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including WB's were six in one skull and one in each of 30 skulls, respectively. The maximum and minimum rates of sutures which had WB's were found in left lambdoid 40.7% and right occipitomastoid 1.3% sutures, respectively. There was only a significant difference between the rate of right and left squamous sutures, (p=0.04). Forty-five skulls were including fifty-five pair of bilaterally and symmetrically located sutures which coincidentally had WB's in each pair. The each of thirty-five skulls had one pair of sutures including WB's and each of ten skulls had two pairs.

Conclusion: In the present study, the rate of WB's were determined as 59.3% in West Anatolian Population. This incidence rate is considerably lower than the other reports, and it may be as a result of racial variations. These divergent bones were more frequently found in left lambdoid sutures (40.7%) and less frequently in right occipitomastoid sutures (1.3%). This study may guide the investigators dealing with the neurosurgery, orthopedy, radiology, anatomy and anthropology in their practice.

P-200

Coexistence of Wormian bones with metopism, and vice versa in adult skulls

Çırpan S, Aksu F, Mas N, Mağden AO

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Objectives: To investigate coexistence of Wormian Bones (WB's) with metopism, and vice versa in adult skulls.

Methods: 160 dry adult human skulls were randomly selected from Dokuz Eylul University of Medical Faculty's Anatomy Laboratory. The skulls were examined for presence of metopism, WB's, coexistence of WB's with metopism and vice versa. Topographic distribution of the WBs were macroscopically evaluated within the skulls including metopism.

Results: The frequency of metopism and WBs in 160 skulls is as 7.50% (12/160) and 59.3% (95/160), respectively, $p<0.05$. The incidence of coexistence of WB's with metopism was found as 11 of 12 skulls (91.66%), whereas the incidence of coexistence of metopism with WB's was found as 11 of 95 skulls (11.58%), $p<0.05$. There were totally 23 sutures including WB's in 11 skulls which had metopism. The number (%) of metopic skulls for each specific suture including WB's were found as: 11 lamdoid sutures in 7/11 (63.63%) skulls, 4 lamda in 4/11 (36.36%) skulls, 2 asterion in 2/11 (18.18%) skulls, 1 squamous in 1/11 (9.09%) skull, 2 sagittal in 2/11 (18.18%) skulls and 3 parieromsatoid sutures in 2/11 (18.18%) skulls. The distribution of these 23 WB's in sutures of 11 skulls including metopisms is determined as follows: 11/23 (47.82%) WB's at lambdoid sutures; 4/23 (17.39%) WB's at lambda; 2/23 (8.69%) WB's at asterion; 1/23 (4.34%) WB's at the left squamous suture; 2/23 (8.69%) WB's at sagittal sutures; 3/23 (13.04%) WB's at parietomastoid sutures.

Conclusion: There was a significant difference in rates between coexistence of WBs with metopism (91.66%) and coexistence of metopism with WBs (11.58%). The factors leading to metopism may also lead to WB's, whereas that the factors leading to WB's may not lead to metopism.

P-201

Suprascapular foramen: a rare variation caused by ossified suprascapular ligaments

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Objectives: The aim of this study was to investigate the incidence of the suprascapular foramen in West Anatolian Population.

Methods: Eighty-one dried human scapulae of West Anatolian people of unknown ages and gender belonging to the Anatomy Department Laboratory of Dokuz Eylül University Medical Faculty were examined macroscopically. The vertical and transverse diameters of the suprascapular foramen and central tickness of the ossified ligaments were measured with caliper in milimeters and digital caliper, respectively.

Results: We observed the suprascapular foramen due to ossification of the suprascapular ligament only in 2 of 81 (2.47%) scapulae. The vertical and transverse diameters of the suprascapular foramen and central thickness of the ossified ligaments (No-1 and 2) were measured as 0.80 mm versus 0.40 mm, 0.36 mm versus 0.20 mm and 0.40 mm versus 0.14 mm, respectively.

Conclusion: The suprascapular foramen caused by ossified suprascapular ligament is rarely observed variation in West Anatolian Population. Early diagnosis of the suprascapular nerve(SN) entrapment causing muscular atrophy is diffucult before the occurence of complaints such as deeply and poorly localized pain. The treatment of the SN compression starts with physical therapy for strengthening the rotator cuff muscles. The nerve blockage by a local anesthetic can relief the pain only for a short time and simultaneously provide diagnosis. It can be treated by surgical removal of the ossified transverse scapular ligament. The ossified suprascapular ligament narrows the suprascapular foramen; therefore, it causes compression of SN and complaints of SN entrapment. It is essential to define precisely the anatomical variations of scapular notch, scapular ligament, SN and vessels for surgeons performing SN decompression surgery, especially with arthroscopic techniques. We assume that the present study may guide the medical doctors and the surgeons during diagnostic and surgical procedures related with suprascapular notch.