Effectiveness of computer-aided diagnosis of colorectal lesions using novel software for magnifying narrow-band imaging: a pilot study

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ABSTRACT
Background and study aims Magnifying narrow-band imaging (M-NBI) enables detailed observation of microvascular architecture and can be used in endoscopic diagnosis of colorectal lesion. However, in clinical practice, differential diagnosis and estimation of invasion depth of colorectal lesions based on M-NBI findings require experience. Therefore, developing computer-aided diagnosis (CAD) for M-NBI would be beneficial for clinical practice. The aim of this study was to evaluate the effectiveness of software for CAD of colorectal lesions.

Materials and methods In collaboration with Yamaguchi University, we developed novel software that enables CAD of colorectal lesions using M-NBI images. This software for CAD further specifically divides original Sano’s colorectal M-NBI classification into 3 groups (group A, capillary pattern [CP] type I; group B, CP type II + CP type IIIA; group C, CP type IIIb), which describe hyperplastic polyps (HPs), adenoma/adenocarcinoma (intramucosal [IM] to submucosal [SM]-superficial) lesions, and SM-deep lesions, respectively. We retrospectively reviewed 121 lesions evaluated using M-NBI.

Results The 121 reviewed lesions included 21 HP, 80 adenoma/adenocarcinoma (IM to SM-superficial), and 20 SM-deep lesions. The concordance rate between the CAD and the diagnosis of the experienced endoscopists was 90.9%. The sensitivity, specificity, positive and negative predictive values, and accuracy of the CAD for neoplastic lesions were 83.9%, 82.6%, 53.1%, 95.6%, and 82.8%, respectively. The values for SM-deep lesions were 83.9%, 82.6%, 53.1%, 95.6%, and 82.8%, respectively.

Conclusion Relatively high diagnostic values were obtained using CAD. This software for CAD could possibly lead to a wider use of M-NBI in the endoscopic diagnosis of colorectal lesions.

Introduction
Early detection and removal of colorectal neoplasia are essential in reducing mortality rates for patients with colorectal cancer [1,2]. Although several modalities are available for colorectal cancer screening [3–6], colonoscopy is considered the most effective because it allows direct visualization and on-site treatment of encountered lesions. Accurately determining the histological features of colorectal polyps using endoscopy could prevent unnecessary endoscopic treatments thus allowing the proposal of adequate surveillance recommendations [7]. Magnifying narrow-band imaging (NBI) enables detailed observation of the microvascular architecture of lesions and can be used for endoscopic differential diagnosis and estima-
tion of invasion depth of colorectal lesions [8, 9]. We have de-
veloped software for computer-aided diagnosis (CAD) of colo-
rectal lesions into nonneoplastic lesions (hyperplastic polyps
[HPs]), adenoma/intramucosal (IM) cancers/submucosal (SM)-
superficial cancers (invasion depth, <1000 µm), or SM-deep
cancers (invasion depth, ≥1000 µm). The aim of this study was
to retrospectively evaluate the effectiveness of CAD of colorec-
tal lesions using our novel software and still images obtained
from M-NBI. The aim of this study is to evaluate the effective-
ness of CAD of colorectal lesions using novel software.

Materials and methods
Software for CAD
Using class-appropriate images obtained with front-view M-NBI,
we determined the region of interest (ROI), converted the im-
ages into grayscale images, visualized the rough vessels
through binarization using the moving average method, de-
leted all colors except the color of the vessel, and removed
isolated points and holes. Subsequently, we used characteris-
tics, such as the average width, length, total length, and con-
centration of the visualized vessel, and the fractal dimension
to extract significant quantitative characteristics. Then, we ex-
tracted the average length, total length, and concentration of
the visualized vessel as the effective quantitative characteris-
tics for classifying colorectal lesions. In corroboration with
Yamaguchi University, we developed software for CAD of le-
sions using the 3 quantitative characteristics. This software for
CAD further broadly divides Sano’s classification, which is the
original colorectal NBI classification [10–12], into 3 groups
(group A, capillary pattern (CP) type I; group B, CP type II + CP type IIIA; group C, CP type IIIB; ▶ Fig. 1), which describe hyper-
plastic lesions, adenoma/adenocarcinoma (IM-SM superficial
lesions), and SM-deep lesions, respectively.

The first step in using this software for CAD is to attach
the M-NBI image to the central window. Subsequently, the ROI to
be evaluated is determined using a cursor. Then, by clicking
“Calculate” and “Classify” on the software for CAD interface,
the M-NBI image can be automatically classified into 1 of 3
groups (▶ Fig. 2).

Histological assessment
All specimens were fixed in 10% buffered formalin and cut into
2-mm slices. The specimens were then examined microscopi-
cally for depth of invasion and classified according to histologi-
tical type. Histological diagnoses were based on the Japanese
classification system of colon and rectal cancers and on the
Vienna classification system.

Statistical analysis
Statistical analysis was performed using SPSS for Windows
(SPSS, release 6.0, 1993; SPSS Inc., Chicago, IL, USA). To deter-
mine differences in diagnostic accuracies between the CAD and
diagnosis of experienced endoscopists for the differentiation
and estimation of invasion depth of colorectal neoplasia, the
Fisher exact and χ² tests were used. A P value <0.05 was consid-
ered statistically significant.

Method
We retrospectively reviewed medical records of 103 consecu-
tive patients with 121 lesions that were evaluated using magni-
fying colonoscopy (CF-H260AZI, CF-FH260AZI; Olympus Medi-
cal Systems) and M-NBI before endoscopic or surgical treat-
ment of colorectal neoplasia at the Jikei University Hospital be-
tween June 2008 and March 2010. An experienced endoscopist
who was blinded to this study selected the most representative
M-NBI image of each colorectal lesion with the highest magni-
fication and identified the ROI. Then, CAD, using our novel soft-
ware, was performed on the ROI. Endoscopic diagnosis was also
conducted using the selected M-NBI image, with the diagnosis
made based on the agreement between 2 experienced endo-
scopists who were not involved in selection of M-NBI images.

▶ Fig. 1 Sano’s classification (modified for this study). In this study, Sano’s classification was further divided broadly into three groups: group A, capillary pattern (CP) type I; group B, CP type II + CP type IIIA; group C, CP type IIIB.
and identification of the ROI, and blinded to other endoscopic images of the lesions and the pathological information. All images were classified into the 3 groups described previously (groups A, B, or C). We then compared the results of the CAD using novel software and the diagnoses by the experienced endoscopists to evaluate the effectiveness of the CAD using novel software in the differential diagnosis and estimation of invasion depth of colorectal lesions.

Results

Based on the histological assessment, the 121 reviewed lesions included 21 HPs, 80 adenoma/adenocarcinoma (IM to SM-superficial) lesions, and 20 SM-deep lesions. Among these lesions, 26 lesions were classified into group A, 79 lesions were classified into group B, and 16 lesions were classified into group C by CAD. By contrast, 21 lesions were classified into group A, 82 lesions were classified into group B, and 18 lesions were classified into group C by the experienced endoscopists. The concordance rate between the CAD using our novel software and the diagnoses by the experienced endoscopists was 90.9% (Table 1).

The sensitivity, specificity, positive and negative predictive values (PPV and NPV, respectively), and accuracy of the novel software for CAD in diagnosing neoplastic lesions were 95.0%, 100%, 100%, 80.8%, and 95.9%, respectively (Table 2). For SM-deep lesions, the rates were 55%, 95.0%, 68.8%, 91.4%, and 88.4%, respectively (Table 3).

| Group A (DS) | Group B (DS) | Group C (DS) |
|--------------|--------------|--------------|
| 21           | 5            | 0            |
| 0            | 75           | 4            |
| 0            | 2            | 14           |

DE, diagnosis by the endoscopists; DS, diagnosis using the software for computer-aided diagnosis. The concordance rate between computer-aided diagnosis using software and experienced endoscopists’ diagnoses was 90.9% (110/121).

| HP (nonneoplastic lesion) | Adenoma/adenocarcinoma (IM, SM-superficial, and SM-deep) (neoplastic lesion) |
|---------------------------|------------------------------------------------------------------------------|
| Group A (DS)              | 21                                                                           |
| Group B + C (DS)          | 0                                                                           |

HP, hyperplastic polyp; IM, intramucosal; SM, submucosal; DS, diagnosis using the software for computer-aided diagnosis. The diagnostic accuracy rate of the computer-aided diagnosis using software was 95.9% (116/121) for neoplastic lesions.
In the diagnoses by experienced endoscopists, all HPs were classified as type A and all neoplastic lesions were classified as type B or C (Table 4). The sensitivity, specificity, PPV, NPV, and accuracy of their diagnoses of SM-deep lesions were 70.0%, 96.1%, 77.8%, 94.2%, and 92.6%, respectively (Table 5).

No significant difference in the accuracies of differential diagnosis of colorectal lesions was observed between the CAD and the endoscopists' diagnosis (P>0.05). Moreover, no significant difference in the diagnostic accuracy of invasion depth was found between the CAD and the endoscopists' diagnosis (P>0.05).

Discussion

Accurately differentiating between neoplastic and nonneoplastic lesions and estimating the invasion depth of colorectal neoplasia are essential in determining appropriate endoscopic treatment. Currently, magnifying chromoendoscopy with dye (indigo carmine/crystal violet), which has high diagnostic accuracy in differentiating colorectal lesions and in estimating the invasion depth of colorectal lesions, should be considered as the standard criterion [13–16]. However, chromoendoscopic observation requires much time, compared not only with white light observation but also with NBI observation [17]. M-NBI enables detailed observation of microvascular architecture and can be used for endoscopic differential diagnosis and estimation of invasion depth of colorectal lesions. However, magnifying observation of colorectal lesions has not been standardized in many Western countries. In addition, use of M-NBI in clinical practice requires knowledge and experience; thus, endoscopic differential diagnosis and estimation of invasion depth of colorectal lesions based on the findings of M-NBI has not become widespread in Western countries [18]. Therefore, a simple and automated interpretation using an objective standard of M-NBI findings would be beneficial for clinical practice.

The results of this study show that relatively high identification rates were obtained with CAD of M-NBI images for differential diagnosis and estimation of invasion depth of colorectal lesions. Moreover, the diagnostic values were not significantly different from those of experienced endoscopists, although several lesions were diagnosed differently by the endoscopists and CAD using software (Fig. 3). In addition, this software for
CAD can be further improved by strengthening the reliability of each quantitative characteristic and seeking new ones.

This study has several limitations. The number of images used in this study was limited, sample size was not calculated, and the images were obtained from a single center. In addition, determination of ROI was conducted by a single experienced endoscopist, thus precluding determination of interobserver agreement. The 2 lesions diagnosed as Group C by the CAD using software but diagnosed as Group B are presented (Fig. 3a, Fig. 3b). One of them had a villous component that often presents blood pooling (Fig. 3b). Considering this result and the software that uses visualized vessel findings for the diagnosis of the lesions, novel software for CAD might have limitations for diagnosis of a villous lesion.

**Conclusion**

With further improvement of the software used in the current study, CAD as aided by this novel software could possibly lead to a wider use of M-NBI in the endoscopic diagnosis of colorectal lesions.

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**Competing interests**

None

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