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Improved ultrasound attenuation measurement method for the non-invasive evaluation of hepatic steatosis using FibroScan[®]

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1 **Abstract**

2 Controlled Attenuation Parameter (CAP) is a measurement of ultrasound attenuation used to
3 assess liver steatosis non-invasively. However, the standard method has some limitations. We
4 aimed to assess the performance of a new CAP method by ex vivo and in vivo assessments.
5 The major difference with the new method is that it uses ultrasound data continuously acquired
6 during the imaging phase of the FibroScan examination. Seven reference tissue-mimicking
7 phantoms were used to test the performances. In vivo performances were assessed on two
8 cohorts (in total 195 patients) of patients using magnetic resonance imaging proton density fat
9 fraction (MRI-PDF) as a reference. The precision of CAP was improved by more than 50% on
10 tissue-mimicking phantoms and between 22% and 41% in the in vivo cohort studies. The
11 agreement between both methods was excellent and the correlation between CAP and MRI-
12 PDFF improved in both studies (0.71 to 0.74, 0.70 to 0.76). Using MRI-PDFF as a reference,
13 the diagnostic performance of the new method was at least equal or superior (area under the
14 receiver operating curve 0.889 to 0.900, 0.835 to 0.873). This study suggests that the new
15 continuous CAP method can significantly improve the precision of CAP measurements ex vivo
16 and in vivo.

17 **Keywords**

18 Ultrasound attenuation, Controlled Attenuation Parameter (CAP), Liver, Steatosis,
19 Elastography, Vibration-Controlled Transient Elastography (VCTE), FibroScan, Proton
20 Density Fat Fraction (PDFF).

1 **Introduction**

2 Nonalcoholic fatty liver disease (NAFLD) is a one of the leading causes of liver disease, found
3 in 20-25% of adults in the developed world (Younossi, et al. 2016). About half of NAFLD
4 patients are obese, with the prevalence of NAFLD in nonobese or lean patients at 15.7% and
5 10.2%, respectively (Harrison, et al. 2021). It has also been reported that 26% of American
6 obese children have NAFLD (Elizabeth, et al. 2019). Thus, it has major health and economic
7 burdens. The severity is worsened as NAFLD can go undetected for some time, increasing the
8 risk of it developing into the more advance and progressive form of nonalcoholic steatohepatitis
9 (NASH), which can manifested further into cirrhosis and liver cancer. A recent study (Harrison,
10 et al. 2021) reported the overall prevalence of NAFLD was 38% and 14% for NASH confirmed
11 by biopsy in a cohort of asymptomatic middle-aged American adults. NAFLD is defined as
12 hepatic steatosis, which is the accumulation of triglycerides within hepatocytes that exceeds 5%
13 of liver weight. Liver biopsy is the gold standard method to assess liver steatosis (Bravo, et al.
14 2001), but it carries strong limitations due to its invasiveness and potential sampling error
15 (Ratziu, et al. 2005, Shahin Merat, et al. 2012).

16 Due to the increasing prevalence of NAFLD and the limitations of liver biopsy for diagnosis,
17 there is a strong need for non-invasive tests to accurately detect hepatic steatosis. Magnetic
18 resonance imaging derived proton density fat fraction (MRI-PDFF) has emerged as a leading
19 non-invasive modality for the assessment of hepatic steatosis (Reeder, et al. 2012, Tang, et al.
20 2013), and as a reliable alternative to the histological assessment of hepatic steatosis in patients
21 with NAFLD (Tang, et al. 2014). However, a wide application of this modality is impaired by
22 its cost and availability. Ultrasound (US) techniques have been proposed since fatty liver is
23 associated with increased US attenuation (Lu, et al. 1999, Gaitini, et al. 2004). In fact, lipid
24 droplets can greatly contribute to energy absorption during US propagation due to their typical
25 dimension in liver tissue (Kanayama, et al. 2013).

1 US attenuation measurement using controlled attenuation parameter (CAP) (Sasso, et al. 2010,
2 Sasso, et al. 2012, Sasso, et al. 2016) (Echosens, Paris, France) was introduced in 2010 to assess
3 liver steatosis non-invasively. CAP measures the attenuation of the US beam that travels
4 through the liver tissue, usually at a frequency of 3.5 MHz. It is available on the FibroScan (FS)
5 device which concomitantly assesses CAP and liver stiffness using vibration-controlled
6 transient elastography (VCTE) (Sandrin, et al. 2003, Tapper, et al. 2015). The operation of
7 FibroScan does not require special skills in US. CAP can be measured using both M and XL
8 probes. The CAP final results are the median and the interquartile range (IQR) of several
9 (typically 10) manually triggered sequential measurements of US attenuation. CAP is expressed
10 in dB/m and ranges from 100 to 400.

11 Several US scanner manufacturers have recently introduced alternative methods to assess US
12 attenuation using B-mode US: ATT (Hitachi Ltd, Japan) (Iijima 2018), ATI (Canon Medical
13 Systems, Japan) (Tamaki, et al. 2018, Koizumi, et al. 2019), and UGAP (GE Healthcare, USA)
14 (Fujiwara, et al. 2018, Bende, et al. 2020), UDFE (Siemens Healthineers, Germany) (Labyed
15 and Milkowski 2020). However, US scanners require that the operator be skilled in US as they
16 must select manually a region of interest on the US image to assess the liver tissue. This can be
17 an advantage in the presence of a liver lesion which would not be detected using FS due to the
18 lack of 2D US imaging.

19 Despite CAP being a good surrogate marker of hepatic steatosis (De Lédinghen, et al. 2014,
20 Cardoso, et al. 2016, De Lédinghen, et al. 2016, De Lédinghen, et al. 2017, Karlas, et al. 2017,
21 Naveau, et al. 2017, Thiele, et al. 2018) and has the ability to monitor the improvement of
22 hepatic steatosis in patients with NAFLD (Paul, et al. 2018, Eddowes, et al. 2019) it has several
23 limitations with its current measurement method. CAP accuracy for detecting fatty liver
24 declines in the presence of high variability (Wong, et al. 2017). In addition, studies on the inter-
25 observer concordance in the CAP values have shown that the mean difference in CAP values
26 between two observers is up to 20 dB/m (Recio, et al. 2013, Ferraioli, et al. 2014). Hence, this

1 difference should be considered in longitudinal follow-up of patients. Lower performances for
2 detecting fatty liver were reported when the IQR is superior to 40 dB/m (Wong, et al. 2017,
3 Mendes, et al. 2018). Whereas another study shows that CAP variability seems to have no
4 influence on diagnostic performance (Naveau, et al. 2017). The main cause of variability is the
5 sensitivity of CAP to the presence of heterogeneities from blood vessels and nodules in the US
6 signal (Audière, et al. 2013). Furthermore, the distribution of steatosis in the liver may be
7 heterogeneous (Qayyum, et al. 2012, Bannas, et al. 2015). [Recent studies \(Fujiwara, et al. 2018,](#)
8 [Ferraioli, et al. 2019, Ferraioli, et al. 2020\)](#) report that US attenuation measurements using B-
9 mode techniques perform significantly better than CAP for steatosis detection with MRI-PDFF
10 as a reference. This increased performance may be attributed to the manual selection of the ROI
11 in the B-mode image which allows the exclusion of structures that may affect the measured
12 values and to the larger 2D ROI which is used to assess ultrasound attenuation. The lack of
13 robustness and precision of the CAP by the standard method is a possible source of suboptimal
14 performances (Petroff, et al. 2021).

15 We have developed an alternative method for CAP measurement, which uses continuous CAP
16 during the imaging phase of the examination with the FS device that we propose will improve
17 the precision of CAP measurement using FS. The aim of this study was to validate the
18 performances of the new method on tissue-mimicking phantoms and retrospectively in cohorts
19 of patients using MRI-PDFF as a reference.

20 **Material and method**

21 **Standard CAP method**

22 CAP measures the US attenuation using US signals collected with the single element US
23 transducer located at tip of the probe of the FS device. Using the standard CAP method, the
24 final CAP results include the median and the IQR (expressed in dB/m) of the individual US
25 attenuation measurements performed during the examination with the FS device. [Individual US](#)

1 attenuation measurements are estimated by processing the US data collected for the shear wave
2 speed measurements, triggered manually by the operator, from which stiffness measurements
3 are derived (Sandrin, et al. 2003). The recommended number of US attenuation measurements
4 is typically 10 since it is recommended that operators perform 10 valid stiffness measurements.
5 Given that a shear wave speed measurement lasts 80 ms, the US attenuation measurements are
6 typically collected during a cumulative duration of less than one second. These individual
7 measurements are distributed over the entire duration of the examination. FS can be used with
8 three different probes (S, M and XL). The standard CAP method is only compatible with M and
9 XL probes (Sasso, et al. 2016). The measurement depths and center frequency with M and XL
10 probes are 25-65 mm and 3.5 MHz, 35-75 mm and 2.5 MHz, respectively. Although the US
11 transducer center frequency is different on the M probe and XL probe, the US attenuation is
12 computed at the same US frequency of 3.5 MHz, leveraging the large bandwidth of US
13 transducers. The lower and upper limits for CAP measurement are 100 dB/m and 400 dB/m,
14 respectively.

15 Principle of the new method (continuous CAP)

16 The main difference between the current and the new method is that the new method uses US
17 signals acquired continuously during the imaging phase of the examination with the FS device.
18 For clarity reasons, the new method will therefore be named ‘continuous CAP method’ in this
19 document. The continuous CAP method is as automated as the initial method. The influence on
20 the operation of the device is very limited. Moreover, the proprietary algorithm (Sasso, et al.
21 2010, Sasso, et al. 2012, Sasso, et al. 2016) used to compute the individual US attenuation
22 measurements using the US signal is identical in both methods. Contrarily to the standard CAP
23 method, the continuous CAP method is compatible with all probes including the S probe
24 (Ferraioli, et al. 2012), which uses a center frequency of 5.0 MHz. The US attenuation is
25 computed at the same US frequency of 3.5 MHz whatever the probe model being used.

1 Three major improvements are implemented in the continuous CAP method. First, the number
2 of individual US attenuation measurements from which CAP is calculated is higher and
3 corresponds to a larger volume of liver tissue sampled. Second, the US signals are qualified
4 using a dedicated validity criteria. And third, the measurement depths are adapted
5 automatically.

6 Increased volume sampling

7 The volume of liver tissue sampled with the standard and continuous CAP methods are
8 schematically represented in figure 1. Using the continuous CAP method, the CAP value is
9 derived from US attenuation measurements which are computed from the US signals acquired
10 continuously in real-time during the imaging phase of the FS examination (i.e., FS imaging
11 mode between stiffness measurements) at a repetition frequency of 20 Hz. At least 200 US
12 attenuation measurements are recommended with the continuous CAP method, which
13 correspond to at least 10 seconds of US acquisition; much larger than the less than 1 second
14 acquisition used with the standard CAP method. Furthermore, during this acquisition time, the
15 liver moves in front of the probe due to breathing with a frequency of approximately 0.5 Hz,
16 and an amplitude of 20 mm, mainly in the cranio-caudal direction (Bussels, et al. 2003).

17 Selection of US signals

18 The selection of US signals used to compute the final CAP value is different in both methods.
19 In the standard CAP method, US signals are selected based on the validity of the shear wave
20 propagation induced when the operator presses on the probe button. In the continuous CAP
21 method, US signals are selected based on the US characteristics of the signals. The selection of
22 US signals is performed automatically using the Liver Targeting Tool (LTT) (Audière, et al.
23 2013), which assesses the absence of heterogeneities in the US signal. LTT is displayed in real-
24 time on the screen of the FS during the examination to assist the operators in finding an optimal
25 measurement site.

26 Measurement depths automated adjustment

1 The continuous CAP method includes an automated adaptation of the measurements depths
2 based on the probe to liver capsule distance (PCD) (Audière, et al. 2010). The purpose is to
3 avoid biases of US attenuation measurements in the presence of subcutaneous tissues in the
4 region of measurements. Several depth ranges are available depending on the probe model: 25-
5 65 mm or 30-70 mm with the M probe, 35-75 mm, 40-80 mm or 45-85 mm with the XL probe.
6 With the S probe, depth ranges are selected manually at the beginning of the exam and
7 correspond to the stiffness measurement depths (S1: 15-40 mm, S2: 20-50 mm).

8 Examination outputs

9 Given the large number of individual measurements collected with the continuous CAP method,
10 a normal distribution of measurements is observed. The final CAP results are expressed as the
11 mean and standard deviation (SD).

12 Test on tissue-mimicking phantoms

13 Tissue-mimicking phantoms characteristics

14 The standard CAP and continuous CAP methods were tested on seven custom reference tissue-
15 mimicking phantoms (Gammex INC, Middleton, WI, USA), which US attenuations are 95, 142,
16 207, 249, 339, 403 and 475 dB/m, with an uncertainty ± 20 dB/m. Reference US attenuation
17 values were measured at the Wisconsin Institute of Medical Research (Madison, WI 53705,
18 USA) for each phantom using a sample of each batch material. A standard narrowband through-
19 transmission substitution technique (Madsen, et al. 1982) was used.

20 Test method

21 The continuous CAP method was evaluated with S, M and XL probes while the standard CAP
22 method was only evaluated with M and XL probes given that the S probe is not compatible. US
23 acquisitions measurements were performed with a FS device acquisition platform connected to
24 a standard computer running Matlab (Mathworks, Natick, MA, USA). The shear wave

1 generation was disabled since the reference US attenuation phantoms were too stiff to obtain
2 valid stiffness measurements. Each set of measurements consisted in scanning a phantom by
3 moving the probe in the center (20 x 20 mm²) of the phantom surface. A motorized linear
4 translation stage (Newport Corporation, Irvine, CA, USA) was used to move the probes at the
5 surface of the phantom, with a displacement speed of 20 mm/s. Acquisitions for the assessment
6 of the continuous CAP method were performed while the probe was moving at the surface of
7 the phantom to mimic the liver movement during the FS imaging mode, allowing to achieve
8 200 US attenuation measurements. Acquisitions for the assessment of the standard CAP method
9 were performed with a step by step displacement of the probe at the surface of the phantom to
10 mimic the acquisition of US signals during the FS sequential stiffness measurements. Ten
11 individual measurements were performed at 10 different locations within the same region of
12 interest used with the continuous CAP method. Acquisitions for both methods were performed
13 at the same depths. Due to the large distribution of the reference US attenuation of tissue-
14 mimicking phantoms, the lower and upper limits for CAP measurement were set to 50 dB/m
15 and 500 dB/m, respectively.

16 Statistical analysis

17 The Shapiro-Wilk test was used to assess the normal distribution of the measurements
18 performed with both methods. For comparison purposes, the standard CAP results were
19 expressed as the mean (instead of median for the standard CAP method) of all performed
20 measurements. The CAP precision is expressed as the SD. The significance of the precision
21 difference between the two methods is achieved through a Student's-test.

22 The intra-class coefficient (ICC) was used to assess the agreement between the two methods
23 and the reproducibility on phantoms, as suggested in (Raunig, et al. 2015). Two other probes
24 of each type were used to estimate the reproducibility of both methods. Agreement was
25 classified as poor (ICC = 0.00-0.20), fair to good (ICC = 0.40-0.75) or excellent (ICC > 0.75)
26 (Fleiss, et al. 2013).

1 In vivo studies

2 The comparison between both CAP methods was performed using clinical data collected during
3 two different studies (study cohorts A and B). MRI-PDFF was used as a reference to identify
4 the ability of both CAP methods to identify patients with a MRI-PDFF of more than 5%. The
5 study protocols conformed to the ethical guidelines of the 1975 Declaration of Helsinki and was
6 approved by the local Ethic committee. Patients were enrolled after written informed consent
7 was obtained. For both study cohorts, CAP measurements were performed with a FibroScan
8 502 Touch configured to record the raw US radio-frequency signals collected during the whole
9 FS examinations. The operators were following the training requirements relative to the
10 standard measurements of liver stiffness by VCTE and CAP. The continuous CAP method was
11 evaluated retrospectively by reprocessing the raw data recorded in examination files of the
12 standard CAP method.

13 Study cohort A

14 Patients referred for a routine liver screening with no prior history of liver disease or alcohol
15 abuse were offered to participate in this prospective prevalence study. All patients who
16 underwent CAP and MRI-PDFF examinations at the Brooke Army Medical Center (San
17 Antonio, Texas, USA) between January 2016 and December 2016 were eligible. MRI-PDFF
18 results were reprocessed with Liver MultiScan IDEAL algorithm (Hardy and Mcpherson 2017)
19 (liver MultiScan™, Perspectum Diagnostics, Oxford, England), which assesses hepatic
20 steatosis, fibrosis and iron content. Region of interest (ROI) was positioned by the clinician on
21 the MRI-PDFF parametric image, taking the most representative area. This area is positioned
22 without taking into account the position of the FS measurement.

23 A total of 201 consecutive patients fulfilled the inclusion criteria (male and female patients, age
24 18 to 80), and consisted of retired and active military personnel and their dependents. Among
25 them, 74 were excluded because the MRI-PDFF could not be performed and 14 because the

1 delay between FS and MRI-PDFF examinations was superior to 100 days. Finally, the study A
2 included 113 patients.

3 Study cohort B

4 Patients referred for a liver MRI examination were offered participation in a prospective
5 prevalence study. All patients who underwent CAP and MRI-PDFF examinations at the
6 ACRIM-Polyclinique Saint-Côme (Compiègne, France) between February 2017 and October
7 2018 were eligible. MRI-PDFF ROI in liver were placed at nearly the same location as the
8 ROI of the FS examination (Bensamoun, et al. 2008, Ternifi, et al. 2018)

9 A total of 90 consecutive patients fulfilled the inclusion criteria (male and female patients, age
10 18 to 80). Among them, five were excluded because the CAP files with raw US data were
11 unusable (corrupted files) and two patients because the matching between FS and MRI
12 examinations was not possible. One patient was also excluded because MRI-PDFF was not
13 performed. Finally, the study B included 82 patients.

14 The two study cohorts were not pulled as they involved different MRI devices associated with
15 different algorithms for the reconstruction of MRI-PDFF maps. Furthermore, the ROI
16 placements were performed by two different teams, with two different techniques as explained
17 above.

18 Magnetic Resonance Imaging

19 MRI-PDFF magnetic resonance imaging-based phenotyping was performed using 1.5T MRI
20 devices (Avanto, Siemens, and Signa HDx, General Electric). Patients were in the supine
21 position. MRI-PDFF results were estimated using the Dixon 3 points method (Ma 2008) in both
22 studies.

23 Statistical analysis

24 CAP results were expressed as the median and the mean of all valid measurements for the
25 standard CAP method and the continuous CAP method, respectively. SD was used to assess the

1 precision of both methods to ease the comparison. The significance of the precision difference
2 between the two methods is achieved through a Student's-test.

3 The ICC were used to assess the agreement between the two methods. [A Bland Altman analysis](#)
4 [was used to determine the bias between the two methods.](#)

5 Data collected in vivo were used to assess the performance of both CAP methods versus MRI-
6 PDFF. Pearson's rank correlations were used to evaluate the relationship between CAP values
7 and log MRI-PDFF. Correlation obtained with both CAP methods were compared using the
8 Hittner's test. The test is significant if the p-value is <0.05 . The performance of both CAP
9 methods for identifying patients with hepatic steatosis defined by MRI-PDFF of more than 5%
10 was assessed using a Receiver Operating Characteristic (ROC) analysis. The diagnostic
11 performance was evaluated in terms of area under the receiver operating curve (AUROC).
12 AUROC obtained with both CAP methods were compared using the Delong test (difference
13 test and non-inferiority test with a 0.02 margin). The test is significant if the p-value is <0.05 .
14 CAP cut-off values were estimated by maximizing sensitivity and specificity (Youden's index).
15 A linear fit was performed between CAP (in dB/m) and the logarithmic transformation of MRI-
16 PDFF (in percentage). All statistical analyses were performed using the R software (The R
17 Foundation for Statistical Computing, Vienna, Austria) and the graphics, stats, pROC, ggplot2,
18 IRR, BlandAltmanLeh and RVAideMemoire packages.

19 **Results**

20 Validation on tissue-mimicking phantoms

21 We assessed the two CAP methods with seven tissue-mimicking phantoms. The comparison
22 and precision of both CAP methods versus reference US attenuations are presented in figure 2.
23 The precision of both CAP methods for each scan is represented by an error bar (\pm SD). The
24 results of the linear regressions between CAP and reference US attenuations are provided on
25 each graph. The relationship is closer to identity with the continuous CAP method than with

1 the standard CAP. As shown in figure 3, the precision (in term of SD) was improved by 57%
2 and 63% for M and XL probes, respectively. The ICC between the standard and continuous
3 CAP methods was 0.996 [0.978; 0.999] and 0.988 [0.935; 0.998], with the M probe and XL
4 probe respectively, showing excellent agreement. In terms of reproducibility, the ICC for both
5 methods are all above 0.98.

6 In vivo validation

7 Patients and examinations characteristics

8 As described above, two study cohorts were formed of 113 patients for cohort A and 82 patients
9 for cohort B. The characteristics of the two study cohorts are provided in table 1. For studies A
10 and B, respectively 83% and 94% of CAP measurements were performed at the same depth for
11 both methods. In study A, 88% of FS examinations were performed by the same expert operator.
12 In study B, FS examinations were equitably distributed between two novice operators.

13 Comparison versus MRI-PDFF

14 The comparison of both CAP methods versus MRI-PDFF in both study cohorts is given in table
15 2. The relationships between MRI-PDFF and CAP are shown figure 4. ROC curves for a MRI-
16 PDFF $\geq 5\%$ are shown figure 5.

17 Agreement between standard and continuous methods, bias, precisions

18 The ICC between the standard and continuous CAP methods was 0.901 and 0.940 for study
19 cohort A and B, respectively. A Bland Altman analysis is presented in figure 6. Compared to
20 the standard method, the CAP continuous method is on average 8.6 dB/m and 5.6 dB/m lower
21 for study cohort A and B, respectively.

22 The precisions of both CAP methods are presented in figure 7. Box-and-whisker plots were
23 used to appraise the precision of both CAP methods. In study cohort A, the precision was
24 improved by 41% and 33% using the continuous CAP method with the M probe and XL probe,

1 respectively. In study cohort B, the precision was improved by 38% and 22% using the
2 continuous CAP method with the M probe and XL probe, respectively.

3 **Discussion**

4 This study demonstrates that the precision of CAP measurement can be improved using the new
5 continuous CAP method. The main difference between the standard and the continuous CAP
6 method was the collection and selection of the US signals used to compute the US attenuation.
7 The continuous CAP method relies on the collection of US signals collected during the imaging
8 mode of the examination with a FS device. Furthermore, only US signals of sufficient quality
9 in terms of homogeneity are automatically selected for computation. The performances of the
10 standard and new methods were studied in phantoms as well as in vivo.

11 The tests on homogeneous tissue-mimicking phantoms of known reference US attenuations
12 demonstrated that both the standard and continuous CAP methods are accurate although the
13 precision with the continuous CAP method was improved by 57% and 63% for M probe and
14 XL probe, respectively. ICC between the two methods and reproducibility tests showed a
15 perfect agreement. The improved precision of CAP measurements using the continuous CAP
16 method was also observed in vivo in the two study cohorts. The precision of CAP was on
17 average improved by 34% with the new method.

18 Given that US signals obtained on tissue-mimicking phantoms are free of artefacts, the
19 improved precision on phantoms may be attributed only to the larger number of US attenuation
20 measurements collected with the new method.

21 The improvement of precision with the continuous CAP method is obtained by collecting the
22 US signals during the imaging mode of the examination with the FS device instead of relying
23 on the US signals collected for liver stiffness measurements. In study cohort A and study cohort
24 B, the number of US attenuation measurements collected during the imaging mode and used
25 for CAP measurement is on average 900 and 1555, respectively. These numbers are much

1 higher than the 10 US attenuation values usually obtained with the standard CAP method.
2 Furthermore, given that these values are collected at a maximum pulse-repetition frequency of
3 20 Hz, they translate into equivalent durations of 45 seconds and 778 seconds, respectively.
4 These durations are much higher than the equivalent duration using the standard CAP method,
5 which is about one second. The longer acquisition time associated with liver movement due to
6 breathing significantly increases the volume of liver tissue sampled with the new method and
7 therefore the spatial averaging. Consequently, the precision of the final CAP value with the
8 continuous CAP method is better than with the standard method. Although different US signals
9 are used for the assessment of CAP and liver stiffness measurements using the continuous CAP
10 method. Both values still reflect the same portion of the liver as they are acquired during the
11 same examination, which combines imaging sequences during which US attenuation values are
12 collected and elastography measurement sequences during which shear wave speed and
13 stiffness values are measured.

14 The continuous CAP method demonstrated superior performances (although not significantly)
15 in terms of AUROCs and correlation with MRI-PDFF in both study cohorts, which suggests a
16 diagnostic performance at least as good as the standard CAP method. The DeLong test with a
17 0.02 AUROC margin demonstrated a significant non-inferiority of the continuous CAP method
18 when compared to standard CAP method. This improvement may be attributed to the improved
19 precision and the enhanced selection of US signals used in both methods. As a matter of fact,
20 in the standard CAP method the selection of US signals is based on the validity of stiffness
21 measurement which may be suboptimal. Indeed, the US attenuation estimate is influenced by
22 the presence of heterogeneities in the US signal which may not affect the shear wave
23 propagation map and the associated shear wave speed assessment. The presence of
24 subcutaneous tissues (fat, muscle, etc.) or blood vessels within the ROI (Shen, et al. 2015)
25 usually result in hyperechogenic artefacts in the US signals, which may - depending on their
26 position in the ROI - give overestimations or underestimations and associated false positive or

1 false negative. The enhanced selection of US signals based on their US characteristics may
2 contribute to decreases in the influence of US artefacts.

3 The ICC between the two CAP methods showed a perfect in vivo agreement, which confirms
4 that the two methods measure the same US attenuation parameter. [The Bland Altman results](#)
5 [show that the new CAP method is on average slightly lower than CAP with standard method.](#)
6 [The automatic ROI selection according to the subcutaneous thickness and the selection of the](#)
7 [valid US signals may explain this trend.](#)

8 The linear regression fits between the standard and the new method versus MRI-PDFF are
9 slightly different in the two study cohorts. This variation may be attributed to differences in the
10 MRI-PDFF measurement methods used in the two study cohorts and to the significantly
11 different BMI distributions in the two study cohorts. The good agreement found between the
12 standard CAP method and the continuous CAP method is supported by using the exact same
13 core algorithm to compute the individual US attenuation values. A good agreement between
14 both methods is important to ensure that the published CAP cut-offs obtained with the standard
15 CAP method can be used with the continuous CAP method. Interestingly, as the relationship
16 between CAP expressed in dB/m and MRI-PDFF expressed in percentage is logarithmic, a
17 relative decrease in MRI-PDFF would result in an absolute decrease in CAP value. For an
18 example, given the coefficients obtained using the regression (table 2), a relative decrease of
19 30% in MRI-PDFF corresponds to a decrease of 14 to 18 dB/m in CAP value.

20 A limitation of this study is that the new method was evaluated retrospectively by reprocessing
21 the raw data recorded during examinations which were performed using a FS device with the
22 standard CAP method. Future studies will help assess the performances of the new method
23 when the operator is provided with the actual real-time information relative to the collection of
24 US attenuation measurements. Another limitation is the use of MRI-PDFF as a reference instead
25 of histopathology. Indeed, MRI-PDFF results may be influenced by several factors including
26 the MRI device model, the calculation method (Liver MultiScan for study cohort A and clinical

1 procedure for study cohort B), the size of the ROI and the manual selection of the MRI-PDFF
2 ROI by the radiologist (Campo, et al. 2017). Some studies assessed the accuracy and
3 reproducibility of MRI-PDFF for multivendor MRI on phantoms (Hernando, et al. 2017,
4 Hayashi, et al. 2018). With a standard reconstruction algorithm, the relative error is inversely
5 proportional to the true fat fraction of phantom. The error is about 20% for low fat fraction and
6 about 5% for high fat fraction. For study cohort A, the delay between FS examination and MRI-
7 PDFF examination can reach several weeks and may compromise the relevance of the results
8 because of the progression of steatosis. With the uncertainties on the etiology of the steatosis,
9 these MRI-PDFF limitations could explain the inconsistency of MRI-PDFF distribution
10 between the two study cohorts. Lastly, in this study no artificial body wall between the FS and
11 the phantom material has been included as we used a single element US transducer with a small
12 aperture of approximately 1 cm². However, it will be of interest to analyze the impact of the
13 artificial body wall on the CAP measurements.

14 **Conclusion**

15 In this study, a new method for CAP measurement was successfully validated on US attenuation
16 reference phantoms and retrospectively on in vivo data from two study cohorts. The continuous
17 CAP method significantly improves the precision of US attenuation assessment. Furthermore,
18 the new method demonstrated higher performances in terms of hepatic steatosis quantification
19 when using MRI-PDFF as a reference and a better correlation with MRI-PDFF. The new
20 method is implemented in FS devices with only minor changes in the operation of the
21 examination. The differences include the introduction of a specific gage to reflect the number
22 of US attenuation measurements, and the use of the mean and the SD instead of median and
23 IQR, respectively. A perfect agreement was found between both methods, indicating that the
24 cut-offs defined for CAP in the literature are applicable to CAP measurements performed with
25 the new method. CAP measured using the continuous CAP method is a promising tool and a
26 reliable alternative or complement the standard CAP method for diagnosing and monitoring

1 hepatic steatosis during longitudinal follow-up of patients with chronic liver disease. These
2 preliminary results should be confirmed in a larger prospective study.

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5 as the expert pathologist Dr. Angelo H. Paredes, from Brooke army medical center.

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7 paper.

8 **Conflicts of interest**

9 Stéphane Audière, Aymeric Labourdette, Céline Fournier, Laurent Sandrin and Véronique
10 Miette are Echosens employees. Stephen A. Harrison is a consultant of Echosens. Redouane
11 Ternifi and Salem Boussida received support from Echosens. All other authors declare no
12 conflicts of interest.

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1 **Figure Caption list**

2 **Figure 1.** Schematic representation of liver tissues sampled with (a) the standard CAP method
3 and (b) the continuous CAP method. PCD = Probe to liver Capsule Distance.

4 **Figure 2.** Comparison of CAP measurements obtained with both the standard and continuous
5 CAP methods with reference attenuation values on seven tissue-mimicking phantoms. The
6 precision is represented by an error bar (\pm SD). Dash lines and equations represent the linear fit
7 between the reference attenuation and the CAP measurement. R^2 is the coefficient of
8 determination of the fit.

9 **Figure 3.** Distribution of CAP precision (SD) obtained with the standard and continuous CAP
10 methods using the M, S and XL probes. The significant test of the precision difference is
11 performed with a t-test (***) = $p < 0.001$). In the box plots, the boundary of the box closest to
12 zero indicates the 25th percentile, a black line within the box marks the median, and the
13 boundary of the box farthest from zero indicates the 75th percentile. The length of the vertical
14 lines above and below the box is 1.5 times the IQR. Outlier: any patient result lying outside the
15 upper or lower whiskers.

16 **Figure 4.** CAP versus MRI-PDFF for study cohort A (a) and study cohort B (b) using the
17 standard and continuous CAP methods. Dash lines represent the linear fit between logarithmic
18 PDFF and CAP. R^2 is the coefficient of determination of the fit. Pearson values are the results
19 of the Pearson correlations.

20 **Figure 5.** Receiver operating curves (ROC) analysis of CAP for the detection of patients with
21 hepatic steatosis defined by MRI-PDFF $\geq 5\%$. Standard CAP method (dash lines) and
22 continuous CAP method (plain line) for study cohort A (a) and study cohort B (b).

23 **Figure 6.** Bland Altman plot of differences between standard CAP method and continuous CAP
24 method measurements vs. the mean of the two measurements. For study cohort A (a) and study

1 cohort B (b), the mean difference (8.6 dB/m, 5.6 dB/m) and the lower and upper limits of
2 agreement (-32.9 and 50.1 dB/m, -31.9 and 43.1 dB/m) are represented as dashed lines.

3 **Figure 7.** Distribution of CAP precision obtained with the standard and continuous CAP
4 methods using the M and XL probes for study cohort A (a) and study cohort B (b). The IQR of
5 the standard CAP method provided for indication only. The significant test of the precision
6 improvement is performed with a t-test (** $p < 0.01$, **** $p < 0.0001$). In the box plots, the
7 boundary of the box closest to zero indicates the 25th percentile, a black line within the box
8 marks the median, and the boundary of the box farthest from zero indicates the 75th percentile.
9 The length of the vertical lines above and below the box is 1.5 times the IQR. Outlier: any
10 patient result lying outside the upper or lower whiskers.

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12

1 **Table 1.** Characteristics of the two study cohorts.

Study cohort	A	B
Patients		
Number of patients	113	82
Male	44%	56%
Age Mean ± SD (years)	53 ± 8	55 ± 19
BMI Mean ± SD (kg/m²)	30 ± 5	27 ± 5
Normal weight / Overweight / Obese	16% / 38% / 46%	38% / 30% / 21%
FS examinations		
M probe / XL probe	69% / 31%	73% / 27%
At least 10 valid measurements	100%	96%
At least recommended number of US attenuation measurements for continuous CAP method	94%	100%
PCD M & XL probes Mean ± SD (mm)	M: 17.4 ± 2.9 XL: 24.0 ± 4.4	M: 16.1 ± 2.9 XL: 21.8 ± 2.6
Standard CAP method values Mean ± SD (dB/m)	275.3 ± 52.3	264.9 ± 57.9
Continuous CAP method values Mean ± SD (dB/m)	266.8 ± 49.3	259.6 ± 56.4
Number of US attenuation measurements Standard CAP method Mean ± SD	10.2 ± 0.8	11.0 ± 3.4
Number of US attenuation measurements Continuous CAP method Mean ± SD	900 ± 599	1555 ± 834
MRI-PDFF examinations		
MRI-PDFF Median [IQR] (%)	2.7 [5.1]	5.83 [9.7]
Delay between MRI-PDFF & FS Median [IQR] (days)	22 [30]	0 [0]

2 SD = standard deviation; PCD = probe to liver capsule distance; US = ultrasound; MRI-PDFF
3 = magnetic resonance imaging - proton density fat fraction; FS = FibroScan; IQR = interquartile
4 range.

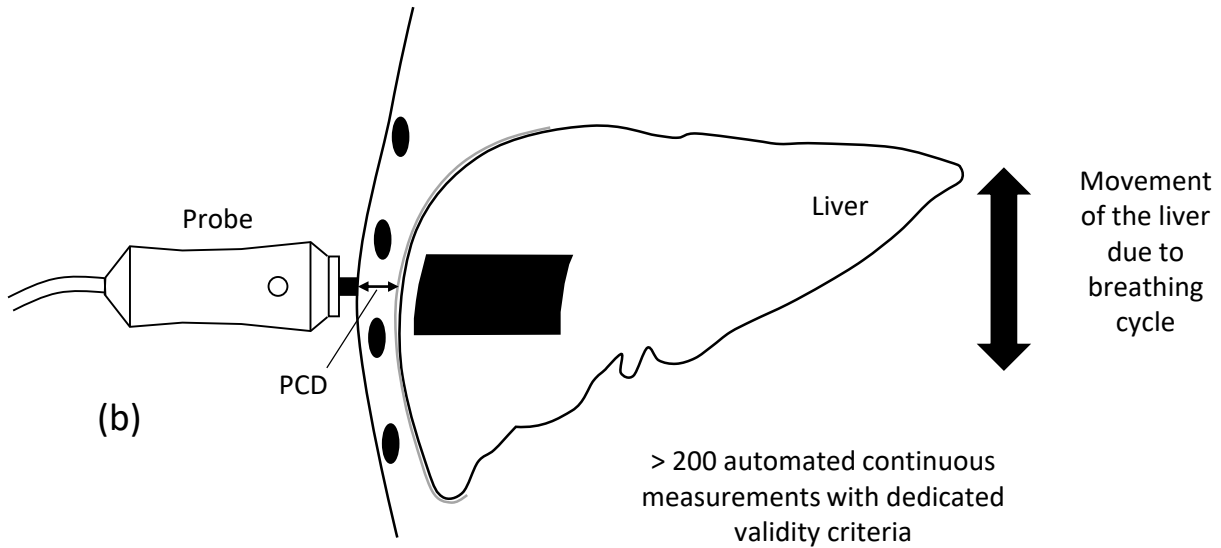
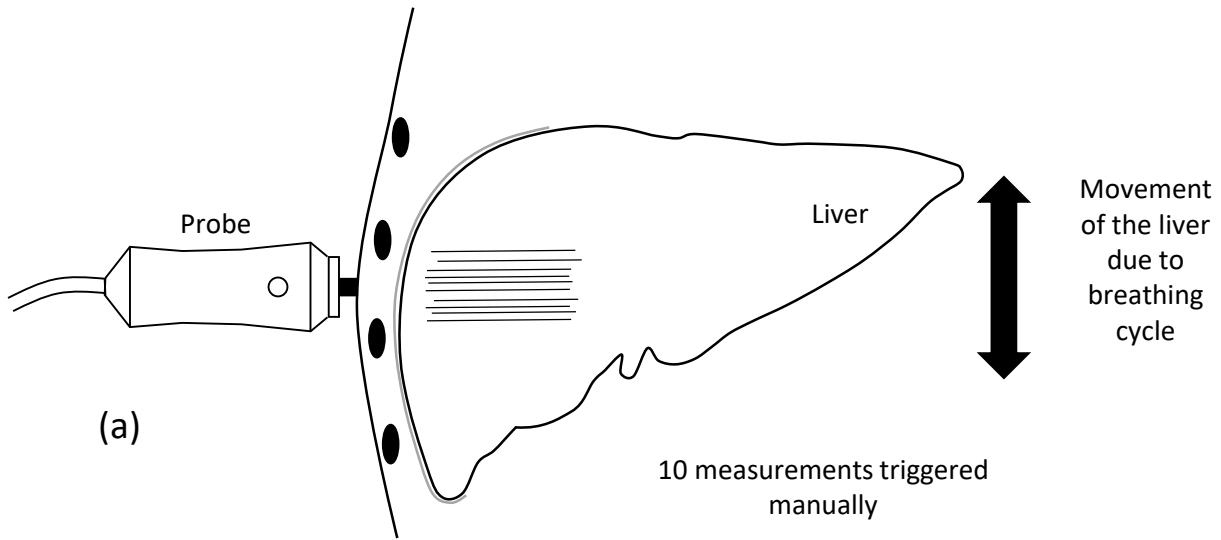
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1 **Table 2.** Comparison of both CAP methods versus MRI-PDFF in the two study cohorts.

Study cohort		A	B
Pearson correlations CAP vs log₁₀(PDFF)	<i>Standard CAP method</i>	0.71 [0.60-0.79]	0.71 [0.58-0.80]
	<i>Continuous CAP method</i>	0.74 [0.65-0.81]	0.76 [0.66-0.84]
	<i>Hittner test p-value</i>	0.22	0.02
Regression CAP = a x log₁₀(PDFF) + b	<i>Standard CAP method</i>	a = 88 b = 231 (R ² = 0.50)	a = 109 b = 172 (R ² = 0.50)
	<i>Continuous CAP method</i>	a = 87 b = 223 (R ² = 0.55)	a = 115 b = 161 (R ² = 0.59)
AUROC PDFF > 5%	<i>Prevalence</i>	32%	59%
	<i>Standard CAP method</i>	0.889 [0.827-0.953] Cutoff (Youden) = 273 dB/m	0.835 [0.745-0.924] Cutoff (Youden) = 264 dB/m
	<i>Continuous CAP method</i>	0.900 [0.838-0.961] Cutoff (Youden) = 286 dB/m	0.873 [0.798 – 0.949] Cutoff (Youden) = 256 dB/m
	<i>Delong test p-value (difference)</i>	0.55	0.06
	<i>Delong test p-value (non-inferiority with a 0.02 margin)</i>	0.02	<0.01

2 PDFF = proton density fat fraction; AUROC = area under the receiver operating characteristic,

3 R² = coefficient of determination



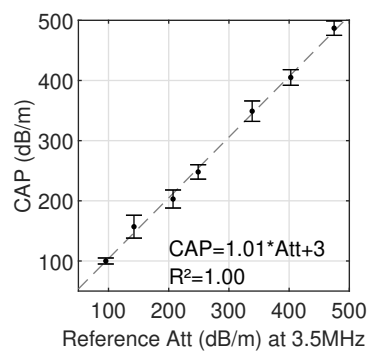
Standard CAP method

Click here to access/continuous CAP method

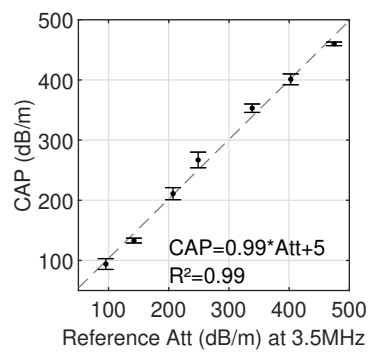
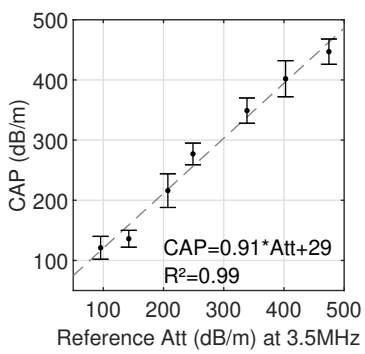


S Probe

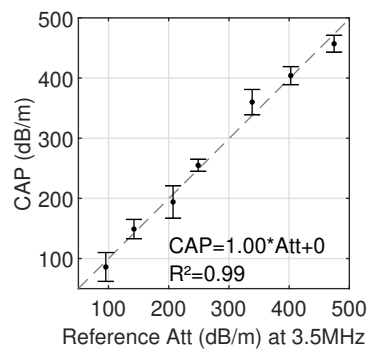
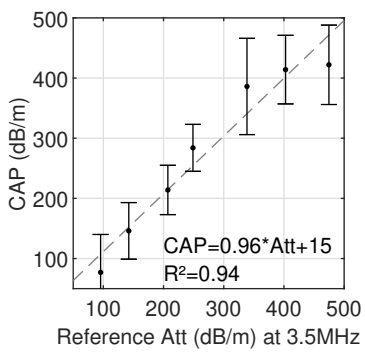
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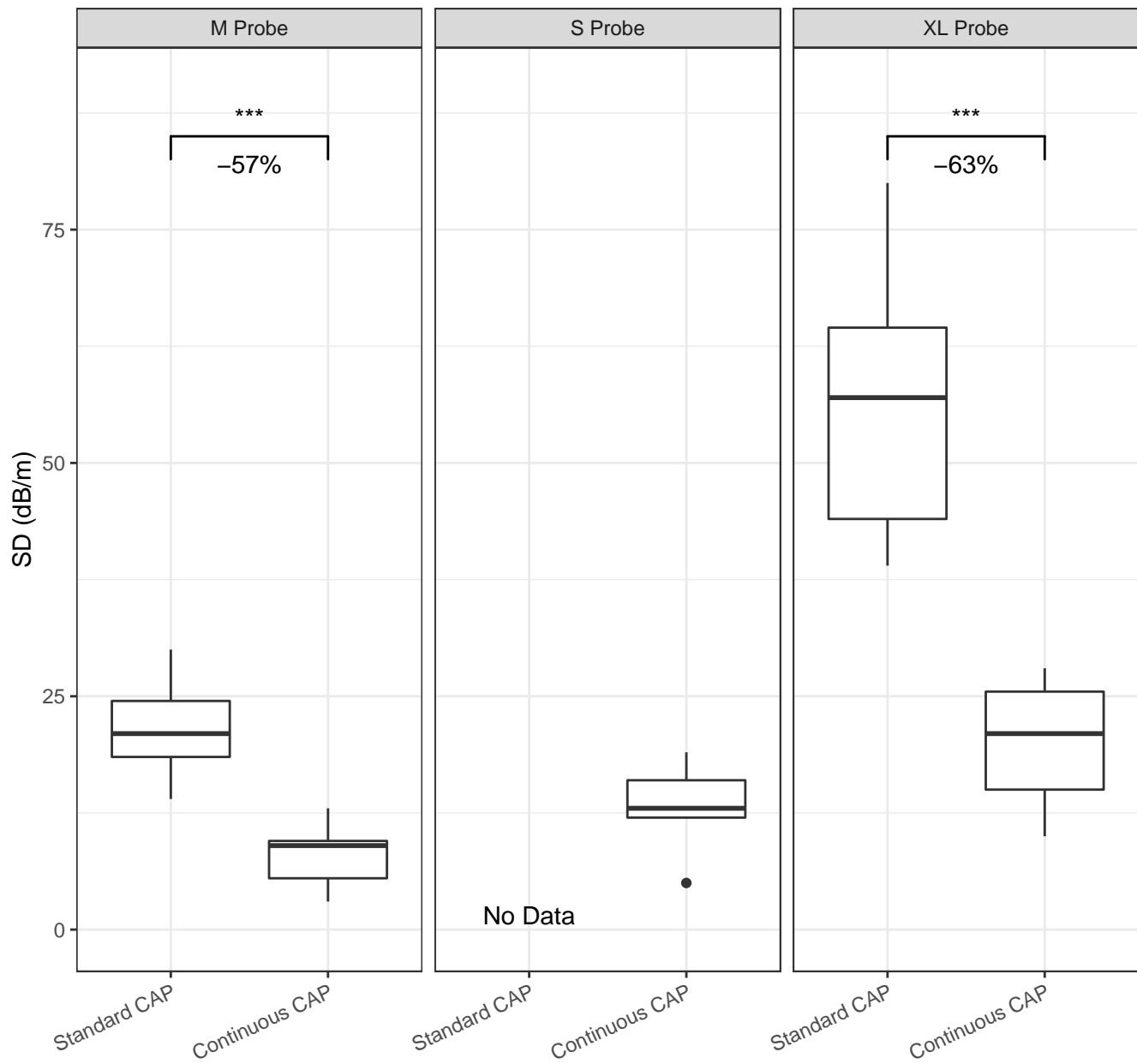


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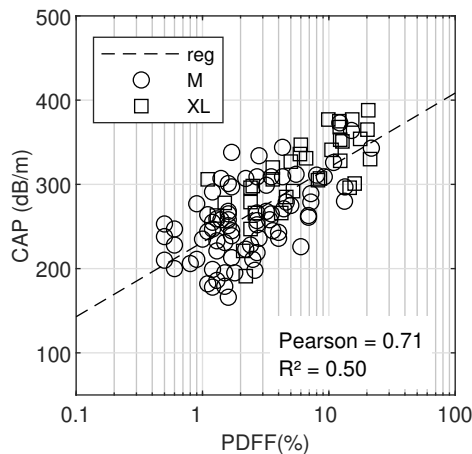


XL Probe



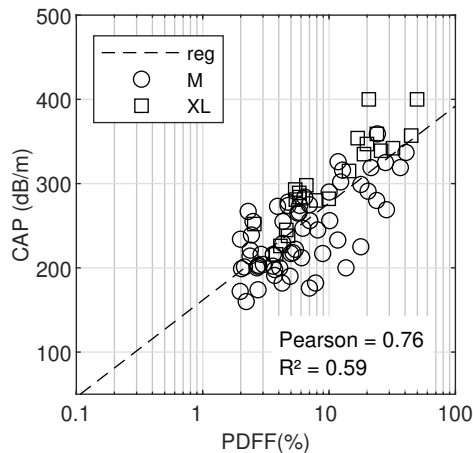
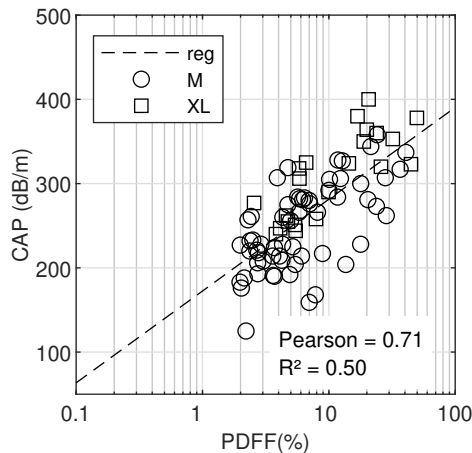
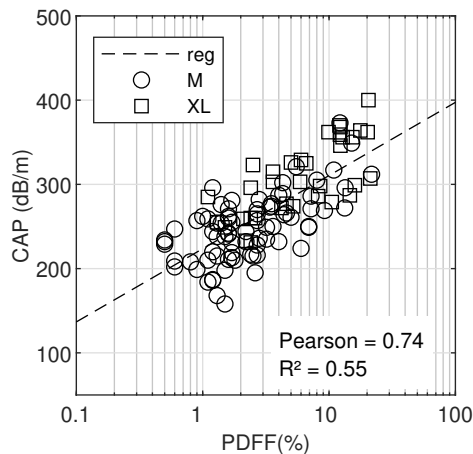


Standard CAP method

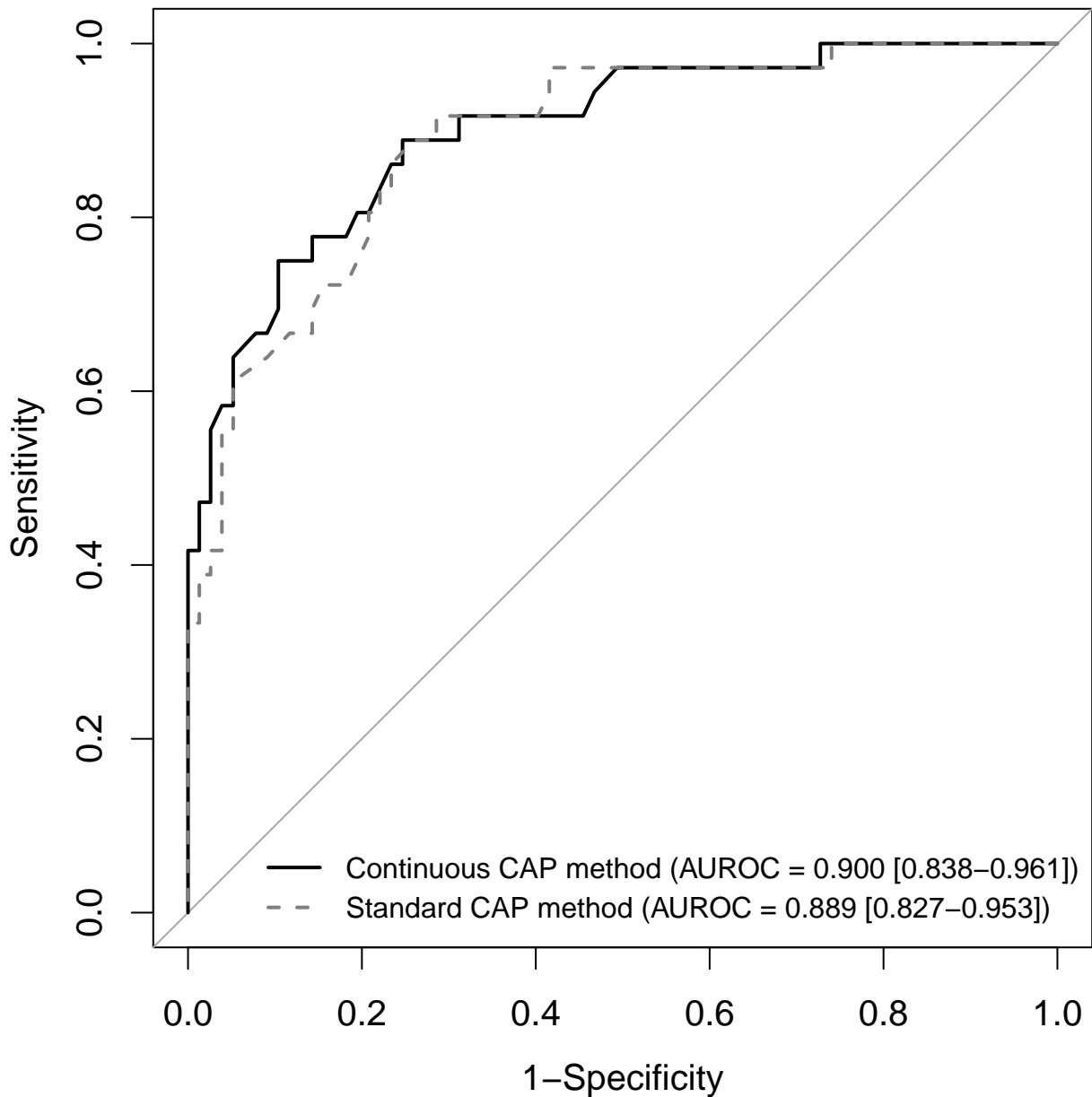


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access/download/figure/figure_4.pdf

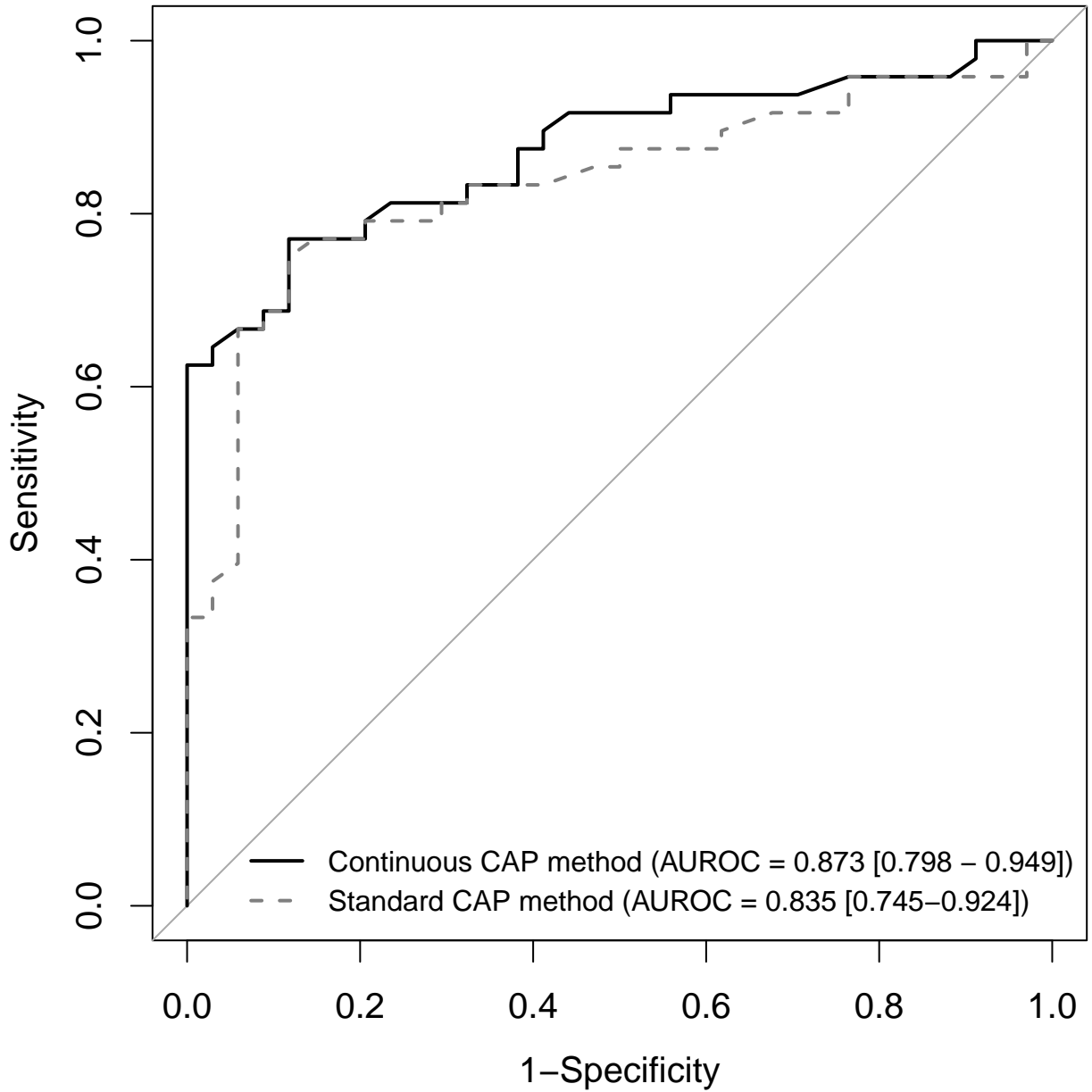
Continuous CAP method



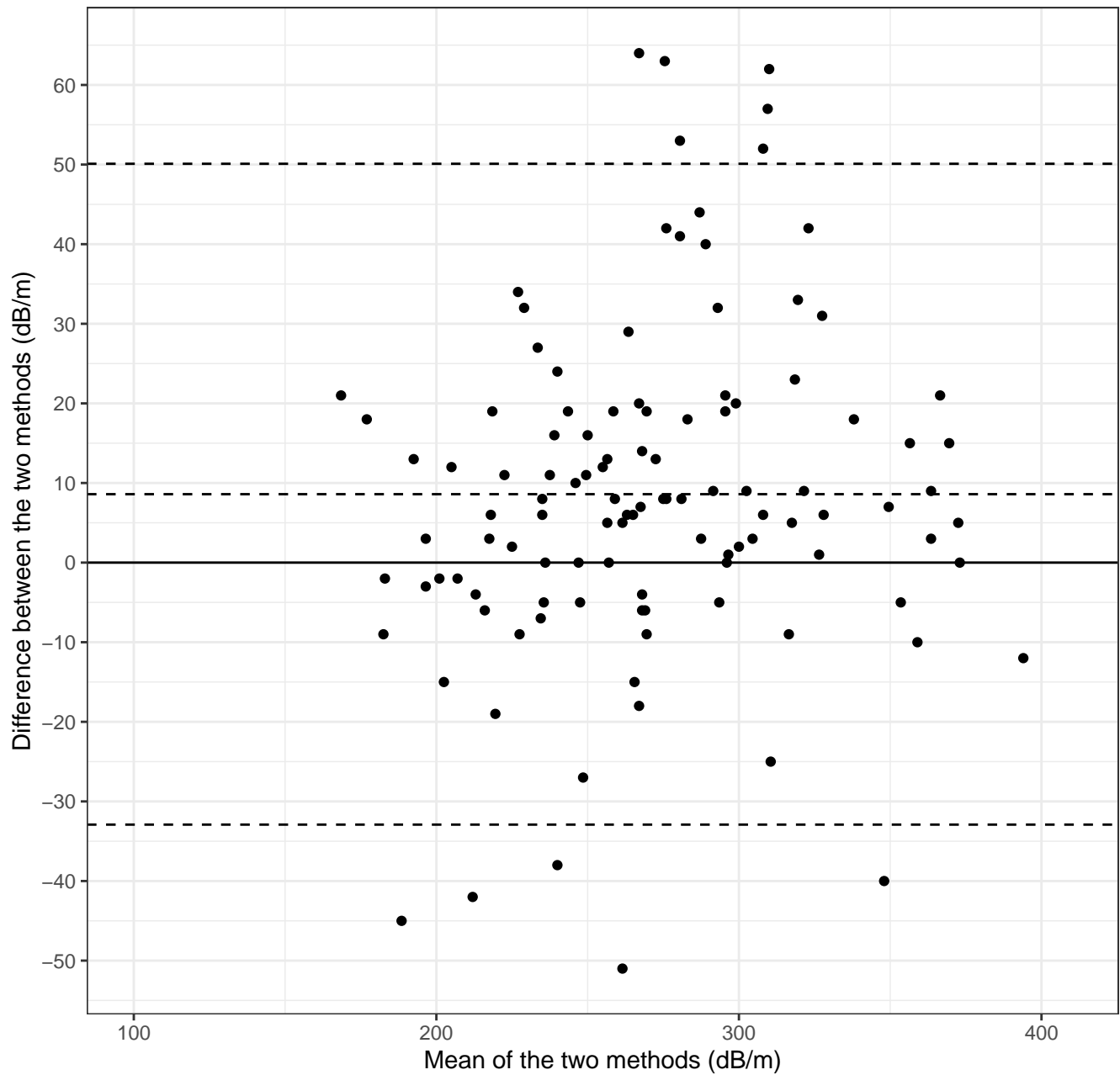
(a)

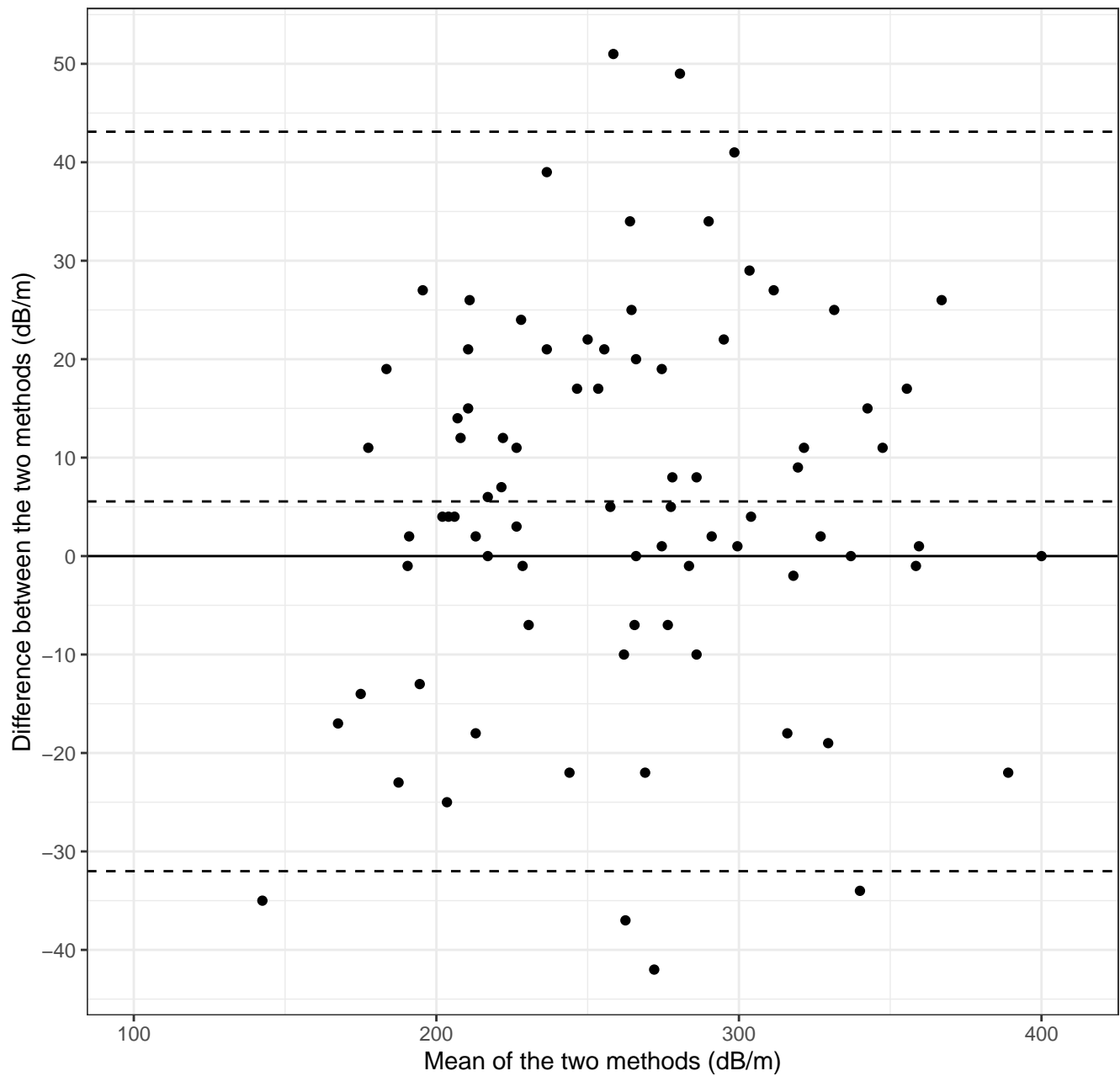


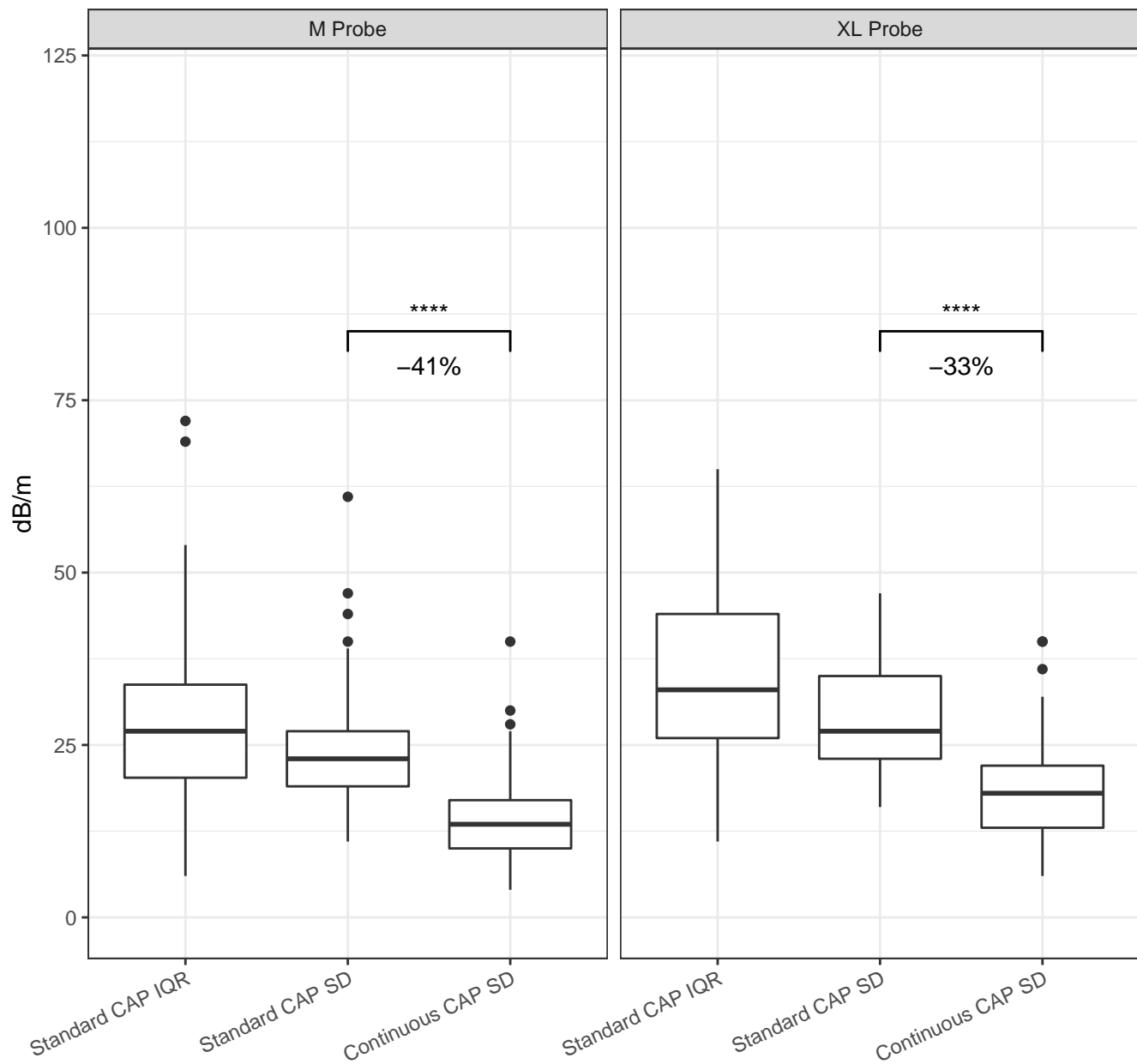
(b)



(a)







Figure

