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## Fully Automatic Hippocampus Segmentation and Classification in Alzheimer's Disease and Mild Cognitive Impairment Applied on Data from ADNI

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### Abstract

The hippocampus is among the first structures affected in Alzheimer's disease (AD). Hippocampal MRI volumetry is a potential biomarker for AD but is hindered by the limitations of manual segmentation. We proposed a fully automatic method using probabilistic and anatomical priors for hippocampus segmentation. Probabilistic information is derived from 16 young controls and anatomical knowledge is modelled with automatically detected landmarks. The results were previously evaluated by comparison with manual segmentation on data from the 16 young healthy controls, with a leave-one-out strategy, and 8 patients with AD. High accuracy was found for both groups (volume error 6% and 7%, overlap 87% and 86%, respectively). In this paper, the method was used to segment 145 patients with AD, 294 patients with Mild Cognitive Impairment (MCI) and 166 elderly normal subjects from the ADNI (Alzheimer's Disease Neuroimaging Initiative) database. Based on a qualitative rating protocol, the segmentation proved acceptable in 94% of the cases. We used the obtained hippocampal volumes to automatically discriminate between AD patients, MCI patients and elderly controls. The classification proved accurate: 76% of the patients with AD, and 71% of the MCI converting to AD before 18 months, were correctly classified with respect to the elderly controls, using only hippocampal volume.

### 1 Introduction

Alzheimer's disease (AD) is the most common cause of dementia; its early and accurate diagnosis is challenging. The hippocampus is a grey matter structure of the temporal lobe known to be affected at the earliest stage of AD, even before the diagnosis can be made, at the stage of Mild Cognitive Impairment (MCI) (Braak et al, 1995). Hippocampal volumetry

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Data used in the preparation of this article were obtained from the Alzheimer's Disease Neuroimaging Initiative (ADNI) database (<http://www.loni.ucla.edu/ADNI>). As such, the investigators within the ADNI contributed to the design and implementation of ADNI and/or provided data but did not participate in analysis or writing of this report. ADNI investigators include (complete listing available at [http://www.loni.ucla.edu/ADNI/Collaboration/ADNI\\_Authorship\\_list.pdf](http://www.loni.ucla.edu/ADNI/Collaboration/ADNI_Authorship_list.pdf)).

on magnetic resonance images (MRI) can thus constitute a useful diagnostic tool (Dubois et al, 2007). Up to now, hippocampal volumetry mostly relies on highly time-consuming manual segmentation, which is rater-dependent, and not feasible in clinical routine.

Automatic segmentation of the hippocampus would overcome these limitations and provide a useful biomarker of AD. The incomplete definition of hippocampal boundaries on MRI scans makes the use of prior information necessary for accuracy and robustness. Prior knowledge can come from statistical information on shape (Kelemen et al, 1999; Shen et al, 2002), deformations (Duchesne et al, 2002) or from registering a single subject atlas template (Csernansky et al, 2000); nevertheless, these methods may be unsuitable for diseased structures. Segmentation using probabilistic information (Fischl et al, 2002, Heckemann et al, 2006) offers more thorough global spatial knowledge compared to single object atlases.

We proposed a fully-automatic method (Chupin et al, 2007 2009) for the segmentation of the hippocampus ( $Hc$ ) and the amygdala ( $Am$ ), based on simultaneous region deformation driven by both anatomical and probabilistic priors. Anatomical information (Bloch et al, 2005) is derived from local anatomical patterns that are stable in controls and patients, around landmarks automatically detected during the deformation. (Chupin et al, 2007). Probabilistic information is derived from an atlas built from the registration of manually segmented  $Hc$  and  $Am$  for 16 young healthy subjects (Chupin et al, 2009). Initialization is obtained from global information and deformation is constrained by local anatomical and probabilistic information.

The goal of this paper is to further evaluate this segmentation method in patients with AD, MCI and elderly controls from the ADNI database (Alzheimer's Disease Neuroimaging Initiative). It will assess the method's robustness with respect to different MRI scanners and acquisition parameters, and with respect to pathology, some of the patients with AD having highly atrophic  $Hc$ . Segmentation accuracy will be evaluated with a qualitative rating protocol. Furthermore, we will assess the ability of resulting  $Hc$  volumes to discriminate AD and MCI patients from elderly controls. We will also study the influence of some of image pre-processing steps, and of age group and normalisation by total intracranial volume. A preliminary version of this work has been presented at the MICCAI CAPH'08 workshop.

## 2 Method

The segmentation is based on the alternate deformation of two objects, one for  $Hc$  and one for  $Am$ , from two initial objects, through homotopic region deformation. It is modelled in a Bayesian framework, the deformation being driven by an iterative energy minimization. This energy is defined with a functional made of five terms: global and local data attachment, regularization and volume and surface terms (Chupin et al, 2007). The initial objects are determined from the probabilistic atlases, inside an automatically extracted bounding box (Chupin et al, 2009). The energy functional is then iteratively minimised for  $Hc$  and  $Am$ , with additional constraints derived from the anatomical and probabilistic priors.

### 2.1 Probabilistic atlases

The datasets from  $N$  (here  $N=16$ ) young healthy subjects were manually segmented by an expert following a protocol ensuring coherence in the three planes. For each of the atlas subject,  $\{S_i, i = 1 \dots N\}$ , the transformation  $T_i$  to the MNI standard space is then obtained through the unified registration and segmentation module of SPM5 (Ashburner et al, 2005) using the native data. The transformation (expressed on a basis of  $\sim 1000$  cosine functions) is then used to propagate the manually labelled binary masks ( $Hc_i$  and  $Am_i$ ) to the MNI space. The atlases  $PA_{Hc}$  and  $PA_{Am}$  are created only once as follows, in the MRI set  $\Omega$

$$\forall v \in \Omega, PA_{Hc}(v) = \frac{1}{N} \sum_{i=1}^N T_i(Hc_i)(v) \text{ and } PA_{Am}(v) = \frac{1}{N} \sum_{i=1}^N T_i(Am_i)(v). \quad (1)$$

$PA_{Hc}(v)$  and  $PA_{Am}(v)$  are the probabilities that  $v$  belongs to  $Hc$  and  $Am$ .

## 2.2 Initialisation

The first step is to compute forward and backward transformations  $T$  and  $T^{-1}$  between native and MNI spaces. Individual atlases  $IPA_{Hc}$  and  $IPA_{Am}$  are created by back-registering the atlases  $PA_{Hc}$  and  $PA_{Am}$  using  $T^{-1}$ .  $IPA_{Hc}$  and  $IPA_{Am}$  are used to automatically define left and right bounding boxes around the structures of interest, as the smallest boxes embedding the non-null probability values in both atlases, with an extra one-voxel margin, for the left and right hemispheres, as illustrated in Figure 1 a.

Atlas local registration failure in the bounding box is automatically detected and corrected when necessary. For this, it is assumed that, if  $IPA_{Hc}$  is locally mis-registered, the 0.5-probability object  $\{v, IPA_{Hc}(v) \geq 0.5\}$  will cover a wider intensity range than if  $IPA_{Hc}$  is correctly registered. Details are given in Chupin et al (2009).

The last step of the initialization procedure is to create initial objects for  $Hc$  and  $Am$ . Each probability map is pruned through thresholding while ensuring that the object is still topologically a single object (conditional pruning) to ensure obtaining one smooth and connected object corresponding to the region with maximal probability in each probability map. The two objects thus obtained are then eroded to create the initial objects (Figure 1b).

## 2.3 Deformation

The deformation is then driven by the iterative minimization of the energy functional. At each iteration, voxel candidates are selected at the border of the deforming objects, for which re-classification will be considered; meta-regions are automatically detected during the deformation, these regions being the interface between  $Hc$  and  $Am$  and 11 families of anatomical landmarks at the border of  $Hc$  and  $Am$  (Chupin et al, 2007). The energy is then minimized on the voxel candidates through an Iterated Conditional Modes procedure. Low and high likelihood zones are defined around the anatomical landmarks from intensity and spatial local relationships, and three zones are derived from the probability maps:  $PZ^0 = \{v, IPA(v) = 0\}$ ,  $PZ^1 = \{v, IPA(v) = 1\}$ ,  $PZ^{0.75} = \{v, 0.75 \leq IPA(v) < 1\}$ . These specific features are modelled in the regularisation term, comparing  $N^O(v)$  the number of  $O$ -labelled neighbours of  $v$  with a standard value  $\tilde{N}$ , with respect to a tolerance  $\sigma_I$  to prevent holes and wires:

$$E_o^I(v) = \left( \frac{\tilde{N} - \gamma_o^{PZ}(v) \gamma_o^{AZ}(v) \cdot (N_o(v) + \alpha_o^T(v))}{\sigma^I} \right)^5. \quad (2)$$

$\alpha^T = 0$ , except for voxels detected as "tail of  $Hc$ " given by a local pattern ( $\alpha^T$  then increases from 0 to 16 in the bounding box posterior half).  $\gamma^{AZ} = 1$ , except for voxels in low and high likelihood zones ( $\gamma^{AZ} = 0.5$  in  $O$ -unlikely and 2 in  $O$ -likely zones).  $\gamma^{PZ} = 1$ , except for voxels in the three probability zones ( $\gamma^{PZ}(v) = 0.75$  in  $PZ^0$ ,  $\gamma^{PZ}(v) = 2$  in  $PZ^1$ ,  $\gamma^{PZ}(v) = 1.5$  in  $PZ^{0.75}$ ). These parameters constrain the deformation by decreasing the regularisation energy in  $O$ -likely zones and vice-versa, as detailed in Chupin et al (2009).

## 2.4. Data analysis: Segmentation and Classification

Using the fully automatic method, we segmented the hippocampus and the amygdala in all subjects using the atlas built from the 16 young controls, and the parameters of the algorithm as described in Chupin et al (2008). The images first underwent SPM5 bias correction, which is available with the unified segmentation module. The automatic segmentations were quality-controlled for the hippocampus with a scale from 0 (unsatisfactory) to 4 (perfect), in order to estimate if the computed volumes were reliable. The three observers (EG, CB and MC) were trained on a common subset of 30 subjects, to ensure coherence between the ratings, and blinded to the clinical diagnosis of the subjects.

Volumes were normalized by the total intracranial volume (TIV) computed by summing SPM5 segmentation maps of grey matter, white matter and cerebro-spinal fluid (CSF), inside a bounding box defined in standard space to obtain a systematic inferior limit. For more robustness with respect to segmentation errors, left and right volumes were averaged. Group differences were assessed using Student's t-test.

For the classification of patients vs controls, each participant was assigned to the closest group as follows. Robust estimates of classification rate, sensitivity and specificity were computed with a bootstrap approach for training set selection. In this procedure, we drew without replacement approximately 75% of each group to obtain a training set. On this training set, we estimated the mean normalized hippocampal volume for each group. Each participant in the remaining 25% was then assigned to the group which mean was closest to the volume of this participant. The procedure was repeated 5 000 times.

## 3 Experiments and Results

### 3.1 Evaluation of segmentation accuracy with respect to manual tracing

Segmentation accuracy for the hippocampus was evaluated by comparing automatic segmentation ( $S$ ) with a reference manual segmentation ( $R$ ) with two quantitative indices:  $RV(S,R) = 2|V_S - V_R| / (V_S + V_R)$ , the error on volumes and  $DO(S,R) = 2V_{S \cap R} / (V_S + V_R)$ , the Dice overlap. We compared the performance of the fully automatic approach with an "atlas-derived" segmentation given by the 0.5-level probability object.

Complete results are given in Chupin et al (2008). In summary, for the 16 young controls used to create the atlas, for the automatic segmentation with a leave-one-out strategy,  $RV = 6\%$  and  $DO = 87\%$ . For 8 patients with AD, fully described in Chupin et al (2007),  $RV = 7\%$  and  $DO = 86\%$ . For the same patients, if we consider the objects derived from the registered atlases,  $RV = 27\%$  and  $DO = 68\%$ . Two examples of segmentation and atlas registration are given in Figure 2. The quality control evaluated the segmentation as correct ( $\geq 3$ ) for 13  $Hc$  (81%), acceptable ( $\geq 2$ ) for 3  $Hc$  (19%) and unsatisfactory ( $< 2$ ) for none.

### 3.2 Segmentation and classification of subjects from the ADNI database

To assess whether our automatic segmentation method can provide a biomarker for AD, we tested the ability of  $Hc$  volumes to discriminate between patients with AD, patients with MCI and elderly controls.

**3.2.1 Subjects**—Data were obtained from the Alzheimer's Disease Neuroimaging Initiative (ADNI) database ([www.loni.ucla.edu/ADNI](http://www.loni.ucla.edu/ADNI)). The ADNI was launched in 2003 by the National Institute on Aging (NIA), the National Institute of Biomedical Imaging and Bioengineering (NIBIB), the Food and Drug Administration (FDA), private pharmaceutical companies and non-profit organizations, as a \$60 million, 5-year public-private partnership. The primary goal of ADNI has been to test whether serial magnetic resonance imaging

(MRI), positron emission tomography (PET), other biological markers, and clinical and neuropsychological assessment can be combined to measure the progression of mild cognitive impairment (MCI) and early Alzheimer's disease (AD). Determination of sensitive and specific markers of very early AD progression is intended to aid researchers and clinicians to develop new treatments and monitor their effectiveness, as well as lessen the time and cost of clinical trials.

The Principal Investigator of this initiative is Michael W. Weiner, M.D., VA Medical Center and University of California - San Francisco. ADNI is the result of efforts of many co-investigators from a broad range of academic institutions and private corporations, and subjects have been recruited from over 50 sites across the U.S. and Canada. The initial goal of ADNI was to recruit 800 adults, ages 55 to 90, to participate in the research – approximately 200 cognitively normal older individuals to be followed for 3 years, 400 people with MCI to be followed for 3 years, and 200 people with early AD to be followed for 2 years. For up-to-date information see [www.adni-info.org](http://www.adni-info.org).

**3.2.2 Experiments**—Three different experiments were considered, in order to evaluate the influence of pre-processing, normalisation by TIV, age groups and segmentation method on classification results. MRI acquisition was done according to the ADNI acquisition protocol (Jack et al, 2008). ADNI images with B1 and “grad warp” corrections were used, as they seemed to correspond to the best quality that could be obtained in clinical routine.

**Experiment 1: feasibility and segmentation quality:** Sixty subjects (30 patients with AD and 30 cognitively normal (CN) subjects) were randomly selected from the ADNI database (Table 1). Thirty patients with AD were initially selected, but one reverted to CN during follow-up and was therefore excluded from our analysis. The 59 images came from 18 centres, resulting in 58 images on 1.5T scanners (GE and SIEMENS) and 1 image on a 3T scanner (SIEMENS). Images were selected at random amongst the available scanning sessions (baseline or screening) for each subject; only volumes derived from images with pre-processing and normalised by TIV were used.

**Experiment 2: effect of pre-processing, group age and normalisation by TIV:** AD and CN subjects (124 patients with AD and 139 cognitively normal (CN) subjects) with and without the pre-processing steps available at the time of the study were selected from the ADNI database (Table 2). The 263 images were chosen at random from all the available scanning sessions (baseline or screening) for each subject. They came from 41 centres, (262 images on 1.5T scanners (GE and SIEMENS) and 1 image on a 3T scanner (SIEMENS)).

**Experiment 3: segmentation of the full database with pre-processing:** We selected all the subjects for whom pre-processed images were available at the time of the study. As a result, 605 subjects (145 patients with AD, 166 CN subjects, and 294 patients with MCI) were selected (Table 3). For each subject, we used the MRI scan from the baseline visit when available and from the screening visit otherwise. We only used images acquired at 1.5T. The 605 images came from 41 centres. Amongst the 210 patients with MCI for whom 18-months follow up was available, 76 converted to AD before 18 months.

We also compared classification results with hippocampal volumes given by our method and those available in ADNI. Semi-automated hippocampal volumetry was carried out using a commercially available high dimensional brain mapping tool (Medtronic Surgical Navigation Technologies, Louisville, CO), that has previously been validated and compared to manual tracing (Hsu et al., 2002). SNT hippocampal volume is measured first by placing manually global landmarks and 22 local landmarks per hippocampus on each MRI scan.



Second, fluid image transformation is used to match each brain to a template brain. Note that the segmentation was also manually edited if the result was not satisfactory.

### 3.2.3. Results

**Experiment 1:** For the 29 patients with AD, the segmentation proved correct ( $\geq 3$ ) for 19 patients (66%), acceptable ( $\geq 2$ ) for 7 patients (24%) and unsatisfactory ( $< 2$ ) for 3 patients (10%). For the 30 elderly controls, the segmentation proved correct for 24 controls (80%), acceptable for 5 controls (17%) and not satisfactory for 1 control (3%). The volumes obtained with the automatic segmentation of the hippocampus (left + right) are displayed in Figure 3. Note that the segmentations which were considered as unsatisfactory still give volumes which are coherent with the classification, and the patients with AD who are likely to be misclassified in fact correspond to reliable segmentations.

The results of group analysis and individual classification using all the segmented volumes are presented in Table 4 for *Hc*. We also found a significant group difference for *Am* between AD and controls (0.95 vs 1.11, 14% atrophy,  $p < 0.05$ ), but using *Am* volume with *Hc* volume in a linear SVM analysis did not improve classification results.

**Experiment 2:** For the second experiment, the goal was to compare the classification performances between several conditions: with and without TIV normalisation, with and without pre-processing and in a reduced age range (between 70 and 80 year old, with 99 CN and 60 AD subjects). We chose not to keep subjects under 70 year old, because the populations were highly unbalanced (more AD than CN subjects), and above 80 year old, because very elderly CN subjects are highly heterogeneous.

Some dependence with age can be observed in all three conditions. Group analyses indicate significant differences in all three conditions, as shown in Table 5, and within the 70–80 year age-range. Classification results are better with pre-processing; they are equivalent with and without TIV normalisation. Restricting the classification problem on a 70–80 year age group increases the classification rate to 82%.

**Experiment 3:** Among the patients with AD, the segmentation proved correct ( $\geq 3$ ) for 69 (48%), acceptable ( $\geq 2$ ) for 57 (39%) and unsatisfactory ( $< 2$ ) for 19 (13%) patients. Among the MCI patients, the segmentation proved correct for 185 (63%), acceptable for 92 (31%) and unsatisfactory for 17 (6%) patients. Among the CN, the segmentation proved correct for 127 (77%), acceptable for 37 (22%) and unsatisfactory for 2 (1%) subjects. Volumes are shown in Figure 4, as a function of age, for the pairs of groups for which classification is considered.

Group analyses for the whole cohort are displayed in the first rows of Table 6. Quality control results show that hippocampal segmentation seems to perform better for CN than for AD; on the other hand, segmentation quality is more difficult to assess for highly atrophic structures. Hippocampal volume significantly differs between AD, MCI or MCI converters and CN, and, more importantly, hippocampal volume significantly differs between MCI converters and non converters, with a 14% atrophy between the groups. Note that MMS difference is very small between the two MCI groups whereas hippocampal volume difference is large and highly significant. Classification results are coherent with those of experiment 2 for AD vs CN. Note that the classification results of MCI converters vs CN are only slightly lower than for AD vs CN, and coherent with the volume difference.

As in experiment 2, classification was also studied for a smaller group of subjects between 70 and 80 year old. This resulted in 67 AD, 143 MCI and 123 CN, and in 69 AD, 42 MCI converters, 65 MCI non converters and 119 CN with 18 months follow up. Group analyses

are displayed in the first four rows of Table 7 and show the same patterns as on the whole cohort. Segmentation quality differences were reduced, but average volume reductions were preserved. Note that the populations are not matched for age, sex and scanner. Classification results all appear better than on the complete cohort; accuracy was 80% for AD vs CN, 74% for MCI converters vs CN and 67% for MCI converters vs MCI non converters.

Amongst the subjects we used, SNT volumes were available for 122 AD and 128 CN, and 186 MCI with 18 months follow-up (65 converters and 121 non converters). Classification results on this population for volumes derived from our method and SNT volumes are given in Table 8. Group analysis is similar for AD vs CN, whereas our volumes tend to show a larger difference between converter and non-converter MCI. Regarding classification, results are similar for converter vs non-converter MCI, whereas, for AD vs CN, the classification is less good for our volumes (76% compared to 80%).

## 4 Discussion

We have demonstrated in this paper that the fully automatic hippocampus segmentation method presented here is accurate for data coming from patients and normal subjects acquired on a variety of MRI platforms, with a systematic qualitative evaluation process (the segmentation proved correct in 63%, acceptable in 31% and not satisfactory in 6% of the cases). It has also proven its usefulness in discriminating between cognitively normal subjects, patients with MCI and patients with AD in a setting which corresponds better to clinical routine. The present study confirms the results that were shown in Chupin et al (2008), while being applied to more realistic datasets. Furthermore, the segmentation process is fast (15 minutes, including 10 for the registration and 5 for bilateral segmentation) and is implemented as the SACHA module in a user-friendly environment (<http://brainvisa.info>).

Most importantly, no parameter tuning or atlas modification was necessary, compared to Chupin et al (2008). The hybrid anatomical and probabilistic priors make the segmentation more robust to pathology and acquisition parameters than the semi-automatic method (Chupin et al, 2007). Furthermore, the partial integration of probabilistic maps as a constraint in the deformation process makes it more robust to pathology than methods that rely more strongly on a single atlas. In fact, it was previously demonstrated that segmentation based on the registration of a single subject atlas does not perform satisfactorily when the atlas does not belong to the same disease category as the subject (Carmichael et al, 2005).

Validation studies on the segmentation of the hippocampus in patients with AD are limited and difficult to compare because of different patient samples and evaluation strategies (Hsu et al, 2002; Crum et al, 2001). Recently, a method based on the registration and segmentation module of SPM5 (Firbank et al, 2008) was evaluated on 9 elderly controls with an RV of 5% and a DO of 74%; and 9 patients with AD, with an RV of 15% and a DO of 67%. Another method, based on finding the best match amongst a library of templates (Barnes et al, 2008), with a refinement step based on intensity, was evaluated on 19 elderly controls, with a DO of 82%, and 36 patients with AD, with a DO of 84%. Finally, a method based on statistically learned image features was evaluated on 21 subjects (7 controls, 7 patients with MCI and 7 patients with AD) from the ADNI database (Morra et al, 2008), and a DO value of 83% were reported.

Using fully automatic volumetry of the hippocampus, we were able to discriminate patients with AD from controls with 76 to 80% accuracy, in the present study. This remains in line with previous results based on manual segmentation which report accuracy between 82%

and 90% for AD, e.g. Frisoni et al (1999), Xu et al (2000). As for automatic methods, very few studies investigated the classification of individual patients. Fischl et al. (2002) detected significant group differences in hippocampal volume but did not investigate classification of individual participants. Using both volume and shape features, Csernansky et al. (2000) reported a sensitivity of 83% and a specificity of 78%. The accuracy that we report for MCI (61 to 63% for the whole group and 71 to 74% for the patients converting to AD before 18 months) is also comparable to that obtained using manual segmentation (between 60%–74%, e.g. Xu et al (2000) and Pennanen et al (2004)). Compared to our results reported in Chupin et al (2008) and Colliot et al (2008) (87% for AD vs controls, 74% for MCI vs controls), the classification accuracies obtained here on the ADNI database are slightly lower. This can be explained by several factors. First, ADNI is a multi-centre database (41 centres, different voxel sizes and acquisition parameters) whereas the data in our previous study came from a single scanner. Moreover, the population includes a large number of subjects with vascular lesions, thus being closer to real life datasets. The systematic quality control procedure allowed establishing that the cases which were not consistent for the classification did not always correspond to cases which were not satisfactory for the segmentation. Classification results without unsatisfactory segmentations did not prove any better, which is likely to be due to the intrinsic variability of the hippocampal volume amongst the study population.

We compared the classification accuracy derived from our method and derived from SNT volumes. Accuracy was similar for converter vs non-converter MCI, while SNT volumes were slightly more discriminative for AD vs CN (80% to 76%). Note that our approach is fully automatic and fast, while the SNT approach requires the placement of more than 22 landmarks per hippocampus, and the unsatisfactory segmentations were manually edited.

In the second experiment, we have also shown that the pre-processing steps that we kept from those available in ADNI have an effect on the segmentation and/or the classification results. These correction steps appear useful in the present study. Furthermore, we have shown that the normalisation by total intracranial volume does not improve classification results; this may be due to errors in the TIV values (due to CSF segmentation), or to the absence of linear relationship between the volume of the hippocampus and TIV.

Groups are not matched for age and gender, and the database includes more controls than patients older than 80 year old; we have shown that age impacts on the classification results. Furthermore, controls over 80 will correspond to a far more variable population than younger controls, as most of them will have cerebral atrophy and ventricular enlargement, and are likely to have incipient dementias. Age groups should be taken into account when devising a diagnostic tool, and careful considerations should be given to the age range.

Finally, results when comparing MCI converters and non converters show that the hippocampus conveys useful information for designing prognostic tools. Nevertheless, hippocampal volume is not yet sufficient for a complete discrimination of the two populations. Shape analysis and/or classification methods using both local and global information may give complementary information and improve classification reliability.

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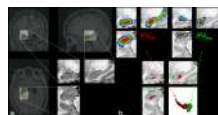


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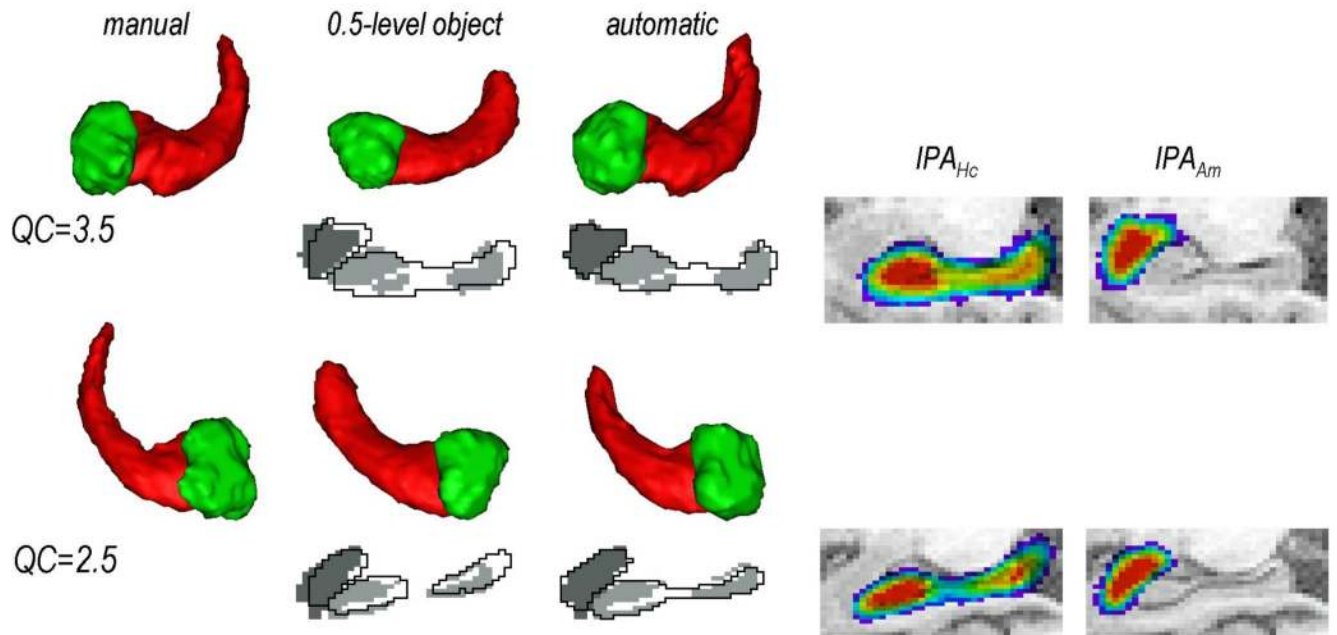
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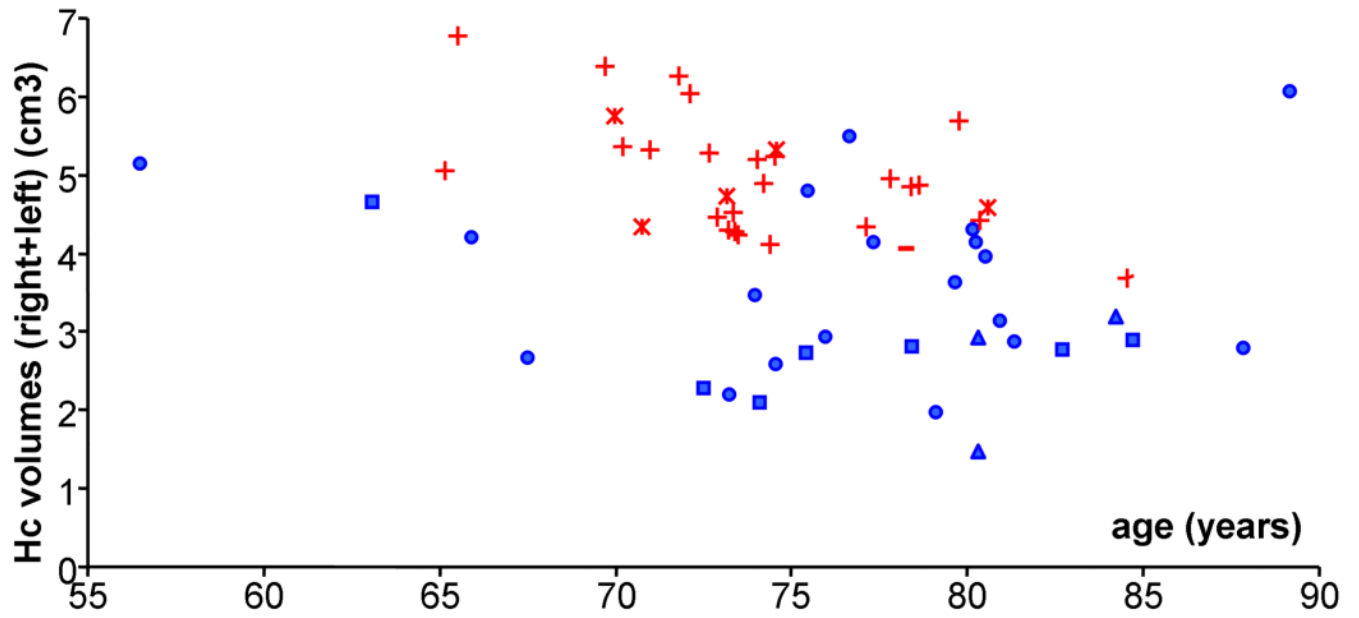
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**Figure 1.** Initialisation: a. extraction of the bounding boxes from the probabilistic atlases, b. extraction of the initial objects from each probabilistic atlas through conditional pruning.

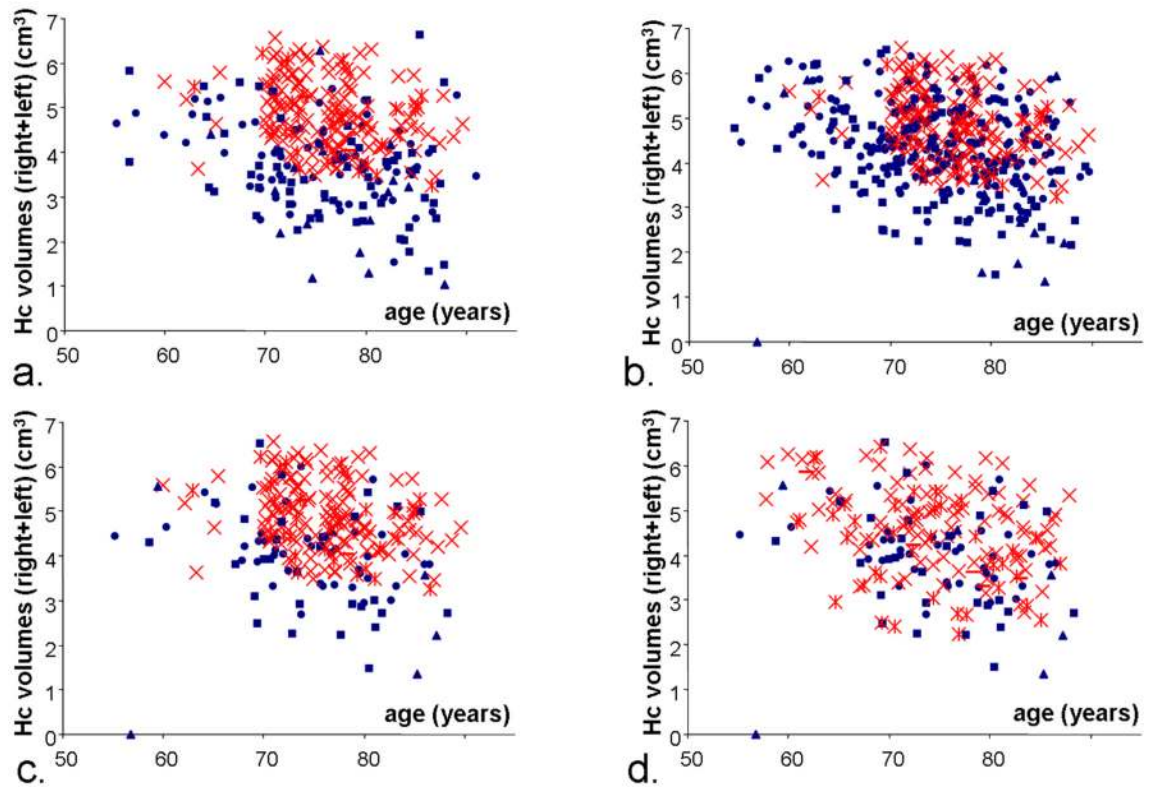


**Figure 2.** 3D-renderings of manual, atlas-derived and automatic segmentations, overlap between segmentations (manual segmentations in shades of grey) and probabilistic atlases, for the best and worst results amongst 8 patients with AD.



**Figure 3.** Experiment 1: Automatically computed (left+right) volumes for the CN (red + for correct segmentations, \* for acceptable segmentations and - for the unsatisfactory segmentation) and AD (blue circles for correct segmentations, squares for acceptable segmentations and triangles for unsatisfactory segmentations) as a function of age.





**Figure 4.**

Experiment 3: Automatically computed volumes corresponding to the classification experiments: a. CN (red crosses) and AD, b. CN (red crosses) and MCI, c. CN at 18 months (red crosses) and MCI converting at 18 months, d. MCI not converting (red crosses) and MCI converting. {x, disc} for correct segmentations, {\*, square} for acceptable segmentations and {-, triangle} for unsatisfactory segmentations

**Table 1**

Experiment 1: study population

Subjects	Number	age	MMS	Centres
CN	30	74 ± 4(65 – 85)	29 ± 1(26 – 30)	13
AD	29	77 ± 7(56 – 89)	23 ± 2(20 – 26)	15

(CN = Cognitively Normal subjects; AD = patients with AD. Values: average+/-standard-deviation (range), MMS = mini-mental state)

**Table 2**

Experiment 2: study population

Subjects	Number	Age	MMS	Centres
CN	139	76 ± 5(60 – 90)	29 ± 1(26 – 30)	37
AD	124	76 ± 7(55 – 91)	23 ± 2(18 – 27)	39

(CN = Cognitively Normal subjects; AD = patients with AD. Values: average +/- standard-deviation (range), MMS = mini-mental state)

**Table 3**

Experiment 3: study population

Subjects	Number	Number with 18 months follow up	Age	MMS	Centres
CN	166	162	76 ± 5 (60 – 90)	29 ± 1 (25 – 30)	40
AD	145	137	76 ± 8 (55 – 91)	23 ± 2 (18 – 27)	39
MCI	294	210	75 ± 7 (55 – 90)	27 ± 2 (23 – 30)	40
MCI <sub>nc</sub>		134	74 ± 7 (58 – 88)	27 ± 2 (24 – 30)	35
MCI <sub>c</sub>		76	75 ± 7 (55 – 88)	26 ± 2 (23 – 30)	28

(CN = Cognitively Normal subjects; AD = patients with AD; MCI = patients with Mild Cognitive Impairment, nc= non converter at 18 months, c=converter at 18 months, MMS = mini-mental state).

**Table 4**

Experiment 1: Two left columns: group comparisons of Hc volumes. Two right columns: classification rate, sensitivity and specificity for classification between AD and CN.

<i>Hc</i> volume (cm <sup>3</sup> )	1.69 vs 2.49	Class. Rate	82%
Mean Vol. reduction	-32%	Sensitivity	75%
Statistical significance	p<0.001	Specificity	89%



**Table 5**

Experiment 2: Top 2 rows: group comparisons of Hc volumes

	no prepro – noTIV	prepro – noTIV	prepro – TIV	prepro, noTIV 70–80
<i>Hc</i> volume (cm <sup>3</sup> )	1.84 vs 2.45	1.77 vs 2.43	1.76 vs 2.49	1.81 vs 2.47
Mean Vol. reduction	–25% ***	–27% ***	–29% ***	–27% ***
Class. Rate	75%	78%	78%	82%
Sensitivity	73%	76%	77%	81%
Specificity	76%	80%	78%	84%

(\*\*\*) p&lt;0.001).

Bottom 3 rows: classification rate, sensitivity and specificity for classification between AD and CN (see text for details).

**Table 6**

Experiment 3: Top 4 rows: group comparisons

	AD vs CN	MCI vs CN	MCIc vs CN	MCIc vs MCInc
MMS	-20% ***	-8% ***	-9% ***	-3% **
Segmentation QC	2.7 vs 3.1 ***	2.9 vs 3.1 ***	2.7 vs 3.1 ***	2.7 vs 2.9
Hc volume (cm <sup>3</sup> )	1.83 vs 2.43	2.14 vs 2.43	1.95 vs 2.43	1.95 vs 2.28
Mean Vol. reduction	-25% ***	-12% ***	-20% ***	-14% ***
Class. Rate	76%	61%	71%	64%
Sensitivity	75%	61%	67%	60%
Specificity	77%	61%	72%	65%
Threshold (cm <sup>3</sup> )	2.13	2.29	2.19	2.11

(\*\*\*) p&lt;0.001,

(\*\* p&lt;0.01).

Bottom 4 rows: classification rate, sensitivity, specificity and threshold for classification (see text for details).

**Table 7**

Experiment 3: Top 4 rows: group comparisons

	AD vs CN	MCI vs CN	MCIc vs CN	MCIc vs MCInc
MMS	-20% ***	-7% ***	-10% ***	-4% **
Segmentation QC	2.7 vs 3.1 ***	2.9 vs 3.1	2.9 vs 3.1 ***	2.9 vs 3.0
Hc volume (cm <sup>3</sup> )	1.80 vs 2.46	2.16 vs 2.46	1.95 vs 2.47	1.95 vs 2.28
Mean Vol. reduction	-27% ***	-12% ***	-21% ***	-14% **
Class. Rate	80%	63%	74%	67%
Sensitivity	80%	63%	75%	65%
Specificity	79%	63%	74%	68%
Threshold (cm <sup>3</sup> )	2.13	2.31	2.22	2.12

(\*\*\*) p&lt;0.001,

(\*\* p&lt;0.01).

Bottom 4 rows: classification rate, sensitivity, specificity and threshold for classification, for restricted age range (70–80) (see text for details).

**Table 8**

Experiment 3: Top 4 rows: group comparisons

	SACHA volumes		SNT volumes	
	AD vs CN	MCIc vs MCIc	AD vs CN	MCIc vs MCIc
<i>Hc</i> volume (cm <sup>3</sup> )	1.85 vs 2.43	1.91 vs 2.28	1.59 vs 2.12	1.69 vs 1.88
Mean Vol. reduction	-24% ***	-16% ***	-25% ***	-10% ***
Class. Rate	76%	65%	80%	65%
Sensitivity	74%	63%	79%	67%
Specificity	78%	67%	81%	64%
Threshold (cm <sup>3</sup> )	2.14	2.10	1.85	1.80

(\*\*\*) p&lt;0.001,

(\*\* p&lt;0.01).

Bottom 4 rows: classification rate, sensitivity, specificity and threshold for classification) for our volumes (SACHA) and the volumes given by ADNI (SNT) (see text for details).