

Classification of Mild Cognitive Impairment with Multimodal Data using both Labeled and Unlabeled Samples

Shaoxun Yuan, Haitao Li, Jiansheng Wu and Xiao Sun

Abstract—Mild Cognitive Impairment (MCI) is a preclinical stage of Alzheimer’s Disease (AD) and is clinical heterogeneity. The classification of MCI is crucial for the early diagnosis and treatment of AD. In this study, we investigated the potential of using both labeled and unlabeled samples from the Alzheimer’s Disease Neuroimaging Initiative (ADNI) cohort to classify MCI through the multimodal co-training method. We utilized both structural magnetic resonance imaging (sMRI) data and genotype data of 364 MCI samples including 228 labeled and 136 unlabeled MCI samples from the ADNI-1 cohort. First, the selected quantitative trait (QT) features from sMRI data and SNP features from genotype data were used to build two initial classifiers on 228 labeled MCI samples. Then, the co-training method was implemented to obtain new labeled samples from 136 unlabeled MCI samples. Finally, the random forest algorithm was used to obtain a combined classifier to classify MCI patients in the independent ADNI-2 dataset. The experimental results showed that our proposed framework obtains an accuracy of 85.50% and an AUC of 0.825 for MCI classification, respectively, which showed that the combined utilization of sMRI and SNP data through the co-training method could significantly improve the performances of MCI classification.

Index Terms—Mild Cognitive Impairment, Classification, Co-training, sMRI, SNP



1 INTRODUCTION

Alzheimer’s Disease (AD) is a progressive and irreversible complex neurodegenerative disease with responsible for about half a million deaths worldwide per year [1]. Mild Cognitive Impairment (MCI) is considered as a preclinical stage of AD. MCI has clinical heterogeneity [2]. Some MCI patients will stay stable (stable MCI, sMCI) after 10-years’ follow-up or even return to normal cognitive status by timely interventions [3], [4]. Other patients will progress to AD (progressive MCI, pMCI) after a period of time [5] and will die after more than three years [6]. Therefore, the classification of MCI is necessary and urgent for identification and effective therapeutic interventions of early AD.

For AD and normal control (NC) classification, good performances have been reported in many studies. Sun et al. [7] presented an accuracy of 92.8% on AD/NC classification using gray matter density, Zhu et al. [8] acquired a 90.3% accuracy using gray matter volume. Compared to AD/NC classifications, the performances of sMCI/pMCI classification are much lower. Davat-

zikos et al. [9] reported an accuracy of 56% in the classification of MCI samples using structural magnetic resonance imaging (sMRI) data from the Alzheimer’s Disease Neuroimaging Initiative (ADNI) cohort, while the sensitivity was quite high (95%) and specificity was quite low (38%). Sun et al. [7] reported an accuracy of 64% using gray matter density map, Salvatore et al. [10] reported an accuracy of 62% using single sMRI feature, Zhu et al. [11] obtained an accuracy 71.3% using gray matter volumes.

Structural imaging findings are classification markers for neurodegenerative disease. Quantitative trait (QT) markers based on sMRI are sensitive to reflect the first morphological changes in the AD brain [12] and have been proved to be associated with MCI progression [13]. Compared with the computed tomography (CT) and positron emission tomography (PET), sMRI has the advantages of high-quality spatial resolution, sufficient contrast, completely non-invasive and lower cost. Medial temporal lobe atrophy extracted from sMRI can be used as an imaging biomarker of AD, and the accuracy of distinguishing AD patients from normal people is up to 89% [14]. MCI is image heterogeneity. Fleisher et al. [15] found that the brain atrophy pattern of MCI patients is consistent with that of AD patients, that is, the structural changes in the medial temporal lobe make MCI patients more likely to progress to AD,

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while Karas et al. [16] found that MCI patients with atrophy of the left temporal lobe parietal lobe and other structures are more likely to progress to AD. Chupin et al. [17] found that hippocampal volume was a potential imaging marker for predicting whether a MCI patient will convert to AD after 18 months. Querbes et al. [18] found that cortical thickness could predict MCI progression after 24 months.

Genetic factors play important roles in the pathogenesis of MCI and AD. Genetic factors contribute up to 79% to the incidence of AD [19] and *APOE* $\epsilon 4$ is the most significant risk factor of AD. MCI is a genetically complex disease and there is no major risk genetic factor known to be related to MCI [20]. Some studies have shown that *APOE* $\epsilon 4$ is correlated with the high risk of MCI [21], while the correlation was not confirmed in other studies [22][23]. Meanwhile, the roles of some well-known AD-related loci in MCI are not clear. Single nucleotide polymorphism (SNP) can be used as features for classification. Ning et al. reported the ability of AD risk loci in AD/NC classification [24]. Rodríguez et al. [25] selected 8 known AD-related loci and found there was no good discrimination for the classification of MCI.

Multimodal data could reflect the biological mechanism of AD and MCI from different views, and also could provide complementary information in classifications which is robust to noise and data heterogeneity [26]. Several studies combined multimodal data to improve classification performance. Liu et al. [27] combined MRI and PET data through convolutional neural networks in AD/NC classification and the accuracy of multimodality (93.26%) was higher than single modality (84.97% of MRI and 88.08% of PET). Supervised learning and unsupervised learning are the two major directions of traditional machine learning [28]. Supervised learning requires all samples are labeled, while unsupervised learning does not. However, the collection of labeled samples is expensive and time-consuming in practice. Semi-supervised learning (SSL) combines labeled and unlabeled samples to improve the generalization ability and performances of classifiers. Unlabeled samples could be used to estimate the intrinsic geometric structure of the actual data [29] and also can provide feature information during the construction of the classification models. Wu et al. [30] used SSL in diabetes disease diagnostic study, and prediction accuracy was 82.29% compared to the supervised learning classifier with an accuracy of 79.17%. An et al. [31] regarded MCI as unlabeled samples in AD/NC prediction and obtained a 1-2% improvement in accuracy compared with the state-of-the-art method. Co-training is a representative algorithm of SSL, which trains two separately classifiers on two sufficient and redundant views [32], that is, each view is sufficient to learn a classifier and these two views are mutually independent. Sun et al. [33] used labeled and unlabeled data in breast

cancer diagnosis through co-training, and the AUC was 7.4% higher than using labeled data only.

To our knowledge, no study has actually considered both labeled and unlabeled samples to classify MCI from multimodal views. In this study, we investigated the possibility of using both labeled and unlabeled MCI samples in the ADNI cohort through co-training to help to classify MCI samples with multimodal data including baseline sMRI and SNP data. First, we built two separated initial classifiers using selected QT and SNP features on original labeled MCI samples derived from the ADNI-1 cohort. Then, unlabeled MCI samples from the ADNI-1 cohort were used in the co-training processes. Finally, random forest (RF) was used to obtain a combined classifier. MCI samples from the ADNI-2 dataset were applied to evaluate the effectiveness of the methods. The workflow of our research is illustrated in Figure 1.

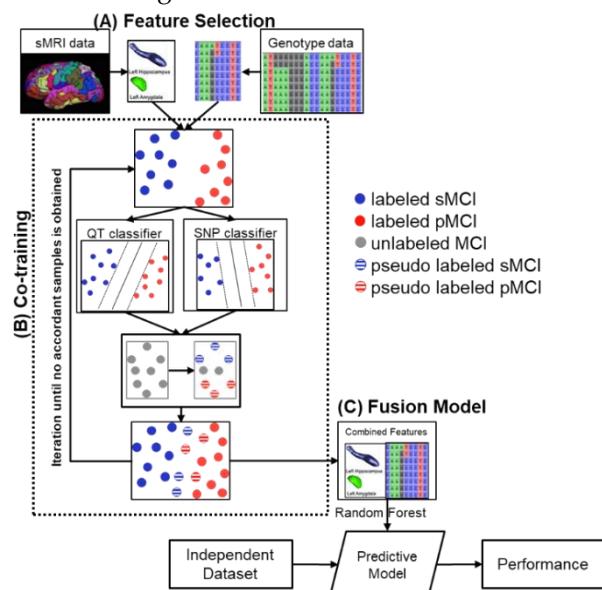


Fig. 1. The workflow of our proposed methods. (A) Feature selection. QT and SNP features are selected from sMRI and genotype data, respectively. SVM is utilized to build initial QT and SNP classifiers using the selected features. (B) Co-training. Unlabeled MCI samples are used in the co-training processes. Two classifiers classify the unlabeled MCI samples and the accordant pseudo labeled sMCI and pMCI samples are added to the labeled MCI samples. (C) Fusion Model. The random forest algorithm is used to obtain a combined classifier. ADNI-2 cohort is used as an independent dataset to evaluate the performance of our predictive model.

2 MATERIALS AND METHODS

2.1 Data Description

Data used in the preparation of this article were obtained from the ADNI database (adni.loni.usc.edu). As such, the investigators within the ADNI contributed

2.4 Feature selections and classification of MCI

Feature selection is an important process that can remove irrelevant, redundant, and noisy features, and directly improve classification performances. Least Absolute Shrinkage and Selection Operator (Lasso) is a popular algorithm for feature selection which penalizes a linear regression model with l_1 -norm [44]. In this study, we used the R packaged names `glmnet` (version 2.0-18) to perform the Lasso method for feature selections. In each round of QT and SNP feature selections, we ran Lasso 100 times and features were ranked by frequency, and features with the same frequency were re-ranked use learning Vector Quantization (LVQ) approach [45]. The selected features of each modal data were based on the feature ranking results. (Figure 1A). The initial QT and SNP classifiers were built on the ADNI-1 labeled MCI samples by SVM method using the selected QT and SNP features.

Co-training [32] is a semi-supervised machine learning method, with which multimodal features and unlabeled samples are used to improve the classification performances. Let L and U represent the labeled and unlabeled MCI datasets, respectively. f_{QT} and f_{SNP} represent the classifiers that were built on L using selected QT and SNP features, respectively. A subset (u) of unlabeled MCI samples were selected from U randomly and classified by f_{QT} and f_{SNP} , respectively. Unlabeled MCI samples classified by QT and SNP classifiers were considered as pseudo labeled MCI samples. s_{QT} and p_{QT} denote the pseudo labeled sMCI and pMCI samples which were classified by f_{QT} respectively, while s_{SNP} and p_{SNP} denote the pseudo labeled samples which were classified by f_{SNP} respectively ($s_{QT} \cup p_{QT} = s_{SNP} \cup p_{SNP} = u$). The accordant pseudo sMCI samples ($s_{QT} \cap s_{SNP}$) and pseudo pMCI samples ($p_{QT} \cap p_{SNP}$) were added to L and the discordant pseudo samples were released back to U . Such processes were iterated until the labels of selected pseudo samples were totally different predicted by the QT classifier and the SNP classifier. As comparisons, we built five different models for the impacts of the different unlabeled sample chosen sizes u (10, 15, 20, 25, and 30) on model performances. The accordant sample sizes and the performances of the combined classifiers of each model are provided in Appendix D. Finally, we got new labeled MCI samples composed of L and accordant pseudo labeled MCI samples (Figure 1B).

Subsequently, the random forest algorithm was used to obtain a combined classifier on the new labeled MCI samples (Figure 1C). RF is a popular algorithm developed by Breiman that uses an ensemble of decision tree classifiers [46]. In our study, the selected QT and SNP features were combined, and the RF algorithm was used to obtain a combined classifier on the new labeled MCI dataset after the iterations were terminated. 83

MCI samples from the ADNI-2 were applied to evaluate the effectiveness of the combined classifier.

2.5 Methods of SNP annotations

To identify the biological significance of the selected SNP loci and corresponding genes, we pursued the following strategies: (1) Ensemble VEP database was used to evaluate the potential effects of SNPs on genes, transcripts, protein sequences and regulatory regions in coding and non-coding regions [47]. (2) HaploReg database was used to explore the regulatory potential and the eQTL information of SNPs [48]. (3) The Brainiac eQTL database was used to analyze the differences in transcriptomic expressions in ten brain regions (cerebellar cortex, frontal cortex, hippocampus, medulla, occipital cortex, putamen, substantia nigra, temporal cortex, thalamus, and white matter) among different genotypes of SNPs [49]. (4) Gene enrichment analysis was performed in STRING database [50].

3 RESULTS AND DISCUSSION

3.1 Sample Statistics

MCI is heterogeneous. The criteria for distinguishing sMCI and pMCI are quite different. Westman et al. [51] categorized 256 sMCI and 62 pMCI according to the diagnostic information of 12-months' follow-up. Cho et al. [52] used 18-months' follow-up as the criterion and obtained 131 sMCI and 72 pMCI. Casanova et al. [53] used 36-months' follow-up and labeled 182 sMCI and 153 pMCI. Wolz et al. [54] categorized MCI samples into sMCI group if a sample was not progressed to AD as of July 2011, and other samples were considered as pMCI. In our views, diagnostic information should be considered at not only a defined time point but also those time points before the defined time point. Meanwhile, samples with diagnosis fluctuate also should not be considered as sMCI or pMCI arbitrary because clinical diagnosis information may be somewhat subjective. Thus in our study, 228 labeled MCI samples from the ADNI-1 cohort were categorized into 115 sMCI and 113 pMCI according to their diagnostic information at 36-months' follow-up, while other 136 MCI samples were considered as unlabeled MCI due to lack of follow-up diagnostic information or diagnosis fluctuate. 83 samples from the ADNI-2 cohort were grouped to 62 sMCI and 21 pMCI according to the previous criterion. The baseline demographic characteristics of all selected MCI samples were summarized in Table 1. In the ADNI-1 cohort, there was no significant difference in age and education year between the sMCI group and the pMCI group ($p = 0.65$, $p = 0.92$, respectively). The sMCI group

had a significantly higher MMSE score and a significantly lower CDR-SB score than the pMCI group ($p = 3.41 \times 10^{-5}$, $p = 2.70 \times 10^{-5}$). The results indicated that the pMCI group showed marked cognitive dysfunctions compared to the sMCI group at baseline in the ADNI-1 cohort.

TABLE 1. The Demographic Characteristics of Selected Samples

	ADNI-1				ADNI-2	
	sMCI	pMCI	uMCI	p-Value	sMCI	pMCI
Number	115	113	136	-	62	21
Gender(F/M)	38/77	40/73	47/89	-	25/37	10/11
Age	74.47 ± 7.27	74.89 ± 6.67	74.85 ± 7.87	0.65	69.61 ± 6.28	72.61 ± 5.35
Edu Year	15.81 ± 2.98	15.85 ± 2.97	15.42 ± 3.13	0.92	16.22 ± 2.54	16.48 ± 2.67
MMSE	27.63 ± 1.67	26.67 ± 1.69	26.79 ± 1.82	3.41×10^{-5}	28.19 ± 1.53	27.67 ± 1.67
CDRSB	1.33 ± 0.63	1.79 ± 0.99	1.69 ± 0.90	2.70×10^{-5}	1.10 ± 0.66	2.24 ± 1.02

Age, education year, MMSE score, and CDRSB score are presented as mean ± standard deviation mode. P-values for differences between the sMCI group and the pMCI group are based on the t-test.

3.2 Selected features for MCI classification

Feature selection is a necessary mid-step, which can reduce computational complexity and improve model performance of machine learning. SNP features reveal molecular-level information, which is complementary to the brain tissue level information from sMRI data. In recent years, a large number of machine learning studies based on multimodal features have been applied in MCI and AD classification and obtained better classification performance than single modal method [55]–[57]. In our study, QT and SNP features were selected from 103 QT features derived from sMRI data and 374 SNP features derived from genotype data, respectively. After feature selection, 32 QT features occur at least one time in Lasso, while 10 QT features with a frequency greater than 60 were selected for further analysis, as shown in Table S3 (Appendix C). Due to the number of SNP features was about 4 times more than QT features, we selected the first 10 top-ranked QT features and the first 40 top-ranked SNP features as input features in our framework (Table 2).

TABLE 2. The First 10 Top-Ranked QT and SNP Features

Rank	QT feature	SNP feature
1	Left Hippocampus Volume	rs9289587.Aa
2	Right Entorhinal Thickness	rs1121030.AA
3	Left Inferiorparietal Thickness	rs677737.AA
4	Right Hippocampus Volume	rs205677.AA
5	Left Amygdala Volume	rs429358.AA
6	Right Supramarginal Thickness	rs892601.AA
7	Right Parsorbitalis Thickness	rs17437668.AA
8	Right Middletemporal Thickness	rs3107546.AA
9	Right Isthmuscingulate Thickness	rs6776238.AA
10	Left Fusiform Thickness	rs2051947.AA

The full list of the selected SNP features is shown in Table S4 (Appendix C).

For QT features, left/right hippocampus, left amygdala, right entorhinal cortex, right isthmus cingulate belong to the limbic system. These structures and right

middle temporal belong to the temporal lobe. Left inferior parietal and right supramarginal belong to the parietal lobe. Right pars orbitalis and left fusiform are part of the frontal lobe and occipital lobe, respectively. The selected QT features in our study, especially such as hippocampus volume, amygdala volume, and entorhinal thickness, have been reported as specific biomarkers for MCI classifications in many previous studies [58].

Genetic factors such as SNP also can be used in disease predictions. As far as we know, no study has applied GWAS-based SNP features for MCI classification. The first 40 top-ranked SNP features belong to 39 SNP loci. The selected SNP loci were belonged to 35 corresponding genes, as shown in Table S4 (Appendix C). Among them, some are putative AD susceptibility genes in previous studies, including *OR5K3* [59], *APOE* [56], *ATXN1* [60], *ADAMTS1* [61] and *SLC10A2* [62]. Some are brain-related or other neurodegeneration disease-related genes, such as *NAPG* [63], *ATP2B2* [64], *ZFPM2* [65], *RUNX1* [66], *CHODL* [67] and *TLE1* [68], being possible candidates for MCI progressive susceptibility. Our selected SNP features may provide an overview of potential genetic mechanisms underlying the heterogeneity of MCI.

To identify the biological significance of the selected SNP loci, we evaluated the effects of all SNP loci on genes, transcripts, and protein sequences, as well as regulatory regions using Ensemble VEP database. Consistent with most studies that most complex disease causal variants are non-coding, only 3.5% the selected SNP loci were exonic variants, with the majority were intronic variants (39.5%), transcript variants of non-coding RNA genes (18.6%) and intergenic variants (16.3%) (Figure 3).

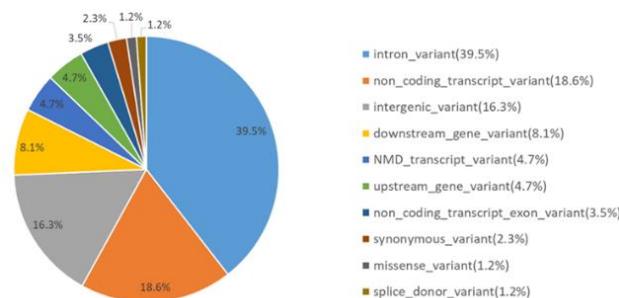


Fig. 3. Percentage of Ensemble Variant Effect Predictor (VEP) consequences of the selected SNP loci. NMD, nonsense-mediated mRNA decay.

For eQTL analyses, we searched the HaploReg database for cis-acting eQTL of the selected SNP loci (Table S2). Of these SNP loci, 37 of them have regulatory potential when considering all tissues according to HaploReg database. A total of 19 SNP loci have eQTL information, and four SNP loci are brain-tissue specific eQTLs (Table 3). SNP rs429358 is the most significant

risk loci of AD and MCI, and is cis-eQTL for *APOE* expression in the human brain [69]. Rs17437668, rs677911 and rs2261950 are eQTLs for *CCDC53*, *MCOLN2* and *HLA-L*, respectively. *CCDC53* was related to the dysfunction of retromer. Retromer was reported to play an important role in the pathological mechanism of dementia in many researches. Retromer transports amyloid precursor protein (APP) to the surface of neurons to keep them from decomposing into the toxic beta-amyloid protein in the endosomes [70], [71]. *MCOLN2* encodes a mucolipin protein. *TRPML1*, a homologous gene of *MCOLN2*, has been found through regulating PPAR γ /AMPK/Mtor Signalling Pathway involved in the progress of AD [72]. *HLA-L* is a family member of human leukocyte antigen (*HLA*) genes. *HLA* genes have been demonstrated to be involved in the progression and pathogenesis of AD [73].

TABLE 3. Brain-Tissue Specific eQTL

Rank	SNP	Tissue	Correlated gene(alias)
5	rs429358	Lymphoblastoid	<i>APOE</i>
7	rs17437668	Brain_Hypothalamus	<i>CCDC53 (WASHC3)</i>
32	rs677911	Brain_Cortex	<i>MCOLN2 (TRPML2)</i>
36	rs261950	Brain_Hippocampus	<i>HLA-L</i>

We searched Braineac database to identify whether these three SNP loci affect corresponding gene expressions or not in ten brain tissues. Significant association between the genotype of rs17437668, rs677911, and *CCDC53*, *MCOLN2* expression level were found (Figure 4). The T allele and especially TT genotype of rs17437668 decreased the *CCDC53* expression in the cerebellar cortex (p=0.018). The G allele and especially GG genotype of rs677911 decreased the *MCOLN2* expressions in the hippocampus (p=0.044), white matter (p=0.031), occipital cortex (p=0.004) and temporal cortex (0.016). Rs261950 is not available in Braineac database.

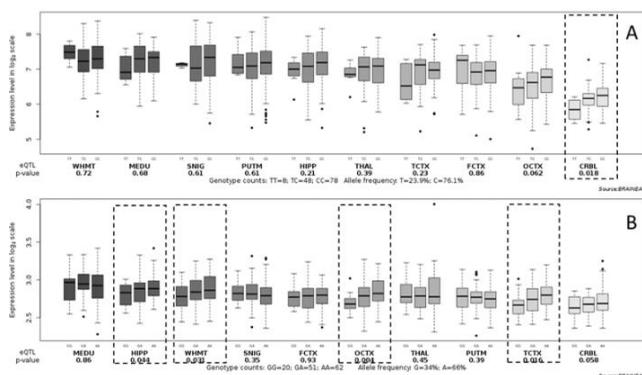


Fig. 4. (A) Effects of rs17437668 genotype on brain *CCDC53* expression level. (B) Effects of rs677911 genotype on brain *MCOLN2* expression level. CRBL, cerebellar cortex; FCTX, frontal cortex; HIPP, hippocampus; MEDU, medulla; OCTX, occipital cortex; PUTM, putamen; SNIG, substantia nigra; TCTX, temporal cortex; THAL, thalamus; WHMT, white matter.

We also conducted Reactome pathway enrichment analyses of our 35 genes using STRING database [50]. There were two significant Reactome pathways, including ion channel transport (HSA-983712) and transport of small molecules (HSA-382551), as shown in Table 4. “Ion channel transport” is the sub-pathway of “transport of small molecules” in Reactome database. Transport of small molecules across the blood-brain barrier plays an important role in the drug delivery of AD [74]. Besides, Furukawa et al. [75] found that the channel proteins on the cell surface are related to AD, and the opening or closing of these channel proteins may be the key to the onset of the AD.

TABLE 4. Significant Reactome Pathway (False Discovery Rate < 0.05)

Pathway	Description	Genes
HSA-983712	Ion channel transport	ATP2B2,ATP6V1C1,BSND,MCOLN2
HAS-382551	Transport of small molecules	ATP2B2,ATP6V1C1,BSND,MCOLN2, APOE,RUNX1,PCSK6

3.3 Classification performances

First, we built two initial SVM classifiers on 228 original labeled MCI samples from the ADNI-1 cohort using 10 selected QT features and 40 selected SNP features. 20 unlabeled MCI samples were selected from 136 unlabeled MCI samples and utilized in each co-training iteration. After 21 times iterations, 69 unlabeled MCI samples were labeled including 61 pseudo sMCI and 8 pseudo pMCI samples (Appendix D), and no accordant pseudo samples were observed between QT and SNP classifiers. Finally, random forest algorithm was used to obtain a combined classifier on the 297 labeled MCI samples including 228 original labeled samples and 69 pseudo labeled samples. 83 MCI samples from the ADNI-2 cohort including 62 sMCI and 21 pMCI samples were used as an independent dataset to examine the effectiveness of our methods. The performances of the single modal QT, the single modal SNP, and the combined RF classifiers before and after co-training are listed in Table 5. Accuracy (ACC), sensitivity (SEN), specificity (SPE), precision (PRE) and area under the curve (AUC) were reported in our study. The ROC curves the single modal QT, the single modal SNP and the combined RF classifiers before and after co-training are shown in Figure 5. The AUC of the combined RF classifier was improved from 0.767 to 0.825 after co-training, as shown in Table 5.

TABLE 5. Classification Performances of the Classifiers Before and After Co-training

		ACC(%)	SEN(%)	SPE(%)	PRE(%)	AUC
before co-training	QT	57.83	90.48	46.77	36.54	0.719
	SNP	75.90	33.33	90.32	53.85	0.607
	RF	72.30	85.70	67.70	47.37	0.767
after co-training	QT	77.11	57.14	83.87	54.55	0.734
	SNP	53.01	76.19	45.16	32.00	0.601
	RF	85.50	76.20	88.70	72.22	0.825

ACC: Accuracy; SEN: Sensitivity; SPE: Specificity; PRE: precision; AUC: Area Under the Curve; QT: quantitative trait; SNP: Single Nucleotide Polymorphism; RF: Random Forest;

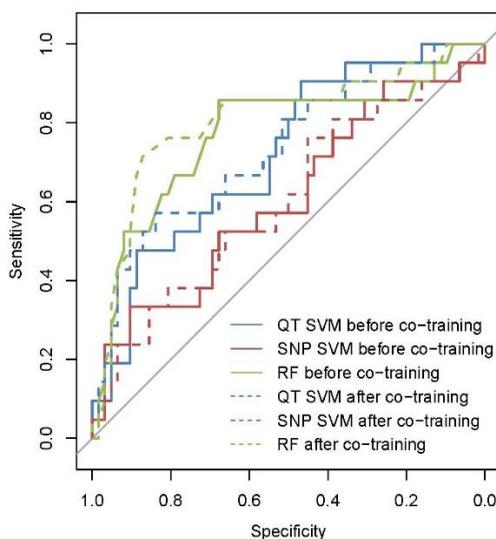


Fig. 5. ROC curves for the QT, SNP, and combined RF classifiers before (solid curve) and after (dashed curve) co-training.

As shown in Table 5, co-training greatly improves the specificity at the price of the sensitivity of combined RF classifier. The sensitivity measures the proportion of correctly identified positive samples (pMCI) while the specificity measures the proportion of correctly identified negative samples (sMCI). For the combined RF classifier before co-training, the potential reason of high sensitivity but low specificity is: many of the sMCI samples are likely to become pMCI and progress to dementia in the near future due to the heterogeneity of MCI [76]. For the combined RF classifier after co-training, the potential reason for the greatly improved specificity at the price of sensitivity is: more pseudo labeled sMCI were selected during co-training processes than pMCI (Table S6, Appendix D), which made the new labeled dataset class imbalanced. In a class imbalanced dataset, the majority class (sMCI) will have a higher accuracy in

prediction and the minority class (pMCI) will have a low accuracy [77]. Considering the low sample size of pMCI, we also reported precision in our study (Table 5). The precision of the combined RF classifier was improved from 47.37% to 72.22% after co-training.

We evaluated our model on the 83 independent samples from the ADNI-2 cohort, 70 samples were classified correctly but 13 samples were classified incorrectly. Two possible reasons, the sample labels or the feature data, may lead to the incorrect classifications. One possible reason is that the incorrect classified sMCI samples may progress to dementia, while the incorrect classified pMCI may back to MCI after a short time. Thus, we investigated later-than-36-months` diagnoses of these incorrect classified samples. The results showed that the diagnoses of these samples with later-than-36-months` diagnosis available were consistent with their diagnosis at 36-month`s (Table S7; Appendix E). We suspected that the sample labels may not be the reason for the incorrect classifications in our study. Another possible reason for the incorrect classifications is that the data distribution of the incorrect classified dataset is more different from the ADNI-1 cohort than the correct classified dataset. A dataset larger than the ADNI-2 cohort should be considered to confirm our hypotheses in future research.

3.4 Comparison with current models

In this section, we compared the performances between our method and previously published studies for the prediction of MCI progression (Table 6). We limited the performance comparisons to studies that used omics data from ADNI database. The conversion time which used to define progressive MCI has a strong influence on results [56] and is a part of the heterogeneity of MCI. Therefore, studies with different conversion times were also included in comparisons.

Previously published studies and our present study used different labeling criteria or different modality data or different evaluation methods, which made the performance comparison indirectly when using accuracy metric. Thus, we used AUC, a robust measurement for performance evaluation [78], to compare the performances among our model with other studies. By comparing with similar studies, it can be seen that the performances of our methods are comparable with other studies, even in an independent cohort.

TABLE 6. Comparison of Performances for sMCI/pMCI Classification

Study	N (sMCI, pMCI)	Conversion period	Modality	Validation	ACC	SEN	SPE	AUC
Cho et al. (2012)	203(131,72)	0-18 months	MRI	Independent dataset	71.0%	63.0%	76.0%	-
Cuingnet et al.(2011)	195(62,133)	0-18 months	MRI	Independent dataset	67.0%	62.0%	69.0%	-
Zhang et al. (2012)	88(50,38)	0-24 months	MRI,PET,CSF	Cross validation	78.0%	79.0%	78.0%	0.77
Lebedev et al. (2014)	139(16,123)	0-24 months	MRI	Independent dataset	82.0%	83.0%	81.0%	-
Beheshti et al.(2017)	136(65,71)	0-36 months	MRI	Cross validation	75.0%	76.9%	73.2%	0.75
Westman et al.(2012)	162(81,81)	0-36 months	MRI,PET	Cross validation	68.5%	74.1%	63.0%	0.76
Young et al.(2013)	143(96,47)	0-36 months	MRI,PET,APOE	Leave one out	74.1%	78.7%	65.6%	0.795
Moradi et al.(2015)	264(100,164)	0-36 months	MRI	Cross validation	74.7%	88.9%	51.6%	0.766
Hu et al.(2016)	131(62,71)	0-36 months	MRI	Leave one out	76.7%	71.8%	82.3%	0.79
Hinrichs et al.(2011)	-	0-36 months	MRI,PET	Leave one out	--	-	-	0.74
Wee et al.(2013)	200(111,89)	0-36 months	MRI	Independent dataset	75.1%	75.1%	63.5%	0.842
Davatzikos et al.(2011)	239(170,69)	0-36 months	MRI,CSF	Cross validation	61.7%	-	-	0.734
Misra et al. (2009)	103(76,27)	0-36 months	MRI	Cross validation	82.0%	-	-	0.77
Present study	228(115,113)	0-36 months	MRI,SNP	Independent dataset	85.5%	76.2%	88.7%	0.825

N: Number of samples; Conversion period: length of time over which MCI conversion is defined; MRI: magnetic resonance imaging; ACC: Accuracy; SEN: Sensitivity; SPE: Specificity; AUC: Area under the curve;

Researchers usually used single-source data, such as MRI, for classifying sMCI and pMCI at different time points of MCI progression. For example, Cho et al. [52] and Cuingnet et al [79] used 18-months' follow-up as the criterion and MRI data to distinguish sMCI and pMCI (accuracy=71.0% and 67.0%). Querbes et al. [18] utilized 24-months' follow-up as the criterion and labeled 50 sMCI and 72 pMCI, and used baseline normalized thickness index from MRI to classify sMCI and pMCI (accuracy=73.0%). 36-months' follow-up was a common-used criterion for sMCI/pMCI classifications in many researches. Wee et al. [80] used the correlation between the average thickness of the cortical regions of interest to conduct SVM classification and obtained surprisingly high accuracy (AUC = 0.84). Beheshti et al. [81] developed a novel diagnosis method that use feature-ranking and a genetic algorithm, and classify MCI using baseline MRI data through standard SVM (AUC=0.75). Other three studies from Moradi et al [82], Hu et al. [83], and Misra et al. [84] achieved AUC of 0.766, 0.79, and 0.77 from MRI data, respectively. It has been proved that features from multimodal data share complementary information for disease diagnoses. Zhang et al. [85] used 24 months' follow-up and multi-modal data to predict MCI progression and obtained an AUC of 0.77. Westman et al. [57] used a multivariate approach that included MRI and PET markers for predicting MCI-to-AD progression and obtained an AUC of 0.76. Young et al. [86] also introduced a novel method using Gaussian process classification to classify sMCI and pMCI through integrating MRI, PET and APOE genotype (AUC=0.73). Hinrichs et al. [87] obtained an AUC of 0.74 from MRI and PET data, while Davatzikos et al [76] obtained an AUC of 0.734 from MRI and CSF biomarkers.

4 CONCLUSIONS

In summary, we presented a framework with multimodal data using both labeled and unlabeled samples for MCI classification. Our results showed that the combined utilization of sMRI and SNP data through the co-training method could significantly improve the performances of MCI classification in the independent dataset, suggesting that brain structure data and genetic data represent different aspects, and are complementary to each other. There are two main directions in future work. First, the unlabeled dataset should be much larger than the labeled dataset to allow for better improvements after co-training. However, the number of unlabeled samples was limited in our study and the performance could be improved by using different data sources. The other point was low-quality unlabeled samples might degrade the classification performances, and techniques such as data editing should be used in the identification and elimination of these abnormal samples.

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