by surgery. Cholecystitis: Inflammation of the gallbladder, causing severe right-sided abdominal pain. A gallstone blocking the duct exiting the gallbladder is usually responsible. Dyspepsia: The feeling of an upset stomach or indigestion. Dyspepsia can result from benign or more serious conditions. Constipation: Having fewer than three bowel movements per week. Diet and exercise may help but many people will need to see their health care providers. Gastritis: Inflammation of the stomach, often causing nausea and/or pain. Gastritis can be caused by alcohol, NSAIDs, H. pylori infection, or other factors. Peptic ulcer disease: Ulcers are erosions and peptic refers to acid. Peptic ulcers are ulcers in the stomach and duodenum (the first part of the small intestine). The usual cause is either an infection with H. pylori or taking anti-inflammatory medications like ibuprofen. Intestinal obstruction: A single area of the small or large intestine can become blocked or the entire intestine may stop working. Vomiting and abdominal distension are symptoms. Gastroparesis: The stomach empties slowly due to nerve damage from diabetes or other conditions. Nausea and vomiting are symptoms. Pancreatitis: Inflammation of the pancreas. Alcohol and gallstones are the most common causes of pancreatitis. Other causes include drugs and trauma; about 10% to 15% of cases are from unknown causes. Hepatitis: Inflammation of the liver, usually due to viral infection. Drugs, alcohol, or immune system problems can also cause hepatitis. Cirrhosis: Scarring of the liver caused by chronic inflammation. Heavy drinking or chronic hepatitis are the most common causes. Ascites: Abdominal fluid buildup often caused by cirrhosis. Ascites may cause the abdomen to protrude impressively. Abdominal hernia: A weakening or gap in the abdominal fascia allows a section of the intestine to protrude. Abdominal distension: Swelling of the abdomen, usually due to an increased amount of intestinal gas. Abdominal aortic aneurysm: A weakening of the aorta's wall creates a balloon-like expansion of the vessel that grows over years. If abdominal aortic aneurysms grow large enough, they may burst. Physical examination: By listening with a stethoscope, pressing, and tapping on the abdomen, a doctor gathers information that helps diagnose abdominal problems. Upper endoscopy (esophagogastroduodenoscopy or EGD): A flexible tube with a camera on its end (endoscope) is inserted through the mouth. The endoscope allows examination of the stomach and duodenum (small intestine). Lower endoscopy (colonoscopy): An endoscope is advanced through the anus into the rectum and colon. Colonoscopy can help identify problems in these areas, such as appendicitis and cancer. Magnetic resonance imaging (MRI scan): Using radio waves in a magnetic field, a scanner creates highly detailed images of the abdomen. In the abdomen, MRI is usually used to check the liver, pancreas, and gallbladder, but a CT scan may also be used. Abdominal ultrasound: A probe on the abdomen reflects high-frequency sound waves off the abdominal organs, creating images on a screen. Ultrasound can detect problems in most abdominal organs, such as the gallbladder, liver, and kidneys. Endoscopic retrograde cholangiopancreatography (ERCP): Using an endoscope advanced to the intestine, a tube is placed into the duct from the pancreas and a fluid that blocks X-rays is squirted into the tubes that serve the gall bladder, liver, and pancreas. Then an X-ray picture is taken to find problems with those organs. pH testing: Using a tube through the nose or a capsule in the esophagus, acid levels in the esophagus can be monitored. This can help diagnose GERD or evaluate a treatment's effectiveness. Upper GI series (with small bowel follow-through): After swallowing a barium solution, X-ray films of the esophagus and stomach are taken. This can sometimes diagnose ulcers or other problems. In some cases they continue taking pictures as the barium courses through the small intestine. Gastric emptying study: A test of how rapidly food passes through the stomach. The food is labeled with a radioactive substance and its movement viewed on a scanner. Biopsy: A small piece of tissue is taken to help diagnose cancer, liver or other problems. Abdominal surgery: Surgery is often necessary for serious abdominal conditions like cholecystitis, appendicitis, colon or stomach cancer, or an aneurysm. Surgery may be laparoscopic (several small incisions and using a camera and small tools) or open (one large incision, what most people think of as a typical surgery). Histamine (H2) blockers: Histamine increases stomach acid secretion; blocking histamine can reduce acid production and GERD symptoms. Proton pump inhibitors: These medicines directly inhibit the acid pumps in the stomach. They must be taken daily to be effective. There is, though, some concern about taking them for more than a few months. Endoscopy: During upper or lower endoscopy, tools on the endoscope can sometimes treat problems (like bleeding or cancer) that are discovered. Motility agents: Medicines can increase contraction of the stomach and intestines, improving symptoms of gastroparesis or constipation. Antibiotics: H. pylori infection can be cured with antibiotics, which are taken with other medicines to help heal the stomach. Laxatives: Various over-the-counter and prescription medicines can help relieve constipation. © 2020 WebMD, LLC. All rights reserved. View privacy policy and trust info The abdominal wall is composed of 5 paired muscles: 2 vertical muscles (the rectus abdominis and the pyramidalis) and 3 layered, flat muscles (the external abdominal oblique, the internal abdominal oblique, and the transversus abdominis muscles). These muscles and their fascial attachments interdigitate and unite to form a sturdy, protective musculofascial layer that gives strength and support to the anterolateral abdominal wall (see the images below). Layers of the abdominal wall. Muscular layers of the abdomen. Ext. = exterior; fasc. = fascia; Inf. = inferior; Int. = interior; m. = muscle. The external abdominal oblique muscle is the largest and most superficial of the 3 paired, flat abdominal muscles. It arises from the lower 9 ribs and interdigitations of the serratus anterior muscle. As the external abdominal oblique courses in an inferior medial direction, its muscle fibers change from thick muscle to a fibrous aponeurosis that inserts medially in the linea alba. Inferiorly, the external abdominal oblique aponeurosis folds back on itself to form the inguinal ligament between the anterior superior iliac spine and the pubic tubercle before inserting onto the pubic tubercle and the anterior half of the iliac crest. Just medial to its insertion on the pubic tubercle, the aponeurosis divides and forms the superficial (or external) inguinal ring. [2] The external abdominal oblique is innervated in a segmental pattern by the anterior rami of the inferior 6 thoracoabdominal nerves (T7-T12). [1] The internal abdominal oblique muscle is the intermediate layer of the 3 paired, flat abdominal muscles. It originates broadly from the anterior portion of the iliac crest, lateral half of the inguinal ligament, and thoracolumbar fascia. The internal abdominal oblique inserts on the inferior border of the 10th-12th ribs, the linea alba, and the pubic crest via the conjoint tendon. The muscle fibers of the internal abdominal oblique course upward in a superomedial orientation, perpendicular to the muscle fibers of the external abdominal oblique. Like the external abdominal oblique, the internal abdominal oblique forms a broad aponeurosis that fuses into the midline and contributes to the rectus sheath. Superior to the arcuate line (see the image below), the internal abdominal oblique aponeurosis splits anteriorly and posteriorly to enclose the rectus muscle and helps form the rectus sheath. However, inferior to the arcuate line, the internal abdominal oblique aponeurosis does not split and only passes anterior to the rectus muscle as part of the anterior rectus sheath. The arcuate line. a. = artery; Ant. = anterior; Ext. = exterior; Inf. = inferior; Int. = interior; m. = muscle; Post. = posterior; v. = vein. The inferior aponeurotic fibers of the internal abdominal oblique muscle course over the spermatic cord, through the inguinal canal, and the medial fibers fuse with the aponeurosis of the transversus abdominis muscle to form the conjoint tendon. [3] The internal oblique is innervated in a segmental pattern by the anterior rami of the inferior 6 thoracoabdominal nerves (T7-T12) and first lumbar nerves (iliohypogastric and ilioinguinal nerves). Of note, all the neurovascular structures supplying the abdominal muscles run in the plane between the internal abdominal oblique muscle and the transversus abdominis muscle, except for the iliohypogastric and ilioinguinal nerves. Initially, they lie on the anterior surface of the quadratus lumborum, then pass laterally into the plane between the transversus abdominis and the internal abdominal oblique. Above the anterior superior iliac spine, they penetrate the internal abdominal oblique and the aponeurosis of the external abdominal oblique muscle. The transversus abdominis muscle is the deepest of the 3 paired, flat abdominal muscles. It originates on the internal surfaces of the 7th-12th costal cartilages, thoracolumbar fascia, anterior three-fourths of the iliac crest, and lateral third of the inguinal ligament. As with the other flat muscles, the transversus abdominis forms a broad aponeurosis that helps make up the rectus sheath before it fuses in the midline to the linea alba. Above the arcuate line, the transversus abdominis aponeurosis contributes to the posterior rectus sheath. Below the arcuate line, it is fused with the other flat muscles as the anterior rectus sheath. (See the image above.) As its name implies, the muscle and aponeurotic fibers run in a transverse direction, except for the inferior most aponeurotic fibers. These fibers curve in an inferomedial direction to unite with the aponeurosis of internal abdominal oblique to form the conjoint tendon, which attaches onto the pubic crest and the pectineal (Cooper) ligament. The inferior aponeurotic fibers are fused to the underlying transversalis fascia, thus forming the posterior wall of the inguinal canal. A small triangular opening in this posterior wall is known as the deep or internal inguinal ring. It is at this opening that the spermatic cord is formed (by the ductus deferens, testicular vessels, and genital branch of genitofemoral nerve) and through which all indirect inguinal hernias develop. [4] The transversus abdominis is innervated in a segmental pattern by the anterior rami of the inferior 6 thoracoabdominal nerves (T7-T12) and first lumbar nerves (iliohypogastric and ilioinguinal nerves). The rectus abdominis muscles are paired, long muscles that run just lateral to the linea alba in a vertical direction from the xiphoid process of the sternum and costal cartilage of the 5th-7th ribs to the pubic symphysis. These muscles function to tense the abdominal wall, flex the trunk, stabilize the pelvis, and aid in childbirth, defecation, micturition, and forced expiration. Each muscle is divided along its course by 3 or 4 transverse fibrous bands known as tendinous intersections, which essentially divide the muscle into a series of interconnected muscles. This results in one's "abs" or "six-pack." The rectus muscles are contained within the rectus sheath, which is formed by the aponeuroses of the external abdominal oblique, internal abdominal oblique, and transversus abdominis muscles. The rectus muscles have a dual blood supply. The superior epigastric artery and vein, which are direct continuations of the internal thoracic vessels, supply the superior half of the rectus muscles. The inferior epigastric artery and vein, which arise from the external iliac vessels just proximal to their passage under the inguinal ligament, supply the inferior portion of the rectus muscles and run superiorly until they anastomose with the superior epigastric vessels. In addition, there are numerous small, segmental contributions from the lower 6 intercostal vessels (see the image below). [3] Abdominal wall vasculature. The rectus muscle is innervated in a segmental pattern by the anterior rami of the T7-T12 thoracoabdominal nerves. [1] The pyramidalis muscle is a small, triangular muscle that lies anterior to the inferior aspect of the rectus abdominis muscles. It originates at the pubic symphysis and attaches superiorly at the linea alba. This muscle functions to tense the linea alba and aid in midline stabilization. The pyramidalis muscle is generally considered insignificant in humans and is, in fact, absent in about 20% of the population. [3] Approximately midway between the umbilicus and the pubic symphysis is an arching, transverse anatomic line known as the arcuate line or the semicircular line of Douglas. Superior to this line, the anterior rectus sheath is composed of the fusion of the aponeuroses of the external abdominal oblique and the anterior leaf of the internal abdominal oblique aponeuroses. (The internal abdominal oblique aponeurosis splits to envelop the rectus muscle at this level.) The posterior rectus sheath above the arcuate line is composed of the fusion of the posterior leaf of the internal abdominal oblique aponeuroses and the transversus abdominis aponeuroses. Inferior to the arcuate line, the anterior rectus sheath is composed of the fusion of all 3 muscle aponeuroses, and little or no posterior sheath exists, because only the thin transversalis fascia runs posterior to the rectus muscle (see the image below). [1, 5] The arcuate line. a. = artery; Ant. = anterior; Ext. = exterior; Inf. = inferior; Int. = interior; m. = muscle; Post. = posterior; v. = vein. The linea alba is a dense, tendinous line created by the decussating aponeuroses of the external abdominal oblique, internal abdominal oblique, and transversus abdominis muscles at the abdominal midline. Between the rectus muscles, it extends superiorly from the xiphoid, continuing inferiorly, where it passes superficially in front of the rectus muscles to attach to the symphysis pubis. Deeper fibers pass behind the rectus abdominis, attaching to the posterior pubic crest to create a triangular lamella known as the "admiricium lineae albae." [2] Above the umbilicus, the well-formed linea alba is wider, progressively narrowing and becoming more vague below the umbilicus to its inferior attachments. The midline laparotomy incision, dividing the linea alba, is one of the most common surgical approaches for abdominal exposure and the most common site of incisional hernia formation. [4] Widening of the superior linea alba can cause a noticeable midline bulge known as a diastasis recti, or separation of the rectus muscles. Diastasis recti is a common and normal condition in newborns and is very common in women who have had multiple pregnancies.

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