GLOBAL VOLUME REGISTRATION FOR MULTIPLE MOTION TYPES IN RESTING-STATE FUNCTIONAL MAGNETIC RESONANCE IMAGES

by

Jenna Marie Schabdach

B. S. Electrical Engineering, Drexel University, 2016

M. S. Electrical Engineering, Drexel University, 2016

M. S. Biomedical Informatics, University of Pittsburgh, 2018

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by

Jenna Marie Schabdach

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Dr. Ashok Panigrahy, Department of Biomedical Informatics

Second member's name, Dept. Aff.

Third member's name, Dept. Aff.

Dissertation Director: Dr. Ashok Panigrahy, Department of Biomedical Informatics

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INSERT ABSTRACT HERE

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1.0   INTRODUCTION

Resting-state functional magnetic resonance imaging (rs-fMRI) measures the blood oxygen level dependent signal in an organ or organ system. This property makes rs-fMRI an invaluable tool for evaluating a patient's neurodevelopmental status or examining functional networks in his brain. To gather enough data to fully evaluate these networks, a series of image volumes must be acquired over a period of several minutes. In a standard rs-fMRI (?), one new image volume is obtained approximately once every two to three seconds. To gather high quality data on such a short timescale, the rs-fMRI suffers from two major limitations: rs-fMR images have low physical resolution and are highly susceptible to motion. The first limitation can be addressed by obtaining an MR image with high physical resolution and registering the rs-fMRI to this structural image, but the second limitation requires the patient to remain as still as possible for the entire duration of the scan. This task is particularly difficult for populations of certain ages or populations who suffer from conditions that affect neurodevelopment. As a result, it is common for an image from a member of one of these populations to contain too much motion to be used in clinical or research applications.

Various behavioral and XX protocols have been developed in an attempt to prevent patients from moving during MRI scans, though many of these protocols are not applicable to younger populations. In particular, a neonate or fetus cannot understand instructions to stay still, and young children who can understand the command have difficulty following it. Sedation is not advisable for these young populations. After a rs-fMR image is acquired, however, it is possible to reduce the positional effects of motion in the image sequence.

Limitations of traditional methods

DAG-based registration

Apply DAG-based registration to neonates and preadolesents

Real goal is to develop a method of registering fetal brain and placental images so that we can further examine the relationship between placental oxygen levels and fetal brain development. Longitudinally, this technique can be used to determine how placental oxygen flow and fetal brain development impact a patient over the course of his or her life. Once the relationship between the placenta and fetal brain development is better understood, we can determine a set of neuroprotective interventions to employ for at-risk patients before they are born.

2.0 BACKGROUND

The topics treated in this chapter can be somewhat obscure. For humanitarian considerations, the chapter will be subdivided.

2.1 RESTING-STATE NETWORKS

The idea of a neuronal network which operated when a person is at rest was proposed in 2001, and then confirmed in 2003 [Raichle et al., 2001] [Greicius et al., 2003]. Resting-state networks are recorded using resting-state functional magnetic resonance images (rs-fMRIs). rs-fMRIs are sequences of image volumes acquired over a period of a few minutes while the patient is in a task-free state. The image volumes themselves have relatively low spatial resolution when compared to structural MRIs, but their temporal resolution is significantly higher as a new volume is acquired every two to three seconds. Each volume records the blood oxygen level dependent (BOLD) signals within the brain at that point in time.

The BOLD signals in rs-fMRI image sequences are analyzed using a process called functional connectivity analysis. Functional connectivity analysis identifies patterns and networks of brain activity. Because the patient is not performing a specific task during a rs-fMRI acquisition, these resting-state networks have the potential to reveal valuable information about a patient's neurodevelopmental status. Some functional connectivity analysis studies have lead to the discoveries of links between specific disruptions in these naturally occurring networks and neurodevelopmental diseases such as autism and attention deficit hyperactivity disorder [Assaf et al., 2010] [Zang et al., 2007]. With further refinements of both acquisition techniques and characterization of these functional networks, clinicians may be

able to use rs-fMRI in early detection protocols to evaluate the neurodevelopmental status of infants and neonates, and in personalized care by identifying patients who may benefit from certain therapies or neuroprotective interventions.

2.2   MEASURING THE EFFECTS OF MOTION

Due to their low spatial and high temporal resolutions, rs-fMRIs are highly susceptible to motion. Even the smallest movement can alter the position of the patient enough to cause the voxels to record signals from different brain regions and tissue types. Even if the movement does not significantly change the recorded position of the subject, it impacts the established spin gradients, which introduces artifacts into the image sequence. Movements cause the orientation of existing spin gradients to change, and the gradients require time to realign to the magnetic field. This recovery time often results in a decrease in the global signal in frames obtained over the following 8-10 seconds, which can affect the functional connectivity analysis [Power et al., 2014].

The effects of motion on rs-fMRIs can be clearly divided into two categories: the effect on patient position and the effect on the recorded BOLD signal.

The effect of motion on patient position is measured in terms of the difference in position between temporally neighboring image volumes. The difference in position is determined using metrics calculated by performing rigid volume registration on the two volumes. In rigid volume registration, one volume is chosen as the reference volume and the other is considered the moving volume. The reference volume remains stationary while the moving volume is translated and rotated in three-dimensional space on top of it. The registration is considered successfully complete when the position of the patient in the moving volume matches the position in the reference volume. The three translation and three rotation parameters used to achieve this alignment are used to calculate the positional change between the image volumes, which is often called the framewise displacement (FD).

Several researchers have proposed different methods for calculating the FD. Power et al., Jenkinson et al., and Dosenbach et al. each propose a slightly different method for

calculating the FD [Power et al., 2012] [Jenkinson et al., 2002] [Dosenbach et al., 2017]. All three FD calculations produce correlated metrics: the FD metric proposed by Power et al. produces measurements approximately twice as large as the metric proposed by Jenkinson et al., and Dosenbach et al. reported a high correlation between their FD and Powers FD [Yan et al., 2013] [Dosenbach et al., 2017].

The effects of motion on the BOLD signal are a little more difficult to measure. They occur because motion disrupts the magnetic spin gradients present in the patient during the scan. The spin gradients need time to recover to the correct magnetic field orientation, and up to eight to ten seconds may pass before the recovery is complete [Power et al., 2014]. While the spin gradients are reorienting, the recorded BOLD signal may vary between temporally neighboring volumes. These changes can be measured using the temporal derivative of the variance in the BOLD signal intensity (DVARS) between the frames [Power et al., 2012].

Even though the effects of motion on the patient position and the recorded signal can be measured, we still need gold standard criteria to determine whether an image containing motion can be used. Patients move slightly due to breathing and cardiac function, and the BOLD signal naturally fluctuates over time. Some motion is expected; however, we need to know how much motion can be present in the image before it is considered to be corrupted by it. Power et al. established thresholds for FD and DVARS to determine the usability of a pair of images:

- FD less than or equal to 0.2 mm from previous volume, and

- DVARS less than or equal to 25 units on a normalized scale of [0, 1000] signal units [Power et al., 2014]

Image volumes that meet these criteria are considered to be low-motion. van Dijk et al. established that approximately five minutes of low-motion data is sufficient for use in functional connectivity analysis [van Dijk et al., 2012]. Unfortunately, it is often difficult to obtain enough low-motion data from patients to use in these analyses.

2.3 MOTION PREVENTION

Various techniques and protocols have been developed to prevent patients from moving during the image acquisition process. Not all of these techniques are suitable for all patient populations, and some techniques have been designed specifically for certain populations populations.

2.3.1 Sedation

Sedation can be used to help a patient tolerate an MRI scan. Murphy and Brunberg retrospectively analyzed seven weeks of data from the MR department and found that 14.2% of their adult patients some form of sedation [Murphy and Brunberg, 1997]. In a study about claustrophobia and MR acquisitions, ELEPHANTS report that out of 55,734 patients who underwent MRI scans, a total of 1,004 patients experienced claustrophobia and 610 of these patients required intravenous sedation before their scans [Dewey et al., 2007]. Even though sedation allowed the patients mentioned in this paragraph to undergo an MRI scan, the authors of both studies note that sedation can result in adverse events and advise the reader to avoid patient sedation if possible.

Sedation can be used with pediatric patients, though the risks are more significant than with adult patients. Studies have shown that sedation for pediatric imaging can lead to hypoxemia and inappropriate sedation levels during image acquisition [Malviya et al., 2000]. Some pediatric patients can also expect "motor imbalance and gastrointestinal effects," as well as agitation and restless for a period of hours after waking from sedation.

A report from the American Academy of Pediatrics and the American Academy of Pediatric Dentistry outlines the minimum set of criteria needed for a pediatric patient to be sedated for a procedure [Coté and Wilson, 2016]:

- The patient must be a suitable candidate for sedation based on their medical history and medical needs.
- At least one responsible person must be with the patient at the medical factility, though the report recommends that two adults are present for patients who use car seats to

travel to and from the facility. This practice ensures that one adult can monitor the patient after the procedure while the other adult drives.

- The clinician administering the sedation must have immediate access to emergency facilities, personnel, and equipment and should monitor the patient for adverse events including respiratory events, seizures, vomiting, and allergic reactions.

- There must be a clear protocol outlined for immediate access to these emergency services.

- Emergency equipment and drugs appropriate for the patient's size and age must be immediately available in case the patient needs to be resuscitated.

- Informed consent must be obtained prior to the procedure.

- Instructions for what to expect and how to transport the patient home safely must be provided to the patient's responsible adult.

- The patient may be held at the facility for prolonged monitoring after the procedure.

- The patient's food and drink intake prior to the procedure should be taken into account to minimize the risk of pulmonary aspiration.

- The patient's health status must be evaluated and verified by the sedation team prior to the procedure.

- The information about the procedure must be correctly documented.

- The facility should have a dedicated recovery area, and the status of the patient should be recorded when he is discharged. The patient should not be discharged if his level of consciousness and oxygen saturation do not meet recognized guidelines.

This report clearly states that the levels of monitoring suggested within should serve as minimum levels of involvement: clinicians should increase patient monitoring as needed for complex cases. Rutman has a similar and detailed perspective on patient monitoring during and after sedation, suggesting that two independent medical personnel should be present during the scan and one should be present until the patient is discharged [Rutman, 2009]. Rutman also notes that all sedation and monitoring equipment must be MR compatible, which is a simple but important safety constraint. This constraint may make sedation less advisable if the appropriate equipment is not available.

Sedation in neonatal and infant populations is not recommended. The U. S. Food and Drug Administration (FDA) issued a warning in late 2016 about repeated use of sedation or

general anesthesia in patients under three years of age or in pregnant women in their third trimester [FDA, 2016]. The warning states that while a single, relatively short exposure to sedative and anesthetic drugs is unlikely to impact the patient, the effects of prolonged exposure to these drugs are still being studied. Studies of sedative and anesthetic drugs in multiple animal models have shown that these drugs can lead to loss of nerve cells in the brain when the animals undergo prolonged, repeated exposure to them during period of brain development. More data is needed to determine if this effect translates to humans.

2.3.2 Education, Distraction, and Behavioral Techniques

Educational material can be used to help the patient understand what to expect during an MRI scan as well as to teach the patient different behavioral coping strategies. The education materials can be used either before arrival at the imaging facility or upon arriving at the imaging facility.

Most of the formal literature focuses on educational, distraction, and behavioral techniques to use during pediatric MRI scans. Many of the following approaches could be adapted for use with adults.

In a review of the available literature, Alexander found several commonly used techniques to educate, comfort, and distract pediatric patients during radiology procedures. Tools such as educational coloring books and short videos can expose patients to the types of equipment they can expect to see using a familiar, engaging medium. Pediatric patients can learn coping strategies to employ during the scan such as breathing techniques, imagery, and positive statements. Alexander notes that allowing a pediatric patient to choose a behavioral coping strategy gives the patient a sense of control and may encourage the patient to cooperate during the MRI acquisition [Alexander, 2012].

Mock scanners and MRI simulators can also help the patient feel more comfortable during the scan. Barnea-Goraly et al. showed that both a commerical MRI simulator and a low-tech mock scanner desensitized pediatric patients between four and ten years of age to the MRI scanner with the results that 92.3% of the acquired images could be used in high-resolution anatomical studies [Barnea-Goraly et al., 2014].

During the MRI acquisition, headphones with music or stories and MR compatible video goggles can distract patients [Alexander, 2012] [Barnea-Goraly et al., 2014] [Harned and Strain, 2001]. Garcia-Palacios et al. performed a case study comparing the efficacy of music and immersive virtual reality tools as distractions during a mock scan [Garcia-Palacios et al., 2007]. They suggest that immersive virtual reality may help decrease patient anxiety during a scan more effectively than music alone.

Another source of distraction for pediatric patients could be the patient's parent or parents. Having a parent involved with the scanning process may calm the patient and encourage him to cooperate; however, patients can become distressed if their parent is distressed [Alexander, 2012].

2.3.3 Sleep Methods for Neonates

2.4 MOTION CORRECTION

2.5 VOLUME REGISTRATION

Liao et al. suggested that a rs-fMRI sequence could be viewed as a hidden Markov model, and reflected this idea in their suggested registration framework [Liao et al., 2016]. Their framework uses the transformation of the previous volume to the reference volume as the initial transformation for the current volume and the reference volume.

3.0   CONCLUSIONS

This is the second chapter of the present dissertation. It is more interesting than the first one, for it is the last one.

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