

Surface-EMG Processing & Classification for Muscle Interfaces

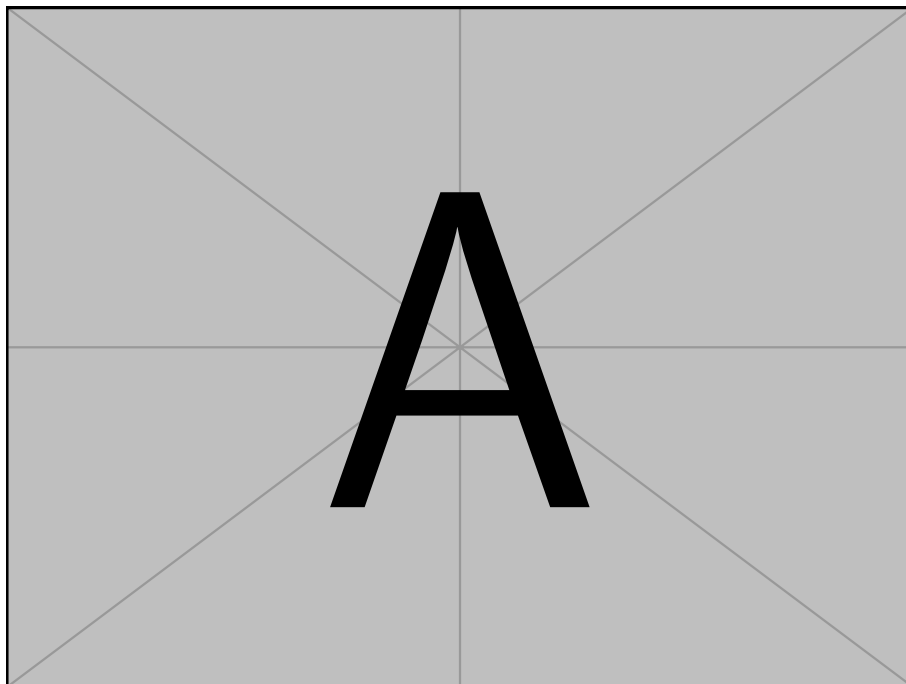
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1 Abstract

Hello, this is my abstract...

2 Acknowledgements

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Glossary

abduction/adduction Movement away/towards the midline of the hand. 14, 15

Congenital A disease or physical abnormality present from birth. 6

flexion/extension The bending movement of the finger. 14

phalange Bone in the finger. 14

sEMG surface-electromyography. 8

traumatic A disease or physical abnormality due to trauma. 6

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3 Introduction

The human hand is one of the most important factors of the human identity. The hand allows a person to perform complex muscolatory combinations to interact with the surrounding world, express complex emotions during speech, and aid in defining a person's individuality and personality [???]. The hands are controlled by a complex combination on precise muscles designed to perform gentle, precise control of the fingers. This allows a person to grasp objects in many different ways, perform complex tasks such as writing, playing musical instruments, or even constructing a house. The hand also acts like a sensory device allowing us to perform precise observations through feeling and touch. This allows a person to understand the environment without seeing it, the hand is able to sensor heat/cold, create complex understanding of geometries and texture through touch and manipulation.

Missing limbs, either Congential or traumatic amputation severely reduces a person's ability to interact with- / understand the world, express themselves and perform simple day-to-day tasks. In order to alleviate some of the drawbacks of missing a limb, amputees are often able to aquire a prosthetic replacement of their lost limb. The aquired prosthetic tries to imitate the movements of the lost limb, through muscle-activated interfaces, that is then used to control the movements of the prosthetic. In the case of hand prosthetics, the prosthetic allows the user to perform simple, day-to-day tasks, and is able to alleviate some of the stress caused to the non-amputated hand through overusage.

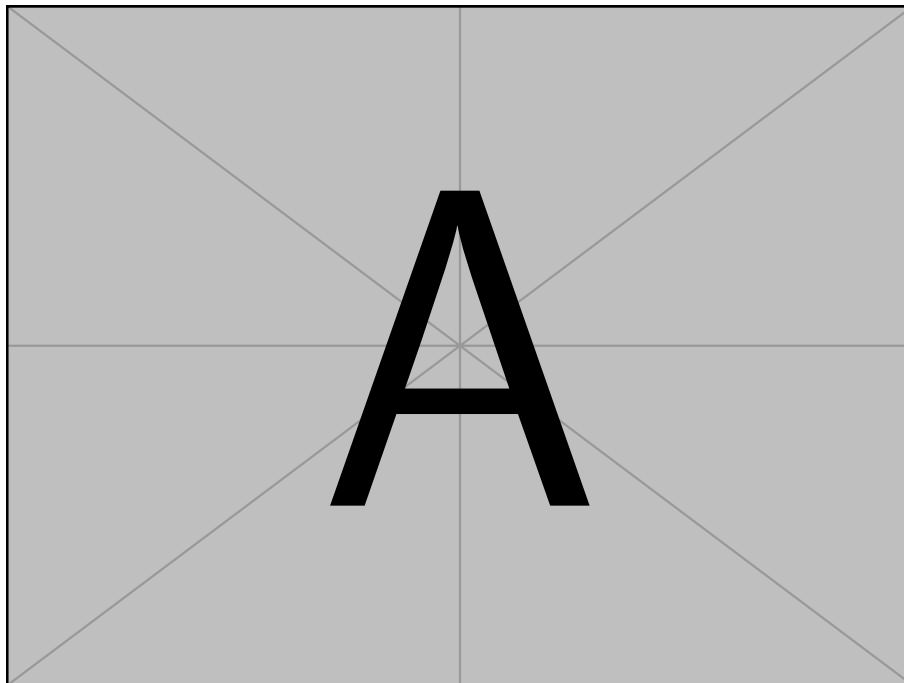


Figure 1: Example figure text

This thesis aims to summarize, and elaborate on current state-of-the-art research and products in the field of prosthetics devices, and products the control of prosthetics and the existing limitations of these state-of-the-art products.

This thesis aims to contribute to the world of prosthetics control, by researching effective methods of collecting sensory data from the lower-/upper-arm, and by doing so, creating an state-of-the-art Artificial Intelligence (AI) based controller, that is able to imitate the intent and movements of a real hand. And by doing so, by improving sEMG controller design to increase functionality and the controllable DoF of the prosthetic, to provide a more true-to-life experience to the prosthetics user, and thus reduce the amount of patients that disregard prosthetics.

This thesis also aims to explore efficient methods of designing a network to identify lower-/upper-arm musculatory intent, with the purpose of controlling a simulated prosthetics device, and by doing so, increase the controllable Degree-of-Freedom for the prosthetics user.

4 Problem Specification

There is a large need for new technology that improves the effectiveness and ergonomics of human hand prosthetics.

Current state-of-the-art products on the market exhibits a severe reduction of controllable Degree of Freedom (Dof) compared to their biological counterparts. These products often rely on simple, grasp control based on 2 or more surface-electromyography (sEMG) interfaces, to classify “open/close” signals for the control scheme. The prosthetics user is then manually required to change grip control-scheme, creating very crude control dynamics that is very different from biological hand-control. A in-depth explanation of “open/close” control can be seen in section ?? This is a great pitfall in the field of Research and Creation of prosthetics, as unsatisfactory function of prosthetics lead to amputees, that exhibit a great deal of stress during the rehabilitation process.

This can cause the patient to repel the rehabilitation process and the prosthetic all-together. The repelling of the prosthetic increase in the cases of the most severe cases of amputation, where the largest amount of control muscles are lost. These amputations are often located further up the limbs, where the loss of mobility and controllability are greatest. The amount of muscles leftover from amputation also dicates the type of prosthetic a patient is able to recieve. Patients of lower-arm amputation has less control over their prosthetic than patients of hand amputation, due to the loss of the muscles in the lower-arm. The loss of control increases as the amputation severity increases, and this is a problem in prosthetics design because it is impossible to create a standardized controller that suits most patient’s needs.

State-of-the-art commercial prosthetics further decrease the controllable DoF in order to increase robustness of the control experience, this is further elaborated upon in ??.

4.1 Motivation

The main goal of this thesis is to provide a meaningful contribution to the world of prosthetics design and control. In order to confine the workload done in this thesis, a set of development goals has been made:

1. Create a software-based, biology-inspired, anatomically realistic simulation of a humanoid lower-arm/hand that is able to imitate the movements of the humanoid limb.
2. Make the prosthetics simulation controllable from a widely-used robotics-software.
3. Design a sEMG muscle pre-processing pipeline for a prosthetics controller.
4. Design a state-of-the-art prosthetics controller based on AI, to control a simulated prosthetics device.
5. Create a custom dataset to train AI based controllers for prosthetics.

6. Test and Validate the created prosthetics controller against state-of-the-art methods.

5 Literature Review

As sensors capability for biological sensing increases in state-of-the-art prosthetics development and research, there becomes a larger need for translating sensor data into usable input data for prosthetics controllers. A lot of research has been done in this area, this research elaborates on different Machine learning or AI-based methods of understanding muscle-based sensor data. The pipeline for converting EMG sensor data to usable input data often contains a pre-processing step, where data is de-noised, and cleaned of potential errors. The pre-processing step can also contain feature extraction such as ... The pre-processing step is then followed by a processing step, this step encompasses the use of a Machine-learning algorithm or a Neural Network, designed to either Classify a grip type, or Regress the angle of the joints. After Classification or Regression a post-processing step can be added where the actual kinematic data is created, and used as input to the prosthetic controller. Popular methods of processing EMG signals will be researched, and elaborated upon, with the aim of identifying robust, effective and implementable methodologies.

5.1 Introduction to Literature

Human Machine Interfaces (HMI), are control systems that enables humans to interact and control a mechanical or robotic system. As explained in the paper [Tech2015], researchers and prosthetists have been developing mechanical prosthetics for many years. One example of such devices would be the ankle-foot-orthoses, a support device strapped to the ankle, used to reliably adjust the pressure applied by the body while walking, to help impaired individuals with walking in a more natural way. [Tech2015] proposes that EMG signal based control research are an ongoing topic in rehabilitation and prosthetics. Generally, EMG is an experiment-based method of evaluating and recording electrical signals from muscles. Specifically, EMG signals emanate from the excitability of muscle fibers through neural control, causing action potentials that cause depolarization and repolarization of the muscle membrane. These polarization changes can be detected using EMG sensors, either through non-invasive or invasive techniques. Invasive EMG signal recording requires the use of a penetrating needle electrode to be placed in the muscle tissue, this method reduces the signal-to-noise ratio (SNR) but can be a cause of discomfort and infection. As an alternative, non invasive EMG sensors, placed at the surface of the skin are called sEMG sensors, they provide much less discomfort and propose no risk of infection to the amputee, at the cost of having an increased SNR. [Tech2015] explains that the muscle fiber membrane has a resting potential of -90 to $-90mV$ when resting. The paper also explains that the amplitude of sEMG signals have a voltage range from 0 to $10mV$, and a frequency range from 10 to $500Hz$.

5.2 Noise in EMG signals

The paper [Tech2015] proposes different noise types that contaminate EMG signals, these noises are defined as electrical signals that are not part of the desired EMG signal. The different noise types found in EMG signals are

- Inherent Noise in Electronics Equipment,
- Ambient Noise,
- Motion Artifacts,
- Inherent Signal Instability,
- Electrocardiographic (ECG) Artifacts,
- & Cross Talking.

Noise in Electronics Equipment exists in all electronic devices, this noise has been proved to be reduced by using electrodes made of silver. **Motion Artifacts** affects EMG signals when the skin and electrodes move in relation to the movement of the underlying muscle. This can cause artifacts due to inconsistent displacement. **Inherent Signal Instability**, The amplitude of EMG signals are quasi-random. Frequency components less than 20 Hz are unstable and affected by firing rate of the motor units. This range is considered unwanted noise. Muscles change based on their active motor units, therefore the EMG signal changes too. **ECG Artifacts** is the electrical activity of the human heart is a huge interference component of EMG signals recorded from the Shoulder Girdle (Shoulder muscle groups). It is very hard to remove ECG artifacts from EMG signals, due to their relative characteristics in the frequency spectrum! **Cross Talk** is undesired EMG signals from muscle groups not commonly monitored. I guess it's a form of EMG leak from undesired muscles.

5.3 sEMG Sensors for Prosthetics

The usage of sEMG sensors propose a lot of obstacles because of noise, but that does not stop sEMG sensors from being part of the state-of-the-art research in prosthetics. In the paper [KeunTaeKim2021] proposes that the usage of sEMG sensors are of great importance in upper-limb classification for prosthetics devices. The paper uses sEMG sensors to classify reaching-to-grasping tasks using a Convolutional Neural Network (CNN) after pre-processing the signal with Principal Component Analysis (PCA) to reduce noise. The processing combination method of PCA-CNN proved to show higher accuracy than Machine Learning methods, such as Support Vector Machine (SVM) with an accuracy of $70.1 \pm 9.8\%$ based on 9 subjects. The paper proposes that the sEMG sensors are placed on the upper-body in combination with the upper-arm for grasping intention classification, specifically, the muscles *Pectoralis*, *Trapezius*, *Latissimus Dorsi* & the *Biceps/Triceps*, see section ?? for placements. In [KeunTaeKim2021], the *Southampton Hand Assessment Procedures (SHAP)* [1] was used to create a dataset. SHAP is designed for the assessment of musculoskeletal and neurological conditions, and can be used to test the effectiveness of prosthetics.

Another paper that proposes the usage of sEMG sensors for prosthetics is [Zhaolong2021]. The paper proposes the usage of different sEMG devices, two of those are the wearable product “Myo Armband”, [2] a discontinued sEMG product consisting of 8 sensors that can be placed below the elbow joint, and the “Delsys Trigno” [3],

a set of individual sEMG sensors that can be worn and record most muscle groups. [Zhaolong2021] proposes the pre-processing of the sEMG data using a Notch filter of 50Hz. Furthermore, the target angles obtained as ground truth targets were reduced in dimensions through PCA, thus having the 6 dominant PC's be the targets. Then, using an "Inverse PCA algorithm", they compute the final control output for the prosthetic. In order to process the sEMG data, [Zhaolong2021] proposes the use of a time window of 200ms, with feature extraction for root mean square (RMS) & zero crossing (ZC). The extracted features were used as input to a nonlinear autoregressive exogenous (NARX) network, a fully-connected multilayer-perceptron (MLP) network combined with a recurrent neural network (RNN).

5.4 Adaptive Grasping Methods

Most state-of-the-art methodologies consist of using sEMG data to predict grasp type classification or joint angle regression. The paper [Yuki2023] proposes that this method becomes a burden for the HMI user, as the severity of the amputation increases and the loss of muscle recording areas become greater. [Yuki2023] takes inspiration from evolutionary robotics, and proposes the use of evolutionary computation to predict stable grasping methods based on touch sensor input. This is done by having a mapping between the touch sensor input of the fingers and the motorcontrol of the joints. [Yuki2023] uses a simulation to train a RNN network, this RNN takes sEMG sensor data, Touch sensor data, distance to the object & object height into account. It is possible to compute distance to / height of object because grasping and training is done entirely in simulation, using a simulated target object, but that the method used would be realisable for prosthetics. The paper concludes that alongside sEMG sensors, touch sensors could be used to appropriate joint motion could be predicted using contact states between hand and object.

The paper [YanchaoWang2022] proposes a passive solution to adaptiveness when grasping. Their method uses an underactuated, compliant linkage mechanism, where the joint rotation of the finger joints can be driven by a single motor. This allows the fingers to not rely on touch sensors, as the method in [Yuki2023] does. [YanchaoWang2022] proposes the use of a sliding window with a size of 250ms. The window is then processed using feature extraction of integral myoelectric value (iEMG), RMS, mean absolute value (MAV) & ZC with a threshold to eliminate low signal fluctuation from noise. The extracted features are used for linear discriminant analysis (LDA) to classify grasping intent. The paper proposes that LDA showed the highest accuracy out of different Machine Learning methods.

5.5 sEMG Classification

5.6 Alternatives to sEMG sensors

5.7 General Overview of Different Areas of sEMG Processing

5.7.1 General Processing choices for muscle data

5.8 Regression or Classification

5.9 State of the Art Methods

6 Methodology

6.1 Design

In order to design a state-of-the-art simulated prosthetic hand, a number of anatomical design choices need to be considered. This thesis tries to create the most anatomically-correct hand simulation available, this will hopefully have a number of positive effects on prosthetics research. By having access to an advanced simulation, it would in turn be able to test and visualize more advanced movement controllers that can facilitate more DoF than current commercial prosthetics. By creating an anatomically correct prosthetic hand simulation, it is hoped that prosthetics users can have more advanced rehabilitation, and learn to have more natural control of their prosthetics. This would create a more natural usage experience, and decrease the percentage of users that reject the usage of their prosthetic altogether.

A set of requirements The simulated anatomically correct hand should be determined in order to create a state-of-the-art prosthetics simulation.

The simulated prosthetic should:

1. Facilitate the same DoF as an anatomically correct hand.
2. Have proportions that closely resemble that of an anatomically correct hand.
3. Be simulated and be controllable in a commonly used robotics software to increase accessibility for researchers.

6.1.1 Brief of used Software

Coppeliassim see [4].

6.1.2 Anatomy

The hand is an anatomically-complex appendage designed to facilitate a large amount of control in different usage scenarios. The hand consists of 27 bones, 14 of these are called phalanges, and make up the 4 fingers and the thumb. These bones, alongside a complex set of ??? muscles facilitates 24 DoF (Not counting Translation of the entire hand).

The individual finger consists of 3 bones called phalange, arranged linearly from the palm of the hand. The 3 finger bones are called the proximal phalange, middle phalange and distal phalange. The joints between the phalanges are able to do flexion/extension movement, while the base of the finger is further able to do abduction/adduction movement.

6.1.3 Simulated Hand Articulation design

In order to translate the biology and anatomy of a real hand into an robotics simulation, we start by denoting the relative lengths of the wrist bones and phalanges by reference, as can be seen in figure 2.

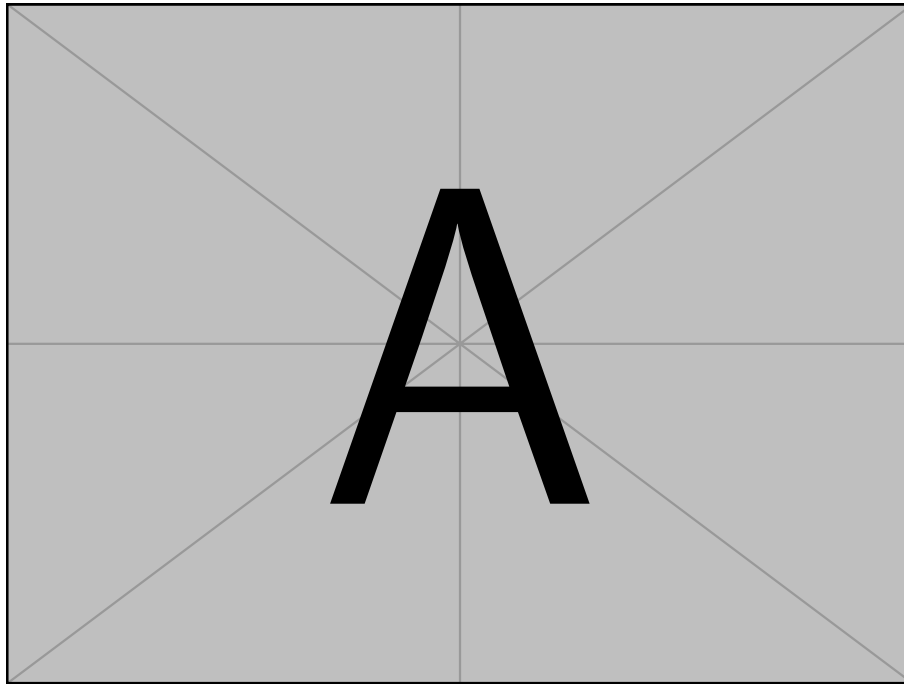


Figure 2: Example figure text

The proportions of the reference is used to denote the bone lengths for the model. The model is implemented in CoppeliaSim ??, The model is created in a hierarchy, the bones are created with cylinders and the joints are created using 1 DoF Revolute joints. As specified in section 6.1.2, some joints of the human hand facilitates 2 DoF of rotation. This is needed in order for the wrist and finger base joints to be able to do abduction/adduction. To simulate this, two 1 DoF revolute joints were placed in series, thus allowing 2 DoF.

6.2 Dataset Creation

In order to train a simulated hand prosthetic, a sophisticated dataset containing the measured relation between muscle activity and the finger placements is needed. The recording of the dataset is done using the software explained in section 6.1.1, namely Motive [5] & EMGworks [6].

6.2.1 Motion Capture Glove

In order to get precise recordings of the motion of the hand and fingers, using Motive [5], fluorescent 3D markers were placed on a glove. The pattern of the marker positions were carefully chosen in order to calculate the angles of the individual finger bones. The precise positions of the 3D markers on the recorder glove can be seen in figure 3.

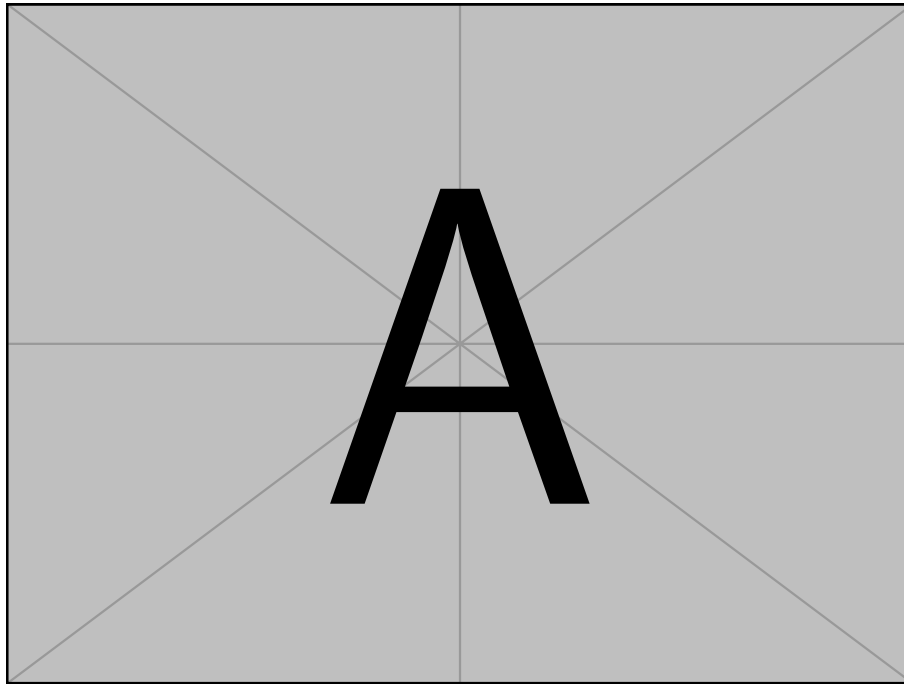


Figure 3: Example figure text

6.2.2 Sensor Locations etc.

The muscle recording sensors are located along the muscles of the forearm, the exact positions can be seen in figure 4.

6.2.3 Trial/motion overview

6.3 Implementation

6.3.1 Data Pre-Processing

6.3.2 Network Design

6.3.3 Software Hand Design

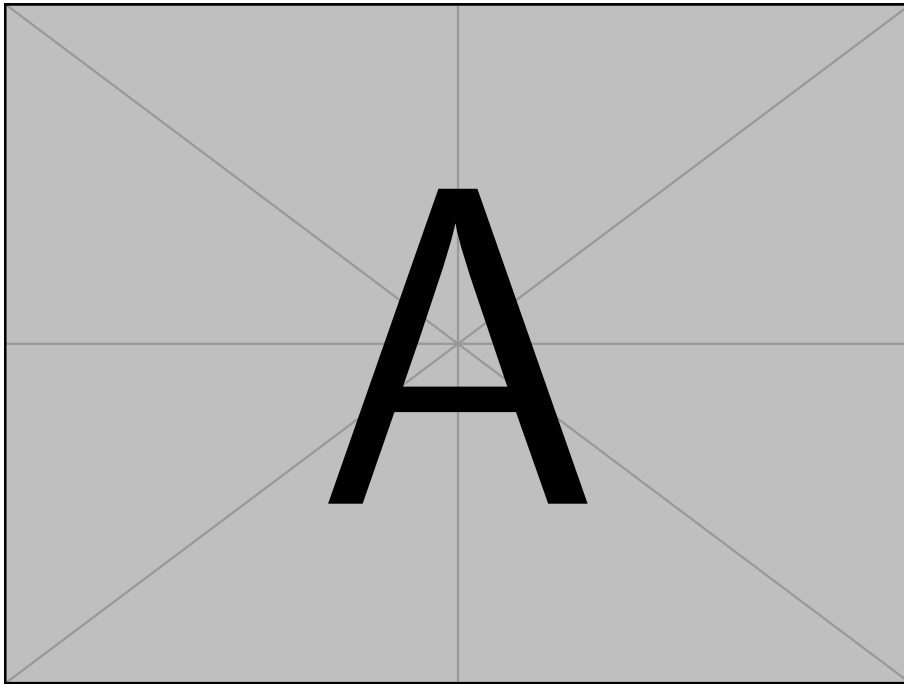


Figure 4: Example figure text

7 Tests & Results

8 Discussion

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9 Conclusion

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9.1 Future Work

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11 References

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