PROJECT REPORT

Segmentation of Chronic Wounds

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1 Introduction

1.1 Motivation

- many people affected by chronic wounds that need to be monitored
- Why is automatic Wound Segmentation so important? And why is it a complex problem?
- Manual segmentation by experts expensive and very time consuming
- experts differ in their segmentation
- different types of wounds have different characteristics
- changing lighting conditions, distance to camera, camera angle, different cameras have impact on result
- controlled environment not feasible in clinical setting
- ideally, we want to be able to take pictures with a smartphone without overly complicated instructions for the person taking the picture
- experience as photographer should not be required, clinical proffessionals should be able to take pictures that are then segmented correctly

- one type: diabetic foot ulcers → are monitored to ensure healing process is optimal and there is no infection, normally long time span [12]

- wounds have complex structure containing different types of tissue with different colour and texture → different regions with borders in between [1]
- heterogeneous wound images

1.2 Research Questions

A recent publication by Oota et al. claims to have improved the state of the art in Wound Segmentation. Such claims always needs to be supported by further research. This project aims to investigate and reimplement the proposed method. This includes comparing it to state of the art methods for semantic segmentation in general and for wounds specifically.

- can the results be reproduced?
- what influence does the input image size have? Can we rescale the images and are able to transfer what is learned
- how robust is the model/architectures to transformations/distortions on the input
- XAI

2 Datasets

Unfortunately, not many datasets on chronic wounds are publicly available [20]. Additionally, they often feature only a specific type of chronic wounds, often diabetic or pressure ulcer. An example for such a specialised dataset is the data from the Diabetic Foot Ulcer Challenge 2022 [12]. However, it is only available after application and therefor not appropriate for this project and its limited

timescope. One other data set featuring foot ulcer wounds is publicly available as part of the Foot Ulcer Segmentation Challenge 2021 [23]. It consists of 1010 images which are augmented to build a data set with a training set of 3645 images and a test set of 405 images. Due to the nature of a challenge, labels for the test set are not available.

WSNET data set The data set mainly used in the scope of this project is the WSNET data set featuring eight different wound types: venous ulcer, trauma wound, diabetic ulcer, surgical wound, arterial ulcer, cellulitis, pressure ulcer and a not further specified group of other wounds [20, 19]. In total it consists of 2686 images and their corresponding masks. This means it consists of more individual images and wound types than the beforementioned publicly available data set. Unfortunately, the wound classification itself is not available. Furthermore, Oota et al. mention another seperate data set for pre-training with wound type classification which is not publicly available as well.

3 State of the Art

3.1 Semantic Segmentation

The segmentation of wounds belongs to the class of semantic segmantation problems, where a pixel-wise classification is performed. In the case of wound segmentation there are two classes: foreground, which is the wound, and background. Deep Learning methods became dominant in the last years because they became more accessible. Fully Convolutional Neural Networks (fCNN) as a starting point in research had the drawback of resulting in a low output resolution and multiple techniques were invented to increase the output resolution [15]. This results in an encoder-decoder architecture as base for the networks, inspired by auto-encoders [4], where the encoder subsamples and the decoder upsamples [18]. In such architectures the encoder generates context information, information in the feature space while the decoder maps this information into the spatial context.

Pre-training for such models requires a huge amount of data. A typical data set for such pre-training is the ImageNet object classification data set [2].

In this project, four different segmentation models are used: U-Net, Linknet, FPN and PSPNet. All are improved architectures about a basic fCNN. Each architecture is described in detail to understand challenges and approaches of localizing information in space.

U-Net U-Net is a convolutional network developed for Biomedical Image Segmentation, based on an encoder-decoder architecture. Encoder and decoder are called contracting and expansive path in the original paper, describing their function. They are also described as context path and spatial path [17]. Both, encoder and decoder consist of different steps to encode and decode the image on different spatial levels. The encoder is a classical CNN; each step consists of two convolutions and a max pooling operation for downsampling. The decoder step upsamples the feature map followed by a convolution. The result is then concatenated with the corresponding feature map from the encdoer

path and convolution is applied again. In the final layer, 1x1 convolution is used to map the feature vector to the desired number of classes. This architecture is visualised in figure 1. [21]

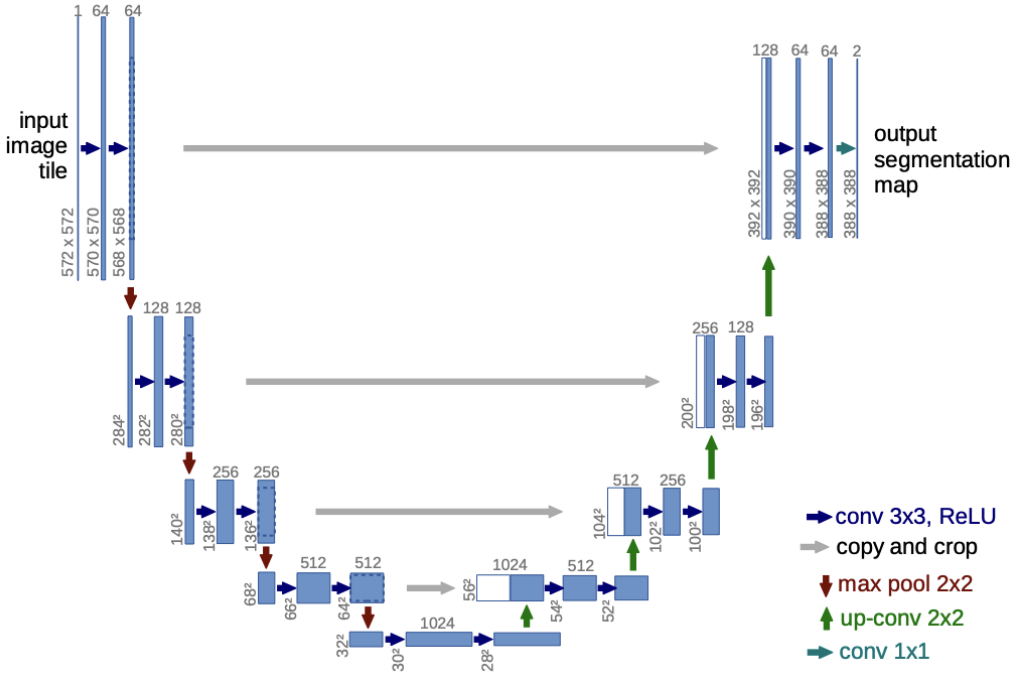

Figure 1: U-Net architecture for 32x32 pixels in the lowes resolution. Blue boxes are feature maps with the number of feature-channels on top of the boxes and the size shown on the left size. Operations are indicated by the arrows. The skip connections are a concatenation. The figure originally create by Ronneberger et al. [21].

The skip connections, connecting the different levels of encoder and decoder prevent a loss of information and extracting the features at different resolutions to retrieve spatial information. By doing this, it is one of the first architectures improving the classical fCNN for semantic segmantation [15]. While U-Net provides spatial localization of features, its ability to generalize to multi-scale information is limited [18].

One restriction is, that the input size must be chosen such that all 2x2 max-pooling operations in the encoder are applied to an even x and y size.

Linknet Similar to U-Net, Linknet contains of an encoder block for downsampling and a decoder block for upsampling. The downsampling is not done by max pooling as it is in the U-Net architecture but by using a stride of 2 in a convolutional layer. Also does the inital encoder block differ from the following blocks as it uses a larger kernel and uses max pooling. The decoder blocks upsample by a factor of 2 in each block. The final block differs again from the previous blocks. The main difference to the U-Net architecture is how the skip connections are used: Similarly to the U-Net, there are skip connections between the corresponding steps of encoder and decoder, but the feature map from the encoder is not concatenated but added to decoder data. The linknet architecture is visualised in figure 2. [4]

The implementation used in this project has four skip connections instead of the original three [11].

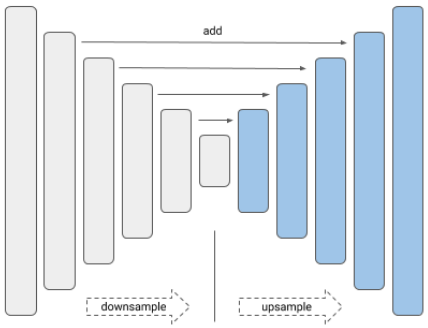

Figure 2: A visualisation of the LinkNet architecture originally provided by Iakubovskii [11].

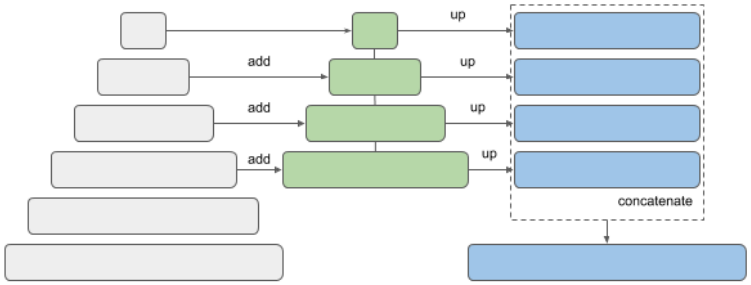

Figure 3: A visualisation of the FPN architecture originally provided by Iakubovskii [11]. Note, that the feature maps can combined either by concatenation or addition.

Similarly to the U-Net, the input size is restricted such that every upsampling operations need to be applied to an even x and y size.

Linknet has been shown to achieve better results than U-Net under similar conditions [8].

FPN The Feature Pyramid Network (FPN) architecture creates feature maps of various sizes in multiple layers [18]. Similar to the other architectures in consists of an encoder and a decoder, called bottom-up and top-down pathway here[14]. Similarly to U-Net, feature maps at different scales with a scaling step of 2 are created in the encoder [14]. In the decoder, the feature maps are upsampled and combined with the encoder information of the same level. Similarly to LinkNet, addition is used in the skip connections, but an 1x1 convolution is applied. By doing this so-called feature pyramids are build, containing features at different resolution. Kirillov et al. proposed a method to use these feature pyramids to obtain a segmentation by merging the feature maps using addition or concatenation [13, 11]. The architecture is visualised in figure 3.

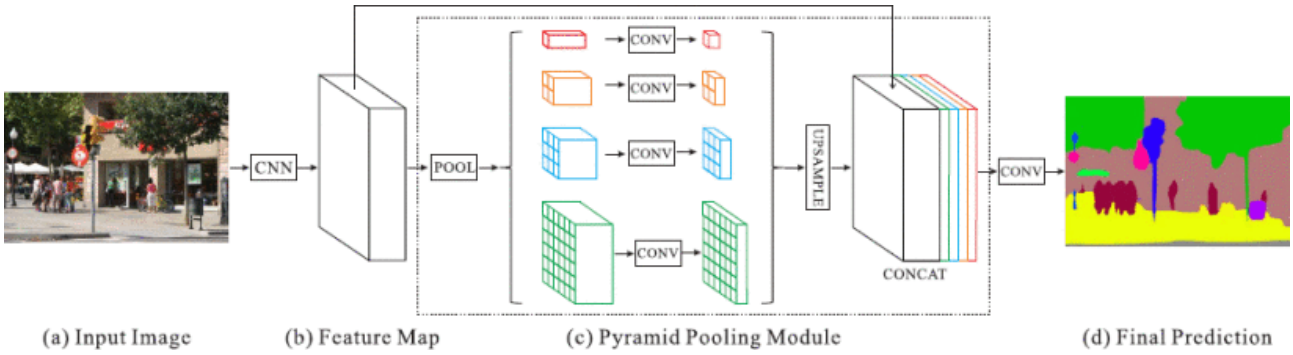

Figure 4: TODO. Originally created by Zhao et al. [24].

PSPNet The main part of the Pyramid Scene Parsing Network (PSPNet) is the pyramid pooling module, visualised in part c of figure 4, which extracts context information at different scales. A feature map extracted with a pre-trained backbone is pooled at different pyramid scales. This means that global pooling and sub-regions on different locations are used to extract features from a global to a more fine-grained scale. Each of those scales is as passed through a 1x1 convolution and afterwards upsampled to the size of the original feature map. All feature maps including the original feature map from the backbone are concatenated and used to extract the final prediction. By this features on different scales are combined. [24, 9]

3.1.1 Evaluation

There exist several methods to evaluate how good a predicted segmentation is. Since semantic segmentation performs a pixel-wise classification, resulting in a segmentation mask, classical metrics such as accuracy and precision are available. Two performance metrics that are commonly used in semantic segmentation in medical imaging are the Dice Coefficient and the Intersetcion over Union (IoU) score. They indicate the segmentation quality better than pixel-wise accuracy [7].

IOUScore The IoU-Score (Intersection over Union), also known as the Jaccard index J describes the ratio between the intersection of the ground truth mask y and the predicted mask $\tilde{y}$ and the union of the predicted and the ground truth mask. By this it compares the similarity of the two masks [5].

$$\text{IoU}(y, \tilde{y} := \frac{\text{Area of overlap}}{\text{Area of union}} \tag{1}$$

$$= \frac{|y \cap \tilde{y}|}{|y \cup \tilde{y}|} \tag{2}$$

Dice Coefficient The Dice coefficient is the F1 score calclulated for the image masks. In terms of intersection and union, this means it calculates the ratio between two times the overlap between ground truth y and predicted mask $\tilde{y}$ and the total area.

$$\text{Dice}(y, \tilde{y}) := 2 \cdot \frac{\text{Area of overlap}}{\text{Total area}} \tag{3}$$

$$= 2 \cdot \frac{|y \cap \tilde{y}|}{|y| + |\tilde{y}|} \tag{4}$$

To gain more insight into the type of the errors the model makes, the rate of false positives and false negatives can be used do differentiate Type I and Type II errors [12].

3.1.2 Loss function

- loss function often uses pixel-wise (weighted) cross-entropy loss even though differentiable approximations of the two metrics exist [7]

3.1.3 Data Augmentation

Data Augmentation is a useful technique to make trained models more robust and accurate. This is especially the case if available data is limited, as the data set size can be either increased or the data set can be made more diverse.

For images, there exist several different possible augmentations. First of all, there are different positional augmentations, including cropping, flipping, rotating and resizing the image. Another class of augmentations are color augmentations, changing the brightness, contrast and saturation of the image. Other augmentations include blurring and dropouts.

Not every augmentation is appropriate for every application. Rotating images of standing animals by 180 degrees for example would not make sense, while rotating images of wounds is appropriate. Therefore, augmentations must be chosen carefully depending on the application.

3.2 Wound Segmentation

As already discussed in the motivation of this project, wound segmentation is a complex problem due to wound characteristics such as different tissues and therefore edges in a wound itself on one side and technical reasons such as e.g. varying lightning, distance to the wound and different angles.

Before Deep Learning became easily accessible and popular, methods based on features describing color and textures, region growing and optimal thresholding algorithms and classical machine learning models were used to perform segmentation [22]. Convolutional Neural Networks replaced manually extracted features by autonomously learned ones [22]. Some methods included pre-processing steps to remove the background by e.g. user interaction indicating the background, using a standardized background when taking the image or using manual feature engineering to detect the background more efficiently and make the wound segmentation task easier. Such non-automatic steps limit the use of the segmentation algorithms because they either require more ressources in the image taking

process, in the segmentation process or are specifically tailored for specific conditions of lighting or camera settings.

The Diabetic Foot Ulcer Challenge 2022 used FCN, U-Net and SegNet with different backbones and categorical cross-entropy loss as baseline for their challenge, indicating those methods reflect the current state of the art that needs to be improved [12]. Generally, such classic models are commonly used and extended with minor adaptions. Two methods stood out in the performed literature review, including more sophisticated adaptions.

Scebba et al. proposed a method consisting of two steps: An object detection step that produces bounding boxes containing the wounds and a second step that performs segmentation on those areas. Segmentation itself is performed using classical architectures for semantic segmentation as described in section 3.1. The loss function used was pixel-wise weighted binary cross entropy loss. Weighting was calculated based on the number of wound and background pixels of each training set fold.

Oota et al. claim they set a new state of the art for wound segmentation while providing a data set together with their work [20]. The latter made them a suitable method for further investigation in the scope of this project. Their approach is described in more detail in the following section.

3.2.1 WSNET

The framework proposed by Oota et al. uses the four before described segmentation architectures: U-Net, LinkNet, PSPNet and FPN. Experiments with different backbones were performed in their work, but in the scope of this project mainly MobileNet [10] is used since it is the smallest one which allows faster training which is needed in the limited time of the project.

ImageNet pre-trained weights are used. WSNET also describes pre-training specific to wounds, called Wound-Domain Adaptive Pretraining. During this pre-training wound images are classified into five different ulcer types.

To make their models more robust, Oota et al. experiment with data augmentiton on the training data and the corresponding masks including optical distortion, horizontal flip, random rotation, blur and more.

Global-Local Architecture The network architecture proposed by Oota et al. is called Global-Local architectures and consists of two segmentation models, a global model and a local model from which the result is combined for the final segmentation. The global model is a standard segmentation model of one of the 4 architectures described before in section 3.1. In the global model, the image (size 192x192x3) is split in 16 non-overlapping patches, resulting in a size of 48x48x3 per patch. The patches are than stacked, resulting in a size of 48x48x(3x16). The patches are the input to 16 local models in parallel, with shared weights between the local models. The output is eventually combined to obtain a full-sized mask. This mask and the output of the global model are concatenated to a mask of size 192x192x2 and a final convolution of size 1x1 results in the predicted mask. This architecture is motivated by the need to combine global signals from the entire image and local signals from smaller

patches for more details. Only capturing local signals might cause an incomplete segmentation for large wounds. [20]

Although the combination of global and local signals sounds reasonable at first, it is interesting, that this approach is combined with segmentation models that already contain different context sizes and localisation in this context sizes, as describey in section 3.1. An explicitly chosen patch size implies some property of the wound images that makes this size particularly important for local information. Oota et al. stated in their paper that they tested different patch sizes and chose 48 because it lead to the best results [20], supporting the theory that this patch size yields more information than others.

Reported Results

- pretraining on wound images improves results
- data augmentation leads to improvements
- local only models significantly worse than global model
- global only models worse than global-local model

4 WSNET

4.1 Code availability and reproduction of the results

Although the code for WSNET [20] is stated to be publicly available, a closer inspection of the linked GitHub repository shows, that this is only partially the case. A lack of documentations makes it hard to make use of the code, especially since the code seems to contain multiple errors, making it only suitable as base for new code.

In the scope of this project, the code was used to create runable models again. Unfortunately, the classes of the wounds are not available, which makes it impossible to perform pre-training as it was described in the original paper [20]. In total there are eight models available: A local model and a combined global-local model for each of the segmentation models Unet, PSPNet, FPN, and Linknet. The Python library used for the segmentation models is `segmentation_models` [11]. The implementation processed showed some differences to the described model architecture. In particular, it was claimed that the wound images were split up in parts of 48 px times 48 px. However, three of the four models, all beside PSPNet, only allow input sizes that are divisable by 32 and the GitHub showed a size of 64 px was used. Another difference between available code and the paper is, that it is claimed that augmentation is not performed on the test images which is not the case in the available code.

Information about the size of training, validation and test set is not given in the paper or code. However, the code reveals, that train and validation set wer just the first x % of the dataset and no randomization was used to separate the test set as it is usually done. In the scope of this project, a split of 70 % training, 15 % validation and 15 % test data is used.

Because the data training for the wound-specific pre-training is not available, the results can only be compared for imagenet pre-training.

- problem with imagenet pretraining: input size for patches is not available, instead the default size of 224 is used, which might impact results negatively

4.2 Comparison of the achieved performance

	Unet		Linknet		PSPNet		FPN	
	IoU	Dice	IoU	Dice	IoU	Dice	IoU	Dice
Local model	0.359	0.523	0.398	0.564	0.373	0.538	0.408	0.574
Global model	0.504	0.668	0.631	0.772	0.458	0.627	0.632	0.772
Global-Local model	0.495	0.658	0.618	0.763	0.476	0.642	0.612	0.758

Table 1: IoU-Scores and Dice Coefficients for the four different models with each Global-Local, Global and Local architecture. The backbone used is mobilenet.

		U-Net		LinkNet		PSPNet		FPN	
		IoU	Dice	IoU	Dice	IoU	Dice	IoU	Dice
(A) Models with ImageNet pretraining	DenseNet121	0.617	0.761	0.617	0.762	0.585	0.736	0.623	0.766
	DenseNet169	0.613	0.758	0.624	0.768	0.596	0.745	0.614	0.760
	MobileNet	0.593	0.742	0.571	0.724	0.561	0.717	0.594	0.743
(B) Models with wound domain adaptive pretraining (WDAP)	DenseNet121	0.648	0.783	0.657	0.800	0.625	0.765	0.652	0.793
	DenseNet169	0.647	0.781	0.651	0.788	0.636	0.773	0.637	0.773
	MobileNet	0.615	0.760	0.611	0.755	0.563	0.718	0.616	0.758
(C) Models with WDAP and data augmentation	DenseNet121	0.680	0.818	0.687	0.820	0.653	0.797	0.680	0.817
	DenseNet169	0.672	0.810	0.675	0.812	0.656	0.801	0.664	0.807
	MobileNet	0.636	0.778	0.647	0.780	0.598	0.744	0.634	0.775
(D) Local (patch-based) models with WDAP	DenseNet121	0.527	0.689	0.537	0.698	0.520	0.682	0.532	0.694
	DenseNet169	0.534	0.696	0.530	0.691	0.519	0.681	0.533	0.696
	MobileNet	0.512	0.673	0.514	0.677	0.493	0.660	0.510	0.670
(E) Global-local models with ImageNet pretraining and data augmentation	DenseNet121	0.648	0.784	0.649	0.786	0.621	0.763	0.651	0.792
	DenseNet169	0.649	0.787	0.650	0.790	0.624	0.767	0.648	0.785
	MobileNet	0.620	0.761	0.621	0.763	0.565	0.722	0.618	0.760
(F) WSNet-FF: Global-local models with WDAP and data augmentation	DenseNet121	0.685	0.823	0.706	0.840	0.663	0.805	0.700	0.834
	DenseNet169	0.684	0.821	0.694	0.830	0.675	0.815	0.680	0.818
	MobileNet	0.650	0.790	0.651	0.792	0.590	0.740	0.651	0.792
(G) WSNet: Global-local models with WDAP, data augmentation, end-to-end fine-tuning	DenseNet121	0.695	0.831	**0.713**	**0.847**	0.683	0.820	**0.707**	**0.840**
	DenseNet169	**0.701**	**0.834**	0.707	0.841	**0.686**	**0.823**	0.697	0.832
	MobileNet	0.661	0.800	0.662	0.800	0.601	0.748	0.661	0.798

Figure 5: Results reported by Oota et al. [20].

- results are comparable with results reported in paper, slightly lower scores
- e.g. Unet IoU score 0.495 with my code, 0.620 in paper (dice score 0.761 vs 0.658)
- others are closer (linknet 0.618 from me vs 0.621 in paper, dice 0.763 in paper and for me)
- maybe differences in training size
- most important thing: the global-local model does not improve about global model
- TODO: explain here or later??
- the results reported by Oota et al. are shown in figure

4.3 Combination of different architectures

- used model architectures localize signals differently by design
- if the patch size really does play a significant role, maybe it makes sense to combine different architecture sizes?

5 Results and Evaluation

5.1 Re-implementation and evaluation of WSNET

- contribution: reimplementation of a framework in a better documented way, making the reconstruction of results easier
- documentation of this implementation
- identified discrepances between paper and available code
- comparison of results
- showed that reported "good" architecture does not yield significant performance increasements
- why: models already capture localized information, this is why those are sota segmenatation frameworks, further localization does not really make sense, maybe rather change parameters of used models to improve results
- Which architecture is suited best for wound segmentation? Why and what other alternatives would there be?

5.2 Robustness of wound segmentation

- augmentations commonly performed to improve robustness of models
- can also be used to access robustness of the resulting model
- for clinical application, lightning and size might vary between images
- batch normalization might further increase this problem (TODO: search references)
-

5.3 Explainability of segmentation results

6 Technical Information

6.1 Prior Experience

I have a strong programming background, consisting of a B.Sc. in Computer Science and three years of work experience in Web Developement with Python. Beside the content of the course Advanced Concepts of Machine Learning, I have no prior experience with Deep Learning.

6.2 Code and Data Availability

The code produced in the scope of the project is available on GitHub: `https://github.com/Zianor/DLIV-chronic-wound-segmentation`. Package versions are included to ensure reproducability.

The used data is available on GitHub as well: `https://github.com/subbareddy248/WSNET/` [19, 20]. Availability on a later point of time cannot be guaranteed.

6.3 Libraries

Several libraries were used in this project. The Deep Learning framework all work is based on is Tensorflow with Keras [16, 6]. The implementation of the 4 used network architectures was provided by the Python library `segmentation_models` [11]. Image augmentations were performed with `Albumentations` [3].

6.4 Learning Process

- Getting familiar with tensorflow
- learning about the state of the art in segmantic segmentation and segmentation of wound images and evaluation methods
- more experience in dealing with paper results and how trustworthy they are
- first, I planned on spending more time on the results of the chosen paper and experimenting with different augmentations and explainability
- after doing research about segmentation models I got sceptical about the general approach and spend a lot of time in researching semantic segmentation and the how and why
-

6.5 Used Hardware

All computations are performed on one of two different machines: a MacBook Air (24 GB RAM, Apple M2 Chip with an 8-core GPU) or a computer with 16GB and a nvidia GeForce GTX 1070 Ti as GPU. The package versions for GPU-utilization on MacOS are included in the package versions on GitHub.

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