**Final Report – IDS 705 – Kyle Bradbury**

**Spring 2022**

**Team 10**

***Prepared by: Fides Schwartz, Jaya Khan, Satvik Kishore, Tego Chang***

**1115/2500 words**

**Abstract**

*Purpose*

The purpose of our project is to use computer vision algorithms to detect a specific type of brain tumor – glioblastoma multiforme – on clinical 3D MRI data.

*Materials and Methods*

We used a dataset collected and labelled by the Radiological Society of North America (RSNA) Brain Tumor Segmentation (BraTS) Challenge 2021, which included 570 cases in the training and 219 cases. Each case represents a patient with a known glioblastoma multiforme and contains four MRI sequences that each provide different information about the anatomical situation in the brain and the tumor. A fifth dataset for each patient contains the ground truth segmentation from the RSNA.

*Results*

We were able to implement a deep learning algorithm that was successful in segmenting the enhancing tumoral rim and the affected brain tissue (edema zone) but not the necrosis zone. For this we used a …

*Conclusion*

Our computer vision project was a full/partial success in segmenting glioblastoma multiforme from clinical MRI scans.

**Introduction**

The RSNA-ASNR-MICCAI Brain Tumor Segmentation (BraTS) 2021 Challenge makes publicly available the largest and most diverse retrospective cohort of glioma patients. Ample manually annotated multi-institutional routine clinically acquired mpMRI scans of glioma are used as the training, validation, and testing data for this year’s BraTS challenge.

Specifically, the datasets used in this year's challenge have been updated, since BraTS'20, with many more routine clinically acquired mpMRI scans from institutions that have not previously contributed to BraTS, increasing the demographic diversity of the represented patient population. Ground truth annotations of the tumor sub-regions are created and approved by expert neuroradiologists for every subject included in the training, validation, and testing datasets to quantitatively evaluate the predicted tumor segmentations of Task 1.

**Background**

Glioblastoma multiforme (GBM) is a WHO grade IV brain tumor which represents one of the most lethal human cancers, with a 5-year survival rate of only 7.2% (1). The incidence of GBM increases with age and shows the highest incidence in the 75–84-year-old age group in the United States (2). The incidence is higher in men than women, as well as in Caucasians than in other ethnicities (3). The first line therapy is usually surgery, followed by radio-chemotherapy. MRI-guided surgery has been established as the method of choice for years, relies on the ability of the surgeon to distinguish the tumor tissue from healthy brain tissue, and is crucial for patient outcomes (4, 5). We would like to segment glioblastoma multiforme based on MRI images, which could be helpful for surgical planning, e. g. when trying to determine how close the tumor is to important areas of the motor cortex. We believe this is worth pursuing, because there is a gap between imaging specialists (radiologists), who are used to seeing 2D images in sequence and transforming them into a 3D image in their head while “reading” a scan and surgeons (neurosurgeons), who are used to seeing and touching the actual tumor tissue but not to translating 2D image data into the 3D tumor they are confronted with in the operating room (6, 7). The planning and surgical approach might benefit from better tumor segmentation, based on the pre-operative MRI scans. In addition, radiotherapy volumes could be planned in a more comprehensive manner and disease progression monitoring could be improved.

**Data**

*Imaging Data Description*

There are 570 cases in the training and 219 cases in the validation set provided by the BraST 2021 Challenge.

All BraTS mpMRI scans were available as NIfTI files (.nii.gz) and describe a) native (T1 – shows brain anatomy very similar to what an autopsy would look like), b) post-contrast T1-weighted (T1Gd – gadolinium-based contrast is taken up by metabolically active tissue; this sequence is compared directly with the native T1 sequence to find active tumor tissue), c) T2-weighted (T2 – shows fluid in tissues better than T1), and d) T2 Fluid Attenuated Inversion Recovery (T2-FLAIR – shows fluid even better than T2 sequences; used primarily to find the edema zone at the edge of the tumor) volumes. They were acquired with different clinical protocols and various scanners from multiple data contributing institutions.

All the imaging datasets have been annotated manually, by one to four raters, following the same annotation protocol, and their annotations were approved by experienced neuro-radiologists. Annotations comprise the gadolinium-enhancing tumor (ET — **label 4** – active tumor tissue that takes up blood and thus gadolinium based contrast), the peritumoral edematous/invaded tissue (ED — **label 2** – brain tissue surrounding the tumor that is affected by it), and the necrotic tumor core (NCR — **label 1** – dead tumor cells). The ground truth data were created after their pre-processing, i.e., co-registered to the same anatomical template, interpolated to the same resolution (1 mm3) and skull-stripped.

**Methods**

Since we did not have

We used Deep Learning Methods specialized in the class of problems known as Semantic image Segmentation. In semantic segmentation, our goal is to classify each pixel in the input image. We will segment each pixel in the MRI scan to be either gadolinium-enhancing tumor (ET — label 4), the peritumoral edematous/invaded tissue (ED — label 2), the necrotic tumor core (NCR — label 1), and any not belong to the previous three, which is unaffected brain tissue. The architecture of the neural network will be that of a U-Net.

This resembles an encoder-decoder network where the first half of the network is a series of convolutional layers that decrease the size of the image after each layer while increasing the number of channels, culminating into a single dense layer composed of many channels and 1 pixel. The second half of the network converts this dense layer back to an image of the dimension as that of the input image, but with the number of channels equal to the number of possible output classes. Thus, the final output will represent the probabilities of each pixel belonging to each of the classes. Since we cannot expect the encoder-decoder mechanism to accurately form borders at the pixel-level, we add skip layer connections connecting across the “U” to guide the formation of pixel-level outputs.

We plan to train these models on Google-Colab to take advantage of the free GPUs. We may need to explore other computational resource offerings if the free-tier of Google Colab does not fit our needs. We will be taking advantage of the well-established deep learning framework Tensorflow. We will also be looking into transfer learning to leverage the power of existing models trained on larger datasets.

**Results**

We were able to implement a neural network based on … that performed … at segmenting the enhancing tumor tissue, … at segmenting the tumoral necrosis zone and … at segmenting the edema zone.

**Conclusions**

Our computer vision project was a full/partial success in segmenting glioblastoma multiforme from clinical MRI scans.

**Roles**

Tego Chang: programming neural network for segmentation of brain tumors

Jaya Kahn: programming neural network for segmentation of brain tumors

Satvik Kishore: programming neural network for segmentation of brain tumors

Fides Schwartz: accessing the dataset, providing domain knowledge about MRI imaging of glioblastoma multiforme, spot-checking segmentation experiments, writing of final report

**References**

(1) Wu, W., et al. (2021). "Glioblastoma multiforme (GBM): An overview of current therapies and mechanisms of resistance." Pharmacological Research 171: 105780.

(2) A. Oszvald, E. Güresir, M. Setzer, H. Vatter, C. Senft, V. Seifert, K. Franz. Glioblastoma therapy in the elderly and the importance of the extent of resection regardless of age, J. Neurosurg. 116 (2) (2012) 357– 364.

(3) M.E. Davis, Glioblastoma: overview of disease and treatment, Clin. J. Oncol. Nurs. 20 (5 Suppl) (2016) S2– S8.

(4) M. Lacroix, D. Abi-Said, D.R. Fourney, Z.L. Gokaslan, W. Shi, F. DeMonte, F. F. Lang, I.E. McCutcheon, S.J. Hassenbusch, E. Holland, K. Hess, C. Michael, D. Miller, R. Sawaya, A multivariate analysis of 416 patients with glioblastoma multiforme: prognosis, extent of resection, and survival, J. Neurosurg. 95 (2) (2001) 190–198.

(5) D.G. Barone, T.A. Lawrie, M.G. Hart, Image guided surgery for the resection of brain tumours, Cochrane Database Syst. Rev. 1 (2014).

(6) Krupinski EA. Current perspectives in medical image perception. Atten Percept Psychophys. 2010;72(5):1205-1217. doi:10.3758/APP.72.5.1205

(7) Mascagni, P, Longo, F, Barberio, M, et al. New intraoperative imaging technologies: Innovating the surgeon’s eye toward surgical precision. J Surg Oncol. 2018; 118: 265- 282. <https://doi.org/10.1002/jso.25148>

(8) https://www.jeremyjordan.me/semantic-segmentation/

(9) https://nanonets.com/blog/semantic-image-segmentation-2020/