



Influence of computed tomography slice thickness on deep learning-based, automatic coronary artery calcium scoring software performance

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Background: The influence of computed tomography (CT) slice thickness on the accuracy of deep learning (DL)-based, automatic coronary artery calcium (CAC) scoring software has not been explored yet.

Methods: This retrospective study included 844 subjects (477 men, mean age of 58.9±10.7 years) who underwent electrocardiogram (ECG)-gated CAC scoring CT scans with 1.5 and 3 mm slice thickness values between September 2013 and October 2020. Automatic CAC scoring was performed using DL-based software (3D patch-based U-Net architectures). Manual CAC scoring was set as the reference standard. The reliability of automatic CAC scoring was evaluated using intraclass correlation coefficients (ICCs) for both the 1.5 and 3 mm datasets. The agreement of CAC severity categories [Agatston score (AS) 0, 1–100, 101–400, >400] between automatic CAC scoring and the reference standard was analyzed using weighted kappa (κ) statistics for both 1.5 and 3 mm datasets.

Results: The CAC scoring agreement between the automatic CAC scoring and reference standard was excellent (ICC 0.982 for 1.5 mm, 0.969 for 3 mm, respectively). The categorical agreement of CAC severity between two methods was excellent for both 1.5 and 3 mm scans, with better agreement for 3 mm scans (weighted κ : 0.851 and 0.961, 95% confidence intervals: 0.823–0.879 and 0.945–0.974, respectively).

Conclusions: Automatic CAC scoring shows excellent agreement with the reference standard for both 1.5 and 3 mm scans but results in lower agreement in the CAC severity category for 1.5 mm scans.

Keywords: Coronary artery calcium (CAC); automatic scoring software; CT slice thickness

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Introduction

The coronary artery calcium (CAC) score obtained from a noncontrast-enhanced, electrocardiogram (ECG)-gated computed tomography (CT) scan is a strong predictor of adverse cardiovascular events in asymptomatic individuals (1). Conventional CAC scoring is performed by manual identification of the calcified coronary artery lesions in each image using dedicated software, which is labor-intensive and time-consuming. Artificial intelligence could help replace this tedious work and increase clinical efficiency.

Several studies evaluated deep learning (DL)-based, automatic CAC scoring software using standard cardiac CT and chest CT (2-5). A recent validation study demonstrated that a DL-based, atlas-based automatic CAC scoring system showed high reliability for Agatston score (AS) and volume [intraclass correlation coefficient (ICC) 0.99 for both] measurements and a high accuracy for risk categorization [κ value =0.94] in three cardiac CT cohort datasets from a single institution (6).

Standard CAC scoring on noncontrast-enhanced ECG-gated cardiac CT requires 2.5–3 mm slice thickness scan. However, CT images with thinner slice reconstruction tend to increase the detection of small CACs and result in higher CAC scores than the standard 3 mm slice thickness (7,8). Moreover, non-ECG-gated chest CT with thinner slices (1–1.25 mm) has been increasingly used for the assessment of the presence and severity of CACs (9,10). Although thinner slices may improve the reliability of CAC scoring by decreasing partial volume effects, they increase image noise, which may negatively affect the automatic detection of CACs. To date, the performance of DL-based, automatic CAC scoring software has not been explored for thinner slice thickness. We hypothesized that a cardiac CT scan reconstructed with thinner slices would increase false-positive results and lower the performance of DL-based, automatic CAC scoring software.

The aim of this study was to evaluate the influence of CT slice thickness on the performance of DL-based, automatic CAC scoring software by evaluating the agreement of CAC scores and risk category classification at 1.5 and 3 mm slice thickness, CAC scoring CT with manual scoring as the reference standard.

Methods

Patients

The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The study was approved by the institutional review board of Severance Hospital and individual consent for this retrospective analysis was waived.

We retrospectively enrolled 1,058 consecutive CT examinations obtained from asymptomatic subjects who underwent cardiac CT for health evaluation at our institution between September 2013 and October 2020. Images of CAC scoring scans in cardiac CT for health evaluation were reconstructed with two slice thickness values (1.5 and 3 mm). Patients with prior history of coronary revascularization (n=30) and without a complete set of reconstructions of two different slice thickness (n=151) were excluded. If a patient had multiple cardiac CT scans (n=33), we included only the most recent examination. A total of 844 patients (mean age, 58.9±10.7; 477 men) consisted of final study population (*Figure 1*). Of these patients, 550 were included in a study by Kim *et al.* (8). The previous study focused on the prognostic value of CAC scores from 1.5 mm slice reconstructions of ECG-gated CT scan in asymptomatic subjects. However, our study focused on the impact of CT slice thickness on DL-based automatic CAC scoring software performance.

CT image acquisition

All subjects underwent cardiac CT using second- or third-generation dual-source CT scanner (SOMATOM Definition Flash or SOMATOM Definition Force, Siemens Healthineers). The standard protocol by the Society of Cardiovascular Computed Tomography was used for image acquisition (11). Noncontrast CT images for CAC scoring were performed with a prospective ECG-gated acquisition protocol (tube voltage; 120 kVp, tube current; 50 mA). Images were obtained with prospective ECG-gating at 70% or 35% of the R-R interval, depending on the heart rate. A medium-sharp kernel and filtered back projection (B35f), specifically designed to enhance the depiction of calcifications, were used for image reconstruction.

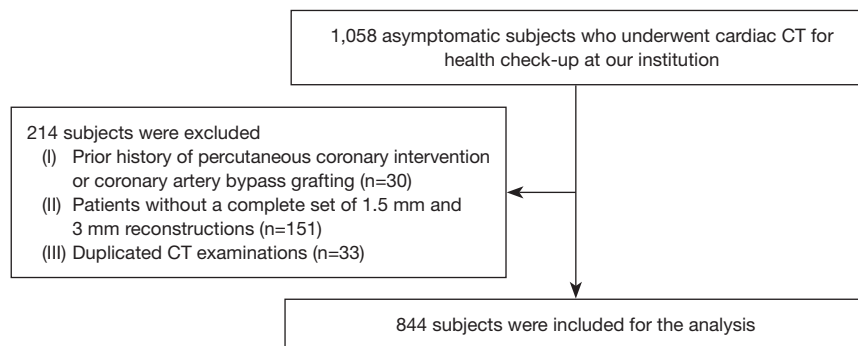


Figure 1 Flow chart: inclusion and exclusions. CT, computed tomography.

From the acquired raw data, the whole volume was reconstructed in nonoverlapping datasets of 1.5 and 3 mm slice thickness. The radiation dose of CAC scoring CT was assessed using the dose-length product.

Automatic CAC scoring software overview

For automatic CAC scoring, we used commercial, DL-based, automated CAC scoring software (AVIEW CAC, Coreline Soft, Co. Ltd.), which automatically calculates the CAC score based on the 3D U-net architecture. First, the software finds the four main coronary arteries: the left main artery (LM), left anterior descending artery (LAD), left circumflex artery (LCX), and right coronary artery (RCA). Second, it finds the regions with attenuation higher than 130 HU that are regarded as calcium candidates on CT images. Then, CAC is calculated by intersecting the segmented coronary artery and the regions considered as calcium candidates. Details of the DL algorithm are specified in a recent study (6). All dataset for training the algorithm was noncontrast-enhanced, ECG-gated CT with 2.5 or 3 mm slice thickness. There was no image preprocessing step for 1.5 mm slice thickness scan before an inference.

The automated analysis software provides AS, volume, and mass score; we used AS and calcium volume (mm^3) for data analysis in this study. To exclude noise, we set a calcium candidate to have at least three pixels with attenuation higher than 130 HU on both manual and automatic scoring methods.

Reference standard CAC scoring and data reporting

A manual CAC scoring method was set as the reference standard, with the use of post-processing software (AVIEW

CAC, Coreline Soft, Co. Ltd.). All 1,688 CT scans were analyzed, in consensus, by two radiologists (YJS and SYK) with 13 and 3 years of experience in cardiac CT, respectively. Any discrepancies in individual scoring were resolved through discussion. The images were randomly ordered, and the observers were blinded to the CAC scores on other slice thickness images or scores by another reader. Images with 3 mm thickness were reviewed first, followed by the 1.5 mm images. A minimum of 1 month was scheduled as a washout period between the scoring of two different slice thickness images to reduce recall bias. Every calcified coronary region of interest was manually identified and color-coded according to the anatomical location. Then, the software calculated the total AS and calcium volume (mm^3) by summation of the individual lesions with CACs. The result of CAC scoring was respectively reported at the total and per-vessel levels, i.e., LM, LAD, LCx, and RCA. We classified the CAC severity of the subjects into four categories based on AS: none (score =0), mild (score 1–100), moderate (score 101–400), and severe (score >400) (12). One hundred (11.8%) CT scans were randomly selected for both thickness values, with even distribution over the CAC severity categories (25 cases in each category), to evaluate inter-observer agreement of manual CAC scoring. Image noise was defined as the standard deviation (SD) of the measured pixel values in HU within a circular region of interest in the ascending aorta at the level of the LM and measured on the 1.5 and 3 mm slice images.

Per-lesion analysis

Per-lesion comparisons between the manual and automatic methods were conducted on both 1.5 and 3 mm scans. Calcified coronary lesions were selected based on the

Table 1 Baseline demographic and clinical characteristics of the study population

Variables	Patients (n=844)
Age (years)	58.9±10.7
Male, n (%)	477 (56.5)
Body mass index (kg/m ²)	24.0±2.8
Hypertension, n (%)	206 (24.4)
Diabetes mellitus, n (%)	139 (16.5)
Dyslipidemia, n (%)	362 (42.9)
Systolic blood pressure (mmHg)	123.2±15.4
Smoking history, n (%)	
Never smoker	481 (57.0)
Former smoker	218 (25.8)
Current smoker	139 (16.5)
Not available	6 (0.7)
Pack-years of smoking (n=50)	38.4±22.9
Total cholesterol (mg/dL)	195.6±39.8
HDL cholesterol (mg/dL)	52.7±13.8
LDL cholesterol (mg/dL)	117.3±35.5

Data expressed as number (%) or mean ± standard deviation. HDL, high-density lipoprotein; LDL, low-density lipoprotein.

structural information generated by the automatic software. All the mismatched lesions were reviewed by two radiologists to analyze the cause of the mismatches and the lesion locations. The mismatched lesions were divided into false-positive results (e.g., wrong vessel segmentation or image noise) and false-negative results (i.e., coronary calcifications missed by automatic software) errors. The per-lesion sensitivity was calculated as (true positive lesion number/total lesion number) × 100. The false-positive rate was calculated as (number of false-positive lesions/total patient number).

Statistical analysis

The mean, SD, and median values were calculated for AS and calcium volume (mm³) obtained using the reference standard and the automatic software. The paired *t*-test was applied to determine the statistical significance of the differences in the image noise between 1.5 and 3 mm scans. Inter-observer agreement of manual CAC scoring and the agreement of the reference standard and the automatic software for AS and calcium volume (mm³)

were evaluated using ICC and Bland-Altman analysis with 95% limits of agreement (LOA) for both 1.5 and 3 mm datasets. ICCs were interpreted as follows: 0.50, poor; 0.50–0.75, moderate; 0.75–0.9, good; and 0.9–1.0, excellent. We applied the half-normal distribution method for non-uniform differences, since the measurement error of CAC score increased with higher CAC scores (13). The 95% repeatability limits were calculated by multiplying the coefficient by $1.96 * \sqrt{\pi/2}$ (14). The agreement of the CAC severity categories (AS 0, 1–100, 101–400, >400) between automatic CAC scoring and the reference standard was analyzed using weighted κ statistics for both 1.5 and 3 mm datasets. Kappa values were interpreted as follows: <0.4, poor; 0.41–0.6, moderate; 0.61–0.8, good; and 0.81–1.0, excellent agreement. A *P* value of <0.05 was considered statistically significant. All analyses were performed using SAS (version 9.2, SAS Institute Inc.).

Results

Patient characteristics

Four-hundred seventy-seven of 844 subjects (56.5%) were men, and the mean age was 58.9±10.7 years (Table 1). The mean body mass index was 24.0±2.8 kg/m² (range, 15.6 to 36.8 kg/m²). Prevalence of diabetes mellitus, hypertension, and dyslipidemia were 16.5%, 24.4%, and 42.9%, respectively, and 16.6% were current smokers.

Inter-observer agreement of manual CAC scoring and agreement between automatic scoring and reference standard

Inter-observer agreement for manual CAC scoring was excellent on both 1.5 and 3 mm slice thickness scans (ICC 0.99 and κ value for risk category 0.992 for both). Bland-Altman plots show the difference between CAC scores by two readers (Figure S1). A confusion matrix for the categorization of CAC severity between both readers is presented in Table S1.

Based on manual scoring, the median AS was 4.28 (interquartile range, 0–55.74) for 1.5 mm scans and median 0 (interquartile range, 0–31.43) for 3 mm scans (Table 2). With the manual scoring method, the proportion of subjects with an AS of zero was 281/844 (33.3%) and 478/844 (56.6%) for 1.5 and 3 mm scans, respectively. There was excellent agreement in AS between 1.5 and 3 mm slice thickness scans with both manual and automatic scoring methods (ICC 0.967 for both; Table S2). The agreement

Table 2 The reliability of the calcium volume (mm³) and Agatston score measurement for the per-patient and per-vessel analyses on 1.5 and 3 mm slice thickness reconstructions

Index	Total	LM	LAD	LCX	RCA
1.5 mm slice thickness					
Agatston score, median	4.28 [0, 55.74]	0 [0, 0]	0 [0, 30.68]	0 [0, 1.22]	0.58 [0, 9.09]
Agatston score, ICC	0.982 (0.979, 0.984)	0.810 (0.785, 0.832)	0.975 (0.971, 0.978)	0.895 (0.881, 0.908)	0.973 (0.97, 0.977)
Agatston score, LOA	10.101 (6.219, 13.983)	-0.222 (-1.498, 1.055)	4.300 (2.276, 6.323)	2.315 (0.724, 3.906)	3.708 (1.644, 5.772)
Volume, mm ³ , median	8.86 [0, 58.55]	0 [0, 0]	0 [0, 27.77]	0 [0, 3.34]	1.73 [0, 16.04]
Volume, mm ³ , ICC	0.980 (0.977, 0.982)	0.810 (0.785, 0.832)	0.976 (0.972, 0.979)	0.896 (0.882, 0.908)	0.966 (0.961, 0.97)
Volume, mm ³ , LOA	8.071 (4.73, 11.413)	-0.338 (-1.335, 0.659)	3.359 (1.793, 4.925)	1.603 (0.303, 2.904)	3.447 (1.508, 5.387)
3 mm slice thickness					
Agatston score, median	0 [0, 31.43]	0 [0, 0]	0 [0, 15.92]	0 [0, 0]	0 [0, 1.37]
Agatston score, ICC	0.969 (0.965, 0.973)	0.805 (0.78, 0.827)	0.936 (0.927, 0.944)	0.867 (0.849, 0.883)	0.982 (0.979, 0.984)
Agatston score, LOA	6.648 (2.013, 11.282)	-0.732 (-2.058, 0.594)	3.641 (0.538, 6.744)	2.18 (0.541, 3.818)	1.559 (0.065, 3.053)
Volume, mm ³ , median	0 [0, 34.38]	0 [0, 0]	0 [0, 18.42]	0 [0, 0]	0 [0, 4.06]
Volume, mm ³ , ICC	0.970 (0.966, 0.974)	0.798 (0.772, 0.822)	0.942 (0.933, 0.949)	0.874 (0.857, 0.889)	0.977 (0.974, 0.98)
Volume, mm ³ , LOA	5.878 (2.019, 9.737)	-0.641 (-1.723, 0.441)	3.005 (0.607, 5.404)	1.918 (0.58, 3.257)	1.595 (0.133, 3.057)

Numbers in parentheses indicate 95% confidence intervals. Numbers in brackets indicate interquartile range. ICC, intraclass correlation coefficient; LOA, limits of agreement; LAD, left anterior descending artery; LCX, left circumflex artery; LM, left main artery; RCA, right coronary artery.

for CAC severity categorization between 1.5 and 3 mm slice thickness reconstructions was good for both reference standard and automatic software [weighted κ ; 0.711 (95% confidence interval, 0.675–0.747) for reference standard and 0.634 (95% confidence interval, 0.594–0.675) for automatic software]. The agreement between the automatic software and the reference standard with respect to the AS and calcium volume (mm³) is summarized in *Table 2*. For the AS, automatically obtained CAC scores yielded high ICCs for both 1.5 and 3 mm scans (0.982 and 0.969, respectively). For the per-vessel evaluation, the ICCs for the AS of the LM, LAD, LCX, and RCA were 0.810, 0.975, 0.895, and 0.973 for 1.5 mm scans and 0.805, 0.936, 0.867, and 0.982 for 3 mm scans (*Table 2*). Bland-Altman plots show differences between CAC scores obtained from two methods (*Figure 2*). ICC for calcium volume was also high for both 1.5 and 3 mm scans (0.980 and 0.970, respectively), with similar values yielded by the ICC for AS in the per-vessel analysis. The mean dose-length product was 51.0±6.0 mGy·cm (range 15 to 96 mGy·cm). Image noise was significantly lower in 3 mm thickness than that with 1.5 mm slice thickness (mean ± SD, 19.8±4.6 vs. 27.1±6.4, P<0.001).

Categorical agreement of CAC severity between automatic scoring and reference standard

A confusion matrix for the categorization of CAC severity is presented in *Table 3*. The categorical agreement of CAC severity between automatic scoring and the manual reference standard was excellent for both 1.5 and 3 mm scans, with better agreement for 3 mm scans [weighted κ ; 0.851 (95% confidence interval, 0.823–0.879) for 1.5 mm and 0.961 (95% confidence interval, 0.945–0.974) for 3 mm]. In total, 106 (12.6%) and 30 (3.5%) scans were misclassified by automatic scoring in the 1.5 and 3 mm scans, respectively; 81 were overestimated and 25 underestimated in the 1.5 mm scans, and 21 were overestimated and nine underestimated in the 3 mm scans. All misclassified scans in 1.5 and 3 mm slice thickness reconstructions were off by one category; 77 and 20 of those shifting from AS 0 on manual scoring to AS 1–100 on automated scoring. No scan was off by two categories in either 1.5 or 3 mm scans.

Per-lesion analysis

Among 844 subjects, the numbers of identified lesions

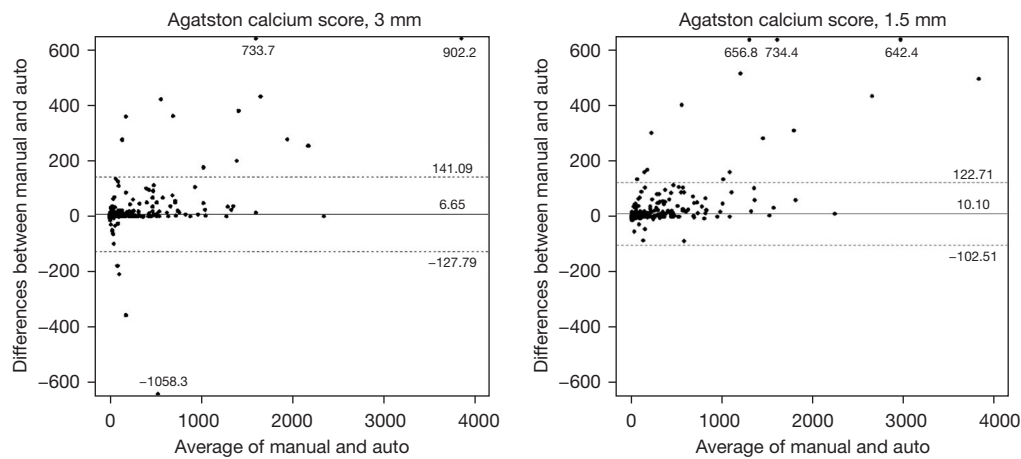


Figure 2 Bland-Altman plots with 95% limits of agreement (dotted lines) comparing automatically obtained Agatston score with reference standard on 3 and 1.5 mm slice thickness scans. Regression formulas for absolute difference are multiplied by $\pm 1.96 * \sqrt{\pi/2}$ to get the 95% limits of agreement, giving limit for 3 mm scan: $Y = 3.753 * \sqrt{\text{Agatston score}}$; and for 1.5 mm scan: $Y = 3.356 * \sqrt{\text{Agatston score}}$.

Table 3 Categorical agreement for CAC severity between reference standard and automatic software on 1.5 and 3 mm slice thickness reconstructions

Standard reference	Automatic software				Total	Same	Shift up	Shift down
	No (0)	Mild (1–100)	Moderate (101–400)	Severe (>400)				
1.5 mm slice thickness								
No (0)	204	77	0	0	281	204	77	–
Mild (1–100)	6	397	4	0	407	397	4	6
Moderate (101–400)	0	10	82	0	92	82	0	10
Severe (>400)	0	0	9	55	64	55	–	9
Total	210	484	95	55	844			
3 mm slice thickness								
No (0)	458	20	0	0	478	458	20	–
Mild (1–100)	0	229	1	0	230	229	1	0
Moderate (101–400)	0	6	76	0	82	76	0	6
Severe (>400)	0	0	3	51	54	51	–	3
Total	458	255	80	51	844			

Columns to the right demonstrate a summary of risk category shifting. CAC, coronary artery calcium.

using the automatic CAC scoring software were 8,168 and 3,086 on the 1.5 and 3 mm scans, respectively. Automatic software yielded per-lesion sensitivity of 91.8% (7,495 of 8,168 lesions) and 95.9% (2,958 of 3,086 lesions) and a false-positive rate of 0.8 and 0.15 per subject (673 and 128 lesions among 844 subjects) for the 1.5 and 3 mm scans, respectively.

For the 1.5 mm scans, the most common cause of false-positive results was image noise (66.4%, 447/673; *Figure 3A*), followed by wrong vessel segmentation (23.6%, 159/673) (*Table 4*). Among 29 aortic wall calcifications falsely detected by automatic software, 21 (72.4%) were classified as RCA lesions. Among 38 false-positive myocardial calcifications, 25 (65.8%) were categorized as

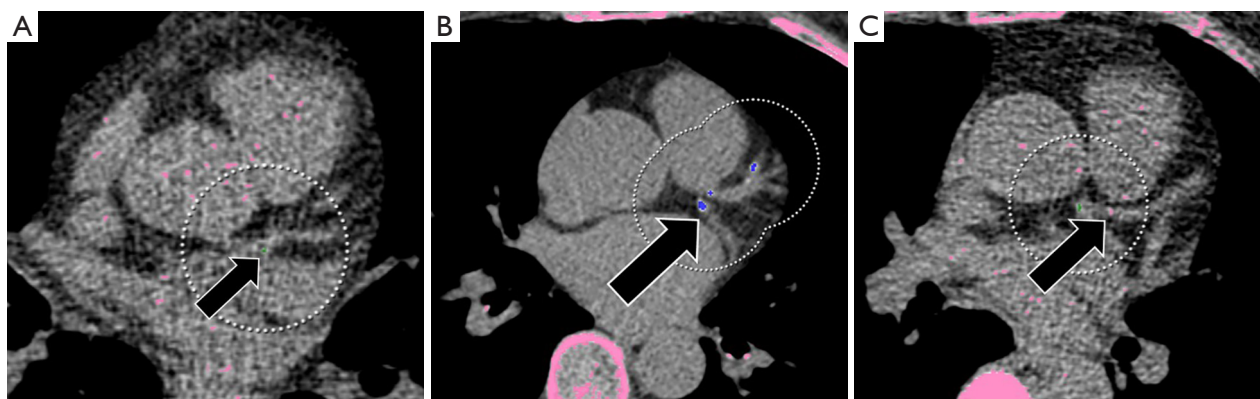


Figure 3 Examples of false-positive or false-negative prediction by the automatic software. (A) A 39-year-old male with mild CAC on 1.5 mm slice thickness scan (Agatston score, 2.5). Black arrow shows false-positive by automatic software within an area of left main coronary artery due to image noise. (B) A 68-year-old female with mild CAC on 3 mm slice thickness scan (Agatston score, 75.4). Black arrow shows false-positive by automatic software on 3 mm slice thickness scan due to wrong vessel segmentation. To be specific, left circumflex artery calcification was incorrectly recognized as a part of the left anterior descending artery. (C) A 72-year-old female with mild CAC on 1.5 mm slice thickness scan (Agatston score, 3.2). Left anterior descending artery calcification was left undetected on a 1.5 mm slice thickness scan. Black arrow shows a false-negative prediction of the 1.5 mm automatic scan. CAC, coronary artery calcium.

LCX lesions. For the 3 mm scans, the main causes of false-positive results were wrong vessel segmentation (59.3%, 76/128; *Figure 3B*) and image noise (23.4%, 30/128). Wrong vessel segmentation includes errors originating from artery segmentation and labeling (e.g., LM labeled as LAD). After excluding wrong vessel segmentation, the number of ‘anatomically’ false-positive results decreased to 514 and 52 in 1.5 and 3 mm scans, respectively (0.6 and 0.06 false-positive lesions per patient, *Table S3*). There were 330 and 208 false-negative results in 1.5 mm (*Figure 3C*) and 3 mm scans, respectively, and the most common location of missed lesions was the LAD (1.5 mm, n=106, 32.1%; 3 mm, n=72, 34.6%).

Discussion

In this study, CAC quantification using DL-based automatic software was evaluated using a manual method as a reference standard for both 1.5 and 3 mm scans. Automatic CAC scoring demonstrated excellent agreement (ICC >0.9) in the AS and calcium volume measurements for both 1.5 and 3 mm scans compared with the reference standard. Although automatic CAC score-based risk group categorization was excellent for both slice thickness scans, 106 (12.6%) and 30 (3.5%) scans were misclassified in the 1.5 and 3 mm scans, respectively. Per-lesion sensitivity was high (1.5 mm, 91.8%; 3 mm, 95.9%), and false-positive

rate was low (1.5 mm, 0.8; 3 mm, 0.15 false-positive lesions per subject). The most common causes of false-positive results were image noise on 1.5 mm scans and wrong vessel segmentation on 3 mm scans.

The reliability of the automatic CAC scoring method in this study (ICC for AS, 0.982 for 1.5 mm and 0.969 for 3 mm; κ value for risk category, 0.851 for 1.5 mm and 0.960 for 3 mm) was comparable to that reported by recent studies (ICC for AS 0.97–0.996, κ 0.919–0.97) (2,6,15). Although many studies using DL-based, automated CAC scoring methods on ECG-gated CAC scoring CT have been reported, to our knowledge, no study has evaluated the influence of reconstructed slice thickness on the accuracy of DL-based, automatic CAC scoring software.

Interestingly, the 1.5 mm slice thickness scan showed excellent correlation and agreement but demonstrated less accurate risk group categorization than the 3 mm scans. One reason could be because the majority of misclassification was from AS 0 using the reference standard to AS 1–100 using the automatic method. Thin-slice reconstruction increases sensitivity to detect small calcifications, but also increases image noise. Excessive image noise can mimic small, calcified lesions and lower the reliability of automatic CAC scoring.

The ability to accurately determine the presence and quantify the severity of CAC is important for the assessment of cardiovascular risk (16). The presence of CACs is

Table 4 Numbers and percentages of false-positive and false-negative lesions of automatic CAC scoring software on 1.5 and 3 mm slice thickness reconstructions

False-positive/-negative	1.5 mm slice thickness	3 mm slice thickness
False-positive	n=673	n=128
Wrong vessel segmentation	159	76
LM	76 (47.8)	51 (67.1)
LAD	20 (12.6)	13 (17.1)
LCX	21 (13.2)	5 (6.6)
RCA	42 (26.4)	7 (9.2)
Image noise	447	30
LM	57 (12.8)	2 (6.7)
LAD	92 (20.6)	7 (23.3)
LCX	130 (29.1)	3 (10.0)
RCA	168 (37.6)	18 (60.0)
Aortic wall	29	11
LM	8 (27.6)	4 (36.4)
LAD	0	0
LCX	0	0
RCA	21 (72.4)	7 (63.6)
Myocardium	38	10
LM	0	0
LAD	5 (13.2)	0
LCX	25 (65.8)	6 (60.0)
RCA	8 (21.1)	4 (40.0)
Sternum	1	1
RCA	1 (100.0)	1 (100.0)
Rib	5	
LAD	5 (100.0)	
Metal artifact	1	
LAD	1 (100.0)	
False-negative	n=330	n=208
LM	59 (17.9)	37 (17.8)
LAD	106 (32.1)	72 (34.6)
LCX	70 (21.2)	50 (24.0)
RCA	95 (28.8)	49 (23.6)

Data are number with percentage in the parentheses. CAC, coronary artery calcium; LAD, left anterior descending artery; LCX, left circumflex artery; LM, left main artery; RCA, right coronary artery.

associated with a higher risk of cardiovascular mortality and morbidity than subjects with AS 0, particularly in asymptomatic individuals (17,18). Moreover, the latest guidelines recommend statin therapy initiation in patients with AS >0 or AS >100 (19,20). Thus, false-negative results may lead to the delayed initiation of preventive management. Conversely, false-positive results may lead to unnecessary treatment. In this study, the specificity for detecting AS 0 subjects is high for both 3 mm [458/478 (95.8%)] and 1.5 mm scans [204/281 (72.6%)], and there was no false-negative in 1.5 or 3 mm scans. False-positive misclassification for subject with AS 0 on automatic scoring occurred in 9.1% (77/844) for 1.5 mm scans and 2.4% (20/844) for 3 mm scans. Considering the reported false-positive misclassification rate (1.9–7.0%) in previous studies of the performance of automatic CAC scoring on ECG-gated CT (2,6,15), the false-positive misclassification in our study was in the acceptable range, despite the slightly higher value for 1.5 mm scans.

Our results demonstrated that the automatic scoring adapted well to the lower slice thickness scan, although false-positive results were more frequent. Therefore, the CT protocol must be carefully considered when applying automatic CAC scoring, especially in non-ECG-gated chest CT of various slice thickness values. Generally, scan acquisition and reconstruction parameters such as slice thickness can affect the quantification of reference CAC scores and lead to differences in the agreement of the CAC severity category between ECG-gate CT and non-ECG-gated CT (9). Our study revealed that scan parameter also affects the performance of an automated CAC scoring algorithm. Some researchers have recently proposed DL-based, automatic CAC scoring for non-ECG-gated chest CT and reported good to excellent performance (2,21–23). However, the impact of slice thickness of chest CT on the performance of automated CAC scoring algorithms has not been well investigated in those studies. Our results suggest that further study using various types of training and validation datasets is needed for the generalization and application of automatic CAC scoring for routine clinical use, especially for non-ECG-gated chest CT.

Most of previous studies on the performance of DL-based, automatic CAC scoring (2,3,6,15) did not perform per-lesion analyses. According to Lee *et al.* (6), the main causes of false-positive results (0.11 per patient) were image noise or artifacts (29.1%), which is in line with our observations. However, wrong vessel segmentation (59.3%) was the main cause for false-positive results for 3 mm scans in this study, followed by

image noise (23.4%).

There are limitations to this study. First, all CT scans were conducted at a single center with asymptomatic individuals. Second, a relatively small number (1.5 mm, n=64; 3 mm, n=54) of individuals with high AS (>400) could have skewed our results. Therefore, further multicenter investigations covering larger varieties of the disease spectrum are needed to assess the generalizability of our conclusions. Third, concerns about the accuracy and clinical impact of CAC scores on 1.5 mm scans could be raised because the current standard protocol for CAC scoring scan applies to 2.5 to 3 mm scans. However, the reference standard supported by double readings and a nearly perfect inter-observer agreement for 1.5 and 3 mm scans helped ensure the reliability of the CAC scoring in 1.5 mm scans. In addition, the prognostic value of the CAC scores on ECG-gated CT with 1.5 mm reconstructions should be further investigated in a future study. Fourth, inter-observer agreement was assessed in only small proportion (11.8%) of CT scans for 1.5 and 3 mm slice thickness scans.

In conclusion, automatic CAC scoring shows excellent agreement with the reference standard for both 1.5 and 3 mm slice thickness scans but results in lower agreement to the CAC severity category in 1.5 mm scans. Understanding the influence of slice thickness on the performance of automatic CAC scoring software is necessary when applying it for clinical practice.

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Footnote

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Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The study was approved by the institutional review board of Severance Hospital and individual consent for this retrospective analysis was waived.

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