Unsupervised Pretraining of Foundation Models for Medical Imaging

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Overview

- Motivation
 - Convolutional networks and their limitations
 - Transformers, strengths and weaknesses
 - Desired properties of a medical imaging foundation model
- Unsupervised Pretraining Methods
 - Masked Autoencoder
 - Contrastive Embedding
 - Query Box Localization
- Results

- Deep learning models can analyze medical images (such as mammograms) to assist in diagnosis [7]
- Many such models use convolutional architectures [2], which incorporate a locality prior
- Such a prior can accelerate learning, but can also be restrictive

- Mammographic screenings capture four standard views of the breasts
 - Medio-lateral oblique (MLO)
 - Cranio-caudal (CC)
 - MLO and CC views are approximately orthogonal



- The standard views are typically examined together to leverage bilateral symmetry
- Reference images are used (when available) to compare to the standard views
- Sometimes lesions will appear in multiple views



A strong mammography model should incorporate all available information:

- Orthogonal nature of MLO and CC views is incompatible with a locality prior
- Additional imaging may be available with similar incompatible relationships
- Textual information may also be available (medical reports)

Similar considerations apply to other medical imaging modalities

Objectives to improve mammographic performance:

- Relax the locality prior
- Support a variable number of additional context images
- Support textual information

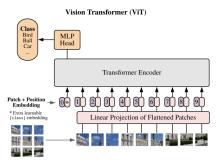
These objectives will also improve performance on other medical imaging modalities like:

- X-ray
- CT
- MRI
- Ultrasound



Vision Transformers (ViTs) can address these objectives:

- Vision Transformers (ViTs) can achieve state-of-the-art results on image classification tasks [5]
- Attention is not restricted by a locality prior
- Transformers are cardinality invariant
- Transformers can support multiple modalities (Med-PaLM2) [8]



ViTs are not without drawbacks:

- They require a large amount of labeled data (JFT-300M) [5]
 - Medical imaging datasets are often small and expensive to label
 - Thousands of images instead of millions or billions
- Or they require clever training methods (DeiT) [9]
- Self attention is expensive to compute (quadratic)
- Relatively difficult to train from scratch
 - Numerical instability
 - Sensitivity to batch size
 - Resource intensive

Masked Autoencoder

- Follows from masked language modeling (BERT) [4]
- Mask a subset of the input patches, regress to the original input



Contrastive Embedding

- Follows from popular contrastive learning methods (DINO) [1]
- Model creates an embedding vector for each image
- Embeddings should be similar for augmented versions of the same image
- Embeddings should be dissimilar for different images

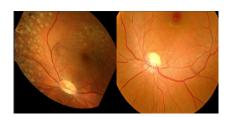


Figure: Global augmentation



Figure: Local augmentation

Query Box Localization

- Inspired by UP-DETR, a pretraining method for detection models [3]
- Regions of interest are randomly selected and augmented
- Given the original image and the augmented image, the model should predict the bounding box of the region of interest

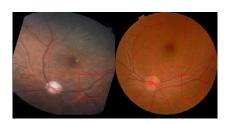


Figure: Original image



Figure: Augmented ROIs

Methods

Architecture:

- Inspired by ViTDet [6]
- Standard patch embedding with log-spaced sinusoidal position embeddings
- Window attention without shifting
- Global attention at periodic intervals

Training:

- One or more of the pretraining methods are incorporated into the training process
- Tasks are cyclically sampled at each minibatch



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