

# Classifying DME vs Normal SD-OCT volumes: A review

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**Abstract**—This article reviews the current state of automatically classify Spectral Domain OCT (SD-OCT) data to identify Diabetic Macular Edema (DME) versus normal subjects. Addressing this classification problem has valuable interest since early detection and treatment of DME play a major role to prevent eye adverse effects such as blindness.

Despite previous works addressing this problem, this article points out the lack of publicly available data and benchmarking suited for this particular task of identify DME vs. normal SD-OCT volumes. The main contribution of this article is to cover these deficiencies by providing a common benchmark, dataset, and a collection of our own implementation of the most relevant methodologies found in the literature.

**Index Terms**—

## I. INTRODUCTION

Eye diseases such as Diabetic Retinopathy (DR) and Diabetic Macular Edema (DME) are the most common causes of irreversible vision loss in individuals with diabetes. Just in United States alone, health care and associated costs related to eye diseases are estimated at almost \$500 M [1]. Moreover, the prevalent cases of DR are expected to grow exponentially affecting over 300 M people worldwide by 2025 [2]. Given this scenario, early detection and treatment of DR and DME play a major role to prevent adverse effects such as blindness. DME is characterized as an increase in retinal thickness within 1 disk diameter of the fovea center with or without hard exudates and sometimes associated with cysts [3]. For many years, fundus images have been the modality of choice to reveal most of eye pathologies [4, 5]. However, Optical Coherence Tomography (OCT) has recently shown to provide useful additional information about cross-sectional retinal morphology [6] (see Fig. [1]), reflected by the growing interest in developing methodologies for this modality. In this sense, great efforts have been placed in retinal layers segmentation, which is a necessary step for retinal thickness measurements [7, 8].

However, few studies have addressed the specific problem of DME automatic detection in OCT, revealing large ground to be covered in terms of: (i) manipulating OCT volumes, (ii) finding radiomix pathology signs, or (iii) appropriated classification strategies.

Advances in any of those regards is of great interest since (i) manual evaluation of Spectral Domain OCT (SD-OCT) volumetric scans is expensive and time consuming [9]. (ii) SD-OCT acquisition has some deficiencies due to eye movement during the scan [10], the reflectivity nature of the retina [11], the fact that OCT suffers from high levels of noise and the overall image quality is inconsistent [12]. (iii) Coexistence of multiple pathologies [10], easy to miss pathology signs [9], or large variability within the pathology treats which difficult to obtain proper radiomix to facilitate the task of classification.

The rest of this article is structured as follows: Section II offers a general idea of the literature state-of-the-art in SD-OCT volume classification. Section III reviews some publicly available datasets and states the need for another one that suits the classification task here described. Section IV proposes an experimental benchmark to compare different methodologies presented in Sect. II. Section V reports and discusses the obtained results, while Sect. VI wraps up our thoughts regarding this work and its possible direction.

## II. BACKGROUND

This section reviews works straightly addressing the problem of classifying OCT volumes as normal or abnormal, regardless of the targeted pathology. The methods are categorized in terms of their learning strategy, namely supervised or semi-supervised learning.

### A. Supervised methods

Supervised learning is based on a fully annotated and labeled training set. In this approach, the labeled training data are used to train the classifier function later used for prediction. Figure 1 illustrates a prevalent framework for supervised learning. Each SD-OCT volume undergoes: (i) *pre-processing* to reduce noise and other acquisition deficiencies which alter the images; (ii) *feature detection* to quantify visual cues like appearance, texture, shape, etc.; (iii) *mapping* in which a sample is either considered as whole (i.e., global) or partitioned into a set of sub-elements (i.e., local dense/sparse

patches, pyramid, etc.); (iv) *feature representation* to associate a descriptor (e.g., concatenation, statistics, histogram, Principal Component Analysis (PCA), Bag-of-Words (BoW), etc.) for each element from the *mapping-stage*. This descriptor packages the visual cues related to the sample; (v) *classification* to determine the associated class of each sample.

Venhuizen *et al.* propose a classification method to distinguish between Age-related Macular Degeneration (AMD) and normal SD-OCT volumes using BoW models [9]. A set of keypoints are detected and selected at each individual B-scan, by keeping the salient points included in the top 3% of the vertical gradient values. Around each of these keypoints, a  $9 \text{ px} \times 9 \text{ px}$  texton is extracted, generating a feature vector of 81 dimensions, later reduce to 9 using PCA. All extracted feature vectors are used to create a codebook using *k*-means clustering. Then, each OCT volume descriptor is represented as a histogram that captures the codebook occurrences and are classified by a Random Forest (RF) composed of 100 trees. The method is tested using a publicly available dataset of 384 OCT volumes [13], achieving an Area Under the Curve (AUC) of 0.984.

Srinivasan *et al.* propose a classification method to distinguish DME, AMD, and normal SD-OCT volumes [14]. Each OCT slice is pre-processed using Block Matching 3D filtering (BM3D) to reduce the speckle noise and is flattened to reduce the inter-patient retinal curvature variations. A multi-resolution pyramid is generated for each pre-processed slice and a Histogram of Oriented Gradients (HOG) feature is computed for each layer. These features are classified using a linear Support Vector Machines (SVM). Note that each individual B-scan is classified into one of the three categories, namely DME, AMD, and normal, and a volume is label to a given class by taking the majority vote of all B-scans. This method is also tested using a publicly available dataset, composed of 45 patients equally subdivided into the three targeted classes. Correct classification rates of 100%, 100% and 86.67% are obtained for normal, DME, and AMD patients, respectively.

Extending the previous work, Alsaih *et al.* aggregate Local Binary Patterns (LBP) to HOG in order to add texture information and reduce the number of dimension using PCA [15].

Lemaître *et al.* propose a method based on LBP features to describe the texture of OCT images and dictionary learning using the BoW models [16]. In this method, the OCT images are first pre-processed using Non-Local Means (NLM) filtering, to reduce the speckle noise. Then, the volumes are mapped into a discrete set of structures: (i) local corresponding to patches, or (ii) global corresponding to volume slices or the whole volume. According to the chosen mapping, LBP or LBP from Three Orthogonal Planes (LBP-TOP) texture features are extracted and represent each volume through histogram, PCA, or BoW representation. The final feature descriptors are classified using RF classifier. This methodology is tested against Venhuizen *et al.* [9] using public and non-public datasets showing an improvement within the results by achieving a Sensitivity (SE) of 87.5% and a Specificity (SP)

of 75%.

Liu *et al.* propose a methodology aiming at classifying B-scan rather than volume. The classification goal is to distinguish between macular pathology and normal OCT B-scan images using LBP and gradient information as attributes [10]. Each OCT slice are flattened before to create a 3-level multi-scale spatial pyramid. From each layer of this pyramid, edges are extracted and LBP descriptors are computed for the flattened slice and the edge map. All the obtained histograms are concatenated into a global descriptor whose dimensions are reduced using PCA. Finally, a SVM with an Radial Basis Function (RBF) kernel is used as classifier. A detection rate with an AUC of 0.93 is achieved, using a dataset of 326 OCT scans with various pathologies.

Albarak *et al.* propose another classification framework to differentiate AMD and normal volumes [17]. Each OCT slice undergoes two pre-processing routines: (i) a joint denoising and cropping step using the split Bregman isotropic total variation algorithm and (ii) a flattening step by fitting a second-order polynomial using a least-square approach. Then, LBP-TOP and HOG combined with LBP-TOP features are extracted from individual sub-volumes from each original cropped volume. These features are concatenated into a single feature vector per OCT volume and its dimension is reduced using PCA. Finally, a Bayesian network classifier is used to classify the volumes. The classification performance of the framework in terms of SE and SP achieve 92.4% and 90.5%, respectively, outperforming the method of Liu *et al.* [10], using a dataset composed of 140 OCT volumes.

Anantrasirichai *et al.* propose to detect glaucoma in OCT images based on a variety of texture descriptor [18]. The texture information is described through LBP, Gray-level co-occurrence matrix (GLCM), wavelet, granulometry, run length measures, and intensity level distributions in combination with retinal layer thickness estimation, without any pre-processing. Each feature vector is projected using PCA before to be classified using an SVM with both linear and RBF kernel. Testing with rather a small dataset of 24 OCT volumes, their proposed method achieved an Accuracy (ACC) of 81.95% while using layer thickness information.

## B. Semi-supervised methods

Sankar *et al.* propose to use a semi-supervised strategy to classify DME vs. normal OCT volumes based on appearance modeling of normal OCT images using Gaussian Mixture Model (GMM) [19]. The main difference between this method and the supervised methodologies lies in the fact that only normal volumes are used to train the system.

For each OCT volume, the B-scans are denoised using NLM filtering, flattened, and resized to ensure homogeneous dimension across all volumes. Each B-scan is vectorized and projected into a lower-dimensional space with  $p$  dimensions using PCA. Subsequently, normal B-scans are modelled using a GMM in which the number of mixture components  $K$  is determined on a validation set. At the testing stage, a scan is classified as normal or DME depending of its Mahalanobis



Fig. 1. Common framework

distance to the learnt model; if the distance is greater than the 97.5% quantile of the Chi-squared distribution with  $p$  degree of freedom. Therefore, a volume is classified as abnormal if the number of abnormal slice is greater than a given threshold, previously determined during the validation procedure. A SE and SP of 93.8% and 80.0 are respectively achieved on a cohort of 32 patients.

### III. DATA

A common dataset is required to compare different methodologies. Despite the fact that lack of public data is a common claim in the medical image community [20], the ophthalmic community has recently made available public dataset, mainly gathered at Duke University [13, 14]. Although these datasets have been used by Venhuizen *et al.* [9] and Srinivasan *et al.* [14], they are not suitable for our problem.

Venhuizen *et al.* have evaluated their framework on a large public dataset of 384 OCT annotated volumes classified either as AMD or normal cases. Our goal, however, remains to focus on the detection of DME rather than AMD, despite the interest of testing the frameworks against a large dataset.

In the contrary, Srinivasan *et al.* have tested their framework using a public dataset containing AMD, DME, and normal volumes [14]. The data, however, have been denoised, aligned, and cropped, without access to the original set of images.

Therefore, we use the Singapore Eye Research Institute (SERI) dataset to conduct this study [21]. This dataset has been acquired by the SERI, using CIRRUS TM (Carl Zeiss Meditec, Inc., Dublin, CA) SD-OCT device. The dataset consists of 32 OCT volumes, subdivided into 16 DME and 16 normal cases. Each volume contains 128 B-scans with a resolution of  $512\text{px} \times 1,024\text{px}$ . All SD-OCT images have been read and assessed by trained graders and identified as normal or DME cases, based on evaluation of retinal thickening, hard exudates, intraretinal cystoid space formation and subretinal fluid (see Fig. 2).

### IV. EXPERIMENTAL SETUP

The experimental set-up is summarized in table II. Where the most relevant works in Sect. II are formulated as the as the 5-steps standard classification procedure described in Fig. 1.

#### A. Implementation details

For reproductivity purposes, the experimentation described in this work can be found in [22], where the image processing and Machine Learning (ML) rapid pipeline prototyping library *Protopclass* [23] has been used to implement the methodologies

TABLE II  
CORRESPONDENCE BETWEEN THE MOST RELEVANT METHODOLOGIES REVIEWED IN SECT. II AND THE PROPOSED EXPERIMENTAL FRAMEWORK.

Ref	Pre-processing	Features	Mapping	Representation	Classification
Venhuizen <i>et al.</i> [9, 24]		Texton	Local	PCA BoW	RF
Srinivasan <i>et al.</i> [14, 25]	BM3D Flattening Cropping	HOG	Global		Linear- SVM
Lemaitre <i>et al.</i> [16, 26]	NLM	LBP LBP-TOP	Local Global	PCA BoW Histogram	RF
Alsaih <i>et al.</i> [15]	BM3D Flattening Cropping	LBP HOG	Local	PCA Histogram	Linear- SVM
Liu <i>et al.</i> [10]	Flatten Aligned	Edge LBP	Local	PCA	RBF- SVM
Sankar <i>et al.</i> [19, 27]	NLM Flattening Cropping	Pixel intensities	Global	PCA	Mahalanobis -distance to GMM

in Tab. II in accordance to proposed experimentation framework. Each methodology implementation can be seen as a plug-in to experiment in [22], while references to stand-alone implementation of these methodologies can be found in Tab. II. All the repositories are publicly available and provided with tests to ensure that our implementation agrees with the results reported by the original works.

Notice that Liu *et al.* train the algorithm at the B-scan level, and SERI dataset provides Ground Truth (GT) at volume level only. Thus, we replicated here the training strategy reported by Srinivasan *et al.* which considers to be abnormal all the B-scans from any abnormal volume [14]. From the methods reviewed in Sect. II, we decline to implement Albarrak *et al.* and Anantrasirichai *et al.*. The former does not provide sufficient implementation details to replicate their results [17]. While, the latter, requires of a layer segmentation stage using a generic segmentation algorithm and further user validation [18].

#### B. Evaluation

All the experiments are evaluated in terms of SE and SP (see Eq. 1) using the Leave-One-Patient Out Cross-Validation (LOPO-CV) strategy, in line with [16]. The SE evaluates the performance of the classifier with respect to the positive class, while the SP evaluates its performance with respect to negative class.

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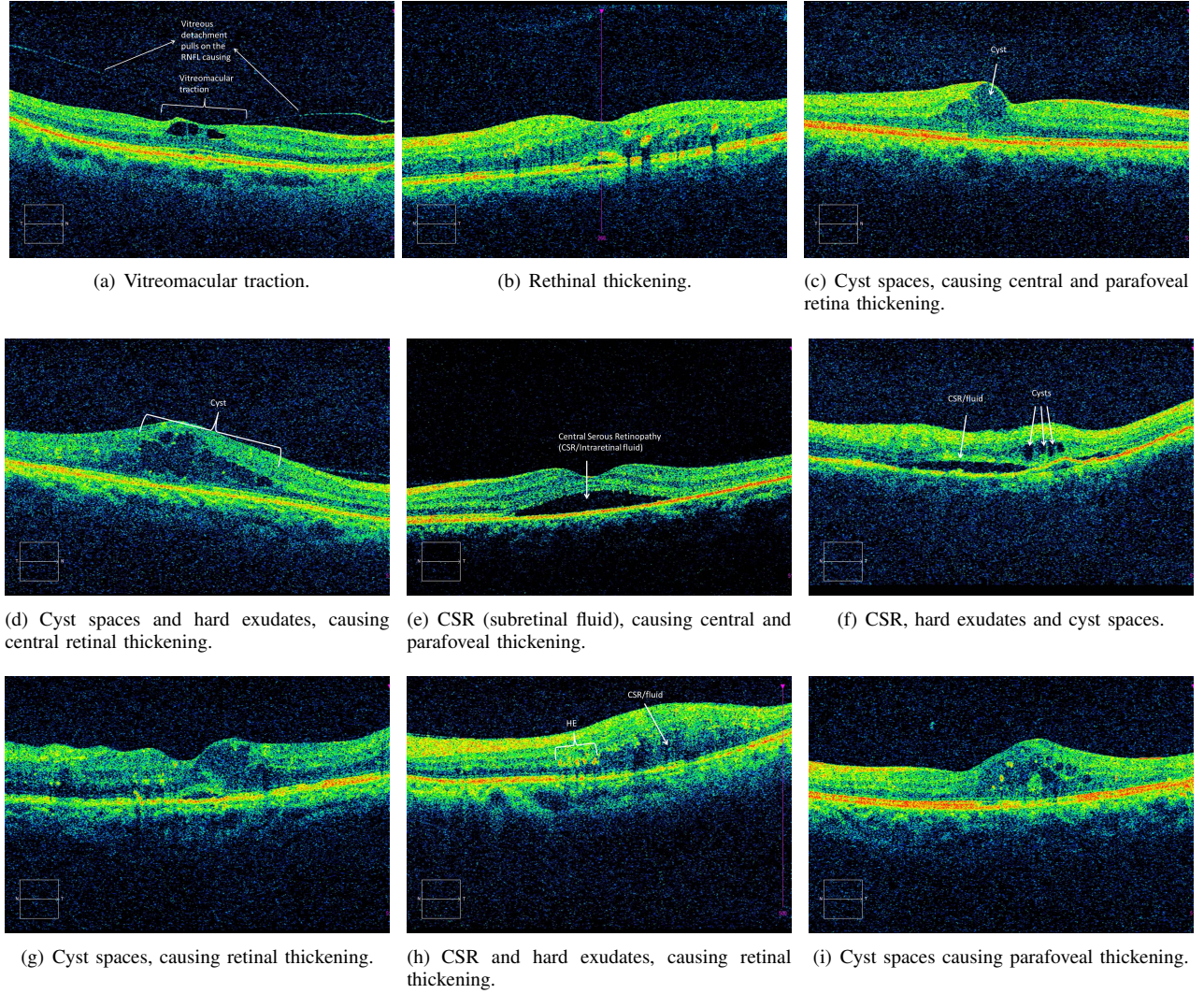


Fig. 2. Examples of DME cases in SERI dataset.

TABLE I  
SUMMARY OF THE CLASSIFICATION PERFORMANCE IN TERMS OF SE AND SP IN (%).

	Srinivasan <i>et al.</i> [14]	Venhuizen <i>et al.</i> [9]	Alsaih <i>et al.</i> [15]	Lemaitre <i>et al.</i> [16]	Liu <i>et al.</i> [10]	Sankar <i>et al.</i> [19]
SE	68.8	61.5	75.0	87.5	68.8	81.3
SP	93.8	58.8	87.5	75.0	93.8	62.5

## V. RESULTS AND DISCUSSION

Table I shows the results obtained in terms of SE and SP, where Sankar *et al.* achieve the best performance, revealing that DME lesions can be modeled accurately based only on a set of normal SD-OCT volumes.

## VI. CONCLUSION AND FURTHER WORK

The work here presented states the relevance of developing methodologies to automatically differentiate DME *vs.* *normal* SD-OCT scans. This article offers an overview of the state-of-the-art methodologies and provides a public benchmarking to

The use of LOPO-CV implies that at each round, a pair DME-normal volume is selected for testing while the remaining volumes are used for training. Subsequently, no SE or SP variance can be reported. However, LOPO-CV strategy has been adopted despite this limitation due to the reduced size of the dataset.

facilitate further studies. In this regard, there are two crucial aspects to improve the work here presented: (i) enlarge the dataset. (ii) reach out for the original authors of those methods in Sect. II that could not be included in Sect. IV because our implementation could not be tested against the original data or we did not achieve the original results.

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