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(54) Title: GENERATION OF ACCURATE HYBRID DATASETS FOR QUANTITATIVE MOLECULAR IMAGING

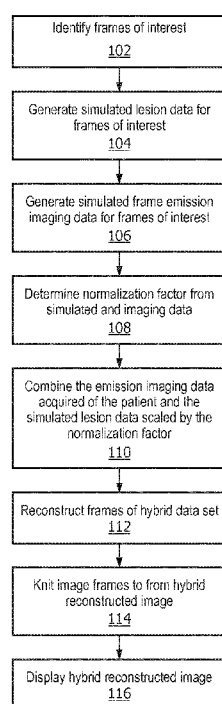


FIG. 2

(57) Abstract: A non-transitory computer readable medium storing instructions readable and executable by an imaging workstation (14) including at least one electronic processor (16) to perform a dataset generation method (100) operating on emission imaging data acquired of a patient for one or more axial frames at a corresponding one or more bed positions, the method comprising: (a) identifying a frame of interest from the one or more axial frames; (b) generating simulated lesion data by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest; (c) generating simulated frame emission imaging data by simulating emission imaging data for the frame of interest of the patient; (d) determining a normalization factor comprising a ratio of the value of a quantitative metric for the simulated patient data and the value of the quantitative metric for the emission imaging data acquired of the same patient for the frame of interest; and (e) generating a hybrid data set comprising the emission imaging data acquired of the patient for the one or more axial frames at the corresponding one or more bed positions with the frame of interest replaced by a combination of the simulated lesion data scaled by the normalization factor and the emission imaging data acquired of the patient for the frame of interest.

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GENERATION OF ACCURATE HYBRID DATASETS FOR QUANTITATIVE MOLECULAR IMAGING

FIELD

The following relates generally to the medical imaging arts, medical image interpretation arts, medical imaging device performance evaluation and optimization arts, image simulation arts, and related arts.

BACKGROUND

A medical imaging device is a medical instrument with diverse applications. In quantitative molecular imaging, the imaging device is used to generate quantitative information about a tumor or other anatomical feature. For such tasks, the imaging data generated by the medical imaging device is reconstructed using an image reconstruction process and the resulting reconstructed image is further processed to generate the quantitative information. Quantitative molecular imaging is impacted by numerous parameters, e.g. spatial resolution of the imaging device, the type and dosage of radiopharmaceutical administered to the patient, the size, weight, and other characteristics of the patient, the type and location of the tumor or other anatomical feature under analysis, and so forth. Evaluation and optimization of a medical imaging device for performing quantitative molecular imaging is challenging due to the large number of such parameters and their varied and often intertwined impact on the imaging results. Evaluation of advanced data processing used in quantitative molecular imaging requires the knowledge of the ground truth for the evaluation. Such evaluation include how time-of-flight, resolution recovery, regularized reconstruction, etc. affect the SUV (standardized uptake value) or other quantitative activity metric of tumors in patient studies.

Due to the complexity of the medical imaging process, it is in principle preferable to use real patient data, that is, medical imaging data actually acquired of a human subject having a tumor or other anatomical feature of the type of interest. However, in real patient data, the absolute quantitation of the tumor/organ uptake is unknown, thus the evaluation does not really have a ground truth to use.

As a workaround approach, a phantom may be imaged. The phantom is designed to mimic specific regions and organs of typical patients, and may include fillable structures to mimic organs/objects of interests, such as refillable spheres to mimic lesions with different size and uptake. A phantom provides an imaging subject for which the ground truth may be known (e.g., the fillable sphere representing a tumor may include a quantity of radioactive material

designed to output the intended radioactivity). However, the phantom does not precisely mimic the complexity of the human anatomy, and this introduces its own uncertainty as to whether imperfections of the phantom (as compared with real human anatomy) have meaningful impact on the simulation results.

Another approach is to generate a hybrid imaging data set which combines simulated tumor data with actually acquired patient imaging data (e.g. from a healthy human subject). The tumor data simulation is performed for the target design-basis activity level (e.g. SUV value). The resulting hybrid dataset is expected to have known quantitation of the tumors/lesions in the clinically relevant background of the actually acquired patient data.

In one approach for generating hybrid imaging data, artificial lesions with known quantitation are added to the reconstructed volume image of the patient, the lesions are re-projected to generate the projection data of the artificial lesions, and this lesion projection data is then added to the projection data of the patient data to obtain the hybrid dataset. *See* Asma E, et al, "Accurate and consistent lesion quantitation with clinically acceptable penalized likelihood images," IEEE NSS/MIC conference record, M23-7, pp. 4062-4066, 2012. Another known approach is to fill spheres of certain sizes and acquire data of such spheres suspended in air in the system that is used for patient studies. The acquired data of the spheres are then added to patient data, scaled for acquisition time, patient attenuation, and so forth. *See* Daube-Witherspoon, et al, "Determination of accuracy and precision of lesion uptake measurement in human subject with time-of-flight PET," J Nucl Med 2014; 55:1-6. Another approach for generating hybrid data for PET data processing evaluations uses Monte Carlo simulation to create inserted lesions. *See* Stute S et al, LuCaS: Efficient Monte Carlo simulations of highly realistic PET tumor images," IEEE NSS Conference proceedings, M06-241, 2008.

The following discloses new and improved systems and methods.

SUMMARY

In one disclosed aspect, a non-transitory computer readable medium stores instructions readable and executable by an imaging workstation including at least one electronic processor to perform a dataset generation method operating on emission imaging data acquired of a patient for one or more axial frames at a corresponding one or more bed positions, the method comprising: (a) identifying a frame of interest from the one or more axial frames; (b) generating simulated lesion data by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest; (c) generating simulated frame emission imaging data by simulating emission imaging data for the frame of

interest of the patient; (d) determining a normalization factor comprising a ratio of the value of a quantitative metric for the simulated data and the value of the quantitative metric for the emission imaging data acquired of the patient for the frame of interest; and (e) generating a hybrid data set comprising the emission imaging data acquired of the patient for the one or more axial frames at the corresponding one or more bed positions with the frame of interest replaced by a combination of the simulated lesion data scaled (in some examples, time-scaled) by the normalization factor and the emission imaging data acquired of the patient for the frame of interest.

In another disclosed aspect, an imaging system includes an image acquisition device configured to acquire one or more images of a patient. At least one electronic processor is programmed to: (a) receive emission imaging data acquired of a patient for one or more axial frames at a corresponding one or more bed positions from the image acquisition device; (b) identify a frame of interest from the one or more axial frames; (c) generate simulated lesion data by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest; (d) generate simulated frame emission imaging data by simulating emission imaging data for the frame of interest of the patient; (e) determine a normalization factor comprising a ratio of the value of a quantitative metric for the simulated data and the value of the quantitative metric for the emission imaging data acquired of the patient for the frame of interest; and (f) generate a hybrid data set comprising the emission imaging data acquired of the patient for the one or more axial frames at the corresponding one or more bed positions with the frame of interest replaced by a combination of the simulated lesion data scaled by the normalization factor and the emission imaging data acquired of the patient for the frame of interest.

In another disclosed aspect, an imaging system includes an image acquisition device configured to acquire one or more images of a patient. At least one electronic processor is programmed to: (a) receive emission imaging data acquired of a patient for one or more axial frames at a corresponding one or more bed positions from the image acquisition device; (b) identify a frame of interest from the one or more axial frames; (c) generate simulated lesion data by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest includes simulating the emission imaging data for the frame of interest of the at least one simulated lesion placed in the frame of interest using a Monte Carlo simulator; (d) generate simulated frame emission imaging data by simulating emission imaging data for the frame of interest of the patient by

simulating emission imaging data for the frame of interest of the patient includes simulating the emission imaging data for the frame of interest of the patient using the Monte Carlo simulator; (e) determine a normalization factor comprising a ratio of the value of a quantitative metric for the simulated data and the value of the quantitative metric for the emission imaging data acquired of the patient for the frame of interest; (f) generate a hybrid data set comprising the emission imaging data acquired of the patient for the one or more axial frames at the corresponding one or more bed positions with the frame of interest replaced by a combination of the simulated lesion data scaled by the normalization factor and the emission imaging data acquired of the patient for the frame of interest; (g) reconstruct each frame of the hybrid data set to generate a corresponding frame image; (h) knit together the frame images to generate a hybrid reconstructed image; and (i) display, on a display device, at least a portion of the hybrid reconstructed image corresponding to the frame of interest.

One advantage resides in providing improved evaluation and optimization of a medical imaging device, software, and algorithms employed for quantitative molecular imaging.

Another advantage resides in providing such improved evaluation and optimization in the context of the medical imaging device acquiring emission imaging data of a patient for one or more axial frames at a corresponding one or more bed positions.

Another advantage resides in providing such improved evaluation and optimization taking into account the impact of acquisition over successive axial frames at corresponding bed positions, especially at knitted boundaries of neighboring axial frames.

Another advantage resides in providing hybrid imaging data having simulated lesion data with acquired emission imaging data of a patient.

Another advantage resides in providing hybrid imaging data with simulated data that is normalized to acquired emission imaging data of a patient.

Another advantage resides in acquiring simulated lesion data in a patient without having to physically acquire lesion data.

Another advantage resides in inserting simulated lesions of various sizes, shapes, and locations in patient imaging data.

Another advantage resides in providing non-uniform attenuation at different locations in the patient by using the attenuation map of the patient in the simulation.

A given embodiment may provide none, one, two, more, or all of the foregoing advantages, and/or may provide other advantages as will become apparent to one of ordinary skill in the art upon reading and understanding the present disclosure.

BRIEF DESCRIPTION OF THE DRAWINGS

The disclosure may take form in various components and arrangements of components, and in various steps and arrangements of steps. The drawings are only for purposes of illustrating the preferred embodiments and are not to be construed as limiting the invention.

FIGURE 1 diagrammatically shows an imaging system according to one aspect;

FIGURE 2 shows an exemplary flow chart operation of the system of FIGURE 1; and

FIGURES 3A-3C illustratively show example images reconstructed from a hybrid data set displayed on the system of FIGURE 1.

DETAILED DESCRIPTION

The following discloses approaches for generating a hybrid data set that combine projection data actually acquired for an imaging subject with tumor projection data simulated by a Monte Carlo simulator. In one approach, the lesions are inserted into the reconstructed volume image of a patient and then the lesions are re-projected to generate projection data of the artificial lesions, which is then added to the patient projection data. However, this approach does not accurately account for the impact of limited FOV when the reconstructed volume image is generated from emission imaging data acquired over several axial "frames" at corresponding bed positions. The approach also fails to capture system physics beyond that embodied by the reconstructed image volume. It also fails to account for the possibly different attenuation of the lesions as compared with the background body tissue.

An improved approach performs Monte Carlo simulation for each successive frame. A simulation is first done of the patient without the added lesions, using the actual attenuation map used in acquiring the actual patient data. The simulated patient data set is compared with the actually acquired patient data set (after conversion to SUV) to determine the normalization factor which matches the simulated patient data and the actual measured patient data for the frame under processing.

A second Monte Carlo simulation is performed for the lesions of the desired activity level (with offset correction for the patient tissue background activity), again using the patient's attenuation map. Alternatively, the second simulation can be for the patient with the lesions after which the simulated lesions data is segregated out. The simulations are done for the same set of frames used in acquiring the actual patient data, so as to capture effects such as

reduced sensitivity at the axial peripheries of the frame. The normalization factor previously generated is used to scale the simulated lesion data, which is then added to the actual patient projection data to generate the hybrid projection dataset. In one approach, the lesion data are scaled during the Monte Carlo simulation by adjusting the simulated acquisition time in accord with the normalization factor.

The axial field of view (FOV) of the PET scanner is typically on the order of 15-25 centimeters (the precise FOV depends on the geometry of the PET scanner, e.g. the number and axial width of PET detector rings). This axial FOV is insufficient to perform a whole-body PET scan of a patient in a single acquisition. Accordingly, the whole-body PET scan is performed by moving the patient stepwise through the PET scanner in successive axial steps. Each step is referred to herein as a bed position (so named because the stepwise movement of the patient is achieved by moving the patient bed from one axial bed position to the next in the succession). At each bed position, a frame of imaging data is acquired – the frame has an axial extent commensurate with the axial FOV of the PET scanner, and is located along the axial direction of the patient at the current bed position. Neighboring frames are typically arranged to be partially overlapping by a few centimeters to ensure complete coverage of the patient and to compensate for reduced sensitivity at the axial ends of each frame. The PET imaging data of each frame are reconstructed to generate corresponding “frame images”, which are then knitted together (e.g. taking into account the tail-off of sensitivity at the peripheries) to form the whole-body image.

Each axial frame can be identified with a corresponding axial section of the reconstructed whole body image. However, the axial section of the whole body image generally differs from the frame image due to contributions to the axial section of the reconstructed whole body image from neighboring frames introduced during the knitting together of the frame images to form the complete whole-body image.

Existing techniques utilize a continuous bed motion acquisition technique for a whole body scan. In such acquisitions, the axial frame or bed position does exist in the image. However, the data can be rebinned into virtual frames. A simulation package can model such bed motion and use the corresponding virtual frames to carry out the rest of a normalization and hybrid generation techniques, as described in more detail below.

With reference to FIGURE 1, an illustrative medical imaging system **10** is shown. As shown in FIGURE 1, the system **10** includes an image acquisition device **12**. In one example, the image acquisition device **12** can comprise an emission imaging device (e.g., a transmission computed tomography (CT) device, positron emission tomography (PET)

device, a single photon emission computed tomography (SPECT) device, a combined PET/CT imaging device, or the like); however, it will be appreciated that other suitable imaging modalities may be used. The system **10** also includes a computer or imaging workstation or other electronic data processing device **14** with typical components, such as at least one electronic processor **16**, at least one user input device (e.g., a mouse, a keyboard, a trackball, and/or the like) **18**, and a display device **20** on which an interactive abnormality/lesion insertion graphical user interface (GUI) **22** can be displayed. In some embodiments, the display device **20** can be a separate component from the computer **14**. The workstation **14** can be in electronic communication with one or more databases (not shown) (e.g., an electronic medical record (EMR) database, a picture archiving and communication system (PACS) database, and the like).

As shown in FIGURE 1, the electronic processor **16** is programmed to perform image acquisition and image processing. For example, the electronic processor **16** is programmed to receive imaging data from the image acquisition device **12** and sort the images into list mode data **50**. The electronic processor **16** is also programmed to perform reconstruction operations (diagrammatically indicated by arrow) **51** on the list mode data to generate a reconstructed emission image **52**, and also generate an attenuation map **54** from a corresponding anatomical image, e.g. a transmission computed tomography (CT) image generated by a CT modality of a combined PET/CT or SPECT/CT imaging device.

As further shown in FIGURE 1, the electronic processor **16** is programmed to implement a Monte-Carlo simulator **56**. In some simulation tasks relevant herein, imaging data are simulated for the imaging subject as represented by the reconstructed images **52**, and/or for tumors simulated to be in the imaging subject. The Monte-Carlo simulation of emission data is performed by sampling emissions (e.g. PET 511 keV gamma emission pair events) for a given distribution of radiopharmaceutical. The sampled distribution may be the radiopharmaceutical distribution in the subject, as represented by the reconstructed emission image **52**, or may be the radiopharmaceutical distribution in a (hypothetical) tumor positioned in the subject, or a combination of the patient and tumor distributions. The Monte Carlo simulator **56** also takes into account absorption statistics for the emission events, using the attenuation map **54**, with random sampling to determine possible outcomes.

The Monte-Carlo simulator **56** simulates emission data **58** for the patient without lesions (using the emission image **52** as the radiopharmaceutical distribution) and for the (hypothetical) lesions (or, in an alternative embodiment, for the lesions in the patient after which the emission data for the lesions is segregated out). In normalization operations **60**, a

comparison of the actual emission imaging data **50** and the simulated patient imaging data (without implanted lesions) is compared to generate a normalization of the emission data for the lesions. The simulated lesion data scaled by the normalization factor and the emission imaging data acquired of the patient are combined to generate a hybrid data set **62**. Generally, the abnormality/lesion insertion GUI **22** allows flexibility for manual or automatic lesion insertion setup so that the Monte Carlo simulations **54** accurately model the emission data for a given clinical scenario. An accurate normalization process **60** assures the lesion has the intended quantitation (SUV) after inserting to the patient data. The attenuation adjustment of the patient data assures the patient data is adjusted if there is extra attenuation from the lesion tissue. The resulting hybrid data set **62** has accurately modeled lesion data inserted to the patient data background.

The hybrid data set **62** comprises list mode data and constitutes a simulation of the list mode data that would be acquired for the imaging subject from which the patient data **50** were acquired if that imaging subject had the tumors simulated by the Monte Carlo simulator **56**. Using techniques disclosed herein, the simulation accurately accounts for effects such as attenuation and the impact of lower sensitivity at the axial peripheries of the axial frames of emission imaging data acquired via axial frames at corresponding bed positions (e.g. to perform a whole-body PET scan). Thus, the hybrid data set **62** may be variously employed in imaging device evaluation and/or optimization **66** to evaluate performance of the imaging device **12**, to optimize aspects of the imaging device **12** such as parameters of the image reconstruction **51** and/or optional image processing such as resolution recovery, use of regularization, post-reconstruction image filtering, and/or so forth.

The at least one electronic processor **16** is operatively connected with a non-transitory storage medium (not shown) that stores instructions which are readable and executable by the at least one electronic processor **16** to perform disclosed operations **51**, **60** and to implement the Monte Carlo simulator **56** and to perform other operations as appropriate (e.g. the imaging device evaluation and/or optimization **66**, and/or in some embodiments control instructions that are executed to control the imaging device **12** to acquire the data **52**, **54**, and/or so forth). The non-transitory storage medium may, for example, comprise a hard disk drive, RAID, or other magnetic storage medium; a solid state drive, flash drive, electronically erasable read-only memory (EEROM) or other electronic memory; an optical disk or other optical storage; various combinations thereof; or so forth.

The illustrative electronic processor **16** is part of the illustrative imaging workstation **14**; however, more generally the system may include one or more electronic

processors variously distributed. For example, in one contemplated embodiment the reconstructed emission image **52** and attenuation map **54** are stored in a PACS and thereafter are retrieved by a network server, cloud computing resource, or the like including an electronic processor (or set of electronic processors, possibly combined in an ad hoc fashion as in cloud computing) which implements the Monte Carlo simulator **56** and processing **60** to generate the hybrid data set **62**, and optionally also the imaging device evaluation and/or optimization **66**.

The hybrid dataset generation operates on emission imaging data acquired of a patient for one or more axial frames at a corresponding one or more bed positions. With reference to FIGURE 2, an illustrative embodiment of the hybrid dataset generation operations is diagrammatically shown as a flowchart. At **102**, a frame of interest is identified from the one or more axial frames. In some embodiments, the one or more axial frames include a plurality of axial frames at successive bed positions. For example, the emission imaging data acquired of the patient for the plurality of axial frames at successive bed positions forms a whole body emission imaging data set.

At **104**, simulated lesion data is generated by simulating emission imaging data for the frame of interest of at least one simulated (e.g., 1 cm diameter sphere filled with certain activity) lesion placed in the frame of interest. The operation **104** is suitably performed by the Monte Carlo simulator **56**. Operation **104** can be implemented by simulating the lesion(s) without surrounding activity (but using the attenuation map **54** to generate matching attenuation/scattering as in the patient data). By simulating for a frame, the effect of reduced sensitivity near the edges of the frame can be appropriately accounted for.

At **106**, simulated frame emission imaging data is generated by simulating emission imaging data for the frame of interest of the patient. The operation **106** is again suitably performed by the Monte Carlo simulator **56**, but here with the radiopharmaceutical distribution being represented by the reconstructed emission image **52** of the patient. The operation **106** again uses the (same) attenuation map **54** as is used in operation **104** to account for absorption/scattering. In the case where the reconstructed image activity (i.e. emission image **52**) extends outside of the frame of interest (as is usually the case for a whole-body PET scan acquired using a plurality of frames), the Monte Carlo simulator **56** may take into account the impact of out-of-field of view (out of FOV) activity again leveraging the attenuation map **54**.

In a variant approach, operations **104** and **106** can be implemented by simulating the lesion(s) together with the imaging subject as represented by the reconstructed emission image **52**. In this approach, each sampled emission (e.g. each 511 keV gamma pair in the case

of PET) is tagged with its source location, and the lesion emission data can then be identified and segregated out from the patient imaging data in post-simulation processing.

At **108**, a normalization factor is determined comprising a ratio of the value of a quantitative metric for the simulated patient data and the value of the quantitative metric for the portion of the emission imaging data **50** actually acquired of the patient for the frame of interest. For example, the quantitative metric may be a mean activity or standardized uptake value (SUV) for a total number of events (i.e., counts) in the acquired imaging data and the simulated imaging data for the frame of interest. This normalization factor accounts for any difference in sensitivity of the actual imaging device **12** as compared with the Monte Carlo simulator **56**.

At **110**, a hybrid data set is generated that combines the original emission imaging data **50** acquired of the patient for the one or more axial frames at the corresponding one or more bed positions with the frame of interest and the simulated lesion data scaled by the normalization factor. For example, the generation of the hybrid data set includes scaling the simulated lesion data by the normalization factor by adjusting the simulation time when simulating the emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest in accord with the normalization factor.

In the case of a whole body PET scan or other multi-frame data acquisition, the operations **102-110** may be repeated for at least one additional frame of interest of the one or more axial frames at the successive bed positions (e.g. for all frames into which at least one lesion is to be inserted). If the lesion(s) to be inserted in the overlapping region of two adjacent frames, the simulation operations **102-110** need to be performed for these two frames separately.

The operations **102-110**, repeated for all frames into which at least one lesion is to be inserted, outputs the hybrid data set **62** of FIGURE 1. The remaining operations **112**, **114**, **116** of FIGURE 2 present a suitable implementation of the imaging device evaluation/optimization operation **66** of FIGURE 1.

At **112**, each frame of the hybrid data set is reconstructed to generate a corresponding frame image. The reconstruction should implement the image reconstruction processing under evaluation or optimization, and may include ancillary operations such as post-reconstruction image filtering.

At **114**, the frame images are knitted together to generate a hybrid reconstructed image. Again, this should employ the frame image fusion processing of the image

reconstruction processing under evaluation or optimization, and may include operations such as smoothing of overlapping portions of neighboring frame images.

At **116**, at least a portion of the hybrid reconstructed image corresponding to the frame of interest is displayed on the display device **20**. Additionally to (or, optionally, in place of) displaying the hybrid reconstructed image, the operation **116** may include quantitative processing such as quantifying the SUV of the tumor(s) in the hybrid reconstructed image. Ideally, these SUV values should match the “ground truth” values of the SUV values of the hypothetical, i.e. simulated, lesions employed in the simulation operation **104**. If the SUV values in the hybrid reconstructed image deviate significantly from these ground truth values, this implies the images of lesions produced by the imaging device **12** with reconstruction **51** implemented as in operations **112**, **114** are not accurately reflecting the true SUV values of the lesions. This may be corrected by improving the reconstruction, or may be corrected heuristically, e.g. by applying an empirical scaling factor to match the hybrid image SUV values with the known ground truth SUV values.

For optimization tasks, the operations **112**, **114**, **116** may be repeated for a test grid of reconstruction parameters or for other variables undergoing optimization, and the results of the operation **116** for the various options used to select optimal parameter values or for other optimization.

With continuing reference to FIGURES 1 and 2, FIGURES 3A-3C show examples of images produced using operations **112** and **114**. These images are generated from a hybrid data set, in which six small lesions **70** were inserted to the data of a patient study. For example, FIGURE 3A shows an image that is reconstructed using a list-mode Maximum Likelihood Estimation Method (MLEM) algorithm. FIGURE 3B shows an image generated using the list-mode MLEM algorithm with regularized reconstruction using a quadratic prior for noise reduction. FIGURE 3C shows an image generated using the list-mode MLEM algorithm with regularized reconstruction using an edge-preserving prior for noise reduction while maintaining lesion contrast. The lesion contrast and definition, as well as the background noise in the images clearly demonstrated the performance differences between the three different reconstruction approaches. In contrast, without the inserted lesions, one would only see the background noise difference between the different reconstruction approaches. These images may be displayed on the display device **20**.

It will be appreciated that, for typical clinical studies, dead time won't be a big issue. For high count rate studies, dead time has much stronger impact. A Monte Carlo simulation of isolated lesions alone might not simulate the same level of dead time factors as

the original patient data. In the normalization steps described above, the data can be simulated with both the background and the lesion. And from the simulated data, the events from the lesion and those from the background can be separated. In this way, if the total count level is high, the dead time effect can be correctly modelled as well.

To reduce the simulation time, multiple approaches can be applied, such as, performing the Monte Carlo simulation **54** for reduced time and scale the results to the patient data count level. Scaling is not exactly equivalent to simulating with full acquisition time, but for some studies (e.g. SUV number), the results are equivalent when the counts are large. Other effects (e.g. decay) also can be included in the scaling factor.

In those cases when the inserted lesions cause higher attenuation from lesion mass than the corresponding tissue in the original data to be merged with, special considerations need to be taken. For example, during attenuation, all the events from the patient data that intercept with the inserted lesion are first identified and the extra attenuation from the lesion is calculated along the direction of each event. A random number is generated to determine if the event is going to be removed from the data (to mimic additional attenuation). The probability that an event is removed from the final data is proportional to the extra attenuation from the inserted lesion. This will enable the insertion of lesions with the real lesion density (usually close to that of soft tissue) in lungs.

EXAMPLE

The following is an example algorithm, implemented on the electronic processor **16**, to perform the disclosed operations:

- Step 1. From a whole body patient study, obtain the reconstructed whole body image, scale the image (grayscale intensity voxel values) to an activity map, assuming the total activity is A, to obtain the activity map (**image_WB_act**); The A only needs to be roughly the same as for the activity level at the time the patient scan started to minimize dead time difference between the patient scan and the later in Monte Carlo simulation;
- Step 2. Identify the section of the image corresponding to the frame of interest (**image_Frame_act**);
- Step 3. Calculate the whole body mean of **image_WB_act** (mean_WB), generate a lesion at the location of interest in **image_Frame_act**, assuming the activity is **lesion_SUV*mean_WB**, where **lesion_SUV** is the desired SUV value of the lesion to be inserted into the patient;

- Since the list-mode data from the lesion will be eventually added to that of the acquired list-mode data of the patient, the lesion activity should be offset by the value at the location of the lesion in **image_WB_act**, assuming **lesion_act_Local** i.e., the lesion activity for simulation should be $\text{act_lesion} = \text{lesion_SUV} * \text{mean_WB-lesion_act_Local}$. Additional smoothing may be applied to **image_WB_act** in the inserted lesion location to reduce uncertainty related to noise.

- Step 4. Use **image_Frame_act** and the corresponding attenuation map to simulate the list mode data of the frame without the lesion (**LM_Frame_simu**), assuming acquisition time T (or the fraction of T for the improved computational performance but later scaling the result appropriately);
- Step 5. From the patient list mode data, identify the portion corresponding to the same frame (**LM_Frame**);
- Step 6. Reconstruct the **LM_Frame** and **LM_Frame_simu** into **IM_Frame** and **IM_Frame_simu**.
- Step 7. Find the ratio of the total of **IM_Frame** and **IM_Frame_simu**. This gives the normalization factor between the simulation and real data: **Norm1** = **IM_Frame/IM_Frame_simu**
- Step 8. Find the mean of **image_Frame_act**: **mean_Frame**, calculate ratio of mean of the whole body to the mean of the frame: **Norm2** = **mean_WB/mean_Frame**. Note that this step is to take care of the potential that the mean of the frame is different from the mean of the whole body;
- Step 9. Scale the time T by **Norm1*Norm2**, then use the lesion and the same attenuation map of the frame to simulate the list mode data of the lesion (**LM_Lesion_simu**), assuming acquisition time $T * (\text{Norm1} * \text{Norm2})$. If the attenuation coefficient of the lesion to be inserted is different from that at the location of the attenuation map of the map, such as in the situation of inserting lesions in lungs, use the attenuation map with inserted extra attenuation from lesion;
- Step 10. Add **LM_Lesion_simu** to **LM_Frame** to simulate the patient data with inserted lesion with true SUV value of **lesion_SUV**.

The disclosure has been described with reference to the preferred embodiments. Modifications and alterations may occur to others upon reading and understanding the preceding detailed description. It is intended that the invention be construed as including all

such modifications and alterations insofar as they come within the scope of the appended claims or the equivalents thereof.

CLAIMS:

1. A non-transitory computer readable medium storing instructions readable and executable by an imaging workstation (14) including at least one electronic processor (16) to perform a dataset generation method (100) operating on emission imaging data acquired of a patient for one or more axial frames at a corresponding one or more bed positions, the method comprising:

- (a) identifying a frame of interest from the one or more axial frames;
- (b) generating simulated lesion data by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest;
- (c) generating simulated frame emission imaging data by simulating emission imaging data for the frame of interest of the patient;
- (d) determining a normalization factor comprising a ratio of the value of a quantitative metric for the simulated data and the value of the quantitative metric for the emission imaging data acquired of the patient for the frame of interest; and
- (e) generating a hybrid data set comprising the emission imaging data acquired of the patient for the one or more axial frames at the corresponding one or more bed positions with the frame of interest replaced by a combination of the simulated lesion data scaled by the normalization factor and the emission imaging data acquired of the patient for the frame of interest.

2. The non-transitory computer readable medium of claim 1, wherein the one or more axial frames include a plurality of axial frames at successive bed positions.

3. The non-transitory computer readable medium of claim 2, wherein the emission imaging data acquired of the patient for the plurality of axial frames at successive bed positions forms a whole body emission imaging data set.

4. The non-transitory computer readable medium of claim 1, further including repeating (a)-(e) for at least one additional frame of interest of the one or more axial frames at the successive bed positions.

5. The non-transitory computer readable medium of either one of claims 1 and 2, wherein:

the operation (b) performs the simulation using an attenuation map of the patient; and

the operation (c) performs the simulation using the same attenuation map of the patient as is used in the operation (b).

6. The non-transitory computer readable medium of claim 5, wherein the operation (b) comprises one of:

simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest in isolation; and

simulating combined emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest together with the patient and then segregating out the simulated lesion data from the simulated combined emission imaging data.

7. The non-transitory computer readable medium of any one of claims 1-6, wherein the quantitative metric is a total number of events in the acquired imaging data and the simulated imaging data for the frame of interest.

8. The non-transitory computer readable medium of any one of claims 1-7, wherein in the operation (b) further includes:

reconstructing the emission imaging data acquired of the patient for the frame of interest and determining a background activity or standardized uptake value (SUV) at the location of at least one simulated lesion placed in the frame of interest; and

offsetting an activity or SUV of the simulated lesion by the background activity or SUV.

9. The non-transitory computer readable medium of any one of claims 1-8, wherein operation (e) includes scaling the simulated lesion data by the normalization factor by adjusting a time of the simulation of the emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest in accord with the normalization factor.

10. The non-transitory computer readable medium of any one of claims 1-9, wherein:

operation (b) simulates the emission imaging data for the frame of interest of the at least one simulated lesion placed in the frame of interest using a Monte Carlo simulator; and

operation (c) simulates the emission imaging data for the frame of interest of the patient using the Monte Carlo simulator.

11. The non-transitory computer readable medium of any one of claims 1-10, wherein the dataset generation method (**100**) further includes:

(f) reconstructing each frame of the hybrid data set to generate a corresponding frame image;

(g) knitting together the frame images to generate a hybrid reconstructed image; and

(h) displaying, on a display device (**20**), at least a portion of the hybrid reconstructed image corresponding to the frame of interest.

12. An imaging system, comprising:

an image acquisition device (**12**) configured to acquire one or more images of a patient;

at least one electronic processor (**16**) programmed to:

(a) receive emission imaging data acquired of a patient for one or more axial frames at a corresponding one or more bed positions from the image acquisition device;

(b) identify a frame of interest from the one or more axial frames;

(c) generate simulated lesion data by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest;

(d) generate simulated frame emission imaging data by simulating emission imaging data for the frame of interest of the patient;

(e) determine a normalization factor comprising a ratio of the value of a quantitative metric for the simulated data and the value of the quantitative metric for the emission imaging data acquired of the patient for the frame of interest; and

(f) generate a hybrid data set comprising the emission imaging data acquired of the patient for the one or more axial frames at the corresponding one or more bed positions with the frame of interest replaced by a combination of the simulated lesion data scaled by the normalization factor and the emission imaging data acquired of the patient for the frame of interest.

13. The system of claim 12, wherein the one or more axial frames include a plurality of axial frames at successive bed positions.

14. The system of claim 13, wherein the image acquisition device (12) is configured to acquire the emission imaging data of the patient for the plurality of axial frames at successive bed positions forms a whole body emission imaging data set.

15. The system of claim 12, further including repeating (a)-(f) for at least one additional frame of interest of the one or more axial frames at the successive bed positions.

16. The system of either one of claims 12 and 13, wherein:
generating simulated lesion data by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest includes performing the simulation using an attenuation map of the patient; and
generating simulated frame emission imaging data by simulating emission imaging data for the frame of interest of the patient includes performing the simulation using the same attenuation map of the patient.

17. The system of claim 16, wherein generating simulated lesion data by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest comprises one of:

simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest in isolation; and

simulating combined emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest together with the patient and then segregating out the simulated lesion data from the simulated combined emission imaging data.

18. The system of any one of claims 12-17, wherein the quantitative metric is a total number of events in the acquired imaging data and the simulated imaging data for the frame of interest.

19. The system of any one of claims 12-18, wherein generating simulated lesion data by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest further includes:

reconstructing the emission imaging data acquired of the patient for the frame of interest and determining a background activity or standardized uptake value (SUV) at the location of at least one simulated lesion placed in the frame of interest; and

offsetting an activity or SUV of the simulated lesion by the background activity or SUV.

20. The system of any one of claims 12-19, wherein generating a hybrid data set comprising the emission imaging data acquired of the patient for the one or more axial frames at the corresponding one or more bed positions with the frame of interest replaced by a combination of the simulated lesion data scaled by the normalization factor and the emission imaging data acquired of the patient for the frame of interest includes:

scaling the simulated lesion data by the normalization factor by adjusting a time of the simulation of the emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest in accord with the normalization factor.

21. The system of any one of claims 12-20, wherein:

generating simulated lesion data by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest includes simulating the emission imaging data for the frame of interest of the at least one simulated lesion placed in the frame of interest using a Monte Carlo simulator; and

generating simulated frame emission imaging data by simulating emission imaging data for the frame of interest of the patient includes simulating the emission imaging data for the frame of interest of the patient using the Monte Carlo simulator.

22. The system of any one of claims 12-21, wherein the at least one electronic processor (16) is further programmed to:

(g) reconstruct each frame of the hybrid data set to generate a corresponding frame image;

(h) knit together the frame images to generate a hybrid reconstructed image; and

(i) display, on a display device (20), at least a portion of the hybrid reconstructed image corresponding to the frame of interest.

23. An imaging system, comprising:

an image acquisition device (12) configured to acquire one or more images of a patient;

at least one electronic processor (16) programmed to:

(a) receive emission imaging data acquired of a patient for one or more axial frames at a corresponding one or more bed positions from the image acquisition device;

(b) identify a frame of interest from the one or more axial frames;

(c) generate simulated lesion data by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest by simulating emission imaging data for the frame of interest of at least one simulated lesion placed in the frame of interest includes simulating the emission imaging data for the frame of interest of the at least one simulated lesion placed in the frame of interest using a Monte Carlo simulator;

(d) generate simulated frame emission imaging data by simulating emission imaging data for the frame of interest of the patient by simulating emission imaging data for the frame of interest of the patient includes simulating the emission imaging data for the frame of interest of the patient using the Monte Carlo simulator;

(e) determine a normalization factor comprising a ratio of the value of a quantitative metric for the simulated data and the value of the quantitative metric for the emission imaging data acquired of the patient for the frame of interest;

(f) generate a hybrid data set comprising the emission imaging data acquired of the patient for the one or more axial frames at the corresponding one or more bed positions with the frame of interest replaced by a combination of the simulated lesion data scaled by the normalization factor and the emission imaging data acquired of the patient for the frame of interest;

(g) reconstruct each frame of the hybrid data set to generate a corresponding frame image;

(h) knit together the frame images to generate a hybrid reconstructed image; and

(i) display, on a display device (20), at least a portion of the hybrid reconstructed image corresponding to the frame of interest.

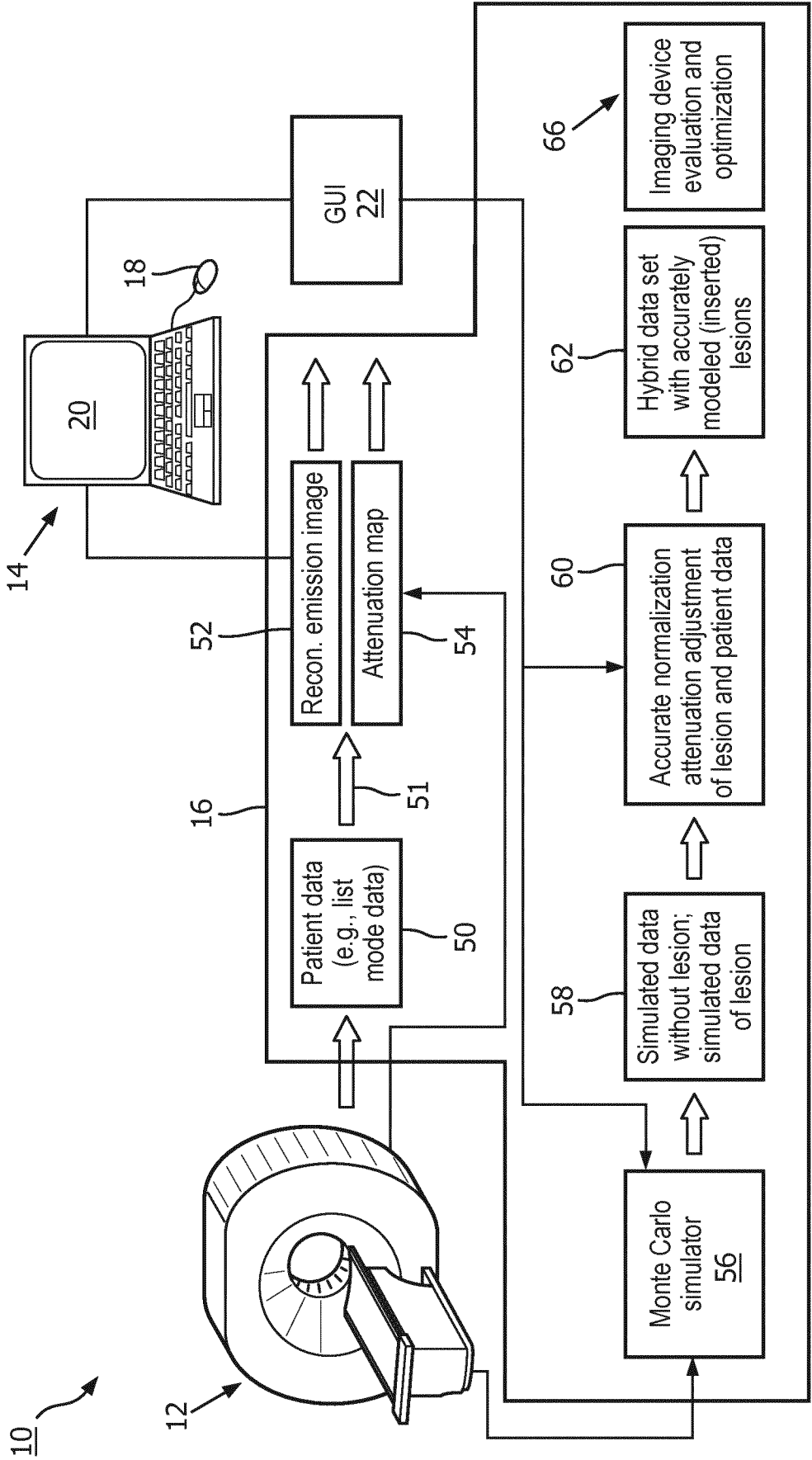


FIG. 1

2/3

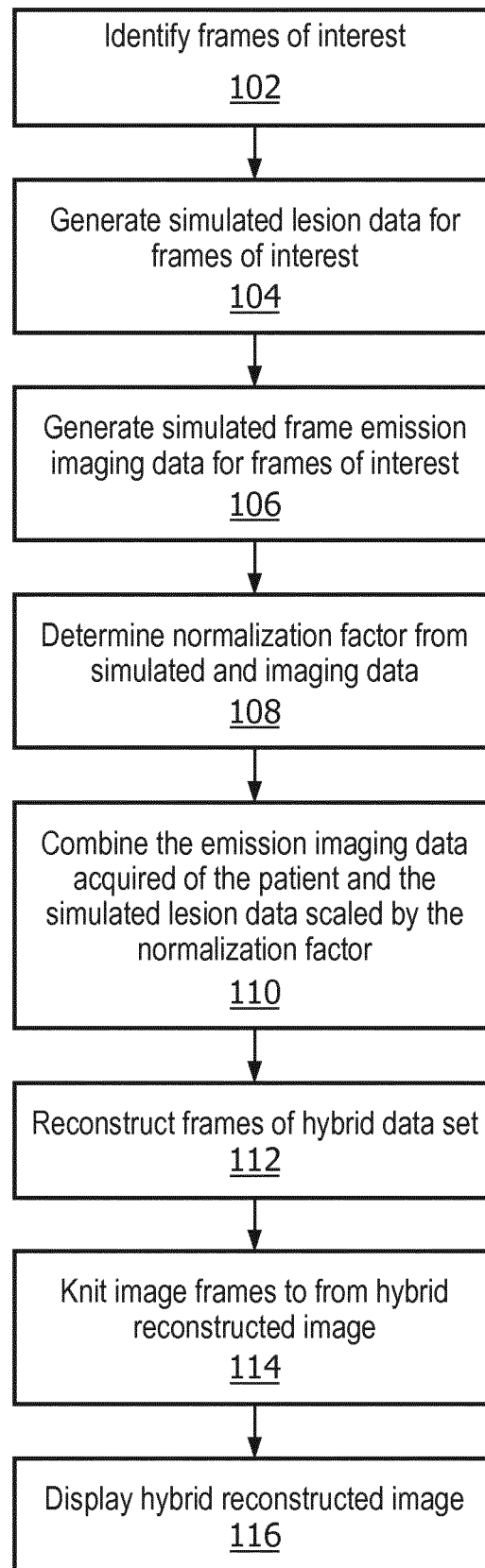


FIG. 2

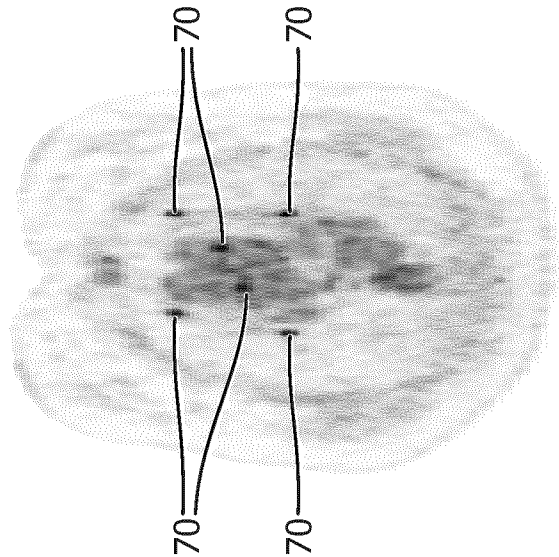


FIG. 3A

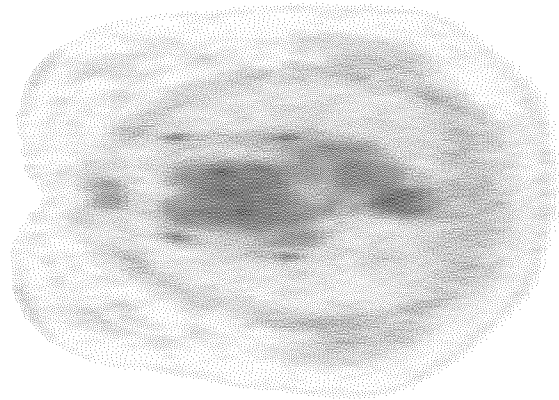


FIG. 3B

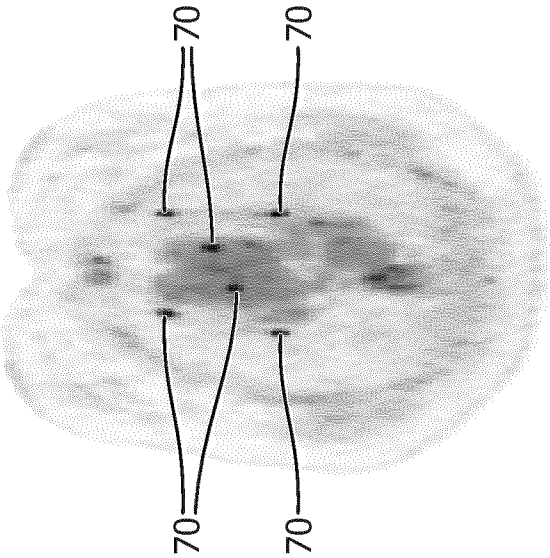


FIG. 3C

INTERNATIONAL SEARCH REPORT

International application No
PCT/EP2018/061083

A. CLASSIFICATION OF SUBJECT MATTER
INV. G06T11/00
ADD.

According to International Patent Classification (IPC) or to both national classification and IPC

B. FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)
G06T

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Electronic data base consulted during the international search (name of data base and, where practicable, search terms used)

EPO-Internal, WPI Data, COMPENDEX, INSPEC

C. DOCUMENTS CONSIDERED TO BE RELEVANT

Category*	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
X	EP 2 360 643 A1 (UNIV GENT [BE]) 24 August 2011 (2011-08-24) abstract paragraph [0033] - paragraph [0036] -----	1-23
X	HABIB ZAIDI ET AL: "Review of Computational Anthropomorphic Anatomical and Physiological Models", PROCEEDINGS OF THE IEEE, IEEE. NEW YORK, US, vol. 97, no. 12, 1 December 2009 (2009-12-01), pages 1938-1953, XP011279521, ISSN: 0018-9219, DOI: 10.1109/JPROC.2009.2032852 abstract Section I Section III D ----- -/-	1,12,23



Further documents are listed in the continuation of Box C.



See patent family annex.

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"Y" document of particular relevance; the claimed invention cannot be considered to involve an inventive step when the document is combined with one or more other such documents, such combination being obvious to a person skilled in the art

"&" document member of the same patent family

Date of the actual completion of the international search

3 August 2018

Date of mailing of the international search report

20/08/2018

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INTERNATIONAL SEARCH REPORT

International application No
PCT/EP2018/061083

C(Continuation). DOCUMENTS CONSIDERED TO BE RELEVANT		
Category*	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
A	WO 2016/178116 A1 (KONINKLIJKE PHILIPS NV [NL]) 10 November 2016 (2016-11-10) the whole document -----	1-23
A	WO 2016/077554 A1 (UNIV WASHINGTON [US]) 19 May 2016 (2016-05-19) the whole document -----	1-23

INTERNATIONAL SEARCH REPORT

Information on patent family members

International application No

PCT/EP2018/061083

Patent document cited in search report	Publication date	Patent family member(s)	Publication date
EP 2360643	A1	24-08-2011	NONE

WO 2016178116	A1	10-11-2016	CN 107636493 A 26-01-2018
			EP 3292426 A1 14-03-2018
			US 2018120459 A1 03-05-2018
			WO 2016178116 A1 10-11-2016

WO 2016077554	A1	19-05-2016	US 2017332983 A1 23-11-2017
			WO 2016077554 A1 19-05-2016
