Anatomy of the Abdominal Wall and Pelvic Floor

Do not fear the pelvic floor—although this topic is popular amongst examiners and seems to be complicated at first glance, there is no need for fear. Here, you get a compact overview and learn everything you need to know about the pelvic floor, the abdominal wall, and the inguinal canal.

Structure of the Bony Pelvis

The pelvis consists of the sacral bone, coccygeal bone, and the paired hipbone. The bones are connected with each other via strong ligaments. On the anterior side, the hipbones fuse to form the pubic symphysis. Dorsally, they are connected to the sacral bone via the taut sacroiliac joint.

The symphysis is sealed by the fibrocartilage interpubic disc. Ligament structures reinforce the connection. The iliosacral joint is an amphiarthrosis with little mobility. It is secured by strong ligaments. During pregnancy, the ligaments between the symphysis and the iliosacral joint loosen, which allows for the enlargement of the birth canal through small movements.
Parts of the Pelvis

The pelvic skeleton with the hipbone and the sacral bone forms a bony funnel. It is divided into an upper **greater pelvis** (pelvis major)—formed by the wings of the ilium, which enclose the bowels—and a **lesser pelvis** (pelvis minor) located below it.

The border between the greater and lesser pelvis is the **terminal line**, which runs from the superior margin of the symphysis over the **pecten ossis pubis** and the **arcuate line** to the **promontory**.

The parts of the skeleton below the terminal line form the lesser pelvis, which contains the pelvic bowels. The lesser pelvis forms the pelvic canal, which, in women, also is the birth canal. It begins at the **superior pelvic aperture**, which is limited by the terminal line and ends with the **inferior pelvic aperture**, which is formed by the tip of the coccygeal bone, the ischial tuberosities, and the inferior pubic branches.

Pelvic Floor

The pelvic canal is caudally sealed by muscles and connective tissue plates. They form the pelvic floor. Its purpose is to safeguard the position of the abdominal and pelvic organs. Its muscles also contribute to the closure of the **anus** and **urethra**.

Parts of the Pelvic Floor

The pelvic floor is divided into **three muscle tiers**: the muscular **pelvic diaphragm** (superior tier) and the muscular-connective tissue ‘**urogenital diaphragm**’ (middle tier). Below the urogenital diaphragm (and therefore located furthest on the ‘outside’), there are the sphincter and cavernous body muscles (inferior tier).

The muscles of the pelvic floor are innervated by branches of the **pudendal nerve** and the **sacral plexus**.
Structure and Function of the Pelvic Diaphragm

The **pelvic diaphragm** is the upmost (innermost) layer of the pelvic floor. **It consists of the levator ani muscle with its three parts:**

- Puborectalis muscle
- Pubococcygeus muscle
- Iliococcygeus muscle

The fibers of the levator ani muscle that originates from the backside of the pubic bone (levator leg) form a V-shaped orifice that is open in a ventral direction and called **levator hiatus**. Ventrally, the urethra runs through the hiatus levatorius and, dorsally, the **rectum**. In women, the **vagina**, which lies between the rectum and urethra, also runs through it.

The muscle fibers insert around the anus in a funnel-shape. They give fibers to the **external anal sphincter** and radiate into the **central tendinous point of the perineum** in front of the rectum. Dorsally, the levator ani muscle is complemented by the inconsistent **ischio coccygeus muscle**, which runs along the **sacrospinal ligament**.

In a tense state, the levator ani muscle forms a transversal plate, which ensures anal continence by deviating the rectum. During defecation and in corpses, the muscles slacken and form a funnel-shape.

The muscles of the pelvic diaphragm are innervated by the **sacral plexus (S2—4)** and arterially supplied by the **internal pudendal artery**.
Structure of the Urogenital Diaphragm

Caudal from the pelvic diaphragm, there is a plate made out of connective tissue (central tendinous point of perineum) and muscles (deep transverse perineal muscle), which seals the ventral part of the levator hiatus. This plate is also referred to as ‘urogenital diaphragm’.

The deep transverse perineal muscle seals the levator hiatus with its horizontally running muscle fibers. It gives off fibers that form the external urethral sphincter muscle. The urethra and (in women) the vagina run through it.

At the dorsal margin of the deep transverse perineal muscle, there is the narrow superficial transverse perineal muscle.

The central tendinous point of perineum (centrum tendineum) is situated between the rectum and the urogenital diaphragm. It is a small area made out of rough connective tissue; smooth muscle fibers, tendons, and fasciae of the pelvic floor radiate into it. It separates the urogenital hiatus from the anal hiatus.

Passages through the Pelvic Floor

The anterior part of the levator hiatus is referred to as the urogenital hiatus, which is covered by the deep transverse perineal muscle. The urethra and the vagina pass through it.

The anal hiatus (anal canal) is formed by the posterior edge of the deep transverse perineal muscle (‘urogenital diaphragm’) and the medial parts of the levator thighs.

Fasciae of the Pelvic Floor

The muscles of the pelvic diaphragm are covered by a fascia on its upside and underside; these are the superior and inferior fasciae of the pelvic diaphragm.

Correspondingly, the urogenital diaphragm is covered by a superior and inferior fascia of the urogenital diaphragm.

The fasciae form the borders for the cavities in the pelvis space and the perineal region.

Outermost Layer of the Pelvic Floor

The sphincter and cavernous body muscles form the most caudally situated layer of the pelvic floor. They include the external anal sphincter muscle and the bulbospongiosus muscle. Their fibers also radiate into the central tendinous point of perineum.

Lateral, there is the ischiocavernosus muscle, which reinforces the cavernous bodies of penis and clitoris and the urogenital diaphragm.
Divisions of the Pelvic Space

The abdominal space located in the lesser pelvis, the pelvic cavity, is divided into several spaces by the peritoneum and the pelvic floor. Cranially, there is the peritoneal cavity of the lesser pelvis. Caudally of the peritoneum, there is the subperitoneal (supralevatoric) space, which is limited caudally by the upper fascia of the levator ani muscle (pelvic diaphragm). The infralevatoric space, also called ischioanal fossa, is below the levator ani muscle.

Caudally, there are the perineal spaces: the deep perineal space, which is almost completely covered by the deep transverse perineal muscle and its fasciae, and the superficial perineal space which is followed caudally by the subcutaneous perineal space.
Vessels and Nerves of the Pelvic Floor

The arterial supply of the pelvic wall and the pelvic floor is provided by branches of the **internal iliac artery**. It gives off the **iliolumbar artery** and the **lateral sacral arteries** towards the pelvic wall, and also the **internal pudendal artery**, which supplies pelvic and reproductive organs as well as the muscles of the pelvic floor.

The internal pudendal artery leaves the pelvis alongside the **pudendal nerve** through the **foramen infrapiriforme**, runs around the **sacrospinal ligament**, and then back into the lesser pelvis into the ischioanal fossa through the **minor ischiadic foramen**. There, it courses alongside the pudendal nerve through the **pudendal canal (Alcock’s canal)**, a duplicature of the fascia of the **internal obturator muscle**, in ventral direction. On its way, it gives off branches to the anal canal, to the perineal region, and to the outer genitals and the urethra.

The innervation of the muscular pelvic floor is provided by direct branches of the **sacral plexus (S2 - 4)** or by the **pudendal nerve** from the same plexus. The pudendal nerve also provides sensory innervation the outer genital organs, the skin of the perineum, and the perianal skin.

Venous drainage

**Foregut**

**Esophagus:**  
- Esophageal > left gastric > hepatic portal

**Stomach:**  
- Left & right gastric > hepatic portal  
- Left gastro-omental > splenic > hepatic portal  
- Right gastro-omental > superior mesenteric > hepatic portal

**Gallbladder:**  
- Cystic > hepatic portal

**Midgut and hindgut**

**Ileum and jejunum:**  
- Ileal and jejunal > superior mesenteric > hepatic portal

**Caecum and appendix:**  
- Ileocolic (appendicular) > superior mesenteric > hepatic portal

**Ascending and transverse colon:**  
- Right colic/ middle colic > superior mesenteric > hepatic portal

**Descending colon:**  
- Middle colic/ left colic > inferior mesenteric > splenic > hepatic portal

**Sigmoid colon and rectum:**  
- Sigmoidal/ superior rectal > inferior mesenteric > splenic > hepatic portal
Pelvic Floor Insufficiency: Development and Consequences

The pelvic floor has several tasks to cover: One one hand, it is supposed to seal the pelvic space and, thus, secure the abdominal and pelvic organs. On the other hand, it controls the sphincter function of the rectum and urinary and genital tracts. Providing passages to these structures lowers the mechanical capacity of the pelvic floor. Weakening of connective tissue and/or muscles can lead to insufficiency of the pelvic floor.

The pelvic organs, e.g. the uterus, might be displaced downward (prolapse of uterus, descensus uteri). This can be the result of, for instance, numerous childbirths. In extreme cases, the displacement of the uterus can go so far as to leave it entirely outside the vagina (third-degree prolapse). Secondary to the uterine prolapse, a descent of the urinary bladder can occur.

A descent of the pelvic floor is often accompanied by incontinence. In mild cases, training of the pelvic floor muscles with pelvic re-education is sufficient treatment; in severe cases, surgical intervention has to be considered.

Abdominal Wall and Inguinal Region

The abdominal cavity and pelvic cavity are surrounded by muscles of the abdominal wall. The pelvis and the pelvic floor muscles seal the abdominal and pelvic cavity in caudal direction; in the cranial direction, the abdominal cavity is bordered by the diaphragm.

Dorsally, there are the posterior abdominal muscles, the back muscles, and the lumbar spine. The anterior and lateral abdominal muscles—the actual abdominal wall—are located ventrally and laterally.
Muscles of the Abdominal Wall

The **abdominal muscles** are divided into:

- Lateral group: obliquus externus abdominis, obliquus internus abdominis, transversus abdominis muscle
- Medial group: rectus abdominis muscle, pyramidalis muscle
- Posterior group: quadratus lumborum muscle, psoas major muscle.

The tendons of the lateral abdominal muscles (aponeuroses) intertwine at the midline to form a longitudinal tendinous line (**linea alba** - white line). In the middle of this line lies the navel (**umbilicus**). Lateral of the linea alba, the aponeuroses of the lateral abdominal muscles, together with the fasciae of the abdominal wall, form the rectus sheath. This sheath surrounds the rectus abdominis muscle up to a point about 4—6 cm below the navel.

Structure of the Rectus Sheath

The aponeurosis of the obliquus externus abdominis covers the **rectus abdominis muscle** ventrally from the outside, while the aponeurosis of the obliquus internus abdominis splits into two sheets laterally of this muscle. One of these sheets runs ventrally, while the other runs dorsally, of the rectus abdominis muscle. The anterior sheet fuses with the aponeurosis of obliquus externus; the posterior one merges with the transversus abdominis aponeurosis.

From about 4—6 cm below the navel (caudal of the so-called **arcuate line**), until reaching the **symphysis**, all aponeuroses of the lateral abdominal muscles run in front of the rectus muscle. The rectus sheath, located anterior, is formed by the aponeurosis of obliquus externus and both sheets of the aponeurosis of the obliques internus as well as by the aponeurosis of the transversus abdominis. Dorsally, the rectus abdominis muscle is only covered by the thin **transversal fascia** and the **peritoneum**.

Fasciae of the Abdominal Wall and Inguinal Ligament

The inner fascia of the abdominal and pelvic wall is the **transversalis fascia**. It extends into the **inguinal canal**, and there it continues as the **internal spermatic fascia**.

The outer **superficial abdominal fascia** radiates (along with the fascia lata of the thigh) caudally from the outside into the **inguinal ligament**.

The inguinal ligament originates from the **superior anterior iliac spine** and runs to the **pubic tubercle**. Between the ligament and the bony pelvis there is a free space, the **subinguinal region**. The **iliopectineal arch**, made out of connective tissue, divides the subinguinal region into the **lacuna vasorum** (medial) and the **lacuna musculorum** (lateral).

The **lacuna musculorum** contains:

- Iliopsoas muscle
- Femoral nerve
- Lateral femoral cutaneous nerve.

The following structures run through the **lacuna vasorum**:

- Femoral artery (lateral)
- Femoral vein (medial)
- Femoral nerve, genitofemoral nerve
- Proximal deep inguinal lymph node (Rosenmüller node).

**Course of the Inguinal Canal**

The **inguinal canal** is situated in the anterior abdominal wall, above the inguinal ligament. There, it runs from the upper lateral to the inferior medial direction, connecting inner and outer abdominal wall. The inguinal canal has a length of approximately 4 cm.

The inner orifice of the inguinal canal is the **deep inguinal ring** (internal inguinal ring). It is formed by the evagination of the **transversalis fascia**, which surrounds the spermatic cord as the **internal spermatic fascia**. The deep inguinal ring lies in the **lateral inguinal fossa**, lateral of the **inferior epigastric vessels**.

The **superficial inguinal ring** (external inguinal ring) also lies above the inguinal ligament. It is formed by a fissure in the aponeurosis of the obliquus externus abdominis. Projected on the inner abdominal wall, it is situated in the **medial inguinal fossa**, medial of the **inferior epigastric vessels**.

**Contents of the Inguinal Canal**

In men, the inguinal canal contains the **funiculus spermaticus** with the **cremaster muscle** and the **internal and external spermatic fascia**, the **ilioinguinalis nerve** and the **genital branch of the genitofemoral nerve**.

In women, the **teres uteri ligament**, the **teres uteri artery**, the **ilioinguinalis nerve** and the **genital branch of the genitofemoral nerve** run through the inguinal canal.
Boundaries of the Inguinal Canal

A popular subject in exams are the boundaries of the inguinal canal:

- Cranial: inferior edge of the obliquus internus abdominis muscle and the transversus abdominis muscle;
- Caudal: inguinal ligament (ligamentum reflexum, caudal fibers of the aponeurosis of obliquus externus);
- Ventral: aponeurosis of the obliques externus abdominis muscle;
- Dorsal: transversalis fascia, interfoveolar ligament.

Inguinal Hernia

In those parts of the abdominal wall where the musculature is not continuous, the chronically increased pressure in the abdominal cavity can lead to an evagination (protrusion) of parietal peritoneum and parts of organs through the surrounding muscles. This is called a hernia.

Inguinal hernias represent the most frequent form of hernias. One distinguishes between indirect (lateral) and direct (medial) as well as congenital and acquired inguinal hernias.

Congenital inguinal hernias are always indirect. The hernial orifice is the deep inguinal ring. The hernial sac makes its way through the inguinal canal and the external inguinal ring into the scrotum.

Through an expansion of the internal inguinal ring, an indirect inguinal hernia can also form in advanced age (acquired indirect inguinal hernia).

A direct inguinal hernia is always acquired. The inner hernial orifice is located in the medial inguinal fossa; the hernial sac passes through the thin abdominal wall, which at this point only consists of transversalis fascia and peritoneum, and protrudes to the outside through the superficial inguinal ring.

Thus, both direct and indirect inguinal hernia come out through the external inguinal ring above the inguinal ligament. In a femoral hernia, however, the hernial sac comes through the lacuna vasorum and appears below the inguinal ligament.
Review Questions

Solutions can be found below the references.

1. The pudendal nerve runs through the Alcock’s canal, a duplicature of the fascia of the

   1. External obturator muscle.
   2. Internal obturator muscle.
   4. Piriformis muscle.
   5. Psoas major muscle.

2. The hernial orifice of an indirect inguinal hernia...

   1. ...is always located in the medial inguinal fossa.
   2. ...is located in 2/3 of the cases in the lateral inguinal fossa.
   3. ...is the deep inguinal ring.
   4. ...lies medial of the epigastric vessels.
   5. ...lies below the inguinal ligament.

3. Which structure runs through the levator hiatus?

   1. Intestinal canal
   2. Bulbus penis
   3. Pudendal nerve
   4. Obturator nerve
   5. Inguinal canal

References


Correct answers: 1B, 2C, 3A

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