INTRODUCTION
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"For all the happiness,
Mankind can gain,
Is not in pleasure -
But in rest from pain."

Pain has been the most distressing symptom which has attracted the attention of the humanity since its evolution. The pain relief has been a constant problem which is a matter of great research in medical profession.

Treatment of pain offers many worthwhile opportunities for anaesthetists for active participation in helping those in distress.

There are various theories of pain mechanism, but none is explanatory. According to Sherrington, (1906) - 'Pain is the psychical adjunct to an imperative protective reflex.' Pain is a specific mode of sensibility, distinct from other sensory modalities such as touch, warmth and cold. Pain can not be defined in words which would mean anything to a person who has not experienced it. It is a subjective affair, though it may be accompanied by measurable physiological responses such as reflex
withdrawal of movements, changes in vasomotor tone, blood pressure, heart rate, breathing and sweating etc.

The management varies according to the difference in the quality of pain. Correctly diagnosed acute cases may be cured with prompt treatment. The conventional methods, be it by drugs, injections, surgery or other means, have their own limitations.

The analgesics like opiates etc. have their own hazards of limited potency, tolerance, addiction, side effects and need for repeated dosage. Moreover the conventional analgesics are tried only after the onset of pain, where they become less effective on account of the increased pain threshold. This handicap leads to an increase in dosage, augmenting the occurrence of complications like respiratory depression. This shortcoming is further enhanced by the need of repeated pricks, disturbing the patient and involving close nursing care, normally not always at hand.

The identification, by Synder, of specific receptors which are sensitive to
narcotics, in the substantia gelatinosa of posterior horn cells of spinal cord, in 1975, has opened a new concept of treatment of pain by introducing the pain-killers intrathecally or epidurally. The major drawback of intrathecal route is the direct introduction of infection to nervous system. Epidural analgesia, therefore, comes far ahead and marks the beginning of a new era. Epidural analgesia blocks motor, sensory and autonomic systems, with the added advantage that its effect vanishes after some time (Crawford, 1975; Taylor, 1977 and Thornburn, 1980).

Not only local anaesthetic agents can be administered epidurally, but also analgesic agents like morphine (Behar, 1979; Bapat, 1979; Joan, 1979; Johnston, 1979), pethidine (Cousins, 1979), fentanyl (Wolfe, 1979) and dilaudid (Leslie, 1979).

Epidural injections of these agents are required in much smaller doses as compared to the quantity required for other conventional routes, resulting in the minimisation of various side effects. It is further selective in blocking the pain pathway only, with no adverse effect on
pulse, blood-pressure and muscle tone.

Alleviation of pain further increases the vital capacity. The cough-reflex is not hampered, thereby reducing the occurrence of post-operative pulmonary complications. Epidural analgesia has an extra advantage of being useful in cases where pain is not responding to analgesics administered through conventional routes.

The present study has been undertaken to mark the supremacy of epidural analgesia over conventional methods, mainly in the post-operative cases.