MDCT evaluation of sternal variations: Pictorial essay

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Abstract
Sternal variations and anomalies have been identified in the past during autopsy or cadaveric studies. Recently, an increasing number of minor sternal variations have been reported with the advent of multidetector computed tomography (CT). Although there are many sternal variations that occur with varying appearance and prevalence, most of them are not recognized or are underreported during routine imaging of thorax. Identification of sternal variations is important to differentiate from pathological conditions and to prevent fatal complications prior to sternal interventions like marrow aspiration or acupuncture. This article aims to describe the minor and asymptomatic sternal variations by multidetector CT and their clinical significance.

Key words: Indian population; multidetector computed tomography; sternal cleft; sternal foramen; sternal variations; suprasternal ossicle; xiphoid foramen

Introduction
Sternal variations can occur in manubrium, body, or xiphoid. With the increasing use of multidetector computed tomography (MDCT), the sternal variations can be identified more frequently. In a large series, sternal variations and anomalies were characterized based on macroscopic[1] and radiographic[2] appearances in autopsy populations. In another series involving living subjects, the frequency of sternal anomalies has been described based on radiograph,[3,4] helical computed tomography (CT),[5,6] and magnetic resonance imaging (MRI)[7] appearances. Recently, sternal variations have been studied by MDCT in different populations.[8-12]

MDCT Protocol
MDCT examinations of chest were performed in our center using 128-slice CT scanner from the level of thoracic inlet to the level of adrenals in a cranio-caudal direction. The entire sternum including xiphoid process was included in all the cases. The common scanning parameters were: 120 kVp, 100-300 mA depending on body mass index, and 64 × 0.625 mm collimation. For isotropic resolution, we recommend 1 mm axial and multiplanar reconstruction image thickness. For better identification of sternal variations, images should be initially analyzed in axial, sagittal, and coronal multiplanar reconstruction (MPR) using bone algorithm followed by maximum intensity projection (MIP) and volume rendering (VR).

Embryology of Sternum
The sternal bone ossifies from a cartilaginous precursor. Beginning from the 5th month of prenatal life to shortly before birth, the ossification centers of manubrium and

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the body and the manubrium (sternal angle) is a palpable clinical landmark.\cite{6-19}

The xiphoid process is a thin and elongated bone that is subject to many variations. It is cartilaginous early in life and may become completely ossified and fused to the sternum body in old age.

**Sternal Variations**

**Suprasternal or episternal ossicle or suprasternal bone**

Suprasternal or episternal ossicle is a small accessory ossicle at the superior margin of manubrium that results from supernumerary ossification centers. It can be unilateral or bilateral.\cite{8} The CT appearance is similar to any other accessory ossicle which occurs in human skeleton. In axial plane, it is well corticated, pyramidal or ovoid in shape, and seen adjoining the superior aspect of manubrium. Oblique coronal or sagittal planes are better in depicting the relation of suprasternal ossicles to manubrium and also to identify smaller or partially fused ossicles [Figure 4A and B]. The incidence of suprasternal ossicle in living subjects is found to vary as reported in previous studies, according to the sample population and ethnicity. In a study by Ogawa et al. (1979), suprasternal ossicle was seen in 6.9% of subjects, whereas in the studies by Stark et al. (1987) and Yekelar et al. (2006), it was seen in 1.5% and 4.1% of the subjects, respectively. The presence of these suprasternal ossicles is usually

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**Anatomy of Sternum**

Sternum is a flat bone which consists of three parts: Manubrium, body, and xiphoid process [Figure 3]. Manubrium is the most cephalad and broadest segment. It has a superior central notch (suprasternal notch) and two lateral fossa (clavicular notch). Manubrium articulates with clavicles and the first two ribs laterally and with the body of sternum inferiorly (manubriosternal joint).\cite{16-19}

The body of the sternum is flat, with an irregular anterior surface. Superiorly, it articulates with the manubrium and inferiorly, it articulates with the xiphoid process at the sternoxiphoidal joint. The lateral borders of the sternum articulate with second to seventh ribs. The angle between

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**Figure 1:** Coronal volume rendered image of sternum shows non fused sternal body segments in a 11 year old child (yellow arrows). This appearance is usually seen in children between 6-12 years of age. Note absence of xiphoid ossification.

**Figure 2:** Coronal volume rendered image of sternum shows partial fusion of sternal body segments in a 17 year old (yellow arrows). The fusion of sternal body segments is usually complete by 25 years of age.
incidental, but they should be differentiated from vascular calcifications, calcified lymph nodes, fracture fragments, and foreign bodies.\[9\]

**Suprasternal tubercle**

Suprasternal tubercle forms when a suprasternal ossicle fuses with manubrium.\[3\] Similar to suprasternal bone, it can be unilateral or bilateral. In CT, it usually appears as triangular or pyramidal bony projection in continuity with the superior margin of manubrium. It is better depicted in coronal and axial planes \[Figure 5\]. Previous studies have reported the incidence of suprasternal tubercle as 1.4% (Ogawa et al.) and 4% (Yekelar et al.). Occasionally, the suprasternal bone and tubercle occur in the same patient \[Figure 6A and B\].

**Manubriosternal and sternoxiphoidal fusion**

Manubriosternal and sternoxiphoidal fusion can be partial or complete. It is best seen in sagittal and oblique coronal planes \[Figures 7 and 8\]. Complete fusion can be seen in younger and older patients. Manubriosternal fusion in the older age group due to degeneration can be associated with bridging osteophytes.\[20\] Inflammatory arthritis (especially ankylosing spondylitis) can lead to similar fusion of manubriosternal joint.\[18,21\] But this pathological ankylosis can be differentiated by its clinical features, involvement of other joints (including sternoclavicular joint and spine), and biochemical markers. In the study by Yekelar et al. (2006), 20% of subjects with complete fusion of manubriosternal and sternoxiphoidal joints were less than 45 years of age and the youngest subject was 20 years old. Similarly, we have encountered complete fusion of manubriosternal joint in a 19-year-old male \[Figure 9A and B\]. This implies that developmental fusion without osteodegeneration can occur in younger age group and should be differentiated from pathological bony ankylosis.\[8\]

**Sternal and xiphoid foramen**

Sternal foramen occurs from incomplete fusion of a pair of sternebrae.\[8\] It can be single or multiple and is usually seen in lower part of the sternal body. CT shows a well-corticated, round to oval-shaped defect in the midline of the sternal body with an average diameter of 6 mm.\[8\] In axial plane, it has a bow-tie appearance\[18\] \[Figures 10-12\]. Previous studies show the incidence of sternal foramen to be around 4.5% of the population.\[5,8\] Sometimes, the sternal foramen can mimic a lytic lesion, especially in bone scintigraphy where it appears as a focal defect.\[22\] In such cases, cross-sectional imaging can have a vital role in diagnosis. Lytic lesions of the sternum, secondary to infection, primary malignancy, or metastases usually have irregular margins, erosions, and a soft tissue component. Identification of such variations is important to prevent fatal complications during sternal marrow aspiration and acupuncture. Since mediastinal structures are unprotected, complications like cardiac tamponade can occur.\[23-25\] Similarly, xiphoid foramen can occur, but is of lesser clinical significance \[Figure 12\].

**Sternal cleft and band**

These vertically oriented midline congenital defects are seen at the junction of the sternal bars.\[8,15,18,26\] Sternal cleft occurs due to failure or incomplete fusion of sternal segments. The sternal defects can vary from a linear fissure to larger defects with complete or partial separation of sternum. The larger defects can be associated with ectopia cordis, omphalocele, or occur as part of complex syndromes (Cantrell’s pentalogy, PHACE syndrome which includes posterior fossa malformations, hemangiomas, arterial anomalies, coarctation of aorta and cardiac defects, eye abnormalities).\[15,27\] Patients with larger defects can
be clinically diagnosed at birth or early childhood and evaluated for associated anomalies. But isolated small clefts are found incidentally during imaging of chest. In CT, they are seen as a linear midline lucent defect with corticated margins in the coronal plane and slit-like defect in the axial plane [Figure 13a-c]. The smaller sternal clefts can be mistaken for a sternal fracture, but CT shows typical appearance of fracture as irregular lucency with non-sclerotic margins. Similar to sternal foramen, clefts should be recognized before any invasive procedure of sternum to prevent complications.

Bands are generally found in the manubrium and sternal body, but not in the xiphoid process [Figures 14 and 15]. Sclerotic band in sternal body is usually seen in the inferior segment in the midline and can occasionally be associated with sternal cleft or foramen.[8] Although sclerotic bands are more common than cleft, they usually have no clinical significance.[8]
Focal defect or notch
Focal defect or notch is usually seen in lower one-third of the body of sternum in the posterior aspect, with an incidence of 7.7% of the population. In some cases, it appears as recently closed or incomplete sternal foramen.8 In CT, it appears as a round or wedge-shaped, well-corticated defect in the posterior sternal cortex [Figure 16A and B]. Although majority of such defects are seen in the posterior cortex, we encountered a case where there was both anterior and posterior cortical defect [Figure 17A-C]. Similar to sternal foramen, focal defect or notch can show photopenic area in bone scintigraphy.22

Xiphoid Ending, Ossification, and Xiphoid Ligament Calcification
Xiphoid ending is classified as single, double, or triple. The most common xiphoid ending is single, followed by double and triple ending.8,12 [Figure 18A-C]. In addition, xiphoid can vary in size (elongated process) and shape (e.g. ventral or dorsal deviation, hook like,
reverse “S” shape). We have encountered few cases of elongated xiphoid process measuring more than 4 cm in length, out of which one was reverse “S” shaped [Figures 19 and 20]. In another subject, the xiphoid process was laterally deviated, resembling a semilunar or “C” shape [Figure 21].
Xiphoid ossification is usually complete in middle and older age. In one study, majority of subjects with no xiphoid ossification were under 30 years of age.\(^8\) Xiphoid ligament calcification (unilateral and bilateral) is usually seen in older age group\(^8\) (>50 years) [Figure 22A and B]. Xiphoid variations are usually of no clinical significance. However, review of literature shows elongated and ventrally deviated xiphoid process can be mistaken for an epigastric mass and cause pain\(^{29,30}\) [Figure 23].
Figure 23: Reformatted sagittal CT of sternum shows an elongated xiphoid process with ventral deviation (yellow arrow). Such variation can mimic an epigastric mass. Also note a sternal foramen (red arrow).

Figure 24: Coronal MIP image of sternum shows a pseudo foramen at sternoxiphoidal junction (yellow arrow).

Figure 25: Coronal volume rendered image of sternum shows non-fusion of upper and mid segment of sternal body in a 60 year old (white arrow).

Figure 26: Coronal volume rendered image of sternum shows longitudinal oval shape of sternal body.

**Sternal pseudo foramen and pseudocleft**

Pseudo foramen and pseudocleft can be seen at...
manubriosternal and sternoxiphoidal junctions due to partial fusion [Figure 24]. They have no clinical significance.

**Non-fusion of sternal body segments**
Fusion of sternal body segments is usually complete by 25 years of age. But non-fusion of sternal body segments can be seen in older age group [Figure 25].

**Shape of sternal body**
The body of sternum has three different shapes – longitudinal oval, flat, and “O” shape [Figures 26-28]. The shape is decided according to the proportion of basic and maximum breadths of the sternal body. The basic breadth is obtained as an average measurement of the upper and lower segments of the sternal body. The upper measurement is between second and third, whereas the lower measurement is between sixth and seventh costal notches, respectively. In a cadaveric study by Selthofer et al., the longitudinal oval type was the standard shape of sternal body. Recently, in a study by Bayarogulları et al. that evaluated postnatal development of the sternum by MDCT, flat type was most commonly seen.

**Conclusion**
The use of multiplanar, curved reconstructions, MIP and VR images has made MDCT the primary imaging method of choice for the evaluation of sternum. Some of the key points regarding sternal variations are as follows.

• Developmental fusion of manubriosternal joint in younger age group should not be misinterpreted as pathological bony ankylosis
• Identification of sternal foramen or cleft prior to invasive procedure of sternum prevents catastrophic complications
• In bone scintigraphy, sternal foramen or defect can mimic lytic lesion
• Elongated and ventrally deviated xiphoid process can present as an epigastric mass.

Thus, the radiologist should be familiar about such variations of clinical importance to prevent complications and misdiagnosis.

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There are no conflicts of interest.

**References**


