

ECG-derived Blood Pressure Classification using Complexity Analysis-based Machine Learning

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Abstract: The recent advancement on wearable physiological sensors supports the development of real-time diagnosis in preventive medicine that demands various signal processing techniques to enable the extraction of the vital signs (e.g., blood pressure). Blood pressure estimation from physiological sensors data is challenging task that usually is solved by a combination of multiple signals. In this paper we present a novel complexity analysis-based machine-learning perspective on the problem of blood pressure class estimation only from ECG signals. We show that high classification accuracy of 96.68% can be achieved by extracting information via complexity analysis on the ECG signal followed by applying a stack of machine-learning classifiers. In addition, the proposed stacking approach is compared to a traditional machine-learning approaches and feature analysis is performed to determine the influence of the different features on the classification accuracy. The experimental data was gathered by daily monitoring of 20 subjects with two different ECG sensors.

1 INTRODUCTION

Real-time diagnosis in preventive medicine can significantly reduce the costs of expensive medical treatments. The real-time preventive diagnosis and on-time alarming in case of abnormal events (Lehocki et al., 2014), demand various signal processing techniques to enable continuous monitoring of vital signs (heart rate, blood pressure, respiratory rate, oxygen saturation), which usually are extracted from wearable sensors data (electrocardiogram - ECG, photoplethysmogram - PPG, phonocardiogram - PCG, breathing sensor, SPO2 sensor). The identification of morphologic characteristics and time intervals within the physiological signals allow continuous monitoring of vital signs and providing medical diagnosis (Cosoli et al., 2015). Blood pressure (BP) is considered to be one of the most valuable vital sign, however it still requires dedicated equipment for its estimation. Moreover, the related research on BP estimation focuses on using several sources of data (e.g., ECG and PPG) due to the complexity of the problem. In this paper we present a method for BP classes estimation by using only ECG as a single source of data.

The relationship between the BP and the morphological changes of the physiological signals is widely discussed in the related work. A huge study encompassing more than 11,000 individuals has been conducted by (Schroeder et al., 2003) where it has been examined whether the hypertension leads to changes in heart rate variability (HRV). The study reports results within 9 years period showing that even though the subjects with hypertension had decreased HRV, there was no significant difference in the HRV between the groups with and without hypertension 9 years after one group was predicted to have a higher risk of developing a hypertension. This confirms the complexity of the problem and suggests that new methods for deriving BP should be considered. (Hasan et al., 2008) investigate the relationship between the heart rate (HR) and the systolic blood pressure (SBP) at 10 healthy subjects. Even though the preliminary results showed positive correlation, the physicians do not completely agree that they proportionally rise together, e.g., in an event of dangerous situation, both the HR and BP might increase; however, the rise of HR, does not automatically trigger the rise of BP - appropriate example are the patients with coronary

artery disease who have normal HR (Heart and Vascular Team, 2016).

ECG alone has never been used for deriving BP, instead most of the published literature refers to the combination of both ECG and PPG. (Nye et al., 2015) performed a deep survey categorizing the methods for deriving BP into three major classes relying on: Pulse Wave Velocity (PWV), Pulse Arrival Time (PAT) and Pulse Transit Time (PTT). PWV is the rate at which the pressure wave moves down the vessel and PTT is the time at which the pressure wave propagates through the arterial tree (Grenwis et al., 2012). PAT is equal to the sum of PTT and the pre-ejection period, however a study (Zhang et al., 2011) indicates that PAT is not an adequate for PTT calculation since it is unable to detect the challenging BP changes.

BP is measured in terms of systolic blood pressure (SBP) and diastolic blood pressure (DBP), the maximum and the minimum value of an arterial pressure tracing, correspondingly. Assuming the PWV is a reliable measure for estimation of the central BP, (i Carós, 2011) provides a comprehensive analysis of the PWV-based techniques for continuous and non-invasive monitoring of BP; even though it is claimed that no clear information is provided on whether PWV is related to SBP, DBP or mean BP. Alternative techniques that do not rely on PWV are also discussed such as those for multi-parametric processing of cardiovascular variables, or those that consider parameters within the heart sounds (PCG analysis). One example is the analysis of R2 - the time interval from a particular R peak in ECG, to the peak of the second heart sound in PCG (Wong et al., 2006). Close inverse correlation between the timing of the second heart sound has been found by SBP (Zhang and Zhang, 2006). (Goli and T., 2014) used PTT derived from ECG R-wave and the maximum first derivative PPG in correlation analysis at 11 healthy subjects. The reported results show PTT to be strongly correlated with SBP (0.734) and the DBP (0.731).

In another study, (Wong et al., 2009) perform a half year study on the relationship between BP and PTT, showing the PTT is highly correlated with SBP, but not with DBP - probably due to the small variations of the DBP. Even though PPG signals are widely used for the purpose of BP estimation and present high prediction accuracy, there are also some experiments that withstand those statements. (Nitzan, 2011) compares multiple methods indicating that PPG is not applicable for the estimation of DBP since no substantial change of blood flow or PPG pulse is found when the cuff pressure decreases. Similarly, (Payne et al., 2006) proves that PTT extracted from ECG and PPG is unreliable marker of beat-to-beat BP.

This research approaches the problem from a completely different perspective of deriving BP from ECG only. The rule presented by (Najarian and Splinter, 2012) states that the healthy biomedical systems are of high complexity and once an abnormality occurs this complexity drops. The complexity decrease has been experimentally proven in the literature for problems related to brain activity in presence of Alzheimers disease (Gómez et al., 2006); comparative EEG study on pathological and healthy groups (Bhattacharya et al., 2000); ECG analysis of ventricular tachycardia and fibrillation (Zhang et al., 2000); complexity loss theory of aging and disease (Costa et al., 2005); complexity analysis of respiratory system (Raoufy et al., 2017), etc.

In order to explore the idea of using ECG complexity analysis, 332 ECG signals were obtained during normal physical activities from 20 subjects of different age groups. During the ECG acquisition, cuff-based BP measurements at different timestamps were manually performed, which later were used to label the ECG signals with one of the BP classification groups reported by (Program et al., 2004): hypotension, normal, prehypertension, stage 1 hypertension, stage 2 hypertension, isolated systolic hypertension (ISH), and hypertensive crisis. Having extracted features using the complexity analysis later discussed in the Sect. 2, two types of Machine-Learning (ML) solutions, a flat (simple) design and a stacking design were developed and compared.

The rest of the paper is organized as follows. Sect. 2 presents the methods and materials used in the ECG signal processing system. Sect. 3 presents the experiments and the obtained results. Sect. 4 and Sect. 5 present the discussion and the conclusions of the study.

2 THE PROPOSED APPROACH

When developing the novel methodology we followed the steps of a typical biomedical signal-processing system (Najarian and Splinter, 2012) presented in Figure 1. The following subsections provide a detailed explanation of the methods and techniques applied in each step.

2.1 The Biological System

The ECG signal presents the electrical activity of the heart. It is recorded by placing electrodes on the individual's chest or limb. The heart system consists of two atria for collecting the blood and two ventricles for pumping the blood. There are two main phases, a

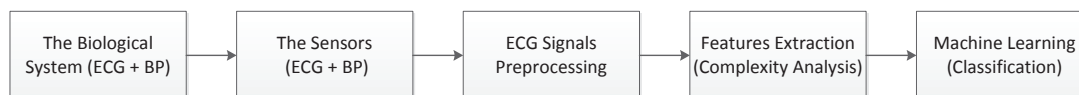


Figure 1: The ECG signal processing system.

filling (resting) phase called diastole, and a pumping (contracting) phase called systole. The deoxygenated blood is collected in the right atrium and therefrom is passed to the right ventricle. While the ventricular is in a systole phase, the deoxygenated blood is pumped to the lungs where it will be oxygenated. The oxygenated blood is received by the left atrium and during the atrial systole it is passed to the left ventricle. The left ventricle is the largest and strongest chamber since it has to pump the oxygenated blood to the rest of the body. A normal HR during resting is about 70 bpm (beats per minute - measure for the rhythm of the heart) (Rangayyan, 2015).

The pressure that is caused by the blood flow on the blood vessels walls is referred to as blood pressure. BP is measured in millimeters of mercury (mmHg), and depending on the different values of the maximum pressure during one heart beat (SBP) and the minimum pressure in between two heart beats (DBP), there are seven categories published online and in the literature (Program et al., 2004; AHA, 2016) presented in Tab. 1.

2.2 The ECG Sensors

The ECG signals used in this research were obtained using two different ECG sensors and the reference BP values were measured by using an electronic sphygmomanometer. Sixteen participants at age 16 - 72 were recorded by using ECG sensor as a part of the Cooking hacks e-Health Sensor Platform (Cooking Hacks, 2016). All the measurements were performed in a sitting position in duration up to 60 seconds at 125Hz sample rate, and a single measurement of the SBP and DBP has been done for each ECG signal. Additionally, 4 participants at age 25 - 27 were recorded using the 180°eMotion FAROS (Bitium Biosignals, 2016) ECG sensor. In this case, the sensor was attached to the participants for at least 4 hours, continuously capturing the electrical activity of the heart at sampling rate of 1000Hz during the daily activities. The participants were required to measure the BP at particular times ranging from 30 minutes to 1 hour. All of the 20 participants had no history of heart problems.

2.3 ECG Signals Preprocessing

A valid ECG information is considered to exist in range of 0.05 - 100Hz (Rangayyan, 2015). The application of the 180 eMotion FAROS sensor produced a high-resolution ECG sampled at frequency of 1000Hz. Those ECG signals were filtered by applying a low-pass Butterworth filter of 18th order and cutoff frequency of 100Hz. The order of the filter was optimally determined based on the filter design specifications. All the signals were trimmed by taking only the last 30 seconds before the BP measurement. Experimentally is observed that 30 seconds of ECG carries the right information for BP class prediction. As a result from the preprocessing, we created a database that consists of 332 signals labeled with the appropriate BP class as described in Tab. 1.

2.4 Feature Extraction from ECG - Complexity Analysis

The ML approach in BP estimation from ECG signal requires building distinguishing feature vectors that will represent the created database. In this novel approach the feature extraction is based on complexity analysis rather than on extraction of the morphological characteristics, the conservative way of processing the ECG signals as described in the literature (i Carós, 2011; Wong et al., 2006; Zhang and Zhang, 2006; Goli and T., 2014; Payne et al., 2006; Wong et al., 2009; Nitzan, 2011).

As mentioned in the Introduction, a normal and healthy biomedical system (the ECG signal) is considered to be a very complex one and once a dramatic change occurs (as is the sudden change in BP), the complexity drops (Najarian and Splinter, 2012). This relationship is already proven in the literature presented (Gómez et al., 2006; Bhattacharya et al., 2000; Zhang et al., 2000; Costa et al., 2005; Raoufy et al., 2017). Considering the complexity features performance presented in the related work (McBride et al., 2014; Morabito et al., 2012; Eke et al., 2002; Cancio et al., 2008), in this research the BP changes are modeled by inspecting complexity measures of the ECG signals to extract six features that define the feature vectors:

Table 1: Blood pressure categorization.

Category	SBP (mmHg)	Logical	DBP (mmHg)
Hypotension	≤ 90	OR	≤ 60
Normal	90-119	AND	60-79
Prehypertension	120-139	OR	80-89
Stage 1 hypertension	140-159	OR	90-99
Stage 2 hypertension	≥ 160	OR	≥ 100
Isolated systolic hypertension	≥ 140	AND	< 90
Hypertensive crisis	≥ 180	OR	≥ 110

2.4.1 Signal Mobility

Signal mobility represents the first-order variations in the signal. Let $x_i, i = 1, \dots, N$ be the ECG signal of length N , and $d_j, j = 1, \dots, N - 1$ be the first-order variation calculated as given in Eq. 1:

$$d_j = x_{j+1} - x_j \quad (1)$$

Then the first-order factors S_0 and S_1 are obtained as follows:

$$S_0 = \sqrt{\frac{\sum_{i=1}^N x_i^2}{N}} \quad (2)$$

$$S_1 = \sqrt{\frac{\sum_{j=2}^{N-1} d_j^2}{N-1}} \quad (3)$$

Hereupon the signal mobility is simply calculated as the ratio between the factors S_1 and S_0 :

$$Mobility = \frac{S_1}{S_0}, \quad (4)$$

providing a quantitative measure of the level of variation along the signal.

2.4.2 Signal Complexity

Signal complexity represents the second-order variations in the signal. Given the first-order variation of the ECG signal $d_j, j = 1, \dots, N - 1$, the second-order variation of the signal is presented by $g_k, k = 1, \dots, N - 2$, or:

$$g_k = d_{k+1} - d_k \quad (5)$$

Consequently, the second-order factor is calculated as:

$$S_2 = \sqrt{\frac{\sum_{k=3}^{N-2} g_k^2}{N-2}}, \quad (6)$$

and the signal complexity is calculated according to the equation:

$$Complexity = \sqrt{\frac{S_2^2}{S_1^2} - \frac{S_1^2}{S_0^2}} \quad (7)$$

To compute both the signal mobility and complexity, we used the Hjorth parameters method (Kugiumtzis and Tsimpiris, 2010).

2.4.3 Fractal Dimension

Fractal dimension is a measure of self-similarity and describes the fundamental patterns hidden in the signal. It works like a magnifier, zooming and comparing different portions of the signal with the entire signal. Higuchi algorithm is one of the most efficient methods for calculating the fractal dimension and we use it as implemented by (Alvarez, 2015). For choosing the maximum number of subseries, k_{max} , we followed the advice by (Doyle et al., 2004). The Higuchi algorithm forms a set of k subseries with different resolutions. For $m = 1, \dots, k$, the new time series X_k^m are formed as follows:

$$X_k^m : x(m), x(m+k), x(m+2k), \dots, x(m + \lfloor \frac{N-m}{k} \rfloor k) \quad (8)$$

Consequently, the length of the curve $X_k^m, l(k)$ is calculated as:

$$l(k) = \frac{(\sum_{i=1}^{\lfloor \frac{N-m}{k} \rfloor} |x(m+ik) - x(m+(i-1)k)|)(N-1)}{(\lfloor \frac{N-m}{k} \rfloor)k} \quad (9)$$

For each k in range 1 to k_{max} , the average length is calculated as the mean of the k lengths $l(k)$ for $m = 1, \dots, k$. The fractal dimension is the estimation of the slope of the plot $\ln(l(k))$ vs. $\ln(1/k)$.

2.4.4 Entropy

Entropy measures the amount of information (the randomness) in the signal. The reduction of entropy considering a signal as ECG is often associated with a disease. The information can be represented through the concept of probability. Assuming X is the ECG signal and p_i is the probability of each outcome x_i within X for $i = 1, \dots, N - 1$. Then, by addressing all the zero/infinity problems, the equation for entropy calculation gets the following form:

$$Entropy = \sum_{i=0}^{N-1} p_i \log\left(\frac{1}{p_i}\right) \quad (10)$$

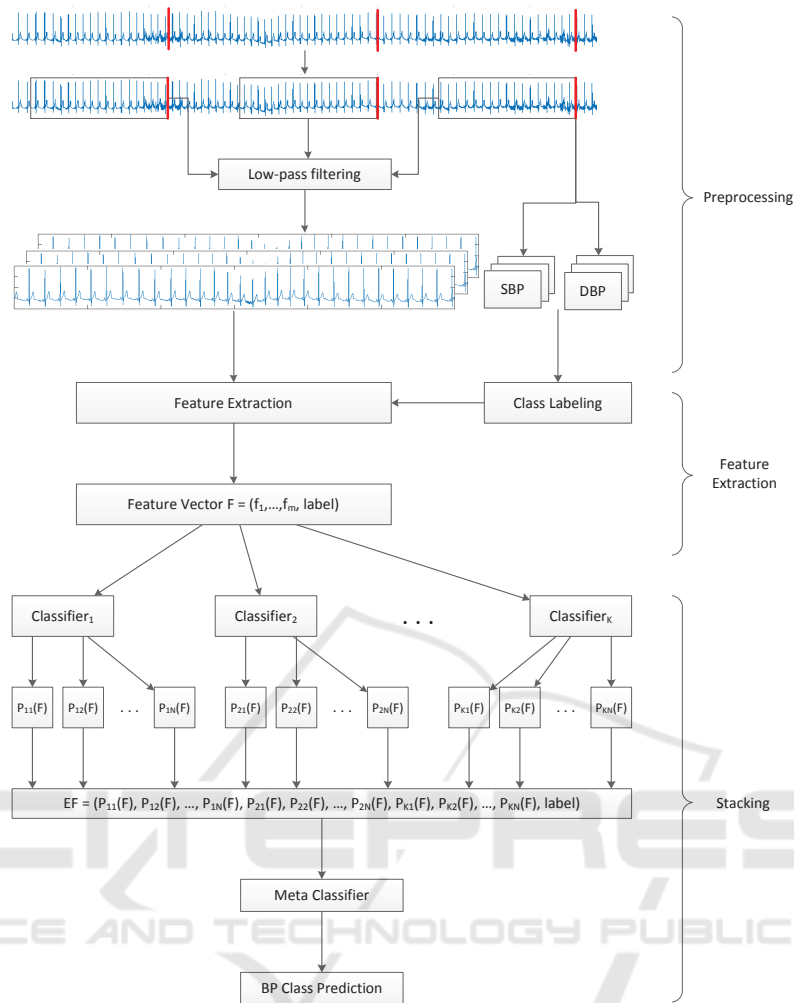


Figure 2: Stacking Design.

2.4.5 Autocorrelation

Autocorrelation calculates the similarity of the signal when it is compared to its shifted version - a similarity will exhibit a peak which is captured and quantitatively measured. Given τ is the amount of shift, the autocorrelation function is calculated as follows:

$$r_{xx}(\tau) = \int_{-\infty}^{+\infty} x(t)x(t-\tau)p_{xx}(x(t),x(t-\tau))dt, \quad (11)$$

where $p_{xx}(x(t),x(t-\tau))$ presents the joint probability density function of $x(t)$ and $x(t-\tau)$.

2.4.6 Age

A simple mathematical model that represents the blood flow in the arteries is made by (Labadin and Ahmadi, 2006). It proves that the blood flow is affected

by the size of the blood vessel. When the left ventricle contracts to push the blood into the aorta (during systole), a pressure wave is generated along the arterial tree. Affected mostly by the age or some other changes in the arterial wall, the vessels become stiffer, meaning the pressure wave velocity increases. As a result, the reflected pressure waves that move back to the heart will also move faster, causing greater systolic pressure to handle the load. Having in mind that the age affect the changes in the arterial wall, participant's age as one of the features is included in the feature vectors.

2.5 The Machine Learning Approach

Fig. 2 presents a detailed scheme of the proposed methodology by following the steps of a biomedical processing system as depicted in Fig. 1. On the top of Fig. 2 an example of raw ECG signal is pre-

sented with red marks (lines) that represent the moment when the subject's BP has been measured. In the next step, the raw ECG signals are segmented by taking windows of 30 seconds before each BP measurement. Then, the low-pass filtering is applied. Having established the database of the ECG signals and the corresponding SBP and DBP values, we proceed with the feature extraction procedure that encompass both the complexity analysis described in Sect. 2.4 and the BP class labeling according to Tab. 1. Hereupon, two ML approaches have been applied to train a model that is able to predict the BP class for a given ECG signal. The first approach is a flat ML design, including the evaluation of seven different classification algorithms as described in Sect. 2.5.1. The second approach is stacking ML design, visually described in Fig. 2 and comprehensively explained in Sect. 2.5.2.

2.5.1 The Flat Design

In the flat design, ML models are trained by using seven different classifiers, which model the data from various aspects:

1. J48 - to rank the features according to the information gain;
2. Naive Bayes (NB) - to consider strong independence between the features;
3. KNN - to consider inter-instance similarity;
4. SVM - to recognize the most distinguishable feature vectors;
5. Random Forest (RF) - to combine multiple models built on varying features set in an ensemble;
6. Bagging (BGG) - to introduce dataset subsampling as a way of reducing the variance of the decision tree-based J48 algorithm, and
7. Boosting (BST) - to introduce instance weighting in the dataset for addressing the mis-recognized instances.

2.5.2 The Stacking Design

Assuming that different algorithms model different structures in the data, we implemented a stacking module presented in the third phase of Fig. 2. The implementation mainly consists of tree phases. The first phase is the application of the seven different classifiers described in the flat design 2.5.1. Each of the classifiers, $K = 1, \dots, 7$, is adapted to produce prediction probabilities (Hall et al., 2009) for a given feature vector, F , to belong in each of the BP classes, $N = 1, \dots, 6$. The goal is to ensemble the probabilities, $p_{11}(F), \dots, p_{KN}(F)$, produced by each of the applied classifiers and create new feature vectors (the second

Table 2: ECG instances categorization.

Category	Instances	Label
Hypotension	3	0
Normal	198	1
Prehypertension	110	2
Stage 1 hypertension	15	3
Stage 2 hypertension	2	4
Isolated systolic hypertension	4	5
Hypertensive crisis	0	6

phase. In the final phase, a meta-classifier (Random Forest) is trained with the new feature vectors.

Leave-one-instance-out principle has been used for both the creation of the probability vectors and the meta-classifier phase. The probability vector for each instance was created when the instance is being left out for testing. Having created the new probability vectors for all instances, the meta-classifier has also been evaluated by the same principle, leaving-one-instance-out. Thus it means that in a particular iteration, one instance is a test instance in both phases at the same time, and the overfitting is avoided.

3 RESULTS

After the preprocessing phase, a database consisting of 332 instances was created. The distribution of the instances is provided in Tab. 2. The majority class is the Normal class consisting of 198 ECG recordings (59.6% of the signals). The more extreme the classes are, the less instances are included since the participants involved in the measurements were random individuals with no diagnosis related to heart or blood pressure problems. The most extreme class, Hypertensive crisis, is completely empty and has been dismissed in the following analysis.

The experiments were performed by using a leave-one-instance-out cross-validation, i.e., the ML models are built by using all the instances except one that is left out for testing. The procedure is repeated 332 times (the number of instances in the database) and the results are averaged. We present three metrics: F-measure as a balanced mean between precision and recall, ROC area to measure the trade-off between the recall and the false positive rate, and the overall accuracy of each classifier. In addition, we performed a 10-fold cross-validation and obtained similar results.

3.1 Flat ML Results

Tab. 3 presents the results for each of the seven distinct classifiers used as part of the flat ML ap-

Table 3: Flat ML results. Leave-one-instance-out evaluation.

Metric	Class	J48	NB	KNN	SVM	RF	BGG	BST
F-Measure	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	1	0.86	0.74	0.85	0.78	0.85	0.88	0.80
	2	0.76	0.12	0.71	0.34	0.71	0.75	0.43
	3	0.58	0.00	0.34	0.00	0.37	0.53	0.00
	4	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	5	0.85	0.14	0.25	0.00	0.66	0.00	0.00
ROC Area	0	0.62	0.53	0.49	0.06	0.40	0.21	0.33
	1	0.80	0.61	0.81	0.61	0.90	0.87	0.31
	2	0.80	0.55	0.78	0.59	0.87	0.83	0.30
	3	0.75	0.68	0.65	0.48	0.85	0.81	0.06
	4	0.29	0.06	0.49	0.53	0.44	0.25	0.56
	5	0.86	0.95	0.62	0.94	0.86	0.95	0.86
Accuracy (%)	all	81.32	54.21	76.80	66.26	78.01	81.32	68.67
Accuracy 10-fold (%)	all	79.81	55.12	76.50	66.26	80.42	78.31	68.67

Table 4: Stacking ML results. Leave-one-instance-out evaluation.

Metric/Class	0	1	2	3	4	5
Precision	1.00	0.97	0.94	1.00	0.00	1.00
Recall	0.33	0.99	0.99	0.73	0.00	0.75
F-measure	0.50	0.98	0.96	0.84	0.00	0.85
ROC Area	0.94	0.99	0.99	0.98	0.42	0.99
Accuracy (%)	96.68					
Accuracy 10-fold (%)	96.68					

Table 5: Confusion matrix. Leave-one-instance-out evaluation.

Real/Predicted	0	1	2	3	4	5
0	1	2	0	0	0	0
1	0	197	1	0	0	0
2	0	1	109	0	0	0
3	0	1	3	11	0	0
4	0	1	1	0	0	0
5	0	0	1	0	0	3
Correctly classified	321					
Incorrectly classified	11					

proach. From the results it can be observed that the least recognized classes are the ones with only a few instances available. However, even for the sparse class "Isolated systolic hypertension (label 5)", J48 has achieved an F-measure of 0.86, and Bagging (also NB) has achieved ROC area over 0.85. For the classes 0 and 4 ("Hypotension" and "Stage 2 hypertension") with the least number of instances, all of the models perform worse in comparison to the performance for the rest of the classes. However, the ROC area measure, even though in range between random and poor prediction, provides promising results for Boosting and J48, and we expect this results to be improved when more instances will be provided. Class 3, "Stage 1 hypertension", is also considered to be

sparse class; however, Random Forest and J48 show slightly better results compared to class 0 and class 4. The classes 1 and 2, "Normal" and "Prehypertension", contain the majority (92.77%) of the all the instances. Random Forest, J48 and Bagging provide the best results, but also KNN and to some extent SVM show promising performance. The results from the overall accuracy ranks the classifiers as follows: J48, Bagging, Random Forest, KNN, Boosting, SVM and Naive Bayes.

3.2 Stacking ML Results

Since all the classifiers in the ML experiments performed well at different cases, we chose to combine their outputs for the purpose of improved classification performance. As meta-classifier we used Random Forest. The stacking design produced the results presented in Tab. 4. It can be seen that this approach improved the prediction even for the sparse classes. The overall accuracy is 96.68%, which is for 15.36 percentage points better than the highest accuracy obtained by the flat ML design.

Tab. 5 presents the confusion matrix for the stacking design. It is a good indicator showing the tendency of the classifier to classify the sparse classes

Table 6: Classification with "Age" elimination.

Classifier	Accuracy (with "Age") (%)	Accuracy (without "Age") (%)
J48	81.32	80.72
NB	54.21	54.82
KNN	76.80	73.49
SVM	66.26	65.96
RF	78.01	76.81
BGG	81.32	76.2
BST	68.67	68.67

Table 7: Feature's information gain.

Feature	Average merit
Age	0.54
Fractal dimension	0.28
Complexity	0.25
Entropy	0.15
Autocorrelation	0.13
Mobility	0.01

Table 8: Variable ECG length accuracy comparison from 10-fold cross-validation.

Accuracy (%)	10s	30s	50s
J48	79.81	79.81	70.27
NB	58.43	55.12	24.32
KNN	74.39	76.50	54.05
SVM	65.96	66.26	70.27
RF	79.21	80.42	62.16
BGG	77.71	78.31	70.27
BST	68.67	68.67	70.27
Mean	72.02	72.15	60.23

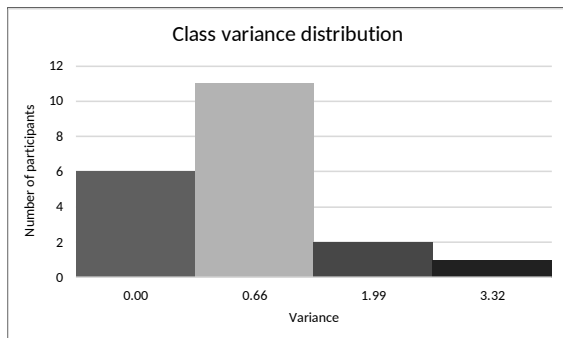


Figure 3: Distribution of the classes variance among the participants.

into the classes 1 and 2 that encompass the majority of the instances.

4 DISCUSSION

The premise of using 30 seconds ECG signals is experimentally proved by using the proposed methodology in the paper considering variable-length ECG windows starting from 10 up to 50 seconds. The flat design produced the accuracy results presented in Tab. 8. The results indicate that the feature extraction methodology is less informative for longer ECG signals. The accuracies for 10 and 30 seconds ECG signals provide nearly same average result; however, the 30s length performs better for KNN, SVM, RF and BGG, thus is considered to be used in the further analysis.

Observing the experimental results in Sect. 3, it can be seen that for the sparse class Isolated systolic hypertension (label 5), J48 has achieved an F-measure of 0.86, and both Bagging and NB have achieved ROC area over 0.95. This results lead to a conclusion that the class itself is easy to be recognized because of its nature (characterized by high SBP and low DBP).

Additional analysis is done on the feature's influence by measuring the information gain (entropy) for each feature with respect to the class labels. Considering the feature ranking presented in Tab. 7, age is found to be the top feature, fractal dimension and complexity is the second and the third most influential attribute, correspondingly. Then follows the entropy, the autocorrelation and mobility at last. It is interesting that the second-order variations (complexity) are found to be more informative than the first-order variations (mobility). Obtaining the top most influential features does not mean they are enough for highly accurate classification, instead the experiments show that the elimination of each of the features ranked bottom-up degrades the accuracy.

Given the fact that the feature age has highest rank in Tab. 7 and also the fact that we performed multiple measurements for each subject, we suspected that age might act as a kind of "ID" and therefore to intrigue person-specific overfitting. In order to eliminate this possibility, we performed additional testings by ex-

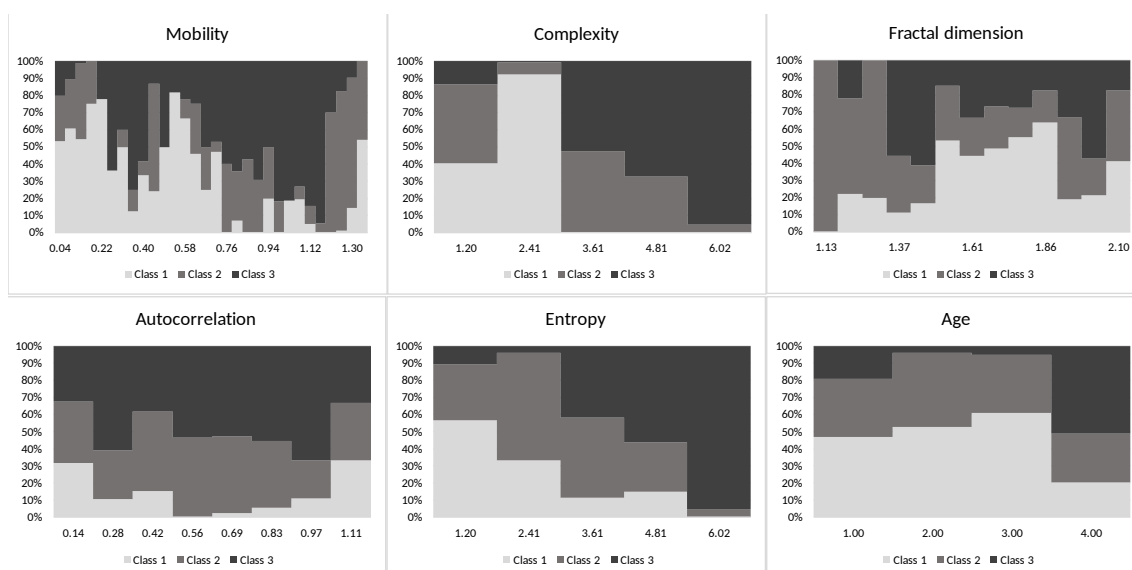


Figure 4: Features absolute values distributions over classes.

cluding the age from the feature vectors.

The results of the overall accuracy for each classifier are presented in Tab. 6 and are compared to the old classification accuracy with the age included in the feature vectors. The results show that the elimination of the age feature degrades the classification for at most 5% at the Bagging classifier and for all the rest there is only minor degradation in the classifiers performance. This eliminates the suspicion of overfitting and actually confirms the assumptions for the age influence provided in Sect. 2.4.

Another suspicion is the person-specific overfitting that might appear due to a small class variance. Fig. 3 presents the classes variance distribution among the different participants. The figure shows that for 14 out of 20 participants the class variance is in range from 0.66 to 3.32, meaning they have suffered variability in their BP measurements.

Fig. 4 presents the absolute values ranges of the features in each of the BP classes. The figure shows the amount of values (as % on the y-axis) corresponding to the given range on the x-axis. Observing the entropy as best visual representative, it can be seen that most of the entropy absolute values obtained from the instances in class 1 range from 1.20 up to 2.40; for class 2 this range tends to be from 2.40 to 3.60, and in class 3 most of the values are in range around 6. For the autocorrelation, it can be concluded that the limits are not so strict for the different classes, as well as for the mobility feature. This is not surprising since both of them have small average merit obtained from the feature’s information gain results; however they still influence the prediction results. For the complexity and the fractal dimension feature, the ranges are more

clear as in the entropy case. The age feature distribution over classes speaks that participants from all the age groups (x-axis) can be found in each class. However, observing the chart it can be concluded that older population suffers from higher BP and belongs to class 2 and 3. The age groups are created according to the age ranges proposed in the literature (Armstrong, 2008).

5 CONCLUSION

The recent efforts on BP estimation mainly focus on the morphological analysis of the physiological signals. The presented novel approach for BP classification takes into consideration complexity analysis of the ECG signal for the feature vectors creation. The experimental results from the flat ML approach confirm that the features are suitable for BP classification, i.e., J48 and Bagging have achieved accuracy of 81%, which is for 21 percentage points better than the majority class.

In addition, we proposed a stacking scheme by combining the output of different ML algorithms. The stacking scheme achieved an accuracy of 96.68%, which is for 15.36% improvement when compared to the best accuracy obtained by the flat ML design, or 36.36 percentage points improvement compared to the majority class.

Compared to the newest related work, the presented results show significant improvement in terms of simplicity and accuracy, avoiding the complex procedures when multiple types of signals and devices are involved for the BP estimation. We performed

several analyses to explain the accuracy improvements and our current hypothesis is that the complexity analysis on the ECG signals provides enough information for accurate BP class estimation. If that is indeed so, future BP measurements may be performed using only an ECG sensor. However, to completely confirm this hypothesis, our method should be evaluated on a bigger dataset with a leave-one-subject-out evaluation technique, including the publicly available physiological signals from the Physionet databases (Goldberger et al., 2000).

Our future work is towards the collection of ECG signals encompassing various ECG sensors and different target groups, since the research community is missing this kind of data. The goal is to create a balanced database, covering the critical BP classes (e.g., hypertensive crisis), and to develop sensor independent methodology for BP estimation. Finally, we plan to improve the methodology to be able to estimate the real SBP and DBP values (e.g., using regression techniques), and thus to contribute to the "single-sensor fits all" paradigm of using as least equipment to derive as much vital signs as possible.

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