

Radiomics: the bridge between medical imaging and personalized medicine

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Abstract | Radiomics, the high-throughput mining of quantitative image features from standard-of-care medical imaging that enables data to be extracted and applied within clinical-decision support systems to improve diagnostic, prognostic, and predictive accuracy, is gaining importance in cancer research. Radiomic analysis exploits sophisticated image analysis tools and the rapid development and validation of medical imaging data that uses image-based signatures for precision diagnosis and treatment, providing a powerful tool in modern medicine. Herein, we describe the process of radiomics, its pitfalls, challenges, opportunities, and its capacity to improve clinical decision making, emphasizing the utility for patients with cancer. Currently, the field of radiomics lacks standardized evaluation of both the scientific integrity and the clinical relevance of the numerous published radiomics investigations resulting from the rapid growth of this area. Rigorous evaluation criteria and reporting guidelines need to be established in order for radiomics to mature as a discipline. Herein, we provide guidance for investigations to meet this urgent need in the field of radiomics.

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Imaging is an important technology in medical science and is used in clinical practice to aid decision making¹. The role of medical imaging, however, is swiftly evolving from being primarily a diagnostic tool to also include a central role in the context of personalized precision medicine². In radiomics^{3,4}, digitally encrypted medical images that hold information related to tumour pathophysiology are transformed into mineable high-dimensional data¹. This information can be harnessed through quantitative image analyses⁵ and leveraged via clinical-decision support systems (CDSS)⁶ to improve medical decision-making. Radiomics builds upon several decades of computer-aided diagnosis, prognosis, and therapeutics research^{7,8}. The process used in radiomics involves the identification of vast arrays of quantitative features within digital images, storage of such data in federated databases (that is, a system in which several independent databases function as a single entity) and the subsequent mining of the data for knowledge extraction and application⁹. Innumerable quantitative features can now be extracted using high-throughput computing from medical images such as CT, MR, and/or PET. The creation of databases that link immense volumes

of radiomics data (ideally with all other pertinent data) from millions of patients to form vast, rapid learning healthcare (RLHC) networks is conceivable, but presents a considerable data management hurdle^{10–13}.

Radiomics is not a panacea for clinical decision-making. Radiomic features (such as intensity, shape, texture or wavelet) offer **information on cancer phenotype as well as the tumour microenvironment** that is distinct and complementary to other pertinent data sources (including clinically obtained, treatment-related or genomic data)¹⁴. Radiomics-derived data, when combined with other pertinent data and correlated and/or inferred with outcomes data, can produce accurate robust evidence-based CDSS.

The potential of radiomics to improve CDSS is beyond doubt¹⁵ and the field is evolving rapidly. The principal challenge is the optimal collection and integration of diverse multimodal data sources in a quantitative manner that delivers unambiguous clinical predictions that accurately and robustly enable outcome prediction as a function of the impending decisions¹⁶. Many published prediction models that account for factors related to both disease and treatment are available, but these models lack standardized

Key points

- Radiomics is becoming increasingly more important in medical imaging
- The explosion of medical imaging data creates an environment ideal for machine-learning and data-based science
- Radiomics-based decision-support systems for precision diagnosis and treatment can be a powerful tool in modern medicine
- Large-scale data sharing is necessary for the validation and full potential that radiomics represents
- Standardized data collection, evaluation criteria, and reporting guidelines are required for radiomics to mature as a discipline

evaluation of their performance, reproducibility, and/or clinical utility¹⁷. Consequently, these models might not be appropriate for CDSS.

In this Review, we describe the process of radiomics along with latest developments in the field. The pitfalls, challenges, and opportunities presented by radiomics to improve CDSS for personalized precision oncology are highlighted, with an emphasis on the methodological aspects of radiomics prediction model development and validation. We explore the advanced and innovative information technologies that are essential for the data management of diverse multimodal data sources. Finally, we offer a vision of the necessary steps to ensure continued progression and widespread acceptance of both radiomics and CDSS.

The workflow of radiomics

Radiomics is defined as the quantitative mapping, that is, extraction, analysis and modelling of many medical image features in relation to prediction targets, such as clinical end points and genomic features. A radiomics study can be structured in five phases: data selection, medical imaging, feature extraction, exploratory analysis, and modelling (FIG. 1). To assess the quality of radiomics studies, we propose the radiomics quality score (RQS).

Data selection

Radiomic analyses begins with the choice of an imaging protocol, the volume of interest (VOI) and a prediction target — the event one wishes to predict. Typically, the entire primary tumour is analysed and linked to available data on treatment outcomes, such as survival. Radiomic analyses can be performed on subregions of the tumour (habitats), metastatic lesions, as well as in normal tissues. Analysis of these regions might yield radiosensitive phenotypes, which has implications for treatment planning strategies. Radiomics analysis, however, is not restricted to radiotherapy and can be applied to any image generated in the clinical setting (FIG. 2).

The importance of using standardized imaging protocols to eliminate unnecessary confounding variability is recognized¹⁸; however, nonstandardized imaging protocols are commonplace. Therefore, reproducibility and

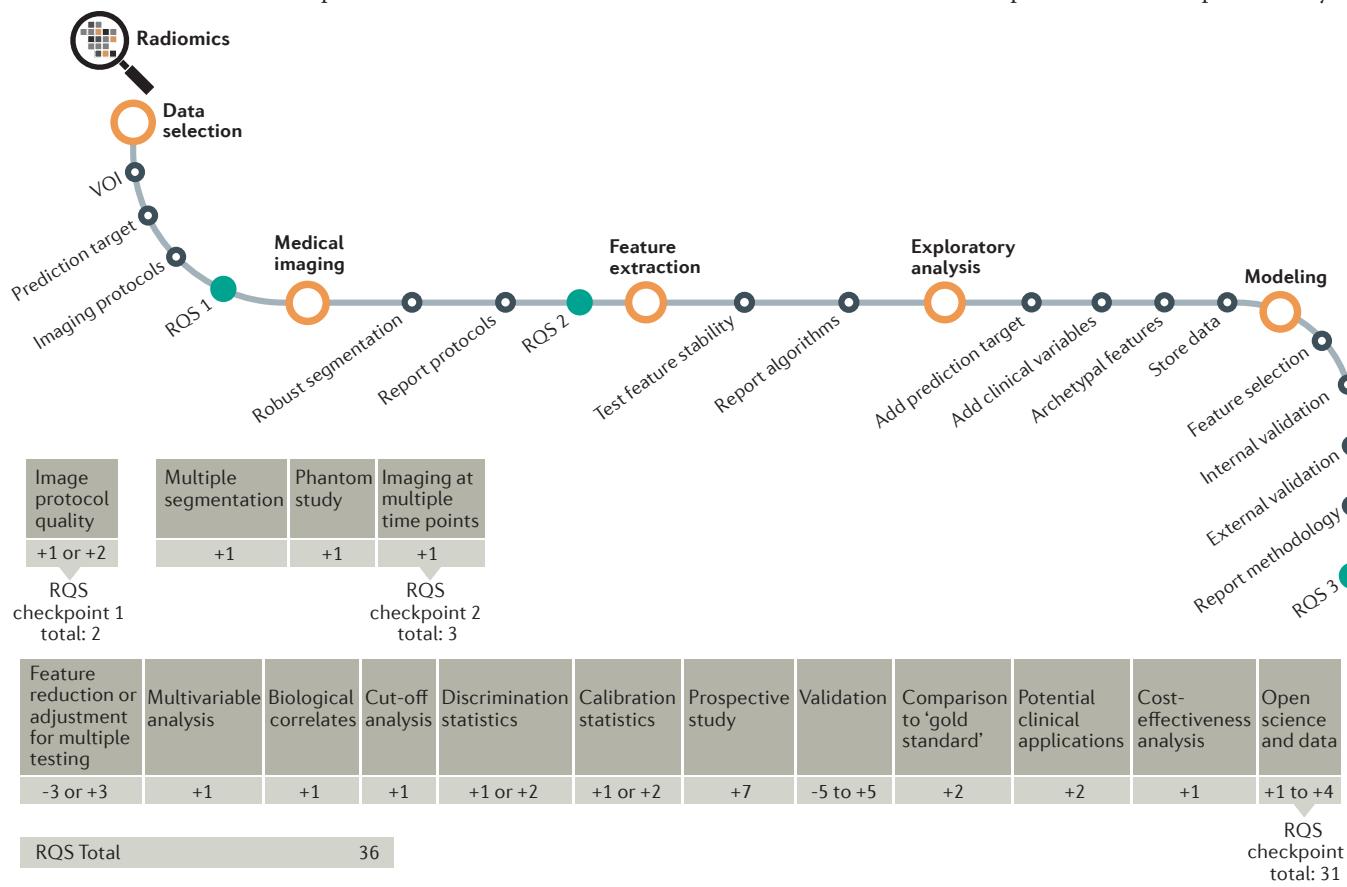


Figure 1 | Flowchart depicting the workflow of radiomics and the application of the RQS. The workflow includes the necessary steps in a radiomic analysis. The RQS both rewards and penalizes the methodology and analyses of a study, consequently encouraging the best scientific practice. RQS, radiomics quality score; VOI, volume of interest.

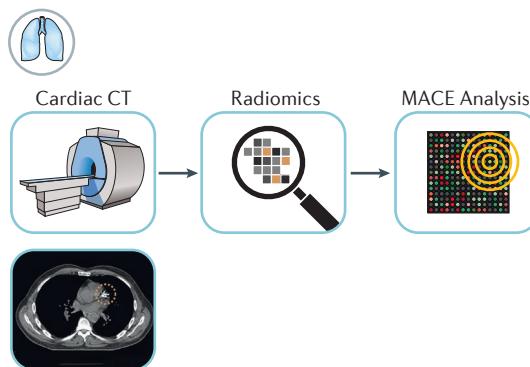


Figure 2 | Radiomics in cardiology. The current gold standard for quantification of coronary calcifications visible on CT is the 'Agatston' method (based upon intensity and volume). Radiomic features can improve quantification, differentiation between calcified and non-calcified plaques, and thus the prediction of Major Adverse Cardiac Events (MACE).

comparability of radiomic studies can be achieved only by extensive disclosure of imaging protocols. We wish to emphasize this point, and provide examples of how protocols should be reported in future radiomics studies (Supplementary information S1).

Medical imaging

Segmentation. VOIs are segmented manually or (semi-)automatically¹⁹. This segmentation determines which voxels within an image are analysed, thus, the variability in segmentation can introduce bias in the evaluation of derived radiomic features²⁰. **Multiple-segmentation** is a method to limit the extent of this bias. Examples that enable robust features to be observed²¹ include: evaluation by multiple clinicians, perturb segmentations with noise, combination of diverse algorithms, or use different stages of the breathing cycle. Key considerations are how the segmentation was performed, and how sensitive the radiomics analysis is to different segmentation methods²². For example, a semi-automatic segmentation method can result in different radiomic features than a manual delineation.

Phantom studies. The determination of inter-scanner and inter-vendor variability of features is important in radiomics²³. In cases in which radiomic studies rely on data from multiple scanners, neglecting this variability can jeopardize the analysis of studies — that is, the proposed radiomic-based prediction model might not perform adequately on external datasets if new data are acquired on different scanners. As data from patients scanned on multiple devices is scarce and subject to uncertainties (such as organ motion, or different imaging protocols), phantom studies are a suitable means to gauge these uncertainties and identify features that rely on the vendor. In essence, phantom studies provide a risk-mitigation strategy to help navigate from the current clinical imaging scenario to the desired optimal imaging scenario.

Imaging at multiple time points. Additional sources of variability in radiomics features are organ motion or expansion or shrinkage of the target volume. Radiomics

features that are strongly dependent on these factors can have limited applicability. To account for these sources of variability, available test-retest data^{24–26} can be exploited to measure radiomics feature stability. For example, two datasets of images acquired within a small period of time from a patient cohort.

Feature extraction

The essence of radiomics is the high-throughput extraction of quantitative image features to characterize VOIs. Feature values are dependent upon factors that can include image pre-processing (for example, filtering, or intensity discretization) and reconstruction (for example, filtered back projection, or iterative reconstruction). Furthermore, variation exists in feature nomenclature, mathematical definition, methodology, and software implementation of the applied feature extraction algorithms^{27–29}. In order to facilitate inter-operability of radiomic features, differences in nomenclature, algorithms, software implementations, as well as other methodological aspects must be elucidated.

Exploratory analysis

Radiomic and non-radiomic features should be combined with the prediction target to create a single dataset. This approach enables the investigation of relationships between features. Groups of highly correlated radiomics features can be identified via clustering, and these features can be reduced to single archetypal features per cluster. Radiomic features that are well-correlated with routine clinical features (such as tumour stage) do not provide additional information. Auxiliary feature data collected from multiple segmentations, multiple imaging, and phantom studies, can be exploited to assess feature robustness. Volatile or robust features can be identified and subsequently excluded from model development. For example, a feature that is robust for the prediction of overall survival for lung cancer (that is, imaged and segmented in a certain way) for a given dataset could be volatile for the prediction of pneumonitis in lung cancer (imaged and segmented in an alternative way) for a given dataset. Thus, the process of feature reduction and/or exclusion should be described clearly.

Modelling

Radiomic modelling involves three major aspects: feature selection, modelling methodology, and validation. Feature selection should be data-driven owing to the vast in-human range of possible radiomics features; such analysis should be performed in a robust and transparent manner. To achieve holistic models, features beyond radiomics (such as data from clinical records, data obtained during treatment or biological and/or genetic) should also be incorporated. Regarding the choice of modelling methodology, the identification of optimal machine-learning methods for radiomic applications is a crucial step towards stable and clinically relevant CDSS; thus, in the ideal scenario, multiple machine-learning methods should be employed³⁰ and the implementation should be comprehensively documented. A non-validated model is

Phantom studies

An artificial structure that imitates human tissue properties is scanned on multiple machines to characterize scan output against a known physical standard.

of limited value; validation is an indispensable component of a complete radiomic analysis. Models must be internally validated and, ideally, should be externally validated.

Feature selection. Depending on the number of filters, feature categories, and other adjustable parameters, the possible number of radiomic features that can be extracted from images is virtually unlimited. The inclusion of all possible features in a model would inevitably result in overfitting, which jeopardizes model performance in patients not previously evaluated. To avoid overfitting, features that lack robustness against sources of variability should be eliminated, and archetypal features selected via dimensionality reduction techniques (such as principal component analysis or clustering). For example, a feature that is archetypal for the prediction of overall survival in patients with lung cancer for a given dataset (imaged and segmented in a certain way) could be redundant for the prediction of pneumonitis in lung cancer for a given dataset (imaged and segmented in an alternative way).

Modelling methodology. The modelling methodology chosen is often a single technique, selected according to the preference and experience of those conducting the study. Different techniques are associated with distinct inherent limitations, which include the independence assumption for features in logistic regression, the need for feature discretization in Bayesian networks, or the network configuration dependency in deep learning. The choice of modelling technique has been shown to affect prediction performance in radiomics³⁰. Thus, multiple-modelling methodology implementations are desirable, but not essential. The key aspect in the selection of a modelling methodology is that, when reported, the work must be entirely reproducible. This goal can be achieved, ideally, by making the software code available (for example, via github³¹). (See Supplementary information S1 material for an overview of machine learning techniques).

Calibration-in-the-large
Describes whether the predictions deviate systematically (intercept), whereas the calibration slope should ideally be equal to 1.

The independence assumption
The definition in terms of conditional probabilities is that the probability of B is not changed by knowing that A has occurred. Statistically independent variables are always uncorrelated, but the converse is not necessarily true.

Feature discretization
The process of converting continuous features to discrete binned interval features.

Bootstrapping
Measures the accuracy (defined in terms of bias, variance, confidence intervals, prediction error, etc.) to characterize the sample distribution by way of repeated random sampling methods.

frequency of tumour recurrence in this group should ideally be 25 out of 100 patients. Calibration can be reported using a calibration plot and calibration-in-the-large/slope. A measure of overall performance is the Brier score, the mean squared prediction error. All statistical methods should be reported for training data and validation data. Valid models should exhibit statistical consistency between the training and validation sets. Bootstrapping techniques can be used to estimate confidence intervals for the abovementioned statistics and should be reported. An externally validated model has more credibility than an internally validated model, because data obtained with the former approach are considered more independent, which reinforces the validation. A large body of literature on validation techniques is available^{32–35}.

Reporting open-access scientific data

Validation is the first step towards a model being accepted in both the scientific and clinical communities. Independent verification of the results is a necessary additional step. Reproduction means verification of the results by independent researchers repeating the analysis using an identical technique and the same dataset and/or patient cohort, ensuring that the analysis is conducted without error. Replication means independent verification of the results by independent researchers repeating the analysis using the same technique and different (but appropriately selected) datasets and/or patient cohorts, aiming for a stronger affirmation of the findings^{36–39}. Radiomic studies involve multiple complex subprocesses (such as data selection, image acquisition, feature extraction, or modelling), each one affected by a wide range of decisions, use of nonstandardized terminology, establishment of parameters, and software selection. Reproducibility and replicability in radiomics are impossible if researchers do not disclose these intricacies. The amount of necessary information far exceeds the limits of a traditional manuscript. We propose that future publications including radiomic results should provide the following as supplementary material: disclosure of imaging protocols, analysed scans, segmentations of VOIs, detailed accounts of how features were extracted (including the formulae), and of the modelling methodology used (ideally, the code). This level of meticulous detail is required in order to facilitate reproduction and replication. Furthermore, multiple radiomics software packages are available and are subject to updates or version-control. We recognize that the publication of data derived from patients might not be feasible in all circumstances. As a minimal means of comparison, and to alleviate this lack of transparency, we propose that researchers publish numerical values of their investigated features computed on the digital phantom described in the supplementary material of this manuscript (available online⁴⁰).

To compare different software implementations for radiomic feature-extraction algorithms, we present an example, in which CT-obtained data of the primary tumour region and the corresponding tumour contours of four patients with lung cancer serve as ‘real-life’ digital phantoms (FIG. 3). Using the preprocessed image data, we calculated a set of commonly used features to serve as a

reference feature dataset (See [Supplementary information S1](#) for a detailed description of the digital phantom image data and calculated features).

The radiomics quality score

There is an urgent need for homogeneous evaluation criteria and reporting guidelines in order for radiomics to develop as a field. [We propose the radiomics quality score \(RQS\)⁴¹](#) to aid assessment of both past and future radiomic studies.

Editors, reviewers, and readers should be able to easily ascertain whether a radiomic study is compliant with best-practice procedures or, alternatively, whether the study investigators have sufficiently justified any non-compliance with guidelines. Publications should clearly state how the study has advanced the field of radiomics by specifically identifying an exigent unmet need. Overly optimistic claims concerning robustness and generalizability diminish scientific and clinical impact and should be avoided. Publications should extensively report study-design, protocols, detailed quality assurance processes, and standard operating procedures. Although the minute technical details of radiomics are tedious, they can greatly influence robustness, generalizability, and confound meta-analyses. Rigorous reporting guidelines are necessary for radiomics to mature^{42–44}. Many journals now encourage and facilitate extensive supplementary materials.

The criteria of the RQS

Overwhelming evidence shows that the quality of reporting of prediction model studies is currently poor³². Full and clear reporting of information is required on all aspects of a prediction model to minimize bias and enhance the usefulness of prediction models. An excellent example is the Transparent Reporting of a multi-variable prediction model for Individual Prognosis Or Diagnosis (TRIPOD) initiative³². Within this initiative, a set of recommendations was established for the reporting of studies developing, validating, or updating a prediction model, regardless of whether the model serves diagnostic or prognostic purposes. We have emulated this approach in a radiomics-specific context, and suggest that studies should be assessed via the RQS (available online⁴¹), for which we identified sixteen key components; each assigned a number of points corresponding to the importance of the respective component detailed in TABLE 1.

Translational potential of radiomics

Since the beginning of this decade, radiomics research has advanced dramatically, revealing the potential of this discipline to substantially improve clinical care (TABLE 2). Advances in hardware and software have enabled the realization of clinically feasible quantitative imaging of tissue pathophysiology.

Radiogenomics

Radiogenomics is associated with two closely related but distinct scientific questions: one is the study of the link between germline genotypic variations and the large

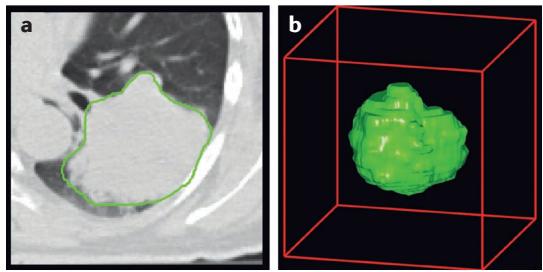


Figure 3 | Radiomics digital phantom data.

a | Representative image of a digital phantom CT image, with the tumour delineation shown outlined in green.
b | A 3D rendering of the tumour region. The reference feature data is provided (please see the [supplementary material](#)).

clinical variability observed in response to radiation therapy⁴⁵, and the other is the study of the link between specific imaging traits and specific gene-expression patterns that inform the underlying cellular pathophysiology⁴⁶. Within the radiobiology community, a common hypothesis is that a proportion of the variance in the phenotype of interest (for example, radiation toxicity) can be attributed to genotypic variation. In the clinical context, this hypothesis materializes in a risk of severe treatment-related toxicity for a minority of patients that limits the prescription of potentially curative doses to a majority of patients. We posit that the overall goal of radiogenomics is to isolate the alleles and corresponding radiomic features that underlie the inherited differences in phenotype. Gene-expression profiling of various human tissues has enriched our understanding of cellular pathways and numerous pathological conditions. Investigation of different cancerous tissues in relation to samples of nonmalignant healthy tissue has elucidated tumorigenic processes and assisted in enhanced staging and sub-classification of various malignancies. Gene-expression signatures, each comprised of dozens to hundreds of genes, can meaningfully improve diagnosis, prognosis, and prediction of response to treatment^{47–52}. Seminal radiogenomic investigations highlighted the link between radiomic features and gene-expression patterns in patients with cancer^{53–55}. One study leveraging survival data in publicly available gene-expression datasets for patients with non-small-cell lung cancer enabled the identification of prognostic imaging biomarkers⁵⁴. This radiogenomics strategy for identifying imaging biomarkers might enable a more-rapid evaluation of novel imaging modalities, thereby accelerating their incorporation into personalized medicine approaches. Another investigation compared clinician-defined features extracted from contrast-enhanced CT images in patients with hepatocellular carcinoma with gene-expression patterns using machine learning with a neural network⁵⁵. Reported combinations of 28 features could reconstruct 78% of the global gene-expression profiles associated with cell proliferation, liver synthetic function, and prognosis. In another study⁵³, features extracted from MR images to predict global gene-expression patterns in patients with glioblastoma multiforme revealed that an infiltrative phenotype was associated with significantly reduced survival.

Table 1 | The radiomics quality score: RQS

| Criteria | Points |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1 Image protocol quality - well-documented image protocols (for example, contrast, slice thickness, energy, etc.) and/or usage of public image protocols allow reproducibility/replicability | + 1 (if protocols are well-documented) + 1 (if public protocol is used) |
| 2 Multiple segmentations - possible actions are: segmentation by different physicians/algorithms/software, perturbing segmentations by (random) noise, segmentation at different breathing cycles. Analyse feature robustness to segmentation variabilities | + 1 |
| 3 Phantom study on all scanners - detect inter-scanner differences and vendor-dependent features. Analyse feature robustness to these sources of variability | + 1 |
| 4 Imaging at multiple time points - collect images of individuals at additional time points. Analyse feature robustness to temporal variabilities (for example, organ movement, organ expansion/shrinkage) | + 1 |
| 5 Feature reduction or adjustment for multiple testing - decreases the risk of overfitting. Overfitting is inevitable if the number of features exceeds the number of samples. Consider feature robustness when selecting features | - 3 (if neither measure is implemented) + 3 (if either measure is implemented) |
| 6 Multivariable analysis with non radiomics features (for example, EGFR mutation) - is expected to provide a more holistic model. Permits correlating/inferencing between radiomics and non radiomics features | + 1 |
| 7 Detect and discuss biological correlates - demonstration of phenotypic differences (possibly associated with underlying gene–protein expression patterns) deepens understanding of radiomics and biology | + 1 |
| 8 Cut-off analyses - determine risk groups by either the median, a previously published cut-off or report a continuous risk variable. Reduces the risk of reporting overly optimistic results | + 1 |
| 9 Discrimination statistics - report discrimination statistics (for example, C-statistic, ROC curve, AUC) and their statistical significance (for example, p-values, confidence intervals). One can also apply resampling method (for example, bootstrapping, cross-validation) | + 1 (if a discrimination statistic and its statistical significance are reported) + 1 (if a resampling method technique is also applied) |
| 10 Calibration statistics - report calibration statistics (for example, Calibration-in-the-large/slope, calibration plots) and their statistical significance (for example, P-values, confidence intervals). One can also apply resampling method (for example, bootstrapping, cross-validation) | + 1 (if a calibration statistic and its statistical significance are reported) + 1 (if a resampling method technique is also applied) |
| 11 Prospective study registered in a trial database - provides the highest level of evidence supporting the clinical validity and usefulness of the radiomics biomarker | + 7 (for prospective validation of a radiomics signature in an appropriate trial) |
| 12 Validation - the validation is performed without retraining and without adaptation of the cut-off value, provides crucial information with regard to credible clinical performance | - 5 (if validation is missing) + 2 (if validation is based on a dataset from the same institute) + 3 (if validation is based on a dataset from another institute) + 4 (if validation is based on two datasets from two distinct institutes) + 4 (if the study validates a previously published signature) + 5 (if validation is based on three or more datasets from distinct institutes) *Datasets should be of comparable size and should have at least 10 events per model feature |
| 13 Comparison to 'gold standard' - assess the extent to which the model agrees with/is superior to the current 'gold standard' method (for example, TNM-staging for survival prediction). This comparison shows the added value of radiomics | + 2 |
| 14 Potential clinical utility - report on the current and potential application of the model in a clinical setting (for example, decision curve analysis) | + 2 |
| 15 Cost-effectiveness analysis - report on the cost-effectiveness of the clinical application (for example, QALYs generated) | + 1 |
| 16 Open science and data - make code and data publicly available. Open science facilitates knowledge transfer and reproducibility of the study | + 1 (if scans are open source) + 1 (if region of interest segmentations are open source) + 1 (if code is open source) + 1 (if radiomics features are calculated on a set of representative ROIs and the calculated features and representative ROIs are open source) |
| Total points (36 = 100%) | |

Table 2 | Radiomics in practice

| Utility | Modality | Features | Cancer | #Pts | Result | Conclusion | Ref |
|--------------------|----------|-------------------------------------------------------|----------------------|-------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| Tumour prognosis | CT | Intensity, shape, texture, and wavelet | Lung and head & neck | 1,019 | Lung: (C-index = 0.65, $P = 2.9 \times 10^{-9}$, Wilcoxon test), and a high performance in H&N1 (C-index = 0.69, $P = 8.0 \times 10^{-7}$, Wilcoxon test) and H&N2 (C-index = 0.69, $P = 3.5 \times 10^{-6}$, Wilcoxon test). | Could predict survival in two entirely independent external cohorts of patients, outperforming the current gold standard of TNM status (radiation or concurrent chemoradiation) | 1 |
| Tumour prognosis | PET | Texture and shape | Oesophageal | 217 | A clinical prediction model (C-index = 0.67) was improved by adding radiomic features (C-index = 0.77); however, at a decision threshold of ≥ 0.9 there was no clear incremental value | Demonstrated that a radiomic PET signature provided statistical incremental value for predicting pathological complete response after preoperative chemoradiation | 118 |
| Tumour prognosis | CT | Intensity, texture, and Laplacian of Gaussian filters | Colorectal | 326 | Training: showed good discrimination (C-index = 0.74) and calibration. Validation: showed good discrimination (C-index = 0.78) and good calibration | Decision curve analysis demonstrated that a final nomogram consisting of the radiomic portal venous-phase CT signature, CT-reported lymph-node status, and carcinoembryonic antigen level was clinically useful | 119 |
| Distant metastasis | CT | Texture, Laplacian of Gaussian and wavelet filters | Lung | 182 | Could predict distant metastasis in an independent validation dataset (C-index = 0.61, $P = 1.79 \times 10^{-11}$). Adding this radiomic signature to a clinical model resulted in a significant improvement ($P = 1.56 \times 10^{-11}$) | Provided superior information than clinical data capturing detailed information of the tumour phenotype and can be used as a prognostic biomarker for distant metastasis | 120 |
| Distant metastasis | CT | Wavelet filters | Lung | 113 | Significantly prognostic for distant metastasis (C-index = 0.67, q-value < 0.1), while none of the conventional and clinical parameters were prognostic. Three conventional and four radiomic features were prognostic for overall survival | Demonstrates that radiomic features have potential to be prognostic for some outcomes that conventional imaging metrics cannot predict in patients receiving stereotactic body radiation therapy | 121 |
| Efficacy | CT | Intensity and texture | Oesophageal | 106 | Significant change in radiomics feature values was observed with increasing radiation dose (pre and post radiotherapy scans). AUC = 0.75 using multiple features in a classifier | Demonstrated the ability to individualize the measurement of patient lung tissue reaction to radiotherapy and assess radiation pneumonitis development | 122 |
| Staging | CT | Intensity, texture, Laplacian of Gaussian filters | Colorectal | 494 | Training: AUC = 0.79, $P < 0.0001$. Validation: AUC = 0.71, $P < 0.0001$. The radiomics signature was an independent predictor for staging | Demonstrated the ability to discriminate between stage I-II from III-IV, which may serve as a complementary tool for the preoperative tumour staging | 123 |
| Screening | CT | Intensity and texture | Lung | 196 | AUC = 0.83, $P < 0.05$. Radiomics performance was commensurate with the McWilliams risk-assessment model | Demonstrated that radiomics at baseline can be used to assess risk for the development of cancer | 124 |
| Survival | MR | Volumetric | Brain | 141 | C-Index = 0.60, $P = 4 \times 10^{-4}$. Volumetric features were significantly associated with diverse sets of biological processes, FDR < 0.05 | Demonstrated the ability to derive the biological state of a glioblastoma tumour that can be used to develop personalized treatment strategies | 125 |
| Survival | CT | Texture | Lung | 282 | C-Index = 0.72, improved accuracy of calibration and the classification of survival outcomes (net reclassification improvement: 0.182, $P = 0.02$). | Decision curve analysis demonstrated that in terms of clinical usefulness, the radiomics nomogram outperformed the traditional staging system and the clinical-pathologic nomogram | 126 |
| Tumour prognosis | CT | Intensity, shape, texture, and wavelet | Oropharyngeal | 542 | C-Index = 0.63, $P = 2.72 \times 10^{-9}$. Kaplan-Meier survival curves were significantly different ($P < 0.05$) between high and low radiomic signature model predictions for all cohorts | Demonstrated external validation of the signature, the signature had significant prognostic power irrespective of the presence or absence of CT artifacts | 127 |

Table 2 (cont.) | Radiomics in practice

| Utility | Modality | Features | Cancer | #Pts | Result | Conclusion | Ref |
|------------------|----------|-------------------------------|------------|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| Overall survival | PET | Shape, intensity, and texture | Pancreatic | 139 | C-Index = 0.66, significantly better than competing prognostic indices (0.48–0.64, Wilcoxon rank sum test $P = 1 \times 10^{-6}$) | Demonstrated external validation of the signature if validated in large, prospective cohorts, the signature might be used to identify patients for individualized risk-adaptive therapy | 128 |
| Recurrence | MR | Shape, intensity, and texture | Breast | 89 | AUC = 0.88, 0.76, and 0.68 for MammaPrint, Oncotype DX, and PAM50 risk of relapse based on subtype respectively, all statistically significant, $P = \leq 0.05$ | Demonstrates that breast MR imaging radiomics shows promise for image-based phenotyping in assessing the risk of breast cancer recurrence | 129 |

Nevertheless, gene-expression profiling relies on surgical procurement of sampled tissue specimens associated with multiple risks and potential complications, consequently rendering it unfeasible for many patients with cancer. In stark contrast to genetic profiling studies, radiomic features^{53,55–59} capture intratumoural heterogeneity in a non-invasive three-dimensional manner, and can be obtained as part of routine clinical care. For example, approximately 15% of triple-negative breast cancers diagnosed globally are associated with poor outcomes after treatment⁶⁰. Reliable techniques for the assessment of HER2 expression (typically fluorescence *in situ* hybridization (FISH)) are expensive and time-consuming. In a study that considered the tumour as well as its surrounding parenchyma, DCE-MRI radiomic image phenotyping provided useful information for the diagnosis of triple-negative breast tumours⁶¹. Currently, the radiogenomics landscape is evolving rapidly from an effort to screen a limited number of candidate genes towards an open-discovery approach into the powerful, but challenging, era of RLHC^{62–66}.

Radiogenomic features provide valuable biomarkers for CDSS^{67–70}; these include prognostic and predictive factors for outcomes⁷¹, such as tumour response to treatment as well as nonmalignant-tissue tolerance to the same treatment. Notwithstanding these virtues, trials of radiogenomics biomarkers are susceptible to experimental and imaging inconsistency; therefore, standardization of assay criteria, image acquisition, segmentation, trial design, and an analytical approach is vital if radiogenomics biomarkers are to be effective diagnostic, prognostic, and predictive tools in oncology⁷².

Radiosensitivity and the tumour habitat

Tumour control following radiotherapy is governed by the following criteria: the quantity of cancer stem cells present in the tumour (which is characteristically associated with pretreatment tumour volume), the innate radiosensitivity of the stem cells, the hypoxic fraction, re-oxygenation of the tumour vicinity and/or repopulation capacity throughout the course of therapy^{73–75}.

Radiogenomic analysis of tumour microenvironments has the capacity to unlock knowledge with respect to the aforementioned criteria^{76,77}. An example is the strong correlation between microvascular density and PET-MR-derived radiomics features reported in patients with primary clear-cell-renal-cell-carcinoma⁷⁸. In general, tumours display considerable variability in

radiosensitivity, which even affects tumour cells of analogous origin or histological type^{79–81}. The quantification of the radiosensitivity of human tumours is presently performed on the basis of the *ex vivo* tumour survival fraction, and the detection of unrepaired DNA double-strand breaks^{82,83}. Preclinical (including prostate, lung, and brain cancers) and clinical (such as cervical, and head-and-neck cancers) studies have proven that tumour-cell radiosensitivity is a key feature for the prediction of outcomes to radiotherapy in patients with prostate, lung, brain, cervical, or head-and-neck cancers^{84–88}. These data, however, were built on results from colony assays that involved technical deficiencies, such as poor plating efficiency (<70%) for human tumours or protracted time required to produce data (up to several weeks).

Overall, these approaches have been undermined by the presence of substantial experimental variability rather than by the existence of interpatient variations in radiosensitivity. Non-malignant tissue toxicity is the dose-limiting factor in radiation oncology; therefore, a comprehensive CDSS should be built upon predictors of dose, tumour-control versus non-malignant-tissue-complication probability ratio, as well as cost-effectiveness⁸⁹, in order to facilitate improved escalated or de-escalated individualized treatments for patients.

Immunotherapy

In the field of oncology, a promising research area is that of biomarkers — in particular, biomarkers for immunotherapy and imaging biomarkers^{90,91}. The stimulation of an antitumour immune response in response to radiotherapy has been well documented⁹². For a robust and vigorous immune response to be elicited, the activation of antigen-specific T-cells coupled with memory effects is required⁹³. Such an immune response is dependent on the expression of specific antigens on tumour cells (neoantigens), which are subsequently identified by the immune system. Neoantigens arise from mutated proteins within the tumour cell. Research results demonstrate that the success rate of immunotherapies relies on the presence of neoantigen-specific T-cells⁹⁴. Moreover, the mutational load of many human tumour types correlates with the cytolytic activity of natural killer cells and T-cells⁹⁵. When a tumour has the potential to be identified by the immune system, a suitable immune response can be coordinated. Importantly, neoantigens must be taken up by antigen-presenting cells (APCs) or dendritic cells (DCs) and subsequently

cross-presented to naïve T-cells⁹⁶. T cells are then converted into tumour-killing cytotoxic T cells. The capacity of radiation to boost immune responses seems to be crucially dependent on the quantity and quality of DCs present in the tumour local environment^{97,98}.

Tumours have diverse means to shield from ample cytotoxic T-cell responses; for example, by interfering with several immune checkpoints, such as PD-L1, a protein with biomarker potential. The mutational load of the tumour has been correlated with clinical responses to anti-PD-1-mediated immunotherapy, for example, in patients with non-small-cell lung cancer^{99,100}. Such biological and genetic features hold potential; radiogenomic analysis will undoubtedly have an important role in leveraging this information in future CDSS. The basic hypothesis, still to be tested, is that tumours with high mutational loads have more neoantigens and, consequently, will be more heterogeneous on radiomic analysis and more sensitive to immunotherapy than tumours with low mutational loads. The exact opposite scenario is noted in response to radiotherapy or chemotherapy; in these situations enhanced radiomics-assessed tumour heterogeneity is an adverse prognostic factor. Regarding the combination of radiotherapy and/or chemotherapy and immunotherapy, no clear indication exists as to which effect will dominate.

Technical aspects

Accredited radiogenomic centres should be established. Stakeholders in the academic, clinical, industry, and regulatory spheres must collaborate to create, sustain, and standardize the required best-practice framework. Radiomic studies are difficult to perform consistently, and thus, accreditation is vital to the advancement of radiomics. Techniques for the workflow of radiomics ought to be independent of vendors and upgrades to hardware and/or software. Radiomic studies should incorporate reproducibility assessments owing to the beneficial ethical, economic and logistical effects they have (such as

informing power calculations and required samples sizes, multicentric trial duration and trial cost). Optimal reproducibility and stability enables multicentre studies to maximize the likelihood of a validated radiomic signature being fit-for-purpose in routine clinical use. Prospective studies sufficiently powered to relate radiomics data to clinical outcomes in appropriate patient populations are pivotal. Indeed, numerous studies are underpowered for sensitivity and specificity; however, study populations should not be skewed by selecting only those patients who are more capable of adhering to complex imaging protocols than the general population. All findings should be published, including true-negatives, false-negatives and false-positives, and the perceived adversity to negative results tempered because the inclusion of substantial bias risks distorting the radiomics landscape.

Economic elements

Multicentric, collaborative and federated efforts are required to share, store, and curate data. Data-sharing enables initiation of highly powered prospective studies and accelerates the development and validation of radiomic signatures derived from new and existing data. Trials conducted in centres that are part of a network can quickly recruit sufficient patient numbers to drive discovery and innovation. Outcome studies should include health economic considerations. Moreover, cost-per-quality-adjusted-life-year comparisons should be conducted with and without radiomics to more accurately determine the economic potential of such studies¹⁰¹.

The way forward for radiomics

Virtual biopsy

In patients with cancer, different parts of the tumour have distinct molecular characteristics; such differences change over time. As it is not possible to biopsy every part of each tumour at multiple time points, the optimal characterization of tumours is not achieved using biopsy samples (FIG. 4).

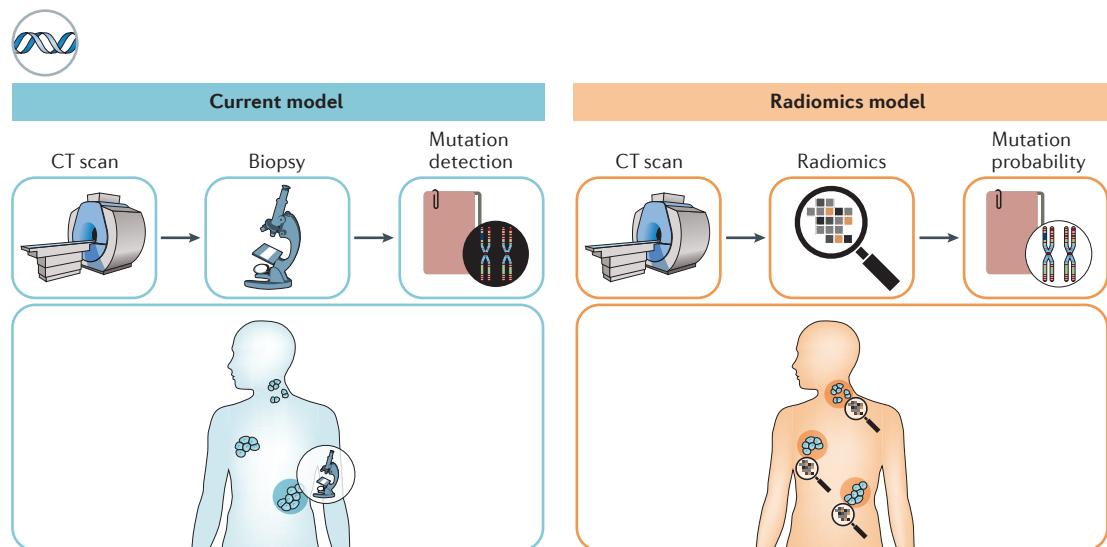


Figure 4 | Radiogenomics analysis can reveal relationships between imaging phenotypes and gene-expression patterns. Such relationships can include expressions of individual genes as well as measures that summarize expressions of specific gene subsets.

Delta radiomics

Published work mainly focused on imaging data acquired at a single time point, mostly imaging tumours before the start of treatment. Delta-radiomics introduces a time component and comprises extraction of quantitative features from image sets acquired over the course of treatment^{102–104}, which provides information on the evolution of feature values¹⁰⁵ (FIG. 5). Delta-radiomics promises to improve diagnosis, prognosis, prediction, monitoring, image-based intervention, or assessment of therapeutic response.

Infrastructure for radiomics

Radiomics demonstrates huge potential to deepen knowledge and broaden the horizons of imaging, in order to achieve greater precision and extraction of *in vivo* biological information. To fully harness the

potential of radiomics, research and clinical communities must embrace an interdisciplinary shared vision of precision medicine. Extracted radiomic features must be stored in searchable databases in order to realize the unprecedented potential for RLHC that routine standard-of-care imaging represents. Hence, RLHC networks can dynamically capture multimodal data and share knowledge across departmental and institutional boundaries, in order to accumulate sufficient datasets for significant statistical power in model development and validation.

Big data

Ideal RLHCs necessitate the 4Vs of ‘big data’: volume, variety, velocity, and veracity of data. The volume of data is important: firstly, the quality of knowledge gained from a study is correlated with the number of patients

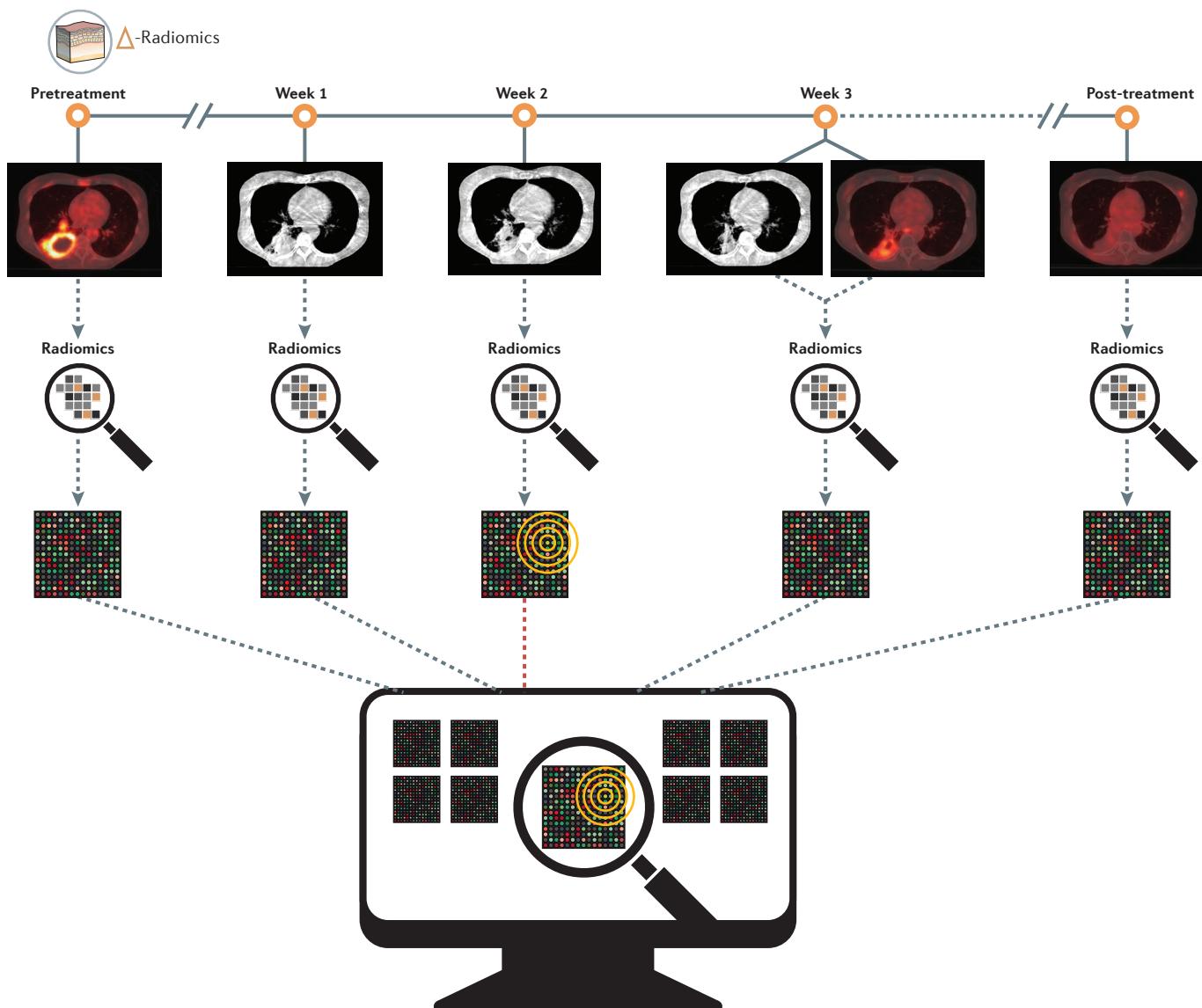


Figure 5 | Schematic overview of a clinical decision-support system graphical user interface illustrating the concept of delta-radiomics. In this example, a clinician requests the radiomic analysis of a patient on the basis of combined longitudinal PET–CT images, potentially enabling improved diagnosis, early response prediction, improved clinical decision-making and, consequently, a better prognosis.

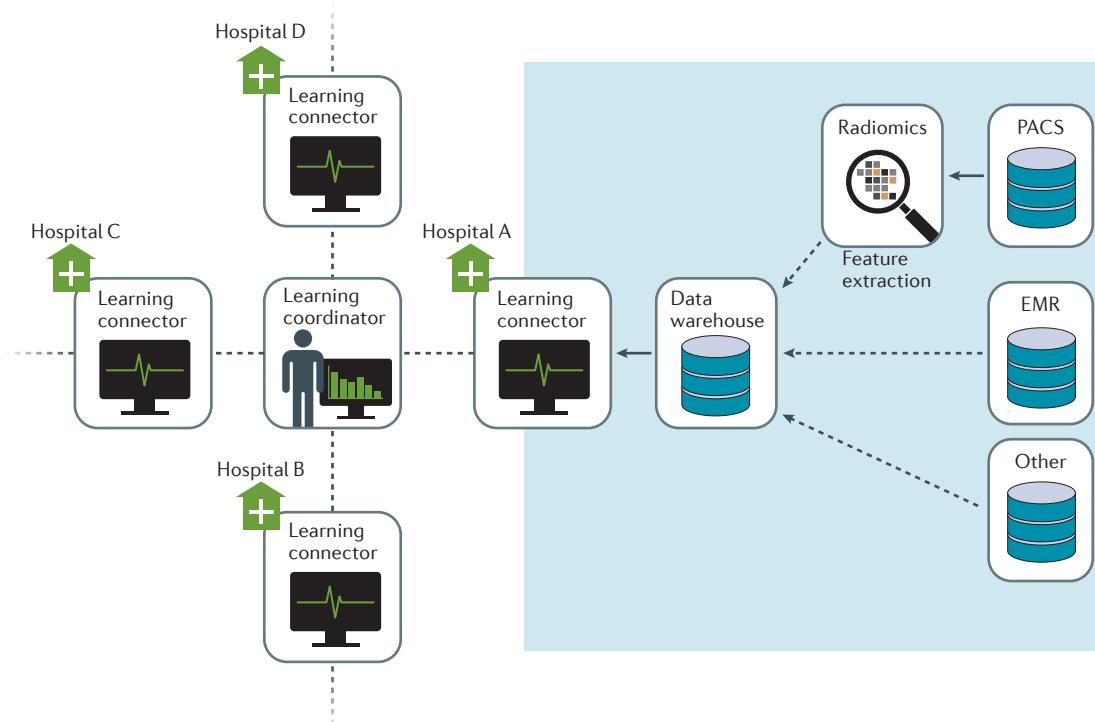


Figure 6 | Schematic diagram of the CAT system. Multiple centres are linked via learning connectors. The connector is the interface where machine learning algorithms (sent from the learning coordinator) learn models from local data. Of note, privacy-sensitive information remains in the institute. Partner sites exist in the Netherlands, Germany, Belgium, Italy, Denmark, Australia, China, India, South Africa, Ireland, UK, USA and Canada. The system is built from a combination of open-source information communication technologies and can deliver data locally via SQL query, or to the wider CAT network via a SPARQL end point. CAT; Computer-assisted theragnostic EMR; electronic medical record; PACS, picture archiving and communication system; SPARQL; simple protocol and RDF query language.

from whom data were obtained. Secondly, a greater data volume enables the acquisition of more variables in the model development phase. Thirdly, knowledge related to patients with rare disease variants is more easily gained from larger datasets. The variety of data, both in terms of treatment and of patient characteristics, is critical for deciding which treatment is optimal for each individual patient. The velocity of data acquisition is important to guarantee that knowledge is gathered as swiftly and perpetually as possible, while the veracity of data is critical to the amount of confidence that can be ascribed to the knowledge gained.

Data sharing

Procuring data of sufficient quality with regard to the 4Vs is central to RLHCs. A pressing need to embrace knowledge and data-sharing technology¹⁰⁶, which transcends institutional and national boundaries¹⁰⁷, drives both the research and clinical communities. The following established obstacles to data sharing¹⁰⁸ are apparent in the medical domain: insufficient human resources or insufficient time, cultural and language difficulties, data recording methods, the political and academic value of data, hazards to reputation, or legal and privacy considerations, to name a few. These issues, although not easy to overcome, must be addressed.

One initiative to accomplish this goal is CancerLinQ¹⁰⁹, the ASCO data centralization approach. Another initiative is worldCAT that consists of a

novel data-federated approach that successfully links radiotherapy institutes in the Netherlands, Germany, Belgium, Italy, Denmark, Australia, China, India, South Africa, Ireland, UK, USA and Canada (FIG. 6)¹¹⁰. In addition, universal streamlined solutions through advanced information communication technologies have been central to the realization of this endeavor, readily facilitating synchronized RLHC in each centre without inclusion of sensitive data, which overcomes the classic barriers to data sharing. Other important links include The Cancer Imaging Archive (TCIA)¹¹¹, The Quantitative Imaging Network (QIN)¹¹², the Quantitative Imaging Biomarkers Alliance (QIBA)¹¹³, and Quantitative Imaging in Cancer: Connecting Cellular Processes with Therapy (QuIC-ConCePT)¹¹⁴.

Ontologies for learning

For RLHCs to succeed, the creation of data with semantic interoperability, also known as ‘machine-readable’ data¹¹⁵ is needed, in which local terms are harmonized from concepts of well-defined ontologies (such as the NCI Thesaurus or ICD-10). Exploiting this technique, the ontology terms serve as a common reference for the data at each institutional site, permitting a unified process for information retrieval enabled by a semantic gateway to the data. A benefit of this approach is that it promotes standardization with respect to data management (such as disease-specific ‘umbrella’ protocols: NCT01855191)^{116,117}.

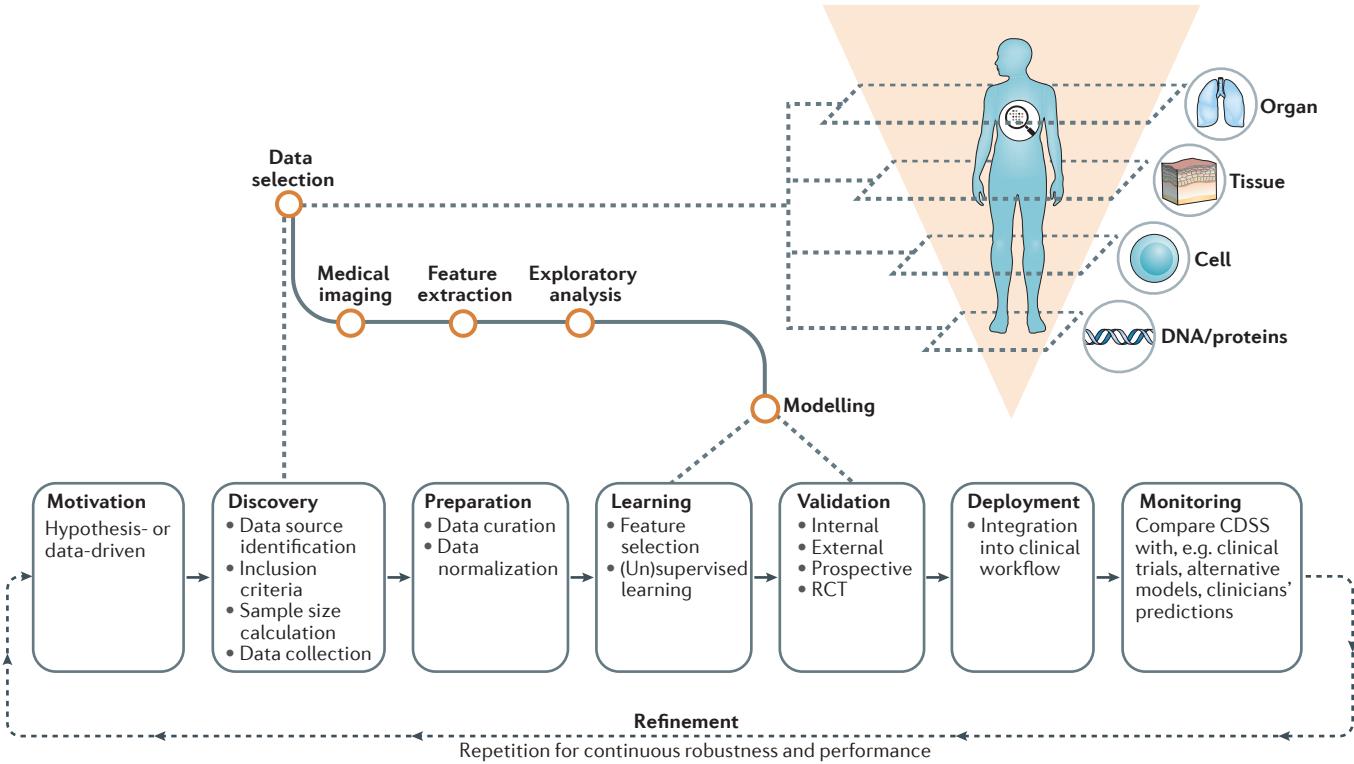


Figure 7 | Overview of the methodological processes for RLHC and how the radiomics workflow fits into the development of a CDSS. Data selection, discovery, collection and preparation, model(s) development/validation and implementation, assessment of clinical utility and ultimately refinement through continuous repetition of the process (quality control and assurance protocols are requisite throughout the process).

Role of radiomics in the future

Picture archiving and radiomics knowledge systems (PARKS) of the future will identify, segment, and extract features from regions of interest. If previous images associated with the same patient are accessible, the earlier identified regions of interest will be automatically identified by the PARKS software. Quantitative image features that are uploaded to a shared database and compared with previous images will be automatically extracted by the PARKS to enhance CDSS for diagnosis, prognosis, and treatment, resulting in improved personalization and precision medicine (FIG. 7). Such capabilities are on the technological, scientific, and clinical horizons, as most current picture archiving and communication systems have the capability to co-register current images with previous images and perform user-interactive segmentation. For the immediate future, the field of radiomics will focus on the creation of suitable infrastructures for powerful RLHC networks that will facilitate the development and validation of models.

Conclusions

Our vision for radiomics is expansive and bold. In the reasonably near future, we envision that CDSS that apply knowledge leveraged from radiomic features mined from global RLHC networks populated by standard-of-care imaging will enable increased personalized delivery of medicine. For this vision to be updated within the routine clinical setting, clinicians and medical physicists must be incentivized to participate in the process. Moreover, standardization is crucial to this endeavor, principally in the acquisition of high-quality data. Standardization underpins coherent clinical guidelines with agreed standards for image acquisition and analysis, as well as data-sharing techniques that exploit matching ontologies. Continuous re-evaluation and demonstration of the clinical utility of a CDSS is as significant as standardizing the development and validation of the design of clinical trials. These crucial steps are the foundation of a successful CDSS. Simultaneous and synergistic advances in RLHC and radiomics will empower the next major breakthroughs in personalization and precision medicine.

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Competing interests statement

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