

The PhysioNet/Computing in Cardiology Challenge 2010: Mind the Gap

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Abstract

Participants in the 11th annual PhysioNet/CinC Challenge were asked to reconstruct, using any combination of available prior and concurrent information, 30-second segments of ECG, continuous blood pressure waveforms, respiration, and other signals that had been removed from recordings of patients in intensive care units.

Fifteen of the 53 participants provided reconstructions for the entire test set of 100 ten-minute recordings. The mean correlation between the segments that had been removed (the “target signals”) and the reconstructions produced using the two most successful methods is 0.9, and the sum of the squared residual errors in these reconstructions is less than 20% of the energy of the target signals.

Sources for the most successful methods developed for this challenge have been made available by their authors to support research on robust estimation of parameters derived from unreliable signals, detection of changes in patient state, and recognition of signal corruption.

1. Introduction

In settings ranging from sleep studies to surgery to sports medicine to intensive care, real-time monitoring of a variety of physiologic signals has become an essential tool for clinicians and researchers. Transient corruption or loss of one or more signals, common in all of these settings, can be disruptive, especially when continuous observations are required in order to rule out rare events or as a basis for forecasting. Signal corruption can be particularly challenging when it mimics features that are associated with pathologic states.

Humans can be remarkably adept at dealing with transient noise and signal loss in these settings. Filling in gaps, and making use of context to recognize and ignore noise, are processes that our sensory and cognitive abilities leave us well-equipped to do. Can algorithmic solutions that take account of the same data, in broader contexts and without fatigue, do as well?

The aim of the PhysioNet/CinC Challenge 2010 was to develop robust methods for filling in gaps in multiparameter

physiologic data (including ECG signals, continuous blood pressure waveforms, and respiration). In a real-world monitoring application, these methods can be applied for many purposes, including:

- robust estimation of parameters such as heart rate, mean arterial pressure, and respiration when the primary signals used to derive these parameters become unavailable or unreliable;
- detection of changes in patient state, when the relationships between signals remain consistent even as individual signals change their behavior; and
- recognition of intervals of signal corruption, when a signal becomes inconsistent not only with respect to its previous history but also with respect to its relationships with other signals.

In this Challenge, participants were asked to reconstruct, using any combination of available prior and concurrent information, segments of signals that have been removed from multiparameter recordings of patients in intensive care units (ICUs).

2. Methods

2.1. Challenge Data Sets

From previously unpublished ICU patient monitor recordings collected by the MIMIC II project [1], we prepared ten-minute records containing at least six simultaneous and continuous signals (digitized at 125 samples/second each). The signals vary across records, and they include ECG, continuous invasive blood pressure, respiration, raw fingertip plethysmogram outputs, and occasional other signals. We prepared one such record from each of 300 randomly chosen monitor recordings, selecting the ten-minute interval at random within each longer recording. In each ten-minute record, the final thirty seconds of one of the signals (also chosen at random, see table 1) was designated as the *target signal*, and it was replaced by a gap (a flat line signal) as shown in figure 1. The goal is to reconstruct this missing 30-second target signal in each record. The modified records were assigned randomly to one of three Challenge data sets of 100 records each:

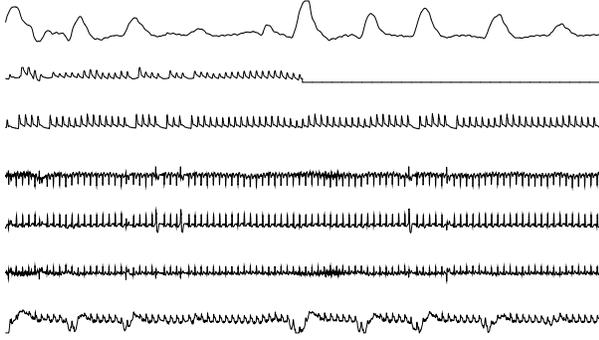


Figure 1. The final minute of a typical 10-minute record from the Challenge data set. From the top, the signals are respiration, raw fingertip plethysmograph output, arterial blood pressure, ECG leads II, “V” (an unspecified precordial lead), and aVR, and central venous pressure. The goal was to reconstruct the missing target signal (in this case, the fingertip plethysmograph output, which was replaced by a flat signal during the final 30 seconds).

Table 1. Distribution of target signals in Set C records.

Target signal to be reconstructed	Records
Arterial blood pressure	19
Central venous pressure	11
ECG	40
Fingertip plethysmograph (raw signal)	14
Intracranial pressure	5
Respiration	11

Set A is a set of 100 records for participants’ use as a training set. Participants were able to obtain scores for Set A reconstructions at any time, but Set A scores were not included in the final rankings of Challenge entries. The target signals were provided for the records in this set. Participants were able to construct additional training data from any of the multiparameter data available from PhysioNet [2], such as the MIMIC II Waveform Database.

Set B is a set of 100 records for which the target signals were withheld until the conclusion of the challenge. Participants were able to obtain scores for Set B reconstructions at any time, but (as for Set A) Set B scores were not included in the final rankings of Challenge entries.

Set C is a set of 100 records, with the target signals withheld. Participants were allowed to submit reconstructions of the target signals at any time, but they received only a single set of scores based on their final submissions, which determined the final rankings and the winners of the challenge.

The Challenge data sets were posted on PhysioNet and remain freely available to support further study [3].

2.2. Scoring for individual reconstructions

Each reconstruction was compared with the corresponding target (reference) signal and was scored using two different methods, one for each of the two Challenge events.

Event 1: The target signal, $V_{ref}(t)$, is subtracted from the reconstruction, $V_{rec}(t)$ to obtain the residual signal, $V_{res}(t)$:

$$V_{res}(t) = V_{rec}(t) - V_{ref}(t) \quad (1)$$

where $t = t_0, t_0 + \Delta t, \dots, t_0 + (n - 1)\Delta t$.

The event 1 figure of merit, Q_1 , varies between 0 and 1 (where 1 represents a perfect reconstruction); it depends on the sum of the squares of the residuals, normalized by the energy (sample variance) of the target signal, E_{ref} :

$$Q_1 = \max\left(1 - \sum_{i=0}^n V_{res}(t_0 + i\Delta t)^2 / E_{ref}, 0\right) \quad (2)$$

where

$$E_{ref} = \sum_{i=0}^n V_{ref}(t_0 + i\Delta t)^2 - \frac{1}{n} \left(\sum_{i=0}^n V_{ref}(t_0 + i\Delta t) \right)^2 \quad (3)$$

If $\sum V_{res}^2$ is 0, the reconstruction is perfect, and $Q_1 = 1$ even if E_{ref} is also 0.

Use of a figure of merit based on the residual signal reflects the importance in many cases of obtaining a good estimate of target signal levels (such as systolic, mean, and diastolic pressures in a continuous blood pressure signal).

Event 2: The quality Q_2 of a reconstruction is defined as the correlation coefficient of V_{ref} and V_{rec} , or 0, whichever is larger. (Correlation coefficients can of course be negative; for the purposes of this challenge, an anticorrelated reconstruction is equivalent to an uncorrelated one, however.)

Use of the correlation coefficient as a figure of merit is motivated by the observation that reconstruction of a filtered signal may be useful in many cases. Such a reconstruction might, for example, provide a basis for reliable estimation of the timing of major fluctuations in a signal (such as QRS complexes in an ECG signal), even if absolute signal levels are not recovered. Unlike Q_1 , Q_2 is relatively insensitive to misestimation of the amplitudes of fluctuations.

2.3. Aggregate (summed) scores

The final ranking of participants is based on summing the Q scores obtained for records in Set C. Participants were encouraged, but not required, to provide reconstructions of all records in Set C.

Both Q_1 and Q_2 are defined so they can vary between 0 and 1, and higher values are better. Participants who

did not submit a reconstruction for a given record received zero scores for that record.

For event 1, each participant’s Set C summed score, C_1 , is the sum of the Q_1 scores for each record in Set C. Similarly, for event 2, the Set C summed score, C_2 , is the sum of the individual Q_2 scores. Since Set C contains 100 records, C_1 and C_2 can vary between 0 and 100.

The summed scores were not normalized by the number of target signals reconstructed, to provide a strong incentive to submit reconstructions of as many of the Set C records as possible.

2.4. Training

Participants were given scores for any number of reconstructions of the records in sets A and B, so an iterative process of improving these scores was possible. They were also provided access to the code of the scoring algorithm [4] so that it was possible to use additional data from PhysioNet or any other source for development and training of their methods. Such training may have been beneficial if it resulted in improving the performance of a reconstruction algorithm on unknown data. Since the only scores reported for set C were for the final reconstruction of each target signal, iterative refinement (“tuning”) was not possible using the data on which the final rankings were based.

3. Results

Fifteen participant-teams submitted reconstructions for all 100 records in set C. Their final scores are illustrated in figure 2, and the top scores are summarized in table 2.

Table 2. Top results for Challenge 2010.

C_1	C_2	Entrant
83.00	90.51	Rui Rodrigues Universidade Nova de Lisboa, Portugal
81.33	89.67	Adam Sullivan, Henian Xia, Joseph McBride, Xiaopeng Zhao University of Tennessee, Knoxville, USA
73.35	84.30	Mohamed Mneimneh, Sahar Elturk Marquette University, USA
70.55	84.09	Ikaro Silva MIT, USA
69.66	81.32	András Hartmann Semmelweis University, Hungary

Figures 3-6 illustrate reconstructions of target arterial blood pressure, ECG, fingertip plethysmograph (“PLETH”), and respiration signals from set C. To the right of each reconstruction, the Q_1 and Q_2 scores are shown.

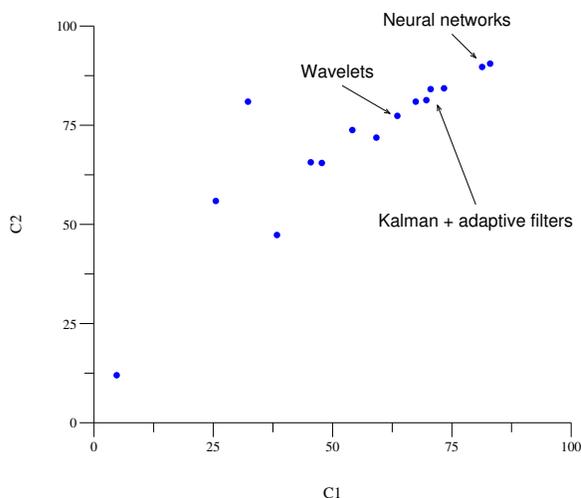


Figure 2. Results for set C. Each participant who submitted a complete set of reconstructions is represented by a point on this plot. Points nearest to the upper right corner represent the most successful reconstructions of the target signals, on average. The primary methods used by the top participants are indicated on the figure.

4. Discussion and conclusions

The two most successful approaches [5, 6], based on neural networks, performed almost equally well, achieving C_2 scores near 90 (corresponding to a mean correlation between the target and reconstructed set C signals of about 0.9). The three next most successful entries relied on Kalman filtering [7], adaptive filtering [8], or both [9]; these also had similar levels of performance, with mean correlations of 0.81 to 0.84. Although this group’s performance was surpassed by the best neural network methods, the reconstructions were nevertheless of excellent quality, and the generally more efficient training possible using the methods of this group may be advantageous in future on-line applications. Other approaches included signal averaging [10], hidden Markov models [11], and principal component analysis [12], achieving generally good results; the most promising alternative approach relies on wavelet decomposition [13].

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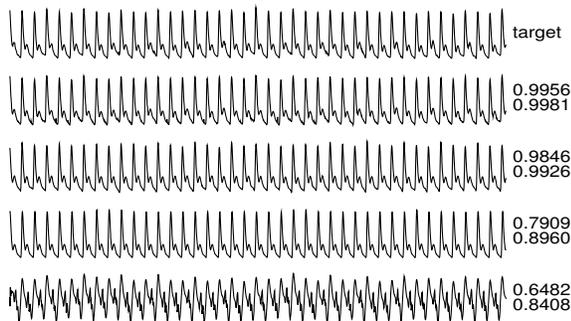


Figure 3. ABP target and reconstructions.

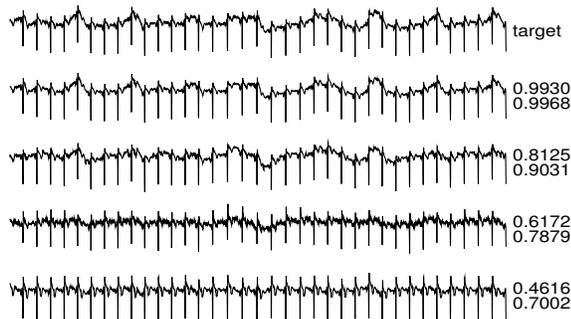


Figure 4. ECG target and reconstructions.

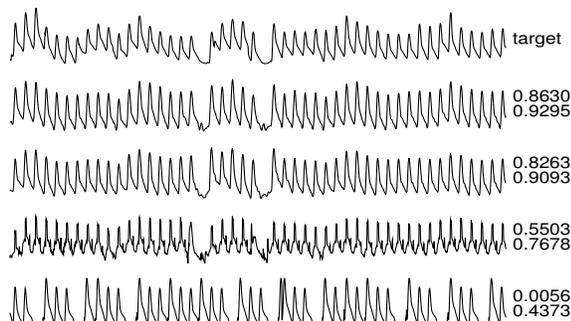


Figure 5. PLETH target and reconstructions.

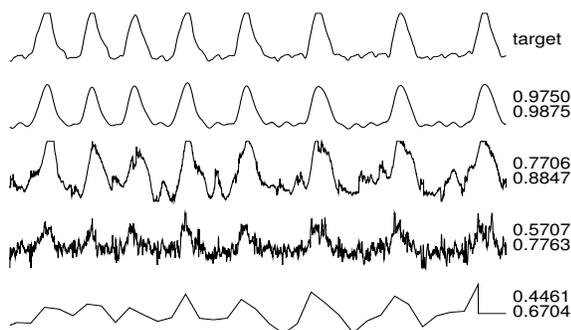


Figure 6. Respiration target and reconstructions.

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