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► **To cite this version:**

Emmanuelle Gras, Yohann Tran, Benjamin Kably, Agnès Lillo-Lelouet, Thibaut Caruba, et al.. Prospective assessment of the frequency of and risk factors for bleeding events in patients treated with cefazolin. *Infection*, In press, 10.1007/s15010-023-02145-1 . hal-04432550

HAL Id: hal-04432550

<https://hal.sorbonne-universite.fr/hal-04432550>

Submitted on 1 Feb 2024

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1 **Prospective Assessment of the Frequency of and Risk Factors for Bleeding Events in**
2 **Patients Treated with Cefazolin**

3

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47 **Short running title:** Bleeding events in cefazolin-treated patients

48

49 **ACKNOWLEDGMENTS**

50 The results of this study were presented as a poster at the Journées nationales
51 d'infectiologie, the French Infectious Disease Society congress in 2021.

52 The authors would like to thank Bastien Rance and Estelle Lu for the extraction of the
53 biological data from the database of the Assistance Publique-Hôpitaux de Paris.

54 The authors would like to thank Marion Lacasse, Marie Berleur, Ségolène Gendraux,
55 Déborah Porez, Pauline Martinet and Matthieu Petit for the help during data collection.

56 **FUNDING DECLARATIONS**

57 Statistical analyses were performed using a grant from AP-HP (Fonds APRES "Appui aux
58 Projets pour le REnforcement du Sens, 2020, Assistance-Publique Hôpitaux de Paris).

59 **STATEMENTS AND DECLARATIONS**

60 The authors do not declare any conflict of interests.

61

62 EG and DL contributed to the conceptualization of the protocol, the investigation, the
63 interpretation of the statistical analysis and wrote (original draft) the manuscript.

64 NG participated in the investigation, the interpretation of the statistical analysis and writing
65 (reviewing and editing) of the final manuscript.

66 YT performed the formal analyses, participated in their interpretation and wrote (reviewing
67 and editing) the final manuscript.

68 ML and BK participated in the investigation and writing (reviewing and editing) of the final
69 manuscript.

70 DS, BS, TC, ML, EB, ALL contributed to the conceptualization of the protocol and wrote
71 (reviewing and editing) the final manuscript.

72 All authors gave their final approval for the version of the manuscript to be submitted.

73 **ETHICAL DECLARATION**

74 The study was approved by a national expert committee (reference 2019-06-01) and was
75 declared to the CNIL (Comité national de l'informatique et des libertés, reference 2213058 v
76 0)

77 **SUMMARY**

78 **Purpose.** Major bleedings have been described with cefazolin. The objective was to
79 determine the frequency of bleeding events in cefazolin-treated patients and to identify risk
80 factors for these complications.

81 **Methods.** Monocenter prospective observational study of all consecutive cefazolin-treated
82 patients. Patients benefited from a daily clinical assessment of bleedings and a twice-a-week
83 blood sampling including hemostasis. Bleedings were classified according to the
84 International Society on Thrombosis and Hemostasis classification: major, clinically relevant
85 non-major bleedings (CRNMB) and minor bleedings.

86 **Results.** From September 2019 to July 2020, 120 patients were included, with a mean age of
87 59.4 (\pm 20.7) years; 70% of them (84/120) were men. At least 1 CRNMB or major bleeding
88 were observed in 10% of the patients (12/120). Compared to patients with no or minor
89 bleeding, patients with CRNMB or major bleeding were, upon start of cefazolin, more
90 frequently hospitalized in an intensive care unit (7/12, 58.3%, vs 12/108, 11.1%, $P < 0.001$,
91 respectively) and receiving vitamin K antagonists (4/12, 33.3%, vs 8/108, 7.4%, $P = 0.019$,
92 respectively). After multivariate analysis, patients receiving vitamin K antagonists the day
93 prior bleeding and/or treated for endocarditis were factors associated with an increased risk
94 of CRNMB or major bleeding (Odd ratio 1.36, confidence interval 95%, 1.06–1.76, $P=0.020$
95 and 1.30, 1.06–1.61, $P= 0.015$, respectively).

96 **Conclusion.** Bleeding events associated with cefazolin treatment are frequent. Close clinical
97 monitoring should be performed for patients treated for endocarditis and/or receiving
98 vitamin K antagonists. Hemostasis work-up could be restricted to these patients.

99

100 **1. INTRODUCTION**

101 Cefazolin, a first-generation cephalosporin, was initially used for surgical prophylaxis [1] with
102 a good safety profile [2,3]. Since 2015, American and European guidelines proposed
103 cefazolin as an alternative to penicillinase-resistant penicillins ([Flu]cloxacillin or oxacillin) for
104 the treatment of endocarditis caused by methicillin-susceptible *Staphylococcus* spp. [4,5].
105 Because of recurring (Flu)cloxacillin or oxacillin stock-outs and rising questions on their
106 safety profile (liver and kidney toxicity), an increasing number of centers positioned cefazolin
107 as a first-line therapy with good efficacy in observational studies [6–8]. An on-going
108 prospective non-inferiority trial is currently enrolling adult patients with methicillin-
109 susceptible *S. aureus* bloodstream infection in order to compare the efficacy of cefazolin and
110 penicillinase-resistant penicillins [9].

111 Soon after commercialization, reports signaled prolonged prothrombin time (PT), of up to
112 20%, eventually associated with major bleedings [10,11]. With the increasing number of
113 patients exposed to cefazolin for longer durations, case reports of bleeding in cefazolin-
114 treated patients seemed to increase [12,13]. In 2017, the Summary of Product
115 Characteristics was modified to stipulate monitoring of PT and vitamin K supplementation if
116 required [14]. The suspected pathophysiological mechanism is the inhibition of glutamate
117 carboxylation, a vitamin-K dependent reaction required for the formation of coagulation
118 factors. This inhibition would be caused by thiol heterocyclic metabolites of various
119 cephalosporins, including cefazolin [15,16], unrelated to vitamin-K antagonist
120 anticoagulants.

121 A recent retrospective monocenter cohort reported 7 major bleedings for 132 included
122 patients (5%) with a significant increase in the activated partial thromboplastin time (aPTT)

123 [17]. However, the assessment of bleedings was not standardized and hemostasis work-up
124 was not complete (no coagulation factors, D-dimer nor fibrinogen measurement).
125 Therefore, we performed a prospective study with the primary objective to measure the
126 frequency of major and clinically-relevant non-major bleedings (CRNMB) in cefazolin-treated
127 patients. Our secondary objective was to identify risk factors for CRNMB or major bleeding in
128 this population.

129 **2. MATERIAL AND METHODS**

130 **2.1. Study design and inclusion process**

131 This monocenter prospective cohort took place in a 700-bed teaching hospital from
132 September 16th, 2019 to July 8th, 2020. All adult patients (> 18 years-old) were included if
133 they were treated > 48 hours with cefazolin, except for refusal of the patient. Non-inclusion
134 criteria were: *i)* septic shock upon cefazolin initiation, defined by persistent mean arterial
135 pressure < 65 mmHg after fluid resuscitation requiring vasoactive drugs and lactate level > 2
136 mmol/L [18], *ii)* patients treated > 72 hours before inclusion, *iii)* hospital length of stay < 48
137 hours and *iv)* estimated life expectancy < 14 days. The sample size was calculated based on
138 the expected 5% prevalence for major bleedings [17] according to the formula : $n = (Z^2 \times p \times$
139 $q) / d^2$, where n = sample size; $Z = 1.96$, Z statistic for a level of confidence; p = expected
140 prevalence; $q = 1 - p$, 0.95 ; d = precision, 0.05 [19]. The minimal number of patients to be
141 included in the study was 73 patients. To avoid loss of data and enable comparison, we
142 decided to include 120 patients, based on the capacity of recruitment evaluated in our
143 hospital. To ensure inclusion of every consecutive patient, daily information was
144 communicated to the principal investigator (EG) by the microbiologist (all *S. aureus* positive
145 blood culture and/or bone and joint biopsy), by the pharmacist (every cefazolin initiation)

146 and by physicians of the antimicrobial stewardship program (every intervention about a
147 cefazolin-treated patient).

148 As part of the daily routine of the infectious disease team, clinical rounds were performed
149 each day in the three intensive care units of the hospital, the orthopedics unit devoted to
150 bone and joint infections and the cardiology and cardiovascular surgery departments. These
151 rounds enabled further identification of patients. Patients could be included several times if
152 they were treated with cefazolin more than once, with ≥ 7 days of cefazolin-free interval
153 between each inclusion.

154 **2.2 Routine management**

155 In our institution, cefazolin was established in 2016 as the first-line treatment of severe
156 infections caused by methicillin-susceptible *Staphylococcus* spp. (endocarditis, bloodstream
157 infection, bone and joint infection). Usual cefazolin dosage was prescribed, with adaptation
158 to the estimated glomerular filtration rate (eGFR, using the Modification of Diet in Renal
159 Disease (MDRD) equation, cut-off 30 mL/min/1.73m²): 2 grams IV bolus followed by a
160 continuous infusion of 80 mg/kg/day dose for patients with an eGFR >30 mL/min/1.73m²
161 and 20 mg/kg twice daily for eGFR <30 mL/min/1.73m². For patients with uncomplicated *S.*
162 *aureus* bloodstream infection, an oral step-down was proposed after 5-7 days of intravenous
163 therapy.

164 **2.3 Biological work-up**

165 A formatted work-up was implemented for this study in order to facilitate prescription and
166 limit missing data. The twice-weekly biological work-up included complete blood count, PT,
167 aPTT, coagulation factors II (FII), V (FV), VII (FVII) and X (FX), fibrinogen using STAR-Max
168 coagulometers (Diagnostica Stago, France). D-dimer were measured using the Vidas D-

169 Dimer[®] assay (Biomérieux, France). Alanine amino-transferase (ALT), aspartate amino-
170 transferase (AST), Gamma-glutamyl transferase (GGT), alkaline phosphatase (ALP),
171 conjugated and free bilirubin and serum creatinine levels were measured using UniCel Dxl
172 800 Access Immunoassay System (Beckman-Coulter, USA). Plasmatic cefazolin concentration
173 was performed using Liquid Chromatography coupled to tandem Mass Spectrometry (LC-
174 MS/MS). Sampling was taken at any time of the day for continuous cefazolin recipients and
175 minutes before next administration for intermittent cefazolin recipients. Plasma cefazolin
176 target concentration at steady state was 40-80 mg/L [20].

177 **2.4 Clinical evaluation**

178 After inclusion, patients benefited from a daily clinical assessment (bleeding, quick Sepsis-
179 related Organ Failure Assessment (qSOFA), edema). All data were prospectively compiled on
180 an electronic Case Report Form hosted on the REDCap platform of our center [21]

181 **(Supplementary method A).**

182 **2.5 Bleeding classification**

183 The International Society on Thrombosis and Hemostasis (ISTH) classification was used to
184 describe bleeding events. The ISTH defines a major bleeding by a fatal bleeding, and/or
185 symptomatic bleeding in a critical area or organ, such as intracranial, intraspinal, intraocular,
186 retroperitoneal, intra-articular or pericardial, or intramuscular with compartment syndrome,
187 and/or bleeding causing a fall in hemoglobin levels of 20 g/L or more, or leading to a
188 transfusion of 2 units or more of whole blood or red cells [22]. A CRNMB is defined as a
189 bleeding not falling under the definition of major bleeding but either requiring medical
190 intervention by a health care professional or leading to increased level of care. “Prompting a
191 face to face evaluation” was not retained as a part of the definition of CRNMB in our study

192 since every patient benefited from a daily clinical assessment, regardless of their bleeding
193 status [23]. A minor bleeding corresponded to any bleeding not classified as major or
194 CRNMB.

195 **2.6 Pharmacovigilance**

196 When a major bleeding or a suspected adverse event was diagnosed in a cefazolin-treated
197 patient, the case was declared to our local pharmacovigilance department, as part of the
198 usual care by the physician in charge of the patient.

199 **2.7 Statistical analysis**

200 For each patient, the first occurrence of the most severe bleeding was considered for group
201 comparison. We compared two groups: "no bleeding or non-clinically relevant bleeding" and
202 "major or CRNMB". Mean (standard deviations, SD) were used for continuous variables.
203 Categorical variables were expressed as number and percentages. An independent analyst
204 performed a univariate analysis using the Fisher or Chi-squared tests for categorical variables
205 and the t-test Student for continuous variables or the Wilcoxon-Mann-Whitney test when a
206 non-parametric test was required. Then, he performed a multivariate analysis based on the
207 minimization of Akaike's Information Criterion. Using multivariate logistic regression tables,
208 we calculated odd-ratios (ORs) with 95% confidence interval (95% IC). All statistical tests
209 were performed with R language on R Studio Software (R Core Team 2021, v4.0.4).
210 The STrengthening the Reporting of OBservational studies in Epidemiology (STROBE)
211 statement was used to report this observational study (**Supplementary method B**) [24].

212 **2.8 Ethics**

213 The study was approved by a national expert committee (reference 2019-06-01) and was
214 declared to the CNIL (Comité national de l'informatique et des libertés, reference 2213058 v

215 0). Patients were informed of the present study and could refuse to participate at any time.

216 Patient confidentiality was ensured with anonymization of their clinical record.

217

218

219 3. RESULTS

220 3.1 Description of the population and characteristics of cefazolin-treated infections

221 From September 16th, 2019 to July 8th, 2020, among 179 consecutive patients screened, 120
222 were included in the study, with a mean age of 59.4 (\pm 20.7) years and 70% of them (84/120)
223 were men (**Figure, Table 1**). Three patients were included twice during the study period,
224 with cefazolin-free intervals of 7, 7 and 194 days, respectively. Patients were mainly
225 hospitalized in surgical wards (58/120, 48.3%), and 15.8% (19/120) were hospitalized in
226 intensive care units (ICU). Mean cefazolin duration was 8.2 (SD \pm 5.1) days.

227 Cefazolin-treated infections were mainly bone and joint infections (50/120, 41.7%), followed
228 by catheter-related infections and endocarditis (18/120, 15%, and 11/120, 9.2%,
229 respectively). Sixty-three of the 120 (52.5%) patients had positive blood cultures.

230 3.2 Description of bleedings

231 Twelve patients (10.0%) experienced major or CRNMB, with a median number of bleedings
232 of 0.65 (\pm 1.45). Overall, 16 major and 3 CRNMB occurred. Major bleedings mostly involved
233 deep organs (upper gastrointestinal tract, hematuria and visceral hematoma in 3, 2 and 2
234 patients, respectively) and bone and joints (hemarthrosis and bleeding of a leg amputation
235 wound in 1 patient each) (**Supplementary Table A**). Of note, two intracranial bleedings
236 occurred. Three CRNMB occurred: 1 catheter-related bleeding, 1 epistaxis and 1 bleeding of
237 a leg amputation. Minor bleedings are described in **Supplementary Table A**. Major and
238 CRNMB bleedings resulted in decreased hemoglobin count for 7 patients, including 2
239 patients with \geq 30 g/L decrease. Red blood cells transfusion was performed in 4 patients, and
240 platelets transfusion for 2 patients. Four patients were transferred to the ICU at the time of
241 bleeding diagnosis (**Supplementary Table B**).

242 3.3 Risk factors associated with CRNMB or major bleedings

243 Compared to patients with no or minor bleeding, patients with CRNMB or major bleeding
244 were, upon start of cefazolin, more frequently treated for endocarditis (4/12, 33.3%, vs
245 7/108, 6.5%, $P=0.013$), had more frequently a qSOFA score of 2 or more (4/12, 33.3%, vs
246 5/107, 4.7%, $P = 0.006$), were more frequently hospitalized in an ICU (7/12, 58.3%, vs
247 12/108, 11.1%, $P < 0.001$, respectively) and receiving vitamin K antagonists (4/12, 33.3%, vs
248 8/108, 7.4%, $P = 0.019$) (**Table 1**). As opposed to that, no significant difference was observed
249 in patients receiving direct oral anticoagulants (1/12, 9.1%, vs 10/108, 9.3%, $P = 1$) (**Table 1**).
250 In addition, they had more frequently positive blood cultures (11/12, 91.7%, vs 52/108,
251 48.6%, $P = 0.005$) (**Table 1**). Cefazolin duration did not impact on occurrence of bleeding (10
252 (SD ± 4.8) vs. 8.0 (SD ± 5.1) days, $P = 0.19$).

253 Patients with CRNMB or major bleedings were more frequently receiving vitamin K
254 antagonists prior to bleeding (3/12, 25% vs 6/108, 5.6%, $P= 0.046$) compared to patients
255 with no or minor bleeding (**Table 2**). No difference was noted in patients receiving direct oral
256 anticoagulants (0/12, 0%, vs 5/108, 4.6%, $P = 1$) (**Table 2**). Regarding last known biological
257 results prior to bleeding, patients with CRNMB or major bleedings had lower PT, FII and FV
258 levels (67.8% ± 16.5 vs 81.8% ± 16.9 , $P = 0.015$ ($n=109$), 66.2% ± 21.6 vs 105.5% ± 30.5 , $P =$
259 0.005 ($n=80$), and 102% ± 17.3 vs 126.9% ± 37.6 , $P = 0.014$ ($n=80$), respectively) compared to
260 patients with no or minor bleedings. In contrast, there was no modification for fibrinogen
261 nor D-dimer levels (**Table 2**). Furthermore, cefazolin concentration was more frequently
262 supra-therapeutic (> 80 mg/L) in these patients ($n=72$, 2/4, 50% vs 8/68, 6.4%) (**Table 2**).
263 Nonetheless, on the day of bleeding, we did not observe differences regarding the
264 proportion of patients with supra-therapeutic cefazolin concentration (>80 mg/L) among the

265 different groups (no bleeding, minor, CRNMB and major bleeding, **Supplementary Figure**).

266 When comparing biological data of patients upon inclusion and the last known results before

267 bleeding, no statistical difference was found to predict bleeding occurrence (**Table 3**).

268 In the multivariate analysis, the factors significantly associated with an increased risk of

269 CRNMB or major bleeding were vitamin K antagonists intake the day prior bleeding and/or

270 cefazolin administration for endocarditis (OR, IC 95%, 1.36 (1.06–1.76), P=0.020 and 1.30

271 (1.06–1.61), P= 0.015, respectively) (**Table 4**). Peripheral edema upon inclusion and the day

272 prior bleeding was a protective factor (OR, IC 95%, 0.71 (0.56–0.90), P=0.006 and 0.84 (0.74–

273 0.96), P=0.012, respectively.

274

275 **4. DISCUSSION**

276 In this prospective monocenter study, we found that 10% of the cefazolin-treated patients
277 had at least one bleeding event classified as CRNMB or major bleeding during their follow-
278 up, based on daily standardized clinical assessment. Risk factors for the occurrence of
279 CRNMB or major bleeding were patients treated for endocarditis and patients receiving
280 vitamin K antagonists the day prior bleeding.

281 To our knowledge, no other prospective study has described the occurrence of bleedings in
282 cefazolin-treated patients with systematic biological exploration. Published clinical trials on
283 cefazolin do not report major bleedings as an adverse event [25,26]. Our result of 10%
284 bleedings contrasts with the 5% of the only retrospective study conducted by Stratzulla *et al.*
285 in 2018 (e.g. 7/132, 5%) [17]. This difference may be explained, along with data loss inherent
286 to the retrospective design (with data retrieved from a software for daily clinical practice),
287 by a less severe profile of patients in this study (no hospitalization in the ICU), who were less
288 frequently receiving vitamin K antagonists (5/132, 4%, vs 12/120, 10%) and no patient
289 treated for endocarditis. Furthermore, our study used the ISTH classification whereas
290 Strazulla *et al.* defined severe bleeding as any bleeding with clinical instability requiring care
291 in ICU. There was a non-significantly higher incidence of greater severity of bleeding in
292 univariate analysis: patients treated for endocarditis, with bloodstream infection upon
293 inclusion and/or hospitalized in the ICU. Other confounding factors for bleeding might be
294 present in this population. In our study, bleedings were not the consequence of coagulation
295 intravascular disorder, as suggested by D-dimer and fibrinogen in normal ranges.

296 In our study, no biological feature was predictive of bleeding, unlike suggested by Strazulla
297 *et al* [17]. In the multivariate analysis, the last available PT level prior bleeding was not

298 statistically significant. In the univariate analysis, even though last available PT and FII prior
299 bleeding were lower in patients with CRNMB or major bleeding than in patients with no or
300 minor bleeding, mean percentage remained more than 60%, making these results difficult to
301 use in daily clinical practice. Delta between biological data upon inclusion and last available
302 prior hemorrhage was not statistically significant either. These findings challenge the
303 recommendation to monitor PT under cefazolin therapy [14].

304 Other β -lactams have been reported to either increase the risk of bleeding or the occurrence
305 of coagulation disorders. A risk scoring system was developed for cephamycin-associated
306 bleeding by Chien *et al.* based on history of bleeding, bleeding tendency, age and chronic
307 hepatic disease [27]. Wang *et al.* reported in a retrospective cohort study of 23 242 patients
308 with propensity-score matching analyses that cefoperazone-sulbactam, compared to
309 ceftazidime, increased the risk of PT prolongation (adjusted OR (aOR), IC 95%, 2.26 (1.61–
310 3.18)), coagulation disorders (aOR, IC 95%, 1.81 (1.43–2.30)), and decreased platelet count
311 (aOR, IC 95%, 1.46 (1.25–1.72)), but did not increase risk of bleeding (aOR, IC 95%, 1.05 (
312 0.79–1.40)) [28]. This led to the mentioning of “bleeding potentially fatal in unknown
313 frequency” on the cefoperazone product information in 2016, mandated by the European
314 Medicine Agency [29].

315 Treatment at therapeutic dose by oral anticoagulation the day prior bleeding was a risk
316 factor after multivariate analysis in our study. Most of patients with major or CRNMB with
317 oral anticoagulation were treated by vitamin K antagonist. An alternative anticoagulant
318 therapy could be discussed in these patients such as heparin (low molecular weight heparin
319 or unfractionated heparin for ICU patient) but further studies are needed to corroborate or
320 refute this finding. Abbas *et al.* reported the risk of bleeding with concomitant antibiotic and

321 phenprocoumon (coumarin-derived vitamin K antagonist) administration [30]. Strongest
322 associations were found for cotrimoxazole and fluroquinolones (OR, IC 95%, 3.96 (3.20–
323 4.91), $P < 0.01$, and OR, IC 95%, 3.41 (2.98–3.89), $P < 0.01$, respectively). Third-generation
324 cephalosporins had the highest risk among β -lactams (OR, IC 95%, 2.37 (1.61–3.49), $P <$
325 0.01). Only 4 cases and 12 controls were receiving first generation cephalosporin, making the
326 absence of risk of bleeding difficult to interpret (OR, IC 95%, 1.39 (0.45–4.32), $P < 0.01$).

327 Drug interactions are frequent causes of adverse events with vitamin K antagonist.
328 Particularly, medications that interfere with the endogenous synthesis of vitamin K could
329 lead to increased anticoagulation: for instance, antibiotics eliminate bacterial flora and
330 worsen vitamin K deficiency and are a risk factor for bleeding [31].

331 Our multivariate analysis revealed that peripheral edema was a protective factor. No clear
332 explanation could be proposed at the light of the literature, but this might be of interest for
333 future pathophysiology research.

334 Our study has several limitations. Given the monocenter design and the absence of other
335 prospective studies, generalizability is difficult. Furthermore, our study design was not made
336 to compare cefazolin over another antibiotic (such as (cl)oxacillin) to compare the incidence
337 of bleeding events. Our study aimed to determine cefazolin-treated patients' phenotypes for
338 which increased clinical surveillance and hemostasis work-up would be useful. Despite a
339 robust design with a daily clinical assessment, some biological data are missing.

340 **5. CONCLUSION**

341 Close clinical monitoring should be performed for patients treated for endocarditis and/or
342 receiving vitamin K antagonists while treated with cefazolin. Given the absence of predictive
343 biological tests, restraining hemostasis work-up to these patients might be sufficient.

344 **6. STATEMENTS AND DECLARATIONS**

345 The authors de not declare any conflict of interests.

346 7. REFERENCES

- 347 1. Bratzler DW, Dellinger EP, Olsen KM, et al. Clinical practice guidelines for antimicrobial
348 prophylaxis in surgery. *Surg Infect* **2013**; 14:73–156.
- 349 2. Wu C-K, Wang J-H, Lee C-H, et al. The outcome of prophylactic intravenous cefazolin and
350 ceftriaxone in cirrhotic patients at different clinical stages of disease after endoscopic
351 interventions for acute variceal hemorrhage. *PloS One* **2013**; 8:e61666.
- 352 3. Alotaibi AF, Mekary RA, Zaidi HA, Smith TR, Pandya A. Safety and Efficacy of Antibacterial
353 Prophylaxis After Craniotomy: A Decision Model Analysis. *World Neurosurg* **2017**; 105:906-
354 912.e5.
- 355 4. Baddour LM, Wilson WR, Bayer AS, et al. Infective Endocarditis in Adults: Diagnosis,
356 Antimicrobial Therapy, and Management of Complications: A Scientific Statement for
357 Healthcare Professionals From the American Heart Association. *Circulation* **2015**; 132:1435–
358 1486.
- 359 5. Habib G, Lancellotti P, Antunes MJ, et al. 2015 ESC Guidelines for the management of infective
360 endocarditis: The Task Force for the Management of Infective Endocarditis of the European
361 Society of Cardiology (ESC). Endorsed by: European Association for Cardio-Thoracic Surgery
362 (EACTS), the European Association of Nuclear Medicine (EANM). *Eur Heart J* **2015**; 36:3075–
363 3128.
- 364 6. Shi C, Xiao Y, Zhang Q, et al. Efficacy and safety of cefazolin versus antistaphylococcal penicillins
365 for the treatment of methicillin-susceptible *Staphylococcus aureus* bacteremia: a systematic
366 review and meta-analysis. *BMC Infect Dis* **2018**; 18:508.
- 367 7. Youngster I, Shenoy ES, Hooper DC, Nelson SB. Comparative evaluation of the tolerability of
368 cefazolin and nafcillin for treatment of methicillin-susceptible *Staphylococcus aureus* infections
369 in the outpatient setting. *Clin Infect Dis Off Publ Infect Dis Soc Am* **2014**; 59:369–375.
- 370 8. Li J, Echevarria KL, Hughes DW, Cadena JA, Bowling JE, Lewis JS. Comparison of cefazolin versus
371 oxacillin for treatment of complicated bacteremia caused by methicillin-susceptible
372 *Staphylococcus aureus*. *Antimicrob Agents Chemother* **2014**; 58:5117–5124.
- 373 9. Burdet C, Loubet P, Le Moing V, et al. Efficacy of cloxacillin versus cefazolin for methicillin-
374 susceptible *Staphylococcus aureus* bacteraemia (CloCeBa): study protocol for a randomised,
375 controlled, non-inferiority trial. *BMJ Open* **2018**; 8:e023151.
- 376 10. Shimada K, Matsuda T, Inamatsu T, Urayama K. Bleeding secondary to vitamin K deficiency in
377 patients receiving parenteral cephem antibiotics. *J Antimicrob Chemother* **1984**; 14 Suppl
378 B:325–330.
- 379 11. Barnes T, Yan S, Kaakeh Y. Necrotizing Esophagitis and Bleeding Associated With Cefazolin. *Ann*
380 *Pharmacother* **2014**; 48:1214–1218.
- 381 12. Gay E, Barthel A, Rouzic N, et al. [Cefazolin and coagulation disorders: a case report]. *Ann Biol*
382 *Clin (Paris)* **2018**; 76:104–106.
- 383 13. Angles E, Mouton C, Perino J, Remy A, Ouattara A. Hypoprothrombinemia and severe
384 perioperative haemorrhagic complications in cardiac surgery patients treated with high-dose
385 cefazolin for infective endocarditis. *Anaesth Crit Care Pain Med* **2018**; 37:167–170.

- 386 14. Résumé des caractéristiques du produit - CEFAZOLINE VIATRIS 1 g, poudre pour solution
387 injectable (IM-IV) - Base de données publique des médicaments. Available at: [https://base-](https://base-donnees-publique.medicaments.gouv.fr/affichageDoc.php?specid=61242331&typedoc=R)
388 [donnees-publique.medicaments.gouv.fr/affichageDoc.php?specid=61242331&typedoc=R](https://base-donnees-publique.medicaments.gouv.fr/affichageDoc.php?specid=61242331&typedoc=R).
389 Accessed 28 November 2022.
- 390 15. Shearer MJ, Bechtold H, Andrassy K, et al. Mechanism of cephalosporin-induced
391 hypoprothrombinemia: relation to cephalosporin side chain, vitamin K metabolism, and vitamin
392 K status. *J Clin Pharmacol* **1988**; 28:88–95.
- 393 16. Wood TC, Johnson KL, Naylor S, Weinshilboum RM. Cefazolin administration and 2-methyl-
394 1,3,4-thiadiazole-5-thiol in human tissue: possible relationship to hypoprothrombinemia. *Drug*
395 *Metab Dispos Biol Fate Chem* **2002**; 30:1123–1128.
- 396 17. Strazzulla A, Chakvetadze C, Picque M, et al. Evolution of haemostatic parameters and risk of
397 bleeding during treatment with cefazolin. *Eur J Clin Microbiol Infect Dis Off Publ Eur Soc Clin*
398 *Microbiol* **2019**; 38:177–183.
- 399 18. Singer M, Deutschman CS, Seymour CW, et al. The Third International Consensus Definitions for
400 Sepsis and Septic Shock (Sepsis-3). *JAMA* **2016**; 315:801–810.
- 401 19. Daniel, Wayne. *Biostatistics: A foundation for analysis in the health sciences*. John Wiley &
402 Sons, Inc., 1999.
- 403 20. Guilhaumou R, Benaboud S, Bennis Y, et al. Optimization of the treatment with beta-lactam
404 antibiotics in critically ill patients-guidelines from the French Society of Pharmacology and
405 Therapeutics (Société Française de Pharmacologie et Thérapeutique-SFPT) and the French
406 Society of Anaesthesia and Intensive Care Medicine (Société Française d’Anesthésie et
407 Réanimation-SFAR). *Crit Care Lond Engl* **2019**; 23:104.
- 408 21. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture
409 (REDCap)--a metadata-driven methodology and workflow process for providing translational
410 research informatics support. *J Biomed Inform* **2009**; 42:377–381.
- 411 22. Schulman S, Kearon C, Subcommittee on Control of Anticoagulation of the Scientific and
412 Standardization Committee of the International Society on Thrombosis and Haemostasis.
413 Definition of major bleeding in clinical investigations of antihemostatic medicinal products in
414 non-surgical patients. *J Thromb Haemost JTH* **2005**; 3:692–694.
- 415 23. Kaatz S, Ahmad D, Spyropoulos AC, Schulman S, Subcommittee on Control of Anticoagulation.
416 Definition of clinically relevant non-major bleeding in studies of anticoagulants in atrial
417 fibrillation and venous thromboembolic disease in non-surgical patients: communication from
418 the SSC of the ISTH. *J Thromb Haemost JTH* **2015**; 13:2119–2126.
- 419 24. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement:
420 guidelines for reporting observational studies - PubMed. Available at:
421 <https://pubmed.ncbi.nlm.nih.gov/18064739/>. Accessed 23 November 2022.
- 422 25. Rao SN, Rhodes NJ, Lee BJ, et al. Treatment outcomes with cefazolin versus oxacillin for deep-
423 seated methicillin-susceptible *Staphylococcus aureus* bloodstream infections. *Antimicrob*
424 *Agents Chemother* **2015**; 59:5232–5238.

- 425 26. Twilla JD, Algrim A, Adams EH, Samarin M, Cummings C, Finch CK. Comparison of Nafcillin and
426 Cefazolin for the Treatment of Methicillin-Susceptible Staphylococcus aureus Bacteremia. *Am J*
427 *Med Sci* **2020**; 360:35–41.
- 428 27. Chien T-L, Hsiao F-Y, Chen L-J, Wen Y-W, Lin S-W. Development and Validation of a Risk Scoring
429 System for Cephamycin-Associated Hemorrhagic Events. *Sci Rep* **2019**; 9:12905.
- 430 28. Wang W, Liu Y, Yu C, et al. Cefoperazone-sulbactam and risk of coagulation disorders or
431 bleeding: a retrospective cohort study. *Expert Opin Drug Saf* **2020**; 19:339–347.
- 432 29. Raine J, Spooner A. Minutes from the meeting on 30 August - 02 September 2016. 2016;
- 433 30. Abbas S, Ihle P, Harder S, Schubert I. Risk of bleeding and antibiotic use in patients receiving
434 continuous phenprocoumon therapy. A case-control study nested in a large insurance- and
435 population-based German cohort. *Thromb Haemost* **2014**; 111:912–922.
- 436 31. Siguret V, Pautas E, Gouin-Thibault I. Warfarin therapy: influence of pharmacogenetic and
437 environmental factors on the anticoagulant response to warfarin. *Vitam Horm* **2008**; 78:247–
438 264.
- 439

Table 1. Patient characteristics upon inclusion and comparison by univariate analysis of the patients with "major or clinically relevant non-major bleeding (CRNMB)" and those without bleeding or minor bleeding based the ISTH classification in a cohort of 120 cefazolin-treated patients.

Patients characteristics^a	Total population n = 120	Major or CRNMB n = 12	No or minor bleeding n = 108	P-value
Demography				
Age	59.4 (20.7)	66.4 (18.1)	58.6 (20.9)	0.18
Male	84 (70.0)	11 (91.7)	73 (67.6)	0.11
BMI	24.5 (4.9)	26.1 (5.5)	24.3 (4.8)	0.31
Hospitalization ward				
Surgery	58 (48.3)	0 (0.0)	58 (53.7)	< 0.001
Medicine	43 (35.8)	5 (41.7)	38 (35.2)	
Intensive care unit	19 (15.8)	7 (58.3)	12 (11.1)	
Comorbidities				
Diabetes	23 (19.2)	1 (8.3)	22 (20.4)	0.46
Solid tumor	13 (10.9)	1 (8.3)	12 (11.2)	1.0
Liver disease	4 (3.3)	0 (0.0)	4 (3.7)	1.0
Daily medication				
Heparin	37 (30.8)	3 (25.0)	34 (31.5)	0.75
Platelet antiaggregation	31 (25.8)	4 (33.3)	27 (25.0)	0.51
Vitamin K antagonists	12 (10.0)	4 (33.3)	8 (7.4)	0.019
Direct oral anticoagulants	11 (9.2)	1 (9.1)	10 (9.3)	1
Anticoagulation type (n = 37)				1.0
Prophylactic	25 (67.6)	2 (66.7)	23 (67.6)	
Curative	12 (32.4)	1 (33.3)	11 (32.3)	
Antidepressant	13 (10.8)	0 (0.0)	13 (12)	0.36
Immunosuppressant	7 (5.8)	0 (0.0)	7 (6.48)	1.0
Enteral feeding	4 (3.4)	0 (0.0)	4 (3.7)	1.0
Parenteral feeding	1 (0.8)	0 (0.0)	1 (0.9)	1.0
Cefazolin-treated infection				
qSOFA (n = 119)				0.006
0-1	110 (92.4)	8 (66.7)	102 (95.3)	
2-3	9 (7.6)	4 (33.3)	5 (4.7)	
Location of infection				
Bone and joint infection	50 (41.7)	3 (25)	47 (43.5)	0.36
Catheter-related infection	18 (15)	0 (0.0)	18 (16.7)	0.21
Endocarditis	11 (9.2)	4 (33.3)	7 (6.5)	0.013
Pneumonia	6 (5)	0 (0.0)	6 (5.6)	1.0
Urinary infection	4 (3.3)	1 (8.3)	3 (2.8)	0.35
Cutaneous infection	4 (3.3)	1 (8.3)	3 (2.8)	0.35
Intra-abdominal infection	1 (0.8)	1 (0.9)	0 (0.0)	1.0
Other ^b	31 (25.8)	4 (33.3)	27 (25)	0.51
Bloodstream infection	63 (52.5)	11 (91.7)	52 (48.1)	0.005
Blood culture positivity (days)	2.9 (2.6)	4.2 (4.8)	2.7 (1.8)	0.33

Blood culture positivity (pair)	3.5 (3.9)	5.1 (7.9)	3.2 (2.4)	0.45
Biology				
Hemoglobin (n=118)	10.5 (1.9)	9.6 (1.5)	10.6 (1.9)	0.058
Platelet (n=118)	309 (157)	261 (217)	315 (150)	0.42
Prothrombin time (n=113)	72.2 (18.7)	58.5 (22.8)	79.4 (16.9)	0.009
aPTT (n=51)	1.0 (0.1)	1.1 (0.2)	1.0 (0.1)	0.21
INR (n=113)	1.3 (0.5)	1.9 (1.4)	1.2 (0.3)	0.11
Factor II (n=41)	101.4 (34.6)	54.0 (21.7)	108.0 (30.7)	0.002
Factor V (n=43)	112.6 (37.1)	82.4 (46.1)	116.6 (34.5)	0.18
Factors VII + X (n=41)	86.8 (29.8)	45.0 (29.3)	92.0 (25.2)	0.019
D-dimer (n=30)	1452 (1535)	1650 (NA)	1445 (1562)	---
Fibrinogen (n=65)	5.7 (1.6)	5.0 (2.0)	5.8 (1.5)	0.35
AST (n=75)	61.0 (224.8)	467.2 (706.5)	29.5 (17.2)	0.25
ALT (n=78)	49.9 (155.4)	262.1 (490.1)	28.9 (32.0)	0.26
Gamma-GT (n=72)	98.8 (160.2)	111.6 (82.5)	98.6 (166.7)	0.73
Alkaline phosphatase (n=77)	141.5 (157.5)	170.7 (157.3)	139.1 (158.4)	0.65
Total bilirubin (n=74)	15.2 (18.1)	37.9 (37.8)	12.8 (18.1)	0.13
eGFR (n=113)	92.6 (51.0)	62.3 (46.7)	96.2 (50.5)	0.033

NOTE. ^aContinuous variables are presented as the mean ± standard deviation and categorical variables are presented as numbers and frequencies, unless otherwise indicated.

Abbreviations: ALT, alanine aminotransferase; aPTT, activated partial thromboplastin clotting time; AST, aspartate aminotransferase; BMI, body mass index (kg/m²); CRNMB, clinically relevant non major bleeding; eGFR: estimated Glomerular Filtration Rate; Gamma-GT, Gamma-glutamyl transferase; INR, index normalized ratio; qSOFA, quick Sepsis-related Organ Failure Assessment. Units: Age, years; hemoglobin, g/dL; platelet, G/L; prothrombin time, Factors II, V, VII+X, %; APTT, seconds; D-dimer, ng/mL; fibrinogen, g/L; AST, ALT, Gamma-GT, alkaline phosphatase, UI/L; total bilirubin, μmol/L; eGFR, mL/min/1.73²

^bOther: bloodstream infection (n=10), heart-device infection (left ventricular assist device or pacemaker, n=7), endovascular infection (n=6), mediastinal infection (n=4), parotitis (n=2), pleural infection (n=1), post-hepatectomy (n=1)

The univariate analysis was performed using the Fischer or Chi-2 tests for categorical variables and the t-test Student for continuous variables or the Wilcoxon-Mann-Whitney test when a non-parametric test was required.

Table 2. Last-known medication and biological results prior hemorrhage of the total population and comparison by univariate analysis of the patients with "major or clinically relevant non-major bleeding (CRNMB)" with patients without bleeding or minor bleeding using the ISTH classification in a cohort of 120 cefazolin-treated patients.

Patients characteristics ^a	Total population n = 120	Major or CRNMB n = 12	No or minor bleeding n = 108	P-value
Daily medication				
Platelet antiaggregation	29 (24.1)	4 (33.3)	25 (23.1)	0.48
Vitamin K antagonists	9 (7.5)	3 (25)	6 (5.6)	0.046
Direct oral anticoagulants	5 (4.2)	0 (0)	5 (4.6)	1
Heparin	82 (68.9)	8 (66.7)	74 (69.1)	1.0
Anticoagulation type (n=82)				0.43
Prophylactic dose	55 (67.1)	4 (50)	51 (68.9)	
Therapeutic dose	27 (32.9)	4 (50)	23 (31.1)	
Antidepressant	13 (10.8)	0 (0)	13 (12)	0.36
Immunosuppressant ^b	5 (4.2)	0 (0)	5 (4.6)	1.0
Enteral feeding	4 (3.3)	0 (0)	4 (3.7)	1.0
Parenteral feeding	1 (0.8)	0 (0)	1 (0.9)	1.0
Biology				
Cefazolin concentration (quantitative, n=72)	56.3 (32.5)	72.6 (33.8)	55.4 (32.4)	0.39
Cefazolin concentration (qualitative, n=72)				0.09
Supra-therapeutic ^c	10 (13.9)	2 (50)	8 (11.8)	
Normal range	62 (86.1)	2 (50)	60 (88.2)	
Cefazolin administration (n=116)				0.37
Continuous infusion	77 (66.4)	6 (50)	71 (68.3)	
Intermittent administration	14 (12.1)	2 (16.7)	12 (11.5)	
None	25 (21.5)	4 (33.3)	21 (20.2)	
Hemoglobin (n=117)	10.1 (1.8)	9.2 (1.8)	10.2 (1.8)	0.08
Platelet (n=117)	317 (152)	241 (214)	326 (142)	0.2
Prothrombin time (n=109)	80.3 (17.3)	67.8 (16.5)	81.8 (16.9)	0.015
aPTT (n=11)	1.1 (0.1)	1.2 (0.2)	1.1 (0.1)	0.21
INR (n=109)	1.2 (0.3)	1.4 (0.5)	1.2 (0.3)	0.15
Factor II (n=80)	102.6 (31.6)	66.2 (21.6)	105.5 (30.5)	0.005
Factor V (n=80)	125.0 (37.0)	102.0 (17.3)	126.9 (37.6)	0.014
Factors VII + X (n=80)	88.0 (25.3) 1836	66.5 (26.6)	89.7 (24.5)	0.087
D-dimer (n=74)	(1508)	2473 (1126)	1809 (1522)	0.42
Fibrinogen (n=89)	5.2 (1.5)	5.1 (1.7)	5.3 (1.5)	0.80
AST (n=98)	32.0	29.8 (16.5)	65.0 (30.9)	0.038
ALT (n=99)	23.4 (26.3) 111.4	58.8 (52.9)	21.1 (22.3)	0.14
Gamma-GT (n=97)	(162.5)	140.2 (71.0)	109.5 (166.8)	0.39

	149.8			
Alkaline phosphatase (n=98)	(151.2)	206.6 (161.2)	146.7 (151.0)	0.46
Total bilirubin (n=98)	12.4 (17.9)	27.7 (20.6)	11.4 (17.4)	0.11
	102.3			
Serum creatinine clearance (n=113)	(52.0)	74.9 (45.1)	105.6 (52.0)	0.045

NOTE. ^aContinuous variables are presented as the mean \pm standard deviation and categorical variables are presented as numbers and frequencies, unless otherwise indicated.

Biological data are the most recent one prior hemorrhage.

^bimmunosuppressants: corticosteroids (n=3) and chemotherapy (n=2) in the "no or minor bleeding" group

^ccefazolin concentration was considered supra-therapeutic if > 80mg/L, depending on the laboratory range

Abbreviations: ALT, alanine aminotransferase; aPTT, activated partial thromboplastin clotting time; AST, aspartate aminotransferase; CRNMB, clinically relevant non major bleeding; eGFR: estimated Glomerular Filtration Rate; Gamma-GT, Gamma-glutamyl transferase; INR, index normalized ratio.

Units: hemoglobin, g/dL; platelet, G/L; prothrombin time, Factors II, V, VII+X, %; APTT, seconds; D-dimer, ng/mL; fibrinogen, g/L; AST, ALT, Gamma-GT, alkaline phosphatase, U/L; total bilirubin, μ mol/L; eGFR, mL/min/1.73²

The univariate analysis was performed using the Fischer or Chi-2 tests for categorical variables and the t-test Student for continuous variables or the Wilcoxon-Mann-Whitney test when a non-parametric test was required.

Table 3. Delta of main biological tests between inclusion value and last available result (in the absence of bleeding) or before hemorrhage (in case of bleeding) in a cohort of 120 cefazolin-treated patients

	Total population n = 120	Major or CRNMB n = 12	No or minor bleeding n = 108	P-value
Delta between inclusion and prior hemorrhage values				
Hemoglobin (n=115)	- 0.41 (1.15)	- 0.49 (0.91)	-0.41 (1.18)	0.77
Platelet (n=115)	6.92 (71.98)	- 20 (91.51)	10.06 (69.23)	0.29
Prothrombin time (n=105)	2.92 (12.69)	9.33 (16.34)	2.1 (12)	0.16
aPTT (n=20)	-0.01 (0.05)	0 (0)	-0.01 (0.06)	0.61
INR (n=105)	-0.08 (0.48)	-0.48 (1.28)	-0.03 (0.21)	0.25
Factor II (n=36)	2.67 (11.18)	8.75 (10.75)	1.91 (11.16)	0.3
Factor V (n=834)	2.21 (21.66)	24 (29.13)	-0.35 (19.61)	0.19
Factors VII + X (n=36)	2.31 (13.04)	19.75 (24.36)	0.12 (9.51)	0.21
AST (n=71)	-30.86 (220.28)	-359.17 (731.11)	-0.55 (16.57)	0.28
ALT (n=75)	-25.96 (140.87)	-243.83 (476.28)	-7.01 (19.05)	0.28
Gamma-GT (n=74)	7.1 (42.28)	13.33 (20.88)	6.51 (43.83)	0.52
Alkaline phosphatase (n=69)	4.59 (34.02)	17.4 (31.07)	3.67 (34.25)	0.39
Total bilirubin (n=70)	-2.09 (10.64)	-15.33 (18.65)	-0.84 (8.83)	0.12
Serum creatinine clearance (n=111)	9.21 (23.1)	12.58 (25.03)	8.8 (22.96)	0.63

Abbreviations: ALT, alanine aminotransferase; aPTT, activated partial thromboplastin clotting time; AST, aspartate aminotransferase; CRNMB, clinically relevant non major bleeding; Gamma-GT, Gamma-glutamyl transferase; INR, index normalized ratio.

Units: hemoglobin, g/dL; platelet, G/L; prothrombin time, Factors II, V, VII+X, %; APTT, seconds; AST, ALT, Gamma-GT, alkaline phosphatase, UI/L; total bilirubin, $\mu\text{mol/L}$.

The univariate analysis was performed using the t-test Student for continuous variables or the Wilcoxon-Mann-Whitney test when a non-parametric test was required.

Table 4. ISTH-based multivariate analysis of the patients with "major and clinically relevant non-major bleeding (CRNMB)" compared to patients with "no or minor bleeding" based on the minimization of Akaike's Information Criterion

Variable	OR (95%)	P-value
Vitamin K antagonists the day before bleeding	1.36 (1.06–1.76)	0.020
Endocarditis	1.30 (1.06-1.61)	0.015
Peripheral edema upon inclusion	0.71 (0.56–0.90)	0.006
Peripheral edema the day before hemorrhage	0.84 (0.74–0.96)	0.012
qSOFA 2-3 upon inclusion	1.22 (0.99–1.51)	0.068
Cause of cefazolin stop: end of treatment of infection	1.22 (0.99–1.50)	0.071
Cause of cefazolin stop: other	1.18 (0.95–1.46)	0.14
Cefazolin intermittent administration	1.00 (0.99–1.01)	0.23
No cefazolin administration upon inclusion	1.06 (0.88–1.27)	0.56
Last available prothrombin time before hemorrhage	0.96 (0.68–1.35)	0.80

NOTE. Abbreviations: ISTH, International Society on Thrombosis and Hemostasis; qSOFA, quick Sepsis-related Organ Failure Assessment.

Population: 99; no bleeding : 87 ; major + CRNMB bleeding : 7

The multivariate analysis was performed based on the minimization of Akaike's Information Criterion. Using multivariate logistic regression tables, odd-ratios (ORs) were calculated.

Figure. Flow chart of patients included in the prospective evaluation of the frequency of and risk factors for bleeding complications in patients treated with cefazolin.

