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Characterization and estimation of lung nodule malignancy using 3D Convolutional Neural Networks in Low-Dose CT

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PRESENTS

Eng. Jonathan Domínguez Aldana

ADVISORY BOARD

PhD Eloy Edmundo Rodríguez Vázquez

PhD Nayeli Camacho Tapia

MD Eduardo Hernández Rangel

MD Adrián Antonio Negreros Osuna

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Contents

Li	st of f	igures	vii
Li	st of t	ables	ix
A	cknow	ledgments	x
Aş	grade	cimientos	xii
Al	bstrac	t	xiv
1	Intro	oduction	1
	1.1	Problem statement	1
	1.2	Motivation	3
	1.3	Research questions	3
	1.4	Hypothesis	4
	1.5	Objectives	4
		1.5.1 General objective	4
		1.5.2 Specific objectives	4
	1.6	Scope	5

2	The	coretical framework 6				
	2.1 Lung cancer and computerized tomography					
		2.1.1	An overview of lung cancer	6		
		2.1.2	Computerized tomography	10		
	2.2	Deep l	earning and neural networks	11		
		2.2.1	Machine learning and neural networks	11		
		2.2.2	Training issues of neural networks	16		
		2.2.3	Optimization algorithms for neural network training	19		
		2.2.4	Hyper parameter optimization	20		
		2.2.5	Convolutional neural networks	21		
		2.2.6	Deep learning and medical imaging	26		
	2.3	Literat	ure review	27		
		2.3.1	Nodule detection algorithms	27		
		2.3.2	Malignancy classification algorithms	30		
3	Met	hods		32		
3	Met 3.1	hods Study	design	32 32		
3	Met 3.1	hods Study 3.1.1	design	32 32 32		
3	Met 3.1	hods Study 3.1.1 3.1.2	design	 32 32 32 33 		
3	Met 3.1	hods Study (3.1.1 3.1.2 3.1.3	design	 32 32 32 33 33 		
3	Met 3.1 3.2	hods Study (3.1.1 3.1.2 3.1.3 Data ir	design	 32 32 32 33 33 34 		
3	Met 3.1 3.2	hods Study (3.1.1 3.1.2 3.1.3 Data ir 3.2.1	design	 32 32 32 33 33 34 34 		
3	Met 3.1 3.2	hods Study (3.1.1 3.1.2 3.1.3 Data ir 3.2.1 3.2.2	design	 32 32 32 33 33 34 34 36 		
3	Met 3.1 3.2 3.3	hods Study (3.1.1 3.1.2 3.1.3 Data ir 3.2.1 3.2.2 Progra	design	 32 32 32 33 33 34 34 36 36 		
3	Met 3.1 3.2 3.3 3.4	hods Study (3.1.1 3.1.2 3.1.3 Data ir 3.2.1 3.2.2 Progra Prepro	design	 32 32 32 33 33 34 34 36 36 37 		
3	Met 3.1 3.2 3.3 3.4	hods Study (3.1.1 3.1.2 3.1.3 Data ir 3.2.1 3.2.2 Progra Prepro 3.4.1	design	 32 32 32 33 33 34 34 36 36 37 38 		
3	Met 3.1 3.2 3.3 3.4	hods Study (3.1.1 3.1.2 3.1.3 Data ir 3.2.1 3.2.2 Progra Prepro 3.4.1 3.4.2	design	 32 32 32 33 33 34 34 36 36 37 38 39 		
3	Met 3.1 3.2 3.3 3.4 3.5	hods Study (3.1.1 3.1.2 3.1.3 Data in 3.2.1 3.2.2 Progra Prepro 3.4.1 3.4.2 The alg	design Research population Type of study Type of study Research duration Research duration nformation sources and manual for data acquisition Data sources Data sources Data acquisition and safety protocols mming frameworks Pixel intensity rescaling Spatial re-sampling Spatial re-sampling	 32 32 32 33 34 34 36 36 37 38 39 41 		

		3.6.1	Candidate nodule detection CNN	45
		3.6.2	False positive reduction CNN	51
	3.7	Malign	ancy classifier	53
	3.8	Morphe	ological estimator	56
		3.8.1	Spiculation estimator CNN	58
		3.8.2	Lobulation estimator CNN	61
	3.9	Cancer	estimator	64
	3.10	Medica	l ethics guidelines	65
4	Resu	lts and	discussion	67
	4.1	Nodule	detector	67
		4.1.1	Candidate nodule detection CNN	67
		4.1.2	False positive reduction CNN	74
	4.2	Malign	ancy classifier	77
	4.3	Morphe	blogical estimator	80
		4.3.1	Spiculation estimator CNN	80
		4.3.2	Lobulation estimator CNN	82
	4.4	Cancer	estimator	85
	4.5	Discuss	sion	89
5	Cond	clusions		92
Ap	pendi	ices		95
A	Info	rmed co	nsent forms	96
B	Scrip	pts for e	ach hospital data base	99
C	Scrip	pts for d	ata normalization	113
D	Script for all detectors 117			

Bibliography

191

List of Figures

1.1	Cancer death statistics in Mexico	2
2.1	The perecptron model	13
2.2	Gradient descent algorithm	15
2.3	Convolution operation example	23
2.4	A typical convolutional layer	25
2.5	Classic Convolutional Neural Network	26
3.1	Example of a CT pixel rescaling	39
3.2	Histograms of CT pixel resolutions	40
3.3	Result of CT preprocessing	41
3.4	Algorithm workflow design	43
3.5	Histograms of nodule dimensions	46
3.6	Example of CT slices containing nodules	47
3.7	Generated nodules for the Candidate Detection stage	48
3.8	Predefined CNN architecture for the Nodule Candidate Detection step	51
3.9	Generated benign nodules for the Malignancy Estimator	55
3.10	Generated likely malignant nodules for the Malignancy Estimator	55

3.11	Correlation matrix of nodular morphological characteristics	58
3.12	Histograms of nodular morphological characteristics	59
3.13	Generated spiculated nodules for the Spiculation Estimator	60
3.14	Generated non-spiculated nodules for the Spiculation Estimator	61
3.15	Generated lobulated nodules for the Lobulation Estimator	63
3.16	Generated non-lobulated nodules for the Lobulation Estimator	63
4.1	Best model architecture for the candidate detection CNN	71
4.2	Summary of the validation metrics of the candidate detection CNN	72
4.3	FROC curve of the candidate detection CNN	73
4.4	Results of the candidate generator CNN applied to database B2	73
4.5	Summary of the validation metrics of the false positive reduction CNN	76
4.6	Summary of the validation metrics of the malignancy classifier CNN	79
4.7	Summary of the validation metrics of the spiculation estimator CNN	82
4.8	Summary of the validation metrics of the lobulation estimator CNN	83
4.9	Cancer estimator deep neural metwork	85
4.10	Summary of the validation metrics of the cancer estimator DNN	88

List of Tables

2.1	Nodule evaluation standard	8
2.2	Summary of related studies	28
3.1	Statistics of CT pixel resolutions	40
3.2	Hyper-parameter sample distributions	50
3.3	Correlation malignancy results	57
3.4	Nodular morphological characteristics scores	60
4.1	Hyper-parameter space for the nodule detection CNN	69
4.2	Best hyper-parameter values of the candidate detection CNN	70
4.3	Final average validation metrics of the candidate detection CNN	72
4.4	False positive reduction CNN validation results	74
4.5	Best hyper-parameter values of the false positive reduction CNN	75
4.6	Final average validation metrics of the false positive reduction CNN	76
4.7	Final average validation metrics of the malignancy classifier CNN	77
4.8	Best hyper-parameter values of the malignancy classifier CNN	78
4.9	Final average validation metrics of the spiculation estimator CNN	80
4.10	Best hyper-parameter values of the spiculation estimator CNN	81

4.11	Final average validation metrics of the lobulation estimator CNN	83
4.12	Best hyper-parameter values of the lobulation estimator CNN	84
4.13	Hyper-parameter space for the cancer estimator DNN	86
4.14	Best hyper-parameter values of the cancer estimator DNN	87
4.15	Final average validation metrics of the cancer estimator DNN	88

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Abstract

Lung cancer has posed a major challenge for health institutions all around the world. Economic and social implications derived from this disease result in efforts to reduce mortality rates and establish better diagnostic procedures. Specifically, technologies such as low-dose computerized tomography (CT) have been implemented to increase early detection accuracy of lung cancer. Even though, there are still major challenges to improve sensitivity and specificity rates of lung cancer prognosis using CT. More precisely, false positives and negatives are still present in the prognosis procedure. In consequence, there are psychological, economic and social problems associated with false positive and negative rates. Some of these problems include economic costs for families and health institutions, patient anxiety, and potential risks of morbidity and/or mortality. Moreover, false negatives represent the main problem due to the potential irreversible consequences that could arise, where survival rates decrease considerably and paliative care is the only alternative to reduce patient suffering. To address these issues, several research studies have developed different Computer Aided Diagnostic (CAD) tools. Thus, the objective of this study is to investigate all related work to develop a better CAD system for automatic lung cancer detection that will help radiologists with CT assessment; and ultimately, will reduce the number of false positives and negatives.

By analyzing all related studies, three main constraints have been identified: 1) few studies have focused on the entire process of lung cancer detection, 2) the best results for each stage of the estimation process were obtained using a lot of computational resources, and 3) state of the art models (for each stage) implement ensemble methods containing a lot of parameters, where many Convolutional Neural Networks (CNNs) are trained, thus increasing model complexity. Therefore, a sequential 3D Convolutional Neural Network (CNN) architecture was proposed to make an end-to-end lung cancer estimation. Four principal components comprised the algorithm: 1) a nodule detector, 2) a malignancy classifier, 3) a morphological nodular predictor, and 4) the final cancer estimator. Only one classic CNN was trained for each one of the first three stages, while the last component was implemented using a classic Deep Neural Network. Moreover, all training was performed on constrained hardware. Specifically, a NVIDIA GeForce GTX 1060 GPU, 24 GB of RAM and an Intel Core 17-7700HQ CPU were used.

A particular Hyperparameter Tuning technique, the "Tree-structured Parzen Estimator", was used for selecting the appropriate network topology for each component. Data for training and validation was obtained from the open source Lung Image Database Consortium (LIDC), while independent data was collected from three hospitals located in the state of Querétaro, in Mexico. Several standard preprocessing techniques were applied before training and validating the networks. Also, augmentation techniques were implemented during training, such as 3D lossless transformations and "Generative Adversarial Networks". A 10-cross fold validation was defined to evaluate the network's performance at each stage, where four metrics were specified: sensitivity, specificity, F1 score, and ROC curve.

Results for the nodule Candidate Generation CNN were successful giving a final sensitivity of 94.1% and an average of 450 FP /CT with a binarization threshold of 0.1. On the other hand, the FPR model did not perform as expected, giving as a result a sensitivity of 0.25 and an average of 41.8 FP /CT. Therefore, efforts must focus in optimizing and improving the FPR model performance. For the spiculation and lobulation estimators, the results were promising giving final sensitivities of 0.9965 and 0.8358 respectiveley, as well as final specificities of 0.9984 and 0.9240. Another

successful result was given by the malignancy classifier, which reported a sensitivity of 1 and a specificity of 1. Although these last results sound promising, further testing must be done to verify them. Finally, the cancer estimator reported a sensitivity of 0 and specificity of 1.

As illustrated in the results, the main problem that was encountered during the research was the development of the false positive reduction stage. Final experiments showed that the best FPR models were obtained when heavy data augmentation was applied to the data, specifically when random nodular translations were included. An important remark resides in the probability estimations computed by almost all of the developed FPR models. Most of the highest detection rates per CT slice were obtained outside of the CT scan. It is possible that with the addition of preprocessing algorithms, all undesired CT regions could be removed to avoid these false positive findings. Poor results may also be attributed to the exclusion of repeated annotations of the same nodule provided by all four radiologists from database A. Thus, it is possible that the restrictions imposed for defining a true positive were too flexible.

An important highlight is to illustrate the sequential design of the algorithm workflow. Due to this sequentiality, many of the poor results obtained in previous steps are reflected in further stages of the algorithm. Specifically, the results obtained for the cancer estimator are explained by this architecture design. Also, one of the main limitations of this research study was the hardware. Although many of the trained models were inspired on more complex architectures, such as ResNet, Inecption Net, Vgg and Inception-Resnet, their abstraction capabilities cannot be compared to the original ones. Even though, this limitation was seen as another contribution of this thesis, to achieve similar results by training models with fewer parameters.

This works has proved the value of CAD models to aid in the detection of lung cancer with some degree of accuracy. It is expected that better technologies will be developed in the future, helping radiologists detect lung cancer in early stages to provide immediate healthcare to patients.

CHAPTER 1

Introduction

1.1 Problem statement

Based on estimates from GLOBOCAN 2018 there are 18.1 million new cancer cases and 9.6 million deaths worldwide associated to the disease. Specifically, lung cancer is the most commonly diagnosed carcinoma in the world representing the highest mortality rate for both genders [1]. In Mexico, since 1998 lung cancer has occupied the first position in mortality rate with respect to other cancers. Fig. 1.1 illustrates different cancer death statistics in Mexico since 1998 [2]. Furthermore, based on the World Cancer report 2014, diagnostic procedures for lung cancer are of great relevance for reducing deaths and increasing patient survival rates. In this case, Low-Dose Computerized Tomography (CT) of chest is the preferred choice to make an initial prognosis [3,4].

The National Lung Screening Trial (NLST) made a comparison in diagnostic accuracy between the CT and chest X-ray. A sample of 53,454 male and female smoker patients, between 55 and 74 years old, was gathered to make the comparison between both technologies. Results showed a mortality rate decrease in lung cancer of 16% using CT, with respect to chest X-ray [5]. Also,



Fig. 1.1. Cancer death statistics in Mexico for several types of carcinomas from 1998 to 2015.

a research study showed the presence of 23% false positives (FP) and a 0-20% range of false negatives (FN) produced by the CT evaluation in the NLST assessment. A specificity of 73.4% and a sensitivity of 93.8% were obtained during the research [6]. Another study exposed that approximately 35.6% of patients will receive at least one FP screen in a three years examination period, of whom 18 will have an invasive procedure [7].

Besides false positives, it is well known that diagnostic accuracy is also related to the radiologist's background and years of expertise. For example, two radiologists can give different diagnosis results even if they analyzed the same CT; a problem referred as inter-grader variability [8]. One of the possible reasons related to these differences consists in the radiologist fatigue, although further research is needed to confirm it. Consequently, there can also be an increase in the false negative rate if the medical doctor is tired [9].

1.2 Motivation

Patients diagnosed with lung nodule false positives may experience anxiety. Furthermore, false positives represent a risk increase in morbidity and/or mortality due to unnecessary diagnostic tests and treatments, deriving in economic implications that directly affect the patient [7].

A statistical research was designed to analyze a sample of 1087 patients, from the "PLCO Screening Trial", to assess the medical and non-medical costs associated with false positive rates presented in lung, prostate, colorectal, and ovarian cancer screens [10]. In this study, 43% of subjects presented at least one FP, from which 83% received follow-up care. The adjusted mean difference of costs between patients, who presented at least one FP and the ones who didn't, was estimated to be \$424,539 US dollars. As a result, there is a pressing need to increase sensitivity and specificity of lung cancer assessment. A potential solution is to develop a Computer Aided Diagnostic (CAD) tool.

There are three main reasons to conduct the research and develop a CAD system:

- Reduction of lung nodule false positive and negative rates encountered in low-dose CT.
- Develop an objective framework to avoid subjective assessments in the diagnosis of lung cancer.
- Reduction in the time invested by the radiologist to detect and characterize lung nodules in low-dose CT.

1.3 Research questions

Three main research questions are formulated to guide this study:

1. What morphological nodular characteristics will allow the automatic detection and characterization of pulmonary nodules using a machine learning algorithm?

- 2. Would the automatic detection and characterization of lung nodules help the radiologist reduce false positives and negatives while assessing a CT?
- 3. Would dividing the malignancy estimation problem in different stages result in better performance of the machine learning algorithm?

1.4 Hypothesis

If a sequence of interconnected 3D Convolutional Neural Networks is developed to detect and characterize pulmonary nodules in low-dose CT, with a sample size of at least 1000 CT for training and testing, then at least 90% sensitivity and 90 % specificity of nodular malignancy estimation can be attained.

1.5 Objectives

1.5.1 General objective

To detect and characterize lung nodules to estimate nodular malignancy probability in low-dose CT with a specificity and sensitivity of at least 90% using a machine learning algorithm based on 3D Convolutional Neural Networks.

1.5.2 Specific objectives

- 1. Preprocess all computerized tomography.
- 2. Define the pipeline architecture in two stages and develop the mathematical model:
 - (a) Design and implement the nodule detector.
 - (b) Develop the nodular characteristics estimators.
- 3. Validate and compare the results with other studies using four different metrics: sensitivity, specificity, F1 score, and ROC curve.

1.6 Scope

The study was developed for a time period of two years at "Centro de Ingeniería y Desarrollo Industrial" (CIDESI), in collaboration with Universidad Anáhuac Querétaro. All computation tasks were done using the following hardware specifications: a Graphics Processing Unit (GPU) NVIDIA GTX 1060, an Intel Core i7-7700 HQ Central Processing Unit (CPU), and 32 GB of Random Access Memory (RAM). A sample size range, between 500 and 2,000 CT, was defined for analysis. Two types of patients were considered to be included in this research study:

- 1. Patients with lung nodules greater than 3 mm in maximum diameter that were assessed as benign by expert radiologists (minimum 6 years of experience).
- 2. Patients with primary lung tumors and/or metastatic carcinomas present in the lungs. Specifically, selection criteria was specified using the clinical staging conventions provided by the International Association for the Study of Lung Cancer (IASLC) [11]. Therefore, Stages 0, IA, IA1, IA2, IA3, IB, IIA, IIB, and IIIA were included in the analysis. More advanced lung cancers were not considered, since such lesions are evident and easily identified in the CT.

Clinical specifications for both patients were defined as: either sex, gender, and ethnic origin. The selection criteria was chosen to generalize detection capabilities, thus allowing the algorithm to be implemented in any clinical context.

CHAPTER 2

Theoretical framework

2.1 Lung cancer and computerized tomography

2.1.1 An overview of lung cancer

The origin of the term cancer goes back to Ancient Greece with Hippocrates, who defined the concept as *carcinos* to describe tumor formation due to ulcers. Such description is attributed to the crab's structure whose projections are similar to the morphology presented by the disease [12]. In general, cancer refers to any malignant tumor formed by unusual cell division, which can penetrate their surrounding organs; a process denominated as metastasis. Generally, tumors can be classified into two types: malignant and benign. Any tumor is considered benignant if it is enclosed and isolated from its surroundings. On the other hand, malignant tumors are characterized by a fast unregulated cell multiplication, which can invade adjacent nearby tissues [13].

It is well known that unregulated cell division of cancer is caused by mutations in specific genes, therefore all cancers are referred to as diseases of the genome [3]. Specifically, it has been reported

that 50% of all cancers are caused by mutations in the p53 tumor suppressor gene [14].

Etiology of the disease is extremely relevant to understand mutation causes. There are several risk factors associated to cancer development, where tobacco smoking represents the most important factor up to date. Other factors include chronic infections, diet, alcohol intake, sun exposure, environmental pollution, and exposure to hazardous environments [3]. The World Health Organization has classified risk factors into two categories: genetic and external. The latter has been subsequently classified into physical, chemical, and biological carcinogens [13].

As defined previously, smoking is considered the most important risk factor related to different types of cancer development. Furthermore, cigarette smoking has been proven to be the main cause for lung cancer in developed countries [3]. Based on The World Cancer Report 2014, lung cancer is one of the most aggressive human cancers presenting a 5-year overall survival of 10-15%. Also, lung cancer has a high incidence rate in men and women presenting 18.1 million new cancer cases and 9.6 million cancer deaths worldwide just in 2018 [1,3].

All classification procedures of the disease have been based primarily on morphological features. Reports have divided lung cancer into four distinct histological types: adenocarcinoma, squamous cell carcinoma, small cell carcinoma, and large cell carcinoma [3]. Also, several efforts have been focused in differentiating disease staging. Therefore, the International Association for the Study of Lung Cancer (IASLC) has published the eighth edition for lung cancer staging, where all classification results with their respective descriptors are shown in Table 2.1. The research article provides a more detailed explanation of the chosen descriptors (N=node, T=tumor and M=metastasis) and the selected criteria for classifying lung cancer staging [11].

As reported by the IASLC, nodule evaluation is a crucial task for making an initial assessment of the patient. In consequence, the American College of Radiology has published an assurance tool for evaluating lung nodules in CT [15]. Generally, all evaluation efforts are focused in evaluating solitary pulmonary nodules (SPN) because the presence of multiple nodules is evidence of metasta-

Staging Group	т	N	Μ
Occult carcinoma	ТΧ	NO	MO
Stage 0	Tis	NO	MO
Sta 101	T1a(mi)	NO	MO
Stage IA1	T1a	NO	MO
Stage IA2	T1b	NO	MO
Stage IA3	T1c	NO	MO
Stage IB	T2a	NO	MO
Stage IIA	T2b	NO	MO
	T1a-c	N1	MO
Stage UP	T2a	N1	MO
Stage IID	T2b	N1	MO
	Т3	NO	MO
	T1a-c	N2	MO
	T2a-b	N2	MO
Stage IIIA	Т3	N1	MO
	Τ4	NO	MO
	Τ4	N1	MO
	T1a-c	N3	MO
Stage IIIB	T2a-b	N3	MO
Stage IIID	Т3	N2	MO
	Τ4	N2	MO
Stage IIIC	Т3	N3	MO
Stage Inc	Τ4	N3	MO
	Any T	Any N	M1a
Stage IVA	Any T	Any N	M1b
Stage IVB	Any T	Any N	M1c

Table 2.1. Staging procedure for lung cancer development based on three different descriptors tumor, node and metastasis.

sis, which indicates a high probability that the tumor does not have its origins in the lungs [16].

A concise definition of a solitary pulmonary nodule is provided in [16], specifying it as a single lesion in a round or oval shape with a diameter ≤ 3 cm in lung parenchyma, surrounded entirely by gas-containing lung tissue. Any lesion having a diameter greater than 3 cm is considered a pulmonary mass. To differentiate a SPN as benign or malignant, there are five factors to be considered [16–18]:

- **Clinical factors:** all solitary pulmonary nodules in non-smoker patients, younger than 35 years old, and without cancer history are considered benign lesions: granuloma, hamartoma (benign malformations) or inflammatory lesion [17].
- **Growth Pattern:** growth development of a SPN is measured in *doubling time*, which is the time it takes for a nodule to double its volume. Any SPN with *doubling time* less than 1 month (infectious lesions) or greater than 2 years (hamartomas) have a high probability of being benign [17]. On the other hand, a lesion presenting a *doubling time* between 30 to 400 days tends to be malignant [16].
- Size: a study showed that the probability of malignancy is less than 1% if the nodule diameter is less than 4 mm, 0.9% if it is between 4 and 7 mm, 18% if the size oscillates in a range of 8-20 mm, and 50 % for diameters between 20 and 30 mm [16].
- **Border Characteristics:** malignant nodules are usually associated with irregular, spiculated, and lobulated contours. For example, a research defined a logistic regression model that estimated a probability between 88% and 94% that a nodule is malignant given that it was lobulated [16]. With respect to spiculation, the term *corona radiata* has been used to describe it as a set of linear densities that radiate from the edge of a nodule into the adjacent lung [17]. Moreover, SPN that are neither spiculated or lobulated present a high probability of being benign [17].
- **Density:** nodule calcification is an important characteristic for differentiating between malignant and benign lesions [16, 17]. A research conducted a study with a sample of 504 patients

with calcified nodules. Results comprised 97% and 3% of benign and malignant lesions respectively. The same study, using a sample of 1109 patients with non-calcified nodules, reported 29% benign lesions and 71% of malignant anomalies [19]. Moreover, there are 5 different types of calcification patterns to detect a benign lesion: central, complete, concentric, laminated, and pop-corn shape [17].

2.1.2 Computerized tomography

Many factors and parameters must be evaluated to make the best possible assessment of SPN, and the best tools must be used to achieve this goal. As described previously, CT has been the preferred choice over chest radiography for lung cancer risk assessment based on the NLST study that compared mortality rates for both technologies [20]. The history of computerized tomography goes back to 1967 with Godfrey Hounsfield, an engineer that developed the first modern CT scanner [21].

Basic principles behind CT screening define a subject to be scanned as being divided into axial slices [22]. A typical CT scanner consists generally of two components that are rigidly linked: an X-ray tube and an X-ray detector located in the opposite side. Both components scan across the subject with a linear translation movement. Many X-ray transmission measurements, at different locations of a specific slice, are performed while both components are moving linearly. When translation is finished for that specific slice, the system is rotated by some angle around the subject. Next, the translation movement is repeated over the patient for the same slice. A complete slice scan is finished when the system has reached 360°. Finally, the process is repeated for each slice comprising the patient [22].

Nowadays, there is a wide variety CT scanner models with different slice thickness resolutions and clever algorithmic solutions for image reconstruction. Even though there have been technology advancements for lung cancer screening, there are still challenges for improving diagnostic sensitivity and specificity [5, 6, 8]. Several solutions have been proposed to address these issues and are defined as Computer Aided Diagnosis (CAD) tools.

2.2 Deep learning and neural networks

With the advent of big computational power resources, availability of a huge amount of data, and better algorithms, deep learning has been a great success in many areas where pattern recognition is required [23–27]. As a consequence, deep learning has been proposed as an excellent CAD tool for the evaluation of medical images. Actually, this area of study has been applied recently to tackle many challenges posed in the prognosis of several diseases using medical imaging techniques [23,28–30].

2.2.1 Machine learning and neural networks

Deep learning is one of the most recent topics developed in machine learning, which is considered one of the seven disciplines of artificial intelligence [31]. Defining precisely the concept of machine learning is difficult because there have been slight changes in its definition throughout history. For example, Peter Norvig and Stuart J. Russell conceive it as the ability of a computer to adapt to new circumstances, to detect and extrapolate patterns [31]. As exposed by Arthur Samuel, machine learning can also be defined as the field of study that gives computers the ability to learn without being explicitly programmed [32]. A definition that is more suitable for recent times is the one provided by Stephen Lucci and Danny Kopec, who defined it as the process by which a computer distills meaning due to exposition of training data [33].

Within machine learning there are three major areas: supervised, unsupervised and reinforcement learning. Given a training set $(\vec{x}^{(1)}), y^{(1)}), (\vec{x}^{(2)}, y^{(2)}), ..., (\vec{x}^{(m)}, y^{(m)})$ where each $y^{(i)}$ was generated by an unknown function y = f(x) and $x^{(i)} \in \mathbb{R}^n$ represent the vector of n inputs for the i^{th} training example, the main objective of supervised learning is to find a function h(x) that approximates f(x) [31]. This problem can be stated in two different tasks depending on the outputs $y^{(i)}$. If the output vector \vec{y} is comprised by a finite number of discrete categories, then approximating f is stated as a classification problem. On the other hand, if the output vector has continuous variables as components, then approximating f becomes a regression task [34]. For this thesis, unsupervised and reinforcement learning are irrelevant, but more information is covered in [31, 34, 35]. Several algorithms have been developed in the supervised learning regime, such as linear and logistic regression, neural networks, support vector machines (SVM), k-nearest neighbors, the perceptron, kernel methods, among others [31, 34, 35]. Specifically, neural networks (NN) are of great relevance in the context of this thesis.

History of NN goes back to 1943 with Warren McCulloch and Walter Pitts, who presented the first theoretical model of a neuron in their paper "A logical calculus of the ideas immanent in nervous activity" [36]. Such model computes a binary sum of the inputs contained in $\vec{x}^{(i)}$ and outputs a predicted value $\hat{y}^{(i)} \in [0, 1]$ depending if a certain threshold is reached. Thus this artificial neuron has the ability to represent any of the three logical operators: AND, OR and NOT.

Later on, in 1949, psychologist Donald Hebb posed the basis for neural learning by stating [37]: "When an axon of cell A is near enough to excite a cell B and repeatedly or persistently takes part in firing it, some growth process or metabolic change takes place in one or both cells such that A's efficiency, as one of the cells firing B, is increased."

Thanks to Hebb's Rule and the theoretical model of McCulloch and Pitts, Frank Rosenblatt developed the basic artificial neuron: The Perceptron [38]. Hebbian learning was represented by weighting each feature contained in a single training example $\vec{x}^{(i)}$ and adjusting them based on a simple update rule: the proportional difference between the estimated output and the observed value $e = y^{(i)} - \hat{y}^{(i)}$, which represents the miss-classification error for the i^{th} training example.

Therefore, the basic model of the perceptron consists on a "squashing" function $f(\vec{x})$ (applying a threshold) computed over a weighted sum of inputs. Moreover, the weighted sum can be computed as the dot product between a vector of neural weights \vec{w} and the input vector for a specific training example $\vec{x}^{(i)}$:

$$z = \vec{w}^T \cdot \vec{x}^{(i)} \tag{2.1}$$



Fig. 2.1. Representation of the perceptron that computes the weighted sum of the input vector components of the i^{th} training example, to make a prediction $\hat{y}^{(i)} \in [0, 1]$. [38].

A simple representation of the perceptron is described in 2.1 where f represents the activation function (threshold computation) and \sum refers to the weighted sum of the inputs $x_1^{(i)}, x_2^{(i)}, ..., x_n^{(i)}$ contained in $\vec{x}^{(i)}$.

One problem with this approach is the inability to compute non-linearly separable functions, such as the XOR boolean operator. As stated by Minsky, computing non-linear functions would require extra layers of several perceptrons, also defined as a hidden layers [39]. Furthermore, the learning rule provided by Rosenblatt do not work because there is no way to adjust weights in the previous hidden layers. In other words, the update rule provides information for the error made only by the last perceptron.

Several years passed until Geoffrey Hinton *et al.* provided an efficient and automatic way for updating all weights in previous layers: the backpropagation algorithm [40]. The learning procedure was defined using the chain rule from calculus, where error derivatives would be computed for each weight in the multi-layer perceptron. In consequence, all weights would be updated based

on how much each one of them contributed to the final prediction error. To make this learning procedure feasible, the activation f was changed for a sigmoid function described in (2.2), which is both non-linear and differentiable. In general, any function f that has a bounded derivative will work using this learning regime [40,41]. It is important to note that f corresponds to the prediction $\hat{y}^{(i)}$ made by the multi-layer perceptron.

$$f = \frac{1}{1 + \exp^{-z}}$$
(2.2)

Therefore, the main objective for training a multi-layer perceptron consists of finding the best combination of neural weights that minimizes the error between all observed values $y^{(i)}$ and predictions $\hat{y}^{(i)}$. Depending on how the error is calculated, the objective can be stated as a regression or classification problem. If the error term is calculated using the averaged squared error over the m training examples as expressed in (2.3), then it is a regression problem. On the other hand, if E is computed using the average log-losses over all training examples as defined in (2.4) it is expressed as a classification task. The expression defined by E is also denoted as the cost function in the machine learning jargon.

$$E = \frac{1}{m} \sum_{i=1}^{m} (y^{(i)} - \hat{y}^{(i)})^2$$
(2.3)

$$E = -\frac{1}{m} \sum_{i=1}^{m} (y^{(i)} log(\hat{y}^{(i)}))) + (1 - y^{(i)}) log((1 - \hat{y}^{(i)}))$$
(2.4)

To update the neural weights, the chain rule of calculus is needed to compute the partial derivatives of the cost function E with respect to each of the weights w_j in the network. Because the objective is to minimize E, an iterative optimization technique defined as Gradient Descent (GD) is applied to update weights after computing the error over all training examples. This update rule is defined in (2.5), where α defines the learning rate (step size) and w_t defines the value of a specific weight in iteration t.

$$w_{t+1} := w_t - \alpha \frac{\partial E}{\partial w_j} \tag{2.5}$$



Fig. 2.2. Illustrative example of Gradient Descent optimization to find the minimum of the error surface E that is parameterized by two weights w_1 and w_2 .

From a geometric perspective, at every iteration GD is calculating the steepest negative direction of the *n* dimensional error surface from a point in space, which corresponds to the current combination of weights. Therefore, after every iteration, the algorithm tries to converge to a minimum of the error surface *E*. An example of this learning procedure is illustrated in 2.2, where the error surface *E* is parameterized by only two weights w_1 and w_2 . The red line describes the trajectory of both weight values as they are updated with each iteration of Gradient Descent.

With this approach, multi-layer perceptrons started to be trained efficiently. Later on, in 1989, Kurt Hornik would prove mathematically that neural networks (NN) could approximate theoretically any function given enough time and computational power [41].

2.2.2 Training issues of neural networks

Even with the beautiful mathematical proof stating NN as universal approximators, Yoshua Bengio *et al.* encountered a problem when training large neural networks: gradients that propagated throughout the network would vanish or explode [42]. Several solutions were proposed to overcome the difficulties of training deep neural networks (DNN): unsupervised training for initializing weights at each layer, weight sharing using different network architectures such as convolutional neural networks (CNN), and using graphics processing units (GPUs) [43–45].

A thorough analysis was conducted by Yoshua Bengio and Xavier Glorot to identify the main causes that resulted in poor performance of the backpropagation algorithm [46]. Two principal findings were reported:

- The non-linear sigmoid function was a poor choice because it presents saturation during training. This resulted in slow learning, which was reflected on several plateaus of the error surface.
- 2. Choosing random weights, without taking into account to which layers they correspond, is a bad decision. As a consequence, subsequent multiplication of derivatives resulted in the exploding/vanishing gradient problem (non constant variance). The solution consisted in random weight initialization with scaling, which resulted in faster training convergence.

As presented in the original paper, normalized initialization, or commonly known as "Xavier initialization", was computed to initialize weights considering the specific layer within the network and performing scaling accordingly. Equation (2.6) defines initialization from a uniform distribution over a symmetric interval considering the number of incoming connections n_j and outgoing connections n_{j+1} of a specific layer within the network.

$$W \sim U[-\frac{\sqrt{6}}{\sqrt{n_j + n_{j+1}}}, \frac{\sqrt{6}}{\sqrt{n_j + n_{j+1}}}]$$
(2.6)

To address the problem of the sigmoid activation function, several efforts were done to search for a better non-linear activation [47, 48]. Results showed that the best f is the simple rectified

linear activation function (ReL), which is expressed in equation (2.7). Actually, any neuron that applies the ReL activation is defined as a Rectified Linear Unit (ReLU).

$$f(x) = max(0, x) \tag{2.7}$$

Although the ReL activation function presents a discontinuity at x = 0, it has proven to have several advantages over the logistic sigmoid activation [49]:

- One main advantage is that the ReL function can represent sparse representations because there is no need for all neurons to be activated simultaneously (many units could output zero). Thanks to this property computation is faster because neurons that are not activated can be ignored.
- It presents a solution to the vanishing gradient problem because the derivative is either 0 or 1. Therefore, backpropagation runs without getting stuck in plateaus.
- 3. Also, more distributed representations are obtained because it does not focus on single neurons, but rather in a multiple combinations of them.

Besides all these ingenious solutions to tackle the vanishing/exploding gradient issue, there is another problem that has been present in any machine learning model: overfitting. A phenomenon that has been defined as: *"having more parameters in the model that can be justified by the data"* [50]. Several techniques have been implemented to reduce its effects during training, and improve model generalization. For example, Geoffrey Hinton *et al.* implemented a very basic, but powerful idea: the dropout technique. It consists on "removing" temporarily some random amount of neurons during training, thus avoiding complex and unnecessary neural adaptation. Therefore, only the most important features are learned by each neuron while activated during the optimization process [51].

A more classical approach in machine learning consists in adding a penalty term to the error function E, a method known as regularization. There are two main types of regularization [52]:

1. L1 (lasso) regularization: it consists on adding the sum of the absolute values of the weights in the NN to the cost function *E*. Expression (2.8) denotes a classical L1 regression problem.

L2 (Ridge or Tikhonov) regularization: also called weight decay, it consists on adding the sum of the squared values of the weights in the NN to the cost function *E*. Expression (2.9) denotes a classical L2 regression problem.

Both types of equations have a regularization parameter $\lambda > 0$ that controls the amount of penalty that is added to the cost function E and is scaled by the amount of training examples m with the factor $\frac{1}{2m}$.

$$E = \frac{1}{m} \sum_{i=1}^{m} (y^{(i)} - \hat{y}^{(i)})^2 + \frac{\lambda}{2m} \sum_{w} |w_j|$$
(2.8)

$$E = \frac{1}{m} \sum_{i=1}^{m} (y^{(i)} - \hat{y}^{(i)})^2 + \frac{\lambda}{2m} \sum_{w} w_j^2$$
(2.9)

Even when overfitting has been reduced considerably, there is another issue that is present: long convergence times to an optimal solution during training. Changes in the probability distributions of activations computed in each layer during training have been reported as one of the main causes for this slow down; a problem that has been defined as internal covariate shift [25]. A solution proposed by Christian Szegedy and Sergey Ioffe was to normalize all layer's inputs x_i to adjust the distributions, such that even if the network parameters change during training, the activations will maintain the same distributions [25]. To achieve this goal, equations (2.10) and (2.11) corresponding to the mini batch mean and variance respectively, are computed.

$$\mu_B = \frac{1}{n} \sum_{i=1}^n x_i \tag{2.10}$$

$$\sigma_B^2 = \frac{1}{n} \sum_{i=1}^n (x_i - \mu_B)^2 \tag{2.11}$$

Normalization is performed on single scalar features producing a distribution with mean 0 and variance 1. Therefore, using the mean and variance of equations (2.10) and (2.11), normalization of a mini batch is calculated with expression (2.12). The variable ϵ is added to avoid singularities during computation.

$$\hat{x}_i = \frac{(x_i - \mu_B)^2}{\sqrt{\sigma_B^2 + \epsilon}}$$
(2.12)

One important thing, as reported by the authors, is that layer representations may change because of these transformations. To avoid this, scale and shift computations are introduced to recover the layer representation power. Equation (2.13) defines both trainable parameters γ and β to recover such representations. This step ensures that the transformation performed over the mini batches are able to represent the identity transform.

$$y_i = \gamma \hat{x}_i + \beta \equiv B N_{\gamma,\beta}(x_i) \tag{2.13}$$

2.2.3 Optimization algorithms for neural network training

To speed up training times, efforts have focused on making adjustments to the learning rule defined in equation (2.5). A classical variant of this algorithm is Stochastic Gradient Descent (SGD), which computes the gradient of E for single training examples instead of all the data contained in the training set, as specified in (2.14). Also, computation of the gradient of E has been defined for batches of training data, a variant called Batch Gradient Descent (BGD) [53].

$$w_{t+1} := w_t - \alpha \frac{\partial E(x^{(i)}, y^{(i)})}{\partial w_i}$$

$$(2.14)$$

A faster optimization algorithm is GD with momentum [53]. The basic idea consists on calculating an exponential weighted average of the past gradients and adding it to the update rule. This helps to damp the oscillations generated in SGD and BGD, thus creating faster update steps in the learning procedure and achieving lower convergence times. Both calculations, for the exponential weighted average and the final update rule, are depicted in equations (2.15) and (2.16), respectively. In equation (2.15), the hyper parameter $\gamma \in [0, 1]$ adjusts the amount of weight assigned to previous gradient results, while v_{t-1} and v_t correspond to the gradients computed in the last and current iterations.

$$v_t = \gamma v_{t-1} + \nabla_w E \tag{2.15}$$

$$w_{t+1} := w_t - \alpha v_t \tag{2.16}$$

Another optimizer that has shown promising results is the Adaptive Moment Estimation (Adam) learning algorithm [54]. This approach builds upon GD with momentum and the RMSprop algorithms by computing the exponential weighted averages of past gradients and their squared magnitudes; followed by their corresponding bias corrections. Equations (2.17) and (2.18) define the calculations needed to compute the exponential weighted averages for both, the gradients and their squared magnitudes. Bias corrections are implemented in expressions (2.19) and (2.20). Finally, the learning update rule defined by Adam, using both bias corrections, is written in equation (2.21).

$$v_t = (\beta_1)v_{t-1} + (1 - \beta_1)\nabla_w E$$
(2.17)

$$m_t = (\beta_2)m_{t-1} + (1 - \beta_2)(\nabla_w E)^2$$
(2.18)

$$\hat{v}_t = \frac{v_t}{1 - \beta_1^t} \tag{2.19}$$

$$\hat{m}_t = \frac{m_t}{1 - \beta_2^t}$$
(2.20)

$$w_{t+1} := w_t - \alpha \frac{\hat{v}_t}{\sqrt{\hat{m}_t} + \epsilon} \tag{2.21}$$

Other optimizers that have been developed throughout the history of NN include RMSprop, Adadelta, Adagrad, Nadam, and AdaMax [53–55].

2.2.4 Hyper parameter optimization

It is important to highlight the large number of hyper parameters that need to be tuned in a DNN to achieve acceptable results. Actually, finding the best set of hyper parameters for a DNN is a difficult task to do by hand because the search space is really large. As exposed by James Bergstra *et al.*,
"hyper parameter optimization is the problem of optimizing a loss function over a graph-structured configuration space" [56].

There have been efforts to create algorithms that search efficiently for the best set of hyper parameter values. One typical approach is grid search, in which all possible combination of values of the hyper parameters are explored in a hyper dimensional "grid". The problem with this strategy comes inevitably from the *curse of dimensionality*, in which the search space size increases exponentially as the number of hyper parameters is increased [57].

Another solution for hyper parameter tuning is random search, which has proven to have better results compared to grid search [56, 57]. In this technique, all values for each hyper parameter are independently sampled from a uniform density from the same space, as the one spanned by regular grid search.

Both techniques are really powerful when the evaluation of the learning algorithm function f is cheap. In other words, when the amount of resources and time required to learn f are low. For DNNs that is not the case, because a lot of time and resources are needed to train them. In such cases, when learning the function $f : X \to Y$ is really expensive, Sequential Model-Based Global Optimization (SMBO) algorithms are the preferred choice to make the hyper parameter tuning [56]. SMBO models try to approximate f with a surrogate that is cheaper to evaluate. Two famous SMBO algorithms are the hierarchical Gaussian Process and the tree-structured Parzen estimator (TPE). Both of them restrict configuration spaces to tree structures [56].

2.2.5 Convolutional neural networks

Until now, the discussion has centered in DNN, but another topic that is of great interest for this dissertation are Convolutional Neural Networks (CNN). As reported in the literature, the first CNN was developed by Kunihiko Fukushima and was named: the *Neocognitron* [58, 59]. A more recent CNN, which resembles most modern architectures and incorporated the backpropagation algorithm,

was implemented by Yann LeCun et al. [60].

As their name suggests, these networks substitute the multiplication operator for the convolution computation in equation (2.1). In a formal mathematical sense, this linear operation defines an integral that expresses the amount of overlap of one function g as it is shifted over another function f. Its identification symbol is the asterisk * and is explicitly stated in expression (2.22) [61].

$$(f*g)(t) = \int_{-\infty}^{\infty} f(\tau)g(t-\tau)d\tau$$
(2.22)

In the deep learning jargon, function f is designated as the *input*, function g as the *kernel*, and the output function as the *feature map* [62]. This definition applies for continuous valued functions that are usually stated in time-domain problems. For the case of CNNs, the discretized convolution operation is implemented over several N dimensions as stated in equation (2.23).

$$(f * g)(t_1, ..., t_i, ..., t_N) = \sum_{\tau_1} \dots \sum_{\tau_i} \dots \sum_{\tau_N} f(\tau_1, \dots, \tau_i, \dots, \tau_N) g(t_1 - \tau_1, \dots, t_i - \tau_i, \dots, t_N - \tau_N)$$
(2.23)

Because CNNs are frequently implemented for pattern recognition in images, the input is usually expressed as I and the kernel as K. In practice, when dealing with spatial domain applications, the *cross-correlation* operation is used instead, which is the same computation as convolution but without flipping the kernel as defined in (2.24). Therefore, this operation is computing the similarity between both signals, the kernel and a specific portion of the image, as the kernel is superimposed over all the image domain. Similar to DNNs, the objective of convolutional neural networks consists in learning the parameters within all kernels K_i , that are convolved with the input I.

$$(I * K)(t_1, ..., t_i, ..., t_N) = \sum_{\tau_1} \dots \sum_{\tau_i} \dots \sum_{\tau_N} I(t_1 + \tau_1, ..., t_i + \tau_i, ..., t_N + \tau_N) K(\tau_1, ..., \tau_i, ..., \tau_N)$$
(2.24)

A very famous application of the convolution operation is the Sobel operator for edge detection [63]. This specific algorithm implements 3x3 kernels that are convolved with images to



Fig. 2.3. Example of the convolution operation using the Sobel operator as kernel.

calculate derivative approximations in the horizontal and vertical directions. Figure 2.3 illustrates the convolution operation implemented using the Sobel operator to detect horizontal edges using a kernel G_y , superimposed over a two-dimensional image I. In this case, a 3x3 kernel G_y is convolved with a 6x6 image I to produce a 3x3 matrix as a result. Only the first convolution computation is shown.

The motivation for using CNNs with respect to classical DNNs resides on three main advantages, sparse interactions, parameter sharing, and equivariant representations [62]. Sparse interactions arise from convolving kernels that are much smaller in size than the input *I*, which derives into fewer parameters associated to each output. On the other hand, DNNs have all input neurons connected to all output units. As a result, DNNs contain a large number of parameters compared to CNNs. Therefore, thanks to sparse interactions, CNNs can build complex structures based on a smaller amount of parameters.

The second advantage of CNNs, parameter sharing, means that a single parameter may be used more than once in the CNN. The reason behind this principle lies in shifting the kernel over the input domain, which forces the application of the same kernel weights (parameters) to different spatial locations within the input I.

Finally, equivariant translation, results naturally from the parameter sharing property. Even if the input I is translated, the representations that are built by the CNN will stay the same. In order words, even if an object is shifted within the image, the CNN will still have the ability to detect it. Thus, these three properties of CNNs provide a powerful framework for object detection and define a clear advantage over classic DNNs.

Modern CNN layers have a different structure compared to classic DNNs. Each layer in a CNN is composed by three different transformations [62, 64]:

Convolutional step: a set of m kernels K_i with equivalent sizes (kxk) are convolved with the n dimensional input I in parallel, giving as a result different tensors ρ_i (with the bias term b_i included) as expressed in equation (2.25). Finally, the different results ρ_i are concatenated in a multi-dimensional array or volume ρ.

$$\rho_i = I * K_i + b_i \tag{2.25}$$

Detection step: a non-linear function f, such as the ReL activation defined in equation (2.7), is applied to each component of the concatenated output of convolutions ρ, to give as a result, a volume γ with components γ_i; as described in (2.26).

$$\gamma_i = f(I * K_i + b_i) \tag{2.26}$$

- 3. Pooling step: it is defined as a function that replaces the output γ_i of the net, at a certain location, with a summary statistic of the nearby outputs δ_i [62]. By adding this step, the CNN keeps the most important abstractions and discards the irrelevant ones (invariance feature extraction), thus reducing computational resources and the number of parameters that need to be trained. There are different types of pooling operations applied to the nearby outputs:
 - (a) Max pooling: calculates the maximum output of a rectangular neighborhood.



Fig. 2.4. Example of a convolutional layer where m kernels are applied to an n dimensional input I. The resulting volumes ρ_i from the convolutional steps are omitted.

- (b) Average pooling: computes the average value of a rectangular neighborhood.
- (c) L^2 pooling: computes the L^2 norm of a rectangular neighborhood.
- (d) Global weighted average pooling: computes a weighted average based on the distance from the central pixel.

An illustrative example of a CNN layer is depicted in Figure 2.4, where each kernel K_i could be seen as the analogous of a neuron in a classical DNN. In this type of layer, m kernels are applied to an n dimensional input I, resulting in ρ_i tensors. Then, a non-linear function f is applied to each convolution result ρ_i resulting in a tensor γ_i . All tensors γ_i are concatenated to produce a final volume γ . Finally, a pooling layer computes the summary statistics at each output neighborhood resulting in the output tensor δ of the layer.

It is important to see that the input volume is reduced after being processed by each CNN layer. Because of this shrinkage effect, some padding operations are also computed in the layers, thus maintaining the volume size and allowing the CNN to generate more powerful abstractions.

Although this is the typical architecture of a CNN layer, more operations can be defined within each layer, such as normalization layers, loss layers, or even fully connected (FC) layers (typical layers of a DNN) [64]. By using the pooling and convolution operations, the CNN becomes a



Fig. 2.5. Model of a classic Convolutional Neural Network architecture.

powerful algorithm that can learn features that are invariant not only to translations, but also to rotations and more complex spatial transformations [62].

An important aspect of CNNs is that the learning procedure is based on the same backpropagation algorithm used by classic DNNs [40]. Therefore, all the techniques described before, to improve and solve different training issues of classic DNNs, can also be applied to CNNs. A typical CNN architecture is shown in Figure 2.5, although variants of this network configuration have also been investigated [24–26, 65, 66]. The classical architecture comprises four main portions, 1) the input layer, 2) a set of convolutional layers, where a typical single layer is illustrated in Figure 2.4, 3) a fully connected layer, and 4) an output layer.

2.2.6 Deep learning and medical imaging

Thanks to the ability of DNNs and CNNs to learn complex patterns within data, they have become the preferred choice to solve image recognition tasks. Many researchers have focused on developing medical tools based on these algorithms to assist in *"image registration, anatomy localization, lesion segmentation, detection of objects and cells, tissue segmentation, and computer-aided detection"* [23]. Specifically, computer-aided diagnosis (CAD) is the topic of main relevance for this dissertation.

In the literature, the typical workflow for designing a CAD system is defined in two steps, 1) candidate generation algorithms and 2) classifiers that output the most probable regions having the disease. As reported by Dinggang Shen *et al.*, CNNs have become the algorithm of choice for developing any of the two aforementioned steps [23]. As it has been stated, the motivation of using deep learning techniques for detecting abnormalities in medical images resides in reducing error rates during evaluation; mainly the number of false positives (FP) and false negatives (FN) [6–8,23].

Although DNNs and CNNs have reported promising results for detecting abnormalities in medical images, its implementation has become a major challenge due to the limited amount of medical data available for training. Even so, many strategies to prevent overfitting have been developed such as data augmentation, transfer learning, and using patches of samples instead of full-sized images [23,67–70]. It is evident that more efforts are required to automate the generation of available medical data to improve the performance of deep learning CAD systems. A problem that depends on the national context of each country and deals with other issues, such as legal and administration matters.

2.3 Literature review

Several CAD tools have been developed to reduce false positive rates and assist radiologists in the evaluation of lung cancer in CT. Most CAD systems implement any of the following four steps: 1) preprocessing of CT, 2) lung segmentation, 3) lung nodule detection, and 4) lung nodule malignancy classification [70, 71]. Recent studies have focused mainly on either lung nodule detection or malignancy classification [28, 68, 70–80]. Table 2.2 gives a brief summary of all related research.

2.3.1 Nodule detection algorithms

Generally, for nodule detection algorithms there are two main steps: 1) candidate selection (CS) and 2) false positive reduction (FPR) [72,79]. A thorough analysis has shown that Convolutional Neural Networks (CNN) outperform any other type of classifiers in the FP reduction and nodule candidate

			EVALUATION METRICS						IMPLEMENTED METHODS				
Authors	Year	ст	ACC	SNS	SPC	F1	ROC	Log Loss	Nodule detector	Malignancy classifier	Lung cancer estimator with combined nodular characteristics	Direct lung cancer estimator	Optimization
Kuruvilla, J. et al.	2013	155	0.91	-	-	-	-	-	-	-	-	 Architecture: NN with variable α, β. Data: geometric parameters of 2D lungs 	GD con ADAM
			0.93	0.91	1	-	-	-	-	-	-	 Architecture: NN with variable β. Data: geometric parameters of 2D lungs 	GD with modified ADAM
Kumar, D. et al.	2015	157	0.75	0.83	-	-	-	-	 Architecture: autoencoder Data: 2D nodules. 	 Architecture: Binary Decision Tree. Data: vector with 200 characteristics. 	-	-	L-BFGS
Madero, O. et al.	2015	151	0.82	0.91	0.74	-	0.81	-	-	 Architecture: SVM with radial basis function. Data: vector with 11 characteristics obtained with wavelets 	-	-	Mult. Lagrange
Dou, Q. et al.	2016	888	-	0.92 with 8 FP/scan	-	-	-	-	 Architecture: three 3D CNN with different receptive fields. Data: 3D nodules. 	-	-	-	SGD with momentum
Kuan, K. et al.	2017	2702	-	0.667	0.77	0.598	-	0.53	Architecture: 3D CNN - ResNet. Data: 3D CT volume portion.	 Architecture: two 3D CNN - ResNet in parallel with variable a. Data 1° network: 3D CT volume portion. Data 2° network: nodules detected by nodule detector. 	Architecture: NN with 2 layers. Data: weighted characteristics obtained from previous networks.	-	GD with ADAM
Hammack, D. et al.	2017	2500	-		-	-	0.85	0.40	Architecture: Ensemble learning with several 3D CNN – ResNets / VGGNets Data: 3D CT volume portion.	Architecture: Ensemble learning with several 3D CNN – ResNets / VGGNets Data:: nodules detected by nodule detector.	Architecture: Ensemble learning with 3D CNN – ResNets. Final classification was done with a Binary Decision Tree. Data: nodules detected by nodule detector.	 Note: 17 CNN were implemented for all stages in the algorithm. 	GD with ADAM and Nesterov momentum
Setio, A. et al	2017	888	-	0.95 and < 1 FP/scan	-	-	-	-	 Architecture: Ensemble learning with 5 different 3D CNN. Data: varies according to architecture. 	-	-	-	Multiple
Liu. et al.	2017	2608 nódulos	-	-	-	-	0.780	-	-	Arquitectura: Ensemble learning with 2D and 3D CNN. Data: nodules with malignancy pathologic confirmation.	-	-	SGD con momento
Ding, J. et al.	2017	888	-	0.922 with 1 FP/scan		-	-	-	Architecture: Faster Region-based CNN.	-	-	-	-
Ross, G. et al.	2018	888	-	0.8929 with 1.789 FP/scan		-	-	-	Architecture: 3D Inception-ResNet.	-	-	-	GD with ADAM
Dai, C. et al.	2018	1000	-	0.91 with 32 FP/scan	-	-	-	-	Architecture: 3D Inception-ResNet.	-	-	-	GD with ADAM
Shen, S. et al.	2018	897	0.842	0.705	0.89	-	0.856		-	Architecture: Hierarchical Semantic CNN with 2 subnetworks: 1° to estimate morphological characteristics and 2° for malignancy classification.	-	-	GD with ADAM
Ardila, D. et al.	2019	42,920	-	-	-	-	0.944	-	Architecture: 3D RetinaNet without feature pyramid network.	-	Architecture: CNN that combines outputs from nodule ROI detector and direct lung cancer estimator.	Architecture: 3D inflated Inception V1 Network.	GD with Focal Loss

Table 2.2. Research studies focused on both stages of the nodule assessment process: nodular detection and malignancy classification.

ABBREVIATIONS

- . • • .
- α = learning rate.

 ACC = accuracy.

 ADAM = adaptive moment estimation.

 β = learning momentum.

 CNN = convolutional neural network.

 FP = false positives.

 F1 = f1 score.

 GD = gradient descent.
- LBFGS = BFGS algorithm with limited memory. Log Loss = logarithmic los. Mult = multipliers. NN = neural network. ResNet = residual network. ROC = receiver operating characteristic. SGD = stochastic gradient descent. SNS = sensitivity. • .
- SPC = specificity.
 SVM = support vector machine..
 CT = computerized tomography.

Theoretical framework

•

selection tasks [72, 79]. An example is illustrated in the LUNA 16 challenge, where more than 95% detection sensitivity was achieved with less than 1 FP/scan using the results of 5 different CNNs and 888 CTs [72]. This research has proved to be the gold standard for the nodule detection task.

Isotropic re-sampling of the CT is a common task to do before nodule detection. Revised literature has defined voxel cubes of $1mm^3$ as a standard choice for uniform volumes [68,81]. Also, lung segmentation is performed to reduce computational expense and focus only on the desired region of interest, thus decreasing analysis time [28,68,72,81].

One research used all of the aforementioned steps: candidate selection, false positive reduction, isotropic re-sampling, and lung segmentation [81]. For candidate generation they used a 3D U-Net-inspired DNN architecture with a sliding window. Centroids from labeled volumes were computed for generating candidate nodules. With respect to false positive reduction, they used nodule volumes as the main feature and a size threshold of $8mm^3$, where any candidate with a lower size was treated as a false positive. An adapted Inception-ResNet architecture [82] was implemented using scaled exponential linear units. The training was performed using a 10 fold cross-validation, where all nodules generated from validation bins were used for the FPR task. Adam optimizer was implemented for optimizing the objective function. The results defined an averaged validation sensitivity of 89.29% with 1.789 FP/scan.

Another study developed a similar approach also using the 3D Inception-ResNet architecture [69]. A data set of 1000 CTs, from the Tianchi Medical Competition, was used for training, validation, and testing, where inputs to the network comprised normalized 64 x 64 x 64 CT patches. Also, both, candidate generation and FP reduction, were performed on the data set. An area under the ROC curve of 78% was obtained as the final result.

For the false positive reduction task, Dou Q. *et al.* developed three typical 3D CNN with different contextual information schemes and several max-pooling layers between convolutional ones [79]. Three receptive fields were proposed: (20x20x6), (30x30x10), and (40x40x26) to capture different

surrounding spatial patterns. The training was performed using Stochastic Gradient Descent and the LUNA 16 Challenge Database comprised by 888 CTs [72]. The results indicated a validation sensitivity of 92.2% with 8 FP/scan.

Finally, Ding, J. *et al.* focused on both, the candidate detection challenge and the false positive reduction task [83]. A Faster Region-based CNN was developed for the candidate detection stage and a classical 3D CNN was designed for the FP reduction step. All the evaluation was performed using the LUNA 16 Challenge Database. A sensitivity of 94.6% with 15 FP/scan was obtained for the candidate detection task. For the FP reduction task, an average FROC-Score of 0.893 was obtained; therefore, attaining the best performance in the LUNA 16 Challenge.

2.3.2 Malignancy classification algorithms

With respect to cancer estimation, a study obtained 93.3% accuracy, 100% specificity and 91% sensitivity using an Artificial Neural Network (ANN) trained with Adaptive Moment Estimation (Adam) and 155 CTs to determine the presence of cancer in a specific CT slice [77]. Another study focused in lung nodule malignancy classification achieving 75.01% accuracy, 83.35% sensitivity and 0.39 FP/scan using a five-layered auto-encoder trained by L-BFGS and 4,323 nodules [78]. To improve malignancy classification of nodules, Shen *et al.* implemented a CNN trained with Adam stochastic optimization algorithm and 897 LDCT. The CNN architecture consisted of two level outputs: 1) low-level radiologist semantic features and 2) a high-level malignancy classification. Results comprised 85.6% Area Under the Curve (AUC), 70.5% mean sensitivity, 88.9% mean specificity, and 84.2% mean accuracy [70]. Also, a research conducted by Madero *et al.* used 151 CTs and applied three wavelet transforms db1, db2 and db3 to extract and select 11 characteristics. A Support Vector Machine (SVM) was developed to perform malignancy classification resulting in 82% accuracy, 90.90% sensitivity and 73.91% specificity [71].

One of the main issues with malignancy classification is the lack of an open source data base with sufficient histopathologic labels. Therefore, few studies have reported results based on tissue confirmation and have focused only in radiologic features. One of these studies trained an ensemble of 2D and 3D CNNs with 2608 nodules and their respective pathologic confirmed labels, thus obtaining an area under the ROC curve of 0.78 [29].

Finally, based on all revised studies, the best results for malignancy classification have been reported by researchers at Google [28]. They used 42,920 CTs from 14,851 patients contained in the NLST study. Using a similar framework to the one proposed in this project, they implemented a two block modular approach. The first block consisted of a Region of Interest (ROI) detection model, where the selected CNN architecture was RetinaNet. All the detected ROIs were obtained either from one or two CTs corresponding to the same patient submitted for follow-up examination. The second block used an end-to-end inflated Inception V1 network, trained with $1.5mm^3$ voxel size volumes to predict cancer within 1 year. Outputs from both blocks were used as inputs to train a single CNN.

There are two major differences in this study with respect to the others. First, they used pathology-confirmed cancer labels as opposed to radiologic assessment scores. Second, they implemented comparison techniques between prior and current CT, to improve malignancy assessment. The final results comprised a 94.4% AUC calculated on a test set containing 6,716 CTs, where predictions were thresholded at three different levels to match the evaluation metrics specified in Lung-RADS [15]. Up until the writing of this thesis, the research published by Google poses the new gold standard for an end-to-end lung cancer risk assessment on CT.

CHAPTER 3

Methods

3.1 Study design

3.1.1 Research population

Population characteristics for this study were defined for the algorithm to be implemented in any Mexican hospital and clinical context. Thus, the following inclusion criteria was specified:

- 1. Gender: either.
- 2. Age: between 18 and 95 years.
- 3. Ethnics: either.
- 4. With or without smoking history.

More precisely, two types of patients were considered in this research as specified in 1.6. Only nodules ≥ 3 mm in diameter were considered, as any smaller lesion is defined as irrelevant based on the Guidelines for Management of Incidentally Detected Pulmonary Nodules in Adults [18].

Determining the sample size for a machine learning algorithm, for both training and validation, is a difficult task. Actually, it is still a major area of research in Computer Science. However, there has been evidence that with more training data CNNs can achieve better performance [84]. Because data is limited in medical applications, there is a major challenge to address when developing deep learning models for CAD systems [23]. Therefore, based on data acquisition limitations rather than sample size calculation; we specified a range with a lower bound of 1000 CT for both training and validation, with no upper bound limit for the required number of CTs. If available in records, histologic studies were also included for cancer label confirmation.

3.1.2 Type of study

The research study was defined by four distinct characteristics:

- Observational: there was no direct or indirect impact on the health of patients when doing the computational analysis of pulmonary nodules. No clinical, surgical, or invasive procedures were needed for this study.
- Retrospective: all analyzed CT scans were taken before this research study was conducted. No specific time interval in the past was specified for collecting CT studies.
- 3. Cross-sectional: it was decided to store and process the CT scan data in a 5 year time period since the start of this project: 01 September 2019 to 01 September 2024.
- 4. Descriptive: there was no comparison between CT scans from different patients or the same patient contained in the sample that was collected.

3.1.3 Research duration

The research was developed in two years: from 20 September 2017 to 01 November 2019. Specifically, CT scans and pathological information were acquired from 05 February of 2019 to 25 August of 2019. Changes to the schedule were due to several complications encountered in the research execution.

3.2 Data information sources and manual for data acquisition

3.2.1 Data sources

- 1. Data base A: this source of information comes from the Lung Image Database Consortium Image Collection (LIDC-IDRI) [85]. Seven academic centers and eight medical imaging companies worked together to build this data base comprised by 1010 CT scans and XML files with annotations done by four experienced thoracic radiologists in a two phase annotation process. In the first blinded-read stage, each radiologist evaluated independently each CT scan and classified all lesions into three categories: "nodule \geq 3 mm," "nodule \leq 3 mm", and "non-nodule \geq 3 mm". In the second phase, all radiologists reviewed their own annotations along with the marks made by the other three. Apart from evaluating nodule locations, eight subjective radiologic characteristics were assessed in a discretized score scale ranging from 1 to 5: subtlety, internal structure, spiculation, lobulation, sphericity, solidity, margin, and likelihood of malignancy.
- 2. Data base B: all low-dose CT scans contained in this data source come from three hospitals located in the State of Queretaro, Mexico; Hospital Star Médica, Hospital H+, and Hospital Ángeles. Several expert radiologists annotated each CT scan providing the bounding box coordinates for locating nodular lesions. Following a similar approach to the LIDC-IDRI database, each radiologist assessed three subjective radiologic characteristics: likelihood of malignancy, spiculation, and lobulation. Nodular assessment was made using the same discretized score scale ranging from 1 to 5. All annotations were made using the Mango software developed by the Research Imaging Institute UTHSCSA and copyrighted by the University of Texas [86]. Also, Excel files were generated to save the marks made by each expert radiologist. Slice thickness of each CT scan was defined to be ≤ 2.5 mm; any thickness greater than this value was discarded.
 - (a) Data Base B1 (Hospital Star Médica): this data base consists of 73 CT scans annotated by an expert radiologist with 5 years of experience in diagnostic radiology and a nuclear radiologist with 7 years of experience in oncological cases. The scanner model used

was a Siemens SOMATOM Definition with a maximum resolution of 64 slices.

- (b) Data Base B2 (Hospital H+): this source comprises 33 CT scans annotated by an expert radiologist with 6 years of experience in interventional radiology and another expert radiologist with 7 years of experience in diagnostic radiology. The scanner model used was a GE Optima CT660 with a maximum resolution of 128 slices.
- (c) Data Base B3 (Hospital Ángeles): this data base constitutes 13 CT scans annotated by an expert radiologist with 20 years of experience in diagnostic radiology and another expert radiologist with 1 year of experience in diagnostic radiology and Positron Emission CT. The scanner model used was a GE LightSpeed with a maximum resolution of 64 slices.
- 3. Data base C: this data base comprises three main information sources: pathology confirmation labels to verify the presence or absence of lung/metastatic cancer and the corresponding associated CT scan. All information was obtained from the LIDC-IDRI data base and two hospitals in the State of Queretaro, Mexico; Hospital H+ and Hospital Ángeles.
 - (a) Data Base C1 (LIDC-IDRI): this data base consists of 130 CT with confirmed diagnosis at patient level and was defined into three categories: 1) benign/non-malignant disease,
 2) malignancy that is a primary lung cancer and 3) a metastatic lesion that is associated with an extra-thoracic primary malignancy (the "unknown" category was excluded). For the diagnosis method all categories were included.
 - (b) Data Base C2 (Hospital H+): this source comprises 8 CT scans from patients with lung/metastatic cancer confirmed with biopsy. The scanner model used was a GE Optima CT660 with a maximum resolution of 128 slices.

Due to the retrospective nature of the study, large amounts of required data and no impact exerted directly or indirectly to the patients it was not mandatory to obtain informed consents from patients. However, in case that the Medical Institution and ethics committee required an informed consent, it was included in Appendix A. All acquisition protocols were conducted based on the legal guidelines stipulated in "*apartado* 5 de la NORMA Oficial Mexicana NOM-004-SSA3-2012, Del expediente clínico y en el apartado 5 de la NORMA Oficial Mexicana NOM-035-SSA3-2012, En materia de información en salud".

3.2.2 Data acquisition and safety protocols

All the steps followed in the acquisition protocol are detailed in this, except for data bases A and C1. It is important to express that strict patient confidentiality was mantained during the research.

- 1. CT acquisition methodology: patient in supine position with elevated arms and maximum inspiration during the acquisition, simple study without intravenous contrast.
- 2. Anonymization: all patient information that is not relevant to this research was removed and sensible data was anonymized.
- 3. Data protection: all information was stored in a hard drive and encrypted using a 256 bits Advanced Encryption Standard (AES).

3.3 Programming frameworks

All scripts and programming were developed using the Python programming language version 3.7.3. Several Python libraries were used to implement all algorithms reported in this dissertation and are enlisted below:

- 1. Tensorflow: an interface for designing machine learning algorithms and an implementation for executing such algorithms [87].
- 2. Keras: a high-level neural networks API, written in Python and capable of running on top of TensorFlow, CNTK, or Theano. It was developed to enable fast experimentation [88].
- 3. Pydicom: a pure Python package for working with DICOM files such as medical images, reports, and radiotherapy objects [89].

- 4. Numpy: the fundamental package for scientific computing with Python [90].
- 5. Scipy: a Python-based ecosystem of open-source software for mathematics, science, and engineering [91].
- 6. Scikit-learn: a Python package containing simple and efficient tools for data mining and data analysis [92].
- 7. Pandas: an open source, BSD-licensed library providing high-performance, easy-to-use data structures, and data analysis tools for the Python programming language [93].
- 8. Matplotlib: is a Python 2D plotting library which produces publication quality figures in a variety of hardcopy formats and interactive environments across platforms [94].
- 9. Hyperopt: is a Python library for serial and parallel optimization over awkward search spaces, which may include real-valued, discrete, and conditional dimensions [95].

3.4 Preprocessing techniques

Based on several research studies, providing a homogeneous and standardized framework for data analysis is crucial to improve performance of deep learning models applied to medical imaging [68,72]. An efficient programming framework was implemented to automate the extraction of nodules annotated by expert radiologists. An Object-Oriented Programming (OOP) approach was developed to extract all information from data bases A and B, where nodules were annotated.

Different scripts were written according to the database where the CT scan was located. An important thing to highlight is that these scripts allow the extraction of nodules with any receptive field specified by the user. Thus, the scripts could be used to develop further research in the future and try similar approaches as the ones reported by Dou Q. *et al.* [79]. Appendix B contains all the scripts developed for each data base.

Normalizing the inputs of any DNN or CNN is a crucial task to accelerate training times, an issue that has been discussed with batch normalization in 2.2.6 [25]. Therefore, two main steps were performed, pixel intensity rescaling and spatial re-sampling. Both preprocessing steps have been implemented by several authors across the literature with slight variations [68, 70, 76, 81, 96]. Appendix C contains all the scripts developed for each data base to perform both steps, pixel intensity spacing and spatial re-sampling.

3.4.1 Pixel intensity rescaling

The Hounsfield scale, named after Godfrey N. Hounsfield, has been used to measure radio density of different materials within the human body. These measurements reflect x-ray attenuation, which is proportional to the physical material density [97]. Typical values include -1000 Hounsfield units (HU) for air and +1000 HU for bones. Values of 1828.50 ± 60.421 HU and 344.45 ± 20.531 HU have been reported for cortical and cancellous bone respectively [98]. Studies have reported radio density levels of lung tissue depending on its level of inflation. Both limits were specified as 100 HU and -1000 HU for non inflated and overinflated lung tissue [99].

Generally, CT scan pixels are not represented in this scale. However, scanner companies provide the rescaling slope s and intercept b in each DICOM file to convert from pixel intensities to HU by using equation (3.1). This expression computes a linear transformation applied to a 3D pixel value intensity matrix $I_{pix}^{(i)}$, which corresponds to the i^{th} CT scan of a set of m scans comprising a certain database.

$$I_{HU}^{(i)} = s(I_{pix}^{(i)}) + b$$
(3.1)

After applying equation (3.1) to all 3D matrices $I_{pix}^{(i)}$, a rescaling operation was performed to define a new range of pixel values that varied from 0 to 1. Based on the radio density values of different structures, air and cancellous bone were defined as the upper and lower bounds of the new range of pixel intensities. Therefore, equation (3.2) was applied to all transformed matrices $I_{HU}^{(i)}$, where $HU_{air} = -1000HU$ and $HU_{bone} = +400HU$ depict the values for both, air and cancellous bone, respectively. A bigger value was chosen to guarantee that all relevant structures, such as lung

$$I_{rescaled}^{(i)} = \frac{I_{HU}^{(i)} - HU_{air}}{HU_{bone} - HU_{air}}$$
(3.2)



Fig. 3.1. Result of pixel rescaling on a specific CT slice obtained from the LIDC-IDRI database.

Finally, any pixel value > 1 was defined as 1 and any pixel value < 0 was specified as 0. Figure 3.1 illustrates the result of rescaling pixel intensities of the middle CT slice of the first patient of the LIDC-IDRI data base.

3.4.2 Spatial re-sampling

Spatial variations have been observed when analyzing scan resolutions for all CT scans included in the LIDC-IDRI database. Figure 3.2 shows the histograms for all spatial pixel resolutions in each CT scan dimension. Means and standard deviations were calculated for each spatial resolution, which are illustrated in Table 3.1. Furthermore, if the final objective is to implement the algorithm in any clinical context, these spatial resolution differences will be always encountered. Thus, it is important to provide a consistent method for adjusting spatial dimensions to have a standard voxel size, where a voxel is defined as 3-dimensional box of material and is represented by a single pixel value within the pixel matrix that composes the CT scan [22].

A target voxel size of $1 mm^3$ was proposed based on implementations developed by other researchers [68, 76, 81, 96]. Therefore, all CT scans were re-sampled to have a voxel size of $1 mm^3$,





Fig. 3.2. Histograms corresponding to spatial resolutions of each CT scan dimension for a sample size of 1010 patients contained in the LIDC-IDRI database.

Table 3.1. Mean and standard deviation calculations of spatial resolutions corresponding to each CT scan dimension.

Dimension [mm]	Mean [mm]	Standard Deviation [mm]
X	0.687859598	0.084697435
Y	0.687859598	0.084697435
Z	1.765376993	1.413438331

using the nearest-neighbor interpolation algorithm with the Scipy programming framework [91]. The nearest neighbor method simply chooses the nearest pixel value to the desired location in the new interpolated matrix [100]. To implement scan rescaling, a resizing factor r must be calculated for each dimension of the scan $I_{pix}^{(i)}$ based on the desired size of the new re-sampled scan $I_{resampled}^{(i)}$.

Equation (3.3) describes the calculation for obtaining the rescaling factor r_D for any dimension D of a specific CT scan $I_{pix}^{(i)}$ by computing the size ratio between the new re-sampled scan size $I_{resampled \ sizeD}^{(i)}$ and the old size $I_{pix \ sizeD}^{(i)}$. Figure 3.3 illustrates the result of re-sampling a single CT scan slice from the LIDC-IDRI database, using the nearest neighbor algorithm, to obtain a voxel volume of 1 mm^3 .

$$r_D = \frac{I_{pix\,sizeD}^{(i)}}{I_{resampled\,sizeD}^{(i)}} \tag{3.3}$$



Fig. 3.3. Original and re-sampled slices of a CT scan obtained from the LIDC-IDRI database.

3.5 The algorithm workflow

Estimating the presence or absence of lung cancer is a difficult task. Therefore, the problem was divided in four specific sub-problems, defined as: 1) detecting nodules in the CT, 2) estimating morphological characteristics of nodular findings, 3) calculating the likelihood of nodule malignancy based on radiologic assessments, and 4) estimating the absence or presence of lung cancer based on different diagnosis methods: biopsy, surgical rejection, progression, response, or a 2-year nodular radiologic review. The algorithm workflow is similar to the end-to-end strategy developed by Ardila *et al.* [28]. A schematic illustrating the algorithm workflow is shown in Figure 3.4. All programming frameworks used for training the CNNs include: Tensorflow, Keras, Hyperopt, and



Numpy.

The process starts by extracting a sub-volume $I_V \in \mathbb{R}^3$ within a normalized CT scan $I_{norm}^{(i)}$, with a specific receptive field $r_{field} = (n_x \ge n_y \ge n_z)$. The first stage comprises a CNN receiving a CT portion I_V , which outputs a conditional probability for nodular presence y_{nodule} , as specified in equation (3.4).

$$\hat{y_{nodule}} = P(y_{nodule} = 1/I_V) \tag{3.4}$$

Based on a specific threshold thr_{nodule} , the algorithm decides if the input I_V corresponds to the presence of nodule $(y_{nodule} = 1)$ or the absence of it $(y_{nodule} = 0)$. If the CNN decided that there was no nodule on I_V , it would slide the window to extract the next CT portion. Otherwise, if it predicted that a nodule was present, a second and third CNNs would receive as input the same sub-volume I_V . The second CNN comprises several sub-networks j, where each one of them would estimate the presence or absence of the j^{th} morphological characteristic $morph_j$ in the previous detected nodule I_V , as defined in equation (3.5).

$$\hat{y_{morph_i}} = P(y_{morph_i} = 1/nodule)$$
(3.5)

On the other hand, the third CNN will output the conditional probability of the detected nodule being malignant or benign, as illustrated in equation (3.6).

$$\hat{y_{malignant}} = P(y_{malignant} = 1/nodule)$$
(3.6)

Similar to the process implemented in the first CNN, the second and third CNNs implement thresholds thr_{morph_j} and $thr_{malignant}$ to decide if their respective anomalies are present in I_V . By sliding the window over the CT scan, different portions I_V are extracted and processed using the process described previously. As a result, the algorithm generates $n_o = j + 1$ output matrices, where $O_{malignancy}$ and $\{O_{morph_1}, O_{morph_2}, ..., O_{morph_j}\}$ correspond to estimation matrices for the presence of both, malignancy and the set of j morphological characteristics.



Fig. 3.4. Schematic describing the inputs of each stage of the algorithm, as well as the outputs estimated by each CNN.

Each component o_i inside the n_o matrices corresponds to a single estimation performed by the respective CNN, which defines if the corresponding anomaly is present in a scan portion I_V given that it was previously defined as a nodule by the first CNN. Because the main interest is to locate nodules and define a probability for the presence of malignancy and a specific set of morphological characteristics, an intersection probability is computed using Equation (3.7), where P(nodule) is calculated with expression (3.4), and P(anomaly/nodule) refers to either the probability computed in Equation (3.6) or the calculation performed using expression (3.5).

$$P(anomaly \bigcap nodule) = P(anomaly/nodule)P(nodule)$$
(3.7)

As a result, all components comprising matrices $O_{malignancy}$ and $\{O_{morph_1}, ..., O_{morph_j}\}$ are changed from conditional probabilities to their respective intersections using Equation (3.7). Finally, a component max estimation is computed for each one of the matrices $O_{malignancy}$ and $\{O_{morph_1}, O_{morph_2}, ..., O_{morph_j}\}$ using Equation (3.8). In this expression, \bar{o}_j represents the maximum value of all the k estimations o_i comprising a specific output matrix j computed by the malignancy classifier or a particular morphological estimator.

$$\bar{o_j} = max_{o_i}O_j \tag{3.8}$$

A classical DNN would receive as input a vector $\vec{x_i} \in \mathbb{R}^{n_o+1}$ that corresponds to the i^{th} patient, which is also represented in Equation (3.9). The first component of $\vec{x_i}$ represents the number of detected nodules $n_{detected}$ by the nodule detector, while the remaining components correspond to all the max estimated values $\bar{o_i}$ that were calculated with Equation (3.8).

$$\vec{x_i} = \begin{bmatrix} n_{detected} & \dots & \bar{o_j} & \dots & \bar{o_{n_o}} \end{bmatrix}$$
(3.9)

Therefore, the classical NN collects the input vectors $\vec{x_i}$, and produces a final estimation y_{cancer} , indicating wether the patient might have cancer. Equation (3.10) defines the conditional probability computed by the last CNN.

$$\hat{y_{cancer}} = P(y_{cancer} = 1/\vec{x_i}) \tag{3.10}$$

3.6 Nodule detector

As specified in Section 3.5, the first step consists in creating a CNN that will take sub-regions I_V from a normalized CT scan $I_{norm}^{(i)}$ as input, and outputs a number $y_{nodule} \in [0, 1]$ where 0 represents "no nodule" and 1 defines "nodule is present". Specifically, this network was divided into two sub-networks: 1) a candidate nodule selection network and 2) a false positive reduction (FPR) architecture; a common approach developed by other researchers [72, 79]. Appendix D contains all the scripts programmed for the nodule detector algorithm.

3.6.1 Candidate nodule detection CNN

The candidate detection (CD) stage consists in detecting "nodule candidates at a very high sensitivity, which typically comes with many false positives" [72]. Data bases A and B (see Section 3.2.1) were used for extracting all the nodules used for training, validating, and testing the algorithm. Only data base A was required for the training and validation stage. All nodule extractions were performed by identifying automatically all labels assigned by at least one expert radiologist, and only nodules ≥ 3 mm were considered as relevant findings; as specified by the Guidelines for Management of Incidentally Detected Pulmonary Nodules in Adults [18].

Additionally, several experiments were performed with different inclusion criteria. More precisely, several experiments included only labels assigned to a specific instance, in which three different levels of agreement were considered: 1) all four radiologists agreed in that specific annotation, 2) at least two experts assigned the same label for a particular nodule, and 3) at least one radiologist labeled the particular instance as nodule.

To verify that multiple labels assigned by each radiologist corresponded to the same instance, the percentage of intersection was computed for all pair combinations of volume labels $V_{radiologist i}$ and $V_{radiologist j}$ using equation (3.11). Any percentage greater than 10% was considered as the same true positive label. With these specifications, a total of 896, 1,374, and the same 1,374 positive instances $n_{pos}^{(i)}$ were collected, for the corresponding three levels of agreement previously defined.

$$Inodule = \frac{V_{radiologist i} \bigcap V_{radiologist j}}{V_{radiologist i}}$$
(3.11)

Because of inconsistencies with the specified nodular receptive field and their corresponding nodule annotations, only 1,347 nodules $n_{pos}^{(i)}$ were considered for building the data set, in which a 10 cross-fold validation was performed. Many CNNs were trained and validated using all the collected data: 896 and 1,347 positive instances, respectively, where several Python generators were built and a classic train/test split of 70%/30% was implemented due to memory constraints. For defining the receptive field size, three histograms corresponding to each dimension size were computed for all nodules $\geq 3 \text{ mm}$ and < 3 mm. All dimensions were obtained after applying both normalization transformations to each CT, as defined in Section 3.4.2 Figure 3.5 illustrate each one of the histograms computed for each nodular size. All sizes were collected after the normalization step was applied (refer to Section 3.4.2). As a result, the optimal receptive field was specified as $(32 \times 32 \times 32)$, which encompasses 97% of all nodule sizes contained in data base A. For future work, multiple receptive fields could be implemented following a similar approach as the one developed by Dou *et al.* [79]. A sample of CT slices containing a nodule is displayed in Figure 3.6.



Fig. 3.5. Histograms representing nodular sizes in each dimension for all nodules contained in data base A.

Because of the limited amount of data, four data augmentation techniques were developed: 1) nine lossless information rotations were applied to each instance: 1) 90°, 180° and 270° rotations with respect to each main axis of the CT, 2) Generative Adversarial Networks (GANs) were developed to generate more artificial nodules [101, 102], 3) nodule rescaling using the nearest neighbors algorithm, and 4) seven random image translations with respect to each possible combination of axes (X, Y, Z, XY, XZ, XYZ) with a maximum translation value of 10 pixels. CNNs were the



Fig. 3.6. Sample of CT slices where different red bounding boxes indicate where the nodule is located within the scan.

preferred architecture for both, the discriminator and generator, when implementing GANs. A receptive field of $(32 \times 32 \times 32)$ was specified for the discriminator input size and the generator output size. The Adam optimization technique, defined in Equations (2.17) - (2.21), was used for training both CNNs. Adam parameters were set to $\beta_1 = 0.5$, $\beta_2 = 0.999$ and $\alpha = 0.0002$. Also, Xavier initialization was implemented by using Equation (2.6).

Due to hardware constraints, a batch size of 32 instances was set for each training step and 3000 epochs (iterations) were specified. An output example generated by the trained GANs can be seen in Figure 3.7, which illustrates a sample of 100 artificial generated nodules. Each artificial nodule has a volume equal to $V_{nodule} = 32 \times 32 \times 32$ pixels. Scripts related with GANs can be seen in Appendix D, where each programming implementation was obtained from [103] and adapted to meet the specifications of this research.

Using both, data rotations and GANs, $n_{pos}^{(i)}$ nodules were augmented to build the entire set of training positive examples, where the number of nodules $n_{pos}^{(i)}$ varied depending on which training





Fig. 3.7. Sample of 100 artificial nodule middle slices generated by the trained GANs after 3000 epochs.

strategy was implemented: a classic train/test split or a 10-cross fold validation. With respect to negative instances $n_{neg}^{(i)}$, random crops not containing nodules were sampled from each normalized CT scan. Also, for some models, several instances labeled as "non-nodule \geq 3mm" were collected from Data Base A.

Also, in many experiments different data augmentation techniques were applied, where three possibilities were considered: 1) only the nine lossless information rotations, 2) only GANs, and 3) both augmentation techniques. As a result, the training set size varied in the number of samples $n^{(i)}$ due to both, the three data augmentation implementations and the three radiologist levels of agreement.

Hyper-parameter optimization was the most difficult challenge to overcome in this research project because of the large number of parameters that needed to be tuned. The tree-structured Parzen estimator (TPE), a SMBO algorithm, was the preferred strategy to search for optimal parameters in the hyper-dimensional configuration space [56]. Specifically, the Hyperopt Python library was used to approximate the surrogate function based on previous observations [95, 104]. Even with this algorithm, there was another major problem to address: selecting the best network configuration to specify the search space of hyper-parameters. As it has been reported in previous

studies, many CNN architectures have been tested for different pattern recognition tasks, such as ResNet, Inception Network, LeNet, Vgg, and Inception-ResNet; to name a few [24–26, 65, 66]. Therefore, several trials were performed with variations of the aforementioned configurations using TPE, where the objective metric was defined as the cost function specified in equation (2.4) specifying the validation loss. Specifically, between 10 and 30 trials (model variations) were evaluated for each of the proposed CNN architectures depending on the complexity and size of the network. For each trial of TPE, a 10-fold cross-validation procedure was chosen for training and validating the nodule candidate generation CNN. Nevertheless, other models used a classic 70%/30% train/test split during the hyper-parameter optimization process. For the 10 fold cross-validation a range of 5 to 20 epochs was chosen because of expensive computation times. On the other hand, for models with a classic train/test split, a range between 15 and 50 epochs was the preferred choice.

Following a similar approach as the one implemented when developing GANs, Adam optimizer and Xavier initialization were selected to train and initialize network weights for each model in a specific TPE trial. For this stage, hyper-parameters β_1 and β_2 , included in equation (2.21), were fixed to specific values $\beta_1 = 0.9$ and $\beta_2 = 0.999$, which have worked well for other type of applications [54]. Thus, these hyper-parameters are not included in the search configuration space allowing a dimensionality reduction of such space.

The parameter configuration search space was defined differently based on each CNN architecture. In other words, different sampling ranges for distinct parameters were defined based on each network topology. For example, Table 3.2 illustrates all the parameters that were proposed for a classical CNN with a particular predefined topology (based on experiments), their search ranges, and their respective sampling distributions. In this case, the specific predefined topology is shown in Figure 3.8, which is basically a typical CNN (see Figure 2.5). Even though, there are slight differences in the proposed architecture:

- 1. The inclusion of batch normalization in each layer by using Equation 2.12.
- 2. The implementation of Tikhonov regularization per layer following a similar computation as

the one defined in Equation (2.9).

- 3. The number of filters F_i are reduced after half of the layers have been defined because of hardware limitations.
- 4. All max pooling layers have constant filter sizes of (3 x 3).
- 5. A final average pooling layer Avg is assigned before the fully-connected layer.

For details corresponding to the specific hyper-parameter configurations of the other predefined network architectures (ResNet, Inception, Vgg, LeNet, Inception-ResNet) refer to Appendix D.

Table 3.2. Hyper-parameters and sampling distributions to establish the sample search space for a specific CNN architecture

HYPER-PARAMETER	SAMPLING DISTRIBUTION	SEARCH RANGE
Learning rate $lpha$	Continuous uniform	[0.0005, 0.001]
Decay learning constant	Continuous uniform	[0.01, 0.05]
Number of filters F_i for the i^{th} block if $i \le m/2$.	Discrete uniform	{0, 1, 2, 3, 4}
Number of filters for the i^{th} block if $i > m/2$.	Discrete uniform	{0, 1}
Filter size f_i for the i^{th} block.	Discrete uniform	{0, 1, 2, 3}
L2 regularization constants l_i for the i^{th} block.	Continuous uniform	[0.0001, 0.01]
Number of <i>x</i> dense layers	Discrete uniform	{0, 1, 2, 3}
Number of units <i>n</i> per dense layer	Discrete uniform	{0, 1, , 15}
Number of average pooling layers	Discrete uniform	{0, 1}

Once the best model configuration was obtained after implementing the TPE algorithm, either a 10-cross fold validation or a classic training/test optimization (based on model training times) was implemented to keep improving the CNN's performance. Different number of training epochs were specified heuristically based on hardware limitations and model complexity. For the nodule



Fig. 3.8. Predefined network architecture and the hyper parameters that need to be tuned using TPE, for the nodule candidate generation step.

candidate detection CNN, the threshold was chosen following the same strategy as reported by Ignacio Sánchez: when the model sensitivity was equivalent to the specificity [105].

3.6.2 False positive reduction CNN

All training data used for this stage came from results obtained by running the CD algorithm. More precisely, once the best CNN architecture for the CD stage was obtained, the algorithm was run over a set of k normalized CT scans $I_{norm}^{(i)}$ contained in database A. As expected, several FP per scan were generated during this process. As its name suggests, the main objective of the FPR CNN is to reduce the false positives generated by the CD CNN. Thereby, all negative data consisted of n_{FP} FP generated from the previous step. On the other hand, following the same approach as the one reported for the CD stage, positive data comprised different number of nodules $n_{nodules}$ depending on the three levels of agreement previously defined. In consequence, the total training data consisted of $m = n_{FP} + n_{nodules}$ instances. Again, due to hardware limitations, the number of training examples was reduced depending on the CNN architecture and training times. A similar methodology reported for the CD stage was applied for the FPR task. Therefore, data augmentation, model selection, training and validation were essentially the same. A summary for every part of the FPR methodology is provided below (for a detailed explanation refer to section 3.6.1):

- 1. **Data preparation:** positive data consists of all $n_{nodules}$ nodules in database A. Moreover, negative data consists of all n_{FP} FP produced by the candidate generation CNN.
- 2. **Data augmentation:** five different data augmentation possibilities were tried following the same procedures of the CD stage: 1) 9 loss-less 3D rotations, 2) GANs, 3) nodule rescaling using the nearest neighbors algorithm, 4) seven random image translations with respect to each possible combination of axes (X, Y, Z, XY, XZ, XYZ) with a maximum translation value of 10 pixels, and 5) different combinations of the aforementioned techniques. No data augmentation was applied to negative instances.
- 3. **Hyper-parameter optimization:** the TPE algorithm was used for selecting the best set of hyper-parameters for each variation of the following network architectures: classic CNN, LeNet, Vgg, ResNet, Inception, and ResNet-Inception. Specifically, TPE was run between 10 to 30 trials depending on training times of each network; where each trial consisted on either a 10-cross fold validation process or a classical split of 70% training data and 30 % test samples.
- 4. Training and validation: once the best CNN was obtained using the TPE algorithm, either a 10-cross fold validation or a classical train/test split process was implemented to keep improving the model. Training and validation during both, hyper parameter searching and best model optimization, were performed using the Adam optimizer and Xavier initialization. For selecting the best threshold, the same technique used in Section 3.6.1 was implemented.

By combining and designing both stages, the nodule candidate detection CNN and the false positive reduction CNN, nodule detection can achieve reliable results. Thus, the algorithm could be implemented in real clinical contexts, where automated detection and standardized nodular assessments are required. Furthermore, by providing a robust nodule detection system, the following stages in this dissertation can be implemented over a solid foundation.

3.7 Malignancy classifier

Several research studies have focused on classifying lung nodules as benign or malignant, regardless of whether nodular assessment was done from a radiologic or histologic perspective (Section 2.3.2 provide a thorough description of these studies). Therefore, the main objective was to develop a CNN that classified a pulmonary nodule as benign or malignant based on a subjective radiologic perspective. Specifically, this algorithm takes as input a portion of a normalized CT scan I_V , previously defined as a nodule by the FPR CNN (refer to Section 3.6.2), and outputs a probability indicating malignancy, as defined in Equation (3.6).

All data for training, validation, and testing was obtained from Data Bases A and B (see Section 3.2.1), where only Data Base A was used for training and validating the architecture. Because malignancy classification is a crucial step in the algorithm, only nodules annotated with an agreement level of all four radiologists was considered. Moreover, to ensure model generalization, a 10 cross-fold validation was performed during model selection and optimization. Therefore, with these considerations, a total of 896 nodules were collected from Data Base A. Even so, there were models where other levels of agreements were considered, but they were discarded when evaluating their training and validation results.

To differentiate between malignant and benign nodules, all malignancy labels provided by the four expert radiologists were binarized, a strategy similar to the one defined by Shen, *et al.* [70]. Therefore, any nodule that was assigned with a malignancy score ≥ 3 was defined as malignant, otherwise it was established as benign. After applying this heuristically convention, 213 nodules were defined as benign and 722 anomalies were specified as malignant. It is important to mention that many experiments were performed without the binarization process. Without binarizing, scores $\hat{y}^{(i)}$ illustrated in Equation (2.4), were computed using the categorical softmax function instead of

its binary variant; the sigmoid unit represented in Equation (2.2).

Because of a lack of data for training and validation, the same two data augmentation techniques from the CD stage were developed to increase the training set size: 1) 9 lossless 3D transformations (90°, 180°, and 270° rotations with respect to each main axis of the CT) and 2) GANs for generating both benign and malignant artificial nodules [101, 102]. Also, there were models where only one of the two augmentation techniques were applied, but those CNNs were not included in the dissertation because of poor performance. Two GANs were implemented to generate benign and malignant artificial nodules. CNNs were the preferred architecture to develop the discriminator and generator for both GANs. As defined in Section 3.6.2, both the discriminator input and generator output sizes were defined with a receptive field size of (32 x 32 x 32). Smooth labeling was implemented during the training process. To establish binary labels, the likelihood of malignancy was set based on a score \geq 3, which was assigned be each of the four radiologists in Data Base A.

The Adam optimization algorithm with Xavier Initialization was chosen for training each CNN, where all hyper-parameter values specified in Equations (2.17), (2.18), (2.19), (2.20), and (2.21) were set to: $\beta_1 = 0.5$, $\beta_2 = 0.999$ and $\alpha = 0.0002$. Finally, due to hardware constraints, a batch size of 32 and 3000 training epochs were defined for optimizing both GANs. Figures 3.9 and 3.10 show the results after training both networks: the malignancy and benign nodule GANs, respectively.

By augmenting both, the malignant and benign samples, using the two augmentation techniques, a total of 6,019 instances were collected for the training set; where 3,000 and 3,020 cases comprised benign and malignant nodules, respectively. For the validation set, 64 benign and 217 malignant instances were included. Following the same procedure of the nodule detector stage (Section 3.6.1), hyper-parameter selection was performed using the TPE algorithm. Again, the same CNN architectures were chosen to solve the binary classification problem: classical CNN, ResNet, Inception Network, Vgg, LeNet, and Inception-ResNet. Each model was adapted to fulfill hardware requirements. To see a specific example refer to Figure 3.8.





Fig. 3.9. Sample of 144 artificial benign nodule middle slices generated by one of the two trained GANs after 3000 epochs.



Fig. 3.10. Sample of 144 artificial nodule middle slices likely malignant generated by one of the two trained GANs after 3000 epochs.

Several trials were performed with variations of the aforementioned configurations using TPE, where the objective metric was defined as the cost function specified in equation (2.4). Specifically, between 10 and 30 trials (model variations) were evaluated for each of the proposed CNN architectures depending on the complexity and size of the network. For each trial of TPE, a 10-fold cross-validation procedure was chosen for training and validating the malignancy classifier CNN. A range of 5 to 20 epochs was chosen because of expensive computation times. Repeating the

same procedure of Section 3.6.1, training was performed using the Adam optimizer with Xavier initialization, and fixing the hyper-parameter values of β_1 and β_2 to 0.9 and 0.999, respectively [54].

Once the best model configuration was obtained, a 10-cross fold validation was implemented to keep improving the CNN's performance. The number of training epochs was specified based on hardware limitations and model complexity. Finally, the binary classifier threshold $thr_{malignant}$ was specified by using the same strategy reported in Section 3.6.1 [105]. It is important to illustrate that to obtain clinical performance for this stage, it is crucial to make accurate lung cancer predictions. Although, training these CNNs with subjective radiologic assessments of malignancy likelihood is not sufficient to provide an objective system that can be deployed in real clinical contexts. Therefore, there are other steps that need to be implemented to ensure the required clinical specifications.

3.8 Morphological estimator

One of the main problems of NN is related to model interpretability, where these models are considered as "black-boxes" [106]. Specifically, in the medical regime, interpretability becomes a major issue to address because of the implications derived from the model predictions; where justifying a medical decision becomes an important task to do when diagnosing and treating a patient. However, several efforts have focused on making interpretable models for lung nodule malignancy classification [70]. Therefore, the main objective is to provide model interpretability and relevant morphological information to justify the final lung cancer prediction. As specified by Lipton, this stage focused primarily on model decomposability, where "*each part of the model admits an intuitive explanation*".

In this case, all intuitions reside on the morphological characteristics of each detected nodule. More concretely, these CNNs will receive as input a normalized sub-volume I_V , which was previously detected as a nodule (refer to Section 3.6.2), and will output a normalized real value y_{morph_j} , which indicates the j^{th} magnitude of a specific morphological characteristic present in that sub-volume. Thus, a value $y_{morph_j} = 0$ indicates the absence of that particular morphological char-
acteristic, while $y_{morph_i} = 1$ illustrates that such property is completely defined in that sub-volume.

In Data Base A, eight subjective radiologic characteristics were annotated (see Section 3.2.2). Two of them are not included in this analysis: the likelihood of malignancy because it has been included already (refer to Section 3.7) and calcification because there are inconsistencies present on the labels assigned by the radiologists. In consequence, there are six remaining characteristics that can be analyzed and incorporated to the workflow. Because of computational time and workflow complexity, a simple statistical analysis was performed to detect the two most positive correlated characteristics with the likelihood of malignancy. More precisely, a correlation matrix was computed for the seven morphological characteristics (including likelihood of malignancy) of all nodules assessed by the four expert radiologists in Data Base A. Figure 3.11 illustrates the correlation matrix and Table 3.3 shows how much each one of the six characteristics were identified as the most positively correlated with respect to likelihood of malignancy: spiculation and lobulation. Therefore, two CNNs were developed to estimate the presence of each characteristic in the previously analyzed sub-volume I_V .

Table 3.3. Correlation results of each morphological characteristic with respect to the likelihood of malignancy.

	malignancy
subtlety	0.21669795
sphericity	-0.1488796
margin	-0.22058295
lobulation	0.30918384
spiculation	0.34524731
texture	-0.10212231

	subtlety	sphericity	margin	lobulation	spiculation	texture	malignancy
subtlety	1	-0.00367608	0.30471617	0.16053637	0.17710993	0.42557599	0.21669795
sphericity		1	0.27903965	-0.20226738	-0.20278752	0.07977542	-0.1488796
margin			1	-0.25946339	-0.27119143	0.68275991	-0.22058295
lobulation				1	0.54423427	-0.05378396	0.30918384
spiculation					1	-0.05689417	0.34524731
texture						1	-0.10212231
malignancy							1

Fig. 3.11. Correlation matrix computed for the eight morphological characteristics of all nodules, colors tending to the green spectrum indicate a higher positive correlation.

3.8.1 Spiculation estimator CNN

Similar to the approach developed for the malignancy classifier, a binarization process was performed for all scores assigned by each of the four expert radiologists in Data Base A; where all training and validation data was collected from data base A. On the other hand, data base B was used for testing purposes.Specifically, all labels (including calcification and likelihood of malignancy) assigned by the four expert radiologists in data base A were collected, giving a total of 2,624 scores for each morphological characteristic (without considering calcification). Subsequently, several histograms were built to identify class imbalances. Figure 3.12 show all the histograms that were computed for each morphological characteristic, where the frequency sum for each histogram give a total of 2,624 scores. On the other hand, Table 3.4 illustrates the number of scores assigned to each class of the morphological characteristics.

To create the most balanced class ratio for spiculation, the binarization process was performed

by assigning "1" to any label score ≥ 2 and "0" otherwise. Also, an agreement level of at least four radiologists, for each detection, was considered. After applying these heuristics, a total of 245 nodules were defined as "spiculated". Moreover, 693 instances were specified as negative examples. Thus, it is important to note the class imbalance present in the two desired characteristics: lobulation and spiculation.

Data augmentation was applied following the same procedure for the Malignancy Classifier: 1) apply the same 9 lossless 3D transformations and 2) develop two different GANs that will generate both, artificial "non-spiculated" and "spiculated" nodules. Training specifications for optimizing both GANs were the same: use the Adam optimizer with Xavier initialization and define the hyper-parameter values to be $\beta_1 = 0.5$, $\beta_2 = 0.999$ and $\alpha = 0.0002$. Also, the same receptive field size was defined for both the discriminator input and the generator output: (32 x 32 x 32). A batch size of 32 and 3000 training epochs were defined for optimizing both GANs. Figures 3.13 and 3.14 show the results of both GANs.



HISTOGRAMS

Fig. 3.12. Histograms computed for each morphological characteristic.

Class	subtlety	Internal Structure	calcification	sphericity	margin	lobulation	spiculation	texture	malignancy
1	181	2609	2	15	169	1681	1847	202	415
2	283	4	5	290	242	521	417	62	720
3	594	0	269	798	344	258	193	170	980
4	722	10	17	875	786	101	87	284	295
5	844	1	16	646	1083	63	80	1906	214

Table 3.4. Number of scores assigned to each class of the eight morphological characteristics.



Fig. 3.13. Sample of 169 artificial "spiculated" nodule middle slices generated by one of the two trained GANs after 3000 epochs.

By augmenting both the "spiculated" and "non-spiculated" samples using the two augmentation techniques, a total of 6,000 instances were collected for the training set, where 3,000 and 3,000 cases comprised "spiculated" and "non-spiculated" nodules, respectively. For the validation set, 207 "non-spiculated" and 103 "spiculated" instances were included.

Using the same procedure of the previous stages, several trials of the TPE algorithm were performed with variations of different CNN configurations (refer to previous sections). Again, the



Fig. 3.14. Sample of 169 artificial "non-spiculated" nodule middle slices generated by one of the two trained GANs.

objective metric was defined as the cost function specified in equation (2.4). Specifically, between 10 and 30 trials (model variations) were evaluated for each of the proposed CNN architectures. A 10-fold cross-validation procedure was chosen for training and validating each new CNN configuration at each TPE trial. Optimization was performed using the Adam optimizer with Xavier initialization, where hyper-parameter values of β_1 and β_2 were defined as 0.9 and 0.999, respectively [54].

After obtaining the best CNN configuration, a 10-cross fold validation was implemented to keep optimizing the best model. In this case, different number of training epochs were specified based on hardware limitations. Finally, the binary classifier threshold thr_{morph_1} was specified by using the same strategy reported in Sections 3.6.1 and 3.7; where j = 1 indicates that spiculation is the first morphological characteristic of the two analyzed nodular properties [105].

3.8.2 Lobulation estimator CNN

Because the procedure is extremely similar to the one developed for the spiculation estimator, a summary is provided with the main steps that were performed to implement the lobulation estimator

CNN:

- 1. **Binarization process:** to create the most balanced class ratio for lobulation, the binarization process was performed by assigning "1" to any label score ≥ 2 and "0" otherwise. Also, an agreement level of at least four radiologists for each detection was considered.
- 2. **Data preparation:** after applying the binarization process, a total of 348 nodules were assigned as "lobulated" and 693 examples were defined as negative instances.
- 3. **Data augmentation:** two different data augmentation techniques were implemented: 1) the same 9 lossless 3D rotations and 2) GANs that generated both "lobulated" and "non-lobulated" nodules. Training specifications for GANs were the same as the ones implemented for the spiculation estimator. Results after training for both networks can be seen in Figures 3.15 and 3.16.
- 4. Hyper-parameter optimization: the TPE algorithm was implemented to select the best set of hyper-parameters for the same CNN configurations (refer to Section 3.7). Specifically, TPE was run between 10 to 30 trials, where each trial consisted on a 10-cross fold validation process.
- 5. Training and validation: once the best CNN was obtained using the TPE algorithm, a 10cross fold validation was implemented to keep improving the CNN. Training and validation during both, hyper-parameter searching and best model optimization were performed using the Adam optimizer and Xavier initialization. For selecting the best threshold thr_{morph_2} , the same technique used in Section 3.6.1 was implemented.



Fig. 3.15. Sample of 100 artificial "lobulated" nodule middle slices generated by one of the two trained GANs after 3000 epochs.



Fig. 3.16. Sample of 100 artificial "non-lobulated" nodule middle slices generated by one of the two trained GANs.

3.9 Cancer estimator

This final step of the algorithm is the most important one, as it integrates all of the aforementioned steps to make a final prediction. Specifically, the predictions are performed given a feature vector $\vec{x_i}$ represented in Equation (3.9), and the output conditional probability is computed by using expression (3.10).

For this step, data base C1 was used for training and validation, while data base C2 was defined for testing purposes. Concretely, all previous algorithms: the nodule detector, malignancy classifier, and morphological estimators, were run over the 130 CT scans of database C1 to compute their respective predictions. Input feature vectors $\vec{x_i}$ were created for each patient CT scan. A variable input size DNN was proposed, where all inputs comprised a variable sized matrix of predictions made by previous estimators. This size variability was produced because each CNN outputs different number of predictions depending on each patient CT scan. Therefore, different sized output matrices $O_{malignancy}$ and $\{O_{morph_1}, O_{morph_2}, ..., O_{morph_j}\}$ resulted for each patient.

In order to solve this problem, instead of implementing a variable sized input, the max prediction over all results contained in each matrix was computed. With this approach, a fixed sized input $\vec{x_i} \in \mathbb{R}^{n_o+1}$ was defined for the DNN, where n_o represents the number of output matrices as defined in Section 3.5. On the other hand, no data augmentation techniques were implemented because of how data was represented. Therefore, there were only 36 corroborated benign cases and 95 malignant instances comprising the whole training and validation sets.

Again, the TPE algorithm was used for determining the best hyper-parameters comprising the DNN. A range between 10 and 30 different trials of the TPE algorithm were run. Also, a 10-fold cross-validation was specified for both, training and validation, of every model at each trial. All training procedures were implemented using the Adam optimizer and Xavier Initialization with fixed hyper-parameters $\beta_1 = 0.9$ and $\beta_2 = 0.999$. After finding the best model, further optimization was performed using the same 10-fold cross validation procedure, where different number of epochs

were specified accordingly.

By integrating all predictors as specified in Figure 3.4, an end-to-end diagnostic process is achieved. Furthermore, not only malignancy and cancer predictions are computed at both, the patient and nodular levels, but some degree of interpretability is defined by including the morphological estimators. With this algorithm workflow, the proposed solution adds an extra level of interpretability that can be help radiologists verify their assessments with a second evaluation tool.

3.10 Medical ethics guidelines

Due to the retrospective nature of the study, large amounts of required data, and no negative impact exerted directly or indirectly to the patients physically or emotionally, it is not mandatory to make informed consents. Nonetheless, in case a Medical Institution and ethics committee requires an informed consent, this was included in Appendix A.

All acquisition protocols were conducted based on the legal guidelines stipulated in "*apartado* 5 de la NORMA Oficial Mexicana NOM-004-SSA3-2012, Del expediente clínico y en el apartado 5 de la NORMA Oficial Mexicana NOM-035-SSA3-2012, En materia de información en salud".

To be coherent with Mexican and International laws, all data will be stored in a hard drive and encrypted using a 256 bits Advanced Encryption Standard (AES). Only people directly related to the research study will have access to the encrypted data. All people working in the project include: Master's student, thesis advisors with a medical degree, and expert radiologists, oncologists, and pathologists from the corresponding medical institutions where data was collected.

Only relevant patient data was used in this study: CT scan, nodular annotations, and histologic confirmation for the presence or absence of cancer. Other data was removed to protect patient's identity and integrity. No procedure included in this research study compromised the patient's physical, mental, and emotional health. No surgical, clinical, or invasive procedure was required for

the research to be conducted.

All legal issues that arise with respect to this dissertation will be responsibility of the people working in the project as stated above, and will be submitted to revision based on the Mexican Law.

CHAPTER 4

Results and discussion

4.1 Nodule detector

4.1.1 Candidate nodule detection CNN

Approximately 100 experiments were run to find the best model for the nodule candidate generator. Several variations of the specifications enlisted below were tried in each experiment:

- 1. Different inspired CNN architectures: AlexNet, LeNet, Vgg, GoogleNet, ResNet, ResNet-Inception, and a classsical CNN.
- 2. Using either one, none or both augmentation techniques: GANs and the 9-lossless 3D rotations.
- 3. Hyper-parameter optimization: manual or TPE algorithm.
- 4. Training during model search: a classical 70%/30% train/test split (with or without Python generators) or a 10-fold cross-validation.

- 5. Training the best model: a classical 70%/30% train/test split (with or without Python generators) or a 10-fold cross-validation.
- 6. Different number of epochs during model search and best model training.
- 7. Negative instances were defined as either random sample crops not containing nodules, labels annotated by radiologists as "non-nodule \geq 3 mm", or both.

During model search, the TPE algorithm tried 10 different model configurations. At each trial, both data augmentation techniques, GANs and nine lossless 3d rotations, were applied to the data set.

A random 10-fold cross validation strategy was chosen for optimizing each model configuration. All hyper-parameters that were tuned with their respective sample distributions and ranges are illustrated in Table 4.1. It can be observed that this hyper-parameter search space is similar to the one displayed in Table 3.2. The main difference is that the network is divided into four stages, where each stage has several blocks *i* concatenated in series. All CNNs in every stages used the same hyper-parameter space configuration with the exception of the final cancer estimator.

The best architecture was a classical CNN trained over 15 epochs using the Adam optimizer and Xavier initialization with fixed hyper-parameters $\beta_1 = 0.9$ and $\beta_2 = 0.999$. Table 4.2 enlists all hyper-parameter values of the best CNN, while Figure 4.1 illustrates its architecture configuration. Again, the topology is similar to the one presented in Figure 3.8, but the pattern of *m* convolutional blocks is repeated with different hyper-parameters at four distinct stages. For example, the best model has two, one, and none convolutional blocks for the first, second, third, and fourth stages, respectively. Each block comprises a convolutional layer, a max pooling layer and a batch normalization layer. This topology is also used for the other CNNs with the exception of the final cancer estimator.

A random 10-fold cross validation strategy was chosen to optimize the best model. Also, the same two data augmentation techniques were applied to the data set giving as a result 14,912 training and 1,657 validation examples at each random fold. Where negative instances included

Table 4.1. Hyper-parameter space configuration and sampling distributions to search the best set of values using the TPE algorithm.

HYPER-PARAMETER	SAMPLING DISTRIBUTION	SEARCH RANGE
Learning rate $lpha$	Continuous uniform	[0.0005, 0.001]
Decay learning constant	Continuous uniform	[0.01, 0.05]
$m_1 =$ number of i blocks for stage 1.	Discrete uniform	{0, 1, 2, 3, 4}
$m_2 =$ number of i blocks for stage 2.	Discrete uniform	{0, 1, 2, 3}
$m_3 =$ number of i blocks for stage 3.	Discrete uniform	{0, 1}
$m_4 =$ number of i blocks for stage 4.	Discrete uniform	{0, 1}
Number of filters F_i for the i^{th} block in stage ≤ 2 .	Discrete uniform	{4, 8, 16}
Number of filters F_i for the i^{th} block in stage > 2 .	Discrete uniform	{16, 32, 64}
Filter size f_i for the i^{th} block in any stage.	Discrete uniform	{(1x1), (3x3), (5x5)}
L2 regularization constants l_i for the i^{th} block in any stage	Continuous uniform	[0.00001, 0.0001]
Number of <i>x</i> dense layers	Discrete uniform	{0, 1, 2, 3}
Number of units <i>n</i> per dense layer	Discrete uniform	{0, 1, , 15}
Number of average pooling layers with pool size $=$ (3x3) and valid padding.	Discrete uniform	{0, 1}

CT random crops not containing anomalies. Specifically, 1,273 nodules (with a radiologist-level of agreement of all four radiologists) represented the positive data set, without applying augmentation techniques.

Table 4.2. Final hyper-parameter values defining the best model configuration of the CD nodule detector.

HYPER-PARAMETER	VALUE
Learning rate $lpha$	0.000636
Decay learning constant	0.031588
$m_1 =$ number of i blocks for stage 1.	2
$m_2 =$ number of i blocks for stage 2.	1
$m_3 = { m number of } i { m blocks}$ for stage 3.	0
$m_4 =$ number of i blocks for stage 4.	0
Number of filters F_i for the i^{th} block in stage ≤ 2 .	8 for stage 1 16 for stage 2
Number of filters F_i for the i^{th} block in stage > 2 .	16 for stage 3 32 for stage 4
Filter size f_i for the i^{th} block in stage 1.	(1x1)
Filter size f_i for the i^{th} block in stage 2.	(3x3)
Filter size f_i for the i^{th} block in stage 3.	(3x3)
Filter size f_i for the i^{th} block in stage 4.	(1x1)
L2 regularization constants l_i for the i^{th} block in stages one and two.	0.00016 for stage 1 0.00019 for stage 2
L2 regularization constants l_i for the i^{th} block in stages three and four.	0.00006 for stage 3 0.00055 for stage 4
Number of x dense layers	0
Number of units <i>n</i> per dense layer	6
Number of average pooling layers with pool size $=$ (3x3) and valid padding.	1
Number of parameters	34,089



Fig. 4.1. Schematic of the best model architecture of the CD nodule detector, which is divided into four stages, each containing different convolutional *i* blocks.

Results for each one of the four validation metrics: log-loss, sensitivity, specificity, and F1 score, are illustrated in Figure 4.2. Specifically, each graph illustrate the average validation scores over the 10 folds during 15 epochs of training. Also, Table 4.3 shows the final validation scores for each metric including the area under the ROC curve.

After optimizing the best model, it was run over 30 CT scans from database A. Specifically, a sliding window with strides($5 \times 10 \times 10$) was developed to extract different CT portions that were classified as "nodule" or "non-nodule". Different binary decision thresholds were defined to obtain a wide range of detection results. To compute the sensitivity metric, all true positive labels were specified with a radiologist-level of agreement of all four radiologists. If the algorithm detected a nodule that had a lower radiologist-level of agreement, it was considered as a false positive. Also, any new detection made by the algorithm, which exceeded a 30% intersection (see Equation (4.1)) with previous detections was not considered as a detection; thus, it could not count as neither a false positive nor a true positive. Figure 4.3 illustrates the resultant FROC curve with eight different

thresholds ranging from 0.1 to 0.9 with 0.1 intervals.



Fig. 4.2. Summary of the four specific target metrics of the candidate nodule detector.

METRIC	SCORE
Sensitivity	0.94184
Specificity	0.9788
F1 Score	0.8487
Area under the ROC curve	0.9995
Log-loss	0.0702

Table 4.3	Final	average	validation	scores	of the	CD	CNN
1ault 7.5.	1 mai	average	vanuation	SCOLCS	or the	$\mathcal{C}\mathcal{D}$	CI111.



Fig. 4.3. Free-Response ROC Curve of the CD CNN.

The candidate generation CNN was applied to a set of 23 CTs contained in database B2 using a threshold of 0.5. True positives were defined as nodules \geq 3 mm following the criteria posed in the Guidelines for Management of Incidentally Detected Pulmonary Nodules in Adults [18]. Results are shown in 4.4. Due to time constraints, further experiments will be conducted using data bases B1 and B3.

Sensitivity	Average FP / CT
0.8	238.56

Fig. 4.4. Results of the candidate generator CNN applied to database B2.

4.1.2 False positive reduction CNN

To reduce false positives, the FPR CNN was developed using a similar approach. Training data consisted on 13,103 false positives (negative instances), generated by the candidate generator using a threshold of 0.3, and the same 1,273 nodules (positive examples). Also, hyper-parameter optimization was implemented using the TPE algorithm, which was run for 7 trials. Each model configuration was optimized using a 10-fold cross validation technique over one epoch.

Data augmentation was performed over the positive examples using two lossless 3D rotations (90° and 180°) with respect to the Z axis, one nodule rescaling using the nearest neighbors algorithm, and seven random image translations with respect to each possible combination of axes (X, Y, Z, XY, XZ, XYZ) with a maximum translation value of 10 pixels. Thus, a total of 13,637 augmented nodules were used for training and validation. Table 4.5 enlists all hyper-parameter values of the best FPR CNN, while the topology of the network is the same as the CD Nodule CNN represented in Figure 4.1.

Afterwards, the best CNN was trained and validated using a classic 70/30% technique over 30 epochs. The same data was used for training and validating the best model. Figure 4.5 illustrates the four statistical metric results. On the other hand, Table 4.6 shows the final values. The same technique, used for the candidate generation CNN, was implemented to compute the optimal binarization threshold [105]. Afterwards, the FPR model was run over 20 CT patient scans by fixing the CD CNN threshold to 0.1 and setting the optimal threshold to 0.65. Final results are illustrated in Table 4.4 indicating a final sensitivity of 0.25 and an average of 41.8 false positives per scan.

Table 4.4. Validation metrics of the FPR CNN after being run over 20 CT scans.

Sensitivity	Average FP / CT
0.25	41.8

Table 4.5. Final hyper-parameter values defining the best model configuration of the FPR CNN after running the TPE algorithm for 10 different models.

HYPER-PARAMETER	VALUE
Learning rate $lpha$	0.00095
Decay learning constant	0.01083
$m_1 =$ number of i blocks for stage 1.	1
$m_2 =$ number of i blocks for stage 2.	2
$m_3 =$ number of i blocks for stage 3.	0
$m_4 =$ number of i blocks for stage 4.	0
Number of filters F_i for the i^{th} block in stage ≤ 2 .	8 for stage 1 16 for stage 2
Number of filters F_i for the i^{th} block in stage > 2 .	16 for stage 3 64 for stage 4
Filter size f_i for the i^{th} block in stage 1.	(1x1)
Filter size f_i for the i^{th} block in stage 2.	(3x3)
Filter size f_i for the i^{th} block in stage 3.	(3x3)
Filter size f_i for the i^{th} block in stage 4.	(1x1)
L2 regularization constants l_i for the i^{th} block in stages one and two.	0.00031 for stage 1 0.00033 for stage 2
L2 regularization constants l_i for the i^{th} block in stages three and four.	0.00008 for stage 3 0.00030 for stage 4
Number of x dense layers	1
Number of units n per dense layer	10
Number of average pooling layers with pool size $=$ (3x3) and valid padding.	1
Number of parameters	742,839



Fig. 4.5. Summary of the four specific target metrics of the FPR CNN.

METRIC	SCORE	
Sensitivity	0.9972	
Specificity	0.9910	
F1 Score	0.9937	
Area under the ROC curve	1	
Log-loss	0.0336	

Table 4.6. Final average	validation scores	of the FPR	CNN
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4.2 Malignancy classifier

Similar to the nodule detector stage, approximately 60 different experiments were performed, where each one of them included variations of the aforementioned specifications that were enlisted in Section 4.1 (excluding the last specification). As stated in Section 3.7, all training and validation data comprised 722 and 213 nodules that were considered as malignant and benign respectively (for details see Section 3.7). After applying both, nine lossless 3D rotations and GANs, the training set was augmented to 6,019 instances: 3,000 and 3,020 benign and malignant examples respectively.

Hyper-parameter optimization was performed using the TPE algorithm, where 15 different model configurations were tried. Each trial implemented a 10-fold cross-validation training, with a total of 5 epochs.Repeating the same procedure, the Adam optimizer and Xavier initialization were implemented during training, with fixed hyper-parameters $\beta_1 = 0.9$, $\beta_2 = 0.999$. Also, the hyper-parameter space is the same as the one illustrated in Figure 4.1. Therefore, the topology schematic is defined in the same way, as the one presented in Figure 4.1. Specifically, Table 4.8 enlists all hyper-parameter values of the best malignancy classifier CNN.

Once the best model was identified, further optimization was performed to improve its classifying capabilities. Specifically, training was done over 30 epochs using the same 10-fold crossvalidation scheme, and the two aforementioned data augmentation techniques: GANs and the nine lossless 3D rotations. Validation results for this final optimization are illustrated in Figure 4.6 and Table 4.7.

METRIC	SCORE
Sensitivity	1
Specificity	1
F1 Score	1
Area under the ROC curve	1
Log-loss	0.008171

Table 4.7. Final average validation scores of the malignancy classifier CNN.

Table 4.8. Final hyper-parameter values defining the best model configuration of the malignancy classifier.

HYPER-PARAMETER	VALUE
Learning rate α	0.0003434
Decay learning constant	0.001285
$m_1 =$ number of i blocks for stage 1.	1
$m_2 =$ number of i blocks for stage 2.	1
$m_3 =$ number of i blocks for stage 3.	1
$m_4 =$ number of i blocks for stage 4.	1
Number of filters F_i for the i^{th} block in stage ≤ 2 .	16 for stage 1 16 for stage 2
Number of filters F_i for the i^{th} block in stage > 2.	8 for stage 3 16 for stage 4
Filter size f_i for the i^{th} block in stage 1.	(3x3)
Filter size f_i for the i^{th} block in stage 2.	(5x5)
Filter size f_i for the i^{th} block in stage 3.	(3x3)
Filter size f_i for the i^{th} block in stage 4.	(5x5)
L2 regularization constants l_i for the i^{th} block in stages one and two.	0.00058 for stage 1 .00007 for stage 2
L2 regularization constants l_i for the i^{th} block in stages three and four.	0.00012 for stage 3 0.0008 for stage 4
Number of x dense layers	2
Number of units <i>n</i> per dense layer	8
Number of average pooling layers with pool size $=$ (3x3) and valid padding.	1
Number of parameters	328,613



Fig. 4.6. Summary of the four specific target metrics of the malignancy classifier CNN.

4.3 Morphological estimator

4.3.1 Spiculation estimator CNN

All data was comprised by 245 nodules that were considered "spiculated" and 693 anomalies defined as "non-spiculated". By applying both data augmentation techniques, 6,000 instances were set for the whole training data.

For this stage, hyper-parameter optimization was run over 15 models by using the TPE algorithm with a 10-fold cross-validation and a training interval of five epochs. Also, the same network configuration of the previous stages was defined for the spiculation estimator. During each model evaluation of TPE, the same optimization specifications of the malignancy classifier, the CD and FPR CNNs were set (see Sections 4.1.1, 4.1.2, and 4.2). Results of the best hyper-parameter configuration are shown in Table 4.10. Further optimization of the best model was performed using the same settings of the malignancy classifier (see Section 4.2). All training results for the four averaged validation metrics are illustrated in Figure 4.7, where all final scores are depicted in Table 4.9.

METRIC	SCORE
Sensitivity	0.9965
Specificity	0.9984
F1 Score	0.9966
Area under the ROC curve	0.9999
Log-loss	0.0133

Table 4.9. Final average validation scores of the spiculation estimator CNN.

Table 4.10. Final hyper-parameter values defining the best model configuration of the spiculation estimator.

HYPER-PARAMETER	VALUE
Learning rate $lpha$	0.0005987
Decay learning constant	0.00374
$m_1 =$ number of i blocks for stage 1.	0
$m_2 =$ number of i blocks for stage 2.	1
m ₃ = number of <i>i</i> blocks for stage 3.	1
$m_4 =$ number of i blocks for stage 4.	0
Number of filters F_i for the i^{th} block in stage ≤ 2 .	16 for stage 1 16 for stage 2
Number of filters F_i for the i^{th} block in stage > 2 .	8 for stage 3 32 for stage 4
Filter size f_i for the i^{th} block in stage 1.	(3x3)
Filter size f_i for the i^{th} block in stage 2.	(5x5)
Filter size f_i for the i^{th} block in stage 3.	(5x5)
Filter size f_i for the i^{th} block in stage 4.	(5x5)
L2 regularization constants l_i for the i^{th} block in stages one and two.	0.00049 for stage 1 0.00009 for stage 2
L2 regularization constants l_i for the i^{th} block in stages three and four.	0.00043 for stage 3 0.00064 for stage 4
Number of x dense layers	0
Number of units <i>n</i> per dense layer	0
Number of average pooling layers with pool size $=$ (3x3) and valid padding.	1
Number of parameters	40,265



Fig. 4.7. Summary of the four specific target metrics of the spiculation estimator CNN.

4.3.2 Lobulation estimator CNN

All data was comprised by 245 nodules that were considered "lobulated" and 693 anomalies defined as "non-lobulated", giving a total of 6,000 instances for the whole training set, after applying both augmentation techniques, GANs and 9 lossless 3D rotations.

Hyper-parameter optimization was run using the TPE algorithm to evaluate 15 different CNNs. Training of each model was performed using a 10-fold cross-validation over 5 epochs. Network search was performed over the same configuration space and CNN topology specified for the previous stages. During each model evaluation of TPE, the same optimizer and hyper-parameters of the Spiculation Estimator were defined (see Section 4.3.1). Results of the best hyper-parameter configuration are shown in Table 4.12. Training of the best model was performed using the same settings of the spiculation estimator (see Section 4.3.1), but with a training interval of 20 epochs. All training results for the four averaged validation metrics are illustrated in Figure 4.8, where all final scores are depicted in Table 4.11.



Fig. 4.8. Summary of the four specific target metrics of the lobulation estimator CNN.

METRIC	SCORE
Sensitivity	0.8358
Specificity	0.9240
F1 Score	0.8306
Area under the ROC curve	0.9831
Log-loss	0.2039

Table 4.11. Final average validation scores of the lobulation estimator CNN.

Table 4.12. Final hyper-parameter values defining the best model configuration of the lobulation estimator.

HYPER-PARAMETER	VALUE
Learning rate $lpha$	0.00055
Decay learning constant	0.03048
$m_1 =$ number of i blocks for stage 1.	0
$m_2 =$ number of i blocks for stage 2.	1
$m_3 = { m number of} i { m blocks}$ for stage 3.	1
$m_4 =$ number of i blocks for stage 4.	1
Number of filters F_i for the i^{th} block in stage ≤ 2 .	32 for stage 1 16 for stage 2
Number of filters F_i for the i^{th} block in stage > 2 .	16 for stage 3 16 for stage 4
Filter size f_i for the i^{th} block in stage 1.	(5x5)
Filter size f_i for the i^{th} block in stage 2.	(3x3)
Filter size f_i for the i^{th} block in stage 3.	(3x3)
Filter size f_i for the i^{th} block in stage 4.	(5x5)
L2 regularization constants l_i for the i^{th} block in stages one and two.	0. 00096 for stage 1 0. 00024 for stage 2
L2 regularization constants l_i for the i^{th} block in stages three and four.	0.00034 for stage 3 0.00034 for stage 4
Number of x dense layers	3
Number of units <i>n</i> per dense layer	14
Number of average pooling layers with pool size = (3x3) and valid padding.	1
Number of parameters	4,227,535

4.4 Cancer estimator

For the final stage, data was built using the output matrices $\{O_{morph_1}, O_{morph_2}, ..., O_{morph_j}\}$ specified in Section 3.9. Specifically, 20 feature vectors $\vec{x_i}$ (described in Equation (3.9)) were obtained after running all previous stages over 20 pathological-confirmed CT scans: 10 benign and 10 malignant cases.

A classical DNN scheme, represented in Figure 4.9 was proposed for performing hyperparameter optimization using the TPE algorithm; thus, reducing the search space considerably. Similar to the schematic provided in Figure 3.8, the general DNN configuration was set to contain five different blocks, where each block *i* has a distinct number of m_i layers containing n_i units. To avoid overfitting, L2 regularization constants were tuned at each block, and a dropout layer was set at the end of the DNN. A detailed list of all the hyper-parameters that were tuned are enlisted in Table 4.13.



Fig. 4.9. Schematic of the DNN representing the cancer estimator.

Table 4.13. Hyper-parameter space configuration and sampling distributions to search the best set of values using the TPE algorithm for the cancer estimator.

HYPER-PARAMETER	SAMPLING DISTRIBUTION	SEARCH RANGE
Learning rate $lpha$	Continuous uniform	[0.0005, 0.001]
Decay learning constant	Continuous uniform	[0.01, 0.05]
Number of \boldsymbol{m}_i dense layers in block i	Discrete uniform	{1, 2, 3, 4, 5}
Number of n_i units in each layer of block i	Discrete uniform	{1,, 1000}
L2 regularization constants l_i for all layers in block i	Continuous uniform	[0.0001, 0.01]
Choose if dropout is implemented or not	Discrete uniform	{0, 1}
Dropout rate	Continuous uniform	{0, 0.01}

With these specifications, the TPE algorithm was implemented to evaluate 10 models. Again, the Adam optimizer with hyper-parameters $\beta_1 = 0.9$ and $\beta_2 = 0.999$, along with Xavier initialization were implemented for training each model. A 10-fold cross-validation scheme was used at each trial. Results indicating the best set of hyper-parameters of the DNN are defined in Table 4.14.

Once the best model was obtained, it was further trained over 300 epochs using the same 10-fold cross-validation strategy. The same approach was chosen: using the Adam optimizer hyper-parameters and Xavier Initialization. Validation results, over the 300 epochs, are depicted in Figure 4.10. Table 4.15 enlists the final scores obtained for each metric: sensitivity, specificity, log-loss and F1 score.

Table 4.14. Final hyper-parameter values defining the best model configuration of the cancer estimator.

HYPER-PARAMETER	VALUE
Learning rate α	0.00089
Decay learning constant	0.01756
$m_0 =$ number of dense layers for block 0.	4
$m_1 =$ number of dense layers for block 1.	3
$m_2 =$ number of dense layers for block 2.	4
$m_3 =$ number of dense layers for block 3.	2
$m_4 =$ number of dense layers for block 4.	3
$m{n}_0=$ number of units in each layer of block 0.	571
$n_1 =$ number of units in each layer of block 1.	370
$n_2 =$ number of units in each layer of block 2.	418
$n_3 =$ number of units in each layer of block 3.	849
$m{n}_4=$ number of units in each layer of block 4.	180
$l_0 =$ L2 regularization constant of all layers in block 0.	0.000679
$l_1 =$ L2 regularization constant of all layers in block 1.	0.002327
$l_2 =$ L2 regularization constant of all layers in block 2.	0.000201
$l_3 =$ L2 regularization constant of all layers in block 3.	0.004646
$l_4 =$ L2 regularization constant of all layers in block 4.	0.003652
Use dropout at the end of each block.	No
Dropout rate.	-
Number of parameters	4,857,030



Fig. 4.10. Summary of the four specific target metrics of the cancer estimator DNN.

METRIC	SCORE
Sensitivity	0
Specificity	1
F1 Score	0
Area under the ROC curve	0.5
Log-loss	3.968

Table 4.15. Final average validation scores of the cancer estimator CNN.

4.5 Discussion

Reviewing the results of this dissertation, it was determined that the detection and characterization of nodular findings was a partially successful. Even though it seems that both, sensitivity and specificity metrics were attained, they do not provide an adequate validation scheme for the nodule detection stage. As it has been stated in several studies, the most relevant validation metric for medical imaging detection applications is the FROC curve [69, 72, 79, 81, 83]. A high sensitivity of 94.1% was obtained for the candidate generation CNN with a binarization threshold of 0.3, along with a high number of false positives per scan.

As illustrated in the results, the main problem that was encountered during the research was the development of the false positive reduction stage. Even though more than 30 models were tested using the TPE algorithm, no successful results were obtained to reduce false positive findings without compromising sensitivity. Final experiments showed that the best FPR models were obtained when heavy data augmentation was applied to the data, specifically when random nodular translations were included. A potential hypothesis to explain this phenomenom resides on the positive to negative ratio encountered in a CT. More concretely, there is a huge amount of CT portions not containing nodular findings compared to CT volumes with nodules. Furthermore, depending on the number of strides specified for the sliding detection window, portions of a single nodule may not be detected by the CNN. Thus, augmenting the positive examples with translational variations may help the algorithm to detect the same nodule even if it is not centered exactly within the detection window.

An important remark resides in the probability estimations computed by almost all of the developed FPR models. Most of the highest detection rates per CT slice were obtained outside of the CT scan. The addition of preprocessing algorithms, could reduce undesired CT regions and decrease the number of false positive findings. Although it was not mentioned in the dissertation, a lung segmentation algorithm was built, but due to inconsistencies during the segmentation it was not included in the algorithm workflow. Poor results may also be attributed to the exclusion of repeated annotations of the same nodule provided by all four radiologists from database A. However, it is possible that the restrictions imposed to define a true positive were too flexible. For example, a study defined as true positives only nodules with sizes greater than 8 mm^3 [83]. Other study removed candidates whose shape was under 33 mm^3 [72]. Thus, it seems that comparing results between frameworks is a major challenge due to different criteria stablished to define true positives and false positives. As a result, many studies may have achieved reasonable results due to these considerations. Other possible cause associated to this undesired behavior, could be related with the sepecified receptive field, an issue that was addressed by Dou *et al.* [79], who specified different receptive fields, and Dai *et al.* who defined a bigger receptive field of (64 x 64 x 64) pixels compared to the receptive field of (32 x 32 x 32) pixels established in this thesis [69].

Because the best results for the FPR model were attained using test time augmentation (augmenting samples during validation), further analysis and research will be conducted using this methodology. Also, the inclusion of statistical metrics, such as curvedness and Shape Index, for generating nodule candidates will be tested; a strategy that was developed in one of the CD models mentioned by Setio *et al.* [72]. More importantly, best results were reported by studies that used ensemble methods to boost model performance [72, 79]. Although one of the main contributions of this thesis consisted on achieving a similar performance by training fewer models, none of the 100 and 30 architectures trained for both, the CD and FPR CNNs, indicated that this can be achieved. Thus, further research will focus in this machine learning technique, along with decision trees and random forests.

Even though the FPR model did not achieved the desired performance, the morphological and malignancy estimators showed remarkable results. Specifically, the malignancy classifier outperformed all related studies that focused on the same research objective [29, 70, 73]. Two possible reasons to explain this boost in performance are: 1) using GANs to generate more artifcial nodules [62] and 2) working with training data comprised only by non-confirmed histo-pathological malignant nodules. Although these results sound promising, further testing must be done to verify them.

Independent testing of the candidate detection CNN was performed using database B2. Results were better than the ones obtained during validation and training. Different strides used in both, training and independent testing, may explain the differences in performance. Bigger strides were applied when running the candidate generation CNN using database B2. Therefore, with bigger strides the number of false positives was reduced. Moreover, one of the main contributions of this dissertation is based on the morphological estimators, as they provide some degree of interpretability to the radiologists. A justification that is also stated by the research conducted by Shen *et al.*.

Due to the sequential design of the algorithm workflow, many of the poor results obtained in previous steps are reflected in further stages of the algorithm. Specifically, the poor results obtained for the cancer estimator are explained by this architecture design. Because the CD and FPR CNNs fail to detect nodules with success, all the generated false positives induce noise to the training data of the cancer estimator. Although one of the key design choices was to select the maximum values of all the computed joint probabilities, there are some false positives that have greater joint probability compared to the true positives. Thus, some modifications will be made to the algorithm workflow to avoid these issues.

One of the main limitations of this research study was the hardware. Although many of the trained models were inspired on more complex architectures, such as ResNet, Inecption Net, Vgg and Inception-Resnet, their abstraction capabilities cannot be compared to the original ones. This limitation was seen as another contribution of this thesis, to achieve similar results by training models with fewer parameters. It is important to state that similar studies have worked with a lot more resources, allowing them to train more complex models, such as the Inception-Resnet architecture [69, 81].

CHAPTER 5

Conclusions

This dissertation started by describing a major health problem worldwide, the high mortality rates associated to lung cancer. Moreover, the literature review showed the major challenges associated to the disease. Specifically, the NLST study showed a high number of false positives when comparing two technologies, low-dose CT and chest X-ray. Furthermore, different research studies showed several complications related to false positives, such as higher economic costs and a risk increase of morbidity/mortality. Inter-grader variability and subjective assessment of CTs have been associated to inconsistencies in the prognosis procedure, which may result in false positives and negatives.

To help in the CT assessment and reduce the effects of the aforementioned problems, several research studies have focused on developing computer aided-diagnostic tools. Some researchers have worked on different stages of the prognostic procedure, such as lung segmentation, candidate nodule detection, false positive reduction, malignancy estimation of nodular findings, and end-to-end cancer diagnosis models. Because very few researchers have centered their efforts in model interpretability, one of the main research questions addressed in this thesis consisted on determining the best set of morphological nodular characteristics to aid in the detection and characterization
of lung nodules. Also, a second question was defined to determine if the automation of nodular detection would help reduce the number of false positives in lung cancer diagnosis. A third and last question was presented to evaluate nodular detection and characterization performance using a divide and conquer strategy.

Based on the results of the morphological estimators, spiculation and lobulation have showed the highest linear correlation with the likelihood of nodular malignancy, a result that will help with model interpretability. The performance of the FPR detector showed that the reduction of false positives require a higher number of models to train with higher complexity. Moreover, errors encountered in the first stages of the algorithm propagate throughout the pipeline. Thus, a sequential design is not adequate for tackling this problem. Different model configurations need to be explored to avoid these sequential bottlenecks.

We can conclude that the main problem resided on the FPR stage. It is ideal to continue the research to optimize the FPR architecture. As exposed in the discussion, several efforts will focus on test-time data augmentation techniques, ensemble methods and different receptive fields. As stated in the beginning, two main contributions of the dissertation consisted on obtaining reliable results with few computational resources, smaller and fewer CNN models. Although none of the two main contributions were attained, further efforts will focus on obtaining results that align with these two objectives. Also, other strategies will be developed to train large ensmebles of models with bigger architectures. Research efforts will be centered in solving the pipeline bottleneck associated to the sequential nature of the algorithm workflow.

Developing a lung cancer end-to-end detection approach is a very complex and challenging task. Even more, trying to develop a limited amount of models with few trainable parameters poses additional constraints that make the problem even harder to solve. It seems that the best solution consists in developing large ensemble of models, with heavy data augmentation techniques, and smart feature engineering for preprocessing CTs. Moreover, a parallel divide and conquer strategy semi-dependent on previous stages, may alleviate some of the problems that can arise within the

pipeline; thus, computing final predictions that are not heavily affected if one of the stages resulted in poor performance.

Lung cancer has posed many social and economic problems to society. However, this works has proved the value of CAD models to aid in the detection of lung cancer with some degree of accuracy. It is expected that better technologies will be developed in the future, helping radiologists detect lung cancer in early stages to provide immediate healthcare to patients.

Appendices

${\sf APPENDIX}\,A$

Informed consent forms

ANEXO A: DOCUMENTO DE CONSENTIMIENTO INFORMADO

En caso de tratarse de un menor de edad, o un paciente que se encuentre en estado de incapacidad transitoria o permanente, o que por su situación legal no pueda expedir el consentimiento libremente, la autorización será otorgada por el familiar más cercano en vínculo que le acompañe, o en su caso, por tutor o representante legal.

DATOS PERSONALES

Nombre del paciente:							
Matrícula:	Edad:	Sexo:		_ Teléfono:			
Domicilio:							
Nombre de la persona que recibió la información y el consentimiento:							
Paciente () Represen	tante legal ()	Familiar ()				
Parentesco:							

REALIZARÁ LOS PROCEDIMIENTOS: Ing. Jonathan Domínguez Aldana

PROCEDIMIENTO: La comprobación histológica por biopsia, la tomografía computarizada del paciente y las anotaciones hechas por el radiólogo experto sobre las características encontradas en la tomografía, serán usados para ser integrados a una base de datos de fácil acceso. Esta base de datos será usada en un protocolo de investigación para alimentar a un algoritmo de inteligencia artificial que ratificará la presencia de cáncer de pulmón.

PROPÓSITO DEL ESTUDIO: Obtener la información clínica pertinente para que sea usada por un algoritmo de inteligencia artificial, que le permita mejorar el diagnóstico temprano de cáncer de pulmón a través de tomografía computarizada.

RIESGOS Y COMPLICACIONES: Ninguno

POR LO TANTO, CON LA ANOTACIÓN VERBAL Y ESCRITA

- Declaro de forma libre y voluntaria sin existir ninguna presión física o moral sobre mi persona, que he comprendido por las explicaciones que se me han proporcionado, el propósito y los riesgos del procedimiento, aclarando las dudas que he planteado. Así mismo declaro que he leído y comprendo totalmente el consentimiento y los espacios en blanco que han sido llenados antes de firmar.
- 2. Estoy enterado(a) que en cualquier momento y sin necesidad de dar explicación, puedo revocar el consentimiento que otorgo.

AUTORIZO

QUE SE ME (LE) REALICEN LOS PROCEDIMIENTOS ANTERIORMENTE PLANTEADOS Y AUTORIZO EL MANEJO DE LAS CONTINGENCIAS DERIVADAS DEL ACTO ARRIBA AUTORIZADO

En

Lugar y fecha

Hora

Nombre y firma de la persona que dio el consentimiento

${}_{\mathsf{APPENDIX}}\,B$

Scripts for each hospital data base

```
classes_angeles.py
```

<pre>temp_scan[i].PixelData = self.pixel_lungs[i - slice_range[0]].tostring() temp_scan[i].save_as(self.saving_path_lungs + '/' + str(i) + '.dcm') print('Scan was saved!')</pre>	
<pre>def load_extracted_lungs(self):</pre>	
<pre>if self.pixel_lungs is []:</pre>	
<pre>if len(os.listdir(self.saving_path_lungs)) is 0: print('There are no extracted lungs saved!') return None</pre>	
<pre># Load results print('Loading scan') loaded_scan = [pydicom.dcmread(self.saving_path_lungs + '/' + s) for s in</pre>	

```
classes_h.py
```

eturn self.torax_pixels[minZ:maxZ, minY:maxY, minX:maxX]

```
true_labels[
```

```
for i in range(0, stepsX, stride[0]):
```

```
minY = coords[2]
```

filter_size

```
fig.savefig(saving_path_slides + '/' + save_name, dpi=300)
```

return rotated

```
def rotate_data(self, data, rotations, angles):
```

return np.array(rotated)

${}_{\mathsf{APPENDIX}}\,C$

Scripts for data normalization

APPENDIX D

Script for all detectors

```
CNN_Models.py
```

, kernel_initializer=kernel_initializer,

```
x = Dense(32) activation='relu' name='fc 1'
```

```
initializer=kernel_initialize:
```

Conv3D(filters=F2, kernel_size=(f, f, f), strides=(1,

_initializer=kernel_initializer

12_regularizer=12_regularizer)

kernel_regularizer=regularizers.l2(l2_regularizer))(X)

```
# First branch - 1 x 1 conv
b1 = Conv3D(F1, (1, 1, 1), strides=(1, 1, 1), padding='same',
```
```
strides=(1, 1, 1), padding='
```

```
# Vary the number of inception blocks
X = X_input
for i in range(0, space['num_inception']):
X = inception_block(X, filters=filters,
bottlenecks=bottlenecks, block=str(i),
kernel_initializer=kernel_initializer,
bias_initializer=bias_initializer,
l2_regularizer_1=L2_s1,
l2_regularizer_2=L2_s2)
# Fully Connected Layer
X = Flatten()(X)
# Add extra dense layers
num_layer = 1
for num_layer in range(0, space['extra_dense']):
extra_units = space['extra_units'] + 1
X = Dense(extra_units, activation='relu', name='fc_' + str(num_layer),
kernel_initializer=kernel_initializer,
bias_initializer=bias_initializer)(X)
if n_classes <= 2:
X = Dense(n_classes, activation='softmax', name='fc_' + str(num_layer + 1),
kernel_initializer=bias_initializer,
bias_initializer=bias_initializer,
bias
```

```
return model
```

Define the input placeholder as a tensor with shape input_shape.

infink of this as your input image: Y input = Input(chappe=input chappe)

```
X = MaxPooling3D(pool size=(2, 2, 2)).
```

```
strides=(2,
```

```
X = Dropout(0.5)(X)
```

```
X = BatchNormalization(axis=4, name=bn_name)(X)
```

```
K = Activation('relu')(X
```

```
X = MaxPooling3D(pool size=3.
```

Dense(1, activation=

return x

def inception resnet block(x,

scale, block_type, block_idx, kernel_initializer, bias_initializer, l2_regularizer, activation='relu'):

"""Adds a Inception-ResNet block.

return model

return Model(inputs=x_input, outputs=x, name='Model_adptative 1')

```
cnn gan.py
```

fake = np.random.uniform(0, 0.3, (batch_size,

if __name__ == '__main__':
 dcgan = DCGAN()
 dcgan.save_parameters()
 dcgan.build_model()
 dcgan.build_model()

gan.train(epochs=train_epochs, batch_size=train_batch_size, save_interval=saving_interval)

from hyperopt import hp, fmin, tpe, STATUS_OK, Trials
from classes_lidc import custom_Keras_Metrics, dataTransformer, NoduleGenerator, MalignancyGenerator
from Keras import Bayesian
from keras import initializers
import time
from keras

```
num_stages = 5
filter_size = [3, 5]
F1_res = [4, 8, 16]
F2_res = [4, 8, 16]
F3_res = [4, 8, 16]
L2_conv_min = 0.0
```

```
ch_size'] = batch_siz
```

```
print('\n Augmenting negative data with GAN...')
generated = dcgan_neg.generate_data(num_pos - num_neg)
x_neg_=_np_compatients(//
```

x_pos = dt.rotate_data(x_pos[:, :, :, :, 0], axis_rot_pos, angles_pos)

n_trial += 1

if not use generator:

```
Get optimal threshold file path
```

hold model {}'.format(saved_model) +

opt_threshold_file = saving_folder + '/optimal

```
pickle.dump(auc, open(auc_file, "wb"))
pickle.dump(opt_threshold, open(opt_threshold_file, "wb"))
```

plt.title('Especificidad del modelo {}'.format(num_model))
plt.ylabel('Especificidad [TP / (TP + FN)]')
plt.xlabel('Iteración')
plt.legend(['datos de entrenamiento', 'datos de validación'], loc='upper left')
plt.show()
print('Saving specificity plot...')
plt.savefig(saving_folder + '/' + 'specificity_plot best model {}.png'.format(saved_model))
summarize history for specificity
plt.figure(5)
plt.plot(saved_history['sensitivity'])
plt.title('Sensibilidad del modelo {}'.format(num_model))
plt.ylabel('Sensibilidad [TN / (TN + FP)]')
plt.xlabel('Iteración')
plt.legend(['datos de entrenamiento', 'datos de validación'], loc='upper left')
plt.show()
print('Saving sensitivity plot...')
plt.savefig(saving_folder + '/' + 'sensitivity_plot best model {}.png'.format(saved_model))
ode_checkpoints

```
os.makedirs(saving_folder)
```

```
# Get positive dat
```

```
_idx = np.where(y_train[:, 0] == 1)
if not load saved and not load best and not load checkpoint:
```

```
model_path = (model_folder
```

```
# Tensorboard callbacks
```

tensorboard = TensorBoard(log_dir=saving_folder + '/logs/{}'.format('best_model{}'.format(saved_model)))
callbacks.append(tensorboard)

num_neg = x_neg.shape[0]

```
pickle.dump(opt_threshold, open(opt_threshold_file, "wb"))
```

plt.figure(3)
plt.plot(avg_dat)
plt.plot(avg_val

```
plt.title(
                                      odelo {}'.format(num_model))
```

plt.xlabel('Iteración')
plt.legend(['datos de entrenamiento', 'datos de validación'], loc='upper left')

plt.ylabel('Especificidad [TP / (TP + FN)]')
plt.xlabel('Iteración')
plt.legend(['datos de entrenamiento', 'datos de validación'], loc='upper left')
plt.show()
print('Saving specificity plot...')
plt.savefig(saving_folder + '/' + 'specificity_plot best model {}.png'.format(saved_model))
summarize history for specificity
plt.figure(5)
plt.plot(saved_history['sensitivity'])
plt.plot(saved_history['val_sensitivity'])
plt.title('Sensibilidad del modelo {}'.format(num_model))
plt.ylabel('Sensibilidad [TN / (TN + FP)]')
plt.xlabel('Iteración')
plt.legend(['datos de entrenamiento', 'datos de validación'], loc='upper left')

slide_nodule_detector_3D.py

from classes_lidc import Utilities, PreProcessor, Detector, custom_Keras_Metrics
from keras.models import load_model, Model
import tensorflow as tf
import os

```
.format(num_model_2,
                      version_3
```

 $model_2 = Nor$

```
start = time.time()
results_2, results_3, results_4, results_5, true_pos_detections, false_pos_detections, true_labels =
    detector.slide_window_3d(
        model_4, model_5, som,
        patient, graph,
        saving_path_gldes,
        saving_path_fp,
        use_fp_reductionuse_fp_reduction,
        use_sevm=use_sum,
        use_maingnancy-use_maingnancy,
        use_sofuction=use_spiculation,
        data_dims=data_dims,
        fliter_size=filter_size,
        stride=stride,
        detection_threshold_2t=threshold_2,
        save_slides=ave_glides,
        save_fp_save_fp,
        graphics_show=graphics_show,
        augment_data_augment_data,
        num_radiologists=num_radiologists)
end = time.time()

parameters_file = saving_path_slides + '/parameters.txt'
f = open(parameters_file, 'v')
f.write(' totrides: ()\n'.format(str(streshold_2)))
f.write(' detection threshold; ()\n'.format(str(threshold_2)))
f.write(' detection threshold; ()\n'.format(str(threshold_2)))
f.write(' time_elapsed; ()\n'.format(str(end - start)))
f.elose()
```

detector class

eturn z_coords

```
= PreProcessor()
```

'.format(num_nodules)))

```
edgecolor='violet',
facecolor='none')
```

self.is_new_tp(detection_cube, true_pos_detections, threshold=0.125):

f.write(' Max prob malignancy and nodule with {0} detections: {1}\n'.format(false_pos + true_pos, str(np.max(results[index_malignancy] * results_3[index_malignancy]))))
else: f.write(' Max prob malignancy and nodule with {0} detections: {1}\n'.format(false_pos + true_pos, 0))
<pre>if len(results[index_spiculation]) is not 0: f.write(' Max prob spiculation and nodule with {0} detections:: {1}\n'.format(false_pos + true_pos, str(</pre>
else: f.write(' Max prob spiculation and nodule with {0} detections:: {1}\n'.format(false_pos + true_pos, 0))
<pre>if len(results[index_lobulation]) is not 0: f.write(' Max prob lobulation and nodule with {0} detections: {1}\n'.format(false_pos + true_pos, str(</pre>
f.write(' Max prob lobulation and nodule with {0} detections: {1}\n'.format(false_pos + true_pos, 0)) f.close()
return results, results_2, results_3, results_4, results_5, true_pos_detections, false_pos_detections, true_label

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