New Zealand Data Sheet

TRAMAL® Capsules
TRAMAL® Solution for Injection
TRAMAL® SR Tablets

WARNINGS

Limitations of use
Because of the risks associated with the use of opioids, TRAMAL® should only be used in patients for whom other treatment options, including non-opioid analgesics, are ineffective, not tolerated or otherwise inadequate to provide appropriate management of pain (see *section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE*).

Hazardous and harmful use
TRAMAL® poses risks of hazardous and harmful use which can lead to overdose and death. Assess the patient's risk of hazardous and harmful use before prescribing and monitor the patient regularly during treatment (see *section 4.4. SPECIAL WARNINGS AND PRECAUTIONS FOR USE*).

Life threatening respiratory depression
Serious, life-threatening or fatal respiratory depression may occur with the use of TRAMAL®. Be aware of situations which increase the risk of respiratory depression, modify dosing in patients at risk and monitor patients closely, especially on initiation or following a dose increase (see *section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE*).

Concomitant use of benzodiazepines and other central nervous system (CNS) depressants, including alcohol
Concomitant use of opioids with benzodiazepines, gabapentinoids, antihistamines, tricyclic antidepressants, antipsychotics, cannabis or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Limit dosages and durations to the minimum required; and monitor patients for signs and symptoms of respiratory depression and sedation. Caution patients not to drink alcohol while taking TRAMAL®.

1. PRODUCT NAME

TRAMAL® (tramadol hydrochloride) immediate release capsules 50 mg
TRAMAL® (tramadol hydrochloride) solution for injection 50 mg/mL, 100 mg/2mL
TRAMAL® SR tablets (tramadol hydrochloride) sustained release tablets) 50 mg, 100 mg, 150 mg, 200 mg

2. QUALITATIVE AND QUANTITATIVE COMPOSITION

TRAMAL® 50 mg capsules are yellow-yellow capsules containing: 50 mg tramadol hydrochloride.

TRAMAL® 50 mg and 100 mg injections contain: tramadol hydrochloride 50 mg/mL.

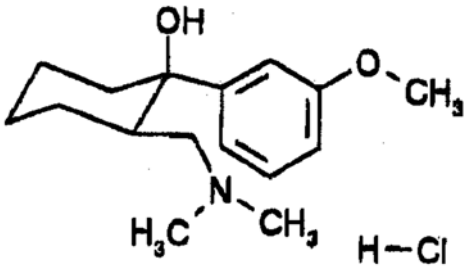
TRAMAL® SR sustained release tablets contain: tramadol hydrochloride in the following dose strengths: 50, 100, 150 and 200 mg.

For full list of excipients, see section *6.1 LIST OF EXCIPIENTS*.

TRAMAL® capsules, TRAMAL® solution for injection, and TRAMAL® SR tablets contain tramadol hydrochloride which is (±) - *cis*-2-(dimethylaminomethyl)-1-(3-methoxyphenyl)-cyclohexanol hydrochloride. Tramadol hydrochloride is an odourless, white to off-white crystalline powder

that is readily soluble in both water and ethanol and has a pKa of 9.41. The water/n-octanol partition coefficient is 1.35 at pH 7. It belongs to the synthetic analgesics class and has opioid-like activity, with the formula: $C_{16}H_{25}NO_2$. HCl. MW = 299.84.

The structural formula of tramadol hydrochloride is:-



The CAS Registry Number is 36282-47-0.

3. PHARMACEUTICAL FORM

TRAMAL® capsules are oblong, yellow/yellow, shiny hard gelatin capsules size 4.

TRAMAL® solution for injection is clear, colourless solution.

TRAMAL® SR 50mg sustained release tablets are pale yellow coloured, round, biconvex, film-coated tablets, engraved with "T0" on one side and Grunenthal logo on the other side.

TRAMAL® SR 100 mg sustained release tablets are supplied as white, round, biconvex, film- coated tablets, engraved with"T1" on one side and the Grunenthal logo on the other side.

TRAMAL® SR 150 mg sustained release tablets are supplied as pale orange-coloured, round, bi-convex, film-coated tablets, engraved with "T2" on one side and the Grunenthal logo on the other side.

TRAMAL® SR 200 mg sustained release tablets are supplied as slightly brownish orange-coloured, round, bi-convex, film-coated tablets, engraved with "T3" on one side and the Grunenthal logo on the other side.

4. CLINICAL PARTICULARS

4.1 THERAPEUTIC INDICATIONS

Relief of moderate to severe pain.

4.2 DOSE AND METHOD OF ADMINISTRATION

Dose

The dose of tramadol should be titrated to the severity of the pain and the clinical response of the individual patient. Tramadol is approved for use in adults, adolescents and children over the age of 12 years. TRAMAL® is contraindicated in all children younger than 12 years

of age and in postoperative management of children younger than 18 years of age following tonsillectomy and/or adenoidectomy (see *section 4.3 – CONTRAINDICATIONS* and *section 4.4 – SPECIAL WARNINGS AND PRECAUTIONS FOR USE - PAEDIATRIC USE*).

The recommended dosage of TRAMAL® capsules, TRAMAL® solution for injection, and TRAMAL® SR tablets respectively are as follows:

TRAMAL® capsules
Oral administration - for the treatment of moderate pain TRAMAL® 50 – 100 mg administered two or three times daily may be sufficient. TRAMAL® 50 mg may be adequate as the initial dose for moderate pain.

For moderate to severe pain, 50 – 100 mg as needed for relief, every four to six hours may be administered. TRAMAL® 100mg is usually more effective as the initial dose for more severe pain.

The maximum daily dose should not exceed 400mg per day.

TRAMAL® solution for injection
Parenteral administration - TRAMAL® injection may be administered by intravenous or intramuscular injection. Few data are available on the administration of TRAMAL® by repeated intramuscular injection. Intravenous injections should be given slowly over 2-3 minutes.

For postoperative pain, an initial bolus of 100 mg should be administered. Subsequent doses of 50 mg or 100mg every four to six hours may be given, up to a total daily dose of 600 mg.

For less severe pain, 50 mg or 100 mg every four to six hours to a maximum of 400 mg per day.

PHARMACEUTICAL PRECAUTIONS
TRAMAL® solution for injection is incompatible with injection solutions containing diclofenac, indomethacin, phenylbutazone, diazepam, flunitrazepam, glyceryl trinitrate or midazolam. TRAMAL® solution for injection is compatible with the following intravenous fluids: 0.9% sodium chloride, 5% glucose, 4.2% sodium bicarbonate, Ringer's solution, Ringer's lactate solution, Dextran 40 (10%) or polygeline 3.5%.

TRAMAL® SR tablets
Oral administration - the recommended dose of TRAMAL® SR in adults and adolescents over the age of 12 years is 100 mg to 200 mg twice daily, preferably morning and evening.

For initial titration therapy, a lower starting dose may be appropriate for some patients.

The tablets are to be taken whole, not divided or chewed, with sufficient liquid, irrespective of food intake.

The maximum daily dose should not exceed 400 mg per day.

Paediatric use - TRAMAL® solution for injection are approved for use in children 12 years old and over. Analgesic dosage of TRAMAL® solution for injection must be individualised by the physician according to the severity of pain as well as on the basis of patient's age and weight.

Renal insufficiency - in patients with renal insufficiency the elimination of tramadol is delayed. In these patient's prolongation of the dosage intervals should be carefully considered according to the patient's requirements. In cases of severe renal insufficiency TRAMAL prolonged-release tablets are not recommended. Since only 7% of an administered dose is removed by haemodialysis, dialysis patients can receive their regular dose on the day of dialysis (see *section 4.4 – SPECIAL WARNINGS AND PRECAUTIONS FOR USE*).

Hepatic insufficiency - TRAMAL® SR should not be used in patients with severe hepatic insufficiency. In these patients, the immediate release (IR) form of oral tramadol (capsule) may be administered if appropriate. In hepatic impairment, the initial oral dose of tramadol is 50 mg of the immediate release formulation. Depending on the severity of the impairment and individual clinical response, the recommended dosage interval (4-6 hours) may require to be extended, and/or the dose level titrated as required (see *section 4.4 – SPECIAL WARNINGS AND PRECAUTIONS FOR USE*).

Pharmaceutical compatibility
TRAMAL® injection is compatible with the following intravenous fluids: 0.9% sodium chloride, 5% glucose, 4.2% sodium bicarbonate, Ringer's solution, Ringer's lactate solution, Dextran 40 (10%) or polygeline 3.5%.

Method of administration

For method of administration see section *4.2 DOSE AND METHOD OF ADMINISTRATION.*

4.3 CONTRAINDICATIONS

Tramadol is contraindicated in:
- individuals with known hypersensitivity to tramadol or any excipients listed in section 6.1
- acute intoxication with alcohol, hypnotics, analgesics, opioids or psychotropic drugs
- patients with severe respiratory disease, acute respiratory disease and respiratory depression
- all children younger than 12 years of age (see *section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE*)
- postoperative management of children younger than 18 years of age following tonsillectomy and/or adenoidectomy (see *section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE*)
- patients who are taking MAO inhibitors or who have taken them within the last 14 days
- known hypersensitivity to opioids
- patients with uncontrolled epilepsy or epilepsy not adequately controlled by treatment.

Tramadol must not be used for narcotic withdrawal treatment.

4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE

Hazardous and harmful use
TRAMAL® contains the opioid tramadol hydrochloride and is a potential drug of abuse, misuse and addiction. Addiction can occur in patients appropriately prescribed TRAMAL® at recommended doses.
The risk of addiction is increased in patients with a personal or family history of substance abuse (including alcohol and prescription and illicit drugs) or mental illness. The risk also increases the longer the drug is used and with higher doses. Patients should be assessed for their risks for opioid abuse or addiction prior to being prescribed TRAMAL®.
All patients receiving opioids should be routinely monitored for signs of misuse and abuse. Opioids are sought by people with addiction and may be subject to diversion. Strategies to reduce these risks include prescribing the drug in the smallest appropriate quantity and

advising the patient on the safe storage and proper disposal of any unused drug (see *section 6.4 SPECIAL PRECAUTIONS FOR STORAGE* and *section 6.6 SPECIAL PRECAUTIONS FOR DISPOSAL*). Caution patients that abuse of oral or transdermal forms of opioids by parenteral administration can result in serious adverse events, which may be fatal.
Patients should be advised not to share TRAMAL® with anyone else.

Respiratory depression and sedation
Tramadol should be administered cautiously in patients at risk of respiratory depression. Serious, life-threatening or fatal respiratory depression can occur with the use of opioids even when used as recommended. It can occur at any time during the use of TRAMAL® but the risk is greatest during initiation of therapy or following an increase in dose. Patients should be monitored closely for respiratory depression at these times.
The risk of life-threatening respiratory depression is also higher in elderly, frail, or debilitated patients and in patients with existing impairment of respiratory function (e.g. chronic obstructive pulmonary disease; asthma), hepatic or renal impairment (see *section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE)*. Opioids should be used with caution and with close monitoring in these patients (see *section 4.2 DOSE AND METHOD OF ADMINISTRATION*). The use of tramadol hydrochloride is contraindicated in patients with severe respiratory disease, acute respiratory disease and respiratory depression (see *section 4.3 CONTRAINDICATIONS*).

The risk of respiratory depression is greater with the use of high doses of opioids, especially high potency and modified release formulations, and in opioid naïve patients. Initiation of opioid treatment should be at the lower end of the dosage recommendations with careful titration of doses to achieve effective pain relief. Careful calculation of equianalgesic doses is required when changing opioids or switching from immediate release to modified release formulations, together with consideration of pharmacological differences between opioids. Consider starting the new opioid at a reduced dose to account for individual variation in response (see *section 4.2 DOSE AND METHOD OF ADMINISTRATION*).

Cases of intra-operative respiratory depression, usually with large intravenous doses of tramadol and with concurrent administration of respiratory depressants, have been reported. Screen patients for risk of substance use disorders, including opioid abuse and misuse, and warn them of the risk for overdose and death associated with the use of additional CNS depressants including alcohol and illicit drugs (see *section 4.5 INTERACTIONS WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTION*).

Sleep-related breathing disorders
Drugs with μ-opioid receptor agonist activity can cause sleep-related breathing disorders including central sleep apnoea (CSA) and sleep-related hypoxemia. Use of these drugs increases the risk of CSA in a dose-dependent fashion. In patients who present with CSA, consider decreasing the total opioid dosage.

Risks from concomitant use of benzodiazepines or other CNS depressants, including alcohol
Concomitant use of opioids and benzodiazepines or other CNS depressants, including alcohol, may result in sedation, respiratory depression, coma and death. Because of these risks, concomitant prescribing of TRAMAL® with CNS depressant medicines, such as other opioid analgesics, benzodiazepines, gabapentinoids, cannabis, sedatives, hypnotics, tricyclic antidepressants, antipsychotics, antihistamines, centrally-active anti-emetics and other CNS depressants, should be reserved for patients for whom other treatment options are not possible. If a decision is made to prescribe TRAMAL® concomitantly with any of the medicines, the lowest effective dose should be used, and the duration of treatment should be as short as possible. Patients should be followed closely for signs and symptoms of

respiratory depression and sedation. Patients and their caregivers should be made aware of these symptoms. Patients and their caregivers should also be informed of the potential harms of consuming alcohol while taking TRAMAL®.

Use of opioids in chronic (long-term) non-cancer pain (CNCP)
Opioid analgesics have an established role in the treatment of acute pain, cancer pain and palliative and end-of-life care. Current evidence does not generally support opioid analgesics in improving pain and function for most patients with chronic non-cancer pain. The development of tolerance and physical dependence and risks of adverse effects, including hazardous and harmful use, increase with the length of time a patient takes an opioid. The use of opioids for long-term treatment of CNCP is not recommended.

The use of an opioid to treat CNCP should only be considered after maximised non-pharmacological and non-opioid treatments have been tried and found ineffective, not tolerated or otherwise inadequate to provide sufficient management of pain. Opioids should only be prescribed as a component of comprehensive multidisciplinary and multimodal pain management.

Opioid therapy for CNCP should be initiated as a trial in accordance with clinical guidelines and after a comprehensive biopsychosocial assessment has established a cause for the pain and the appropriateness of opioid therapy for the patient (see *Hazardous and harmful use*, above). The expected outcome of therapy (pain reduction rather than complete abolition of pain, improved function and quality of life) should be discussed with the patient before commencing opioid treatment, with agreement to discontinue treatment if these objectives are not met.

Owing to the varied response to opioids between individuals, it is recommended that all patients be started at the lowest appropriate dose and titrated to achieve an adequate level of analgesia and functional improvement with minimum adverse reactions. Immediate-release products should not be used to treat chronic pain, but may be used for a short period in opioid-naïve patients to develop a level of tolerance before switching to a modified-release formulation. Careful and regular assessment and monitoring is required to establish the clinical need for ongoing treatment. Discontinue opioid therapy if there is no improvement of pain and/or function during the trial period or if there is any evidence of misuse or abuse. Treatment should only continue if the trial has demonstrated that the pain is opioid responsive and there has been functional improvement. The patient's condition should be reviewed regularly and the dose tapered off slowly if opioid treatment is no longer appropriate (see *Ceasing Opioids*).

Tolerance, dependence and withdrawal
Neuroadaptation of the opioid receptors to repeated administration of opioids can produce tolerance and physical dependence. Tolerance is the need for increasing doses to maintain analgesia. Tolerance may occur to both the desired and undesired effects of the opioid. Physical dependence, which can occur after several days to weeks of continued opioid usage, results in withdrawal symptoms if the opioid is ceased abruptly or the dose is significantly reduced.

Withdrawal symptoms can also occur following the administration of an opioid antagonist (e.g. naloxone) or partial agonist (e.g. buprenorphine). Withdrawal can result in some or all of the following symptoms: dysphoria, restlessness/agitation, lacrimation, rhinorrhoea, yawning, sweating, chills, myalgia, mydriasis, irritability, anxiety, increasing pain, backache, joint pain, weakness, abdominal cramps, insomnia, nausea, anorexia, vomiting, diarrhoea, increased blood pressure, increased respiratory rate and increased heart rate.
Symptoms of withdrawal reactions from tramadol hydrochloride are similar to those occurring during opiate withdrawal and may include: agitation, anxiety, nervousness, insomnia,

hyperkinesia, tremor, pyrexia, myalgia, chills and gastrointestinal symptoms. Other symptoms that have very rarely been seen with tramadol discontinuation include panic attacks, severe anxiety, hallucinations, paraesthesias, tinnitus and unusual CNS symptoms (i.e. confusion, delusions, personalization, derealization, paranoia).

When discontinuing TRAMAL® in a person who may be physically-dependent, the drug should not be ceased abruptly but withdrawn by tapering the dose gradually (see *Ceasing opioids* and *section 4.2 DOSE AND METHOD OF ADMINISTRATION*).

Tramadol is not recommended as a substitute in opioid-dependent patients. Although tramadol is an opiate-agonist, it cannot suppress opioid withdrawal symptoms. Animal experiments have shown that under certain circumstances the administration of tramadol may provoke a withdrawal syndrome in opioid-dependent monkeys.
Because of the difficulty in assessing dependence in patients who have previously received substantial amounts of opioid medications, caution should be used in the administration of tramadol to such patients.

In patients with a tendency for drug abuse or dependence, treatment with tramadol should only be carried out for short periods under strict medical supervision.

Accidental ingestion/exposure
Accidental ingestion or exposure of TRAMAL®, especially by children, can result in a fatal overdose of TRAMAL®. Patients and their caregivers should be given information on safe storage and disposal of unused TRAMAL® (see *section 6.4 SPECIAL PRECAUTIONS FOR STORAGE* and *section 6.6 SPECIAL PRECAUTIONS FOR DISPOSAL*).

Hyperalgesia
Hyperalgesia may occur with the use of opioids, particularly at high doses. Hyperalgesia may manifest as an unexplained increase in pain, increased levels of pain with increasing opioid dosages or diffuse sensitivity not associated with the original pain. Hyperalgesia should not be confused with tolerance (see *Tolerance, dependence and withdrawal*). If opioid induced hyperalgesia is suspected, the dose should be reduced and tapered off if possible. A change to a different opioid may be required.

Ceasing opioids
Abrupt discontinuation or rapid decreasing of the dose in a person physically dependent on an opioid may result in serious withdrawal symptoms and uncontrolled pain (see *Tolerance, dependence and withdrawal*). Such symptoms may lead the patient to seek other sources of licit or illicit opioids. Opioids should not be ceased abruptly in a patient who is physically dependent but withdrawn by tapering the dose slowly. Factors to take into account when deciding how to discontinue or decrease therapy include the dose and duration of the opioid the patient has been taking, the type of pain being treated and the physical and psychological attributes of the patient. A multimodal approach to pain management should be in place before initiating an opioid analgesic taper. During tapering, patients require regular review and support to manage any increase in pain, psychological distress and withdrawal symptoms.

There are no standard tapering schedules suitable for all patients and an individualised plan is necessary. In general, tapering should involve a dose reduction of no more than 10 percent to 25 percent every 2 to 4 weeks (see *section 4.2 DOSE AND METHOD OF ADMINISTRATION*). If the patient is experiencing increased pain or serious withdrawal symptoms, it may be necessary to go back to the previous dose until stable before proceeding with a more gradual taper.

When ceasing opioids in a patient who has a suspected opioid use disorder, the need for medication assisted treatment and/or referral to a specialist should be considered.

Serotonin syndrome
Serotonin syndrome, a potentially life-threatening condition, has been reported in patients receiving tramadol in combination with other serotonergic agents or tramadol alone (see *sections 4.5 INTERACTION WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTION, 4.8 UNDESIRABLE EFFECTS* and *4.9 OVERDOSE*).

If concomitant treatment with other serotonergic agents is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose escalations.

Symptoms of serotonin syndrome may include mental status changes (including anxiety, agitation, and confusion), autonomic instability (including diaphoresis, tachycardia, hyperthermia, hypertension, vomiting, and diarrhoea), and neuromuscular abnormalities (including muscle rigidity, myoclonus, tremor, and hyperreflexia).
If serotonin syndrome is suspected, a dose reduction or discontinuation of therapy should be considered depending on the severity of the symptoms. Withdrawal of the serotonergic drugs usually brings about a rapid improvement.

Galactose intolerance
TRAMAL® SR tablets contain 2.5 mg lactose monohydrate per tablet. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose- galactose malabsorption should not take this medicine.

Acute abdominal conditions
The administration of tramadol may complicate the clinical assessment of patients with acute abdominal conditions.

Increased intracranial pressure or head trauma, shock or reduced levels of consciousness
Tramadol should be used with caution in patients with increased intracranial pressure, head injury, shock or a reduced level of consciousness of uncertain origin. Pupillary changes (miosis) from tramadol may obscure the existence, extent, or course of intracranial pathology. Clinicians should also maintain a high index of suspicion for adverse drug reaction when evaluating altered mental status in these patients if they are receiving tramadol.

Seizure risk
Convulsions have been reported in patients receiving tramadol at the recommended dose levels. The risk may be increased when doses of tramadol exceed the recommended upper daily dose limit. In addition, tramadol may increase the seizure risk in patients taking other medication that lowers the seizure threshold (see *section 4.5 INTERACTION WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTION*). Patients with epilepsy or those susceptible to seizures should only be treated with tramadol if there are compelling circumstances.

Anaphylactoid reactions
Serious and rarely fatal anaphylactoid reactions have been reported in patients receiving tramadol. These reactions often occur following the first dose. Other reported reactions include pruritus, hives, bronchospasm and angioedema.

Intra-operative use
In one study using nitrous oxide/tramadol anaesthetic technique (with only intermittent

administration of enflurane “as required”), tramadol was reported to enhance intra-operative recall. Hence its use during potentially very light levels of general anaesthesia should be avoided.

Two recent studies of tramadol administration during anaesthesia comprising continuous administration of isoflurane did not show clinically significant lightening of anaesthetic depth or intra-operative recall. Therefore, providing the current practice of administering continuous, potent (volatile or intravenous) anaesthetic agent is followed, tramadol may be used intra-operatively in the same way as other analgesic agents are routinely used.

Long-term use
Tramadol has been studied in controlled clinical trials for periods of up to three months. In one small uncontrolled study, patients with cancer pain received a dose of 150 mg tramadol per day for up to six months. Beyond six months no clinical studies investigating the safety and efficacy of tramadol are available.

When tramadol treatment of pain is required long-term, careful and regular monitoring should be carried out to establish whether, and to what extent, ongoing treatment is necessary.

CYP2D6 metabolism
Tramadol is metabolised by the liver enzyme CYP2D6. If a patient has a deficiency or is completely lacking this enzyme an adequate analgesic effect may not be obtained. Estimates indicate that up to 7% of the Caucasian population may have this deficiency. However, if the patient is an ultra-rapid metaboliser there is a risk of developing side effects of opioid toxicity even at commonly prescribed doses.

General symptoms of opioid toxicity include confusion, somnolence, shallow breathing, small pupils, nausea, vomiting, constipation and lack of appetite. In severe cases this may include symptoms of circulatory and respiratory depression, which may be life threatening and very rarely fatal. Estimates of prevalence of ultra-rapid metabolisers in different populations are summarised in Table 1 below:

Table 1: Prevalence of ultra-rapid metabolisers in different populations

Population	Prevalence %
African/Ethiopian	29%
African American	3.4% to 6.5%
Asian	1.2% to 2%
Caucasian	3.6% to 6.5%
Greek	6.0%
Hungarian	1.9%
Northern European	1% to 2%

Adrenal insufficiency
Opioid analgesics may occasionally cause reversible adrenal insufficiency requiring monitoring and glucocorticoid replacement therapy. Symptoms of acute or chronic adrenal insufficiency may include e.g. severe abdominal pain, nausea and vomiting, low blood pressure, extreme fatigue, decreased appetite, and weight loss.

Endocrine effects
Opioids, such as TRAMAL, may influence the hypothalamic-pituitary-adrenal or –gonadal axes. Hormonal disturbances that have been observed include an increase in serum prolactin and decreases in plasma cortisol and testosterone. Clinical symptoms may manifest from these hormonal changes.

Androgen deficiency may manifest as low libido, impotence, erectile dysfunction, amenorrhea, or infertility.

Neonatal Withdrawal Syndrome
Chronic use of tramadol by the mother at the end of pregnancy may result in a withdrawal syndrome (e.g. hypertonia, neonatal tremor, neonatal agitation, myoclonus, convulsions, apnoea or bradycardia) in the neonate. In many reported cases the withdrawal was serious and required treatment. The syndrome is generally delayed for several hours to several days after birth. (See *Section 4.6 - USE IN PREGNANCY*).

Hepatobiliary disorders
Opioids may cause dysfunction and spasm of the sphincter of Oddi, thus raising intrabiliary pressure and increasing the risk of biliary tract symptoms and pancreatitis. Therefore, TRAMAL has to be administered with caution in patients with pancreatitis and diseases of the biliary tract.

Gastrointestinal Toxicity
Reports of significant oesophageal dysfunction have been observed via high-resolution manometry in patients taking opioid medicines on a long-term basis. Discontinuation or weaning of opioids should be considered in patients presenting with oesophageal complaints including but not limited to dysphagia, regurgitation, or non-cardiac chest pain.

Renal and hepatic disease
With the prolonged half-life in these conditions, achievement of steady state is delayed, so that it may take several days for elevated plasma concentrations to develop (see below – *HEPATIC DISEASE* and *RENAL DISEASE*).

HEPATIC DISEASE
Metabolism of tramadol and M1 is reduced in patients with advanced cirrhosis of the liver. In cirrhotic patients, dosage reduction is recommended or prolongation of the dosage intervals should be carefully considered according to the patient's requirements (see section 4.2 *DOSE AND METHOD OF ADMINISTRATION* and *5.2 PHARMACOKINETIC PROPERTIES*).

RENAL DISEASE
In patients with renal insufficiency the elimination of tramadol is delayed. In these patients prolongation of the dosage intervals should be carefully considered according to the patient’s requirements. In cases of severe renal insufficiency TRAMAL prolonged-release tablets are not recommended. As tramadol is removed very slowly by haemodialysis or haemofiltration, post-dialysis administration to maintain analgesia is not usually necessary (see *section 4.2 DOSE AND METHOD OF ADMINISTRATION and 5.2 PHARMACOKINETIC PROPERTIES*).

USE IN THE ELDERLY
In subjects over the age of 75 years, serum concentrations are slightly elevated and the elimination half-life is slightly prolonged. Subjects in this age group are also expected to vary more widely in their ability to tolerate adverse drug effects. Daily doses in excess of 300 mg are not recommended in patients over 75 years.

PAEDIATRIC USE
The use of tramadol hydrochloride is contraindicated in all children younger than 12 years of age and in postoperative management of children younger than 18 years of age following tonsillectomy and/or adenoidectomy.

Post-operative use in children
Extreme caution should be exercised when tramadol is administered to children for post-operative pain relief and should be accompanied by close monitoring for symptoms of opioid toxicity including respiratory depression**.**

There have been reports in the published literature that tramadol given post-operatively in children after tonsillectomy and/or adenoidectomy for obstructive sleep apnoea, led to rare, but life threatening adverse events.

4.5 INTERACTION WITH OTHER MEDICINES AND OTHER FORMS OF INTERACTION

Use with Central Nervous System (CNS) Depressants -

Tramadol should be used with caution and in reduced dosages when administered to patients receiving CNS depressants such as alcohol, opioids, anaesthetic agents, phenothiazines, tranquilisers, sedative/hypnotics, antihistamines, centrally active anti-emetics(see *section 4.4 WARNINGS AND PRECAUTIONS*).

The combination of tramadol with mixed opiate agonists/antagonists (e.g. buprenorphine, pentazocine) is not advisable because the analgesic effect of a pure agonist may be theoretically reduced in such circumstances.

Use with other serotonergic agents - the presence of another drug that increases serotonin by any mechanism should alert the treating physician to the possibility of an interaction. Concomitant therapeutic use of tramadol and serotonergic medicines such as selective serotonin re-uptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), MAO inhibitors (see *section 4.3 CONTRAINDICATIONS*), tricyclic antidepressants and mirtazapine may cause serotonin toxicity.

Withdrawal of the serotonergic medicines usually brings about a rapid improvement Drug treatment depends on the nature and severity of the symptoms.

Use with coumarin derivatives - caution should be exercised during concomitant treatment with tramadol and coumarin derivatives (e.g. warfarin) due to reports of increased international normalised ratio (INR) with major bleeding and ecchymoses in some patients.

Drugs which reduce the seizure threshold - tramadol can induce convulsions and increase the potential for selective serotonin re-uptake inhibitors(SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants, antipsychotics and

other seizure threshold lowering agents (such as bupropion, mirtazapine, tetrahydrocannabinol) to cause convulsions.

Use with MAO inhibitors - tramadol should not be used in patients who are taking MAO inhibitors or who have taken them within the last fourteen days, as tramadol inhibits the uptake of noradrenaline and serotonin (see *section 4.3 CONTRAINDICATIONS*).

Use with anticholinergics - Concomitant administration of opioids with anticholinergics or medications with anticholinergic activity may result in increased anticholinergic adverse effects

Other interactions - tramadol does not appear to induce its own metabolism in humans, since observed maximal plasma concentrations after multiple oral doses are higher than expected based on single-dose data. Tramadol is a mild inducer of selected drug metabolism pathways measured in animals.

Concomitant administration of tramadol with carbamazepine causes a significant increase in tramadol metabolism, presumably through metabolic induction by carbamazepine. Patients receiving chronic carbamazepine doses of up to 800 mg daily may require up to twice the recommended dose of tramadol.

Tramadol is metabolised to M1 by the CYP2D6 P450 isoenzyme. Drugs that selectively inhibit that isoenzyme (quinidine, phenothiazines, antipsychotic agents) may cause increased concentrations of tramadol and decreased concentrations of M1. The clinical consequences of these potential effects have not been fully investigated.

Concomitant administration of tramadol with cimetidine does not result in clinically significant changes in tramadol pharmacokinetics. Therefore no alteration of the tramadol dosage regimen is recommended.

Other drugs known to inhibit the CYP3A4 isoenzyme of cytochrome P450, such as ketoconazole and erythromycin, may inhibit the metabolism of tramadol (via *N*-demethylation) and probably the metabolism of the active *O*-demethylated metabolite (M1). The clinical importance of such an interaction has not been studied.

In a limited number of studies, the pre- or post-operative application of the antiemetic 5-HT3 antagonist ondansetron increased the requirement of tramadol in patients with postoperative pain.

4.6 FERTILITY, PREGNANCY AND LACTATION

Post marketing surveillance does not suggest an adverse effect of tramadol on fertility.
In rats tramadol dosages from 50 mg/kg/day upwards caused toxic effects. Published data suggest an adverse influence of tramadol in rodents on male sexual and testicular function, potentially resulting in impaired fertility.

USE IN PREGNANCY - CATEGORY C

There are no adequate and well-controlled studies with tramadol in pregnant women therefore, tramadol should not be used during pregnancy. Studies in animals using IV or IM routes of administration have not been conducted.

Tramadol has been shown to be embryotoxic and foetotoxic in mice, rats and rabbits in maternally toxic doses of 120 mg/kg in mice, or higher in rats and 75 mg/kg in rabbits, but was not teratogenic at these dose levels. No harm to the foetus due to tramadol was seen at doses that were not maternally toxic.

No drug-related teratogenic effects were observed in progeny of mice, rats or rabbits treated with tramadol (75 mg/kg for rats or 175 mg/kg for rabbits). Embryo and foetal toxicity consisted primarily of decreased foetal weights, skeletal ossification and increased supernumerary ribs at maternally toxic dose levels. Transient delays in development or behavioural parameters were also seen in pups from rat dams allowed to deliver. Embryo and foetal lethality were reported only in one rabbit study at 300 mg/kg, a dose that would cause extreme maternal toxicity in the rabbit.

In peri- and post-natal studies in rats, progeny of dams receiving oral (gavage) dose levels of 50 mg/kg or greater had decreased weights and pup survival was decreased early in lactation at 80 mg/kg (6-10 times the maximum human dose). No toxicity was observed for progeny of dams receiving 8, 10, 20, 25 or 40 mg/kg. Maternal toxicity was observed at all dose levels. Tramadol crosses the placenta.

LABOUR AND DELIVERY
Tramadol should not be used in pregnant women prior to or during labour unless the potential benefits outweigh the potential risks, because safe use in pregnancy has not been established. Chronic use during pregnancy may lead to neonatal withdrawal symptoms (see *section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE - Neonatal Withdrawal Syndrome*). If tramadol were to be used during labour, it may cause respiratory depression in the newborn. Tramadol has been shown to cross the placenta. The mean ratio of serum tramadol in the umbilical veins compared to maternal veins was 0.83 for 40 women given tramadol during labour.

The effect of tramadol, if any, on the later growth, development, and functional maturation of the child is unknown.

USE IN LACTATION
Tramadol is not recommended during breast feeding, because its safety in infants and newborns has not been studied.

Low levels of tramadol have been detected in breast milk. Following a single intravenous 100 mg dose of tramadol, the cumulative excretion in breast milk within 16 hours post-dose was 100 µg of tramadol (0.1% of the maternal dose) and 27 µg of M1.

4.7 EFFECTS ON ABILITY TO DRIVE AND USE MACHINES

Due to its sedative effect, patients should be advised to avoid driving or operating machinery whilst taking tramadol. Even when taken according to instructions, tramadol may cause effects such as somnolence and dizziness and therefore may impair the reactions of drivers and machine operators. This applies particularly in conjunction with other psychotropic substances, particularly alcohol.

4.8 UNDESIRABLE EFFECTS

Adverse reactions that may occur after administration of tramadol resemble those known to occur with opioids. Adverse reactions were recorded in 13,802 patients from trials with different formulations of tramadol.

Table 1 lists the nature and incidence of reactions (in CIOMS format where very common ≥1/10; common ≥ 1/100 and <1/10; uncommon ≥ 1/1000 and <1/100; rare ≥ 1/10,000 and <1/1000; and very rare ≤ 1/10,000) in clinical trial and post-marketing experience:

Table 1

Cardiac disorders
Uncommon: tachycardia, flushing, palpitations
Rare: bradycardia

Investigations
Rare: increase in blood pressure

Vascular disorders
Uncommon: orthostatic dysregulation (postural hypotension, tendency to collapse and cardiovascular collapse)

Respiratory, thoracic and mediastinal disorders
Rare: dyspnoea, respiratory depression (when the recommended doses are considerably exceeded and other respiratory depressant substances are

administered concomitantly)
Very rare: worsening of asthma (causality not established)

Not known: Hiccups, Central sleep apnoea syndrome

Gastrointestinal disorders
Very common: nausea
Common: vomiting, constipation, dry mouth
Uncommon: dyspepsia, diarrhoea, abdominal pain, flatulence, urge to vomit
Not known: pancreatitis

Metabolism and nutrition disorders
Rare: changes in appetite
Not known: hypoglycaemia

Cases of hyponatremia have been reported in literature.

Hepatobiliary disorders:
Very rare: elevated liver enzymes
Not known: spasm of sphincter of Oddi

Nervous system disorders
Very common: dizziness
Common: autonomic nervous effects (mainly dry mouth, perspiration), headache sedation, asthenia,
Uncommon: trembling
Rare: speech disorders, paraesthesia, coordination disturbance, tremor, seizures, involuntary muscle contractions, syncope
Not known: serotonin syndrome

Psychiatric disorders
Rare: hallucinations, confusional state, sleep disturbance, delirium, anxiety, nightmares, changes in mood (usually euphoric mood, occasionally dysphoria), changes in activity (usually suppression, occasionally increase), changes in cognitive and sensorial capacity (e.g. decision behaviour, perception disorders) physical dependence, withdrawal syndrome (see *section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE – Tolerance, dependence and withdrawal and ceasing opioids*)

Musculoskeletal and connective tissue disorders
Rare: motor system weakness

General disorders and administration site conditions:
Common: fatigue

Endocrine
Very rare: Syndrome of inappropriate antidiuretic hormone secretion characterised by hyponatraemia secondary to decreased free-water excretion
Not known: adrenal insufficiency
androgen deficiency

Cases of SIADH (syndrome of inappropriate antidiuretic hormone secretion) have been reported in literature.

Skin and subcutaneous tissue disorders
Common: sweating
Uncommon: skin reactions, pruritus, rash

Immune system disorders
Rare: shock reactions, anaphylaxis, allergic reactions

Renal and urinary disorders
Rare: micturition disorders (difficulty in passing urine and urinary retention), dysuria

Eye disorders
Rare: miosis, mydriasis, visual disturbance (blurred vision)

The incidence of “non-specific CNS irritation” (dizziness), “autonomic nervous effects” (perspiration), “orthostatic dysregulation (tendency to collapse and cardiovascular collapse) and tachycardia and “nausea/urge to vomit/vomiting” can be increased with rapid intravenous administration and also tends to be dose dependent. No tests of significance have been performed.

REPORTING OF SUSPECTED ADVERSE REACTIONS
Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions https://pophealth.my.site.com/carmreportnz/s/

4.9 OVERDOSE

SYMPTOMS
Symptoms of overdosage with tramadol are similar to those of other centrally acting analgesics (opioids) and include miosis, vomiting, cardiovascular collapse, consciousness disorders including coma, convulsions, respiratory depression, respiratory arrest and death.
Serotonin syndrome has also been reported.
Toxic leukoencephalopathy has been observed with opioid overdose.

TREATMENT
Should overdosage occur, general emergency measures should be implemented. Keep the respiratory airways open, and maintain respiration and circulation. If overdosage is due to ingestion of an oral dose form.

Activated charcoal may reduce absorption of the drug if given within 1-2 hours after ingestion. In patients who are not fully conscious or have impaired gag reflex, consideration should be given to administering activated charcoal via a nasogastric tube, once the airway is protected.

Naloxone will reverse respiratory depression, but not all symptoms caused by overdosage with tramadol. Convulsions occurring in mice following the administration of toxic doses of tramadol could be suppressed with barbiturates or benzodiazepines, but were increased with naloxone. If convulsions are observed, diazepam should be given intravenously. Naloxone did not change the lethality of an overdose in mice.

Tramadol is minimally eliminated from the serum by haemodialysis or haemofiltration. Therefore treatment of overdosage with tramadol with haemodialysis or haemofiltration alone is not suitable for detoxification.

For risk assessment and advice on the management of overdose please contact the National Poisons Centre on 0800 POISON (0800 764766).

5. PHARMACOLOGICAL PROPERTIES

5.1 PHARMACODYNAMIC PROPERTIES

Pharmacotherapeutic group: other opioids

ATC Code: N02AX02

Tramadol is a centrally-acting synthetic analgesic of the aminocyclohexanol group with opioid-like effects. It is not derived from natural sources, nor is it chemically related to opiates. Although pre-clinical testing has not completely explained the mode of action, at least two complementary mechanisms appear applicable: binding to μ-opioid receptors and inhibition of re-uptake of noradrenaline and serotonin. The opioid-like activity of tramadol derives from low affinity binding of the parent compound to μ-opioid receptors and higher affinity binding of the principal active metabolite, *O*-desmethyltramadol, denoted M1, to μ-opioid receptors. In animal models, M1 is up to 6 times more potent than tramadol in producing analgesia and 200 times more potent in μ-opioid binding. The contribution to human analgesia of tramadol relative to M1 is unknown.

Both animal and human studies have shown that antinociception induced by tramadol is only partially antagonised by the opiate antagonist naloxone. In addition, tramadol has been shown to inhibit re-uptake of noradrenaline and serotonin *in vitro*, as have some other opioid analgesics. These latter mechanisms may contribute independently to the overall analgesic profile of tramadol.

The analgesic effect is dose-dependent, but the relationship between serum concentrations and analgesic effect varies considerably between individuals. In one study, the median serum concentration of tramadol required for effective post-operative analgesia was 300 ng/mL, with individual values ranging from 20 to 990 ng/mL.

Apart from analgesia, tramadol may produce other symptoms similar to that of opioids including: dizziness, somnolence, nausea, constipation, sweating and pruritus. However, tramadol causes significantly less respiratory depression than morphine. In contrast to morphine, tramadol has not been shown to cause histamine release. At therapeutic doses, tramadol has no clinically significant effect on heart rate, left ventricular function or cardiac index. Orthostatic changes in blood pressure have been observed.

5.2 PHARMACOKINETIC PROPERTIES

Tramadol is administered as a mixture of two stereoisomers; the following information refers to the combined concentration of both isomers. Tramadol has a linear pharmacokinetic profile within the therapeutic dosage range.

ABSORPTION
Tramadol is rapidly and almost completely absorbed after oral administration of 50 mg capsules following a mean absorption delay (t_0) of approximately thirty minutes. The absorption half-life ($t½$) is 23 ± 11 minutes. After oral administration of two 50 mg capsules, the mean absolute bioavailability (f_{abs}) is 68-72%, and the peak serum level (C_{max}) is reached two hours (range one to three) after administration. The mean peak plasma concentration (C_{max}) is approximately 280 ng/mL after oral administration of two capsules. At this time, the mean serum concentration after intravenous injection is 1.46 times higher, amounting to approximately 410 ng/mL.

Oral administration of tramadol with food does not significantly affect its rate or extent of absorption. Therefore tramadol can be administered without regard to food.

After repeated oral administration of 50 mg and 100 mg tramadol capsules at six hourly intervals, steady state is reached 30 to 36 hours after the first administration and the bioavailability is greater than 90%. The plasma concentrations at steady state exceeded by 52% and 36% those extrapolated from the single dose administration studies with 50 mg and 100 mg capsules, respectively. This can be explained by first pass metabolic saturation.

After intramuscular injection of 50mg tramadol, the bioavailability is approximately 100%, and the peak serum level is attained after 45 minutes (range 15 to 90).

After oral administration of TRAMAL® SR, more than 90% of tramadol is absorbed. After a single dose, the mean absolute bioavailability is approximately 70%, irrespective of the concomitant intake of food. Oral bioavailability increases to 90% after repeated administration. The difference between absorbed and bioavailable tramadol is due to first-pass metabolism (maximum of 30%). The administration of TRAMAL® SR every 12 hours and TRAMAL® (immediate release) every 6 hours at the same daily dose, resulted in similar peak and trough serum tramadol concentrations and total tramadol exposure for the two preparations.

Serum tramadol concentrations in young males treated with TRAMAL® SR (mean ± sd)

	Single Dose		Steady State	
	100 mg	200 mg	100 mg q12 h	200 mg q12 h
Peak (ng/mL)	142 ± 40	260 ± 113	293 ± 113	579 ± 149
Time to peak (h)	4.9 ± 0.8	4.8 ± 0.8	3.5 ± 1	3.9 ± 1.1
Trough (ng/mL)	-	-	156 ± 87	265 ± 67

DISTRIBUTION
Tramadol is rapidly distributed in the body, with a volume of distribution of 2 – 3 L/kg in young adults. The volume of distribution is reduced by about 25% in those aged over 75 years. Plasma protein binding is about 20% and is independent of concentration up to 10 µg/mL. Saturation of plasma protein binding occurs only at concentrations outside the clinically relevant range.

Tramadol crosses the placental and blood-brain barriers. Very small amounts of tramadol and M1 are found in breast milk (0.1% and 0.02% respectively of the administered dose).

METABOLISM
Tramadol is extensively metabolised after oral administration. The major metabolic pathways appear to be *N* - and *O* -demethylation and glucuronidation or sulfation in the liver. Only *O* -desmethyltramadol (M1) is pharmacologically active. Production of M1 is dependent on the CYP2D6 isoenzyme of cytochrome P450. Patients who metabolise drugs poorly via CYP2D6 may obtain reduced benefit from tramadol, due to reduced formation of M1. *N*-demethylation is catalysed by the CYP3A4 isoenzyme of cytochrome P450. The inhibition of one or both types of the isoenzymes CYP3A4 and CYP2D6 involved in the biotransformation of tramadol may affect the plasma concentration of tramadol or its active metabolite.

EXCRETION
Tramadol and its metabolites are excreted mainly by the kidneys, with a cumulative renal excretion (tramadol and metabolites) of approximately 95%. In young adults approximately 15 – 19% of an administered dose of tramadol is excreted in the urine as unmetabolised drug. In the elderly, this increases to about 35%. Biliary excretion is of little importance. In

young adults, the half-life of tramadol is 5 – 7 h and the half-life of M1 is 6 – 8 h. Total clearance is approximately 430 – 610 mL/min.

Pharmacokinetics in patients with hepatic or renal impairment
Elimination of tramadol and M1 is impaired in patients with hepatic or renal impairment (see *section 4.4 SPECIAL WARNINGS AND PRECAUTIONS FOR USE*). In patients with hepatic impairment, the mean half-life of tramadol was found to be 13 h (range up to 19 h), and the mean half-life of M1 was 19 h (range up to 36 h). In patients with renal impairment including subjects with considerably decreased CL_{Cr} [< 5mL/min] the mean half-life of tramadol was 11 h (range up to 20 h), and the mean half-life of M1 was 17 h (range up to 43 h).

Pharmacokinetics in the elderly
In the elderly (age over 75 years), the volume of distribution of tramadol is decreased by 25% and clearance is decreased by 40%. As a result, tramadol C_{max} and total exposure are increased by 30% and 50%, respectively, but the half-life of tramadol is only slightly prolonged (by 15%).

5.3 PRECLINICAL SAFETY DATA

Carcinogenesis, mutagenesis and impairment of fertility
Tramadol was not mutagenic in the following assays: Ames *Salmonella* microsomal activation test, CHO/HPRT mammalian cell assay, mouse lymphoma assay (in the presence of metabolic activation), dominant lethal mutation tests in mice, chromosome aberration test in Chinese hamster cells, and bone marrow micronucleus tests in mice and Chinese hamster cells. Weakly mutagenic results occurred in the presence of metabolic activation in the mouse lymphoma assay and micronucleus tests in rat cells. Overall, the weight of evidence from these tests indicates tramadol does not possess a genotoxic risk to humans.

A slight, but statistically significant increase in two common murine tumours (pulmonary and hepatic) was observed in a mouse carcinogenicity study, particularly in aged mice dosed orally up to 30 mg/kg for approximately two years. Although the study was not conducted using the Maximum Tolerated Dose, or at exposure levels expected in clinical use, this finding is not believed to suggest risk in humans. No such findings occurred in a rat carcinogenicity study.

6. PHARMACEUTICAL PARTICULARS

6.1 LIST OF EXCIPIENTS

TRAMAL® 50 mg capsules:
Excipients include: cellulose-microcrystalline, magnesium stearate, sodium starch glycollate, silica-colloidal anhydrous. Excipients in the capsule shell are: iron oxide yellow (CI 77492), titanium dioxide (CI 173015), sodium lauryl sulphate and gelatine.

TRAMAL® 50 mg and 100 mg injections:
Excipients are: sodium acetate, Water for Injections.

TRAMAL® SR sustained release tablets:
Excipients are: hypromellose10^5 mPa.s, silica-colloidal anhydrous, magnesium stearate, microcrystalline cellulose. Excipients in the film coat are: hypromellose 6 mPa.s, lactose monohydrate, macrogol 6000, propylene glycol, purified talc, titanium dioxide, quinoline yellow aluminium lake CI 47005 (150 and 200 mg tablets only), iron oxide red CI 77491 (150 and 200 mg tablets only), iron oxide yellow CI 77492 (50 and 200 mg tablets only) and iron oxide black CI 77499 (200 mg tablet only).

Excipients with known effect: Lactose.

6.2 INCOMPATIBILITIES

Not applicable

6.3 SHELF-LIFE

TRAMAL® capsules have a shelf-life of 36 months when stored below 30°C.

TRAMAL® solution for injection and TRAMAL® SR 100, 150 and 200 mg tablets have a shelf-life of 60 months when stored below 30°C.

TRAMAL® SR 50 mg tablets have a shelf life of 36 months when stored below 30°C.

6.4 SPECIAL PRECAUTION FOR STORAGE

For storage conditions of the medicine, see *section 6.3 SHELF-LIFE*.

6.5 NATURE AND CONTENTS OF CONTAINER

TRAMAL® 50mg immediate release capsules-packs of 6, 10, 20, 30 and 50 capsules.

TRAMAL® 50, solution for injection-pack containing 5 ampoules of 1 mL each.

TRAMAL® 100, solution for injection-pack containing 5 ampoules of 2 mL each.

TRAMAL® SR 50 mg, 100 mg, 150 mg and 200 mg sustained release tablets - packs of 20 and 60 tablets.

Not all pack sizes may be marketed.

6.6 SPECIAL PRECAUTIONS FOR DISPOSAL

TRAMAL® capsules
If your doctor tells you to stop taking TRAMAL® capsules or it passes its expiry date, ask your pharmacist what to do with any TRAMAL® capsules that are left over.

TRAMAL® solution for injection
If your doctor tells you to stop taking TRAMAL® or it passes its expiry date, ask your pharmacist what to do with any TRAMAL® that is left over.

TRAMAL® SR tablets
If your doctor tells you to stop taking this medicine or the expiry date has passed, ask your pharmacist what to do with any TRAMAL® SR that is left over.

7. MEDICINE SCHEDULE

Controlled Drug (C2)

8. SPONSOR

Seqirus (NZ) Ltd
PO Box 62 590
Greenlane, Auckland 1546
New Zealand
Telephone: 0800 502 757

9. DATE OF FIRST APPROVAL

TRAMAL® capsules – 25/9/1997
TRAMAL® solution for injection - 25/9/1997
TRAMAL® SR 50mg – 2/11/2006
TRAMAL® SR 100 mg – 2/3/2000
TRAMAL® SR 150mg – 2/3/2000
TRAMAL® SR 200 mg – 2/3/2000

10. DATE OF REVISION OF THE TEXT

26 February 2026

TRAMAL® is a registered trademark of Grunenthal GmbH used by Seqirus as authorised user.

SUMMARY TABLE OF CHANGES

Section changed	Summary of new information
4.2, 4.3, 4.4, 4.8	Multiple editorial changes/corrections
4.4	Addition of warnings for endocrine effects, neonatal withdrawal syndrome, hepatobiliary disorders, and gastrointestinal toxicity.
4.8	Inclusion of adverse reactions with frequency not known: Pancreatitis, spasm of sphincter of Oddi, adrenal insufficiency and androgen deficiency.
4.9	Addition of statement ‘toxic leukoencephalopathy has been observed with opioid overdose’.