Presentation notes

Introduce background of Diabetic Retinopathy. Mentions statistics of DR. Mention the strain on resource and the need for better easier referral. Mention authors partnership with Phelcom Technologies.

High level over the solution architecture and a brief description of convolutional neural networks

<https://medium.com/@RaghavPrabhu/understanding-of-convolutional-neural-network-cnn-deep-learning-99760835f148>

Architecture resembles VGG-16 in terms of arrangement of pooling and conv layers. Whereas the fully-connected stage is more inspired by the o\_O solution.

Modelled the problem as a classification rather than a regression. Referral rather than severity

Convolutional layer neurons/filters convolve over input. Then after element wise multiplication with the receptive field the result is summed and outputted to a feature/activation map. Also the output is passed through the activation function (Leaky ReLU)

Strides can be applied to reduce the dimensionality of the input.

Pooling layers merge neighbouring features into one. (Downsampling)

* Very small receptive field (3 X 3)
* Pooling layers separate 2 or 3 convolutional layers
* Convolutional layers start at 32 filters and double after each pooling layer
* Stride in 1st & 3rd convolutional layers
* Leaky RELU (accelerates the convergence of the gradient in comparison with conventional activation functions)

The 1024 units of the hidden dense layers employ dropout with a probability of 0.5. (Dropout tries to prevent a model overfitting)

Gradient of loss function got via backpropagation. How we use that to adjust the weights is the choice. Accelerates GD by accumulating a velocity in the direction of the downward gradient. Accelerates convergence in areas of low curvature. Nesterov momentum computes a partial update to the position allowing for a more responsible stable change in velocity.

L2 regularisation (ridge regression): Is to help prevent overfitting. Adds the squared magnitude of the weight to the loss function. Penalising the weights of the nodes more. + 0.0005 \* sum(weights^2)

For the loss function cross entropy is used because the problem is a (binary) classification not a regression (for which mean squared error would be used).  
“seek a set of model weights that minimize the difference between the model’s predicted probability distribution given the dataset and the distribution of probabilities in the training dataset. This is called the cross-entropy.”

Binary CE = - ylog(p) + (1-y)log(1-p)

Operations/perurbations performed before submission to the network. Operations are done by choosing a random variable from a range for each operation. Example: between 0-360 for rotations, translations between 40 and -40. # of perturbed versions of each class depend on the balance weights of that class that is inversely proportional to the number of images(inputs) for each class.

Pertubations

* + Geometric (Zoom, rotations, cropping.. etc)
  + Photometric (Contrast enhancements, histogram equalisations)

Keep classes balanced while inflating training set. Proportions the same because augmentations applied to all images.

Training simplified versions of the CNN that require less training samples and then using learned parameters as a starting point for the next stages

Pseudo-random because same perturbations are always applied to all images.

Feature vectors are extracted by CNN for each image (version) final feature vector for an image is the mean and standard deviation of the 20 feature vectors of each of its versions.

Extract features in last pooling layer of CNN

Datasets collected at different times, in different hospitals and with different cameras.

Reiterate data augmentation was needed because number of parameters much higher than the number of available training images.

CV is balanced by class (stratified CV).

Messidor-2:

Graded by specialists according to ICDR severity scale.

DR2:

Referral labels provided for 435 by experts

EyePACS:

* + 35,126 for images training & 53,576 for testing
  + Size ranges from 320 x 211 to 5184 x 3456 pixels
  + Includes both left and right eyes graded by severity
  + Converted labels from Severity to Referral Necessity

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Comparison of progressive improvements. On **receiver operating characteristic curve**

Please note o\_O is better but it an ensemble of six classifiers. Ours is one better expert classifier.

And this is on the Kaggle dataset. Next slide we see that our one does better for cross-dataset validation, which is more realistic of the real world because the different dataset have very different acquisition conditions and it shows our algorithm generalises well to new data.

datasets have very different acquisition conditions. Here we show the results of training on Kaggle dataset but then testing on DR2 and Messidor-2.

Extracting features provides us with flexibility to choose different machine learning algorithms. We choose to use A Neural Network and Random Forest.

Using the best solution from the previous section trained on Kaggle data (exploiting per-patient analysis only when we have access to images of both eyes)

NN:

2 layers 32 units, 3rd layer 2 units. ReLU activation.

Layers intercalated by feature pool layers. Trained the network for 100 epochs using Adam Optimizer (adaptive learning rate **optimization** algorithm)

RF:

Extensive grid search for hyper parameters maximising AUC. Trying 50-300 estimators/trees and gini/entropy criterion.

All experiments used 200 or 300 and entropy

Here we train CNN on Kaggle and use it as a feature extractor for DR and messidor-2. Then run the classifiers on the extracted features???

These results corroborate the hypothesis that it is possible to train a robust data-driven solution to precisely pinpoint diabetic retinopathy referral needs, independently of operators and camera settings of the training set of images.

Note: one of the previous leading solutions run against the Messifor-2 dataset was by Abramoff et el. It had 98% AUC after adopting CNNs however ours had equally remarkable results at 98.2% --

Therefore reinforcing that detecting DR lesions is not essential for a reliable and effective DR screening. NOTE ALSO we don’t use messidor-2 data to train or omptimse our CNN that is done by Kaggle data this shows robustness of the method.

Adapted the o\_O solution for a binary classification problem and evaluated its efficiency and effectiveness.

Recall o\_O is an ensemble of six methods trained with features extracted from 2 CNNs.

Performed the tests using one “GeForce GTX TITAN X”.

Simulated real time diagnostic environment screening 50 patients (100 images)

Time is time to:

* Loading all libraries
* Loading parameters of CNN
* Pseudo-augmenting input images
* Inference of higher probability among eyes

Memory is:

* Disk space for CNN params
* 2 hidden layer neural networks in memory

Our method has huge improvements in space and time efficiency. And also slight improvements in classification effectiveness.

Idea of transfer learning comes from the idea that many deep neural networks trained on natural images learn similar features: textures, corners, edges, colour blobs… etc.

2 types=>

Feature Extraction: Freeze the CNN and use it to extract features

Fine Tuning: Freeze the former high level layers and fine tune the later layers

Source problem: Severity assessment, Target Problem: Referral Assessment

Here we train a CNN of the same architecture to work with to assess severity of DR (five outputs in the decision layer instead of 2) we also use our previously mentioned improvements (data aug, multi-res ..etc)

Fine tuning is better. With RF

On the left provide decision for each eye

On the right provide decision based on both eyes. And out performs as you would imagine.

Same here: Fine tuning is better. With RF

Although these results confirm that patient based is better than per image.