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Wolters Kluwer Health | Ovid — Primal Pictures Interactive Anatomy

ANATOMY.TV

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Due to the growth in the use of our products, Primal Pictures must upgrade its servers and firewalls to increase the capacity of our systems. This will affect all our web sites on **Sunday, October 9th, from 10:00 am until 4:00 pm British Standard Time.**

Product Quizzes

Systemic Anatomy

Systemic Edition

Sports & therapy

- Acupuncture
- Anatomy for Exercise
- Anatomy Trains - Second Edition
- Functional Anatomy
- Hand Therapy
- Pilates
- Sports Injuries: Foot 2/e
- Resistance Training
- Sports Injuries: Knee 2/e
- Sports Injuries: Shoulder 2/e

Regional Anatomy

Human Anatomy Regional Series:

- Head & Neck
- Spine
- Shoulder
- Hand
- Thorax & Abdomen
- Pelvis
- Hip
- Knee
- Foot

Primal Interactive Human:

Other titles by Region:

- Essential Regional Anatomy
- Regional Study Guide

Speciality titles

- 3D Head: basic neuroanatomy
- 3D Head: pediatric comparisons
- Dentistry
- 3D Real-time Dentistry
- Hand 2/e
- Radiology: Thorax, Trunk
- Urology
- Spine: Clinical
- Spine: Chiropractic
- Pelvic Floor Disorders

Surgery

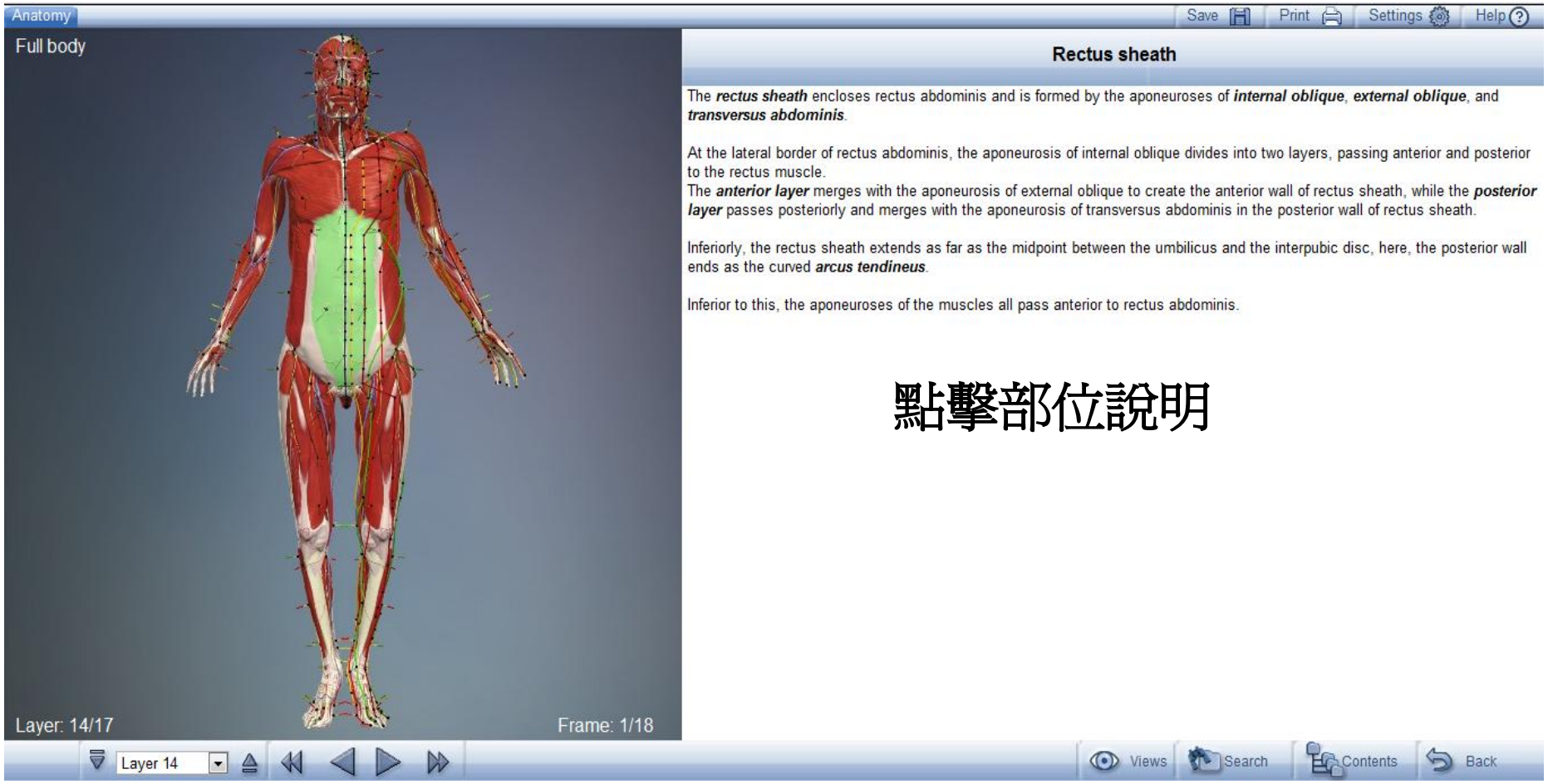
- Axilla
- Knee
- Knee Arthroplasty
- Hip Arthroplasty
- Podiatric Medicine

模組區份

- **區域**
  - 按人體的各部位做模組的呈現
    - Ex. 頭、頸、手、足……等九個部位
- **主題**
  - 按特定主題呈現解部位
    - Ex. 3D頭部、牙科、脊椎……等10個主題
- **手術**
  - 針對手術的主題獨立出來，共計5個主題
- **運動、治療**
  - 針對治療及運動傷害所獨立出來的主題
    - Ex. 針灸、皮拉提斯……等共計10個主題

運動醫學 – 針灸

全身圖示



點擊部位說明

轉換部位

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針位說明

Anatomy

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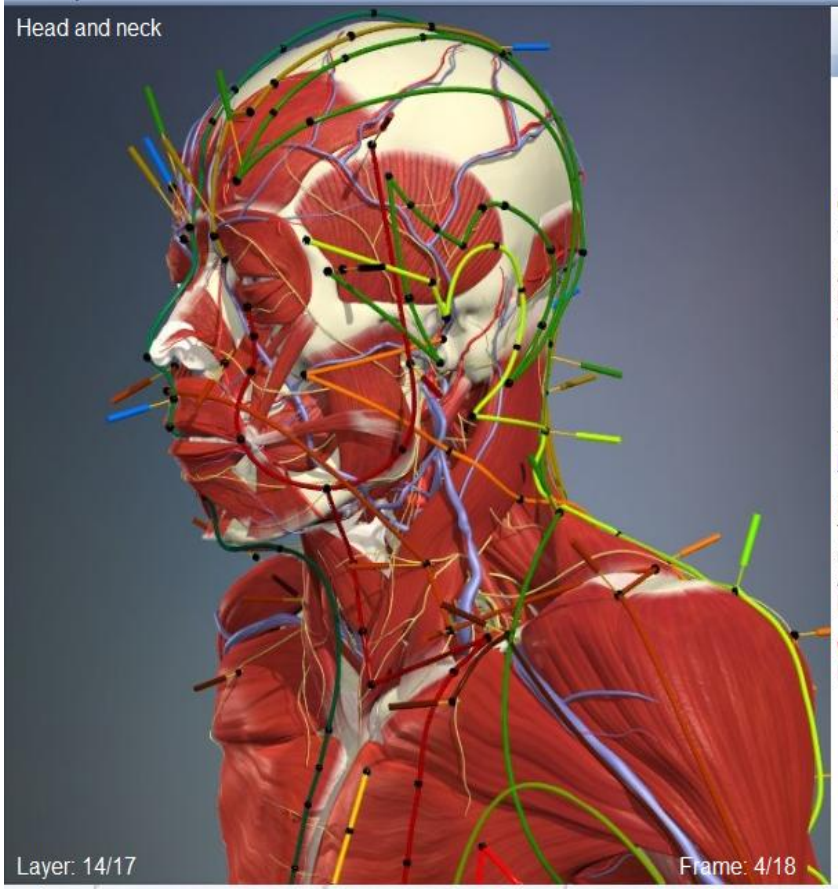

Layer 14

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Acupuncture needle: TE14

肩 隅

穴位說明

Chinese name
Jianliao.

Acupuncture point position
Posterior and inferior to the lateral extremity of the acromion of the scapula, in the depression between the middle and posterior fibres of deltoid.

Needle track
Between the fibres of deltoid, into infraspinatus.

Target structure
Infraspinatus or teres minor.

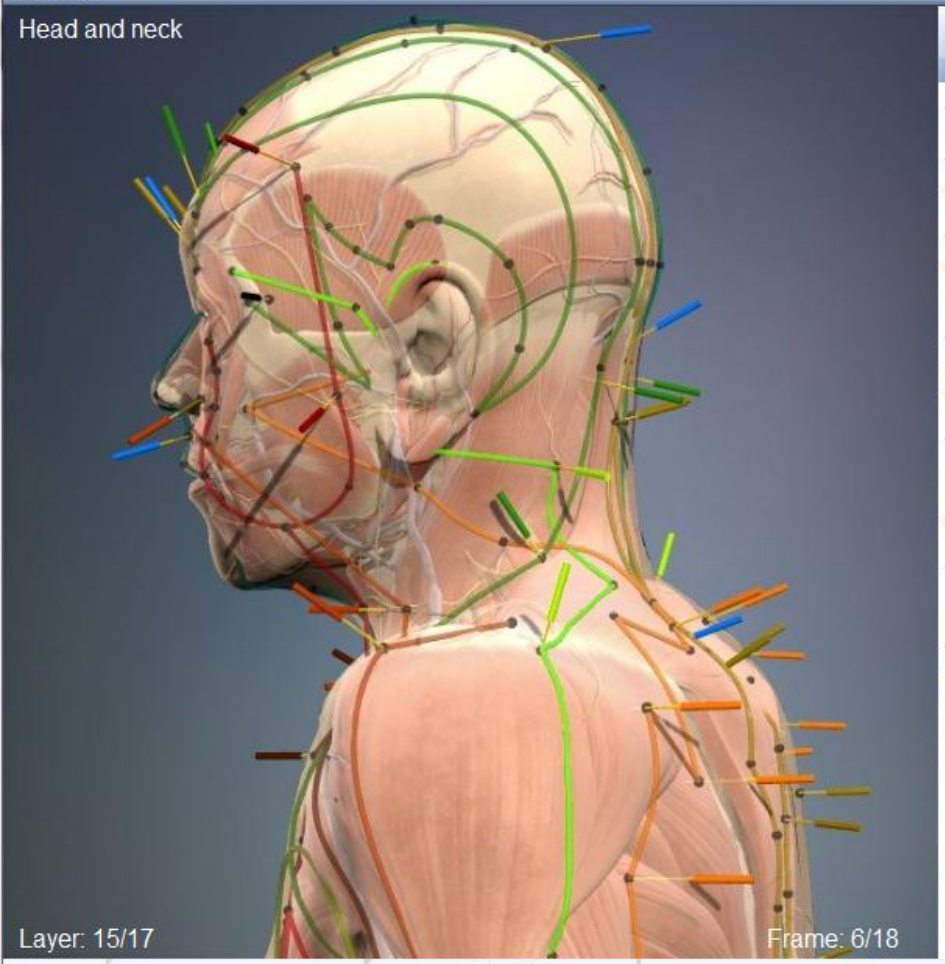
Notes
The traditional description involves needling TE14 with the arm abducted to 90 degrees and the palm facing down, angling the needle towards the centre of the axilla - in this position the needle track may include teres major and latissimus dorsi.
An alternate angulation is inferior oblique towards the elbow - with this angulation the needle track may include teres minor and the long head of triceps.

WARNINGS
Nil.

筋絡說明

www.anatomy.tv/atv2/mainwindow.aspx?ref=0&titleid=26&svrid=0&App=acupuncture#

Anatomy | Save | Print | Settings | Help



Layer 15 | Views | Search | Contents | Back

Triple Energizer Meridian

筋絡說明

This structure is the ***triple energizer meridian***.

Twelve ***principal meridians*** are symmetrically arranged on each side of the body, with the *yin* meridians traversing the anterior surface of the body and the *yang* meridians its posterior surface.

The principal meridians are the most important in clinical practice. The *Spiritual Axis* (circa 200 BC) states that "*it is because of the twelve principal meridians that people live, disease is formed, and people are treated.*"

There are also 8 ***miscellaneous meridians***, two of which have been shown here; the *Governing Vessel* and the *Conception Vessel* meridians. They are usually included with the twelve principal meridians due to their clinical importance.

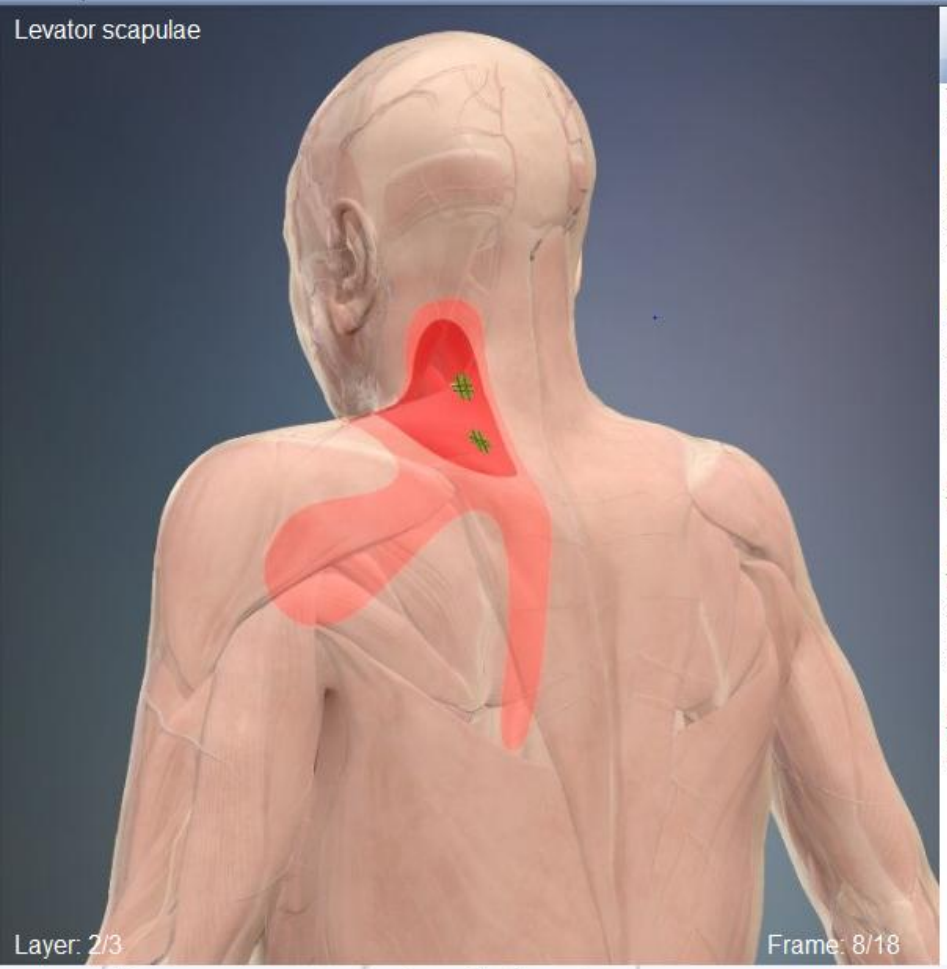
The meridians are perceived to course in the myofascial layer of the body and course through the trunk and limbs, and also penetrate the body cavities to connect with the organs. The traditional theories of the organs and meridians are interwoven such that they are not considered independent entities, but rather the focus of traditional theory has been on their functional interrelationships. This is the reason that each of the meridians bears the name of an organ.
The modern concept of ***myofascial meridians*** is supported by independent anatomic evidence of the meridians. These myofascial meridians are anatomical lines that transmit strain and movement through the body's myofascia around the skeleton. Myofascial meridians are postulated to occur along body paths where connective tissues (including myofascia, tendons, and ligaments) not only have anatomical continuity but also exhibit only a gradual change in tissue orientation (i.e. direction and/or depth of connecting fiber structures). This anatomical configuration conceptually allows strain to be transmitted across the structures in a given myofascial meridian. Some of the myofascial meridians extend the entire length of the body, whereas others are regional (e.g. from chest to fingers). The distributions of these myofascial meridians strongly correlate with the distributions of meridians.

In this program the meridians are only shown on the left side of the model, but if necessary the image can be flipped by using the '*Show zoom and flip controls*' option in the '*Settings*' window.

疼痛觸發點

Anatomy

Save | Print | Settings | Help



Layer 2

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Trigger point: Levator scapulae

Trigger points in the levator scapulae are probably the second most commonly seen in clinical practice, and cause pain at the base of the neck with stiffness that limits neck rotation to the involved side.

Location
One common trigger point region of the levator scapulae is in its mid-portion at approximately the C7-T1 spinal level where this muscle literally twists, and the other common trigger point region for this muscle is near the superior angle of the scapula where it inserts.

Myofascial referred pain pattern
Its myofascial referred pain pattern is concentrated from the posterior mid-cervical region extending to the superior angle of the scapula and some posterolaterally to the area overlying the shoulder joint, and the lower trigger point may also produce referred pain medial to the scapula to the level of its inferior angle. Clinical involvement of this trigger point region may produce a presentation that is similar to that of torticollis.

Acupuncture point
The acupuncture point SI14 enters the lower trigger point region of the levator scapulae muscle.

Meridian
The distribution of the small intestine principal meridian corresponds well with the myofascial pain pattern of the levator scapulae over the nape of the neck to the posterior shoulder joint region, and the small intestine sinew channel distribution encompasses all of the levator scapulae myofascial referred pain distribution.

Regional pain indications
The clinical indications of SI14 for shoulder and scapular pain as well as neck rigidity with inability to turn the head correspond well with the levator scapulae lower trigger point region's regional pain indications.

運動醫學 – 手功能訓練

Interactive Anatomy: Interactive Hand - Therapy Edition - Google Chrome

www.anatomy.tv/start.asp?app=handtherapy...ewwin=&framesize=&h=768&w=1366&GuideResId=&GuideIndex=&isStudent=

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- Therapy Text
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    - MP Joint of the Thumb - Ulnar Collateral Ligament Injury
    - Testing Stability of the First CMC Joint
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    - DIP Joint - Ligament Testing
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    - PIP Joint - Stiffness
    - DIP Joint - Stiffness
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    - CMC Joint - Rheumatoid Deformities
    - Thumb IP Joint - Rheumatoid Deformities
    - PIP Joint - Common Rheumatoid Deformities
    - DIP Joint - Rheumatoid/Osteoarthritis Deformities
    - Rheumatoid Deformities of the Wrist
    - Distal Ulna - Rheumatoid Deformities
    - CMC Joint - Osteoarthritis
  - Tenosynovitis
    - De Quervain's Tenosynovitis
    - Flexor Tenosynovitis
    - Extensor Tenosynovitis in Rheumatoid Arthritis, Retinacular Level
  - Manual Muscle Testing
    - Manual Muscle Testing, Pronator Teres
    - Manual Muscle Testing, Flexor Carpi Radialis

Volar Plate Testing

MP Joint

Stabilize the metacarpal (movie) and passively hyperextend the MP joint. It should not go further nor be more painful than the other MP joints in the same individual.

PIP Joint

Stabilize the proximal phalanx (movie) and push the middle phalanx toward hyperextension. The joint should have a non-painful, secure end point equal to that of the other uninjured fingers.

DIP Joint

Stabilize the middle phalanx (movie) and passively hyperextend the DIP joint. It should not go further nor be more painful than other DIP joints in the same individual.

Thumb IP Joint

Stabilize the middle phalanx (movie) and passively hyperextend the thumb IP joint. It should not go further nor be more painful than other thumb IP joints in the same individual.

Jump to Top of Text

手功能訓練手法說明

下午 06:35
2011/10/5

www.anatomy.tv/start.asp?app=handtherapy&startres=00000&newwin=&framesize=&h=768&w=1366&GuideResId=&GuideIndex=&isStudent=

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    - Extensor Tenosynovitis in Rheumatoid Arthritis, Retinacular Level
  - Manual Muscle Testing
    - Manual Muscle Testing, Pronator Teres

Volar Plate Testing

MP Joint

Stabilize … individual…

…ther nor be more painful than the other MP joints in the same

PIP Joint

Stabilize … the other …

…joint should have a non-painful, secure end point equal to that of

DIP Joint

Stabilize … individual…

…o further nor be more painful than other DIP joints in the same

Thumb IP

Stabilize … same indi…

…t go further nor be more painful than other thumb IP joints in the

Jump to Top of Text

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圖像的說明

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  - Manual Muscle Testing
    - Manual Muscle Testing, Pronator Teres
    - Manual Muscle Testing, Flexor Carpi Radialis

MP Joint - Stiffness

MP joint stiffness (image) creates a pattern of extrinsic flexion of the IP joints. It is commonly seen in traumatic hand injuries where a combination of edema and immobilization are present.

These conditions create a stiffening of the volar plate such that it can no longer fold "out of the way" during flexion of the joint. Thus immobility of the volar plate can contribute to difficulty in regaining flexion. Unlike the PIP joint, regaining extension is usually not problematic due to the less extensive check rein ligament portion of the MP volar plate.

Edema reduction is mandatory before any techniques can be effective to regain MP joint motion.

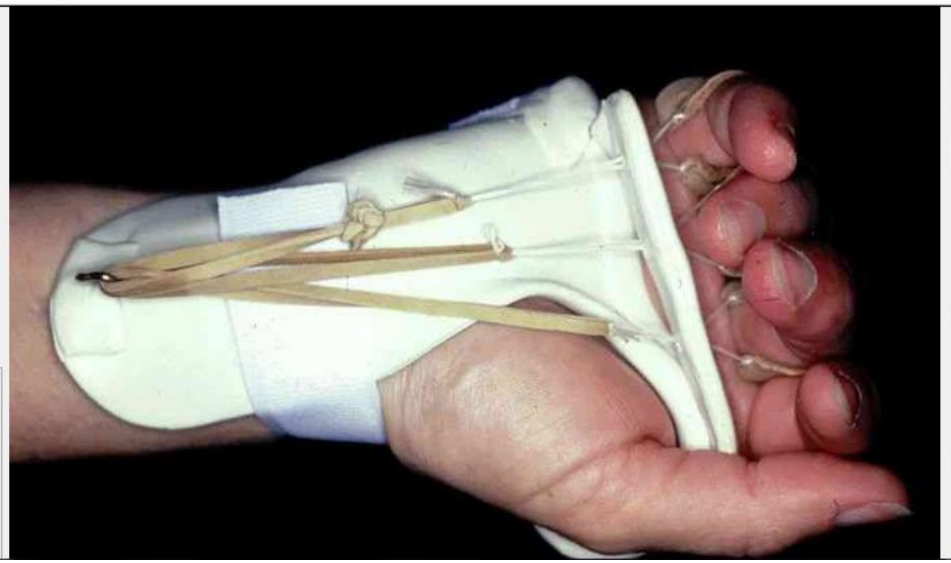
Appropriate splinting (Slide 1 (image) , Slide 2 (image)) is necessary to regain flexion as the primary flexors of the joint (the intrinsic muscles) are not strong enough to regain the ligament length needed in flexion.

Appropriate MP joint splinting, palmar view. - Google Chrome

www.anatomy.tv/slideviewer.asp?slideres=37100620

LABEL | MOVE | NO ZOOM | EXIT

Zoom 77 % GO



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測試題庫

Palm Model | Low Quality

DEEP | Layer 1 | SUPERFICIAL

Question: 1 of 5

Easy Level

The answer is: First metacarpal

- [x] First metacarpal
- [ ] Second metacarpal
- [ ] Third metacarpal
- [ ] Trapezium
- [ ] Fourth metacarpal

REVEAL

0 ☑ ☐ ☒ ☐ 1

NEW QUIZ

運動醫學 – 運動傷害

運動傷害造成說明及治療影片

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- Sports Injuries
  - Clinical assessment/examination
    - Inspection
    - Palpation
    - Passive movements
    - Active movements
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    - Standing assessment
    - Walking assessment
    - Functional tests
    - Lumbar spine assessment
    - Tests focusing on specific diagnoses
  - Imaging
    - General principles of imaging
    - Plain radiography
    - Arthrography
    - Bone scintigraphy
    - Computed Tomography
    - Magnetic Resonance Imaging
    - Ultrasound
  - Podiatry
    - Foot exercises
    - Padding and taping
      - Taping techniques
      - Padding
    - Athletic footwear
      - Introduction to athletic footwear
      - Anatomy of the athletic shoe
    - Orthoses
      - Introduction to orthoses
      - Orthotic science
    - Gait analysis and biomechanical examination
      - Gait analysis and biomechanical examination techniques
      - Pelvis, hip, and leg examination
      - Knee and lower leg examination

Passive movements

This should assess range of movement at the ankle (movie) , subtalar (movie) , midtarsal (movie) , and metatarsophalangeal (MTP) joints (movie) .

Dorsiflexion at the ankle can be assessed more effectively on standing. Limitation of dorsiflexion may be due to tightness of the Achilles tendon (labeltext) /calf muscles or due to a bony block at the front of the ankle.

The passive range of movement of a single joint may vary depending on the position of an adjacent joint. The range of movement of the subtalar joint (movie) is best assessed with the ankle in maximal dorsiflexion. This locks the wider part of the talus (labeltext) into the ankle joint. The range of movement of the ankle also depends on whether the ankle is supinated or pronated (topictext) .

The range of movement of the first MTP joint (movie) is dependent on the position of the ankle joint. More dorsiflexion of the MTP joint occurs when the ankle is plantarflexed. Maximal dorsiflexion of the first MTP joint (i.e. with the ankle plantarflexed) should ideally be about 90 degrees for classical dancers and about 60 degrees for runners. Significant limitation of dorsiflexion in these two activities will increase the risk of injury to the joint and elsewhere in the foot and leg.

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搭配圖文說明運動傷害造成的因素

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- SAQ (Speed agility, and quickness)
- Sports specific training
- Biomechanics
  - Human gait and foot types
  - Gait analysis
    - Introduction to gait analysis
    - Swing phase walking
    - Stance phase walking
    - Walking versus running gait
- Overview of injuries
  - Bone injuries: overview
    - Fractures: introduction
    - Early management of fractures
    - Active rehabilitation of fractures
    - Complications of fractures
  - Injuries to ligaments, tendons and muscles
  - Injuries to joints
- Acute/trauma injuries
  - Lower leg and ankle
    - Tibial fractures
    - Ankle fractures
    - Achilles tendon rupture
    - Peroneal tendon disorders
      - Peroneal tendon tears
      - Peroneal tendon subluxation
    - Posterior tibialis tendon ruptures
    - Sprains
      - Lateral ankle ligament sprains
      - Syndesmosis sprains
      - Medial ankle ligament sprains
  - Foot
    - Talar fractures
      - Talar fractures: overview
      - Fractures of the talar neck
      - Fractures of the talar body
      - Fractures of the lateral process of the talus

1. A transverse fracture can be caused by direct violence, accompanied by local tissue damage or by avulsion of a muscle insertion. (Slide 1 (image) , Slide 2 (image))

2. An oblique or spiral fracture is usually caused by a twisting force applied at a distance. Soft tissue damage may occur at a site distant from the fracture. (Slide 1 (image) , Slide 2 (image) , Slide 3 (image))

3. A greenstick fracture occurs in the more yielding bones of children which have more connective tissue matrix and less mineral than adult bones. The bone does not break completely i.e. an incomplete fracture occurs. (Slide (image))

4. A crush fracture occurs in cancellous bone as a result of direct compression. (Slide (image))

5. A comminuted (image) fracture has more than two fragments. Gross comminution occurs as a
(Slide (image))

6. A pathological fracture occurs from trivial violence through bone that is already weakened
metastatic carcinoma, osteomalacia, osteoporosis and Paget's disease etc. **Closed and open f**

A closed fracture (syn. simple fracture) has no communication between the site of the fracture ar

An open fracture (image) (syn. compound fracture) has a wound in the skin surface which cor
contaminate an open fracture site and multiply as time goes by. Therefore, the treatment of
thoroughly cleaned and covered with sterile dressing until formal surgical debridement is carried
cannot be achieved without tension on the tissues. These patients require broad spectrum anti
previously been immunised or human antitetanus globulin for those who had not received immunis

Stress fracture

A stress fracture can arise from repeated abnormal cyclical loading of normal bone (fatigue frac
fracture). A common example is the march stress fracture (image) of the second metatarsal
unaccustomed running in athletes.

See also: Metatarsal stress fractures (topictext)

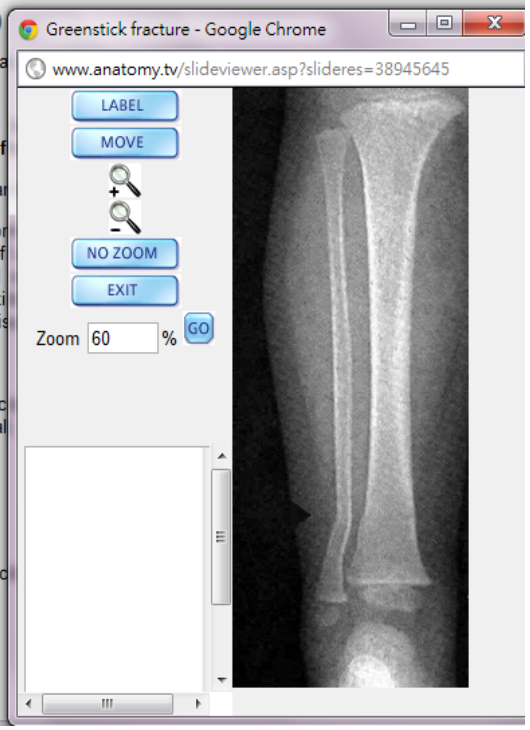
Fracture healing

The aim of fracture healing is to restore the integrity of the damaged bone, thereby allowing func
Slide 2 (image)) of fracture healing are:

1. Stage of inflammation.

2. Stage of callus formation.

3. Stage of consolidation



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PRIMAL

Ankle | Low Quality

DEEP | Layer 2 | SUPERFICIAL

Talus

Anatomy Text

The talus is the second largest bone of the tarsus and forms the summit of the foot. It articulates superiorly with the tibia and fibula at the ankle joint, and inferiorly with the calcaneus at the talocalcaneal joint. (image) Anteroinferiorly it forms a further articulation with the calcaneus and navicular at the talocalcaneonavicular joint (image) . The talus is a short bone which consists of a head, neck and body. A number of ligaments attach to the talus, but no muscles or tendons are attached to it.

Jump to Top of Text

搭配解剖位置的說明

手術：針對各式手術提供文字影像的說明

www.anatomy.tv/start.asp?app=podmed&startres=00000&newwin=&framesize=&h=768&w=1366&GuideResId=&GuideIndex=&isStudent=

此網頁為 英文 您要翻譯網頁內容嗎？ 翻譯 不需要 永遠不要翻譯英文 選項

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        - Hallux valgus: presentation and diagnosis
        - Hallux valgus: treatment
      - Surgical procedures for hallux valgus
        - General considerations for surgery to correct hallux valgus
        - Silver bunionectomy
        - Chevron/Austin osteotomy
        - L/Reverdin/Green osteotomy
        - Osteotomy of the first metatarsal shaft (Gudas-Scarf)
        - Osteotomy of the Hallux (Akin)
        - Keller arthroplasty for hallux valgus
        - Post operative recovery after hallux valgus surgery
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        - Treatment for lesser metatarsal deformities/injuries
          - Conservative treatment for lesser metatarsal deformities/injuries
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            - General considerations for lesser metatarsal surgery
            - Weil osteotomy
      - Tailor's bunion
        - Tailor's bunion
        - Surgery for Tailor's bunion
    - Digital surgery
      - Deformities
        - Hammer toe/mallet toe
        - Lesser digit deformities

Silver bunionectomy

Occasionally patients present with a painful and prominent first metatarsal medial eminence but no significant first MTP joint pain. Other patients complain of pain over the □union area but are not concerned or troubled by the deviation of the hallux. In diabetic and rheumatoid patients there may be a history of repeat ulceration over the first MTP joint or recurrent bursitis and in the elderly, the medial eminence may be continuously painful due to pressure from shoes and associated atrophic skin. In these patients with specific needs, a simple bunionectomy may alleviate symptoms.

Note : this procedure does not address the underlying pathology in true hallux valgus and is therefore not indicated for the management of hallux valgus. This procedure is also inadequate where an increased intermetatarsal angle dictates that an osteotomy is required.

Surgical technique

1. The medial metatarsal eminence is approached via a dorsomedial incision (movie) .
2. The wound is deepened through layers with small venules tied off or coagula
3. With a power saw the medial eminence (movie) is resected and the bone ra
4. The dorsomedial margin of the metatarsal head is rounded (movie) to provid ove an excessive amount of the medial eminence in an attempt to achieve a narrow fo

Post operative recovery

Patients can expect to be back into wide footgear after two weeks but delay most patients this simple procedure can bring great pain relief allows for early mobili

of Text

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        - Treatment for lesser metatarsal deformities/injuries
          - Conservative treatment for lesser metatarsal deformities/injuries
          - Surgical procedure
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            - Weil osteotomy
      - Tailor's bunion
        - Tailor's bunion
        - Surgery for Tailor's bunion
    - Digital surgery
      - Deformities
        - Hammer toe/mallet toe

Silver bunionectomy

Occasionally patients present with a painful and prominent first metatarsal medial eminence but no significant first MTP joint pain. Other patients complain of pain over the ☐union area but are not concerned or troubled by the deviation of the hallux. In diabetic and rheumatoid patients there may be a history of repeat ulceration over the first MTP joint or recurrent bursitis and in the elderly, the medial eminence may be continuously painful due to pressure from shoes and associated atrophic skin. In these patients with specific needs, a simple bunionectomy may alleviate symptoms.

Note : this procedure does not address the underlying pathology in true hallux valgus and is therefore not indicated for the management of hallux valgus. This procedure is also inadequate where an increased intermetatarsal angle dictates that an osteotomy is required.

Surgical technique

1. The medial metatarsal eminence is approached via a dorsomedial incision (movie) .
2. The wound is deepened through layers with small venules tied off or coagulated and the capsule and periosteum are reflected from the bone.
3. With a power saw the medial eminence (movie) is resected and the bone r
4. The dorsomedial margin of the metatarsal head is rounded (movie) to provi
excessive amount of the medial eminence in an attempt to achieve a narrow

Post operative recovery

Patients can expect to be back into wide footgear after two weeks but dela
patients this simple procedure can bring great pain relief allows for early mob

針對該領域的題庫

ANATOMY | CONTENTS | QUIZ | PODIATRY | HOME

Heel Model (close up) | Low Quality

DEEP | Layer 16 | SUPERFICIAL

Question: 1 of 5

Easy Level

The answer is: Fibro-Fatty Tissue of the Heel

- [x] Fibro-Fatty Tissue of the Heel
- [x] Flexor Retinaculum
- [x] Medial Plantar Nerve
- [x] Dorsal Metatarsal Veins
- [x] Sural Nerve

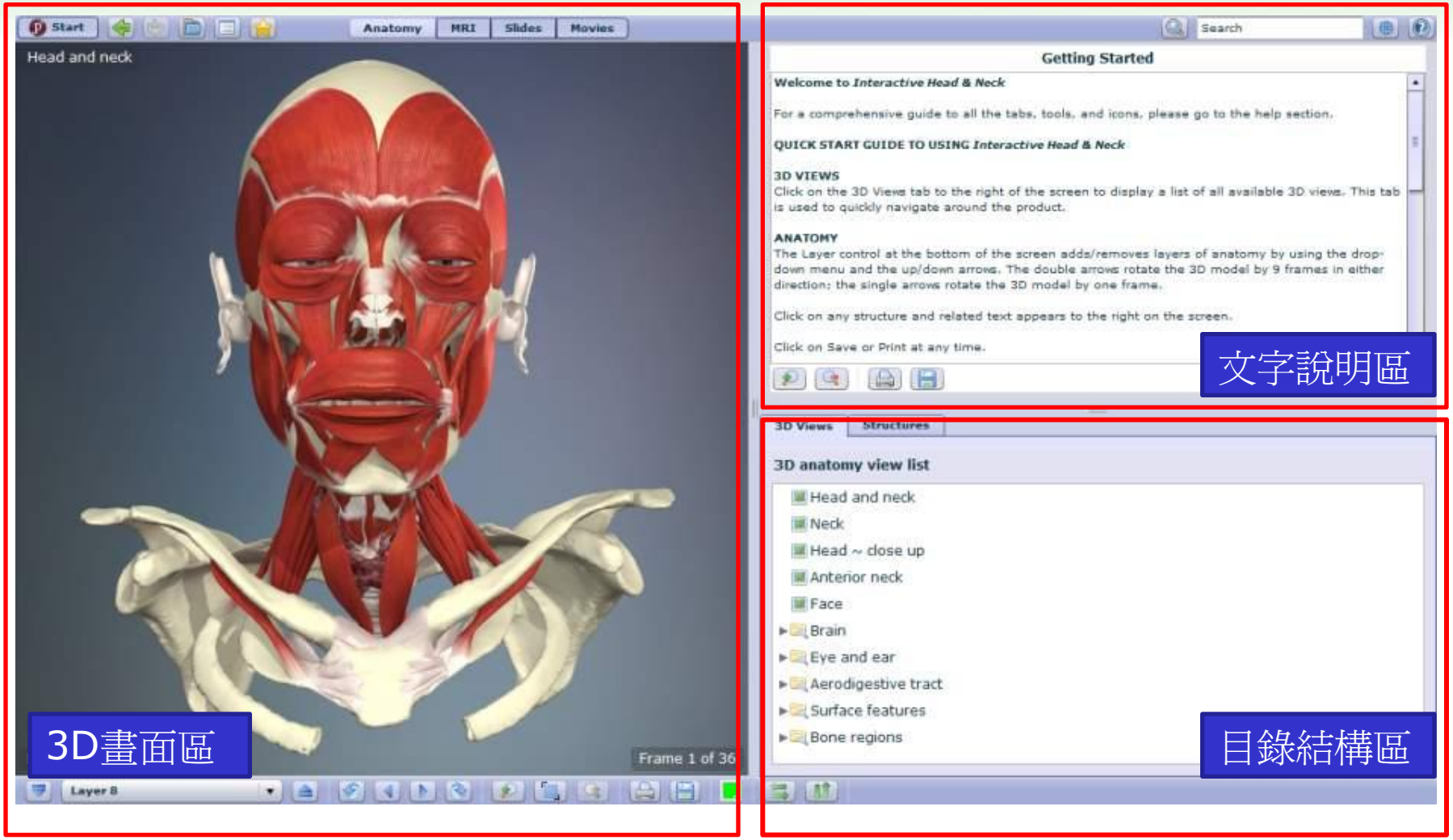
REVEAL

0 ☑ ☐ ☒ ☐ 1

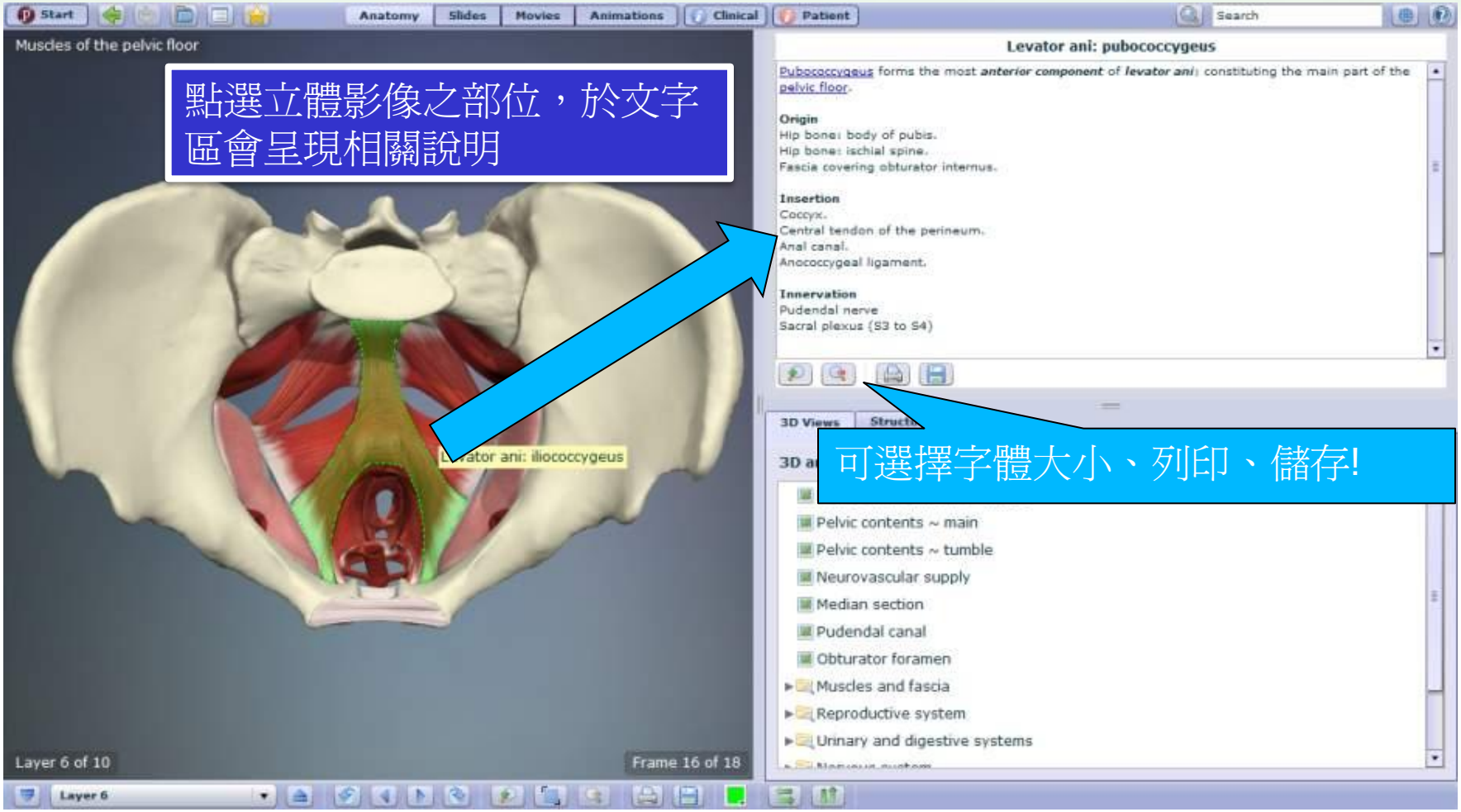
NEW QUIZ

00:00:05

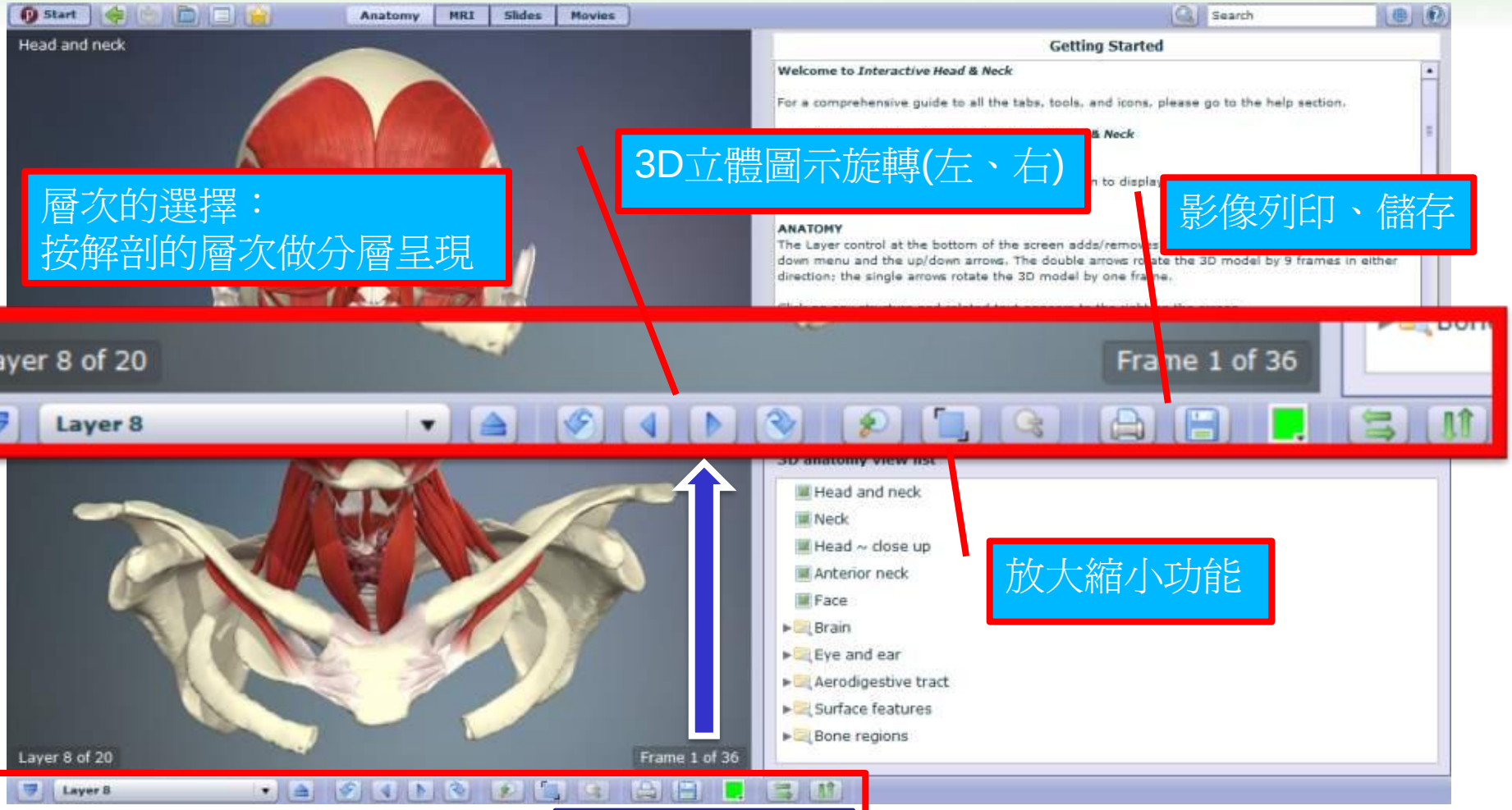
Regional Anatomy



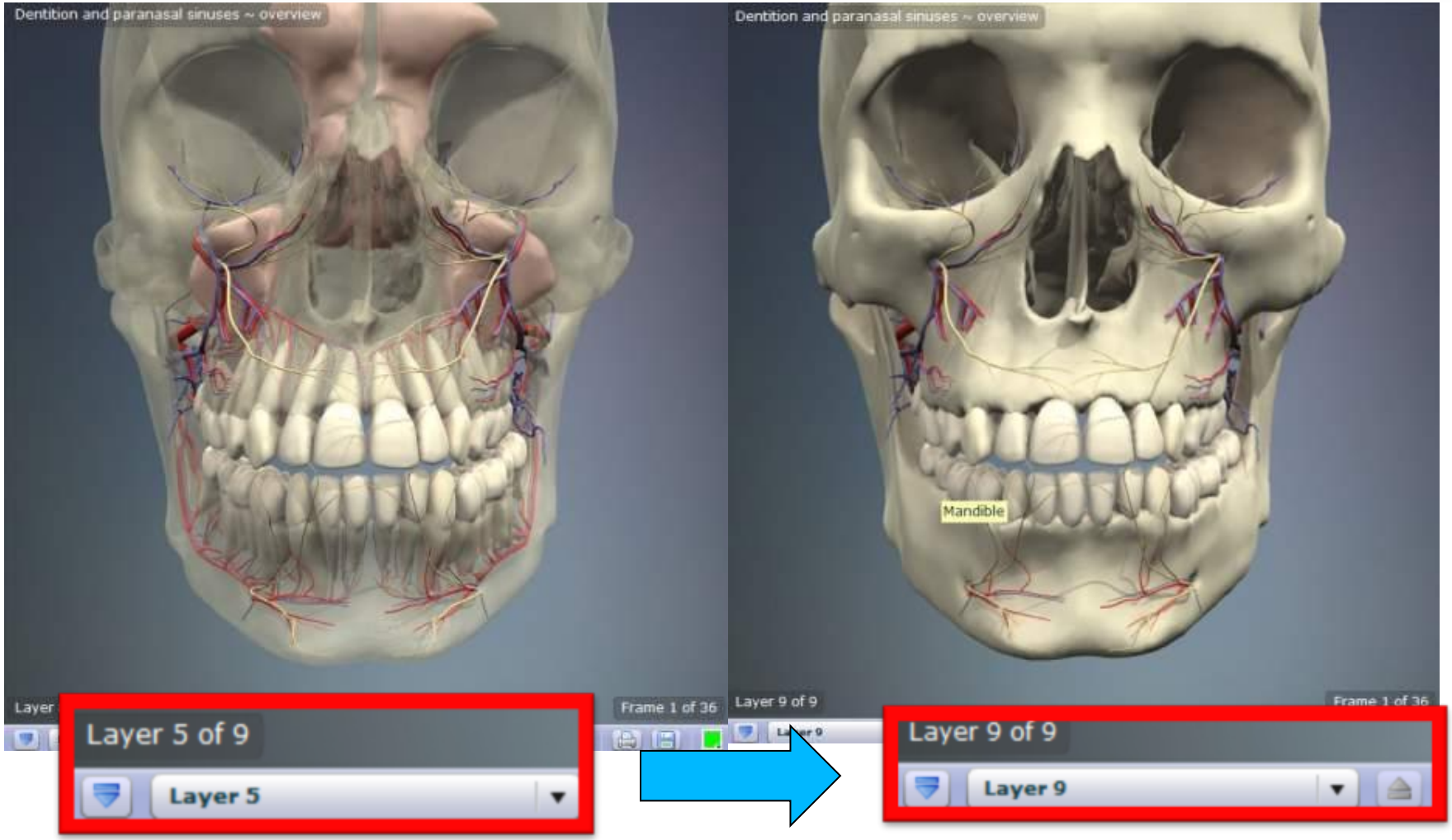
文字說明


Start
Anatomy
Slides
Movies
Animations
Clinical
Patient
Search
Muscles of the pelvic floor
點選立體影像之部位，於文字區會呈現相關說明
Levator ani: pubococcygeus
Pubococcygeus forms the most anterior component of levator ani, constituting the main part of the pelvic floor.
Origin
Hip bone: body of pubis.
Hip bone: ischial spine.
Fascia covering obturator internus.
Insertion
Coccyx.
Central tendon of the perineum.
Anal canal.
Anococcygeal ligament.
Innervation
Pudendal nerve
Sacral plexus (S3 to S4)
3D Views
可選擇字體大小、列印、儲存!
Pelvic contents ~ main
Pelvic contents ~ tumble
Neurovascular supply
Median section
Pudendal canal
Obturator foramen
Muscles and fascia
Reproductive system
Urinary and digestive systems
Layer 6 of 10
Frame 16 of 18
Layer 6

3D互動


Start
Anatomy
MRI
Slides
Movies
Search
Head and neck
Getting Started
Welcome to Interactive Head & Neck
For a comprehensive guide to all the tabs, tools, and icons, please go to the help section.
ANATOMY
Layer 8 of 20
Frame 1 of 36
Layer 8
Head and neck
Neck
Head ~ close up
Anterior neck
Face
Brain
Eye and ear
Aerodigestive tract
Surface features
Bone regions
層次的選擇：
按解剖的層次做分層呈現
3D立體圖示旋轉(左、右)
影像列印、儲存
放大縮小功能
3D互動功能鍵

不同的層次



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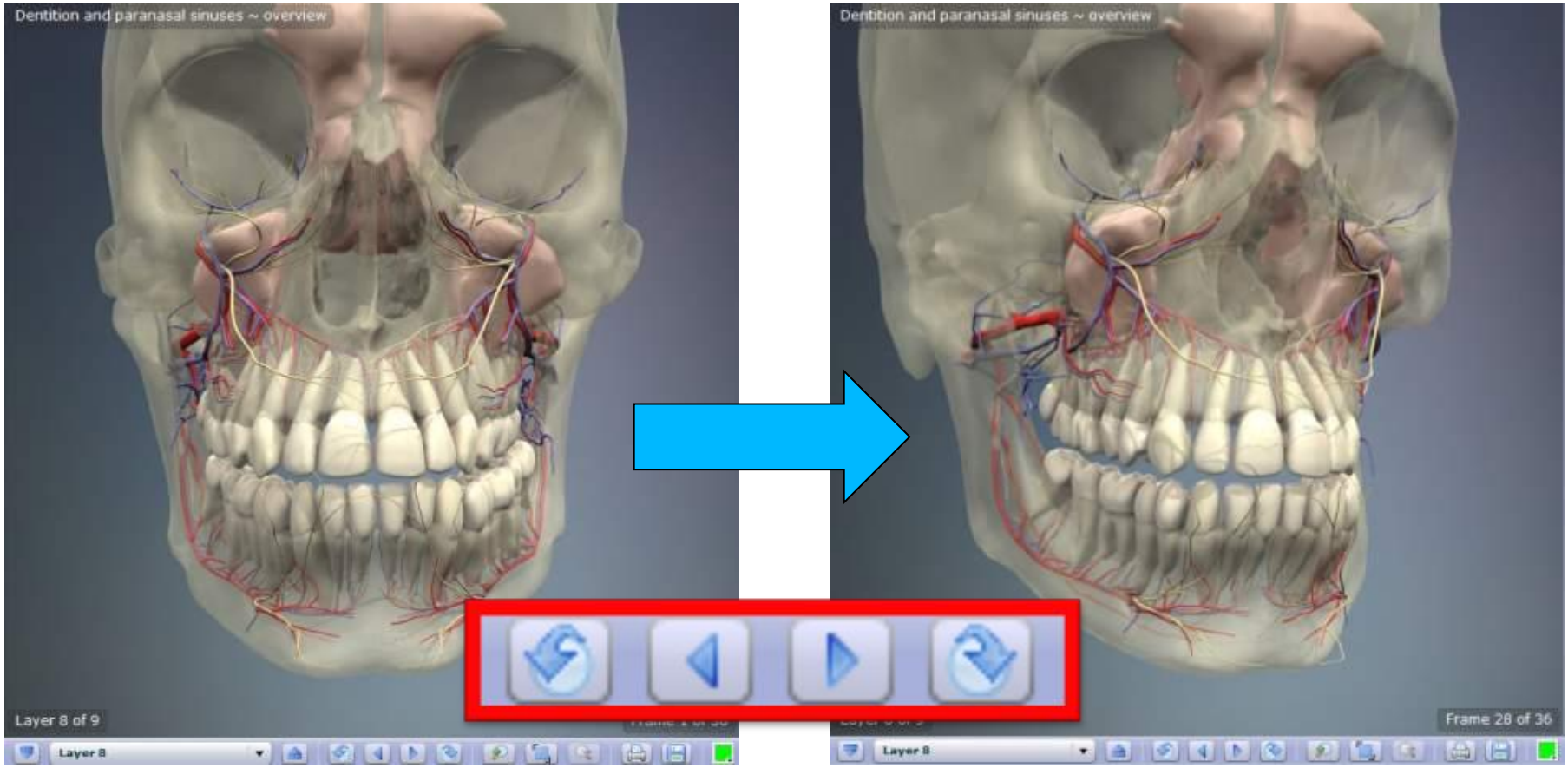
飛資得醫學資訊

不同的角度



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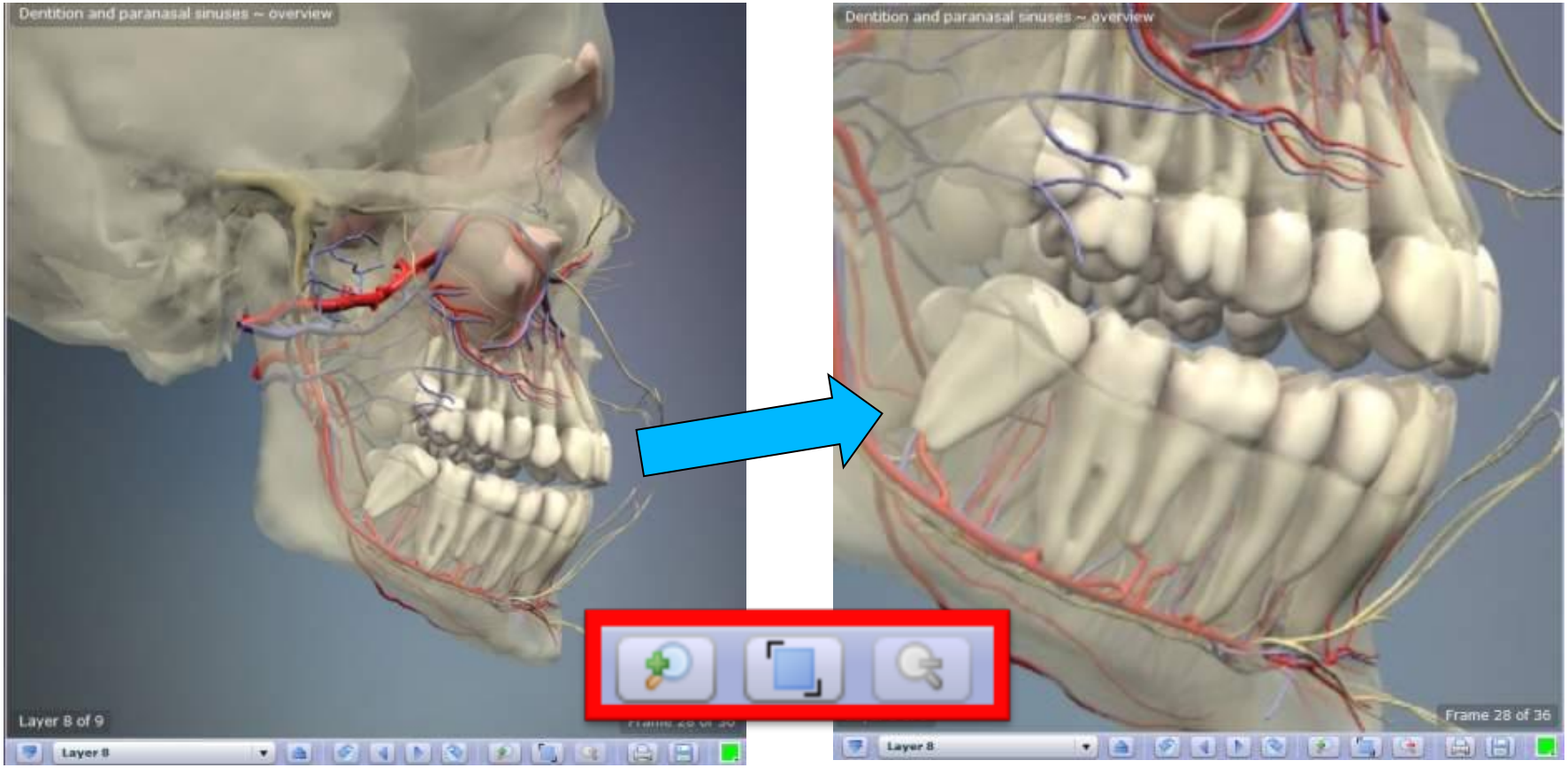
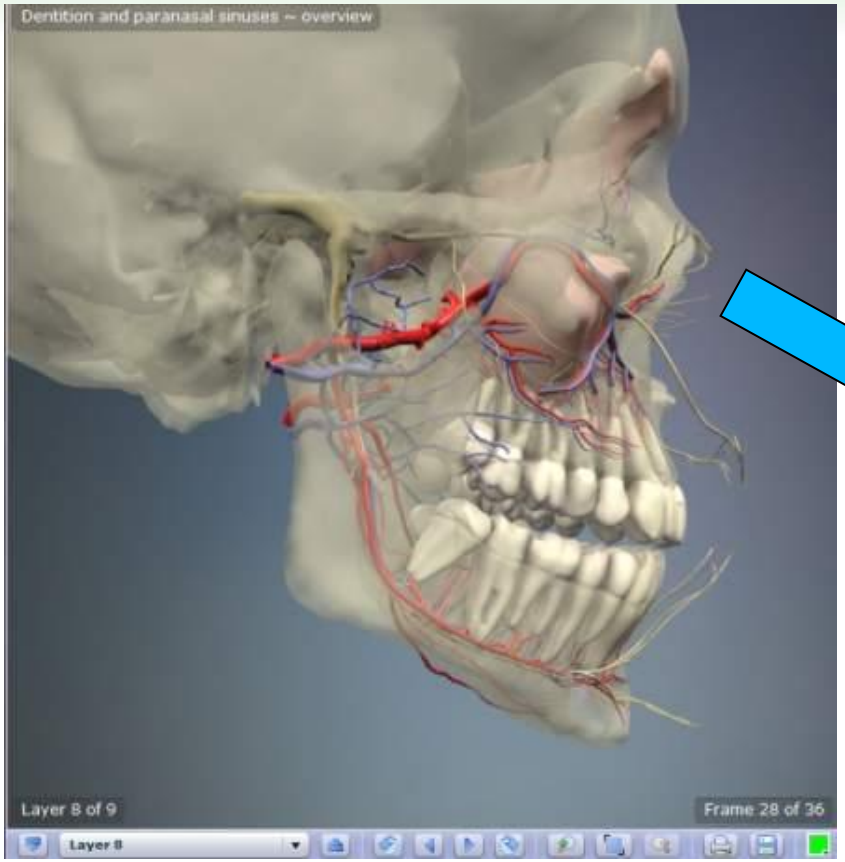
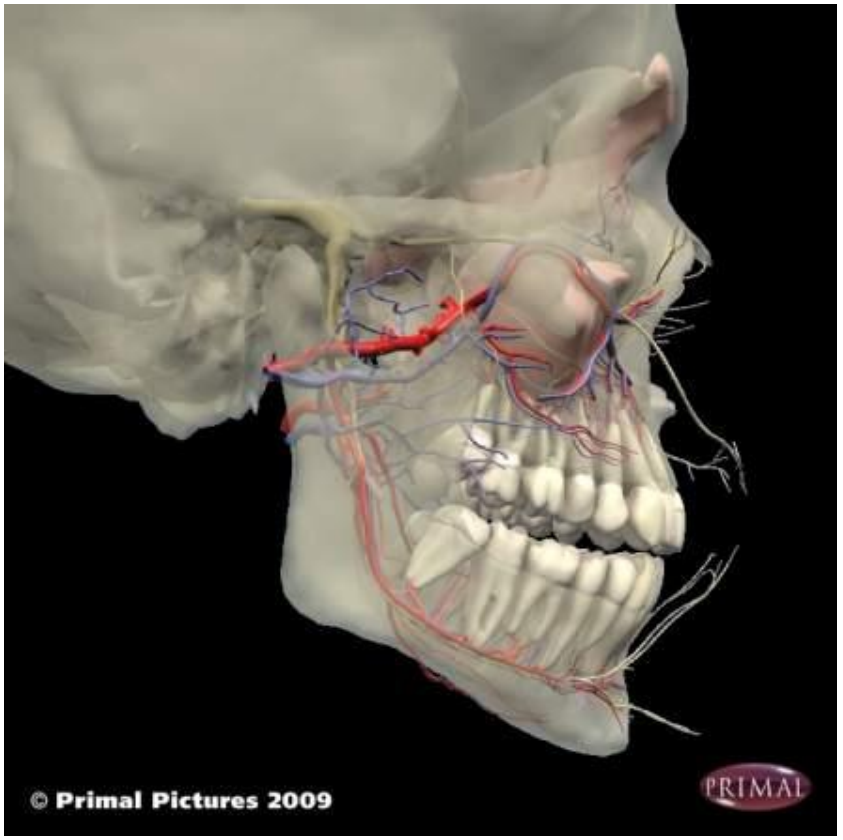
飛資得醫學資訊

放大、縮小


Dentition and paranasal sinuses ~ overview
Layer 8 of 9
Layer 8
Dentition and paranasal sinuses ~ overview
Frame 28 of 36
Layer 8

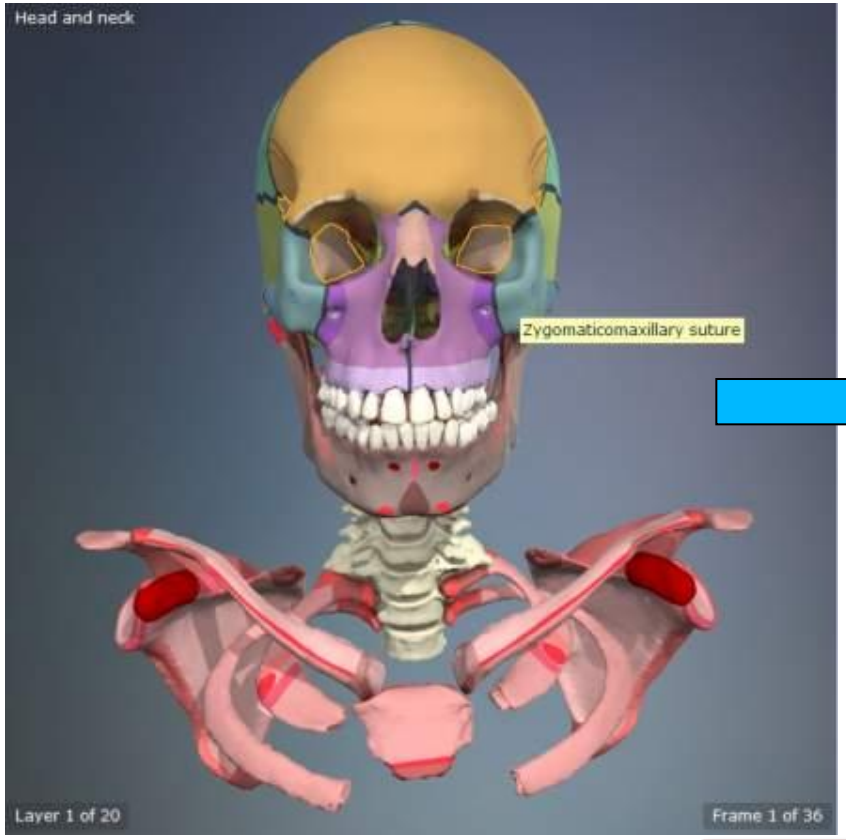
圖片儲存、列印

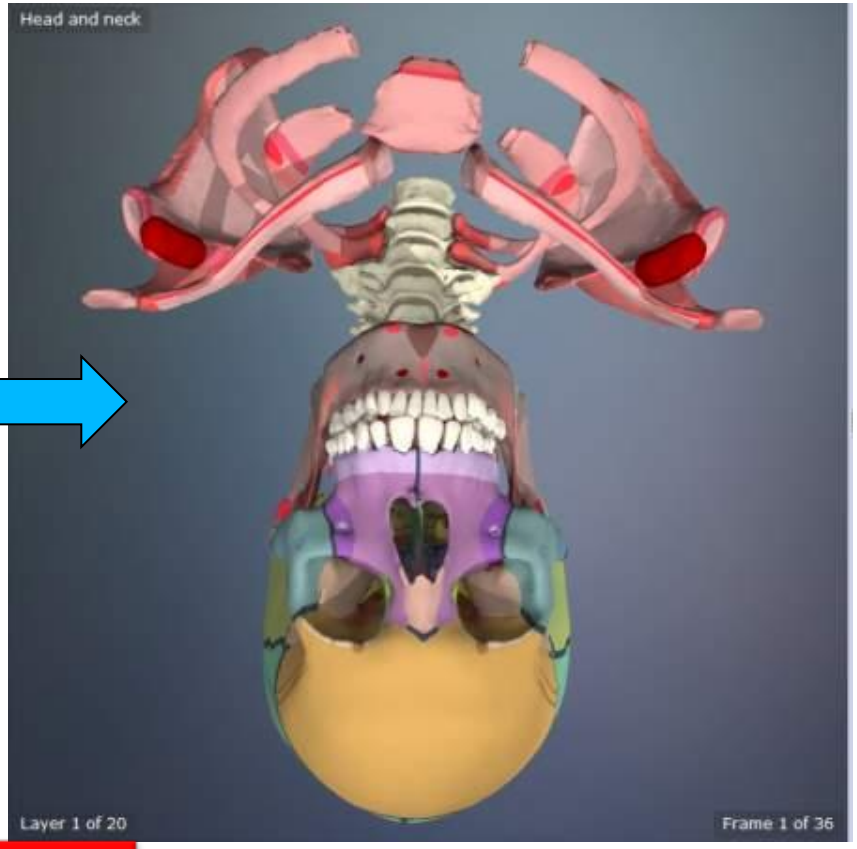




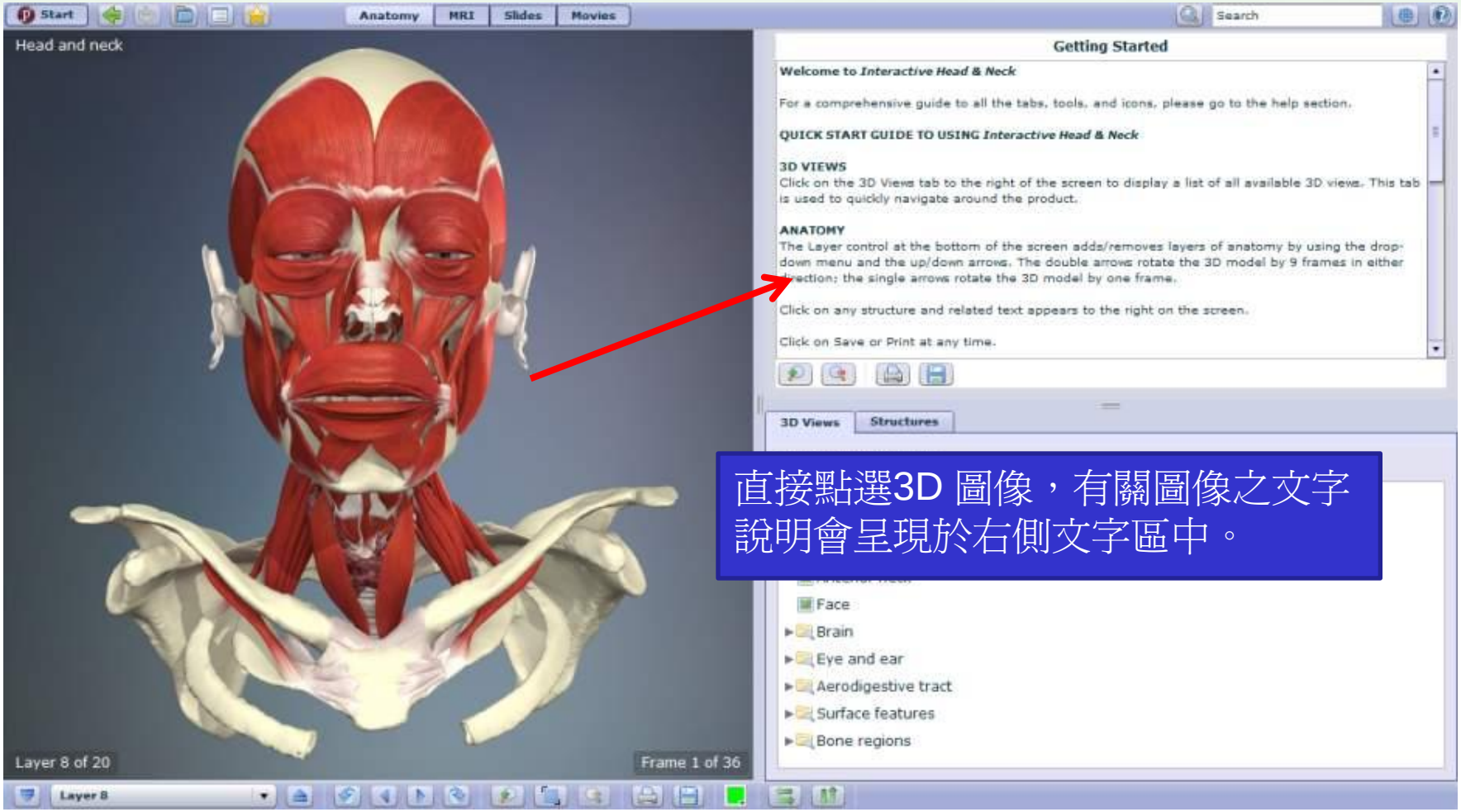
系統會自動將您的圖片加上來源!

上下、左右顛倒呈現


Head and neck
Zygomaticomaxillary suture
Layer 1 of 20
Frame 1 of 36

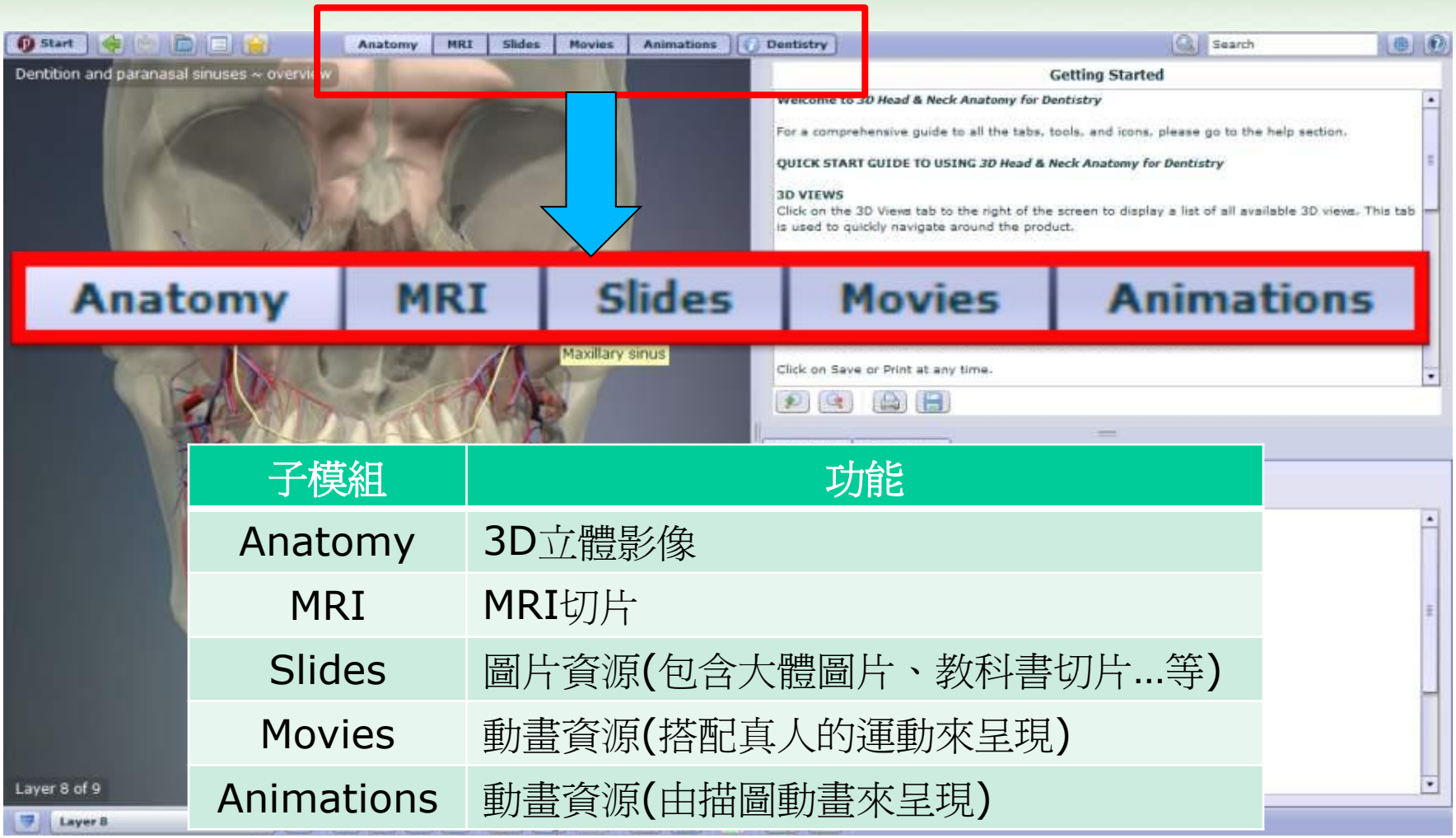

Head and neck
Layer 1 of 20
Frame 1 of 36

文字說明



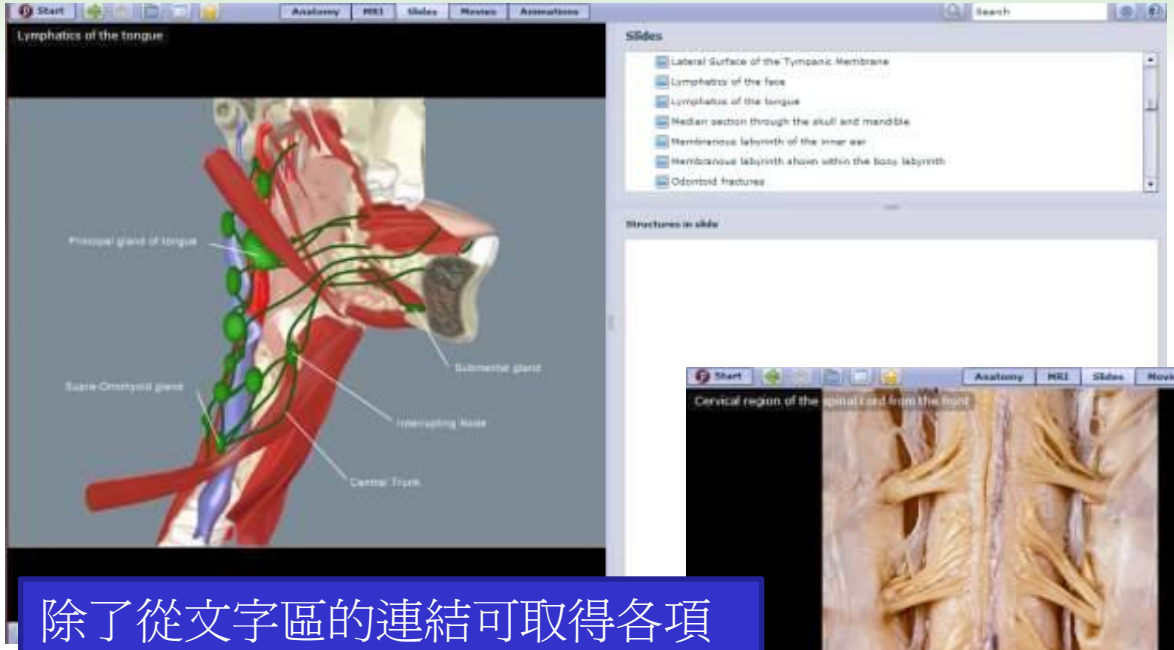
直接點選3D 圖像，有關圖像之文字說明會呈現於右側文字區中。

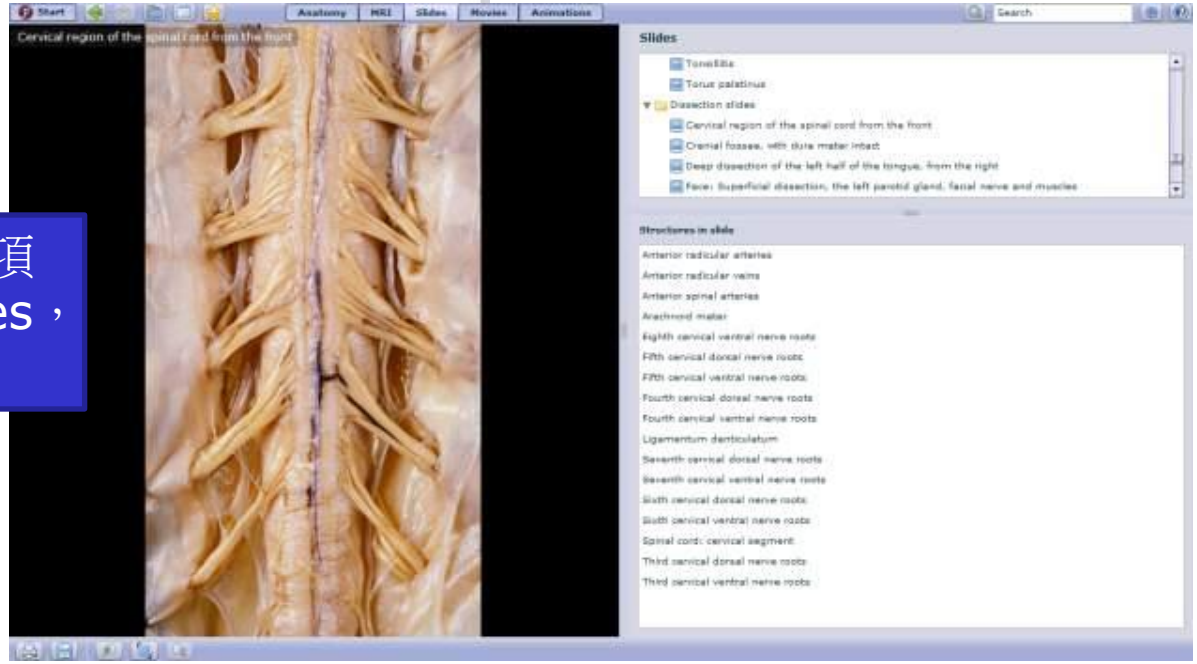
Anatomy子模組



子模組	功能
Anatomy	3D立體影像
MRI	MRI切片
Slides	圖片資源(包含大體圖片、教科書切片...等)
Movies	動畫資源(搭配真人的運動來呈現)
Animations	動畫資源(由描圖動畫來呈現)

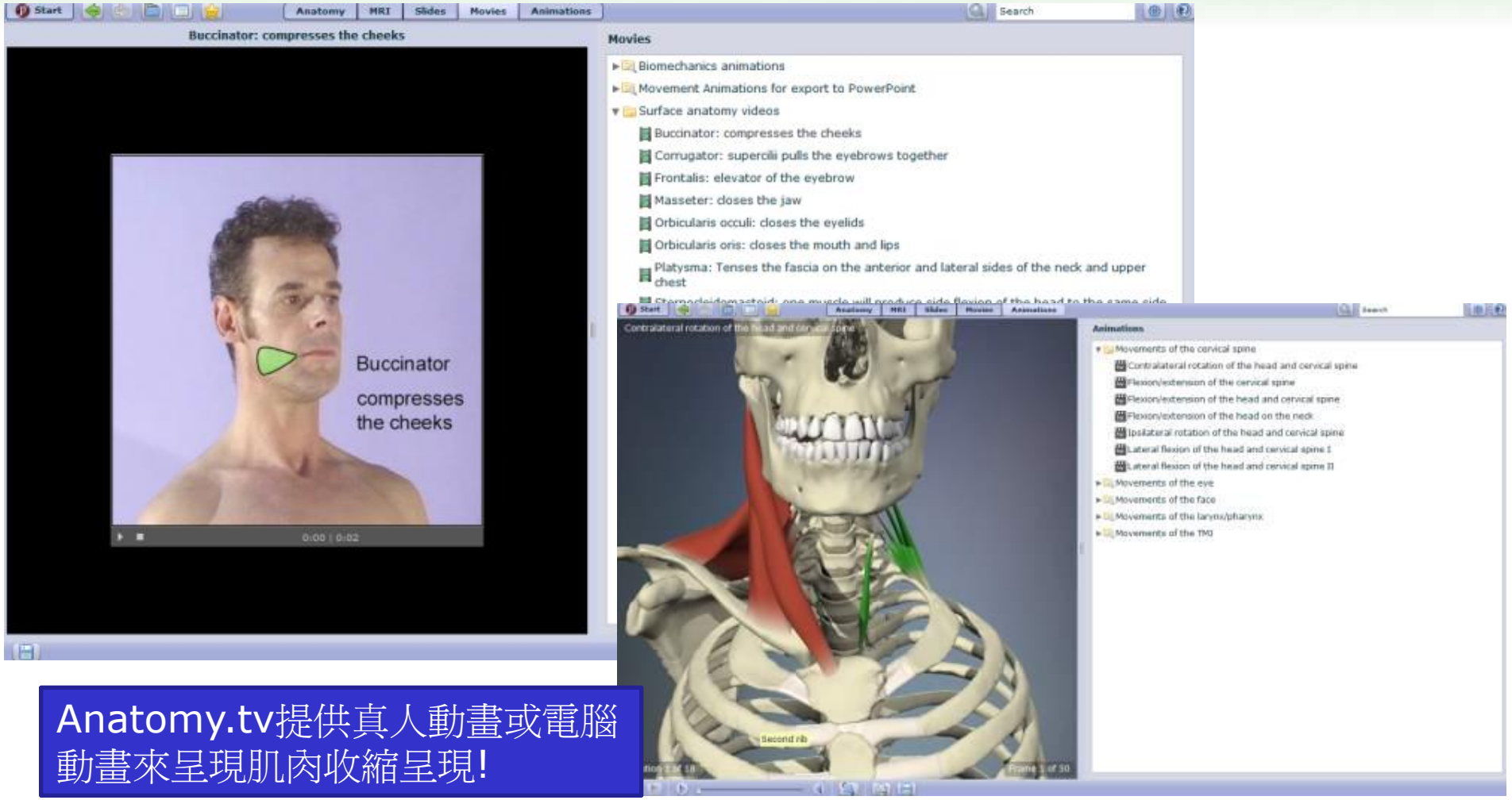
圖片資源





除了從文字區的連結可取得各項資源外，您亦可直接進入Slides，進入取得圖片資源!!

動畫資源



Anatomy.tv提供真人動畫或電腦動畫來呈現肌肉收縮呈現!

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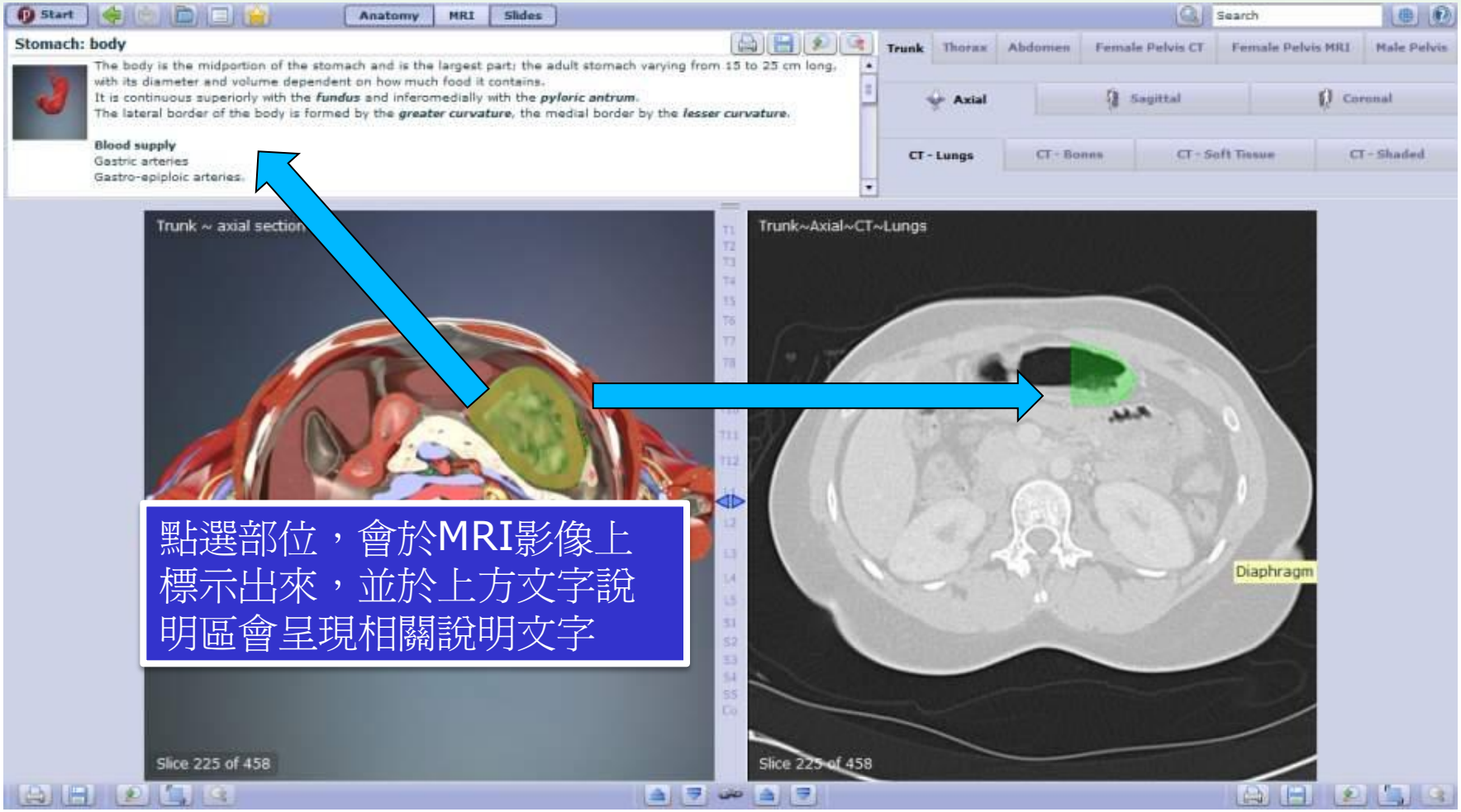
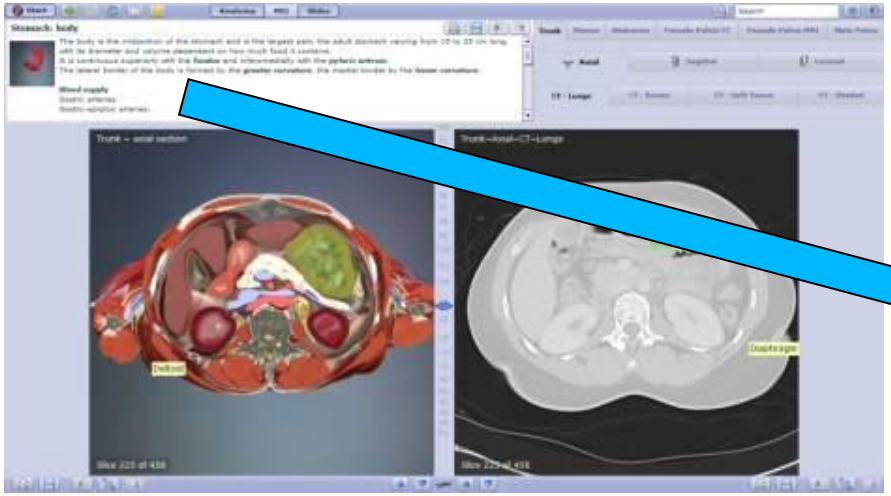
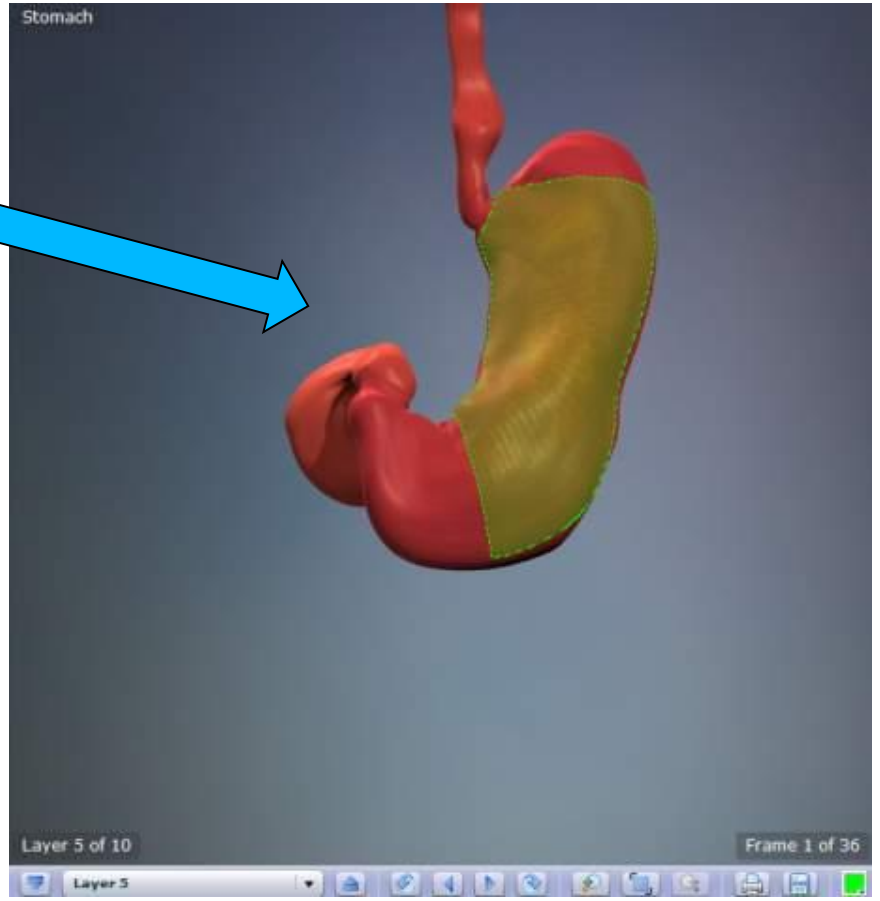
飛資得醫學資訊

MRI


Start
Anatomy
MRI
Slides
Search
Stomach: body
The body is the midportion of the stomach and is the largest part; the adult stomach varying from 15 to 25 cm long, with its diameter and volume dependent on how much food it contains.
It is continuous superiorly with the fundus and inferomedially with the pyloric antrum.
The lateral border of the body is formed by the greater curvature, the medial border by the lesser curvature.
Blood supply
Gastric arteries
Gastro-epiploic arteries.
Trunk
Thorax
Abdomen
Female Pelvis CT
Female Pelvis MRI
Male Pelvis
Axial
Sagittal
Coronal
CT - Lungs
CT - Bones
CT - Soft Tissue
CT - Shaded
Trunk ~ axial section
Trunk~Axial~CT~Lungs
Diaphragm
Slice 225 of 458
Slice 225 of 458
點選部位，會於MRI影像上標示出來，並於上方文字說明區會呈現相關說明文字

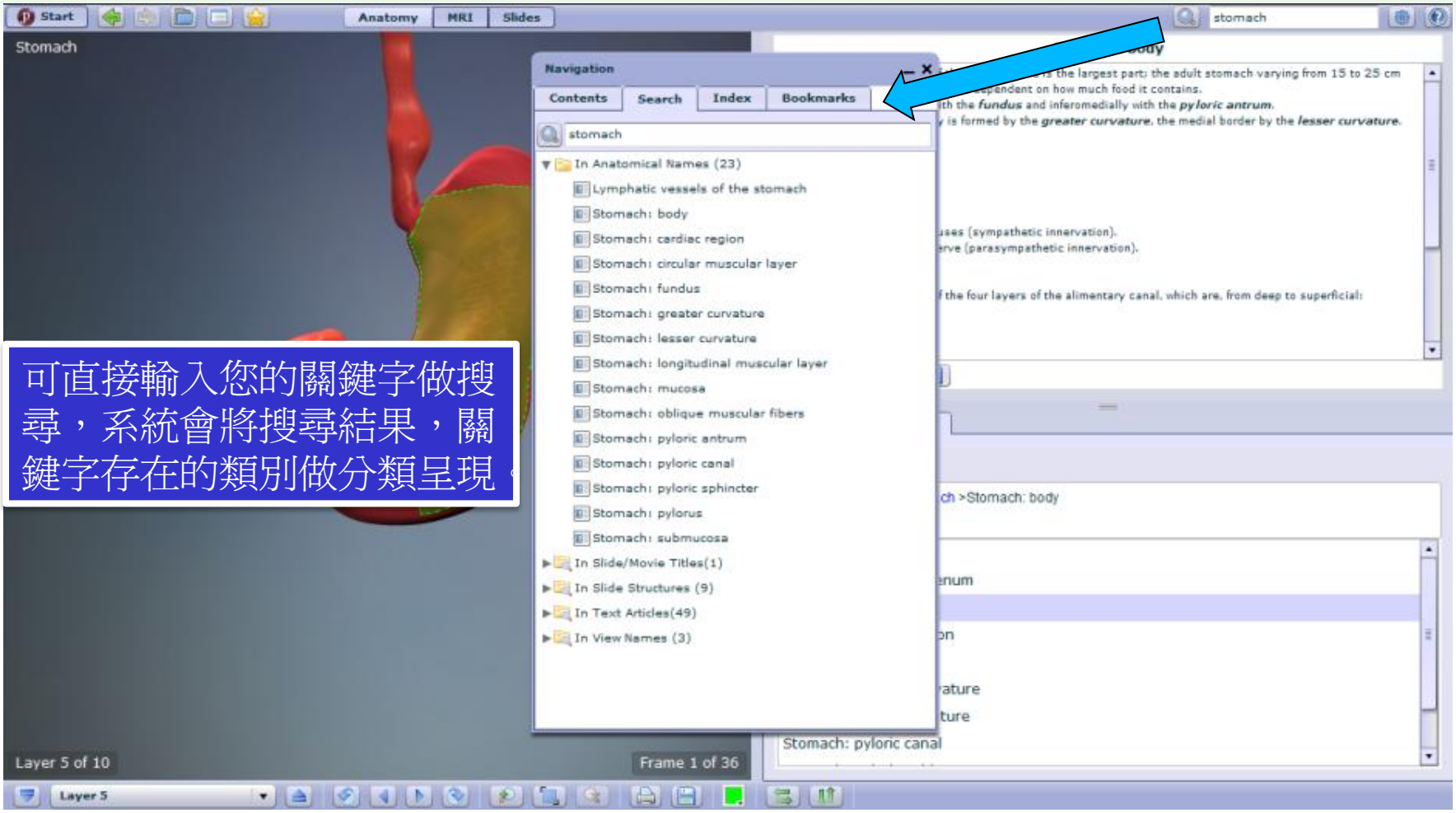
資料的串連



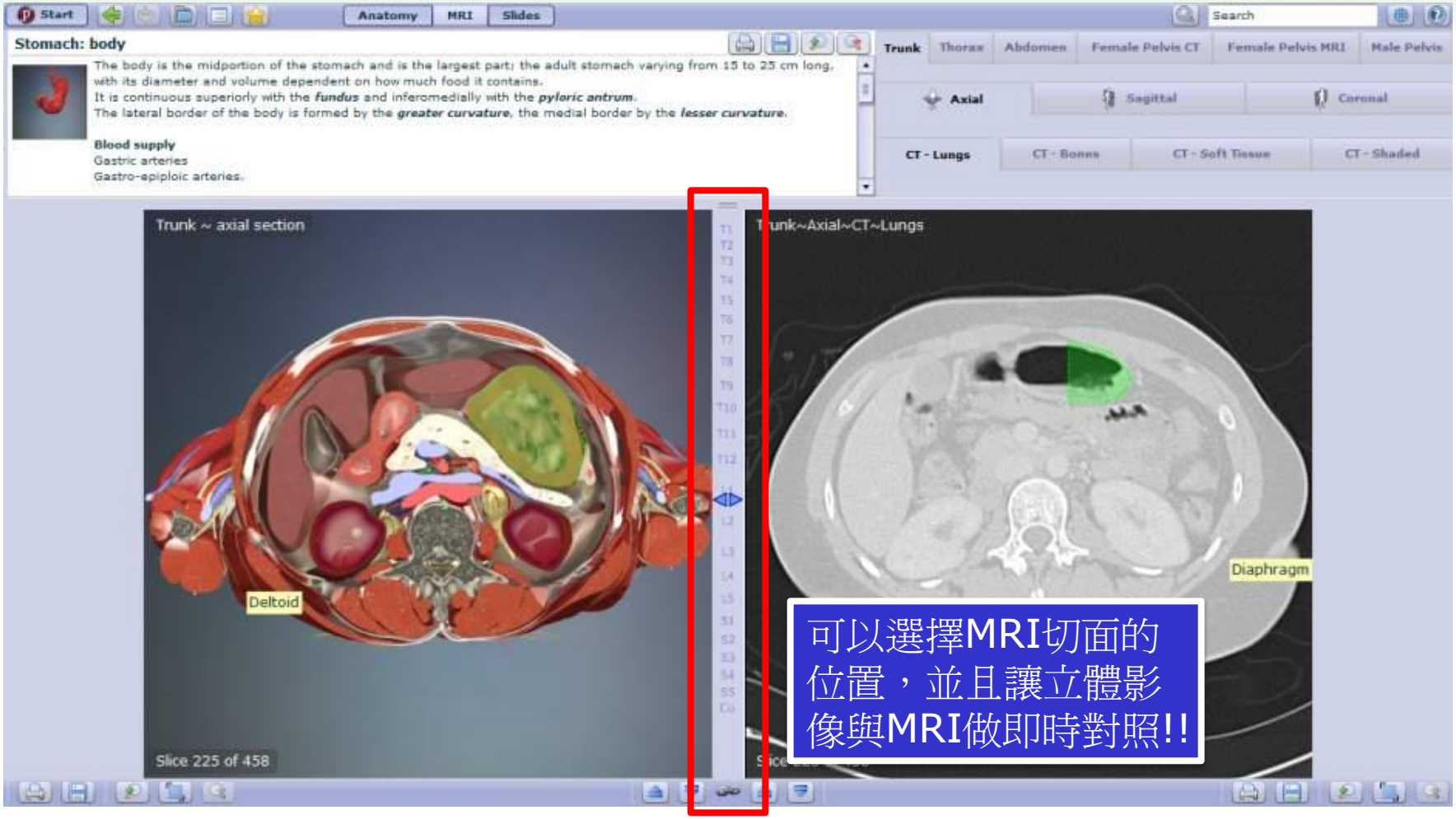


點選左上角的小圖示，即可串連至3D立體影像模式；從另外的角度切入!!

資料搜尋


Start
Anatomy
MRI
Slides
Stomach
stomach
Navigation
Contents
Search
Index
Bookmarks
stomach
In Anatomical Names (23)
Lymphatic vessels of the stomach
Stomach: body
Stomach: cardiac region
Stomach: circular muscular layer
Stomach: fundus
Stomach: greater curvature
Stomach: lesser curvature
Stomach: longitudinal muscular layer
Stomach: mucosa
Stomach: oblique muscular fibers
Stomach: pyloric antrum
Stomach: pyloric canal
Stomach: pyloric sphincter
Stomach: pylorus
Stomach: submucosa
In Slide/Movie Titles(1)
In Slide Structures (9)
In Text Articles(49)
In View Names (3)
可直接輸入您的關鍵字做搜尋，系統會將搜尋結果，關鍵字存在的類別做分類呈現
Layer 5 of 10
Frame 1 of 36
Layer 5
Stomach: pyloric canal

MRI


Start
Anatomy
MRI
Slides
Search
Stomach: body
The body is the midportion of the stomach and is the largest part; the adult stomach varying from 15 to 25 cm long, with its diameter and volume dependent on how much food it contains.
It is continuous superiorly with the fundus and inferomedially with the pyloric antrum.
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Blood supply
Gastric arteries
Gastro-epiploic arteries.
Trunk
Thorax
Abdomen
Female Pelvis CT
Female Pelvis MRI
Male Pelvis
Axial
Sagittal
Coronal
CT - Lungs
CT - Bones
CT - Soft Tissue
CT - Shaded
Trunk ~ axial section
Deltoid
Slice 225 of 458
Trunk~Axial~CT~Lungs
Diaphragm
可以選擇MRI切面的位置，並且讓立體影像與MRI做即時對照!!

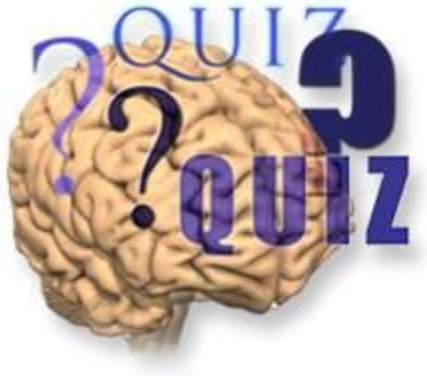
MRI:不同切面、型式


Start
Anatomy
MRI
Slides
Stomach: body
Search
Trunk
Thorax
Abdomen
Female Pelvis CT
Female Pelvis MRI
Male Pelvis
Axial
Sagittal
Coronal
CT - Lungs
CT - Bones
CT - Soft Tissue
CT - Shaded
您可依照您要所觀察的切面位置或型式做任意的選擇!!
Deltoid
Diaphragm
Slice 225 of 458
Slice 225 of 458

Quiz


ANATOMY.TV
LOG OFF
Home
My Profile
Faculty area
Student area
Help
Site map
Product Quizzes
進入Quiz
Systemic Edition
Sports & therapy
Acupuncture
Anatomy for Exercise
Anatomy Trains
Functional Anatomy
Hand Therapy
Pilates
Resistance Training
Sports Injuries: Foot 2/e
Sports Injuries: Knee 2/e
Sports Injuries: Shoulder 2/e
Regional Anatomy
Human Anatomy Regional Series:
Head & Neck
Spine
Shoulder
Hand
Thorax
Pelvis
Hip
Knee
Foot
Other titles by Region:
Essential Regional Anatomy
Regional Study Guide
Dentistry
3D Real-time Dentistry
Hand 2/e
Radiology: Thorax, Trunk
Urology
Spine: Clinical
Spine: Chiropractic
Pelvic Floor Disorders
Surgery
Axilla
Knee
Knee Arthroplasty
Hip Arthroplasty
Podiatric Medicine

Anatomy Quiz



This web site uses pop-up windows to ease navigation. Please ensure that your web browser allows pop-ups for www.anatomy.tv before proceeding.

Regional Anatomy
Human Anatomy Regional Series:

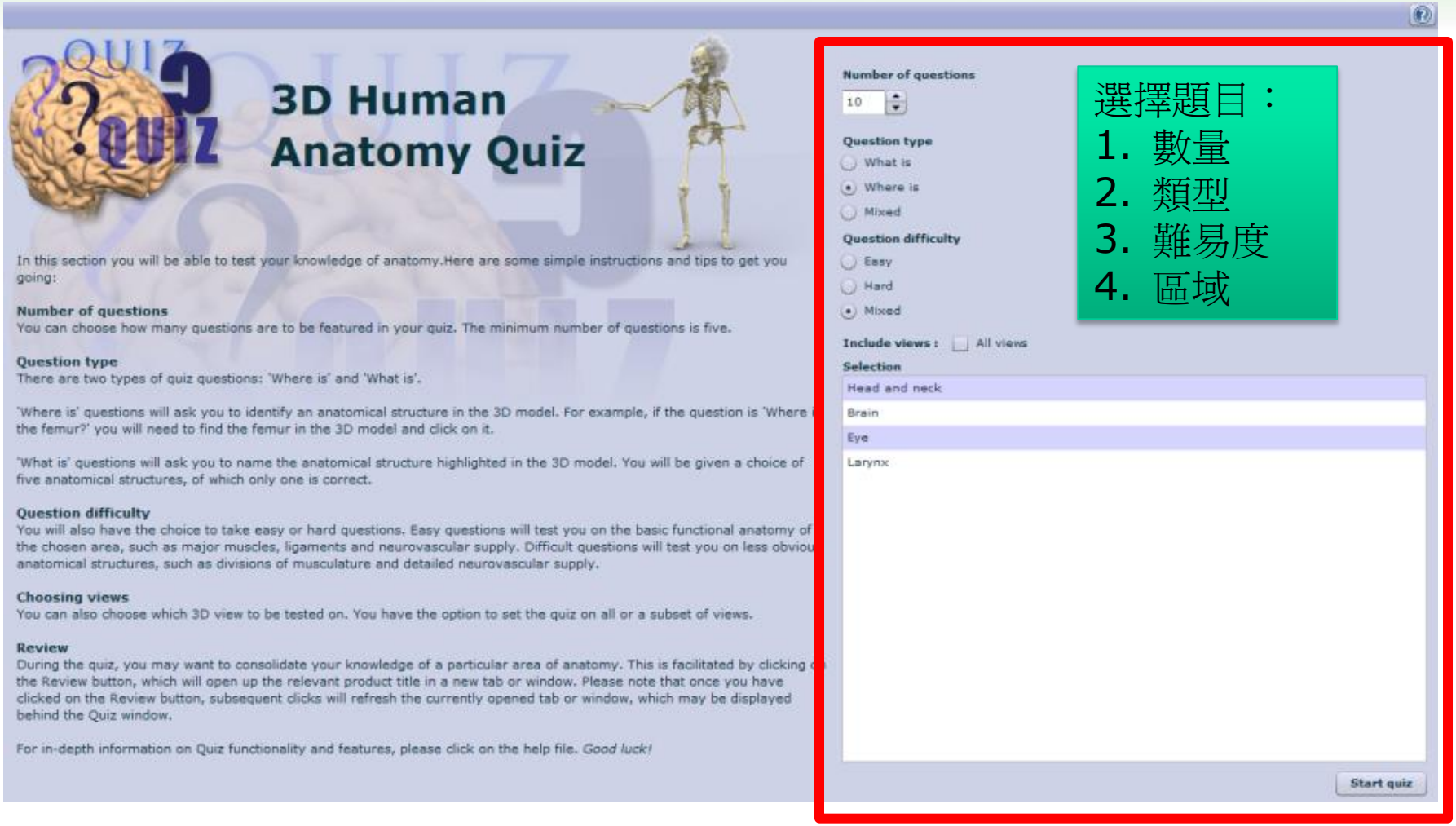
- Head & Neck
- Spine
- Shoulder
- Hand
- Thorax & Abdomen
- Pelvis & Perineum
- Hip
- Knee
- Foot

Functional Anatomy

- Functional Anatomy

依照部位、功能來選
擇您所要測驗的題目!

Quiz:



選擇題目：
1. 數量
2. 類型
3. 難易度
4. 區域

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飛資得醫學資訊

題目類型之一：Where is it ?

New Quiz

Head and neck

Where is Inferior root of ansa cervicalis?

Find and click on the structure in the 3D model to answer the question.

由右手邊的題目，於左手邊的影像上選出正確的位置!

Incorrect - You selected Epicranius: frontal belly of occipitofrontalis (Syn. frontalis).

The Inferior root of ansa cervicalis will be shown if you click on the Reveal button.

Please click on the Review button to review your knowledge in this area.

Pass | Mark

Reveal | Review | Next

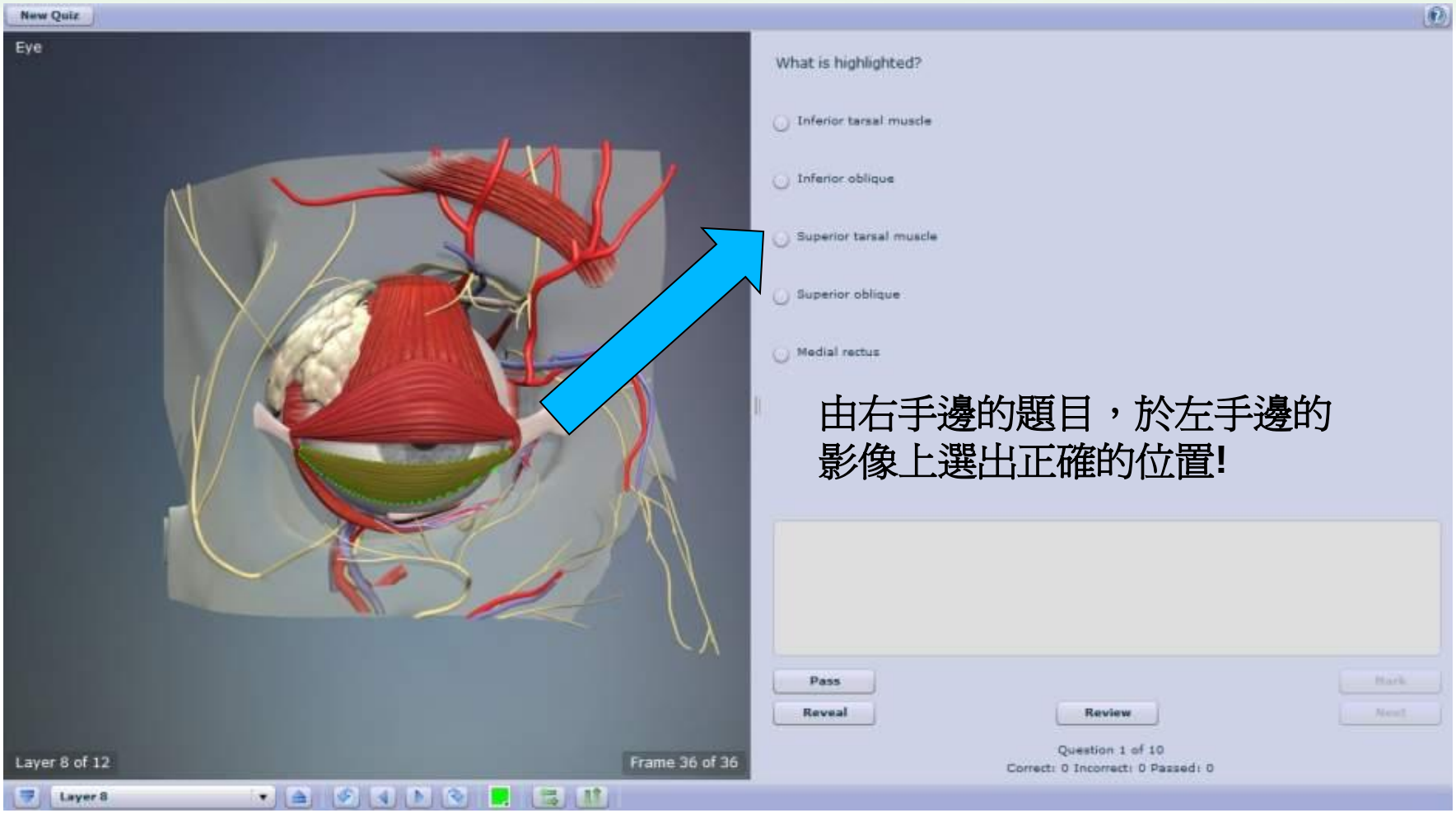
Question 2 of 10

Correct: 0 Incorrect: 1 Passed: 1

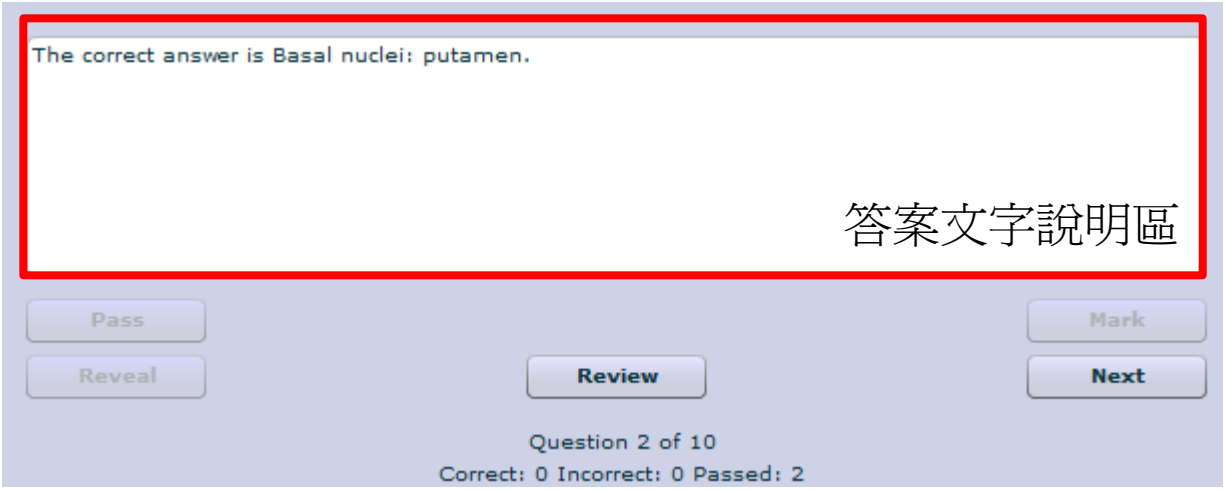
Layer 11 of 20

Frame 33 of 36

題目類型之一：What is it



Quiz 功能



按鈕	功能
Pass	略過此題目
Reveal	取得答案
Review	連結回Anatomy.tv再次觀察
Mark	確認所選取之答案
Next	下一題

Thank You!

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飛資得醫學資訊