

Comparing methods of measurement: why plotting difference against standard method is misleading

J Martin Bland, Douglas G Altman

Summary

When comparing a new method of measurement with a standard method, one of the things we want to know is whether the difference between the measurements by the two methods is related to the magnitude of the measurement. A plot of the difference against the standard measurement is sometimes suggested, but this will always appear to show a relation between difference and magnitude when there is none. A plot of the difference against the average of the standard and new measurements is unlikely to mislead in this way. We show this theoretically and by a practical example.

Lancet 1995; **346**: 1085–87

Introduction

In earlier papers^{1,2} we discussed the analysis of agreement between methods of clinical measurement. We had two issues in mind: to demonstrate that the analyses then in use were incorrect and misleading, and to recommend a more appropriate method. We saw the aim of such studies as to determine whether two methods agreed sufficiently well for them to be used interchangeably. This led us to suggest that the analysis should be based on the differences between measurements on the same subject by the two methods. The mean difference would be the estimated bias, the systematic difference between methods, and the SD of the differences would measure random fluctuations around this mean. We recommended 95% limits of agreement, mean difference plus or minus 2 (more precisely, 1.96) SDs which would tell us how far apart measurements by the two methods were likely to be for most individuals.

Figure 1 shows a typical data set, the measurement of systolic blood pressure by a test method, finger pressure, and a standard method, arm blood pressure. This is a random subsample of 200 observations from a larger data set.^{3,4} The subsample was taken to avoid cluttered graphs. The mean difference, finger minus arm, is 4.3 mm Hg and the SD is 14.6. Hence the lower 95% limit is $4.3 - 1.96 \times 14.6 = -24$ mm Hg and the upper 95% limit is $4.3 + 1.96 \times 14.6 = 33$ mm Hg. Thus we estimate that for 95% of subjects the finger measurement will be between 24 mm Hg below the arm measurement and 33 mm Hg above it.

For the mean and SD of the differences to be meaningful estimates we must assume that they are reasonably constant throughout the range of measurement. We suggested checking this assumption graphically.^{1,2} The usual plot, method one versus method two, is inefficient because the points tend to be clustered

along the line of equality (figure 1), especially if the two methods give closely related measurements. We therefore proposed that the difference be plotted against the average of the measurements by the two methods (figure 2). In figure 2 we have also added the 95% limits of agreement and the regression line of difference on average. The main departure from assumptions we were expecting was an increase in variability, shown by an increase in the scatter of the differences, as the magnitude of the measurement increased. There may also be a trend in the bias, a tendency for the mean difference to rise or fall with increasing magnitude. Either would show that the methods did not agree equally through the range. In figure 2, for example, there is an increase in bias with magnitude, shown by the positive slope of the regression line. Such deviations from assumptions can often be dealt with by a suitable transformation, usually logarithmic.² In particular, this approach will be effective if the differences are proportional to the magnitude of the measurement.

The 95% limits of agreement approach has been widely adopted and *The Lancet* paper² widely cited.⁵ However, it is sometimes argued that when one method may be regarded as a gold standard, it is presumably more accurate than the other method and so we should plot the difference against the gold standard.^{6,7} We think that this idea is misguided and is likely to lead to misinterpretation. Here we will show why, and that the plot of difference against average is almost always preferable.

Plotting difference against average

We denote our standard measurement by S , the new or test measurement by T , their variances by σ_S^2 and σ_T^2 , and their correlation by ρ . If the study includes a wide range of measurements, and unless the two methods of

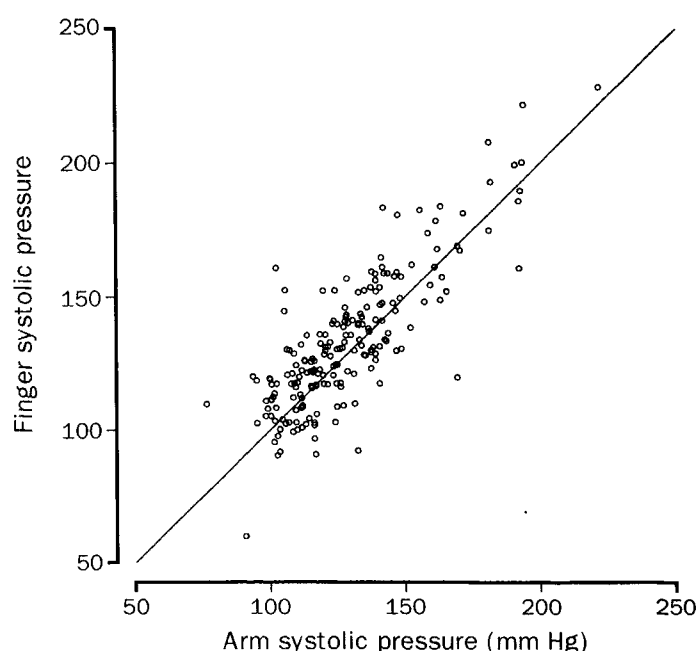


Figure 1: Test and standard measurements, with line of equality

Department of Public Health Sciences, St George's Hospital Medical School, London SW17 0RE, UK (J M Bland PhD); and Medical Statistics Laboratory, Imperial Cancer Research Fund, London WC2 (D G Altman BSc)

Correspondence to: Dr J Martin Bland

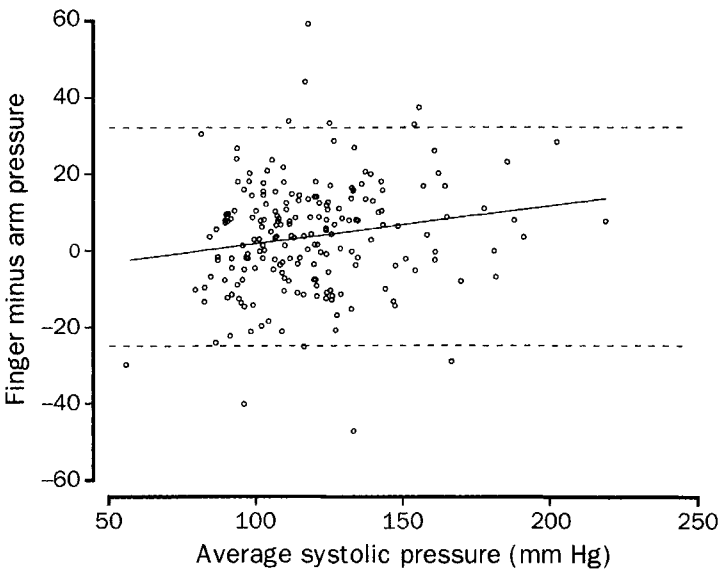


Figure 2: **Difference against average of test and standard measurements, with 95% limits of agreement (broken lines) and regression line**

measurement have very poor agreement, we expect σ_T^2 and σ_S^2 to be similar and ρ to be fairly large, at least 0.7. We can examine the possibility of a relation appearing in the plot from the expected correlation coefficient between difference and average, which can be shown to be:

$$\text{Corr}[T-S, (T+S)/2] = \frac{\sigma_T^2 - \sigma_S^2}{\sqrt{[(\sigma_T^2 + \sigma_S^2)^2 - 4\rho^2\sigma_T^2\sigma_S^2]}}$$

This is zero if the variances are equal, and will be small unless there is a marked difference in the variability between subjects for the two methods.

If there is a genuine trend in the difference with increasing magnitude of the measurement, the variances will be different. For example, if the test measurement tends to be less than the standard for low values of the measurement and greater than the standard for high values, the test measurement will have more very low and more very high values than the standard, and so will have a greater variance. Thus there will be a non-zero correlation between difference and average, and the plot of difference against average should show the trend.

The two methods of measurement may also have different variances in the absence of a genuine association between difference and magnitude, due to one method having greater measurement error (variation within the subject) than the other. This will only be noticeable if one

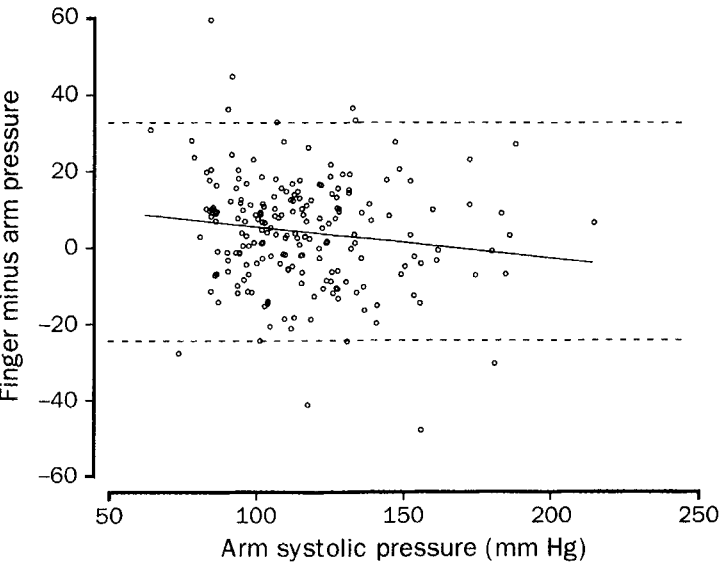


Figure 3: **Difference against standard measurement, with 95% limits of agreement (broken lines) and regression line**

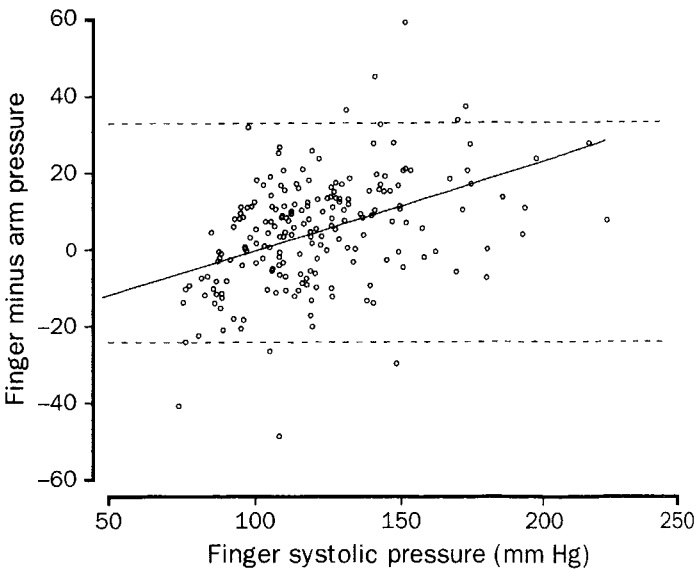


Figure 4: **Difference against test measurement, with 95% limits of agreement (broken lines) and regression line**

method has considerably more measurement error than the other, otherwise the effect will be swamped by the variation between subjects in the quantity being measured. We can estimate this measurement error only by making repeated measurements by the same method. In the ideal study, each method would be used at least twice on each subject, in random order, to avoid any time or order effects.²

For the blood pressure data, the correlation between difference and average is 0.17 (95% CI 0.03 to 0.30, $p=0.02$), suggesting that the difference increases with the magnitude of the measurement, although the relation is weak (figure 2). The variances of the two methods differ for the blood pressure data, being 542 for the standard arm-measurement and 658 for the test finger-measurement (variance ratio of test/standard=1.21, 1.03 to 1.42).

Plotting difference against standard

The expected correlation between difference (Test–Standard) and standard is:

$$\text{Corr}[T-S, S] = \frac{\rho\sigma_T - \sigma_S}{\sqrt{[(\sigma_T^2 + \sigma_S^2 - 2\rho\sigma_T\sigma_S)]}}$$

This correlation will usually be negative. In particular, if there is no difference between the variances of the two methods and so no relation between difference and magnitude, the plot of difference against standard will still show a correlation. In this case, the formula reduces to $-\sqrt{[(1-\rho)/2]}$.

This spurious correlation will be small when the methods being compared are themselves highly correlated, and will increase as the correlation between the two methods themselves falls. For the blood pressure data, the correlation between finger and arm pressures is 0.83. The expected correlation between difference and standard in the absence of any genuine relation between difference and magnitude is therefore $-\sqrt{[(1-0.83)/2]} = -0.29$. The plot of test minus standard difference against standard shows a downward slope (figure 3). The correlation between difference and standard is -0.14 (-0.28 to 0.00 , $p=0.04$). Thus we have a negative correlation between difference and standard as predicted, although it is smaller than we would have

expected. This is because there appears to be a positive correlation between difference and magnitude in this example.

The expected correlation between difference and test measurement is:

$$\text{Corr}[T-S, T] = \frac{\sigma_T - \rho\sigma_S}{\sqrt{[(\sigma_T^2 + \sigma_S^2 - 2\rho\sigma_T\sigma_S)]}}$$

This correlation will usually be positive. Thus in the absence of a genuine association between difference and magnitude, the plot of difference against test measurement will suggest a positive relation (figure 4), whereas the plot of difference against standard will suggest a negative one (figure 3). This shows that both plots are liable to be very misleading and any relation found liable to be an artifact of the method of analysis. For the blood pressure data the correlation between difference and the measurement by the test method, finger blood pressure, is 0.44 (0.32 to 0.54, $p < 0.0001$). Thus we get significant correlations in different directions!

Conclusions

The plot of difference against standard measurement will show a relation, whether there is a true association between difference and magnitude or not. The plot of difference against the average is more useful in almost all applications to medical measurements.

References

- 1 Altman DG, Bland JM. Measurement in medicine: the analysis of method comparison studies. *Statistician* 1983; **32**: 307-17.
- 2 Bland JM, Altman DG. Statistical methods for assessing agreement between two methods of clinical measurement. *Lancet* 1986; *i*: 307-10.
- 3 Close A, Hamilton G, Muriss S. Finger systolic pressure: its use in screening for hypertension and monitoring. *BMJ* 1986; **293**: 775-78.
- 4 Altman DG, Royston JP. The hidden effect of time. *Stat Med* 1988; **7**: 629-37.
- 5 Bland JM, Altman DG. This week's citation classic: comparing methods of clinical measurement. *Curr Contents* 1992; **CM20** (40): 8.
- 6 International Committee for Standardization in Haematology (ISCH). Protocol for evaluation of automated blood cell counters. *Clin Lab Haematol* 1984; **6**: 69-84.
- 7 Kringle RO. Statistical procedures. In: Burtis CA, Ashwood ER, eds. *Textbook of clinical chemistry*. 2nd ed. Philadelphia: WB Saunders, 1994: 384-53.

BOOKSHELF

Infections of the gastrointestinal tract

Edited by Martin J Blaser, Philip D Smith, Jonathan I Ravdin, Harry B Greenberg, Richard L Guerrant. New York: Raven. 1995. Pp 1610. \$282. ISBN 0-7817-0226-7

Infectious diseases of the gastrointestinal tract remain one of the most prevalent ills that afflict mankind. For centuries they have been among the leading causes of death in the materially disadvantaged countries of the world and have been key contributors to malnutrition and growth retardation in children. The past few decades have seen significant advances in our understanding of these diseases on several fronts: pathophysiological, microbiological, epidemiological, and clinical. These advances have occurred at a whirlwind pace, creating an urgent need for a synthesis of current knowledge, bringing together works of many different disciplines. This book meets this need.

This is the most impressive textbook yet on gastrointestinal infection. It is certainly the longest at 1610 pages from 162 contributors, and perhaps the priciest. I would also rate it as the best.

An entertaining account of the history of cholera sets the scene. With an eighth pandemic perhaps looming and a seventh pandemic still raging in South America, our understanding of gut infection has benefited immensely from the continuing battle with this ancient scourge. Two excellent sections on the contrasting epidemiological scenes of diarrhoeal diseases in developing and developed countries, complement this part. The second

and third parts deal in considerable depth with the key elements in the pathogenesis of intestinal infection—intestinal microflora, gastrointestinal mucin and other non-immune defence mechanisms, microbial adherence, the nature of intestinal transport defects, and development of local and systemic immunity. A whole section has been devoted to M cells, those fascinating cells that seem to act as a bridge between the microbes and the mucosal immune cells allowing immune surveillance without mucosal infection. These highly detailed, often technical, sections may not hold the attention of a busy clinician for too long but will be valuable to anyone interested in the immunology of gut infection.

The different gastrointestinal syndromes of infective origin are covered with admirable clarity in the next three parts. The readers will find the approaches to diagnosis and management of watery and inflammatory diarrhoeas useful. The individual infections are then dealt with in part VII with appropriate emphasis on the microbiology, epidemiology, pathophysiology, diagnosis, and treatment. There are useful chapters on the roles of microbiology laboratory, endoscopy, and radiology in evaluating patients with infective diarrhoea.

The conclusion of this book covers the status of currently available

vaccines and the prospects of new bacterial and viral vaccines. There is much research and interest in this field as only a handful of aetiological agents account for the vast majority of infections of clinical and epidemiological importance. This is followed by excellent reviews of antimicrobial resistance and the growing problem of nosocomial gastrointestinal tract infections.

This book is a considerable achievement. It provides an extremely comprehensive coverage of all aspects of gastrointestinal infections and should be accessible to everyone with an interest in this area.

B K Mandal

Department of Infectious Diseases and Tropical Medicine, Delaunays Road, Crumpsall, Manchester M8 5RB, UK

A summer plague

Polio and its survivors—*Tony Gould*. New Haven/London: Yale University Press. 1995. Pp 366. \$35/£19.95. ISBN 0-300-06292-3.

A Summer Plague is the latest in the long progression of books and periodicals that have documented the rise and fall of poliomyelitis during the 20th century. The book is a celebration of the triumphs that emerged from the ashes of anguish and despair such as the celebration of a courageous American President, Franklin D Roosevelt, whose dedication in combating the disease during the aftermath of the Great Depression and in the midst of World War II