

Tramadol prescribing in primary care

The Medicines Management Team are advocating cautious prescribing of tramadol and regular patient reviews.

Aims:

- Promote safe and appropriate prescribing of tramadol, and ensure regular review.
- Raise awareness of the potential harms associated with the misuse and dependence of tramadol.
- Reduce the risk of patients having adverse drug reactions and interactions.

Tramadol:

- Tramadol is licensed for the treatment of moderate to severe pain. But has not been shown to be more effective or better tolerated than other weak opioid analgesics such as codeine.
- Produces analgesia by two methods: an opioid effect and enhancement of the serotonergic and adrenergic pathways.
- The Advisory Council on the Misuse of Drugs (ACMD) recommended the change to schedule 3 CD due to concerns of misuse and increase in the number of related deaths.

Key Prescribing Points:

- Tramadol treatment should be short and intermittent and only used for moderate and severe pain.
- Maximum dose should not exceed 400mg in 24 hours. If using for persistent pain, prescribe tramadol as modified release as immediate release preparations are more associated with tolerance and problem drug use.
- Tramadol is a schedule 3 CD. Department of Health guidance is for prescriptions to be limited to a supply of up to 30 days' treatment. If the prescription is issued for a longer period, the prescriber must justify that there is a clinical need and will not cause an unacceptable risk to patient safety and document this in notes.
- Patients discharged on tramadol for acute pain from secondary care should be reviewed after discharge, and treatment discontinued where appropriate to ensure they are not continued on treatment for longer than necessary.
- Patients initiated on tramadol should be supplied as acute prescription and reviewed at three months to discourage long-term use for patients with acute pain. After 3 months, there is evidence to suggest that the pain is no longer acute and has become a chronic condition. If no other alternative analgesic is considered suitable, and tramadol is considered to be appropriate as part of the pain management plan, and there are no contra-indications then tramadol should be reviewed every 3 to 6 months.
- Review should consider: How and when it is taken? Have alternatives been tried? (both medication and non-medication approaches). Can it be stepped down or stopped gradually?
- Only prescribe tramadol if first-line opioids/opioid combination products (codeine, co-codamol) are not appropriate or not tolerated.
- Tramadol should not be co-prescribed with other opioids/ opioid combination products.
- Vigilance needed: patients requesting extra or interim prescriptions of tramadol, as this may indicate that the patient's pain is not being managed appropriately, or that the patient is stockpiling or diverting supplies.
- Avoid abrupt withdrawal after long-term treatment. The dose must be reduced slowly to ensure patient safety and to minimise the risk of withdrawal symptoms and/or adverse reactions.

Use with Caution in:

- Patients taking other interacting drugs eg: warfarin, SSRIs, TCAs, mirtazapine, venlafaxine, antipsychotics, epilepsy medications and other medication that can lower the seizure threshold.
- Patients with a history of addiction or dependence.
- Patients with a history of depression.
- Patients with a history of epilepsy or those susceptible to seizures: only prescribe in these patients if there are compelling reasons.
- Use with caution in patients with impaired hepatic and/or renal function. In patients with renal and/or hepatic 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 and/or severe hepatic insufficiency tramadol is not recommended.

Other Information:

The WHO analgesic ladder:

Step 1: Non-opioids (i.e. paracetamol +/- NSAID)

Step 2: Weak opioids in combination with non-opioids (i.e. paracetamol +/-NSAID + codeine 30-60mg four times a day)

OR

(paracetamol +/-NSAID + tramadol 50-100mg four times a day)

Step 3: Strong opioids in combination with non-opioids (i.e. paracetamol +/-NSAID + morphine)

Weak opioids include: codeine, dihydrocodeine and tramadol.

Strong opioids include: buprenorphine, fentanyl, hydromorphone, methadone, morphine, oxycodone

Recommendations:

- Audit and review patients currently prescribed tramadol with a view to stepping down and gradually stopping treatment.
- Ensure regular analgesic review as withdrawal symptoms and dependence have been reported with prolonged administration of tramadol.
- Review quantities prescribed and frequency of ordering including potential overuse by patients.
- Do not routinely use tramadol and do not start new patients on tramadol.
- Ensure optimal use of other non-opioids and weak opioids.

References:

1. Advisory Council on the Misuse of Drugs. ACMD consideration of tramadol. Feb 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/144116/advice-tramadol.pdf
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