INTRODUCTION
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"Pain is perfect misery and worst of all evils and accessive over - twins all patients". This was the impression given by the Milton in his "Paradise lost". There has been various techniques for pain relief in the medical profession from ancient times. The major advance in surgery occurred after synthesis of lignocaine by Lofgren in 1943. The lignocaine is the derivative of diethyl amino-acetic acid. Lignocaine and bupivacaine both are members of aminoamide class of local anaesthetics. Lignocaine has a great supremacy over several other local anaesthetic agents because of being potent and yet safe with least incidence of side effects as well as toxic effects. Inspite of this, an everlasting search is continued to find out an ideal agent which besides being a potent analgesic, is free from local irritation equally effective topically and relatively with less systemic toxicity. Lignocaine contain properties of quick onset and prolonged duration of analgesic and is stable on storage and on sterilization.

While the bupivacaine has acquired a reputation for the slow onset, hence in the busy hospital it would seem attracting to use an agent having fast onset and
retaining the desirable long duration characteristic of bupivacaine.

Previously, it appeared that etiodocaine will fulfil this requirement. The feature to produce prolonged motor blockade by etiodocaine is not desirable.

Regional analgesia like intradural and extradural analgesia does not cause the hypnosis like effect as in the general anaesthesia.

Subdural as well as epidural analgesia are techniques which can be adopted for lower abdominal surgery without interfering with function of other organs and systems. Therefore, advantageous in the poor risk patients, emergency cases with uncontrolled systemic diseases or when general anaesthesia might be unsuitable and hazardous. The technique itself is simple, effective, quite safe and cheap for the lower abdominal surgery.

Large and busy hospitals and over-worked emergency services can not afford to hospitalize all the patients for longer period and most of these patients require emergency surgical treatment, are not allowed for quick general anaesthesia without suitable preparation. The patients may very safely be allowed to go home post-operatively and the procedure involves minimum theatre pollution.
Spinal analgesia has achieved wide-spread popularity as a simple and effective method of producing conduction block for surgery after introduction in 1868 by August Bier.

Peridural analgesia was first introduced into the clinical practice in 1921 by Pages. Ekblom and Widman (1966) used bupivacaine for the first time in the epidural analgesia. A significant long duration of action of bupivacaine is so much that cumbersome and complicated procedures like continuous catheter technique in intradural and extradural analgesia. To minimise the dose and frequency of analgesic drugs during post-operative period.

Both spinal and epidural analgesia have advantages and disadvantages. Spinal analgesia has some advantages as compared with epidural analgesia (Moore and Brideburg, 1698), such as faster analgesia and the height of conduction block is more controlled. Failure of conduction and unsatisfactory block is less and less dose is required. On the other hand, epidural analgesia also has some definite advantages over the spinal analgesia like avoidance of post-spinal headache, minimum chance of meningitis, lesser fall in B.P. with minimal risk of nausea and vomiting in the post-operative period.

The clinical advantages of mixing local anaesthetics for epidural and intradural blockade have not been demonstrated clearly.
The aim of the proposed work is a comparative evaluation of intradural and extradural blocks, using bupivacaine and lignocaine mixture, for lower abdominal surgery.

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