A healthy 2-week-old boy was seen for his initial well-child examination and was noted to have a 3 × 2-cm firm raised lesion over his occipital area. There was no history of trauma since his birth. The birth history consisted of an infant born at 39 weeks' gestation to a 27-year-old primigravida mother who was preeclamptic and had positive culture findings for group B streptococcus. The delivery was notable for shoulder distocia and nuchal cord. After delivery the infant had a bruised head and petechiae over his entire face. There was no swelling in the occipital area. The patient did well and was discharged home on day 2 of life without complications.

Findings from physical examination were unremarkable except for a 2 × 3-cm swelling over the occipital area and crepitus palpable along the transverse occipital suture line. He had normal findings on neurological examination. There was concern regarding possible fracture from abuse or trauma sustained at birth. Skull radiographs were obtained (Figure 1 and Figure 2).

From the Sections of Pediatric Radiology (Dr Mercado-Deane) and General Pediatrics (Dr Brummund), Medical College of Georgia (Dr Parente), Augusta.
Denouement and Discussion

Inca Bone

Inca bones are a result of faulty ossification in the interparietal area of the occipital squama. The occipital squama consists of a supraoccipital area that develops in cartilaginous bone and an interparietal area that is ossified in membranous bone. Inca bones form when an additional pair of ossification centers develop in the interparietal area and do not fuse with the remainder of the occipital bone. They are located at the lower border of the interparietal occipital suture and slightly above the external occipital protuberance. The Inca bones fuse completely by age 40 years.

The distinction between the Inca bone and a skull fracture is accomplished by noticing the irregular contour of the edges of the Inca bone compared with the smoother, linear course of a skull fracture. The distinction is important in avoiding the patient and the family experiencing an evaluation for nonaccidental trauma.

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REFERENCES


New Feature: Clinical Problem Solving

The Editor is seeking submissions for a new feature, Clinical Problem Solving, which will combine Picture of the Month, Radiological Case of the Month, and Pathological Case of the Month. Our aim is to demonstrate the thinking process of a master clinician involved in approaching a patient with an unknown disease. The discussion of such cases should place the clinician’s expertise into the context of the prevailing medical literature on the topic. Manuscripts should be between 3000 and 4000 words and may include photographs and radiographs.