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Final Degree Project

**Biomedical Engineering Bachelor**

**“Predictive modelling of Loss Of Consciousness under general anaesthesia“**

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**Abstract**

Loss of consciousness in general anaesthesia induction is a process of great interest not only in study and understanding of human consciousness, but particularly in the evaluation of the state of a patient in an operating room. This project creates and evaluates a simple ML model for binary consciousness classification under TIVA propofol-remifentanil TCI mediated general anaesthesia. Using as only inputs NIBP, Heart rate and Propofol and Remifentanil effect site concentrations the model is capable of determining the state of arousal of the patient between conscious and unconscious at every moment.

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# Introduction

This project has been conducted at the Systems Pharmacology Effect Control-Modelling (SPEC-M) Reserch Group of the Department of Anaesthesiology of the Hospital Clinic of Barcelona.Data collection was performed in the Operating Room (OR) number 4 of the Major Ambulatory Surgery Unit of the Hospital Clinic. The data used in the project has been collected inside this OR.

## Objectives

The objectives mentioned below are conceived around the expressed interest of the anaesthesiology team to have a fast prediction of the level of consciousness ie the moment of achieving uncosnciousness. Even though anaesthesiologists have great knowledge in this matter, no predicted parameter is now a days used to directly approach this state of arousal patients and the anesthesiologist should rely on indirect measures of unconsciousness such as the electroencephalogram.

Therefore, the principal aims of this project is **to generate, train and validate a model in order to predict the level of Loss of Consciousness (LoC) of a patient undergoing general anaesthesia with the administration of Propofol and Remifentanil**.

In order to achieve the main goals of the project, several sub-goals are defined:

Firstly, it is crucial to **get deeply familiarized with the surgical environment, anaesthetic procedures and methods, and recorded physiollogical parameters**, which will be done through practical sessions in gynaecological operating room 4 during two whole months.

Last but not least, it is necessary **to properly use a control version software**, generating a commit every time an improvement has been made on the code until the final application is done, and correctly handling possible errors.

## Methodology and Structure

### Version Control System

In order to achieve the goals of the project, a version control of the working methodology has been applied. Specifically, a Git Version Control System on GitHub has been implemented. These systems are used to generate parallel branches of entire working directories or folders from master (original) one so several people can work parallelly on different issues related to the same code or files, without overlapping issues. Git repositories have the option to merge the work done to the original file, the same way your colleagues do, and to therefore integrate all the work done.

This approach is also useful for a unipersonal project, as this methodology is utterly strict with the improvements to be uploaded in the Git repository. The point is that the user keeps making commits to GitHub, that is analogous to “saving”, when you develop a part of the whole implementation you must do. When the whole work is done, you merge the branch you were working to the original one, containing a working code just without the implementation you just created. This way GitHub not only permits correct organisation of improvement implementation of the code through branching as seen in the figure below, but it lets the user return to earlier commits in time if there has been any problem and recovering a code that does work properly. The commits in Figure 1 are shown as coloured dots, and all the line with same colour dots is a branch. The whole of the image would represent a coding project.

Diagram, schematic

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Figure 1: Git structure (Noble desktop, 2021).

As seen in the Figure to the left, two people (or more) can work simultaneously on different branch implementations and later merge them into the original master branch. On the other hand, it can be the same person working parallelly on different implementations, which is our case.

### Project Structure

The structure of the project is composed of several files divided in two main groups: Model and Report. Regarding the Model group, there are several files explained below and in the Report group there is this word document containing all the information of the project.

Inside the model group we can find several archives: The archives folder; containing the CSV files of the patients’ data, the “TrainTestMatrices” folder; containing the CSV files with the data frames used to train and test the models, the “.pickle” archives; which are the already trained models for later usage, “.png” images of plots; generated inside the code for model explanation, and last but not least four python files containing the code of the project. These four python files are called libraries.py, Train\_Test\_adquisitions.py, Model.py and example.py.

* libraries.py: includes all the libraries needed and is directly imported to the other “.py” files for their use.
* Train\_Test\_adquisitions.py: Takes the raw data from patients CSV and pre-processes it, selecting the patients matching the needs of the model and taking the given seconds around the target event of LoC. Later it cleans the data and separates it for model training and testing.
* Model.py: Takes the output data from previous file and trains and tests the models, and saves them for later use
* example.py: Taking the model already trained and validated, takes a new patient and computes its moment of LoC.

The documents structure is shown in the Figure below, as it is presented in GitHub webpage.

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Figure 2: GitHub archives distribution.

This four-file code structure has been chosen because functional programming, which is based on defining the functions (duties) of the code in a file and implementing them on another, generates much clearer and understandable codes. Furthermore, comments have been written all over the four archives to further improve their understanding.

### Project workload

The structure of the project is divided in three differentiated temporal sections corresponding to the main three workloads of the project:

* Practical sessions in the operating room
* Working from home on the data and documents
* Document submission and personal presentation.

Firstly, practical sessions in the OR take place, where data is collected from the anaesthesia and surgical procedures in OR-4 of the Major Ambulatory Surgery Unit on Tuesdays and Thursdays from September until November. In this section, Dr. Pedro Gambús guides the recording and collection of the intraoperative data and gives explanations around the activity undergone in the operating room and the parameters recorded.

Secondly, work from home takes place. In this section procedures like data analysis and document preparation are performed. Data preparation and model building, training and validation are performed using python language and Visual Studio Code user interphase. The packages used in the data analysis are a wide range, with special mention to scikit-learn. This package is a python package specifically designed for ML programming. In this section PhD undergraduate Joan Altés guides the programming process.

Finally, documents submission and presentation take place.

# Background

In interventions under general anaesthesia some methods are used by the anaesthesiologists in order to determine the state of consciousness of the patient. Typical examples of clinically relevant functional measurements to determine LoC are presence or absence of verbal response to an homogenous command, loss of eyelash reflex, and presence or absence of corneal reflex,. If the three of them are negative or absent, the patient is considered to be unconscious, thus permitting further actions such as securing the airway by means of a laryngeal mask or laryngoscopya and intubation followed by the surgical procedure itself. [podria haverhi referencia]

This clinical assessment has been frequently endorsed by the introduction of indexes, mostly extracted from EEG signal processing, that try to indirectly indicate the depth of hypnotic effect of the patients. Bispectral Index (BIS) is an example of this approach, which gives a value between 0-100, being 0 complete absence of electrical activity in the frontal neurons and 100 completely conscious. Recommended optimal values of BIS under general anaesthesia range from 40-60 (Mathur S, 2021 Jan-. Available).

In the approach proposed, the goal was to generate an index independent from EEG but trained to identify at every second the state of consciousness of the patient through training with previous patients’ recorded data of easy access, such as NIBP, HR, and propofol and remifentanil effect site concentrations.

### General Anaesthesia

General anaesthesia is a drug induced reversible state of loss of consciousness, with loss of both protective reflexes as well as lack of perception of painful stimulation (Smith G, 2021). Depending on the anaesthetics administered and their effects in the brain and muscles the effects of the anaesthesia are discerned in four different parts: unconsciousness or hypnosis, analgesia, amnesia and skeletal muscle relaxation. (Siddiqui BA, 2021)

That general anaesthesia is a reversible coma state of the patient is a widely accepted statement in the clinical environment. Although the patterns of EEG activity observed in comatose patients depend on the extent of the brain injury, they frequently resemble the high–amplitude, low-frequency activity seen in patients under general anaesthesia, therefore supporting this analogy (Emery N. Brown, 2010). This comparative rises an immediate question: How much anaesthetics are enough for an intervention under general anaesthesia? The desired effects upon CNS does not remain isolated: when anaesthetic drugs are administered a wide range of other parameters such as HR, Contractility, SVM, MAP and respiratory functions are modulated. Once the desired therapeutic effect is achieved, further increasing concentrations of anaesthetics generally enhance these undesired effects of the drugs both within the surgical procedure and less drastically throughout the recuperation process. It is therefore accepted that the optimal concentrations of anaesthetics in a surgical procedure is the one that achieves the desired therapeutic effects and not more than that (Khurram Saleem Khan, Sept. 2013, págs. 100-105).

Table 1: Systemic effects of i.v. agents. SVR, systemic vascular resistance; MAP, mean arterial pressure; CBF, cerebral blood flow (Khurram Saleem Khan, Sept. 2013, págs. 100-105)

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The final desired therapeutic effect when performing general anaesthesia is to achieve the LoC state of the patient, where the effect of the anaesthetics is strong enough to start with the surgical procedure without risk of awakening of the patient, but avoiding the undesired increased effect of administering too much anaesthetics as shown in Table 1.

Several pharmacological models and approaches such as Target Controlled infusion (TCI), EEG suppression analysis and BIS analysis have been implemented to achieve the goal of administering only the dose of anesthetic drugs required to achieve the desired effectto individualize drug dosing (Guarracino F, 2005) and will be further discussed in the Anaesthetic drugs and Anaesthesia monitoring chapters respectively.

#### States of anaesthesia

As stated in the previous section, the states of anaesthesia are not part of a continuous process towards being under general anaesthesia, but the different effects expected from anaesthetic drugs which might be necessarily combined to achieve the therapeutic effect necessary to start the intervention safely. These states of anaesthesia are unconsciousness, which refers to patients’ unawareness state; analgesia, which refers to patients’ incapacity of feeling painful stimuli; amnesia, which refers to patients’ inability to remember; and akinesia, which refers to patients immobility.

**Hypnosis and unconsciousness**

The state of hypnosis, which is analogous to unconsciousness, is typically defined as a state of impairment of cognitive functions in the patients’ brain that blocks patients’ adequate response to external stimuli, regarding attention and perception (Jason A. Campagna, 2003). Hypnosis is induced by hypnotic agents such as propofol, and there are several levels of hypnosis evolving in a continuum of deeper intensity of effect for instance: drowsiness, sedation and unconsciousness.

The mechanisms of action involved in the process of hypnosis have not yet been determined accurately as a whole. Nevertheless, in the last decades it has been shown that different molecular targets in various regions of the nervous system are involved in the multiple components of anaesthetic action, and these targets can vary between specific anaesthetics. When talking about unconsciousness induction the main inhibitory neurotransmitter involved is Gamma-aminobutyric acid (GABA). This neurotransmitter acts selectively modulating GABAA receptors (Hemmings HC Jr, (2005), págs. 503-510), which are ligand-gated ion channels persistently opening the channels and therefore inhibiting synapses in big areas of the brain (Hemmings HC Jr, 2005).

Even though several indexes mostly related to EEG have been used to quantitate the level of hypnosis of patients under general anaesthesia, our intraoperative ability to evaluate levels of consciousness still remains limited. An example of this approach is Bispectral index (BIS), but further research in this field is still necessary to construct deterministic models involving hypnosis induction and its effects upon patients.

**Analgesia**

In 2020 the International Association for the Study of Pain proposed a review of the definition of pain. The new accepted definition stated that pain was "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage" (Srinivasa N Raja, 2020). Therefore, analgesia could be defined as the state of mind that permits the inhibition of painful sensations in situations where it would be expected, such as in tissue damage derived from surgical action.

**Amnesia**

The term amnesia refers to the impossibility of a patient to remember or recall any moment or event that they perceived during the transient state. Hypnotic agents cause unconsciousness by suppressing neural mechanisms mediating arousal and awareness, but they can also cause amnesia by disrupting mechanisms of memory consolidation.

When a high enough dose of a hypnotic agent is administered, information from the outside world is not processed by the patient and, thus, no conscious memories are formed. In this sense, all hypnotic agents are amnesic at a certain dose (Robert A. Veselis, 2009, pág. 2). Furthermore, hypnotic agents acting on GABA receptors such as propofol might have amnesic effect even at lower sedative doses (Robert A. Veselis, 2009, pág. 1).

**Akinesia**

The term akinesia refers to the inability to perform a clinically perceivable movement. It can present as a delayed response, freezing mid-action, or finally total abolition of movement (Ramakrishnan S, 2021). In general anaesthesia akinesia is typically achieved by means of hypnotic and analgesic agent combination although depending on the type of surgery and anesthetic drugs and doses used, it is sometimes necessary to administer a neuromuscular blocking agent, such as Rocuronium, to achieve muscle relaxation to avoid movement or even muscle contraction during the course of the surgical intervention.

#### Anaesthetic drugs

Anaesthetic drugs are the chemical compounds administered to patients in order to achieve the different states of anaesthetic desired. Depending on if the desired effect is local anaesthesia, sedation, general anaesthesia, or others the anaesthetic drugs, their quantities and the way of administration are chosen.

Anaesthesia drugs can either be inhalational or intravenous. Inhalation anaesthesia techniques means an intravenous induction usually with propofol combined with remifentanil or other opioid as analgesic drug, followed by a maintenance with an inhalation anaesthetic such as desflurane of sevoflurane combined with an intravenous opioid to avoid response to noxious stimulation. Total intravenous anaesthetics (TIVA) refers to the administration of anaesthetic agents via intravenous route during the whole anaesthetic procedure including induction and maintenance. Compared to inhalational anaesthesia, TIVA shows several benefits including better hemodynamic stability, better recovery conditions and reduced post-operative incidence of nausea and vomiting (Total Intravenous Anesthesia (Tiva)- A Brief Review., 2018).

The infusion of TIVA can either be administered manually through an initial bolus injection, or through the usage of algorithm-mediated infusion pumps, such as TCI.

**TCI**

Progress in computing technology has allowed the development of target controlled infusion devices, with drugs delivered to achieve specific predicted target site blood drug concentrations. Target controlled infusion (TCI) systems have been developed as a standardised infusion system for the administration of opioids, propofol and other i.v anaesthesics. Pharmacokinetic-pharmacodynamic (PKPD) models including demographic covariate factors such as age, weight, gender and height are incorporated in the control system of the infusion pump. After entering in the infusion device the demographic data relevant as significant covariate factor for the PKPD model, the user sets the target concentration desired to be achieved either in plasma or effect site. According to the PKPD model, every ten seconds the systems injects the bolus dose of drug required to achieve the target concentration selected. Then it maintains such target concentration constant during the time required. The latter being done by adjusting the rate of a constant infusion to compensate for the amount of drug distributed from the blood to the tissues as well as the drug that is being cleared from the organism.(Wilson, 2017). (Guarracino F, Target controlled infusion: TCI., 2005).

In the figure below we can see the comparison of a bolus injection (right) versus target-controlled infusion (left). The Blue line is the plasmatic concentration of propofol, the red line is the effect site concentration, and the green line is a measure of the hypnotic effect. Here we can observe that through TCI systems we achieve a more stable and controlled effect of the anaesthetic agent, propofol in this specific case.

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Figure 3: Bolus vs TCI anaesthetic infusion (Brian J.Anderson, 2019, págs. 177-198)

Regarding drug classification, anaesthetic drugs are divided first on their effect and later on their type. Most common drug types used in TIVA are hypnotic and analgesic drugs, sometimes combined with other directly injected i.v drugs if necessary, such as Rocuronium for muscle relaxation. In the Hospital Clinic a mixture of propofol and Remifentanil is used, as this hypnotic and analgesic altogether have demonstrated to create a synergic effect, achieving the desired therapeutic effect with less concentration of both drugs (Mertens MJ, 2003).

Table 2: Most used Total Intra Venous Anaesthetics (Roop Kaw, 2014).

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**Propofol**

Propofol is an intravenous hypnotic agent used for procedural sedation, during monitored anaesthesia care, or as an induction agent for general anaesthesia. It may be administered as a bolus or with TCI. Propofol is prepared in a lipid emulsion which gives it the characteristic milky white appearance. Strict aseptic technique must be used when drawing up propofol as the emulsion can support microbial growth (Folino TB, 2021).

Propofol also induces amnesia, as stated in the chapter 2.1.1.1 States of anaesthesia, as information from the outside world is not processed by the patient and, thus, no conscious memories are formed. This anaesthesic agent interacts with GABA receptor mediated ionic channels between others, as shown in figure below.

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Figure 4: Neurophysiological mechanisms of propofol’s actions in the brain. Propofol enhances γ-aminobutyric acid receptor type A (GABAA)-mediated inhibition in the cortex, thalamus, and brainstem. Shown are three major sites of action: postsynaptic connections between inhibitory interneurons and excitatory pyramidal neurons in the cortex; the GABAergic neurons in the thalamic reticular nucleus (TRN) of the thalamus; and postsynaptic connections between GABAergic and galanergic (Gal) projections from the preoptic area (POA) of the hypothalamus and the monoaminergic nuclei, which are the tuberomammillary nucleus (TMN) that releases histamine (His), the locus ceruleus (LC) that releases norepinephrine (NE), the dorsal raphe (DR) that releases serotonin (5HT); the ventral periacqueductal gray (vPAG) that releases dopamine (DA); and the cholinergic nuclei that are the basal forebrain (BF), pedunculopontine tegmental (PPT) nucleus, and the lateral dorsal tegmental (LDT) nucleus that release acetylcholine (ACh). Also shown is the lateral hypothalamus (LH) that releases orexin (Patrick L. Purdon, 2015, págs. 937–960).

Upper figure shows the inhibitory action of propofol in various sites of the brain, including cortical and subcortical structures. The disconnection between these two cerebral structures has been widely discussed to be the main component in loss of consciousness in patients anaesthetised with this drug (P. Guldenmund, 2015).

**Remifentanil**

Remifentanil, a fentanyl derivative, is a short acting, nonspecific esterase metabolised, selective mu-opioid receptor agonist, with a pharmacodynamic profile typical of opioid analgesic agents. Notably, the esterase linkage in remifentanil results in a unique and favourable pharmacokinetic profile for this class of agent. Adjunctive intravenous remifentanil during general anaesthesia is an effective and generally well tolerated opioid analgesic in a broad spectrum of patients, including adults and paediatric patients, undergoing several types of surgical procedures.

As mentioned in the section 2.1.1.1 States of Anaesthesia, remifentanil is used as an intravenous analgesic and usually infused together with propofol, as they have presented a synergic combination achieving the same therapeutic effect with less concentration of both agents (Mertens MJ, 2003).

**Rocuronium**

Rocuronium bromide is an amino steroid non-depolarizing neuromuscular blocker or muscle relaxant used in modern anaesthesia to facilitate tracheal intubation by providing skeletal muscle relaxation, commonly required for surgery or mechanical ventilation. Rocuronium is also commonly used to avoid unvoluntary hiccups while operating.

In general, neuromuscular blocking agents are divided between depolarizing and non-depolarizing. Depolarizing muscle relaxants act as acetylcholine (ACh) receptor agonists, whereas nondepolarizing muscle relaxants function as competitive antagonists as seen in figure below (Butterworth, 2013, pág. chapter 13).

Diagram

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Figure 5: Action of neuromuscular blockers on Acetylcholinergic ion channels (Marieke Kruidering-Hall, 2016)

When comparing, non-depolarizing blockers are reversed by [acetylcholinesterase inhibitor](https://en.wikipedia.org/wiki/Acetylcholinesterase_inhibitor" \o "Acetylcholinesterase inhibitor) drugs since non-depolarizing blockers are competitive antagonists at the ACh receptor so can be reversed by increases in ACh. On the other hand, the depolarizing blockers already have ACh-like actions, so these agents have prolonged effect under the influence of acetylcholinesterase inhibitors. Administration of depolarizing blockers initially produces fasciculations (a sudden twitch just before paralysis occurs). This is due to depolarization of the muscle. Also, post-operative pain is associated with depolarizing blockers (Neuromuscular blocking agents, 2021).

### Anaesthesia monitoring

#### Basic anaesthesia monitoring

Anaesthesia monitoring is a crucial control system to guarantee the correct physiological state of the patient under surgery. Several sensors are used to record data based on biomedical signals and biomedical parameters in order to analyse in situ the correct state of the patient and also to later process the data to obtain information and generate models, as it is the goal of this project.

The list of variables recorded in the CMA OR number 4 through anaesthesia monitoring are the following:

Table 3: Recorded variables in this project. Redundant variables have been excluded, and we the same variables recorded for propofol have been recorded for remifentanil. (Altès, 2020, pág. 26)

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**Electrocardiogram**

Electrocardiogram (abbreviated as EKG or ECG) is a relationship between voltage and time recorded from cutaneous electrodes positioned in different derivations. Willem Einthoven first invented it in 1902. An EKG is an integral part of the initial evaluation of a patient suspected of having a cardiac-related problem or, in our case, a biomedical signal recorded in the OR to detect cardiac abnormalities throughout the operation, either way produced by the general anaesthesia or the operation itself (Yasar Sattar, 2021).

Several parameters can be derived from ECG as heart rate (HR) and ST segment. HR changes might have relationship with hypnotic and analgesic effect (Jeanne, 2009, págs. 91-96). It is generally desirable to maintain HR between 40 and 100 beats per minute during an intervention.

**Arterial blood pressure**

Arterial blood pressure can be measured invasively for accurate results, throughout the use of an arterial catheter with a pressure transducer attached to the end. This invasive approach is usually introduced in the radial arteria. On the other hand, non-invasive arterial blood pressure (NIBP), which is the usual approach unless specific indications are met, is measured with an automated oscillatory cuff every ... seconds (Gbenga Ogedegbe, 2010, págs. 571-586).

It is desirable to keep mean NIBP above 60mmHg and systolic NIBP and diastolic NIBP below 140 and 90mmHg, and there are drugs available to modulate the NIBP of the patient.

**Pulse oximetry**

Pulse oximetry is a non-invasive method to measure the oxygen saturation in the blood by emitting light at specific wavelengths through tissue (most commonly the fingernail bed). Deoxygenated and oxygenated haemoglobin absorb light at different wavelengths (660 nm and 940 nm respectively), the absorbance at the characteristic wavelengths is then assessed to give a saturation value from 0 to 100% (Torp, Modi, & Simon., 2021).

**Capnography**

Capnography is the monitoring of the concentration or partial pressure of carbon dioxide (CO2) in the respiratory gases. During general anaesthesia the patient is intubated, and capnography shows the effectiveness of CO2 elimination through the lungs into the anaesthesia equipment. It is therefore useful to assess the correct intubation of the patient. Indirectly, it monitors the production of CO2 by tissues and the circulatory transport to the lungs (Pandya & Sharma., 2021).

#### Advanced monitoring systems

##### Electroencephalogram

EEG is the recording of electric activity of the pyramidal neurons of the brain cortex. It can be shown as a continuous graph of voltage against time. The electric activity recorded corresponds to the anatomical cortical area where electrodes have been located. It is a contouous non-invasive measure of brain activity. It consistently reflects the changes induced by anesthetic drugs. It might indirectly reflect activity from subcortical regions due to their straight electrical interaction (Patrick L. Purdon, 2015, págs. 937-960). Several amthematical approaches have been proposed and used to analyze the complexity of EEG. Fourier analysis performed through the so called Fast Fourier Transform algorithm to the EEG the signal allows to quantitate activity in the frequency domain (Shaker, 2003).

A picture containing text, outdoor, sky, document

Description automatically generatedMany of the changes that occur in the brain with changes in consciousness states of the patients can be readily observed in unprocessed EEG recordings. Different behavioural and neurophysiological states induced by anaesthetics are associated with different EEG waveforms. For example, the figure below shows the EEG of the same patient in different states of propofol-induced sedation and unconsciousness (Patrick L. Purdon, 2015, págs. 937–960).

EEG patterns in general anaesthesia are altered depending on the drugs used, the dose and duration of infusion, with significant variance between subjects. In general anaesthesia low frequency, high amplitude EEG profiles are enhanced as unconsciousness deepens (Emery N. Brown, 2010).

Furthermore, in section F of the figure we can observe a burst suppression event, where periods of high amplitude and frequency (called burst) are followed by low frequency and amplitude, even isoelectric zones (the suppression). It is a sign of unnecessarily high level of unconsciousness, and the facultative normally uses this information to adjust the anaesthetic dose or infusion rate.

Figure 6: EEG time domain visualizations in different unconsciousness levels (Patrick L. Purdon, 2015, págs. 937–960)..

As the raw EEG is complex to analyse by the non-expert user, several approaches of EEG-based indexes have been developed to information of the state of the patient. This indexes generally extract parameters from the EEG through signal processing techniques, for later introducing this information into a confidential algorithm to obtain a 0-100 index representative of the state of unconsciousness of the patient (Mathur S, 2021 Jan-. Available).

Bispectral Index (BIS) is one of the most popular EEG-based indexes, and it has been designed to assess the hypnotic effect of anaesthesia, being 0 complete absence of electric activity of the frontal neurons and around 100 completely conscious. BIS monitoring has shown to impact positively in patients’ time of extubation, postoperative recovery, memory loss and cognitive impairment in general (Carlos Rogério Degrandi Oliveira, 2017 Jan-Feb, págs. 72-84).

The main drawback of EEG as a monitoring biosignal is that it is an advanced monitoring approach, being slightly difficult to place, interpretate and with fungible sensors of relatively high price. Unlike ECG, EEG is not used in all the surgical interventions.

### Model theory

In general terms a system can be defined as a box (or transfer function), with a process happening inside of it, which takes some input arguments and delivers some output results. Depending on the processes inside the box and the type of inputs and outputs the system can be classified in several ways. If the process inside the box is not known, it is called a black box.

Graphical user interface, application

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Figure 7: Example of a black box system transforming some discrete data (blue) to continuous (red).

As a matter of fact, any type of modelling is intrinsically a representation, numerical or not, of the part of the world surrounding us we wish to study. When models are developed, some input variables or characteristics are used, and some others are excluded; it is therefore straightforward that a models can be good enough to be useful or not but will never pretend to explain a real process in its whole complexity. Otherwise, they will try to simplify the studied system in a way the results have significance.

If a given system is particularly a mathematical model, which is a representation of the reality based on mathematical relationships, it can be classified in several ways explained below (Pospeev, 2019):

* Deterministic vs probabilistic: The model’s output is the same always for a given set of input values, or otherwise it has an intrinsic randomness which makes the output values vary even for the same set of input values. In this last case we usually see that state variables of the system are not described by unique values, but for probabilistic equations.
* Static vs. dynamic: State variables in static models are not time dependant but in steady state, while in dynamic models state variables do depend on time.
* Discrete vs. continuous: The equations inside the model follow a continuous paradigm or a discrete one. For instance, the parameters we measured in the OR room were recorded every 1 second, so our model will be discrete.
* Linear vs. nonlinear: Referring the distribution of the mathematical approximations to represent reality, if they are based on linear relationships or of higher order relationships.
* Etc.

#### Predictive modelling

When talking about predictive modelling, the adjective predictive stands for its finality to obtain information about what is going to happen in the future based on information of the past.

For instance, sophisticated predictive models are used to predict health events in patients and to screen high risk individuals, such as for predicting cardiovascular disease, breast cancer or anaesthetic complications and events. Predictive modelling does not inherently belong to any of the classifications stated above but takes different forms depending on its characteristics and those of the algorithms inside it.

Diagram

Description automatically generatedTherefore, a model is predictive if it uses information from the past, e.g., past examples, in order to achieve a future prediction or output result. Even though the term Machine Learning model is frequently used, what we are handling is a predictive model, which inside it we are using a ML algorithm. Also, methods and algorithms used inside the model can be of several types and origins: basic statistics, time-dependant causal equations, AI algorithms such as ML and DL, and a long etcetera.

Diagram

Description automatically generated

Figure 8: Visualization of algorithms vs. artificial intelligence vs. machine learning vs. deep learning (Author: Johannes Vrana, Vrana GmbH, Licenses: CC BY-ND 4.0)

Figure 9: Predictive modelling scheme (Parthasarathy, 2021)

But what is exactly ML and what has in common with AI? AI is a set of algorithms and techniques which pretend to mimic or assemble human like mental processes to accomplish tasks which usually require of human intelligence. ML is a subset of the AI paradigm, which is characterised by being capable of learning without being explicitly programmed. Finally, DL is a subset of ML characterised by a brain-like net of artificial neural networks (NN) which the DL algorithm uses to learn, also without being explicitly programmed but using vast amounts of data.

##### ML algorithms

In this section we will review three of the most spread ML algorithms, Support Vector Components, Random Forest Classifier and K-Nearest neighbour.

**Support Vector Machine**

SVM is a supervised machine-learning algorithm that provides classification, regression, and outlier detection. SVM learns by creating a separating “line” between the two class points of the training data (e.g. drawn in a x-y plane). This “line”, which actually is a hyperplane, must perfectly separate the two classes, and its distance from both classes is to be maximized (Pushpa Singh N. S., 2021, págs. 80-111).

Chart, scatter chart

Description automatically generated

Figure 10: SVM diagram (Pushpa Singh N. S., 2021, págs. 80-111).

Still regarding learning, the closest points to the margin (the hyperplane, also call decision boundary) are called “Support Vectors” and are the ones defining the behaviour of the SVM. The distance from the points to the decision boundary is computed, and, and the minimum value of this whole is considered the functional margin of the model respect to the dataset. Obviously, the larger the functional margin, the better predictive characteristics will be present in the model. Finally, if it is not possible to separate the two classes through a linear approach, the “Kernel trick” is use, meaning that the model projects the los dimensionality information provided to higher dimensional spaces where the separation easier (Pushpa Singh N. S., 2021, págs. 80-111).

Finally, after the training is done, the classifier just draws the new data, the one to be predicted, into the same plane, and depending on the side of the hyperplane where it falls it will be classified as one class or the other.

Diagram

Description automatically generated**Random forest classifier**

Figure 11: Random Forest classifier diagram (Siddharth Misra, 2020, págs. 243-287)

RF classifier is an ensemble method that trains several decision trees in parallel with bootstrapping followed by aggregation, jointly referred as bagging. Bootstrapping indicates that several individual decision trees are trained in parallel on various subsets of the training dataset using different subsets of available features, as seen in Fig.9. Bootstrapping ensures that each individual decision tree in the random forest is unique, which reduces the overall variance of the RF classifier (Siddharth Misra, 2020, págs. 243-287).

Regarding the ensemble of trees, each internal node (seen as a circle in Figure 9) represents a 'test' on an attribute (e.g., whether a coin flip comes up heads or tails), each branch represents the outcome of the test, and each leaf node represents a class label (decision taken after computing all attributes).A node that has no children is a leaf (Donges, 2021).

For the final decision, RF classifier aggregates the decisions of individual trees; consequently, RF classifier exhibits good generalization. RF classifier tends to outperform most other classification methods in terms of accuracy without issues of overfitting and does not need feature scaling (Donges, 2021).

***k*-Nearest neighbour classifier**

KNN is a nonparametric, supervised machine-learning method used for classification and regression. Predictions are made for a new input (X) by examining the complete training set and summarizing the value or classification of the K nearest instances. Distance-based methods like Euclidean or Manhattan or Minkowski are used to define the K instances in the training dataset that are most similar or “near” in order to predict the output class label of the new input (X) (Pushpa Singh N. S., 2021, págs. 89-111).

Diagram

Description automatically generated with medium confidence

Figure 12: KNN diagram (Pushpa Singh N. S., 2021, págs. 89-111)

If for instance we take the Euclidean example in figure above, for k=3 we get that out new input X with classification unknown has two blue neighbours and one red, it will therefore be classified as blue. On the other hand, if K=5, we get 4 red neighbours and two blue, and the output would be therefore red.

#### Model performance

Evaluating a model performance is a crucial part of model construction, as the metrics obtained from this analysis and the concrete needs of the problem to be solved or predicted will determine if the model is valid or not for the purpose it was created. In general, several metrics are used to evaluate model performance depending on the type of problem to solve and the model used. In our concrete case, the most common methods used to evaluate ML binary classification model performance are confusion matrix and ROC curve.

**Confusion Matrix**

Confusion matrices represent counts from predicted and actual values. The output “TN” shown in the figure below stands for True Negative which shows the number of negative examples classified correctly as negative. Similarly, “TP” stands for True Positive which indicates the number of positive examples classified as positive. The term “FP” shows False Positive value, i.e., the number of actual negative examples classified as positive; and “FN” means a False Negative value which is the number of actual positive examples classified as negative.

Table 4: Confusion matrix diagram

Table

Description automatically generated

From confusion matrices we obtain these four values, which are later used to compute the metrics which evaluate the model, but they already offer a glimpse of the model performance at first sight. This mentioned metrics are Accuracy, Precision, Recall and F1-Score, which are explained below (Pushpa Singh, 2021, págs. 88-111).

The accuracy of a model is calculated using the given formula below.

Equation 1: Accuracy formula

As shown above, accuracy of an algorithm is represented as the ratio of correctly classified patients (TP+TN) to the total number of patients

Regarding precision or specificity of an algorithm, it represents the ratio of correctly classified patients as positive (*TP*) to the total patients predicted to be positive (*TP*+*FP*).

Equation 2: Precision formula

This metric gives us knowledge about how many patients are actually positive from the whole that has been classified as positive

Recall or sensitivity metric is defined as the ratio of correctly classified positive patients (*TP*) divided by total number of patients are actually positive.

Equation 3: Recall formula

The perception behind recall is how many patients have been classified as positive from the total amount of patients that actually are positive. Recall is also called as sensitivity, meaning the ability of the model to predict a positive when analysing one.

F1 score is also known as the F Measure. The F1 score states the equilibrium between the precision and the recall with the formula below:

Equation 4: F1-Score formula

As seen in Equation 4, F1-score is computed as the harmonised mean between precision and recall. This metric is useful because dumb models predicting unbalanced data can generate an output classifying every sample as the major category, therefore being useless as a classificatior but presenting good metrics in, for instance, accuracy and recall. Harmonised mean (HM) is an operator that strongly penalises extreme values. This means that if precision and recall are different from each other, as in the situation explained above, the HM will penalise the metric more than the arithmetic mean. Therefore F1-score is more sensible to extreme precision and recall values and gives us more meaningful information of the performance of the model (Tavish Srivastava, 2019).

**Receiver Operating Curve (ROC)**

ML predictive models usually provide a probability for the classification, instead of an actual classification, and later a threshold is defined to determine at which probability we consider the value to one output or the other. For instance, if we are classifying binary between 0 and 1, the model gives us a probability of 0.82 to be 1, if we put the threshold at 0.8, the output would be classified as 1, but if we put it at 0.9 it would be classified as 0. It is then desirable to determine at which threshold the model classifies better the observations, and in this scenario is where the ROC acquires importance.

A receiver operating characteristics (ROC) graph is a technique for visualizing, organising, and selecting classifiers based on their performance (Fawcett, 2006, págs. 861-874). But an actual binary classifier represented in a ROC would be drawn as a point. The characteristic curve, which usually resembles something like in the figure below, is the different values of sensitivity and 1-Specificity that present the binary classifier for each of the possible thresholds defined. This way we can assess the point, depending on our interests, where we will define the final threshold of the model.

Chart

Description automatically generated with medium confidence

Figure 13: ROC critical points (Zoronza, s.f.)

In the figure above we can observe some critical points and depending on the problems’ necessities we will choose a point or another as the final threshold. For instance, if it is not so important to detect all real positives but it is to avoid false positives, point B would be chosen as it never classifies a negative person as positive, while it still correctly classifies some of the real positives.

The most common way to assess the whole performance of the model at all the thresholds is to compute the area under the curve (AUC), which is a parameter that goes from 0 to 1, with 1 being a perfectly accurate model, that is, sensitivity equals 1 even when specificity equals 1, and 0.5 representing half of the predictions right, that is, random probability which is illustrated by a straight line from origin to top right corner in ROC curve shown in figure above.

“Lu NOU CONENÇA AQUÍ”

## State of the art

There has been a surge of research into various neurobiological underpinnings of consciousness in the past decade. The theories regarding this complex phenomenon have not yet come to converge into a standarised deterministic theory that can be used to correctly direct consciousness models.

Most of the approaches regarding the study of consciousness have been developed around the raw EEG signal or derived parameters, such as (Patlatzoglou K, 2020 Jul), who uses 3D Convolutional Neural Networks to assess the state of consciousness of the patient using raw EEG.

Another interesting State of The Art approach comes from (Jesus Pujol, 2021) who proposes fMRI BOLD imaging combined with a repetitive task to assess the effect of some parameters like age, sex and propofol in a LoC survival analysis.

Finally, other approaches that must also be taken into consideration are consciousness related parameters, such as BIS. Even though this parameter does not assess LoC in a particular way but rather consciousness state of the patient in general terms. BIS and similar approaches will be also reviewed in next Section 3. Market Analysis

# Market analysis

**¿Quién está trabajando en esto?**

**¿Dónde? Artículos, patentes, etc.**

**Análisis de Mercado (¿Existente? ¿Qué aporta? ¿Nuevo? ¿Para qué?)**Sectores a los que se dirige

Evolución histórica del mercado

Perspectivas futuras del mercado

# Solution implementation

## Concept engineering

The project is conceived around the interest in knowing the state of consciousness of a patient under general anaesthesia. Knowing this information is of critical value for an intervention under general anaesthesia because knowing the patient is unconscious is determining to start the intervention, as well as to acknowledge that the patient has not experienced anaesthesia awareness. The desired concept is to use widely recorded parameters in surgeries as input variables to generate a new parameter indicating consciousness. A key point to take into consideration is that the desired new parameter regarding patients’ consciousness should not represent an extra workload for the OR professionals, nor imply the modification of patients’ monitoring habits. This way it is possible to guarantee lower cost and easy implementation of the solution, even its viability.

### Different solutions

**Solution 1:**

The first approach thought was to assess the problem as a classification problem, based on statistical correlational threshold, where some of the recorded parameters with proven correlation to patients’ arousal state were studied to know at what values the patient presented arousal. This way a weighted new parameter could be created and validated.

However, this approach presented some issues with the capacity of finding directly extractable features that were significant for the desired output. Also, this approach would be too sensitive to interpersonal variability between patients and could be easily biased when introducing different scenarios as intraoperative drug administration for managing patients’ biological constants.

**Solution 2:**

In the second proposed solution the use of EEG signals recorded through the intervention was assessed. EEG are known to present tight relation with the state of arousal of the patient, and it has been the focus of several approaches to solve the desired problem, as stated in Section 3. The use of EEG signal or EEG derived parameters was also taken apart, as EEG monitoring is an advanced monitoring technique and it is not implemented in all the ORs, and it needs a special sensor and a professional to place it. Also, EEG signal processing requires of advanced signal analysis skills which are beyond the time limitations of this project.

**Solution 3:**

The third solution proposed is to implement a type of human-like learning algorithm, such as ML and DL algorithms, in order to solve the problem. This kind of algorithms not only are capable of learning from historical data, but sometimes they are also capable of extracting the importance of the variables used to determine the outcome. This approach would not only help in the selection of parameters needed to predict the state of arousal, it also is capable of learning from the recorded data from previous operations and usually presents greater performance than simpler statistical models as those proposed in solution 1.

On the other hand, ML and DL algorithms need a lot of data and vast amounts of data respectively, if such requirements are met their performance usually surpasses the ones obtained with other type of models.

### Proposed Solution

A simple solution is the key. It must be easily implementable in an OR where professionals already have a lot of work to do, and ultimately hand an easily understandable, significative and reliable information without imposing changes in the functioning of the OR, the surgery or the monitoring techniques.

In light of the above, the problem we aim to solve is a conscious/unconscious binary classification problem that must be solved using monitoring parameters generally available in ORs, that do not increment workload for the sanitary professionals and that do not require of any investment neither in machinery nor in extra sensors. Therefore, the proposed solution to solve this problem is to implement a simple python code, which uses as input some generally recorded parameters in ORs, and that is capable of processing this information to introduce it to a ML model and obtain a binary classification value (0 or 1) to assess if the patient is conscious or unconscious. This solution has been chosen over the other two for its simplicity as it does not require investment or intervention of the practitioners. It is also capable of extracting the most valuable parameters to determine the output in a measurable way, and it is not dependent on EEG.

An agreement has not been reached yet about which is the event that precedes actual LoC, as discussed in Section 2. Background. In this direction, the recorded event chosen to define unconsciousness in this project is when the patient loses its verbal response. Therefore, what we are actually predicting is the loss of verbal response of the patients, which is a conservative criteria.

Finally, ML algorithms have been chosen over DL algorithms as they are faster to train, simpler to implement and last but not least, they do not require the vast amount of data needed in DL, whose requirements exceeds our records.

## Detail engineering

The first step to implement our solution is to accurately define the problem and our desired results, as shown in Section 4.1.2. As the solution proposed is based on a ML predictive algorithm, the second step is to obtain the needed data. In our case the data used has not been specifically recorded for this project, but it is systematically gathered by the anaesthesiology team from OR number 4 as mentioned in Section 1. It could be said that we are taking advantage from a dataset which is continuously being recorded by the practitioners.

Once we are clear about what we want to do and by what means, it is crucial for the project to define an objective way to evaluate its results. The basis of some statistical methods for model performance have been mentioned in Section 2.1.3.2, so metrics such as ROC AUC, accuracy and F1-Score will assess the performance of the model and therefore the results of the project.

At this point we have a clear intention, the method to obtain the desired results and the parameters used to define project’s success. Now we can start to define the actual parts of the project. As seen in figure below, a ML project starts by pre-processing the data to obtain a clearer and easier to handle dataset. Also this process is iterative with exploratory analysis, as it is important to avoid artifacts in the dataset and keep visualising the final shape the data is acquiring. Once artifacts, such as empty values, have been removed, the data must be processed according to models’ necessities and ours, as some models require for instance normalised data. Data is later separated into train and test data. Further explanation on the process is detailed in Section 4.2.1 below.

When the preliminary steps, pre-processing and exploratory analysis are done, the development of the model starts. First, a feature importance analysis is performed, in order to later select the most significative variables to introduce to our model. Later, the given ML model or models are trained with this data.

Finally, the last step of the project is model testing and documentation writing. As a part of any model generation, after training comes the testing. The testing dataset generated in the data pre-processing step is a part of our data that the model has never seen. This data is used to validate the model: input values are given to the model and then weather the model prediction are correct or not is checked. Here the performance metrics specified in Section 2.1.3.2 are used to evaluate if the model is performing well. Later, the functioning of the model must be explained in the documentation, as professionals usually do not rely on methods that are not scientifically supported or that have not been validated. In the sections below, from 4.2.1 to 4.2.4 the steps of the project will be explained in detail.

*note: In order to correctly implement functional programming and VCS along all the steps of the project, four python codes have been created as well as different directories to contain patients’ CSVs and code outputs, as explained in Section 1.2.2 Project Structure.*

### Data pre-processing and Exploratory analysis

**Data acquisition**

Regarding data acquisition, the variables recorded are defined in chapter 2.1.2 Anaesthesia monitoring, and “events”. A special customizable keyboard was used where events were programmed so that it could be entered with only one keystroke. It allowed a fast entry of events with minimal error.Nevertheless, the data used in the model has not been specially compiled for this project, as mentioned in 1st paragraph of Section 4.2. The data used is from a previous study (Semimechanistic models to relate noxious stimulation, movement, and pupillary dilation responses in the presence of opioids.

Marco-Ariño N, Vide S, Agustí M, Chen A, Jaramillo S, Irurzun-Arana I, Pacheco A, Gonzalez C, Jensen EW, Capsi-Morales P, Valencia JF, Troconiz IF, Gambus PL, Larson MD.

CPT Pharmacometrics Syst Pharmacol. 2021 Oct 30. doi: 10.1002/psp4.12729)study, which means that the gender covariate factor of the patients in our set of data is female. The data management is controlled by Dr. Pedro Gambús and PhD Student Joan Altés from a safe online cloud server in a Coma Separated Value (CSV) format. Each CSV file is a different patient intervention file, compiling high resolution data at a rate of 1 second per observation (or line). Legal aspects regarding patients’ data will be discusses in Section 7. Legal Aspects.

**Data loading and processing**

Firstly, the “libraries.py” archive is created, and all the needed libraries are hosted in there. This archive is later called in the other three in order to import all the libraries as a block avoiding repetition in the code.

The second python archive is now created and named “Train\_Test\_adquisition.py”. The function read\_csv()is used to read the file that comprehends all the variables, attributes and characteristics of each patients’ file. It is then used to collect all the patients with recorded ‘EVENTS’ of type ‘verb’ and ‘verbal’, which are the names for loss of verbal response in the surgery. Visual Studio Code inline visualization is used for exploratory analysis, as well as plots and histograms to detect distributions over the data.

Later, a for loop is used to iterate on each of these patients’ CSV file and process its extracted dataframe. This processing is made mainly through two functions: finder() and data\_preprocessing(). Trough finder() function we obtain each patients’ moment of loss of verbal response. Later, this moment is taken by data\_preprocessing( ) and used to delimit 60 seconds above and below loss of verbal response. Then, and also inside data\_preprocessing(), the interpolate() function is used to fill gaps of 2 recurrent values or less using a linear interpolation of the values below and above.

Handling empty values (NAN values in python) is done because almost no ML model supports empty values, and if we just eliminate all the observations (lines of the data frame) containing any empty value the data is drastically reduced. Finally, some more empty values are handled, deleting the whole observation in some cases, and filling the gap with the mean value of the variable or 0, depending on each case. For instance, all observations previous to Remifentanil start of infusion are empty, but its information is useful as in most cases Propofol has already been infusing for several seconds, then we just fill the gaps prior to infusion with 0s instead of deleting them. Once NaN handling is done, the data\_preprocessing( ) function returns two dataframes: one with all the variables and 120 observations processed of the patient and one with the state of consciousness of the patient for each of the 120 seconds.

**Data saving**

Finally, each patients’ processed data frame is randomly stored in any of the learning or testing data sets and concatenated to the previous patients’ information. This dataframes, X\_Train, y\_train, X\_test and y\_test, which are data (X) and consciousness state (y) are saved in new CSV files to be read later by the Model.py python script. The archive “Train\_Test\_adquisition.py” finishes here.

### Model training

At this point of the process, we already have the most important checkpoint: the data processed and ready to introduce it to the model for its training. Now the third python file “Model.py” is created. In this file the models will be trained and tested, and later saved for further use.

**Dataframe import and model training**

Firstly, the four dataframes for train and test of the models are loaded with the function read\_csv() from the saved archives in the section above. The first model, Support Vector Components is initiated and trained with the fit() function, introducing X\_train (processed data from the selected variables used for the model) and y\_train (conscious or unconscious state of the patient for each observation of the X\_train dataframe). The same is done with the second model, a Random Forest Classifier. The parameters used to tune the models are either selected automatically if the model permits, or iteratively based on which ones show better results. Model outcome is seen to perform similarly independently on the values of the parameters chosen.

Once the model is trained, the predicted values for both of them are computed with the predict() function and the predict\_proba() function. The predict() function directly provides the binary outcome prediction (0 or 1), while the predict\_prova() provides the probability of falling into the class 1. Predicting the probability is interesting in order to perform the ROC curve, as it is based on computing iteratively the True Positive Rate (TPR) and False Positive Rate (FPR) for different thresholds used to consider the output as 0 or 1 (e.g. if the probability of being unconscious or 1 is 0.7 and the threshold is at 0.8, this case would be considered conscious or 0).

### Model Validation

**Graphical user interface

Description automatically generatedModel** **validation**

Model validation is also studied in “Model.py” archive. In order to evaluate the model metrics such as AUC, accuracy and F1-Score have been used. First of all, the ROC curve and its AUC for both models are performed. We can observe in the figure on the right that both models perform generally well, with high AUC values and with high values of TPR for still low values of FPR, meaning that we can identify most unconscious moments without increasing uncontrollably the False Positives. It can be observed that SVC performs a bit better that RFC in terms of AUC.

Figure 14: ROC-AUC

Table

Description automatically generatedTable

Description automatically generatedRegarding accuracy and F1-Score, both models also perform with high values, all of them above 0.84.

Table 5: RFC metrics

Table 6: SVC metrics

Concretely, SVC overperforms RFC in precision, recall, F1-Score on both predicting consciousness and unconsciousness, as seen in the tables below.

Also, confusion matrices are useful to visually comprehend how a model is performing. The confusion matrices for both models are shown below.

Chart, treemap chart

Description automatically generatedChart, treemap chart

Description automatically generated

Figure 15: Confusion matrix for RFC

Figure 16: Confusion matrix for SVC

Logo

Description automatically generated with low confidenceFeature importance

Another feature importance is applied using RFC feature importance characteristic in order to glimpse the weight of each of the variables in the outcome of the model. The results are shown in figure on the right. It is visible that Propofol effect site concentration is the vairable that contributes the most to predict the event of LoC, which is consistent with previously expected results.

Figure 17: Feature importance analysis with RFC.

Finally, both models are saved in "SVM\_model.pickle" and “RandomForest\_model.pickle" respectively, using python’s with open file handling methodology, in order to save them for later use. Here ends the “Model.py” archive

### Example

There final aim of the algorithm is to predict the moment of LoC of a patient. In order to assess its methodology and performance around this event, all the explanation in this Detailed Engineering Section has been developed. On the other hand, it is useful to visually observe what the model outputs around LoC.

In order to do this, a patient previously separated from train and test datasets has been used to exemplify what the model is doing.

As we can see, the model (once binarised) returns a 0 or a 1 for every set of parameters coming from the patient. In the figure below the clinical evaluation of LoC (red) being 0 conscious and 1 unconscious compared to the predicted values (blue) following the same logic can be seen.

Diagram

Description automatically generated

Figure 18: General overview of the project's code.

## Chronogram and execution

Time management is one of the key points of a project success. A first glimpse of this project task segmentation is reviewed in Section1.4.2 Project workload, and in this section it is presented in detail.

The Figure below is a GANTT diagram, representing the different tasks forming the project, their time domain, their completion % and a visual time-dependant representation of the mentioned characteristics.

A GANTT diagram is a project managing tool used to generate an overall look on project follow-up, and that pretends to help in managing time. This figure is just an example of the current situation at the moment of writing this documentation.

**Graphical user interface, application

Description automatically generated**

Figure 19: GANTT diagram of the project

# Technical Viability

## Specifications and technical characteristics

The aim of the project is to develop a ML predictive model to assess LoC event under general anaesthesia. At this point of the project, it is interesting to acknowledge the possibilities of the proposed solution to come to a good end.

One of the most famous project management tools used to evaluate the situation of the solution is the SWOT diagram. This analysis tool defines the solution situation regarding solutions’ internal attributes (Strengths and Weaknesses) and external world (Opportunities and Threads). As shown in the section below, this SWOT analysis generates a general overview on the solution regarding its real situation, and facing it to not only its capacities, but also to regarding external factors.

## SWOT

Diagram

Description automatically generated

As can be seen on the figure, the main strengths of the project go around its simplicity for interpretation and implementation, as it uses typically recorded variables in ORs. It also discusses opportunities in the sense that, even though it is still restricted to a small demographic group and only useful to predict LoC as discusses in Section 8.2 Limitations, the model is potentially integrable with other predictors inside an OR.

Finally, external threads such as professionals’ reluctance to incorporate predictive algorithms to aid in clinical decisions are a barrier for the model incorporation to the clinical environment. Another huge thread is the fact that even though needed variables are always recorded in almost every intervention, data format and handling is usually different for most monitoring commercial systems, and integration is not that easy

Figure 20: SWOT Analysis

# Economic viability

In order to correctly manage a project, economic studies of the costs must be performed, as usually a pre-defined budget and an idea is all we have, and it is crucial to delimit the project to an extent we can economically assume to avoiding the undesired scenario of having to stop the project before it end.

Regarding the Economical point of view, the project has three different types of expenses. First of all the Hardware expenses, which include all the material needed to analyse the data and do the project. In here, none of the expenses derived from data acquisition like the OR, human resources from healthcare professionals, monitoring systems and sensors etc. have been taken into consideration because these are expenses the hospital would have independently of the realisation of this project.

Table 7: Hardware Budget

|  |  |
| --- | --- |
|  | Hardware |
|  | Cost (€) |
| MacBook Air Computer | 1130 |
| Data acquisition | 0 |
|  | 1130 |

On the other hand, all the software machinery used to do the project is either of open source, or free to use, with the great exception of a diagram web service called Canva, which has a price of 110 euros per year as shown in the Table below.

Table 8: Software Budget

|  |  |
| --- | --- |
|  | Software |
|  | Cost |
| Python Programming | Open source |
| ML packages | Open source |
| Canva diagram generator | 110 €/year |
| Visual Studio Code | Free |
|  | 110 |

Finally, the table below is an estimation of the cost of the human resources used in the project, which is 5500 euros.

Table 9: Human Resources Budget.. Business cost of labour per hour has been used, instead of workers' labour per hour salary for more accurate results

|  |  |  |  |
| --- | --- | --- | --- |
|  | Human Resources | | |
|  | Cost (€  /hour | Hours | Cost |
| Biomedical Engineering Student | 10 | 350 | 3500 |
| Anaesthesiologist MD | 35 | 40 | 1400 |
| Undergraduate PhD Student | 20 | 30 | 600 |
|  |  |  | 5500 |

It is therefore straightforward that the total cost of implementation of this project is of 6740 euros.

# Legal aspects

Regarding regulatory issues, the product derived from this project belongs to a class of medical products called Software as Medical Device (SaMD) which is defined by the International Medical Device Regulators Forum (IMDRF) as "software intended to be used for one or more medical purposes that perform these purposes without being part of a hardware medical device."

The Food and Drug Administration of the United States (FDA) considers AI based SaMD as a special paradigm inside SaMD. The IMDRF SaMD risk categorization framework takes a risk-based approach to categorize SaMD based on intended use, similarly to traditional risk-based approaches used by the FDA. In fact, the risk categorization is based on these two factors (FDA, 2021):

1. **Significance of information provided by the SaMD to the healthcare decision**, which identifies the intended use of the information provided by the SaMD – i.e., to treat or diagnose; to drive clinical management; or to inform clinical management.
2. **State of healthcare situation or condition**, which identifies the intended user, disease or condition, and the population for the SaMD – i.e., critical; serious; or non-serious healthcare situations or conditions.

The health care condition in an intervention under general anaesthesia would be considered between non-serious and serious. On the other hand, the significance of information provided by our algorithm is to inform clinical management but could also be to drive the clinical management at some point. It is therefore straightforward that the risk categorization for our product is Class I and Class II, as seen in the Table below .

Table 10: SaMD IMDRF risk categorization (FDA, 2021).

Table

Description automatically generated

Following the recommendations for Class I and II products approval, our SaMD requires an evaluation of: performance, used inputs and intended use. All these elements that have been covered in this project. FDA also enhances good machine learning practices (GMLP), that include assessing the relevance of the data used to train the model for the specific application and an appropriate level of transparency and understandability of generated outputs towards the users.

Regarding European Union regulations, SaMD is not specifically treated inside Europeran Medicines Agency (EMA), but our project must match a more general regulation for Medical Device Applications called Medical Device Regulation (MDR). This MDR standards also perform a risk categorization based on the intended purpose of the devices and their inherent risks and, in general terms, the MDR requirements match those of the FDA.

Once the requirements are met the product should not have problems to pass the regulations, even though further studies in biased training should first be successfully accomplished in order to obtain the approvals.

# Discussion and Future Prospects

## Implications

The point that SVC and RFC models show good overall performance in predicting the LoC event of a patient during anaesthesia inductionmeans several benefits from a clinical point of view.

First of all, the clinical support to practitioners with a model being trained with huge amounts of historical data goes in the direction of personalised medicine, if the model is correctly trained with balanced and unbiased data. This way practitioners can obtain a fast and unbiased information regarding LOC coming from already collected data that has been analysed to provide predictive ability.

On the other hand, the digitalisation LoC evaluation is a first step to minimise the contact of medical professionals with the patient under general anaesthesia, an especially interesting implication regarding infective transmissible pathologies such as SARS CoV-2.

Finally, the same digitalisation of this duty is interesting from the process automation point of view. Automation and prediction does not mean taking away decision abilities from the attending anesthesiologist but rather providing another source of information to support the process of decision making. Even though prediction of intraoperative events can be of clinical usefulness it does not pretend to replace practitioners’ work, but rather improve surgical performances and practitioners comfort. Also, these predictive capacities constitute an initialfirst step towards a partially automated anaesthesia process, that even though it would never be desirable, could be of crucial interest in extreme situations where no medical professionals are available, such as in war zones, remote locations, spatial stations etc.

## Limitations

The limitations of a project are defined as the barriers and difficulties acknowledged during or even prior to execution that were not possible to handle or overcome. Limitations are boundaries or problems that have made some goals of the project totally or partially unachievable. In our particular case and given that our project is based in data analysis and model generation, it would be expected that most of the limitations were found around the quality, structure, composition or origin of the data.

As mentioned above, the first limitation that came up when achieving our goals was the origin of the data. Due to the nature of the OR where our patients’ data is collected, the samples used to both train and test the model are composed mainly by individuals of female sex, from Mediterranean origin and of advanced age. This clear under representation of male sex, different ethnics and ages limits the possibility of model generalisation. In order to evaluate the models’ applicability to individuals of different characteristics than the ones used to train and test the model further validation tasks should be performed.

On the other hand, the model is not simply a LoC model, but a ML model trained to predict loss of verbal response, as a surrogate measure of LOC, event during induction of general anaesthesia. This means that as the samples used to train the model where from 60s before and after the patients fell unconscious, the applicability of the model to assess consciousness state of the patient at any other moment of the intervention rather than anaeshtesia induction would not correspond without previous validation. Also, the model does not predict LoC, but loss of verbal response as a surrogate measure of LOC. This is due to the limitation of LoC concept, which has no scientifically defined measurable expression, and therefore loss of verbal response is the used to assess LoC.

Furthermore, the inputs of the model, which go from NIBP to HR and Remifentanil and Propofol effect site concentrations limit the types of general anaesthesia where the model can be used. It is therefore straightforward that the model is limited to TIVA-TCI Propofol and Remifentanil mediated general anaesthesia. In the same direction, another limitation of the project is the necessity of software integration, as the four input variables mentioned above come from Anaesthesia monitor (NIBP and HR) and from the TCI automatic pumps (CePropo and CeRemi). Without the integration of this information, it is not possible for the model to compute the predictions.

Finally, the last limitation is regarding the selected variables used to train the model. The first selection was done under the supervision of Dr Pedro Gambús, who has a wide knowledge on the topic and mentored the most logical selection. This means that the initial feature selection was not properly handled by feature importance techniques or by statistical evidence but rather informally.

## Recommendations and Future Prospects

Future studies around this project should start by performing a prospective validation of the model with balanced data, as mentioned in Section 8.2. Limitations in paragraph 2, in order to perform a reliable generalisation on a wider population. Performance of the model should be given in ROC AUC and results showed with confidence intervals.

Another recommendation for future implementation is the study of DL algorithms to perform the same predictions achieved with ML in this project and compare performances. As data gathering is a continuous process done in the OR number 4, it is possible that in some time enough data will be gathered to adequately train and validate DL models with high complexity structures.

Some more future implementations related to patients’ consciousness such as anaesthesia awareness could also be studied with little modifications of the proposed models, and it would be of clinical interest to prophylactically predict this undesirable scenario in surgical interventions. Other intraoperative events such as patient movement, BAR suppression and hypotension between others could be or are already being modelled with similar approaches to the one proposed, and to prototype an integrated system of this predictions into the OR infrastructure is a future prospect to take into consideration.

Finally, introduction of new data such as health habits, comorbidities and data from same patients’ past interventions would be an improvement in current personalised medicine approaches. Also, feature engineering to automatically select important variables to perform predictions is a strong recommendation that, even though it has not been implemented in this project, is part of good AI programming practices to improve models’ performance.

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# Annex

“Libraries.py” archive contains all the needed libraries in order to compile the code.

|  |
| --- |
| libraries.py |
| #Importing common libraries  from numpy import \*  import pandas as pd  import matplotlib.pyplot as plt  from os import chdir  from pandas.io.parsers import read\_csv  from scipy.interpolate import interp1d  import random  import pickle  # Import datasets, classifiers and performance metrics  from sklearn.metrics import ConfusionMatrixDisplay, roc\_auc\_score, roc\_curve, accuracy\_score, auc  from sklearn import datasets, svm, metrics  from sklearn.model\_selection import train\_test\_split  from os import chdir, getcwd  print('libraries imported') |

In this Train\_Test\_Matrices.py archive the X\_train, y\_train, X\_test and y\_test matrices are generated and saved for later use.

|  |
| --- |
| Train\_Test\_acquisitions.py |
| from libraries import \*  path = '/Users/marcpalomercadenas/Desktop/TFG/TFG/archives/VARIABLES.xlsx'  source = pd.read\_excel(path)  #Input feature selection  selected\_features = ['ECG\_HR', 'NIBP\_MEAN','PROPO\_CE', 'REMI\_CE']  def finder(patient\_dataframe, word1, word2):  patient\_dataframe.reset\_index(drop = True)    #We initialize the local variables and the error counter  #to know how many patients are being lost without verbal response  idx = []  a = 0  b = 0  patient\_dataframe.reset\_index(drop=True)    #We search for "verb'" inside the event feature  try:  idx = list(patient\_dataframe['EVENT']).index(word1)  except ValueError:  a = 1  #We search for "verbal" inside the event feature  try :  idx = list(patient\_dataframe['EVENT']).index(word2)  except ValueError:  b = 1    #If neither of the options has been useful to detecting the verbal response the error increases  if a\*b == 1:  idx = []  return idx  # entering the df of a patient and moment o verbal response (idx) and the desired features it returns the patient df casted to 120s and interposalted and the resulting output (LoC = 0 or 1)  def data\_preprocessing(patient\_dataframe,idx,selected\_features):    #We look fort first Propo value (its index) and if none is found the patient is taken appart  patient\_dataframe.reset\_index(drop = True)  fvi = patient\_dataframe[‘PROPO\_CE’].first\_valid\_index()    #Only generate a valid data and LoC if the there is a start of Propo induction and if it is before LoC event (it would not makes sense otherwise.)  if fvi != None and idx > fvi:  #Temporal acotation  a = patient\_dataframe.loc[fvi:(2\*idx-fvi),:]  a.reset\_index(drop=True)  #Interpolem NaNs  a.interpolate(method=’linear’, limit\_direction=’forward’, axis=0)  #LoC binarisation (creatinc a vector of 0 until positive verbal response, and the other are 1)  #Generatinc LoC feature from ‘Event’ extraction  a[‘LoC’] = 0  a.loc[idx:,’LoC’] = 1    #Here we define the selected features  a = a.loc[:,[‘ECG\_HR’, ‘NIBP\_MEAN’,’PROPO\_CE’, ‘REMI\_CE’, ‘LoC’]]  #NaN handling  a.loc[:,’REMI\_CE’] = a.loc[:,’REMI\_CE’].fillna(0)  a = a.dropna()  #Defining the values to be returned  LoC = a[‘LoC’]  a = a.loc[:,selected\_features]  #If the condition is not met, return empty dfs  else:  a = pd.DataFrame(columns= selected\_features)  LoC = pd.DataFrame()      return [a, LoC]  #Variable initialization  general\_dataframe = pd.DataFrame()  X\_train =[]  X\_test = []  y\_train = []  y\_test = []  available\_event = 0  no\_event = 0  e = 0  available\_index = 0  available\_patient = 0  #Extracting patients df and iterating over it  for patient\_ID, event\_state in zip(source[‘ID’],source[‘EVENTS’]):  if event\_state == ‘AVAILABLE’:    #Counting the patients with record of EVENTS  available\_event = available\_event +1  #Reading the current archive of the patient  path = ‘/Users/marcpalomercadenas/Desktop/TFG/TFG/archives’  chdir(path)  archive = pd.read\_csv(patient\_ID+’.csv’)  #Finder returns the index of the verbal response  index = finder(patient\_dataframe = archive, word1 = “verb’”, word2 =”verbal”)  #If there is index of verbal response, there is verbal response  if index != []:  available\_index = available\_index+1    #We cut the patients’ dataframe info +/- 1 minute from the loose of verbal response  frame, LoC = data\_preprocessing(archive,index,selected\_features)    #We concat the 120 seconds patients’ dataframes for later analysis and visualization  pd.concat([general\_dataframe, pd.concat([frame, LoC], ignore\_index = True)], ignore\_index= True)  #If the patient had verb resp on propo+remi, the dataframe shouldn’t be empty:  if len(frame) != 0:  available\_patient = available\_patient +1  #Data scaling. There are a lot more types of scaling  from sklearn.preprocessing import MaxAbsScaler  scaler = MaxAbsScaler()  frame = scaler.fit\_transform(frame)  # Split data into train and test subsets, randomly and putting whole patients in train or test, to avoid overfitting.  X = random.uniform(0,1)  if x < 0.5:    X\_train.append(frame)  y\_train.append(LoC)  else:  X\_test.append(frame)  y\_test.append(LoC)      else:  e = e+1  else:  no\_event = no\_event +1  #Glimpse of the amount of patients being used and those not  print(f’There are {available\_index} patients from {available\_index + no\_event} with verbal response recording’)  print(f’There are {round((available\_patient)\*100/available\_index,1)}% of patients from the {available\_index} with recorded neg. verbal response which data is handled’)  #Concatenation the patients’ data for model training  X\_train = concatenate((X\_train))  X\_test = concatenate(X\_test)  y\_train = concatenate(y\_train)  y\_test = concatenate(y\_test)  #Saving the matrices to csv so that the results don’t change constantly  pd.DataFrame(X\_train).to\_csv(‘/Users/marcpalomercadenas/Desktop/TFG/TFG/TrainTestMatrices/X\_trainn.csv’)  pd.DataFrame(X\_test).to\_csv(‘/Users/marcpalomercadenas/Desktop/TFG/TFG/TrainTestMatrices/X\_test.csv’)  pd.DataFrame(y\_train).to\_csv(‘/Users/marcpalomercadenas/Desktop/TFG/TFG/TrainTestMatrices/y\_train.csv’)  pd.DataFrame(y\_test).to\_csv(‘/Users/marcpalomercadenas/Desktop/TFG/TFG/TrainTestMatrices/y\_test.csv’) |

Finally, the Model.py archive generates and validates the SVC and RFC models.

|  |
| --- |
| Model.py |
| #Importing libraries  from libraries import \*  #Reading train and test dataframes  X\_train = pd.read\_csv('/Users/marcpalomercadenas/Desktop/TFG/TFG/TrainTestMatrices/X\_train.csv', index\_col = 0)  X\_test = pd.read\_csv('/Users/marcpalomercadenas/Desktop/TFG/TFG/TrainTestMatrices/X\_test.csv', index\_col = 0)  y\_train = pd.read\_csv('/Users/marcpalomercadenas/Desktop/TFG/TFG/TrainTestMatrices/y\_train.csv', index\_col = 0)  y\_test = pd.read\_csv('/Users/marcpalomercadenas/Desktop/TFG/TFG/TrainTestMatrices/y\_test.csv', index\_col = 0)  # Create a classifier: a support vector classifier  SVM = svm.SVC(gamma='scale', probability= True) #, probability = True  SVM.fit(X\_train, y\_train)  # Create 2nd classifier: a Random forest classifier  from sklearn.ensemble import RandomForestClassifier  rfc = RandomForestClassifier(n\_estimators=10, random\_state=42)  rfc.fit(X\_train, y\_train)  #Predictions  predicted\_SVM = SVM.predict(X\_test)  y\_pred\_proba\_SVM =SVM.predict\_proba(X\_test)[:,-1]  predicted\_rfc = rfc.predict(X\_test)  y\_pred\_proba\_rfc =rfc.predict\_proba(X\_test)[:,-1]  #------- MODEL PERFORMANCE-------  # Roc and Auc  false\_positive\_rate, true\_positive\_rate, thresholds = roc\_curve(y\_test, y\_pred\_proba\_SVM)  roc\_curve\_plot = metrics.plot\_roc\_curve(SVM, X\_test, y\_test, alpha = 0.8)  ax = plt.gca()  rfc\_disp = metrics.plot\_roc\_curve(rfc, X\_test, y\_test, ax=ax, alpha=0.8)  plt.title('ROC curve')  plt.ylabel('True positive rate')  plt.xlabel('False positive rate (positive label: 1)')  plt.savefig('ROC curve')  plt.show()  # Ploting metrics extracted from Confusion matrix and CM itserlffor SVM  print(  f"Classification report for classifier {SVM}:\n"  f"{metrics.classification\_report(y\_test, predicted\_SVM)}\n"  )  # true digit values and the predicted digit values.  disp = ConfusionMatrixDisplay.from\_predictions(y\_test, predicted\_SVM)  disp.figure\_.suptitle("Confusion Matrix for SVM")  print(f"Confusion matrix for SVM:\n{disp.confusion\_matrix}")  plt.savefig('ConfusionMatrix for SVM')  plt.show()  # Ploting metrics extracted from Confusion matrix and CM itserlffor rfc  print(  f"Classification report for classifier {rfc}:\n"  f"{metrics.classification\_report(y\_test, predicted\_rfc)}\n"  )  # true digit values and the predicted digit values.  disp = ConfusionMatrixDisplay.from\_predictions(y\_test, predicted\_rfc)  disp.figure\_.suptitle("Confusion Matrix for rfc")  print(f"Confusion matrix for rfc:\n{disp.confusion\_matrix}")  plt.savefig('ConfusionMatrix for rfc')  plt.show()  # %%  #---------Feature importance--------  feature\_names = ['ECG\_HR', 'NIBP\_MEAN','PROPO\_CE', 'REMI\_CE']  importances = rfc.feature\_importances\_  plt.pie(importances, labels = feature\_names)  # %%  #Saving our model  with open("SVM\_model.pickle", "wb") as file:  pickle.dump(SVM, file)  with open("RandomForest\_model.pickle", "wb") as file:  pickle.dump(rfc, file)  print('Models Saved') |