Letters to the Editor-in-Chief

ERRORS IN TRANSRECTAL ULTRASONIC PLANIMETRY OF THE PROSTATE: COMPUTER SIMULATION OF VOLUMETRIC ERRORS APPLIED TO A SCREENING POPULATION:
REGARDING BANGMA ET AL. UMB 21(1):11–16; 1995

To the Editor-in-Chief:

With interest we’ve read the contribution by Bangma et al., in Ultrasound in Medicine and Biology 21(1) about the errors in transrectal ultrasonic planimetry of the prostate. It is an interesting study towards the errors introduced in a clinical application of numerical integration, in the case of prostatic volumetry. However, we would like to make some comments to their investigations, results, and the conclusions.

The authors examined the influence of three errors in this volumetry: the salami effect, the capsizing effect, and the first step effect using a computer simulation. The errors of the three effects were assessed with computer simulations using ellipsoid-shaped objects with varying length, height, and width. The volumes of the objects obtained with planimetry were compared to the exact ellipsoid volume. The authors kept the most important parameter in numerical integration, the intersection distance, fixed on 5 mm.

An interesting investigation is presented concerning the salami effect introduced when the transverse sections are not perpendicular to the longitudinal axis of the geometrical body. The authors are right when they state that this effect may lead to different surfaces and might even influence the number of cross-sections. As long as the probe is retracted along its own axis, the thickness of the slices is not influenced by this effect, as can be seen from Fig. 2 in their article.

They also conclude that the salami effect in planimetry is mainly dependent on the length of the ellipsoid, while in caliper measurements this angulation effect depends on the angle $a$. However, in planimetry the effective length of the ellipsoid is dependent on the angle $a$ as well; the effective length is the distance between the two tangential planes at the apex and base of the ‘prostate.’ This distance between the tangential planes is depending on the angle $a$ and the shape of the prostate. When the prostate length is larger than the prostate height, as normally seen in the clinic, the effective length of the prostate under angulation will always be smaller than the actual length. Therefore, the number of cross-sections taken under angulation will always be equal or smaller than expected from the actual prostate length. On the other hand, for prostates with a larger height than length, the angulation effect may be advantageous, since a larger effective length can be obtained and, therefore, a larger number of cross-sections may be taken from the same object.

From the computer analysis, it was concluded that the errors of the salami effect and the capsizing effect were larger for shorter ellipsoids. However, not only the salami and capsizing effect is measured in this case, but also the effect of the intersection distance. For theoretical analyses it makes no difference whether you reduce the length of the object or increase the intersection distance with the same proportion. Not the intersection distance itself, but the intersection distance relative to the length of the object to be integrated is important for numerical integration. When no other parameters are changed during numerical integration, like the selection of the first section, the errors obtained in an ellipsoid of 30-mm sliced with 5-mm are the same as for an ellipsoid of 40-mm sliced with 4-mm intersection distance. This means that not the salami or capsizing effect, but the fact that less cross-sections are used to determine the volume will introduce larger errors in shorter prostates. Also, their conclusion that the first-step effect in the computer simulation was especially seen in ellipsoids whose shape is low and broad, does not hold true. An ellipsoid shape is described by the following function:

$$\left(\frac{x}{a}\right)^2 + \left(\frac{y}{b}\right)^2 + \left(\frac{z}{c}\right)^2 = 1$$

with a prostate width $2*a$, height $2*b$, and length $2*c$. Cross-sections in the plane $z = z_0$, perpendicular to the $z$ axis can be described by

$$\left(\frac{x}{a\sqrt{1 - \left(\frac{z_0}{c}\right)^2}}\right)^2 + \left(\frac{y}{b\sqrt{1 - \left(\frac{z_0}{c}\right)^2}}\right)^2 = 1,$$

The area of these cross-sections used to obtain the planimetric volume can thus be described by $\pi*a*b*(1 - (z_0/c)^2)$ and thus linearly related to the height and width of the prostate. The sum of a discrete number of areas obtained with fixed distance is, therefore, also related to the height and width. The relative error is obtained by dividing the numerical volume by the exact analytical volume:

$$\frac{\sum \pi*a*b\left(1 - \left(\frac{z_0}{c}\right)^2\right)}{\pi\frac{a}{6}b\frac{c}{6}} = \frac{\left(1 - \left(\frac{z_0}{c}\right)^2\right)}{c}$$

This expression for the relative error shows that not the width or height but the length of the prostate is the determining factor. Again, the error is produced by the fact that less cross-sections are used.

In conclusion, because the assessment of the influences of the salami, capsizing, and first-step effect are combined with a varying prostate length, it is hard to extract the influences of each effect individually. Indeed, the effects are
summarized in a practical application and the article gives a good overview of the errors to be expected in prostatic volumetry with 5-mm intersection distance. However, how prostatic volumetry can be improved by reducing one of the effects cannot be extracted from the article. This is also reflected in the conclusions where the authors state that to minimize these errors introduced by the three effects the caliper length should be compared to the number of cross-sections. In our opinion, this is a cryptical description for a recommendation to use a fixed number of cross-sections instead of a fixed intersection distance. However, this is not the solution to overcome the influences of one of the effects. Also, the introduction of a critical area to define the first step sizes, nor the introduction of a critical area to define the first step.

Assessing the comments of Dr. Aarnink and his colleagues, we feel that we might not have made our point clear enough. Naturally, the salami effect does not change the thickness of slices measured perpendicular to the slice surface in planimetry, only their apparent thickness along the length axis of the ellipsoid. The salami and capsizing effect cause missing steps. Aarnink and colleagues correctly remark that missing steps due to angulation of the ellipsoids introduce errors. Angulation may even introduce extra steps when the height of the ellipsoid is almost as large as the length and the angulation is extreme (45°): we observed this in our model in very few cases, in which the measured volume exceeded the calculated volume by up to 0.6%. This extreme angulation is a rather uncommon phenomenon in urologic practice. However, we also observed a variation in volumetric error when no steps were missing according to ellipsoid length, so that this observation must have been introduced by the salami and capsizing effect. The combined relative error of the missing step together with this additional error is illustrated in the graphs of our article (Figs. 5 and 6).

When noting that the first step effect is independent of the height and width of the ellipsoid, Dr. Aarnink and his colleagues are correct, as long as the ellipsoid does not make rotational movements. In our example used to produce Table 1, we inadvertently did not state that this example-ellipsoid was capsized over 30°. Rotation makes the volumetry dependent on height and width. Subsequently, the shape of the ellipsoid influences the volumetric outcome.

Shape may clearly contribute to the volumetric error. Thus, simulation of a 50-mm ellipsoid with 5-mm step size is only identical to a 40-mm ellipsoid with 4-mm step size if length and height are decreased in the same proportion. In urologic practice, the shape of the prostate also influences, although less than volume, the image of the target organ that the clinician wishes to treat. Our article has been an attempt to improve on our understanding of the ultrasonic images we generate, leading to even greater accuracy and reproducibility.

REFERENCE


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