

RESEARCH NOTE

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Radiomics combined with clinical characteristics predicted the progression-free survival time in first-line targeted therapy for advanced non-small cell lung cancer with EGFR mutation

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Abstract

Objective: This study was to explore the most appropriate radiomics modeling method to predict the progression-free survival of EGFR-TKI treatment in advanced non-small cell lung cancer with EGFR mutations. Different machine learning methods may vary considerably and the selection of a proper model is essential for accurate treatment outcome prediction. Our study were established 176 discrimination models constructed with 22 feature selection methods and 8 classifiers. The predictive performance of each model were evaluated using the AUC, ACC, sensitivity and specificity, where the optimal model was identified.

Results: There were totally 107 radiomics features and 7 clinical features obtained from each patient. After feature selection, the top-ten most relevant features were fed to train 176 models. Significant performance variations were observed in the established models, with the best performance achieved by the logistic regression model using gini-index feature selection (AUC = 0.797, ACC = 0.722, sensitivity = 0.758, specificity = 0.693). The median R-score was 0.518 (IQR, 0.023–0.987), and the patients were divided into high-risk and low-risk groups based on this cut-off value. The KM survival curves of the two groups demonstrated evident stratification results ($p = 0.000$).

Keywords: Non-small cell lung cancer, EGFR-TKI, Radiomics, Machine learning

Introduction

The EGFR-TKIs (epidermal growth factor receptor-Tyrosine kinase inhibitors) such as gefitinib and erlotinib are used as the first-line treatment for NSCLC (non-small cell lung cancer) patients with EGFR mutation. However,

acquired resistance is usually observed after 9–13 months of evident tumor response [1]. Moreover, primary resistance would tend to affect the therapeutic efficacy of TKIs by leaving with only a few months of reaction time. In this sense, exploring an effective prognostic marker to predict the development of TKIs resistance of EGFR positive patients will be clinically meaningful to allow physicians to timely adjust the treatment strategies.

Radiomics is able to extract quantitative imaging biomarker regarding the biological, prognostic and predictive hidden information from medical images. Successful application of CT-based (computed tomography) radiomics has witnessed in NSCLC prediction and prognosis

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[2], in particular for prediction of EGFR mutations [3, 4], and EGFR-TKI prognosis [5, 6]. These studies empirically adopted different ML (machine learning) methods to build the predictive model, e.g., RF (random forest) [3, 4] or LASSO regression [5–7], it is still unclear how to choose an appropriate ML algorithm for modeling and which model is more superior over the other.

The goal of current study is to explore the most appropriate radiomics modeling method to predict the progression-free survival of EGFR-TKI treatment in advanced non-small cell lung cancer with EGFR mutations. In order to screen patients suitable for EGFR-TKI therapy.

Main text

Patients

A total of 100 patients with stage IIIB-IV EGFR positive NSCLC patients treated with EGFR-TKIs in the Affiliated Cancer Hospital of Guangzhou Medical University between January 2016 and December 2019 met the inclusion criteria and were finally recruited. The inclusion criteria were as follows: (1) stage IIIB-IV lung adenocarcinoma confirmed by histopathology; (2) patients of EGFR mutations with confirmed 19del or 21L858R; (3) no treatments received prior to EGFR TKIs therapy; (4) the EGFR-TKIs therapy was used as the first-line treatment; (5) with complete CT images within 2 weeks before EGFR-TKIs treatment. The exclusion criteria included: (1) age less than 18 years old; (2) underwent any other antitumor therapies; and (3) with incomplete clinical records or CT images.

Patients with 19del or 21L858R mutations have received gefitinib, erlotinib, or other EGFR-TKIs as first-line treatment. Drugs were orally administrated daily until disease progressed. Treatment efficacy evaluations included routine laboratory tests and chest CT scans at least every 4–12 weeks. PFS was estimated from the beginning time of EGFR-TKIs therapy to the date of disease progression or death. The outcome is assessed within 3 months of the targeted therapy via the RECIST1.1 criterion. Patients' clinical characteristics including sex, age, stage, smoking status, mutations, TKIs and outcome are summarized in Additional file 1: Table S1.

Methods

Image acquisition and feature extraction

Pretreatment CT scans were acquired after intravenous injection of 100 ml ioversol (Heng Rui Pharmaceuticals, Jiangsu China), with scanning parameters of 120 kV, 160 mAs, 0.6 s rotation time, and image matrix size of 512×512 . All patient images were stored in DICOM format. The VOI (volume of interest) on CT images was delineated independently by two radiologists using

3D-slicer software (slicer4.10.2, <https://www.slicer.org>). The VOI delineation was performed slice-by-slice on the CT images with standard mediastinal (window width, 400 HU; window level, 40 HU) and lung (window width, 1500 HU; window level, -700 HU) window settings. The conformity of delineated VOIs were measured by the Dice similarity coefficient. The two delineated VOIs with Dice index greater than 0.9 were averaged to yield the final VOI. Discrepancies on the lesion boundary (Dice < 0.9) were resolved by further discussions until mutual consensus were reached.

Radiomics features extraction were conducted within the VOIs utilized an open-source python package Pyradiomics [8]. Extracted features ($n=107$, Additional file 1: Table S2) included: (1) first order features ($n=18$); (2) shape features ($n=14$); (3) GLCM (gray level co-occurrence matrix) features ($n=24$); (4) GLSZM (gray level size zone matrix) features ($n=16$); (5) GLRLM (gray level run length matrix) features ($n=16$); (6) NGTDM (neighboring gray tone difference matrix) features ($n=5$); (7) GLDM (gray level dependence matrix) features ($n=14$).

Prediction modeling

Noted that our goal was to identify the most significant variables that could discriminate patients with fast and slow progression. Thus, the dimension reduction was necessary to improve the accuracy in the later step of building the machine learning model for classification. Therefore, the feature selection was conducted before constructing the models, and the most related features to this study were selected.

Prediction modeling was performed on 107 radiomics features combined with 7 clinical features (including sex, age, stage, smoking status, mutations, TKI, and outcome). A specific model was constructed by a feature selection procedure followed by a particular classifier. In this study, 22 feature selection methods and 8 classifiers (Additional file 1: Table S3) were studied, and therefore resulting in 176 prediction models (different combinations of 'feature selection' + 'classifier') to be evaluated. In each prediction model, we empirically set the number of selected features to 10 to balance the patient sample size vs. feature numbers.

The prediction model was evaluated via a repeated (5 times) five-fold CV (cross-validation), where 80% and 20% of the dataset were respectively reserved for model training and validation. To reduce the effect of the imbalance, the SMOTE (synthetic minority oversampling) [9] technique was applied on the training set in each fold of the CV. The prediction performances were quantified by the area under the AUC (receiver operating characteristic (ROC) curve), ACC (accuracy), SEN (sensitivity), and SPE (specificity).

Statistical analysis

All statistical analyses were conducted using the SPSS (version 22.0). Comparison between groups of classified variables used chi-square test. The Kaplan–Meier algorithm was used to estimate the survival curves that were compared by the log-rank test. Normality of data distribution was assessed by the Kolmogorov–Smirnov test. The student’s t-test was used for normally distributed continuous variables and the Mann–Whitney U test was used for non-normally distributed continuous variables. A *p*-value of <0.05 was regarded as statistically significant.

Results

Patient characteristics

A median PFS (10 months) of the whole patient cohort was used to divide patients into a rapidly progressing group (*n*=49) and a slowly progressing group (*n*=51). The median age of all patients was 59 years. More patients with 19del mutation were found in the slow-progression group (19del vs 21L858R, 59.6% vs 37.5%); In contrast, more 21L858R mutation patients were found in the fast-progression group (19del vs 21L858R, 40.4% vs 62.5%). Significant difference in mutation site of the two groups was observed (*p*=0.03). In the slow progression group, 44 (63.8%) patients exhibited ‘CR (complete remission)’ or ‘PR (partial remissions)’ after EGFR-TKIs therapy, while only 5 (16.1%) patients were categorized as ‘SD (stable diseases)’ or ‘PD (progressive diseases)’ (by RECIST1.1 criteria). In contrast, in the rapid-progression group, only 25 patients (36.2%) achieved CR or PR after EGFR-TKIs therapy, and 26 patients (83.9%) were classified as SD or PD. The clinical factor of ‘CR + PR’ outcome was found to be associated with better prognosis (*p*=0.03) by the univariate analysis.

Model performance comparisons

The 107 radiomics features and 7 clinical features were obtained from each patient. In each of the 176 model, the top-ten most relevant features were selected by feature selection and fed to train a classifier in each model. The performances of the 176 models are depicted as a AUC heatmap as shown in Additional file 1: Fig. S1. The other quantitative performance metrics as such ACC, SEN, SPE of each model were detailed in Additional file 1: Fig. S2. Evident prediction performance variations were observed in the evaluated models. The average AUC of all 176 models is 0.591 with the maximum AUC of 0.797 achieved by the model built with LR (Logistic Regression) and gini-index feature selection (ACC=0.722, SEN=0.758, SPE=0.693). While the worst model (SVM (support vector machine) and JMI (joint mutual

information) feature selection) only yield AUC=0.371, ACC=0.559, SEN=0.611 and SPE=0.507. The performance of the best 10 models was listed in Table 1. The mean AUC tends to significantly (*p*=0.000) decline to 0.524 if only radiomics features were used for modeling, as compared with the AUC heatmap shown in Additional file 1: Fig. S3. Each of the 176 models were respectively trained by all the features (*n*=114, including 107 radiomics and 7 clinical features) and cross-validated by the five-fold cross-validation. The most relevant features had been selected in each model, and we can count and rank their frequencies of being selected as the top feature, as shown in Table 2. The top-ten features most selected were marked in blue in Additional file 1: Fig. S4. Among these top-ten features, four features including two texture features (glcm-difference variance: 14.59±6.63 vs. 18.16±8.71, *p*=0.024; glszm-small area emphasis: 0.68±0.04 vs. 0.70±0.03, *p*=0.003) and two clinical features (mutation, *p*=0.03; outcome, *p*=0.000) showed a statistically significant difference between the slow progression group and the fast progression group.

Prognostic performance

We stratified patients by the R-score (risk score) given by the best model, i.e., the Gini-index-LR model evaluated from the 176 models. The estimated median R-score 0.518 (IQR, 0.023–0.987) was used as the cut-off value to stratify the high-risk group from the low-risk group. The higher the R value, the higher the likelihood of rapid progression. The KM (Kaplan–meier) method and the Log-Rank test were used to evaluate and compare the survival curves of the high-risk group and the low-risk group. The ROC and KM survival curves (*p*=0.000) of Gini-index-LR method were shown in Fig. 1.

Table 1 Feature selection methods and classifiers for the top ten models

Classifier	Feature selection method	AUC	ACC	Sensitivity	Specificity
Logistic	gini-index	0.797	0.722	0.758	0.693
Logistic	II-I21	0.763	0.681	0.716	0.653
Bagging	CIFE	0.764	0.671	0.636	0.707
Logistic	relieFF	0.759	0.662	0.676	0.655
Bagging	MRMR	0.743	0.662	0.616	0.729
Bagging	MIFS	0.742	0.670	0.656	0.673
Adaboosting	f-score	0.740	0.671	0.756	0.593
SVM	MRMR	0.739	0.712	0.733	0.695
SVM	CIFE	0.734	0.692	0.713	0.676
SVM	MIFS	0.734	0.712	0.733	0.695

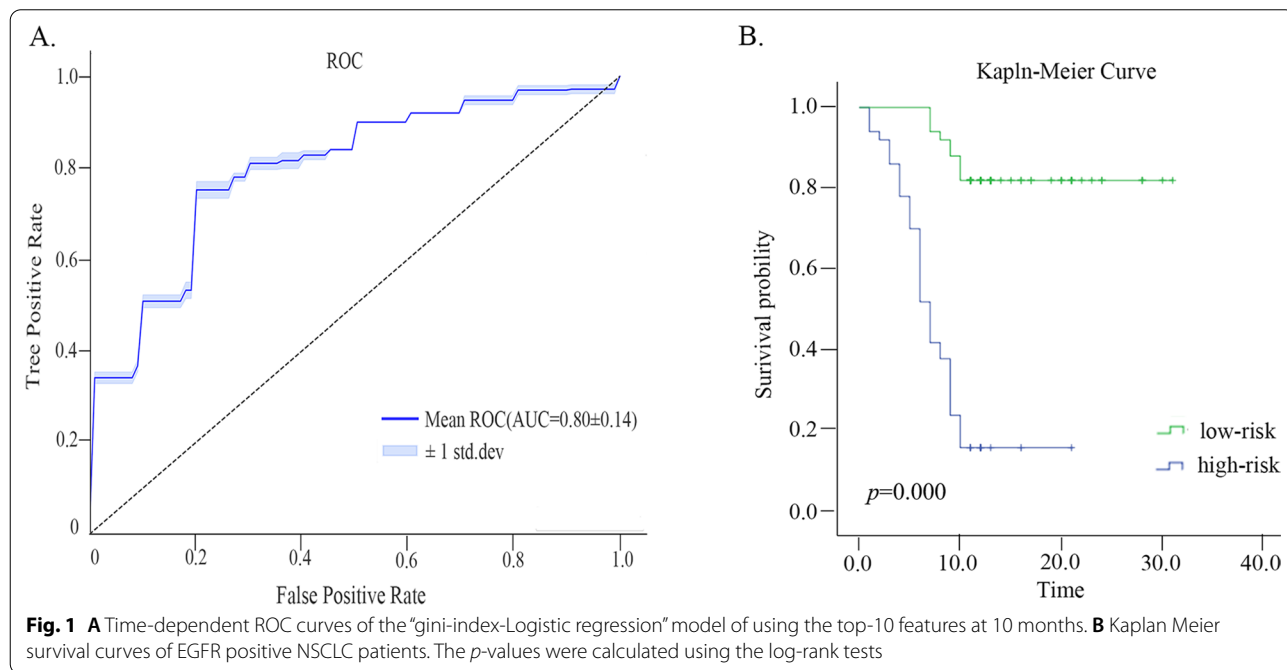
Table 2 The top ten features and the corresponding mean (\pm SD) value (or median (IQR)) and the p -value between the slow and fast progression groups

Feature category	Feature	Slow-progress	Fast-progress	p -value	
Shape-based (n=4)	Elongation	0.76 \pm 0.12	0.71 \pm 0.13	0.067 ^a	
	Least Axis Length	30.06 \pm 11.91	20.53 \pm 8.85	0.234 ^a	
	Flatness	0.59 \pm 0.14	0.55 \pm 0.13	0.229 ^a	
	Major Axis Length	52.25 (19.52,110.61)	46.56 (23.28,145.60)	0.858 ^b	
First-order based (n=1)	Inter quartile range	140 (36,560)	154 (42,385)	0.962 ^b	
Texture	GLSZM (n=1)	Small Area Emphasis	0.68 \pm 0.04	0.70 \pm 0.03	0.003 ^a
	GLCM (n=1)	Difference variance	14.59 \pm 6.63	18.16 \pm 8.71	0.024 ^a
Clinical based (n=3)	Smoke	-	-	0.238 ^c	
	Mutation	-	-	0.030 ^c	
	Outcome	-	-	0.000 ^c	

^a t-test

^b Mann-Whitney U test

^c Chi-square test



Discussion

A particular prediction model can be built with a feature selection followed by a classifier. Given a large pool of available feature selection methods and different classifier algorithm, their combinations may result in a large number of prediction models to choose from. In this study, we constructed and comprehensively evaluated 176 models using 22 feature selection methods and 8 classifiers. The best model method was gini-index-logistic (AUC=0.797). The R-score derived from the gini-index-logistic model was validated on the KM curve, and

had also achieved satisfactory stratification result. We have observed that the other models, e.g., the CIFE-Bagging (AUC = 0.764), the Il-121-LR (AUC = 0.763), and the ReliefF-LR (AUC = 0.759) also demonstrated high predictive performances. In general, the predictive models built with the LR classifier seemed to perform better than those models built with the RF classifier, which has been used in previous investigations for EGFR mutations prediction modeling [4].

In this study, we have identified two CT image textural features, i.e., the GLCM-derived feature "DV (Difference

Variance)" and the GLSZM-based feature "SAE (Small Area Emphasis)" to be significantly associated with progression ($p=0.003$ and $p=0.024$). The DV is a measure of heterogeneity that places higher weights on differing intensity level pairs that deviate more from the mean. The lesions on the fast-progression group (DV: 18.16 ± 8.71) seemed to be more heterogeneous than the slow-progression group (DV: 14.59 ± 6.63). While the SAE is a measure of the distribution of small size zones [8]. The fast-progression group had greater SAE values than the slow-progression group (0.70 ± 0.03 vs. 0.68 ± 0.04), which was indicative of more smaller size zones and more fine textures from the lesion on CT image that might be correlated with progression.

Similar to Hong et al. [10] study, we also found that the EGFR mutation type was indicative of patient prognosis. In addition, we identified complete or partial remission (CR or PR) within 3 months after EGFR treatment as a prognostic factor. This finding was consistent with clinical observations and previous studies, e.g., Mizuki et al. [7] claimed that the proportional volume change at 8 weeks was related with overall survival in EGFR-mutant advanced NSCLC patients treated with first-line EGFR-TKIs.

In summary, our study screened out an optimal model to predict progression-free survival time of NSCLC patients treated with first-line EGFR-TKI within a machine learning based framework.

Limitations

This study has several limitations need to be addressed. First, this was a single institutional study where the patient sample size was relatively small. An independent external validation cohort was lacked to confirm the generalization capability of the model and the associated findings presented here. Second, we didn't delve into the effect of the number of features on the model. Third, the number of the clinical factors studied in the model were relatively small. We have observed increased AUC values when clinical features were incorporated into the model rather than using image texture feature alone. Improved model performance might be expected if more clinical or pathological factors were embedded.

Abbreviations

EGFR-TKIs: Epidermal growth factor receptor-Tyrosine kinase inhibitors; NSCLC: Non-small cell lung cancer; PFS: Progression-free survival; CT: Computed tomography; ML: Machine learning; RF: Random forest; VOI: Volume of interest; GLCM: Gray level co-occurrence matrix; GLSZM: Gray level size zone matrix; GLRLM: Gray level run length matrix; NGTDM: Neighboring gray tone difference matrix; GLDM: Gray level dependence matrix; CV: Cross-validation; SMOTE: Synthetic minority oversampling; AUC: Receiver operating characteristic (ROC) curve; ACC: Accuracy; SEN: Sensitivity; SPE: Specificity; CR: Complete remission; PR: Partial remissions; SD: Stable diseases; PD: Progressive diseases; LR: Logistic Regression; SVM: Support vector machine; JMI: Joint mutual

information; R-score: Risk score; KM: Kaplan–Meier; DV: Difference Variance; SAE: Small Area Emphasis.

Supplementary Information

The online version contains supplementary material available at <https://doi.org/10.1186/s13104-022-06019-x>.

Additional file 1: Table S1 Demographics and characteristics of the 100 patients. **Table S2** Radiomics features. **Table S3** Feature selection methods and classifiers used for discrimination models. **Figure S1** Heatmap representing AUC of 176 models was constructed from the clinical features and radiomics features. **Figure S2** Heatmap representing the ACC(A),SEN(B) and SPE(C) of 176 models constructed from clinical features and radiomic features. **Figure S3** Heatmap representing AUC of 176 models constructed from radiomic features. **Figure S4** Histogram of the number of times that each feature is selected in the five-fold cross validation.

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Author contributions

JMZ and LS are responsible for writing the article. ZWL and XZ are responsible for the modification and quality control of the articles. LJW, TCZ and LS are responsible for the image acquisition and analysis. YWY, ZWL and JMZ are responsible for compiling the medical records. All authors read and approved the final manuscript.

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Availability of data and materials

The data that support the findings of our study are available from the Affiliated Cancer Hospital of Guangzhou Medical University but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of the Affiliated Cancer Hospital of Guangzhou Medical University.

Declarations

Ethics approval and consent to participate

This study was approved by the ethics review board of the Affiliated Cancer Hospital of Guangzhou Medical University, considered as a retrospective study and therefore waived the need for patient informed consent.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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