Introduction

Ultrasound (US) has evolved to be one of the major medical imaging systems, being responsible for one of five medical images used for medical diagnosis, and is used in nearly all hospitals and clinics [Jensen]. The use of medical US has mayor advantages over other imaging modalities (magnetic resonance and computer tomography) such as: minimal invasion, low cost, ease to use, the ability to obtain images in real time from different perspectives, and no ionizing radiation [Halliwell]. Although these advantages, the use of conventional 2D US may have some drawbacks; the 2D US images represent thin planes of the patients, choosing the visualization plane of the lesion is difficult since the user must mentally integrate many 2D images to form an impression of the 3D anatomy and pathology; finding the same location of the visualization plane is difficult since the US probe is controlled manually. This problems may be corrected by using 3D US [Fenster].

Three-dimensional ultrasonic imaging is becoming a widespread practice in clinical environments due to the potential applications based on 3-D representation. It provides some interesting benefits: the spatial relationships among 2D planes are preserved, allowing an offline examination of scans previously recorded, renderization and visualization of planes that cannot be acquired because of geometrical constrains imposed by the US probe and the patient anatomy [Estepar]. High quality and instantaneous 3D imaging remains a long term goal of medical US research [Rohlling]. Several 3D US techniques have been reported in the past few years, but these can be coarsely classified as derived from 3D probes and those that obtain a 3D data from 2D B-scans acquired in rapid succession [Estepar]. Using 3D probes, where 3D volume is imaged directly from a single probe position can simplify the reconstruction of the 3D data set since the geometry of the acquired data is known making real-time 3D reconstruction possible; but this approach does not allow for fine control of the location of the 2D planes, the reconstructed volume geometry and size is constrained by the probe, and the probes are expensive compared with 2D US probes [Honggang]. Three-dimensional ultrasound probes are bulkier than conventional 2D probes, because of this, researchers have developed approaches to convert a conventional 2D US transducer into one that is capable of 3D imaging [Fenster 2]. In freehand acquisition, the operator holds the probe and manipulates it in the usual manner over the anatomy to be view and images in arbitrary positions and orientations are acquired. This technique offers special advantages because the operator can select optimal views and accommodate complex patient surfaces and is not limited to the transducer geometry and size [Fenster 3]. However the reconstruction step is still an acute problem with regards to computation time and reconstruction quality because of the sparsity of data [Pierrick].

Mainly there are two different approaches for volume reconstruction. The first kind of methods, reverse approach or Voxel Based Methods (VBM), take the positions of the voxels within the volume and find the appropriate pixels within the US images. The second approach, are methods based on solving the forward approach, as tacking the position of each pixel within the B-mode images and finding the appropriate voxel positions within the volume, this methods are called Pixel Based Methods (PBM) [Schiepers]. The last are often more accurate by assigning the pixel values to the nearest voxel and allow several pixels to contribute to the values of each voxel, which is an improvement over the VBM algorithms and with a fast enough implementation, a PBM could be constructed as an iterative method, building the volume along with images being collected and be made into a real-time reconstruction; also [Solberg].