Optimal Presentation Modes for Detecting Brain Tumor Progression

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*AJNR Am J Neuroradiol* 2011, 32 (9) 1652-1657
doi: https://doi.org/10.3174/ajnr.A2596
http://www.ajnr.org/content/32/9/1652
A common task in radiology interpretation is visual comparison of images from 2 or more time points to assess for changes in the status of a patient’s disease. This type of comparison task began when images were collected on film, and it continues in the era of PACS. However, computer technologies are available that allow for other modes of image display, but image comparison continues to be performed by using side-by-side display mode. Image registration is a technique where 3D images (including 2D multisection images) are aligned with each other, correcting for differences in section angulations and position. Computers also can use information from multiple image types as well as time points in ways that objectively characterize unique properties, such as types of change. Although the value of image registration has been described, image comparison continues to be performed by using side-by-side display mode alone, or with subtraction versus side-by-side mode. One alternative is “flicker” display mode, in which a pair of images is alternately displayed at the same location on the screen. Perceptual scientists have demonstrated that flicker display allows for detection of very subtle changes, and indeed, it is used for detection of changes due to irreversible image compression. Other methods for detecting subtle changes include image subtraction and change detection. Most radiologists are familiar with subtraction from methods such as digital subtraction angiography. Change detection involves computation that uses more than 1 image also allowing flicker display mode; FLAIR = fluid-attenuated inversion recovery; FN = false-negative; FP = false-positive; GBM = glioblastoma multiforme; GTR = gross total resection; LCS = lower confidence interval; LGG = low-grade glioma; N = normal side-by-side display only; NLF = normal side-by-side display with flicker; NF = normal side-by-side display with flicker; RECIST = response evaluation criteria in solid tumors; S = subtraction images with side-by-side display; SF = subtraction images with flicker display mode; STR = subtotal resection; TN = true-negative; TP = true-positive; TTP = time to progression; UCL = upper confidence interval.

**Optimal Presentation Modes for Detecting Brain Tumor Progression**

**BACKGROUND AND PURPOSE:** A common task in radiology interpretation is visual comparison of images. The purpose of this study was to compare traditional side-by-side and in-place (flicker) image presentation modes with advanced methods for detecting primary brain tumors on MR imaging.

**MATERIALS AND METHODS:** We identified 66 patients with gliomas and 3 consecutive brain MR imaging examinations (a “triplet”). A display application that presented images in side-by-side mode with or without flicker display as well as display of image subtraction or automated change detection information (also with and without flicker display) was used by 3 board-certified neuroradiologists. They identified regions of brain tumor progression by using this display application. Each case was reviewed using all modes (side-by-side presentation with and without flicker, subtraction with and without flicker, and change detection with and without flicker), with results compared via a panel rating.

**RESULTS:** Automated change detection with or without flicker \( P < .0027 \) as well as subtraction with or without flicker \( P < .0027 \) were more sensitive to tumor progression than side-by-side presentation in cases where all 3 raters agreed. Change detection afforded the highest interrater agreement, followed by subtraction. Clinically determined time to progression was longer for cases rated as nonprogressing by using subtraction images and change-detection images both with and without flicker display mode compared with side-by-side presentation.

**CONCLUSIONS:** Automated change detection and image subtraction, with and without flicker display mode, are superior to side-by-side image comparison.
Materials and Methods

Examination Selection

After institutional review board review and approval, we found 66 subjects with MR imaging brain examinations and surgically confirmed brain gliomas that met the following criteria: 1) they must have had 3 MR imaging examinations performed at our institution, by using our standard brain tumor protocol, over a course of no more than 8 months (8 months was used to effectively exclude patients who had intervening scans at other institutions, or other unusual tumors or circumstances); 2) the original radiologist interpretation of the second examination must have indicated either no change or slight/possible progression (specific terms were selected and must have been in the text of the report); and 3) the 3 examinations had to be free from significant artifact (eg, patient motion). The MR imaging examination included pre- and post-contrast T1-weighted images (TR, 400–600 ms; TE, <20 ms), T2-weighted FLAIR images (TR, 11 000 ms; TE, 144 ms), and T2-weighted images (TR, 2000–2200 ms; TE, 80–100 ms), all with FOV 22–26 cm and 1 NEX. The sequences were acquired in the oblique-axial plane aligned with the anterior/posterior commissure line with 4-mm section thickness, 0-mm intersection spacing, and approximately 1-mm in-plane resolution. Please note that we refer to these images as “3D,” because they have a regular X, Y, and Z spacing, though they were all 2D spin-echo acquisitions.

Image Processing

We selected the Pre, Post, FLAIR, and T2 sequences from each of the 3 examinations in the triplet. All sequences were registered to match the postgadolinium sequence of the second examination. We used a modified version of the normalized mutual information method from the Insight Toolkit (http://www.itk.org). After registration, each series from examination 1 was subtracted from the corresponding registered images in examination 2. Examination 3 was only used for the panel for cases where the comparison between examination 1 and examination 2 (first pair of examinations) was equivocal. Hence, this was not done for most cases.

We also applied an automated change detection algorithm to the first pair of examinations. This algorithm uses information from both examinations, as well as knowledge about biology and MR imaging artifacts to produce change maps (Fig 1).

Examination Presentation

A display application allowed raters to see all 4 pulse sequences from the first 2 examinations; they were not allowed to see the third examination. Because the examinations were registered, the application always “linked” the images, ie, changing the section changed all sequences for both examinations (Fig 2).

In addition to the 4 acquired series from the 2 examinations, there were 2 additional computed image sets: subtraction and change detection images. During a reading session, some examinations were viewed with subtraction images, change detection images, or only the original images; and among these 3 methods, these may or may not have had flicker display. So, each session presented 10 unique examinations in 6 presentation methods. If neither subtraction nor change detection images were available, we referred to that as normal or N display mode; S meant subtraction images could be viewed; and C meant change detection images could be viewed. For each of these modes, the rater might also “flicker” (F) between images, creating a total of 6 presentation modes (N, NF, S, SF, C, and CF). When subtraction or change detection images were available, the flicker could also alternate between the subtraction or change detection image and the original image, to allow the reader to see the actual image data that resulted in the subtraction or change detection image appearance. The display application allowed the user to mark areas of tumor progression, along with their certainty level on a 1–3 scale as well as record the amount of time spent reviewing the case.

Data Collection

Three board-certified neuroradiologists reviewed each of the 66 cases in all of the display modes. Over the course of the 6 rating sessions, all 66 examinations were presented with all possible display modes. The rating sessions were conducted over a period of 4 months.

The radiologists were requested to mark each noncontiguous area of tumor progression, along with a certainty rating (1 = possible, 2 = probable, 3 = certain). Because this study focused on progression of the examination, if there was 1 area marked with a certainty of 1 and another marked as 3, the examination was rated as 3.

Establishment of Criterion Standard

There were 2 criterion standards for this study. The first criterion standard was a binary decision as to whether there was progression present on the second examination. This standard was used for sensitivity and specificity calculations. Each of the 66 cases was reviewed by all 3 neuroradiologists in a panel format, where the panel was asked to determine whether progression was present, and if so, the location(s) of progression. Sixty-three of the 66 cases had unanimous panel ratings of progressive or nonprogressive disease on the basis of the images. For the 3 cases lacking unanimity, the clinical history was reviewed, and a final determination was made via a panel review of examination 1 and examination 2 (first pair of examinations) in conjunction with examination 3.

The second criterion standard was the TTP, which was used for
determining which method could best predict the time to progression, by using RECIST criteria. Independently and blinded to other findings, one author (B.J.E.) also reviewed the subsequent clinical history and imaging by using RECIST5 to assign the progression date. The TTP was defined as the time from the second examination date to the time of this progression date.

**Statistical Methods**

This study uses a “case certainty” rating by taking the maximum value of all lesion ratings for a given examination. The case rating was then converted to a binary “progression” (maximum rating of 2 or 3) versus “no progression” rating (maximum rating of 0 or 1) for purposes of computing the descriptive statistics (see On-line Table 2; first criterion standard). Sensitivity and specificity for each of the 6 presentation modes were calculated separately for each of the 3 reviewers as well as for when all 3 reviewers agreed. Comparisons of sensitivities and specificities among the presentation modes were done in a pairwise manner by using the McNemar test. The area under the receiver operator characteristic curve was calculated for each reader for each method, along with 95% confidence intervals.

Agreement among the reviewers within each presentation mode was assessed by using \( \kappa \) statistic. All of the statistical tests were 2-sided, and \( P \) values < .05 were considered statistically significant. No adjustment was made for multiple comparisons.

Survival curves for time to progression based on all 3 rater agreement also were produced. All analyses were performed by using SAS software, version 9.1 (SAS Institute, Cary, North Carolina).

**Results**

**Subject Demographics**

The demographics and brain tumor types are shown in Online Table 1. These data reflect the demographics of the patients at the time that the first examination was performed.

**Display Method Comparison**

We found that automated change detection with or without flicker as well as subtraction with or without flicker was significantly better than traditional side-by-side mode if we required all 3 raters to agree, as well as for most readers for sensitivity (On-line Tables 2 and 3). There was not a significant difference between change detection with or without flicker and subtraction with or without flicker. There was no difference in specificity between any of the methods.

In those cases where all 3 readers agreed, sensitivity and specificity were higher for all methods. This subgroup also showed significantly better sensitivity for change detection with or without flicker and subtraction without flicker over side-by-side mode.

The receiver operator characteristic curves show a trend for
For cases rated as progressing in this study, there was no statistically significant difference in the TTP, though there was a trend for the side-by-side display method to perform worse.

Discussion

We found an improvement in rater performance when using advanced tools for display. Automated change detection and subtraction significantly increased the ability to detect subtle progression of primary brain tumors, relative to the traditional side-by-side-image comparison method. They also had value in determining that a given case was truly negative: if a case was considered nonprogressive after using these tools, there was a greater TTP than if these tools were not used. Although change detection and subtraction showed similar performance, it is important to note that they are fundamentally different, in that subtraction highlights changes, but the observer must always determine whether this change is “real.” Change detection includes a step where that decision threshold is set and probably accounts for the trend for greater agreement between observers.

We had expected that the automated change detector might have an efficiency advantage (more rapid time to rate a case) because it integrates information from several images into a single image to determine possible areas of progression, but this was not demonstrated here. It may be that the change detector was overly sensitive and labeled areas as progression that, after careful study, were not progression. This may be worth a separate investigation.

It was expected that flicker would show a significant advantage in determining tumor progression, particularly because flicker mode was the method preferred by the panel to decide difficult cases. We did not see an advantage for flicker, perhaps because this display method was new to 2 of the 3 raters, and they may not have used the technique optimally. NF should have taken longer than N, because when using flicker as a first-line strategy (rather than a confirmatory strategy) on images with changing acquisition parameters, the rater should have stared at various regions of the flicker image for every section, for several seconds per region. That an increased time was not observed suggests that the raters did not benefit from flicker because they failed to use it optimally. We do note that
Once registration is complete, other processing and display options are available, the most obvious being image subtraction. Image subtraction has been used in some cases where the images were acquired in the same spatial setting (eg, subtraction angiography), though algorithms have been proposed for images acquired in the same spatial setting (eg, subtraction). Image subtraction has been used in some cases where the options are available, the most obvious being image subtraction. Rigid registration works well for certain anatomies where the body parts remain fairly fixed, such as the abdomen, but rigid registration does not work well for other body parts such as the brain. Rigid registration works well for certain anatomies where the body parts remain fairly fixed, including the brain and skull. Schellingerhout et al demonstrated the clinical utility of image registration applied to head CT, for both agreement of radiologic interpretation and a reduction in time to report an examination. For other body parts such as the abdomen, rigid registration does not work well, and either subregions must be selected or warping must be applied.

Once registration is complete, other processing and display options are available, the most obvious being image subtraction. Image subtraction has been used in some cases where the images were acquired in the same spatial setting (eg, subtraction angiography), though algorithms have been proposed for adjusting for different patient positions in projection radiographs. Postacquisition computed registration opens up many new possible applications. The value of subtraction has been demonstrated in several MR applications, including multiple sclerosis and brain tumors. In the Tan et al study, they used a custom application that always showed old and new examinations in a combined registered and subtracted image; but the value of each display mode was not evaluated.

The report by Alpert et al describes the use of image registration and subtraction of CT scans without and with contrast material for improving diagnosis of vascular lesions. They also made the argument that the technology was mature and should be routinely applied in clinical practice. However, their report was focused on the accuracy of registration with few clinical examples and did not document the clinical value in terms of sensitivity, specificity, or efficiency. Takao et al describe the application of a nonrigid registration method to chest CT and describe good visual results. They also presented subtraction images as a good way to allow improved perception of changes over time. Unfortunately, they did not take the next step of formally testing it versus other display methods with multiple radiologists. Other applications described inlcude detection of posttraumatic changes, as well as changes due to inhalation of 100% oxygen. We note, however, that this report did not document any comparison to other display modes, nor evaluate its possible clinical value.

We did not study the value of detecting small changes in brain tumors. The difference in this study suggests that there may at least be prognostic value and that may be important in deciding how aggressively to manage patients, especially with continuing advancements in therapy. The value for low-grade tumors may be greater, though we did not separately study low- versus high-grade tumors. It is not uncommon practice to observe tumors until they dedifferentiate or “go bad.” Having the ability to detect subtle changes may allow us to detect the change earlier and possibly allow intervention before the tumor grows so large that it cannot be completely resected or aggressively treated.

These display modes also may be of value in clinical trials and may lead to new treatment algorithms. The cost of conducting a clinical trial is directly proportional to the duration of a study and the number of subjects. These are both directly affected by the tumor measurement method. A technique that could reliably detect small progressions might allow clinical trials to be conducted on smaller cohorts (because of less variability) with a shorter duration (because of higher sensitivity). There are some important limitations to this study. We recognize that 1 of the standards used here was based on the opinion of the panel and not on biopsy proof. Biopsy proof is hard to obtain in change analysis method studies, because getting tissue to measure the state at the baseline time point will disturb the follow-up images. It is possible that all 3 radiologists will incorrectly assign an examination pair to 1 category. In that case, the method that most agrees with the 3 raters will look good but will be equally wrong. We also note that we did not power this study to account for multiple comparison adjustments.

We did compare the results with TTP, which is broadly used in clinical trials, but it is partially based on imaging measures and therefore is somewhat circular. Because RECIST is based on large imaging changes (ie, >20% increase in the maximum dimension of the tumor versus the baseline examination), it is rather insensitive, and because it is based on 1 unidimensional measure, it also has a large amount of noise due to variations in positioning of the measurement line. In our case, we did show that having a negative examination (“no progression” based on this study’s definition) by using the registered change detection or subtraction images with or without flicker display did predict stability for a longer period than without these tools. There was not a difference for cases where there was progression. We suspect that this may be due to the fact that detecting small changes early when presently there is no effective treatment may not have an impact.
on outcome. In addition, this information about early progression was not available to the treating physician, so there was no opportunity to alter treatment. We should also note that the ability to detect early progression might allow for new treatment algorithms or yet to be developed therapies that could result in some improved outcome, though this is speculation.

The display application was not incorporated into our clinical PACS. Translating this research application into a clinical software application will be challenging unless vendors provide support for these tools and display modes. We believe this represents an opportunity for vendors to develop innovative solutions that could potentially improve patient care and might give them a competitive advantage.

Another limitation is that these results cannot be generally applied to all body parts. The brain is a relatively fixed structure and is amenable to rigid registration. Other studies of rigid registration have demonstrated little advantage or even disadvantages for structures that move, such as those in the abdomen. Therefore, the applicability of this study is limited to the rigid structures such as the head or spine, until a suitable registration method has been found.

Conclusions

This study has demonstrated that image registration with subtraction or automated change detection improves sensitivity, specificity, interrater agreement, and efficiency for assessment of changes in brain tumors on MR imaging. We did not see an advantage for flicker display by itself versus traditional side-by-side display mode, though there was a trend. We believe that the resulting improvement in rater accuracy and speed warrants broader adoption of image registration with subtraction or change detection in clinical practice. Flicker display may also be valuable and is simple to implement once registration has been performed.

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