

HIERARCHICAL CLUSTERING TO PREDICT THE RESPONSE OF CARDIAC RESYNCHRONIZATION THERAPY IN PATIENTS WITH HEART FAILURE

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Abstract

The heterogeneous nature of today's evolving health databases requires new techniques and approaches to process these data and extract clinically useful information. This relevant information obtained can be used to improve the response rate of cardiac resynchronization therapy (CRT) in patients with heart failure. Hierarchical clustering (HC) which is an unsupervised ML technique may uncover clusters within the bulk of data of the patient population which is useful for strategies toward precision and personalized medicine. This study aims to investigate how HC can be used to automatically group a bulk of clinically acquired CRT data into clusters and subgroups that could confer clinically relevant information. About 165 patient data were used in the study and the analysis resulted in 4 different phenogroups with varying response rates. Some features were statistically significant when compared within the subgroups. Lastly, the study concludes that HC can be used to integrate and analyze different kinds of clinical data to aid in the identification of HF patient subgroups that are likely to respond to CRT.

INTRODUCTION

Personalized medicine as a clinical model separates people into different groups. This classification aids doctors and researchers to predict and tailor accurate, efficient, and highly effective treatments and prevention strategies for certain groups of patients with particular ailments. As opposed to using generalized treatments for all groups of people with certain diseases with little consideration for the differences in patients. Heart failure (HF) is a

disease known to have different signs and symptoms in a variety of patient groups with some treatments having little to no success. Cardiac resynchronization therapy (CRT) for HF patients is a therapy where individualized treatments for every unique patient could help overcome the limitations of traditional HF treatments.

Cardiac Resynchronization Therapy

Cardiac Resynchronization Therapy (CRT) is a type of medical treatment that is used for the treatment of patients suffering from various degrees of heart failure. It comprises the use of a specialized pacemaker medically referred to as a cardiac resynchronization therapy pacemaker (CRT-P) or an implantable cardioverter- (CRT-D) which is designed to improve the functionality of the heart. CRT is a standard clinical treatment for a group of end-stage HF patients where a device sends little electrical charges to both lower chambers of the heart to help them beat together in a synchronized pattern which improves the heart's ability to pump blood and oxygen to the body[1]. This device is implanted under the patient's skin in the chest region and connected to one of two leads placed inside the heart. The function of the device is to send electrical impulses to the two ventricles of the heart; the heart pumping efficiency is improved through the synchronization of the contractions made possible by this device, further helping patients with symptoms such as fatigue, shortness of breath, and swollen legs. CRT is considered for heart failure patients who have explored correcting their heart condition through medication therapies without success. While this therapy is suitable for heart failure patients who have moderate to severe

symptoms with irregular heartbeat, or reduced ejection fraction, it is not suitable for patients with diastolic heart failure, mild HF symptoms, or patients whose left and right heart chambers beat synchronously. However, it may also be recommended for heart failure patients who have QRS complex (ventricular depolarisation) on their electrocardiogram, an indication that electrical impulses in the heart are not properly synchronized or are delayed.

Cardiac Resynchronization Therapy Devices

CRT devices help the heart beat more efficiently and help to monitor HF condition so that the physician can provide the right treatment. A CRT device has two main components which are the pulse generator and the thin insulated wires called leads which deliver a small amount of electrical energy to the heart to help restore the normal timing of the heart. The two types of CRT devices are the cardiac resynchronization therapy pacemaker (CRT-P) or biventricular marker and the same device with a built-in implantable cardioverter defibrillator called cardiac resynchronization therapy defibrillator (CRT-D) [1]. The devices enhance the outcome in heart failure patients; however, there is also a significant portion of patients that does not respond to the therapy devices [2]. Several studies have shown improved CRT response prediction that includes varying criteria such as the Left Bundle Branch Block (LBBB), Left Ventricle (LV) activation time, intrinsic QRS deflection onset as well as the frequency content and area of the Q wave, R wave and S wave (QRS). QRS shows the electrical impulse as it spreads through the ventricles and indicates ventricular depolarization. Just like all medical procedures, CRT has its potential complications and risks which may include device malfunction, bleeding, and infection. These potential risks as well as the benefits should be discussed with patients in order to determine whether they find it an appropriate treatment option.

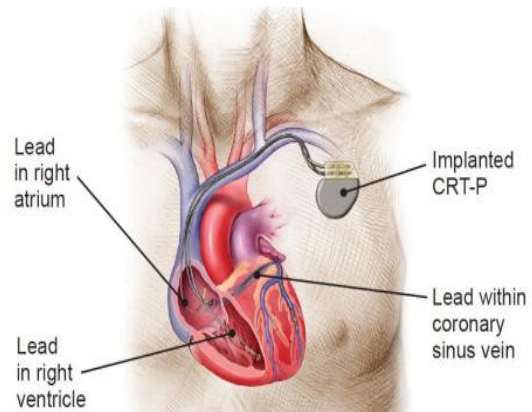


Figure 1: implanted Cardiac Resynchronization Therapy Pacemaker (Source 1)

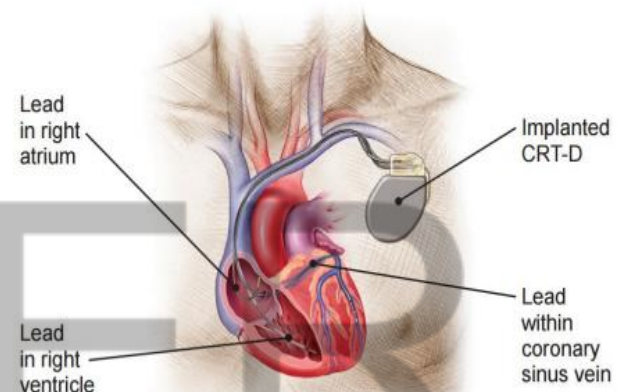


Figure 2: implanted Cardiac Resynchronization Therapy Defibrillator (Source 1)

Indications of Cardiac Resynchronization Therapy

The guidelines from the American Heart Association/American College of Cardiology Foundation (AHA/ACCF) for the management of HF which was published in 2013 were harmonized with the AHA/ACCF/Heart Rhythm Society (HRS) 2012 and referred to as the updated ACC/AHA/HRS guidelines [3]. The criteria for CRT implantation are New York Heart Association (NYHA) functional class II and III with sinus rhythm, Left ventricular Ejection Fraction (LVEF) < 35%, QRS width > 150 ms or 120 to 150 ms with Ventricular Electrical Dyssynchrony (ED) by LBBB. Although about 30% of patients do not respond to CRT due to common variables such as low LVEF, sinus rhythm, LBBB pattern, QRS duration >150ms on electrocardiogram (ECG),

and the New York Heart Association (NYHA) class II, III, and ambulatory IV symptoms. This study also includes not only the Electrical Dyssynchrony (ED) data, which would be QRS enlargement (> 150 ms) and LBBB but also the presence of Mechanical Desynchronization (MD).

Machine Learning

Machine learning is a subfield of Artificial Intelligence that comprises the development of models and algorithms to enablement of computers to make decisions and predictions based on data inputs. It is used in a wide range of applications including supervised and unsupervised learning, allowing computers to recognize and classify data based on what was learned from the training data. The current trend in data analysis is towards technical approaches such as Machine Learning (ML) and even more powerful techniques like deep learning which uses neural networks to solve complex problems. However, deep learning requires a large set of data and this volume of data is often lacking in clinical medicine to aid better clinical predictions [4]. Machine learning is a part of artificial intelligence that gives computer systems the ability to learn automatically with little to no human intervention and it adjusts its actions accordingly without being explicitly programmed. Machine learning improves the analysis of large quantities of data and is being used in a variety of applications like predictive analytics, email filtering, and computer vision. Awan et al [5] discussed the application of machine learning methods in diagnosis, classification, readmissions, and medication adherence in patients with heart failure. Also, ML techniques have been applied to identify distinct phenogroups in HF patients with preserved ejection fraction (HFpEF) as well as several diseases [6,7]. Thus, machine learning approaches may be used to improve CRT response prediction in patients with heart failure.

Supervised machine learning is a machine learning system that uses algorithms to predict output variables (future events or analysis) based on the labeled input data (training dataset). While supervised ML provides targets for any new input after sufficient training, it requires a massive dataset to train on, the interpretation of results varies, and it is susceptible to errors. On the other hand, unsupervised ML requires no training or labeling as it explores unlabelled data and can draw inferences from datasets to describe hidden structures [4]. Unsupervised ML groups or clusters patients together based on multiple characteristics in the dataset, which could be clinical, demographic, or measured. The grouping of similar patients together in varying groups or dimensions, then makes it possible to analyze the similarities in the groups of patients and relate them to clinical outcomes or therapeutic responses.

Hierarchical Clustering

Hierarchical clustering is a clustering algorithm that is used in data mining and machine learning. It involves a bottom-up approach that is initiated by considering each data point as a separate cluster and subsequently merging the closest clusters until all available data points are unified into a single cluster. The hierarchical clustering technique is a good way to reveal anatomical subgroups from clinical data as they do not need any prior information about the population of the study. Also, HC does not require conditioning of an expected number of subgroups in contrast to K-means clustering which involves specifying a required number of subgroups. Some studies have applied HC techniques to 3D patient shape data and the outcome depends hugely on the clustering distance metrics and linkage option of choice [8].

Furthermore, HC results are graphically depicted in a tree-like structural diagram called a dendrogram that shows how similar objects are grouped together, while dissimilar objects are grouped on different branches of the tree.

However, assessment of the similarity or dissimilarity and clustering results of objects is dependent on the similarity or distance metric is chosen where low inter-object distance connotes high similarity. Also, the linkage function is another huge determinant of how objects are linked together to form a subgroup. Choosing the appropriate distance or linkage combination is necessary to achieve meaningful results.

Aim And Significance of The Study

An area where clustering of patient groups could improve the selection of patients and accurately predict their clinical outcome is CRT for HF patients. This is due to the fact that despite clear criteria for which patients should undergo CRT, a significant percentage of patients do not respond to this treatment option [9]. This study hypothesized that new approaches based on unsupervised ML techniques which incorporate demographic, clinical, and Echocardiographic (ECG) and Single Photon Emission Computed Tomography Myocardial Perfusion Imaging (SPECT MPI) data including both electrical and mechanical dyssynchrony may be used to better depict how ML can be utilized to phenogroup HF patients in correlation to their characteristics and predict clinical response.

Supervised ML mainly trains a model on a labeled dataset where the input data is split into training and test datasets and the algorithm learns to predict the output from the input data. Thus, unsupervised ML is used for this study instead of supervised ML because our aim is to identify hidden patterns or underlying grouping structures in our data in order to better predict heart failure patients' subgroups that are likely to respond to CRT. We utilized data from ten centers in 8 countries with NYHA functional class II, III, and IV with sinus rhythm, LVEF < 35%, QRS width > 150 ms or 120 to 150 ms with Ventricular Electrical Dyssynchrony (ED) by Left Bundle Branch Block (LBBB) to determine if HC as an unsupervised ML technique could help discover unknown patterns in the data and to identify the

patient subgroups that are more likely to respond to CRT.

RELATED LITERATURE

Several studies have tried to find parameters or factors that could significantly improve CRT efficacy. The use of Single Photon Emission Computed Tomography (SPECT) images to assess LV's latest activation was shown in [10] to improve the rate of placing LV on target and ultimately produced a positive improvement in CRT response. Other studies have used machine learning approaches to predict mortality in patients with coronary artery disease. Cikel et al [4] researched the use of ML to accurately phenogroup selected CRT patients to determine trends that can result in improved CRT response. The study used unsupervised learning methods to help in the identification of patients likely to respond to the therapy by integrating clinical features with echocardiographic data on myocardial infarction and left ventricular volume changes that were measured over an entire cardiac cycle.

The results from the study showed that full unsupervised ML techniques can provide a clinically relevant classification of a heterogeneous group of HF patients which can aid the identification of patient subgroups most likely to respond to particular therapies. However, the paper reiterated that the feasibility of the proposed model for phenogrouping HF patients and in clinical decision-making should be assessed in a prospective controlled trial. Additionally, Matthew et al [9] also used machine learning-based unsupervised clustering analysis to identify clinically distinct phenotypic subgroups in a highly dimensional mixed-data group of individuals with heart failure with preserved ejection fraction (HFpEF). This study was able to identify phenogroups of HFpEF patients with distinct clinical characteristics and lasting outcomes.

METHODOLOGY

Study Design and Patient Population

The population used for this study has been previously used by a prospective, multicentre, non-randomized trial: 'Value of intraventricular synchronism assessment by gated-SPECT myocardial perfusion imaging in the management of heart failure patients submitted to cardiac resynchronization therapy' (IAEA VISION-CRT) [11]. In brief, the VISION-CRT trial involves subjects from ten centers in 8 countries (Brazil, Chile, Colombia, Cuba, India, Mexico, Pakistan, and Spain). The main investigators of the respective countries recorded all the clinical, CRT, and follow-up information in individual forms for each patient. The data from the Myocardial Perfusion Imaging by Gated Single Photon Emission Computed Tomography (gSPECT MPI) were recorded too. The overall data was collected by the central management center in the IAEA headquarters in Vienna. The subjects underwent a detailed clinical and gated SPECT MPI evaluation before recruitment to the study and all patients provided written informed consent. The criteria for patient inclusion were: symptomatic HF patients over 18 years old with NYHA functional class II, III or ambulatory IV with HF for at least three months before enrolment; LV ejection fraction $\leq 35\%$ from ischemic or non-ischemic causes, measured according to the usual procedure at the participating center for inclusion, although LVEFs used for analysis came from the nuclear core lab; sinus rhythm with LBBB configuration defined as a wide QRS duration ≥ 120 ms. The Exclusion criteria were: pregnancy or breast-feeding; arrhythmias that prevented the gated acquisition; right bundle branch block; a major coexisting illness affecting survival less than one year; acute coronary syndromes, coronary artery bypass grafting, or percutaneous coronary intervention in the last 3 months before enrolment and within 6 months of CRT implantation. The patients were classified as 'responders' to CRT if they had an increase of LVEF $> 5\%$ or a decrease in End Systolic Volume (ESV) $< -15\%$ as measured by gated SPECT MPI at

follow-up. Others were classified as non-responders.

SPECT MPI Evaluation

Gated SPECT scans were performed about 30 minutes after injection using 20-30mCi of ^{99m}Tc sestamibi or tetrofosmin of 740 to 1110 MBq. The images were acquired in gamma cameras using 180° orbits with a complimentary 8 or 16 frames ECG-gating. The Ordered Subset Expectation maximization (OSEM) method with three iterations and ten subsets filtered by a Butterworth filter to the power of 10 and a cut-off frequency of 0.3 cycles/mm were used to reconstruct the images and this was done by Emory Reconstruction Toolbox (ERTtoolbox; Atlanta, GA). The resulting reoriented short-axis images were sent to Emory Cardiac Toolbox (ECTb4, Atlanta, GA) for automated accessing of LV function, including LVEF, left ventricular end-systolic volume (LVESV), left ventricular end-diastolic volume (LVEDV), LV shape, including end-systolic eccentricity (ESE) and end-diastolic eccentricity (EDE), and LV mechanical dyssynchrony and includes phase standard deviation (PSD) and phase bandwidth (PBW) [11].

Baseline Attributes

The complete data of clinical assessment, baseline SPECT MPI, and clinical six-month follow-up data were obtained in only 177 patients out of the initial 199 patients that underwent CRT. About 11 patients among the 177 patients died before follow-up and 1 patient had an extremely low ESV which is an outlier caused by the low resolution of gated SPECT MPI when measuring a small heart. This study finally utilized the data from 165 patients for its analysis. The covariates consist of a range of domains including demographics, clinical variables, laboratory data, SPECT MPI measurements, and an electrocardiographic parameter. Overall, a total of 26 continuous and

categorical variables were used in the clustering analysis

Characterisation of Phenogroups

An agglomerative hierarchical clustering algorithm was used to group similar objects into clusters such that each observation starts in its own cluster and pairs of clusters are merged as one moves up the hierarchy. The hierarchical relationship between the different sets of data is shown in a tree-like diagram called a dendrogram. Furthermore, the distance between the data points on the x-axis represents the dissimilarities between the points while the height of the blocks on the y-axis represents the distance between the clusters. Of the three most common linkage methods: single, complete, and average linkage methods, the complete linkage method was used to merge the clusters in the dendrogram as it tends to find compact clusters of approximately equal diameters. The complete linkage method also avoids the disadvantage of the alternate single linkage method where clusters are forced together due to single objects being close to each other, even when many of the objects in each cluster may be largely distinct from each other. The number of clusters was chosen by drawing a horizontal line to the longest line that traverses the maximum distance

up and down without intersecting the merging points. This was done on our dendrogram at both a distance of 600 which gave 2 clusters and a distance of 400 which gave 4 clusters and the respective numbers of clusters were analyzed separately. Having done the analysis, 4 clusters were finally used for further analysis as it was more statistically significant.

After the clusters were grouped into four, the differences in demographics, clinical variables, laboratory data, SPECT MPI measurements, and echocardiographic parameters were compared between the phenogroups. Continuous variables were summarized in means and standard deviations while categorical variables were summarized in numbers and percentages. The differences between groups were tested using a one-way ANOVA for continuous variables and a Chi-squared test for categorical variables. A p-value of <0.05 was considered statistically significant. The resulting dendrogram was internally validated by shuffling the dataset and reducing the number of rows and columns to create clusters and compare their differences in terms of clinical characteristics and the response outcome. Clustering the phenogroup into 4 clusters was more statistically significant and the ML algorithm used for all the analysis in this study was done in python version 3.

```
# Calculate the distance between each sample
# Linkage method defines how the distance between clusters is measured
# In complete linkage, the distance between clusters is the distance between the furthest points of the clusters
# In single linkage, the distance between clusters is the distance between the closest points of the clusters.

# Perform the necessary imports
from scipy.cluster.hierarchy import linkage, dendrogram
import matplotlib.pyplot as plt

# Calculate the linkage: mergings
mergings = linkage(df1, method='complete')

# Plot the dendrogram, using varieties as labels
plt.figure(figsize=(35,15))
dendrogram(mergings,
           |   labels=df1.index.tolist(),
           |   leaf_rotation=90,
           |   leaf_font_size=8,color_threshold=240)
plt.show()

# Control number of clusters in the plot + add horizontal line.
plt.figure(figsize=(35,15))
dendrogram(mergings,
           |   labels=df1.index.tolist(),
           |   leaf_rotation=90,
           |   leaf_font_size=8,color_threshold=240)
plt.axhline(y=400, c='black', lw=1, linestyle='dashed')
plt.show()
```

Figure 3: Code snippets of Hierarchical clustering

Table 1: Baseline characteristics of the study patients by phenogroups

S/N	FEATURES	OVERALL AVERAGE (meanSD) (count(%)) N=165 (98R, 67NR) 59%R	PHENO-GROUP ONE n=42 (21R, 21NR) 50%R	PHENO-GROUP TWO N=81 (55r, 26NR) 68%R	PHENO-GROUP THREE N=16 (10r, 6NR) 63%R	PHENO-GROUP FOUR N=26 (12R, 14NR) 46%R	GROUP P-VALUE
1	ACEI_or_ARB	136(82%)	29(69%)	72(89%)	14(88%)	21(81%)	0.049
2	Age	60±11	61±10	61±12	58±10	58±10	0.1
3	CAD	51(31%)	16(38%)	23(28%)	2(13%)	10(38%)	0.213
4	Concordance	40(25%)	12(29%)	16(20%)	6(38%)	6(23%)	0.412
5	DM	41(25%)	8(19%)	22(27%)	6(38%)	5(19%)	0.424
6	ECG_pre_QRSd	161±25	156±23	159±24	61±28	176.6±21	0.00092
7	Gender	M=98(59%) F=67(41%)	M=31(74%) F=11(26%)	M=33(41%) F=48(59%)	M=13(81%) F=3(19%)	M=21(81%) F=5(19%)	0.0
8	HTN	97(59%)	29(69%)	40(49%)	11(69%)	17(65%)	0.116
9	LBBB	165(100%)	42(100%)	81(100%)	16(100%)	26(100%)	1.0
10	MI	35(21%)	11(26%)	12(15%)	2(13%)	10(38%)	0.047
11	NYHA	I=46(28%) III=101(61%) IV=18(11%)	I=12(29%) III=27(64%) IV=3(7%)	I=28(35%) III=47(58%) IV=6(7%)	I=3(19%) III=9(56%) IV=4(25%)	I=3(12%) III=18(69%) IV=5(19%)	0.094
12	Race I – Africa II – ASIA III – CAUCASIAN IV – HISPANIC V – INDIAN	I=17(10%) II=6(4%) III=23(14%) IV=87(53%) V=32(19%)	I=6(14%) II=1(2%) III=5(12%) IV=24(57%) V=6(14%)	I=4(5%) II=3(4%) III=14(17%) IV=37(46%) V=23(28%)	I=2(13%) II=2(13%) III=1(6%) IV=8(50%) V=3(19%)	I=5(19%) II=0(0%) III=3(12%) IV=18(69%) V=0(0%)	0.033
13	SPECT_pre_EDE	0.5±0.2	0.5±0.1	0.6±0.2	0.5±0.2	0.5±0.2	0.17
14	SPECT_pre_EDSI	0.8±0.1	0.8±0.1	0.8±0.1	0.9±0.1	0.9±0.1	0.13
15	SPECT_pre_EDV	257.6±105	277.8±38	176±44	476.3±55	347.1±30	<0.001
16	SPECT_pre_ESE	0.6±0.2	0.6±0.2	0.6±0.2	0.4±0.2	0.4±0.2	0.009
17	SPECT_pre_ESSI	0.8±0.1	0.8±0.1	0.8±0.1	0.9±0.1	0.9±0.1	0.004
18	SPECT_pre_ESV	192.7±96	209.2±28	117.4±37	396±62	275.2±27	<0.001
19	PECT_pre_LVEF	27.7±10.3	24±7.0	4.1±9.5	17.1±5.1	20.6±6.0	0.003
20	SPECT_pre_PBW	152.4±73.8	191.7±66.3	106.5±49.7	239.9±47.9	178.2±64.9	0.24
21	SPECT_pre_PSD	48.8±19.7	56.7±15.6	37.6±15.7	72.9±15.2	55.8±17	0.09
22	Smoking	27(16%)	7(17%)	15(19%)	2(13%)	3(12%)	1.0

23	SPECT_pre_50scar	25±14.4	29.2±13.6	17.8±11.5	35.1±15	31±14.3	0.827
24	LVEF	25±6.0	24.5±4.4	27.2±5.6	20.4±5.4	22±6.7	0.005
25	Echo_pre_EDV	192±36.8	193.3±17	180.7±33	195.3±10	224.4±30	0.0002
26	Echo_pre_ESV	149±37.9	155.3±21.6	132.3±30.8	157±18.3	187.7±53.5	0.00006

RESULTS

Of the 165 patient data used in this unsupervised learning study, there was a 59% response rate where 98 participants responded to CRT and 67 patients had no response. The race population was 53% Hispanic, 19% Indian 14% Caucasian, 10% African, and 4% Asian. The baseline characteristics of the study population are shown in Table 1. For all the patients, the age was 60 ± 11 years, and 98 (59.4%) patients were male. Fifty-one (30.9%) patients had a previous history of CAD while 97 (58.8%) had Hypertension (HTN). About 27(16%) are smokers while 41 (24.8%) had diabetes mellitus (DM). Although the study data have NYHA class II, III, and IV, NYHA class III was predominant in the data with a rate of 61%. Myocardial infarction was not prevalent among the participants as it was present in only about 21%.

There were no statistically significant differences in age and the NYHA class distributions across phenogroups. Participants in phenogroup 1 had the lowest mean of ECG_pre_QRSd and a high number and rate of HTN as compared with the other groups. Phenogroup 2 had the highest burden of DM and the most significant response rate in females. It is also the group with the

highest response rate and the least rate of hypertensive patients. While phenogroup 3 had the least burden of CAD and MI and the highest rate of DM. Phenogroup 4 had the least responders to CRT, the highest rate of NYHA class III patients, and the largest ECG_pre_QRSd mean as compared with the other groups. While phenogroup 1 and 4 had the same intermediate rates of both CAD at 38% and DM at 19%, phenogroup 1 and 3 had the same intermediate burden of HTN at 69%.

Among SPECT MPI parameters, phenogroup 1 participants had an intermediate high mean values for LVEF, SPECT_pre_LVEF, SPECT_pre_PSD and SPECT_pre_PBW as compared with the other phenogroups. While phenogroup 2 had the least mean values for SPECT_pre_EDV, SPECT_pre_ESV and SPECT_pre_50scar but has the highest mean and standard deviation of SPECT_pre_LVEF when compared with the other groups. Phenogroup 3 had the highest means for SPECT_pre_PBW, SPECT_pre_PSD and SPECT_pre_50scar values. The highest mean and standard deviation of SPECT_pre_ESV values are found in this group as well. Finally, the highest mean and standard deviation of Echo_pre_ESV and Echo_pre_EDV were in phenogroup 4.

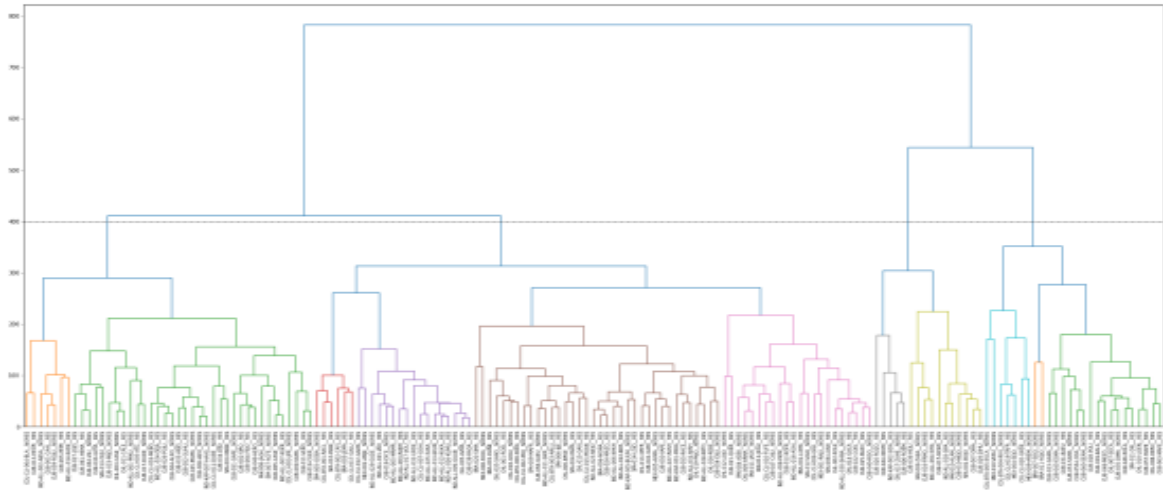


Figure 4: Hierarchical Clustering Dendrogram

Table 2: Dissimilarity between phenogroups

S/N	Phenogroup 1	Phenogroup 2	Phenogroup 3	Phenogroup 4
	<ul style="list-style-type: none"> - Least mean of ECG_pre_QRSd - Intermediate high values for LVEF, SPECT_pre_LVE F, SPECT_pre_PSD, SPECT_pre_PBW 	<ul style="list-style-type: none"> - Highest responder group - High proportion of patients with Diabetes Mellitus - Most significant response rate from females - Least rate of hypertensive patients - Has the highest mean and a wider range of SPECT_pre_LVEF - Least mean of SPECT_pre_EDV and SPECT_pre_ESV values - Least mean and standard deviation of SPECT_pre_50scar values 	<ul style="list-style-type: none"> - Has the highest mean and a wider range of SPECT_pre_EDV values - Has lowest rate of NYHA class III patients - Has the highest mean and a wider range of SPECT_pre_ESV values - Has the highest mean of SPECT_pre_PSD and SPECT_pre_50scar values 	<ul style="list-style-type: none"> -Has least responders to CRT - Has longest QRS duration - Has highest rate of NYHA class III patients - Has a high SPECT_pre_50scar mean and the highest standard deviation - Has the highest mean of Echo_pre_EDV values - Has the highest mean and standard deviation of Echo_pre_ESV values

DISCUSSION

Heart failure is a disease characterized by multiple syndromes and its response to therapies is based on a couple of factors such as biomarkers, clinical data as well as imaging parameters. Conventional techniques to predict outcomes within HF subgroups rely on isolated parameters such as QRS morphology, presence or absence of specific comorbidities, HF cause, cardiac structure, and function amongst others. Thus, while the use of echocardiographic analysis tools to assess cardiac structure and function can establish subgroups of HF patients at higher risk for negative outcomes [12], echocardiographic data contains a lot of information representing several time points in a cardiac cycle this is replaced by single measurements in standard quantitative data analysis which does not take into account the complex events of the entire cardiac cycle.

In this study, hierarchical clustering as a form of unsupervised ML has been shown to aid the integration of demographic data, clinical data, laboratory data, and SPECT MPI parameters to group patients with certain diseases such as HF. The research demonstrates the value of combining different sets of descriptors to find patients that are more likely to respond to CRT as compared to the results gotten from independent analysis of clinical parameters only. The results from the study prove that unsupervised ML approaches can be used to combine standard clinical parameters, ECG data, and imaging parameters to provide a clinically interpretable and meaningful classification of the heterogeneous phenotypes of HF patients and the likelihood of patients in certain subgroups to respond to specific treatment therapies.

While studies such as Chung et al [13] tried to find a single echocardiographic measure of dyssynchrony to improve the selection of HF patients for CRT beyond the current guidelines without success. This study combines heterogeneous data in an unsupervised manner to ultimately find groups of patients with similar characteristics toward CRT response. The unsupervised ML method used allows the natural clustering of patients and results in the

identification of patient subgroups in relation to their CRT response. Specifically, Phenogroups 2 and 3 had a higher rate of response at 68% and 63% respectively over the overall rate at 59%. Phenogroups 1 and 4 had the least response rate at 50% and 46% respectively. About 14 parameters were statistically significant when compared within the 4 phenogroups. SPECT_pre_PSD, Echo_pre_ESV, Echo_pre_EDV, LVEF, SPECT_pre_PBW, MI, SPECT_pre_LVEF, SPECT_pre_ESV, SPECT_pre_ESSI, SPECT_pre_ESE, SPECT_pre_EDV, ECG_pre_QRSd, gender and ACEI_or_ARB.

Some limitation of this study includes the small size used as well as the fact that HC does not work well with missing data. Though, the race parameter was significant in this study, this cannot be ascertained as the data was majorly from North America, South America and Asia. This means the data may be skewed towards a certain race over others and this is another limitation of this study. Furthermore, the results gotten from this study need to be externally validated. For future directions, further analysis using other unsupervised techniques such as principal component analysis may be able to ascertain the result or to help uncover other relevant clinical information. Another future work is the use of supervised classification to validate the result gotten in this study.

CONCLUSION

This study concludes that unsupervised ML approaches such as HC can be used to integrate and analyze ECG data, imaging parameters, and clinical data to aid in the identification of HF patients' subgroups that are likely to respond to CRT. The results show that HC can provide a clinically relevant classification of a heterogeneous cohort of HF patients which can serve as a data-driven basis to identify patient phenogroups likely to respond to specific therapies. However, the feasibility of this HC approach for patient phenogrouping in HF and its contribution to the clinical decision-making needs to be evaluated with a large dataset,

externally validated, and used in a prospective controlled trial.

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