

SUMMARY OF PRODUCT CHARACTERISTICS

1 NAME OF THE MEDICINAL PRODUCT

Marol 150mg Prolonged-release tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Marol Tablets are prolonged release tablet containing 150mg of Tramadol hydrochloride.

For a full list of excipients, see section 6.1

3 PHARMACEUTICAL FORM

Prolonged release tablet

Marol 150mg tablets are off white, capsule shaped tablets, 14.3 mm long

4 CLINICAL PARTICULARS

4.1 Therapeutic indications

Treatment of moderate to severe pain

4.2 Posology and method of administration

Treatment goals and discontinuation

Before initiating treatment with Marol tablets, a treatment strategy including treatment duration and treatment goals, and a plan for end of the treatment, should be agreed together with the patient, in accordance with pain management guidelines. During treatment, there should be frequent contact between the physician and the patient to evaluate the need for continued treatment, consider discontinuation and to adjust dosages if needed. When a patient no longer requires therapy with tramadol, it may be advisable to taper the dose gradually to prevent symptoms of withdrawal. In absence of adequate pain control, the possibility of hyperalgesia, tolerance and progression of underlying disease should be considered (see section 4.4).

Route of Administration

Oral use

Posology

The dose should be adjusted to the intensity of the pain and the sensitivity of the individual patient.

Unless otherwise prescribed, Marol tablets should be given as follows:

Adults and adolescents older than 12 years:

The usual initial dose is 50-100mg tramadol hydrochloride, twice daily, morning and evening.

If pain relief is insufficient, the dose may be titrated upwards to:

150 mg or 200 mg tramadol hydrochloride, twice daily.

For doses not practicable with this strength, other strengths of this medicinal product are available.

Marol tablets should be swallowed completely, without breaking or chewing, independent of meals, with sufficient liquid.

A daily dose of 400 mg of tramadol should not be exceeded, except in special clinical circumstances.

Under no circumstances should Marol tablets be used for longer than absolutely necessary.

If long-term pain treatment with Marol is necessary in view of the nature and severity of the illness, then careful and regular monitoring should be carried out (if necessary with breaks in treatment) to establish whether, and to what extent, further treatment is necessary.

Paediatric Population

Marol Tablets are not suitable for children under the age of 12 years.

Elderly patients

A dose adjustment is not usually necessary, in patients up to 75 years without clinically manifest hepatic or renal insufficiency not associated with clinical manifestation. In elderly patients (above 75 years) elimination may be prolonged. Therefore, if necessary the dosage interval is to be extended according to the patient's requirements.

Renal insufficiency/dialysis and hepatic impairment

In patients with renal and/or hepatic insufficiency the elimination of tramadol is delayed. In these patients, prolongation of the dose interval should be carefully considered according to the patients requirements.

4.3 Contraindications

Marol tablets are contraindicated:

-in hypersensitivity to tramadol hydrochloride, or to any of the excipients listed in section 6.1.

-in acute intoxication with alcohol, hypnotics, analgesics, opioids or other psychotropic medicinal products

-in patients who are receiving MAO-inhibitors, or who have taken them within the last 14 days (see section 4.5),

- in patients with epilepsy not adequately controlled by treatment

-for use in narcotic withdrawal treatment

4.4 Special warnings and precautions for use

Do not use for acute post-operative pain owing to the increased risk of persistent post-operative opioid use (PPOU) and opioid-induced ventilatory impairment (OIVI)

Tolerance and opioid use disorder (abuse and dependence)

Tolerance, physical and psychological dependence, and opioid use disorder (OUD) may develop upon repeated administration of opioids such as Marol tablets. Repeated use of Marol tablets can lead to opioid use disorder (OUD). A higher dose and longer duration of opioid treatment can increase the risk of developing OUD. Abuse or intentional misuse of Marol tablets may result in overdose and/or death. The risk of developing OUD is increased in patients with a personal or a family history (parents or siblings) of substance use disorders (including alcohol use disorder), in current tobacco users or in patients with a personal history of other mental health disorders (e.g. major depression, anxiety and personality disorders).

Before initiating treatment with Marol tablets and during the treatment, treatment goals and a discontinuation plan should be agreed with the patient (see section 4.2). Before and during treatment the patient should also be informed about the risks and signs of OUD. If these signs occur, patients should be advised to contact their physician.

Patients will require monitoring for signs of drug-seeking behaviour (e.g. too early requests for refills). This includes the review of concomitant opioids and psycho-active drugs (like benzodiazepines). For patients with signs and symptoms of OUD, consultation with an addiction specialist should be considered.

Drug withdrawal syndrome

Prior to starting treatment with any opioids, a discussion should be held with patients to put in place a withdrawal strategy for ending treatment with tramadol.

Drug withdrawal syndrome may occur upon abrupt cessation of therapy or dose reduction. When a patient no longer requires therapy, it is advisable to taper the dose

gradually to minimise symptoms of withdrawal. Tapering from a high dose may take weeks to months.

The opioid drug withdrawal syndrome is characterised by some or all of the following: restlessness, lacrimation, rhinorrhoea, yawning, perspiration, chills, myalgia, mydriasis and palpitations. Other symptoms may also develop including irritability, agitation, anxiety, hyperkinesia, tremor, weakness, insomnia, anorexia, abdominal cramps, nausea, vomiting, diarrhoea, increased blood pressure, increased respiratory rate or heart rate.

If women take this drug during pregnancy, there is a risk that their newborn infants will experience neonatal withdrawal syndrome.

Tramadol is not a suitable substitute in opioid-dependent patients. Although it is an opioid agonist, tramadol cannot suppress morphine withdrawal symptoms.

Hyperalgesia

Hyperalgesia may be diagnosed if the patient on long-term opioid therapy presents with increased pain.

This might be qualitatively and anatomically distinct from pain related to disease progression or to breakthrough pain resulting from development of opioid tolerance. Pain associated with hyperalgesia tends to be more diffuse than the pre-existing pain and less defined in quality. Symptoms of hyperalgesia may resolve with a reduction of opioid dose.

Marol Tablets may only be used with particular caution in opioid-dependent patients with head injury, shock, a reduced level of consciousness of uncertain origin, disorders of the respiratory centre or function, increased intracranial pressure.

In patients sensitive to opiates the product should only be used with caution. Care should be taken when treating patients with respiratory depression, or if concomitant CNS depressant drugs are being administered (see section 4.5), or if the recommended dosage is significantly exceeded (see section 4.9) as the possibility of respiratory depression cannot be excluded in these situations.

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.

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, 4.8 and 4.9).

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, autonomic instability, neuromuscular abnormalities and/or gastrointestinal symptoms.

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.

Sleep-related breathing disorders

Opioids can cause sleep-related breathing disorders including central sleep apnoea (CSA) and sleep-related hypoxemia.

Opioid use increases the risk of CSA in a dose-dependent fashion. In patients who present with CSA, consider decreasing the total opioid dosage.

Convulsions have been reported in patients receiving tramadol at the recommended dose levels. The risk may be increased when doses exceed the recommended upper daily dose limit (400 mg).

In addition, tramadol may increase the seizure risk in patients taking other medicinal products that lowers the seizure threshold. (see section 4.5). Patients with epilepsy or those susceptible to seizures should only be treated with tramadol if there are compelling circumstances.

Concomitant use of tramadol and sedative medicines such as benzodiazepines or related drugs may result in sedation, respiratory depression, coma and death. Because of these risks, concomitant prescribing with these sedative medicines should be reserved for patients for whom alternative treatment options are not possible. If a decision is made to prescribe tramadol concomitantly with sedative medicines, the lowest effective dose should be used, and the duration of treatment should be as short as possible.

The patients should be followed closely for signs and symptoms of respiratory depression and sedation. In this respect, it is strongly recommended to inform patients and their caregivers to be aware of these symptoms (see section 4.5).

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 below:

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%

Post-operative use in children

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. 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.

Children with compromised respiratory function

Tramadol is not recommended for use in children in whom respiratory function might be compromised including neuromuscular disorders, severe cardiac or respiratory conditions, upper respiratory or lung infections, multiple trauma or extensive surgical procedures. These factors may worsen symptoms of opioid toxicity.

4.5 Interaction with other medicinal products and other forms of interaction

Marol tablets should not be combined with MAO-inhibitors (see section 4.3).

In patients treated with MAO inhibitors in the 14 days prior to the use of the opioid pethidine, life threatening interactions on the central nervous system, respiratory and cardiovascular function have been observed. The same interactions with Marol tablets as with MAO inhibitors cannot be ruled out during treatment with Marol.

Concomitant administration of Marol tablets and other centrally depressant medicinal product, including alcohol may potentiate the CNS effects (See section 4.8).

The concomitant use of Marol tablets with gabapentinoids (gabapentin and pregabalin) may result in respiratory depression, hypotension, profound sedation, coma or death.

The results of pharmacokinetic studies have so far shown that on the concomitant or previous administration of cimetidine (enzyme inhibitor) clinically relevant interactions are unlikely to occur. Simultaneous or previous administration of carbamazepine (enzyme inducer) may reduce the analgesic effect and shorten the duration of the action.

The concomitant use of opioids with sedative medicines such as benzodiazepines or related drugs increases the risk of sedation, respiratory depression, coma and death because of additive CNS depressant effect. The dose and duration of concomitant use should be limited (see section 4.4).

Tramadol can induce convulsions and increase the potential for selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants, antipsychotics and other seizure threshold-lowering medicinal products (such as bupropion, mirtazapine, tetrahydrocannabinol) to cause convulsions.

Concomitant therapeutic use of tramadol and serotonergic drugs, such as selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors

(SNRIs), MAO inhibitors see section 4.3), tricyclic antidepressants and mirtazapine may cause serotonin syndrome, a potentially life-threatening condition (see sections 4.4 and 4.8).

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

Other active substance known to inhibit CYP3A4, such as ketoconazole and erythromycin, might inhibit the metabolism of tramadol (N-demethylation) and probably also the metabolism of the active O-demethylated-metabolite. The clinical importance of such an interaction has not been studied. (See section 4.8).

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

4.6 Fertility, pregnancy and lactation

Pregnancy

Animal studies with tramadol revealed at very high doses effects on organ development, ossification and neonatal mortality. Tramadol crosses the placenta. There is inadequate evidence available on the safety of tramadol in human pregnancy. Therefore tramadol should not be used in pregnant women.

Regular use during pregnancy may cause drug dependence in the foetus, leading to withdrawal symptoms in the neonate.

If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.

Tramadol - administered before or during birth - does not affect uterine contractility.

Administration during labour may depress respiration in the neonate and an antidote for the child should be readily available.

Breast-feeding

Administration to nursing women is not recommended as tramadol may be secreted in breast milk and may cause respiratory depression in the infant.

Fertility

Post marketing surveillance does not suggest an effect of tramadol on fertility. Animal studies did not show an effect of tramadol on fertility.

4.7 Effects on ability to drive and use machines

Even when taken according to instructions, Marol tablets 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.

This medicine can impair cognitive function and can affect a patient's ability to drive safely. This class of medicine is in the list of drugs included in regulations under 5a of the Road Traffic Act 1988. When prescribing this medicine, patients should be told:

- The medicine is likely to affect your ability to drive
- Do not drive until you know how the medicine affects you
- It is an offence to drive while under the influence of this medicine
- However, you would not be committing an offence (called 'statutory defence') if:
 - The medicine has been prescribed to treat a medical or dental problem and
 - You have taken it according to the instructions given by the prescriber and in the information provided with the medicine and
 - It was not affecting your ability to drive safely

4.8 Undesirable effects

The most commonly reported adverse reactions are nausea and dizziness, both occurring in more than 10 % of patients.

The frequencies are defined as follows:

Very common: $\geq 1/10$

Common: $\geq 1/100, < 1/10$

Uncommon: $\geq 1/1000, < 1/100$

Rare: $\geq 1/10\ 000, < 1/1000$

Very rare ($< 1/10,000$)

Not known (cannot be estimated from the available data).

Cardiovascular disorders:

Uncommon: cardiovascular regulation (palpitation, tachycardia). These adverse reactions may occur especially on intravenous administration and in patients who are physically stressed.

Rare: bradycardia

Investigations:

Rare: increase in blood pressure

Vascular disorders:

Uncommon: cardiovascular regulation (postural hypotension or cardiovascular collapse). These adverse reactions may occur especially on intravenous administration and in patients who are physically stressed.

Metabolism and nutrition disorders:

Rare: changes in appetite

Respiratory, thoracic and mediastinal disorders:

Rare: respiratory depression, dyspnoea

If the recommended doses are considerably exceeded and other centrally depressant substances are administered concomitantly (see section 4.5), respiratory depression may occur.

Worsening of asthma has been reported, though a causal relationship has not been established.

Not known: hiccups

Nervous system disorders:

Very common: dizziness

Common: headache, somnolence

Rare: speech disorder, paraesthesia, tremor, epileptiform convulsions, involuntary muscle contractions, abnormal coordination and syncope.

Not known: serotonin syndrome

Convulsions occurred mainly after administration of high doses of tramadol or after concomitant treatment with medicinal products which can lower the seizure threshold (see sections 4.4 and 4.5).

Psychiatric disorders:

Rare: hallucinations, confusion, delirium, anxiety, sleep disturbances and nightmares. Psychic adverse reactions may occur following administration of Marol tablets which vary individually in intensity and nature (depending on personality and duration of treatment). These include changes in mood (usually elation, occasionally dysphoria), changes in activity (usually suppression, occasionally increase) and changes in cognitive and sensorial capacity (e.g. decision behaviour, perception disorders).

Not known: drug dependence (see section 4.4)

Eye disorders:

Rare: blurred vision, miosis, mydriasis

Gastrointestinal disorders:

Very common: nausea

Common: vomiting, constipation, dry mouth.

Uncommon:

retching; gastrointestinal discomfort (a feeling of pressure in the stomach, bloating), diarrhoea

Skin and subcutaneous tissue disorders:

Common: hyperhidrosis

Uncommon: dermal reactions (e.g. pruritus, rash, urticaria)

Musculoskeletal and connective tissue disorders:

Rare: motorial weakness

Hepato-biliary disorders:

In a few isolated cases increase in liver enzyme values has been reported in a temporal connection with the therapeutic use of tramadol.

Renal and urinary system disorders:

Rare: micturition disorders (dysuria and urinary retention).

Immune system disorders:

Rare: allergic reactions (e.g. dyspnoea, bronchospasm, wheezing, angioneurotic oedema) and anaphylaxis

Metabolism and nutrition disorders:

Not known: hypoglycaemia

General disorders and administration site conditions:

Common: fatigue.

Uncommon: drug withdrawal syndrome

Symptoms of withdrawal reactions, similar to those occurring during opiate withdrawal, may occur as follows: agitation, anxiety, nervousness, insomnia, hyperkinesia, tremor and gastro intestinal 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, depersonalisation, derealisation, paranoia).

Drug dependence

Repeated use of Marol Tablets can lead to drug dependence, even at therapeutic doses. The risk of drug dependence may vary depending on a patient's individual risk factors, dosage, and duration of opioid treatment (see section 4.4).

Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system using the Yellow Card Scheme, Website: www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store.

4.9 Overdose

Patients should be informed of the signs and symptoms of overdose and to ensure that family and friends are also aware of these signs and to seek immediate medical help if they occur.

Symptoms

In principle, on intoxication with tramadol symptoms similar to those of other centrally acting analgesics (opioids) are to be expected. These include in particular miosis, vomiting, cardiovascular collapse, consciousness disorders up to coma, convulsions and respiratory depression up to respiratory arrest.

Serotonin syndrome has also been reported.

Treatment

The general emergency measures apply. Keep open the respiratory tract (aspiration), maintain respiration and circulation depending on the symptoms.

The antidote for respiratory depression is naloxone. In animal experiments naloxone had no effect on convulsions. In such case diazepam should be given intravenously.

In case of intoxication orally, gastrointestinal decontamination with activated charcoal or by gastric lavage is only recommended within 2 hours after tramadol intake. Gastrointestinal decontamination at a later time point may be useful in case of intoxication with exceptionally large quantities or prolonged-release formulations.

Tramadol is minimally eliminated from the serum by haemodialysis or haemofiltration. Therefore treatment of acute intoxication with Marol tablets with haemodialysis or haemofiltration alone is not suitable for detoxification.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Pharmacotherapeutic group: other opioids; ATC code N 02 AX 02

Tramadol is a centrally acting opioid analgesic.

It is a non-selective, complete agonist of μ -, δ - and κ -opioid receptors with a higher affinity for μ -receptors. Other mechanisms contributing to the analgesic effect are the inhibition of the neural noradrenalin reuptake and an enhancement of serotonin release.

Tramadol has an antitussive action. In Contrast to morphine, analgesic doses of tramadol over a wide range have no respiratory depressant effect. Also gastrointestinal motility is less affected. Effects on the cardiovascular system tend to be slight. The potency of tramadol is reported to be 1 / 10 (one tenth) to 1 / 6 (one sixth) that of morphine.

Paediatric population

Effects of enteral and parenteral administration of tramadol have been investigated in clinical trials involving more than 2000 paediatric patients ranging in age from neonate to 17 years of age. The indications for pain treatment studied in those trials included pain after surgery (mainly abdominal), after surgical tooth extractions, due to fractures, burns and traumas as well as other painful conditions likely to require analgesic treatment for at least 7 days.

At single doses of up to 2 mg/kg or multiple doses of up to 8 mg/kg per day (to a maximum of 400 mg per day) efficacy of tramadol was found to be superior to placebo, and superior or equal to paracetamol, nalbuphine, pethidine or low dose morphine. The conducted trials confirmed the efficacy of tramadol. The safety profile of tramadol was similar in adult and paediatric patients older than 1 year (see section 4.2).

5.2 Pharmacokinetic properties

More than 90% of tramadol is absorbed after oral administration. The mean absolute bioavailability is approximately 70 %, irrespective of concomitant intake of food.

The difference between absorbed and non-metabolised available tramadol is probably due to low first-pass effect. The first pass-effect after oral administration is a maximum of 30%.

Tramadol has a high tissue affinity ($V_{d,\beta} = 203 \pm 40$ l). Protein binding is about 20%.

Following a single oral dose administration of tramadol 100 mg as capsules or tablets to young healthy volunteers, plasma concentrations were detectable within approximately 15 to 45 minutes within a mean C_{max} of 280 to 208 mcg/L and T_{max} of 1.6 to 2h.

Tramadol passes the blood-brain and placenta barrier. Very small amounts of the substance and its O-demethyl derivative are found in the breast-milk (0.1% and 0.02% respectively of the applied dose).

Elimination of half-life $t_{1/2\beta}$ is approximately 6 h, irrespective of the mode of administration. In patients above 75 years of age it may be prolonged by a factor of approximately 1.4.

In humans tramadol is mainly metabolised by means of N- and O-demethylation and conjugation of the O-demethylation products with glucuronic acid. Only O-desmethyltramadol is pharmacologically active. There are considerable interindividual quantitative differences between the other metabolites. So far, eleven metabolites have been found in the urine. Animal experiments have shown that O-desmethyltramadol is more potent than the parent substance by the factor 2-4. Its half life $t_{1/2\beta}$ (6 healthy volunteers) is 7.9 h (range 5.4-9.6 h) and is approximately that of tramadol.

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.

Tramadol and its metabolites are almost completely excreted via the kidneys. Cumulative urinary excretion is 90% of the total radioactivity of the administered dose. In cases of impaired hepatic and renal function the half-life may be slightly prolonged. In patients with cirrhosis of the liver, elimination half-lives of 13.3 ± 4.9 h (tramadol) and 18.5 ± 9.4 h (O-desmethyltramadol), in an extreme case 22.3 h and 36

h respectively have been determined. In patients with renal insufficiency (creatinine clearance < 5 ml/min) the values were 11 ± 3.2 h and 16.9 ± 3 h, in an extreme case 19.5 h and 43.2 h, respectively.

Tramadol has a linear pharmacokinetic profile within the therapeutic dosage range.

The relationship between serum concentrations and the analgesic effect is dose-dependent, but varies considerably in isolated cases. A serum concentration of 100 - 300 ng/ml is usually effective.

Paediatric population

The pharmacokinetics of tramadol and O-desmethyltramadol after single-dose and multiple-dose oral administration to subjects aged 1 year to 16 years were found to be generally similar to those in adults when adjusting for dose by body weight, but with a higher between-subject variability in children aged 8 years and below.

In children below 1 year of age, the pharmacokinetics of tramadol and O-desmethyltramadol have been investigated, but have not been fully characterized. Information from studies including this age group indicates that the formation rate of O-desmethyltramadol via CYP2D6 increases continuously in neonates, and adult levels of CYP2D6 activity are assumed to be reached at about 1 year of age. In addition, immature glucuronidation systems and immature renal function may result in slow elimination and accumulation of O-desmethyltramadol in children under 1 year of age.

5.3 Preclinical safety data

On repeated oral and parenteral administration of tramadol during 6 to 26 weeks in rats and dogs and oral administration for 12 months in dogs haematological, clinico-chemical and histological investigations showed no evidence of any substance-related changes. Central nervous manifestations only occurred after high doses considerably above the therapeutic range: restlessness, salivation, convulsions, and reduced weight gain. Rats and dogs tolerated oral doses of 20 mg/kg and 10 mg/kg body weight respectively, and dogs rectal doses of 20 mg/kg body weight without any reactions.

In rats tramadol dosages from 50 mg/kg/day upwards caused toxic effects in dams and raised neonate mortality. In the offspring retardation occurred in the form of ossification disorders and delayed vaginal and eye opening. Male fertility was not affected. After higher doses (from 50 mg/kg/day upwards) females exhibited a reduced pregnancy rate. In rabbits there were toxic effects in dams from 125 mg/kg upwards and skeletal anomalies in the offspring.

In some *in-vitro* test systems there was evidence of mutagenic effects. *In-vivo* studies showed no such effects. According to knowledge gained so far, tramadol can be classified as non-mutagenic.

Studies on the tumourigenic potential of tramadol hydrochloride have been carried out in rats and mice. The study in rats showed no evidence of any substance-related increase in the incidence of tumours. In the study in mice there was an increased incidence of liver cell adenomas in male animals (a dose-dependent, non-significant

increase from 15 mg/kg upwards) and an increase in pulmonary tumours in females of all dosage groups (significant, but not dose-dependent).

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Calcium hydrogen phosphate dihydrate (E341),
Hydroxypropylcellulose (E463),
Colloidal anhydrous silica (E551),
Magnesium stearate (E470b)

6.2 Incompatibilities

Not applicable

6.3 Shelf life

3 years

6.4 Special precautions for storage

This medicinal product does not require any special storage conditions.

6.5 Nature and contents of container

Clear Al / PVC blisters in carton boxes in packs of 10, 20, 30, 50, 60, 90, 100, 120, and 180 tablets.

Opaque Al / PVC blisters in carton boxes in packs of 10, 20, 30, 50, 60, 90, 100, 120, and 180 tablets.

6.6 Special precautions for disposal

No special requirements

7 MARKETING AUTHORISATION HOLDER

Morningside Healthcare Ltd.

Unit C, Harcourt Way

Leicester

LE19 1WP

United Kingdom

8 MARKETING AUTHORISATION NUMBER

PL 20117/0046

**9 DATE OF FIRST AUTHORISATION/RENEWAL OF THE
AUTHORISATION**

11/11/2024

10 DATE OF REVISION OF THE TEXT

17/01/2025