Determination of ceftriaxone in human plasma using liquid chromatography–tandem mass spectrometry [version 1; peer review: awaiting peer review]

Thamrong Wongchang 1,2, Markus Winterberg 1,3, Joel Tarning 1,3, Natthida Sriboonvorakul 2, Sant Muangnoicharoen 2, Daniel Blessborn 1,3

1Mahidol-Oxford Tropical Medicine Research Unit (MORU), Faculty of Tropical Medicine, Mahidol University, Bangkok, 10400, Thailand
2Department of Clinical Tropical Medicine, Faculty of Tropical Medicine, Mahidol University, Bangkok, 10400, Thailand
3Centre for Tropical Medicine & Global Health, Nuffield Department of Medicine, University of Oxford, Oxford, OX3 7FZ, UK

Abstract
Ceftriaxone is a cephalosporin antibiotic drug used as first-line treatment for several bacterial diseases. Ceftriaxone belongs to the third generation of antibiotics and is available as an intramuscular or intravenous injection. Previously published pharmacokinetic studies have mainly used high-performance liquid chromatography coupled with ultraviolet detection (HPLC-UV) for the quantification of ceftriaxone. This study aimed to develop and validate a bioanalytical method for the quantification of ceftriaxone in human plasma using liquid chromatography followed by tandem mass spectrometry (LC-MS/MS). Sample preparation was performed by protein precipitation in combination with phospholipid-removal techniques for cleaning up matrix interferences. The chromatographic separation was performed on an Agilent Zorbax Eclipse Plus C18 column with 10 mM ammonium formate containing 2% formic acid: acetonitrile as mobile phase at a flow rate of 0.4 ml/min. Both the analyte and cefotaxime (internal standard) were quantified using the positive electrospray ionization (ESI) mode and selected reaction monitoring (SRM) for the precursor-product ion transitions m/z 555.0→396.1 for ceftriaxone and 456.0→324.0 for cefotaxime. The method was validated over the concentration range of 1.01-200 μg/ml. Calibration response showed good linearity (correlation coefficient > 0.99) and no significant matrix effects were observed. The intra-assay and inter-assay precision were less than 5% and 10%, respectively, and therefore well within standard regulatory acceptance criterion of ±15%.

Keywords
Ceftriaxone, bioanalytical method, human plasma, liquid chromatography tandem mass spectrometry
This article is included in the Mahidol Oxford Tropical Medicine Research Unit (MORU) gateway.

**Corresponding author:** Daniel Blessborn (danielb@tropmedres.ac)

**Author roles:** Wongchang T: Investigation, Methodology, Validation, Writing – Original Draft Preparation; Winterberg M: Supervision, Writing – Review & Editing; Tarning J: Conceptualization, Funding Acquisition, Project Administration, Writing – Review & Editing; Sriboonvorakul N: Resources, Writing – Review & Editing; Muangnoicharoen S: Resources, Writing – Review & Editing; Blessborn D: Investigation, Methodology, Supervision, Validation, Writing – Review & Editing

**Competing interests:** No competing interests were disclosed.

**Grant information:** This work was supported by the Wellcome Trust (104926) and the Bill & Melinda Gates Foundation (OPP1133769).

**Copyright:** © 2019 Wongchang T et al. This is an open access article distributed under the terms of the Creative Commons Attribution Licence, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

**How to cite this article:** Wongchang T, Winterberg M, Tarning J et al. Determination of ceftriaxone in human plasma using liquid chromatography–tandem mass spectrometry [version 1; peer review: awaiting peer review] Wellcome Open Research 2019, 4:47 (https://doi.org/10.12688/wellcomeopenres.15141.1)

**First published:** 08 Mar 2019, 4:47 (https://doi.org/10.12688/wellcomeopenres.15141.1)
Introduction
Antibiotic resistance development is a serious global health concern. The number of deaths from drug-resistant infections is predicted to increase from 700,000 to 10 million deaths annually by 2050 with an estimated cost of up to US$ 100 trillion.

The impact of resistance will increase patient mortality, morbidity, length of hospitalization, and health-care costs. Furthermore, development of widespread antibiotics resistance decreases the number of effective antibiotics rapidly, and new drug discovery does not demonstrate a healthy pipeline of novel drug to combat this rapidly increasing issue. Therefore, all strategies to preserve efficacy of available drugs should be considered. Only through an in-depth understanding of the pharmacokinetic and pharmacodynamic (PK/PD) properties of a drug, can we achieve an evidence-based dosing (i.e. right drug, at the right dose and time). However, accurate and reliable bioanalytical methods for drug determination is a fundamental element to obtain reliable pharmacokinetic data.

Ceftriaxone is an important antibiotic drug that has been used as a first-line treatment for several bacterial infectious diseases for more than 30 years. Although the drug was discovered in the 1980s by Hoffmann-La Roche, some PK/PD properties, particularly in neonates, have not been well defined. Published pharmacokinetic studies were mostly performed in adults, excluding populations such as neonates with severe infections, infants, and malnourished young children. To be able to perform PK/PD studies on these groups, a sensitive and selective bioanalytical method is needed.

Most of the previously published methods for ceftriaxone determination were performed by high performance liquid chromatography coupled with ultraviolet detection (HPLC-UV), which is less sensitive and requires larger sample volume compared to LC-MS/MS assays. The large sample volumes required for the HPLC-UV detection render these assays inappropriate for measuring drug levels in neonates, infants and young children. Another drawback of the HPLC-UV techniques are long analysis times, often 10 to 20 minutes per sample.

The objective of this study was to develop and validate an accurate and sensitive bioanalytical method for ceftriaxone determination in low volume human plasma using LC-MS/MS. Only a few research publications have reported using LC-MS/MS for ceftriaxone determination in human biological samples. Thus, this will be among the first methods for ceftriaxone determination by LC-MS/MS and an alternative option to the already published methods.

Methods
Materials and reagents
Ceftriaxone disodium salt was supplied by Sigma-Aldrich Chemicals (St Louis, MO, USA). The internal standard, cefotaxime sodium salt, was from Santa Cruz Biotechnology (Dallas, TX, USA). Formic acid (LC-MS grade), ammonium formate (LC-MS grade) and ammonium bicarbonate (LC-MS grade) were supplied by Honeywell Fluka (Seelze, Germany). Acetonitrile, methanol and water (LC-MS grade) were obtained from J.T Baker (Phillipsburg, NJ, USA). Citrate phosphate dextrose (CPD) human plasma was provided by Thai Red Cross Society (Bangkok, Thailand). Ethylenediaminetetraacetic acid (EDTA), Li-heparin and Na-heparin human plasma were acquired from six different healthy donors at Faculty of Tropical Medicine, Mahidol University (Bangkok, Thailand). Ethical approval for the method development and validation was sought from the Ethics Committee of the Faculty of Tropical Medicine, Mahidol University, Bangkok, Thailand (certificate no. MUTM 2018-028-01). All healthy volunteers provided a written informed consent before blood donation.

Sample preparation
Preparation of standard and working solutions. Stock solutions of ceftriaxone (10 mg/ml) and cefotaxime (10 mg/ml) were prepared in water and methanol, respectively. The solutions were stored in cryo vials at -80°C. Working solutions of ceftriaxone were prepared by serial dilution of the stock solution in water and used for spiking of plasma samples. All solutions were allowed to equilibrate to room temperature before use. Haemolysed plasma was made by adding frozen and subsequently thawed whole blood to spiked plasma samples in an amount of 1.5% of total volume, which equals 2-2.5 g/l haemoglobin, resulting in moderately haemolysed plasma.

Preparation of calibration standards and quality control samples. Calibration standards and quality control samples (QC) were prepared from two separate stock solutions to confirm the accuracy of the preparation. CPD human plasma was used to

Figure 1. Molecular structures. Structures of ceftriaxone (A) and the internal standard cefotaxime (B) are shown.
Linearity was evaluated by the selected reaction monitoring (SRM) was used to detect and quantify the precursor-product ion transitions m/z 555.0→396.1 for ceftriaxone and 456.0→324.0 for cefotaxime with a collision energy of 20 and 39 V, respectively.

Method validation
The method was validated according to the US Food and Drug Administration (FDA) guidelines on bioanalytical method validation16. Accuracy and precision were determined by analysing five replicates of five concentrations (1.01, 2.97, 24.1, 155, 200 μg/ml) from four separate runs. The over-curve samples of 400 μg/ml were diluted with blank plasma (1:10) to evaluate dilution integrity. Accuracy was calculated by comparing the mean measured concentration to the nominal concentration at each QC level. Precision of the assay was evaluated by using analysis of variance (ANOVA) via the Analysis ToolPak add-in to Microsoft Excel 2016 (Microsoft, Redmond, WA, USA) and reported as the relative standard deviation (%RSD).

Linearity, selectivity and recovery. Linearity was evaluated by individually analysing the calibration standards from four separate runs. The regression model that resulted in the best accuracy of back-calculated concentrations of the calibration curves and QC samples was selected as the most appropriate regression model. Linear regression models, non-weighted and with weighting (1/x and 1/x^2), as well as quadratic model with 1/x weighting, were evaluated.

Selectivity was evaluated by injecting blank extracted samples and potentially interfering drugs during post-column infusion. Six blank heparin plasma samples from six different blood donors and samples containing different anticoagulants (EDTA, CPD, Li-heparin and haemolysed Na-heparin) were used for the analysis. Potentially interfering drugs (i.e. acetaminophen, doxycycline and azithromycin) were also evaluated. The occurrence of a peak response at the retention time of the analyte or potentially interfering drugs during post-column infusion.

Matrix and carry-over effects. Matrix effect was assessed by both post-column infusion (qualitative visualization) and post-extraction spiking (quantitative evaluation). Heparin plasma from six different donors was used for the analysis as well as haemolysed plasma. Different anticoagulants EDTA, CPD, Li-heparin were evaluated. The matrix factor was calculated by comparing the peak response of post-spiked blank plasma samples to the average peak response of analyte in neat reference solution at the same nominal concentrations. Two concentrations (low and high) at 2.97 and 155 μg/ml were evaluated.

Recovery was determined by comparing the peak response of individual QC samples to the average peak response of extracted blank plasma post-spiked at the same nominal concentration. Five replicates of each concentration were evaluated.

Mass spectrometry. An API 5000 triple quadrupole mass spectrometer (SCIEX, MA, USA) was used for the detection and quantification. Data acquisition and analysis were performed using the Analyst® 1.7 software (SCIEX, MA, USA). The TurboV ionisation source (TIS) interface was operated in the positive ion mode with a drying temperature of 500°C. The interface voltage was set to 5.5 kV. The curtain, nebulizer, TIS gas pressure and declustering potential were set at 35, 50, 55 psi and 90 V, respectively. The selected reaction monitoring (SRM) was used to detect and quantify the precursor-product ion transitions m/z 555.0→396.1 for ceftriaxone and 456.0→324.0 for cefotaxime with a collision energy of 20 and 39 V, respectively.
Stability. Spiked plasma stored at ambient temperature and at 4°C for 48 h was used to evaluate short-term stability. Long-term stability of spiked samples at -80°C was evaluated after 7 months. Freeze-thaw stability was evaluated for plasma samples and haemolysed plasma samples for five cycles. The samples were stored at -80°C for 24 h followed by unassisted thawing at room temperature for 2–3 h and subsequent re-freezing at -80°C. The stability of precipitated samples stored at ambient temperature (about 23°C) for 4 h was also evaluated. The stability of extracted samples in the LC autosampler kept at 10°C was evaluated by re-injecting the calibrators and QC samples 65 h after initial injection.

Results and discussion

The calibration range of 1.01-200 μg/ml was based on pharmacokinetic data from previously published studies, taking into account the sensitivity and linearity of the MS instrument. Reported population mean peak levels of ceftriaxone was reported to be below 200 μg/ml after a standard 2-g daily dose in critically ill patients with sepsis. There is a possibility that some clinical samples have higher concentrations of ceftriaxone than covered by the calibration range. However, to maintain the ability to quantify these high-concentration samples, sample dilution integrity needs to be shown. An over-curve sample concentration of 400 μg/ml was evaluated for dilution integrity and demonstrated that such samples can be diluted and quantified using the developed method. Plasma concentrations, 24 h after administration of ceftriaxone, were reported to be 5.3, 9.3 and 15.1 μg/ml after 0.5-g, 1-g, and 2-g of intravenous dose, suggesting adequate sensitivity to quantify the drug in patients to evaluate the pharmacokinetic properties.

Deuterium-labelled ceftriaxone (d3) was evaluated as an internal standard. It was substituted by cefotaxime because ceftriaxone interfered with the ceftriaxone-d3 signal in the LC-MS/MS instrument. This could be explained by the isotopic distribution of ceftriaxone, were some isotopes have the same mass as ceftriaxone-d3 and hence cause interference. There are other stable isotope internal standards, but these could not be evaluated due to time and funding restrictions. Thus, a substitute internal standard (cefotaxime) was chosen, which belongs to the same class of antibiotic as ceftriaxone but the two drugs are not administered together.

Sample preparation and extraction

Various extraction solvents were evaluated for protein precipitation. Adding an acid, such as acetic acid or formic acid, often improves the precipitation of proteins and can improve recovery. However, acidic storage conditions affected the stability of ceftriaxone and degradation was observed. Neat acetonitrile and methanol both worked well as protein precipitation solvents. The results indicated that acetonitrile yielded lower ceftriaxone extraction recovery than methanol. However, higher reproducibility was achieved with acetonitrile. To improve the sample purity further, three different phospholipid removal filtration plates were evaluated; HybridSPE (Supelco, PA, USA), Ostro (Water, MA, USA) and the Phree plate. The HybridSPE plate retained ceftriaxone, giving very low recovery yield. Both Phree and Ostro phospholipid removal plates showed similar performance. The Phree plate was selected based on price and performance.

Instrumentation and chromatographic condition

Peak tailing of ceftriaxone has been observed and reported in the literature previously. Various chromatographic columns (i.e. C18, C6-phenyl, CN and amide stationary phases) and mobile phases were screened in this study, but peak tailing of ceftriaxone could not be eliminated completely. Best peak shape was obtained with the C18 end capped column from Agilent Zorbax Eclipse Plus and used throughout validation experiments.

The ESI MS was operated in the positive ion mode and generated several abundant ceftriaxone fragment ions; m/z 396.3, 324.1, 167.3, 125.4 and 112.0 (Figure 2). Three of these fragment ions (m/z 396.3, 167.3 and 125.4) were evaluated for signal intensity and selectivity, and for any signs of interference. The precursor-product ion transition m/z 555.0>396.1 was selected as the quantification trace because it showed approximately twice the intensity compared to the other two fragments.

Validation

The US FDA (2001) guideline on bioanalytical method validation was followed for assay validation. Accuracy and precision were evaluated by an ANOVA approach and all concentration levels were within the acceptance criteria, including the over-curve dilution integrity samples (Table 1). Alternative anticoagulants (EDTA, Na-heparin, Li-heparin) were evaluated at low and high QC levels and were within the acceptance criteria (Table 2). Raw data are available on Figshare.

Linearity, selectivity and recovery

The calibration curve was evaluated for linearity by different calibration models. The model that described the best concentration-response relationship was a linear regression with 1/x² weighting, resulting in an accuracy of back-calculated concentration ranging from 92.1–104%. For selectivity, no interfering peaks were present in the blank plasma injections from the six different donors. Moreover, injection of possible concomitant drugs (i.e. acetaminophen, azithromycin and doxycycline) did not produce any interference. Blank plasma samples with CPD, EDTA, sodium heparin, lithium heparin and a sodium heparin sample with haemolysis were also evaluated. None of the anticoagulants or the haemolysis sample produced any interference.

The use of Phree and Ostro plates to remove phospholipids showed similar recovery of ceftriaxone but the Phree plate was selected based on price and performance. In contrast, almost 100% of ceftriaxone was absorbed by the HybridSPE, and therefore this extraction approach was excluded. The Phree plate and heparin plasma was used for determining ceftriaxone recovery. The results showed a recovery of 30–35%. There was a clear recovery difference using different anticoagulants, where CPD plasma generally achieved 10–15% higher recovery compared to heparin and EDTA about 5–10% higher compared to heparin.
Table 1. Accuracy and precision of ceftriaxone determination. The method was validated by analysing five replicate samples of each concentration and repeated over four days. Accuracy and precision must not exceed 15% for each concentration, except for the LLOQ that should not deviate by more than 20%.

<table>
<thead>
<tr>
<th>Value</th>
<th>Nominal conc. (μg/ml)</th>
<th>Intra-assay precision (%RSD)</th>
<th>Inter-assay precision (%RSD)</th>
<th>Total-assay precision (%RSD)</th>
<th>Accuracy (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LLOQ</td>
<td>1.01</td>
<td>4.31</td>
<td>4.18</td>
<td>4.29</td>
<td>0.50</td>
</tr>
<tr>
<td>QC 1</td>
<td>2.97</td>
<td>4.22</td>
<td>3.95</td>
<td>4.18</td>
<td>-13.6</td>
</tr>
<tr>
<td>QC 2</td>
<td>24.1</td>
<td>3.94</td>
<td>5.57</td>
<td>4.24</td>
<td>-8.90</td>
</tr>
<tr>
<td>QC 3</td>
<td>155</td>
<td>2.21</td>
<td>8.68</td>
<td>4.00</td>
<td>-13.0</td>
</tr>
<tr>
<td>ULOQ</td>
<td>200</td>
<td>3.29</td>
<td>8.71</td>
<td>4.59</td>
<td>2.80</td>
</tr>
<tr>
<td>Over-curve</td>
<td>400</td>
<td>3.59</td>
<td>9.29</td>
<td>4.95</td>
<td>-3.50</td>
</tr>
</tbody>
</table>

LLOQ, lower limit of quantification; QC, quality control; ULOQ, upper limit of quantification; Over-curve, i.e. sample dilution 10 times; RSD, relative standard deviation.

Table 2. Accuracy and precision of ceftriaxone in different anticoagulants. The method was validated by analysing five replicate samples of each concentration and repeated over four days. Accuracy and precision must not exceed 15% for each concentration. However, accuracy is not reported since the QC samples were compared against a calibration curve using CPD plasma and the recovery difference would bias the accuracy result.

<table>
<thead>
<tr>
<th>Anticoagulant</th>
<th>Nominal conc. (μg/ml)</th>
<th>Intra-assay precision (%RSD)</th>
<th>Inter-assay precision (%RSD)</th>
<th>Total-assay precision (%RSD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDTA, QC 1</td>
<td>2.97</td>
<td>5.52</td>
<td>5.56</td>
<td>5.54</td>
</tr>
<tr>
<td>Na-Heparin, QC 1</td>
<td>2.97</td>
<td>7.53</td>
<td>13.5</td>
<td>8.75</td>
</tr>
<tr>
<td>Li-Heparin, QC 1</td>
<td>2.97</td>
<td>7.35</td>
<td>9.00</td>
<td>7.64</td>
</tr>
<tr>
<td>EDTA, QC 3</td>
<td>155</td>
<td>3.81</td>
<td>4.76</td>
<td>3.98</td>
</tr>
<tr>
<td>Na-Heparin, QC 3</td>
<td>155</td>
<td>4.10</td>
<td>10.5</td>
<td>5.62</td>
</tr>
<tr>
<td>Li-Heparin, QC 3</td>
<td>155</td>
<td>3.77</td>
<td>5.40</td>
<td>4.07</td>
</tr>
</tbody>
</table>

QC, Quality Control; RSD, Relative Standard Deviation.
Using the same anticoagulant in both calibrators and study samples is therefore important to avoid a bias in the result.

Matrix effect and carry-over. Matrix effect evaluation during post-column infusion did not show any increase or drop in ceftriaxone or internal standard signal. Injection of possible concomitant drugs or plasma with different anticoagulants, including haemolysis-plasma, did not show any increase or decrease in the signal. To determine matrix effects quantitatively, extracted blank plasma post-spiked was compared with neat solution at the same nominal concentration, revealing no significant matrix suppression or enhancement. Some of the QC1 samples experienced some degree of enhancement, of which CPD as anticoagulant at QC1 level exhibited a 27% signal enhancement, while the QC3 sample had no effect at all but with a tendency to suppress the signal (Table 3). Matrix effects have also been reported by other authors, affecting only the lowest concentrations.\textsuperscript{14,15,22} The internal standard did not show any matrix effects. A stable isotope internal standard would have been desirable in this case and would most likely have experienced the same matrix effect and compensated for any potential differences in the signal. Carry-over was prevented by adding a washout step using ammonium bicarbonate and an increase in run-time (Figure 3).

Stability. The stability samples were quantified using a calibration curve in CPD plasma. Stability samples in CPD plasma were compared to the average measured concentration of CPD QC samples added in the same run. The CPD calibration curve was also used to quantify heparin and EDTA stability samples due to limited supply of volunteer donor blood. However, since EDTA and heparin have different recovery from plasma compared to CPD, a direct comparison would be biased. Thus, stability samples were instead compared with the average measured concentration of the precision and accuracy of each anticoagulant. Short-term stability for up to 24 h at ambient temperature (about 23°C) and 4°C for ceftriaxone was confirmed in all anticoagulants and for CPD plasma up to 48 h. Long-term stability at -80°C was evaluated after 7 months (224 days) and showed good stability for all anticoagulants. QC samples in all anticoagulants presented good stability after freeze-thaw over five cycles, including plasma with moderate haemolysis. Protein precipitated samples also showed good stability when stored at ambient temperature (about 23°C) for 4 h prior to transferring the supernatant to the Phree phospholipid removal plate (Table 4). Extracted samples in the LC autosampler, up to 65 h, showed less than 10% variation in QC concentrations if the full set of calibrators and QC was re-injected. However, comparing the original injection with the 65-h injection did show a loss of about 20%; however, the change is equal over the whole concentration range and will not be noticed if the full set of calibrators and QC are re-injected.

Conclusion
The use of LC-MS/MS resulted in higher sensitivity and selectivity than HPLC-UV. The developed method requires only a small volume of plasma (100 μl) and will allow for pharmacokinetic studies in children and other groups with limited sampling capabilities. However, there might still be a limitation for very small children, infants and neonates where only a very small amount of blood can be obtained from venepuncture or capillary sampling. Moreover, the incorporation of phospholipid removal techniques for sample preparation could reduce some matrix interferences and preserve the MS instrument and column, enabling long-term usage without interruptions. Carry-over problems were solved by modifying the LC-gradient program by including an additional washout sequence. However, the spiked QC samples in EDTA and heparin plasma showed lower recovery than CPD. Thus, it is important to use the same anticoagulant in calibration curves and clinical samples for analysis. Spiked plasma samples showed good stability in various conditions over a short term and the extracted samples can be re-injected from the LC autosampler up to 65 h after extraction.

| Table 3. Matrix effects from different donors in heparin plasma and different anticoagulants. Donors A to F are individual donors collected using sodium heparin as anticoagulant. Other anticoagulants were collected from individual donors and are not from the same source. |
|-----------------|-----|-----|-----|-----|-----|
| Concentration   | Donor | EDTA | CPD | Li-Hep | Na-Hep |
| QC 1, 2.97 μg/ml| A    | 1.12 | 1.18 | 1.10 | 1.03 | 1.07 | 1.04 | 1.10 | 1.27 | 1.10 | 1.17 |
| QC 3, 155 μg/ml | B    | 0.93 | 0.87 | 0.93 | 0.91 | 0.93 | 0.88 | 0.93 | 0.96 | 0.90 | 0.91 |
| IS for QC 1, 2 μg/ml | C | 0.99 | 1.03 | 1.00 | 1.01 | 1.01 | 1.01 | 1.03 | 1.02 | 1.03 | 1.05 |
| IS for QC 3, 2 μg/ml | D | 1.01 | 1.05 | 1.03 | 1.05 | 1.01 | 1.03 | 1.04 | 1.04 | 1.03 | 1.05 |

Hep, Heparin; QC, Quality Control; IS, internal standard.
Figure 3. Overlay of ceftriaxone at LLOQ concentration and the first blank injection after injecting five ULOQ samples, presenting no significant carry-over.

Table 4. Stability of ceftriaxone in plasma under different conditions. Due to the recovery difference between anticoagulants, EDTA, Na-heparin and Li-heparin are compared to the average concentration of the four precision and accuracy batches for each anticoagulant and are presented as percentages.

<table>
<thead>
<tr>
<th>QC1, 2.97 µg/ml</th>
<th>RT 24 hrs</th>
<th>RT 48 hrs</th>
<th>4°C 24 hrs</th>
<th>4°C 48 hrs</th>
<th>F/T cycle 3</th>
<th>F/T cycle 5</th>
<th>Precipitated 4hrs in RT</th>
<th>-80°C 224 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD</td>
<td>106</td>
<td>100</td>
<td>102</td>
<td>103</td>
<td>97.7</td>
<td>94.0</td>
<td>94.2</td>
<td>103</td>
</tr>
<tr>
<td>CPD haemolysis</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>88.4</td>
<td>99.3</td>
<td>-</td>
</tr>
<tr>
<td>EDTA</td>
<td>105</td>
<td>-</td>
<td>113</td>
<td>-</td>
<td>103</td>
<td>103</td>
<td>98.0</td>
<td>95.5</td>
</tr>
<tr>
<td>Na-Hep</td>
<td>103</td>
<td>-</td>
<td>109</td>
<td>-</td>
<td>100</td>
<td>98.7</td>
<td>96.8</td>
<td>93.7</td>
</tr>
<tr>
<td>Na-Hep haemolysis</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>91.3</td>
<td>97.6</td>
<td>91.9</td>
<td>-</td>
</tr>
<tr>
<td>Li-Hep</td>
<td>105</td>
<td>-</td>
<td>98.3</td>
<td>-</td>
<td>95.7</td>
<td>99.5</td>
<td>103</td>
<td>96.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QC3, 155 µg/ml</th>
<th>RT 24 hrs</th>
<th>RT 48 hrs</th>
<th>4°C 24 hrs</th>
<th>4°C 48 hrs</th>
<th>F/T cycle 3</th>
<th>F/T cycle 5</th>
<th>Precipitated 4hrs in RT</th>
<th>-80°C 224 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPD</td>
<td>99.8</td>
<td>99.6</td>
<td>101</td>
<td>103</td>
<td>99.1</td>
<td>95.0</td>
<td>101</td>
<td>109</td>
</tr>
<tr>
<td>CPD haemolysis</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>98.6</td>
<td>94.3</td>
<td>-</td>
</tr>
<tr>
<td>EDTA</td>
<td>105</td>
<td>-</td>
<td>104</td>
<td>-</td>
<td>97.9</td>
<td>95.5</td>
<td>90.9</td>
<td>92.8</td>
</tr>
<tr>
<td>Na-Hep</td>
<td>103</td>
<td>-</td>
<td>106</td>
<td>-</td>
<td>97.5</td>
<td>93.7</td>
<td>88.2</td>
<td>94.5</td>
</tr>
<tr>
<td>Na-Hep haemolysis</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>90.4</td>
<td>88.5</td>
<td>88.8</td>
<td>-</td>
</tr>
<tr>
<td>Li-Hep</td>
<td>101</td>
<td>-</td>
<td>108</td>
<td>-</td>
<td>96.1</td>
<td>94.2</td>
<td>91.4</td>
<td>98.8</td>
</tr>
</tbody>
</table>

Hep, heparin; RT, ambient room temperature (about 23°C); F/T, freeze and thaw; "-", not available.
Data availability

Figshare: Supplementary files ceftriaxone plasma. https://doi.org/10.6084/m9.figshare.7775819.v1

The following underlying data are available:

- Long-term stability 224 days.txt (Quantification data for long-term stability calculations of ceftriaxone in CPD, EDTA, Na-heparin and Li-heparin plasma)
- Precision and Accuracy run 1.txt (Quantification data for run 1 out of 4, for the accuracy and precision used in ANOVA calculations)
- Precision and Accuracy run 2.txt (Quantification data for run 2 out of 4, for the accuracy and precision used in ANOVA calculations)
- Precision and Accuracy run 3.txt (Quantification data for run 3 out of 4, for the accuracy and precision used in ANOVA calculations)
- Precision and Accuracy run 4.txt [Quantification data for run 4 out of 4, for the accuracy and precision used in ANOVA calculations]
- Recovery and matrix effects.txt (Peak areas of extracted QC samples, blank plasma post spiked and reference in neat solution for recovery and matrix effect calculations).
- Stability 4 hrs Haemolysis and Precipitation at RT.txt (Quantification data for the stability of precipitated samples in clear plasma and haemolysed plasma in different anticoagulants, stored 4 h in room temperature before transferring supernatant to Fhree plate).
- Stability Freeze and Thaw.txt (Quantification data for testing repeated freeze and thaw stability of ceftriaxone in plasma using different anticoagulants including haemolysed plasma).
- Stability LC-stability over 65 hrs.txt (Quantification data testing ceftriaxone stability, comparing the difference in quantified concentration from original injected samples re-injection 65 h later).
- Stability RT and 4C 4hrs-48hrs.txt (Quantification data testing ceftriaxone stability in plasma with different anticoagulants stored in room temperature or in 4°C for 24 h (CPD tested up to 48 h)).

Data are available under the terms of the Creative Commons Zero “No rights reserved” data waiver (CC0 1.0 Public domain dedication).

Grant information
This work was supported by the Wellcome Trust (104926) and the Bill & Melinda Gates Foundation (OPP1133769).

Acknowledgements
We would like to thank Karrrawee Kaewhao at Mahidol-Oxford Tropical Medicine Research Unit for valuable assistance in the development and validation of the method.

References


