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Pain is one of man's most compelling experience. It is an unpleasant sensation frequently associated with physical damage, therefore often described by the patients in connection with injury. Sherrington (1906), in his classical work on the central nervous system has defined pain as, "the psychical adjunct to an imperative protective reflex". This concept draws attention to the protective aspect of pain in preventing body injury from noxious stimuli. It is considered a signal from a warning device, but, like other expressions of the regulatory mechanisms within the body, it sometimes, functions in an unsatisfactory way. It is not only a distressing experience, but if continued, it may have harmful effects on the vital organs leading to impairment of function or even tissue damage (Wolff and Wolf, 1958).

The persistence of pain may interfere with the surgical procedures and make them very distressing for the patient and also more difficult for the surgeon. Hence its alleviation during surgery is, therefore, the raison d'être of anaesthesia.

The endeavour of modern anaesthesiology stems around the attainment of ideal operating conditions (Co-operative and painfree patient) with the total body physiology maintained as near normal as possible. In order to hit the bull's eye, anaesthesiology today, is
armed with a number of drugs and techniques, which have some thing or other to boast their supremacy over the others, but still the eye could not be perforated.

General anaesthesia, although the most effective method of pain relief, is not without the risk of alterations in the cardiovascular and respiratory functioning, as also a definite change in body chemistry. These changes may not be of significance in normal patients but may have vital role to play in increasing the post-operative morbidity and mortality, in patients with metabolic and systemic disorders. With the suppression of reflexes the possibility of regurgitation and aspiration, under general anaesthesia, is also enhanced, particularly in patients with full stomach undergoing emergency surgery.

The absence of these limiting factors add a feather to the cap of local anaesthesia, thereby increasing its popularity under such circumstances. The discovery of a number of safe and potent local analgesic drugs, along with the evolution of various simple techniques of field blocks, has made them still more acceptable to the population as such.

One such technique, INTRAVENOUS REGIONAL ANALGESIA is a simple, effective, cheap and safe method of pain relief during surgery over limbs and can be repeated again and again. It claims special preference in busy hospitals and overworked emergencies where availability
of beds is a problem and rapid turnover of the patients, a must. Moreover most of the patients requiring emergency surgical intervention are not suitably prepared for an early general anaesthesia.

Almost a century has elapsed since local analgesic drug was injected intravenously by August Bier (1906) in 134 cases with no adverse effects. Several series were thereafter reported, but the technique got little attention. The credit for reintroducing intravenous regional analgesia in clinical practice goes to Holmes (1963), who suggested that lignocaine acted upon the motor and sensory nerve endings. He was ably supported by the studies of several workers, (Miles et al, 1964; Fleming et al, 1966, and Adriani, 1968). On the other hand Sorbie and Chacha (1965), concluded, on clinical and electrophysiological grounds, that the local anaesthetic acted mainly on the nerve trunks.

Various local analgesic drugs have been employed in this technique viz chloroprocaine, Lidocaine, Prilocaine and Bupivacaine etc, but an agent of choice which should provide wide margin of safety, rapid onset and longer duration of action is still at large. The occurrence of thrombophlebitis in subjects receiving chloroprocaine may be due to its acidity and contraindicates its use. Prilocaine is less likely to produce signs of central nervous system toxicity than lidocaine and is equally
as effective as lidocaine but however it has the disadvantage of producing methaemoglobinaemia. Lidocaine is to be used with caution to avoid sensitivity reactions. Bupivacaine takes its own time to give full effect. Hence it can well be seen that every drug has one or the other limiting factor. Therefore under these circumstances the local analgesic, CENTBUCRIDINE, discovered at C.D.R.I. Lucknow, is employed in this technique to establish whether the drug is superior or not to the present conventional local analgesic drugs.