Artificial Intelligence extension of the OSCAR-IB criteria

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Abstract

Artificial intelligence (AI) based diagnostic algorithms have achieved ambitious aims through automated image pattern recognition. For neurological disorders, this includes neurodegeneration and inflammation. Scalable imaging technology for big data in neurology is optical coherence tomography (OCT). We highlight that OCT changes observed in the retina, as a window to the brain, are small, requiring rigorous quality control pipelines. There are existing tools for this purpose. Firstly, there are human-led validated consensus quality control criteria (OSCAR-IB) for OCT. Secondly, these criteria are embedded into OCT reporting guidelines (APOSTEL). The use of the described annotation of failed OCT scans advances machine learning. This is illustrated through the present review of the advantages and disadvantages of AI-based applications to OCT data.

The neurological conditions reviewed here for the use of big data include Alzheimer disease, stroke, multiple sclerosis, Parkinson disease, and epilepsy. It is noted that whilst big data is relevant for AI, ownership is complex. For this reason, we also reached out to involve representatives from patient organizations and the public domain in addition to clinical and research centers. The evidence reviewed can be grouped in a five-point expansion of the OSCAR-IB criteria to embrace AI (OSCAR-AI). The review concludes by specific recommendations on how this can be achieved practically and in compliance with existing guidelines.

Introduction

Sophisticated artificial intelligence (AI) based algorithms not only enable discrete layer segmentation of retinal optical coherence tomography (OCT) scans, but can identify novel retinal features. A prominent recent example is automatic clinic referral via deep learning based on retinal layer analysis [1]. The current OSCAR-IB quality control (QC) criteria take algorithmic quality components into account (the A-criterion) but the criteria are not adapted to AI-based algorithms [2]. Given the recent success and rapid developments in this field, it is timely to build on the OSCAR-IB QC criteria to address the challenges of AI and big data specifically.

To this purpose it is critical to acknowledge that accuracy is paramount to the interpretation of retinal OCT in neurological disease. Judgments are highly dependent on quantitative data of individual retinal layers. Key components are thickness, degree of change and alteration of the topography. The retinal layer thickness changes seen in neurological disorders are much more subtle [3-7] than the pathologies seen in the ophthalmologic diseases, now successfully detected by AI-based methods [1,8,9]. For neurodegenerative diseases relevant annual retinal layer atrophy rates are just above the axial image resolution of

contemporary spectral-domain and swept-source OCT techniques [5]. For this reason, image QC is paramount. Over the past decade, big OCT data has accumulated in neurodegenerative and neuroinflammatory diseases. These data are attractive for the development of AI strategies. The expectation is to improve the accuracy of OCT-based quantification, diagnostic sensitivity and specificity, discover novel surrogates for monitoring disease progression as well as outcome metrics for clinical trials. Fully automated AI-based strategies are transferable from highly specialized services to primary care. The test throughput is also scalable to include, for example high street opticians. Both will aid with the logistics of patient care through local centers.

In 2012, we proposed the first consensus OCT QC criteria, OSCAR-IB [2]. The name served as a mnemonic for seven distinct QC criteria to be remembered; (i) **O**bvious errors, (ii) **S**ignal strength, (iii) **C**entration of scan, (iv) **A**lgorithm failure, (v) **R**etinal pathology, (vi) **I**llumination, (vii) **B**eam placement. This was followed by international validation [10] and endorsement to reporting guidelines [11]. The OSCAR-IB QC criteria which was developed in a multiple sclerosis (MS) network, and have since been broadly accepted. This success is at least in part due to the demand for clarity and transparency on being practical to 'get simple things right'. A similar approach is warranted for the role of AI in relation to OCT data in neurodegenerative diseases.

Review of evidence for need of QC

AI-based strategies are at risk for propagation of systematic errors, imbalance and bias due to subtle differences in data acquisition or post-processing. There is justified concern about the lack of QC standards for big data [12,13]. The rise of big data is in part driven by the hope of improving P4 medicine: predictive, preventive, personalized and participatory care [14]. For example, integrative prediction models encompassing as many as 63 variables have been proposed to enable personalized predictions of individuals' outcomes and guide treatment decisions in myeloproliferative neoplasms [15]. The implications that AI driven approaches will have for individuals can easily be influenced by bespoke sources of bias fed into the model as discussed below.

Importantly, minimal variation in image acquisition can cause substantial errors in the quantitative data [16,17]. Strategies based on AI are excellent in recognizing changes between images, but do not necessarily know how the human OCT operators have acquired an image. This can mislead the AI-based strategy with a downstream effect of possible misdiagnosis, mismanagement and harm. The risk for such a situation to occur increases with rapidly rising numbers of OCT scans to be evaluated. It may introduce systematic errors if imbalances exist between populations or centers., e.g. due to service capacity issues or automation of our health care systems. The possible medico-legal ramifications are also evident.

Review of failures and successes of retinal OCT in neurological diseases

To date, OCT data in MS and related disorders is most consistent as most reports adhered to the OSCAR-IB QC criteria and followed the APOSTEL reporting guidelines [2,11]. Results are more heterogeneous for other neurological diseases because of lack of standardization. There is evidence for an early publication bias in Alzheimer disease (AD) reports [6]. Subsequent data were not supportive of the earlier enthusiasm. Few of the reports on AD followed a rigorous QC approach. This similarly applies to reports of OCT in Parkinson disease (PD) [18,19], amyotrophic lateral sclerosis (ALS) [20-23], stroke [24], epilepsy [4,25] and schizophrenia [26].

Review of successes of AI in neurological diseases

There are critical successes for the use of AI in neurological disease. For example urgent triaging of individuals from brain imaging to neurosurgery [27]; earlier diagnosis of AD [28]; identifying suitable candidates for epilepsy surgery [29]; and regulation of adaptive deep brain stimulation in movement disorders [30]. Imaging-based trial outcome measures in neurology include almost all neurodegenerative, neurovascular and neuroinflammatory conditions alongside tumors [31]. Imaging data have become multi-modal. This adds to complexity and time needed by human readers and reporting. Likewise, histological data can now be used for machine and deep learning [32].

The review committee

The ophthalmological community has driven advances in AI-based analysis of retinal OCT [1]. The committee for this review has been expanded (Table 1). We included representatives from neurological sub-specialties who have used retinal OCT data for diagnostic and prognostic purposes, as well as treatment trial outcome measures. We have also engaged with experts in the fields of AI and bio-engineering and bio-statistics and two not-for-profit organizations (www.ern-eye.eu and www.imsvisual.org).

The patient voice

The importance of patient involvement as a key stakeholder has been recognized [33] and contributed to the development of conceptual models [34]. On a day to day practical level, the experience has demonstrated that individuals tolerate retinal OCT well. It is non-invasive, non-contact, quick and provides instant feed-back. The possibility to display images directly to the individuals and discuss changes has given them more confidence and insight in their care [35]. This good partnership has helped in working together to build trust, supporting treatment decisions and making OCT scans available for research. There is a need to maintain this mutual trust at a time where the immense amount of data accumulated now permits AI inspired projects on big data. None of this is possible without patient participation, their consent and feed-back. A key concern of patients and their advocates is that their data will be

misused. Individuals have a higher level of confidence in not-for-profit stakeholders than in government or private companies [36].

Data Protection and Privacy

Due to the requirement of very large training data-sets for optimal performance, most current clinical AI systems have been developed using routinely collected data which have been anonymized. Anonymization of medical images presents specific challenges, however, particularly images of individually-unique structures such as the neurosensory retina [37]. Even when carefully anonymized, there is at least a theoretical risk of re-identification for such images, either now or with some future technology [38]. Therefore, we recommend a multi-step approach to addressing data protection and privacy. Firstly, retinal OCT scans should be anonymized according to current national and international standards [39]. This includes removal of any imaging meta-data such as patient names, dates of birth, or medical record numbers, obscuration of hospital visit dates, plus careful consideration of any associated clinical meta-data (e.g., merging of categories/classes if they contain only a limited number of examples) [40]. Secondly, a range of additional safeguards should be put in place. Technical safeguards include the requirement to store data in trusted research environments with access controls and audit logs; contractual safeguards include prohibitions against linkage or attempted re-identification of

data. Importantly, every attempt should be made to minimize the data shared to that required for the clinical or research purpose - this is a fundamental principle of much data protection regulations, including the European General Data Protection Regulation (GDPR). Finally - and perhaps most importantly - it is vital to engage in patient and public engagement and involvement at the earliest possible stage. This includes making patients aware that their data is being used for research, publishing study protocols, and giving patients the opportunity to opt-out. By adopting a cautious and engaged approach such as this, we believe it is possible to reduce any data protection risks while maximizing the potential for future patient benefit. In the future, a range of technical solutions, including federated learning and homomorphic encryption, should help further mitigate these risks [41].

Search strategy and selection criteria

We reviewed three databases, PubMed, Web of Science and Google Scholar between 01-JAN-1963 and 23-APR-2020 without language restriction. We chose the English version of a manuscripts if the same group had published similar data in Dutch, French, German, Italian or Spanish. The search terms used were "optical coherence tomography" or "OCT" combined with "artificial intelligence", "machine learning", "deep learning", "multiple sclerosis", "optic neuritis", "dementia", "Alzheimer", "Parkinson", "motor neuron disease", "amyotrophic lateral sclerosis", "stroke", "cerebrovascular accident",

"schizophrenia", "patient voice". We also reviewed articles included in three systematic reviews previously conducted [3,5,8].

Methods

Firstly, we reviewed the original OSCAR-IB criteria to clarify which of the QC failures require an individual to be re-assessed or to be excluded if for example post-hoc homogenization approaches fail. Having to recall a patient for a failed test is not desirable, is problematic and is expensive. Secondly, we reviewed approaches to rectifying QC failures by image post-processing. Thirdly, we examined the outcome of our AI-based methods for irregularities, identical to the approach taken in the original OSCAR-IB report [2]. The terminology of terms explicitly related to AI is summarized in Table 2.

Defining QC for AI: RASCO

Firstly, there is a clear and justified fear of the misuse of big data [37]. Secondly, the patient-physician relationship must be supported to provide an optimal experience. Thirdly, demonstration of the capability of the AI strategy enhances the ability to produce high quality and relevant effectiveness research. Fourthly, it promotes accountability. Fifthly, it provides the grounding for the production of reproducible studies. Together, the definition of QC for AI can be summarized by five pillars which were named individually or in combination in the literature reviewed (Figure 1). The mnemonic, **RASCO, stands for Reproducibility (R)**, **A**ccountability for decisions made (A), to be

supportive of the patient-physician relationship (S), **C**apability ranging from machine learning (ML) supported OCT quality control assessment to time and resource efficient decision making (C), and **O**penness with and trust in public opinion (O) is pertinent, given the personal data protection issues discussed above.

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Big data

The utility of AI in medical applications is more dependent on data quality than quantity. The new research field of big data has contributed considerably to the advancement of medical science by analysis of large data-sets. Until recently, it had not been easy to accumulate enough data to create a large data repository and analyses were too complicated or lacked statistical and computer power. A critical area of weakness of big data can be the granularity and quality of the source data entered. In essence, the quality of outputs or results of AI-based assessments should not be expected to exceed the underlying quality of the data being analyzed (input data). This underpins the importance of maintaining the highest standards of quality, even in the AI space. As we are at the dawn of AI for OCT research, one of our aims is to facilitate the generation of the high-quality data needed for future research in the field.

Prospective OCT image QC

Each OCT scan should prospectively be labeled as QC fail or not. There are several reasons why a scan may fail QC. Each failed scan should be annotated with a complete list of reasons. An efficient way is to use the capital letters of the OSCAR-IB criteria [10]. To avoid a potential bias by eliminating scans from the sickest individual who may have difficulties with the test, this needs to be explicitly noted. Retinal and systemic co-morbidities require careful clinical evaluation with more in-depth ophthalmic phenotyping than hitherto done in most neurological studies [43].

QC failure may result in two situations: (1) where an error can be corrected at post-processing; and (2) where the error requires recalling and repeating the test

Human led OCT image QC is a time-consuming task so it is desirable for this to be performed using AI strategies. We suggest making use of the above-described annotation of failed scans for ML of OSCAR-IB criteria (Figure 2). This will enable the training of future AI algorithms to separate good from insufficient quality OCT scans. The next application step within the pool of scans designated as being of inadequate quality will be to identify those scans which may be subjected to post-acquisition correction approaches, thereby making them high quality, and enabling their safe and accurate utilization. This is a crucial step as it allows for AI training in auto-correction. Scans which failed OSCAR-IB and are not correctable must be excluded from any further AI steps.

Taken together this leaves a staged approach to QC in AI: (1) Automated AI OCT QC rating using validated OCT QC criteria [2,10]; (2) where possible AI QC correction during image post-processing, or if not possible patient recall for repeat acquisition; (3) Final step of AI-based image analysis. This will typically make use of pattern recognition and be the key step forward for the primary research questions. A limitation to keep in mind is that presently it is not possible to exclude ophthalmological co-morbidities without a clinical assessment.

AI artifact vulnerability

We have not identified reports on the vulnerability of algorithms to misclassification due to the use of different OCT devices or software versions. Even seemingly small updates have the potential to cause significant differences which if left unnoticed can bias results [44].

Ground truth

The definition of ground truth is disease-specific. It should be stated explicitly how the ground truth was defined. At the minimum for AD and other neurodegenerative dementias, epilepsy, MS, optic neuritis (ON), neuromyelitis optica spectrum disorder (NMOSD), PD, adherence to consensus investigation protocols and diagnostic criteria will be required. As diagnostic criteria in most

neurological diseases are regularly updated, this needs to be taken into account.

Statistics

The descriptive statistics reviewed were mostly based on binary classifiers such as a disease is present "yes/no". These models should include a comment on proportional bias [45]. This is needed to interrogate how much the AI-based prediction agrees with the ground truth. The definition for an acceptable ground truth needs to include the level of evidence on which it was based. For binary and multi classifier models the degree of inter-rater agreement should be stated to permit judging on how stable the ground is.

Graphs can be presented in a way that allows judgment of the degree of over-fitting and underestimation relevant in comparing differences between AI and ground truth. Many studies used Bland-Altman plots [46] or analyzed the performance of AI and ground truth based on a receiver operator curve (ROC) based area under the curve (AUC). This gives comparative estimates of sensitivity, specificity and the positive predictive value (PPV) as a measure of overall accuracy. This is particularly relevant for relatively rare diseases. It was recommended to complementing area under the curve ROC (AUROC) values by precision-recall (Precision is the PPV and recall is the sensitivity in the AI

literature) curves (AUPRC) [8]. This was found to be of relevance for unbalanced data-sets (substantially more subjects in one of the groups compared).

Cut-off level calculation

Reporting of calculation of cut off values included the use of independent cohorts, a graphical ROC based approach, the Youden Index, k-fold cross-validation or hold-out validation approaches to obtain accurate estimations of AI-based cut-off performance.

Power calculations

We did not yet find consistent reports of the inclusion of power calculations to studies, which are relevant for randomized controlled trials using AI-based outcome measures [47]. It is recommended that sample size estimates be performed before developing an algorithm and repeated after study completion. The gain in power, meaning a more robust statistical result, is just as informative for future research as the potential cost savings by optimizing numbers. Lastly, the standardized effect size, likely to come from AI, was recommended to be aligned with distribution, and anchor health economics to inform clinical trials on what will be a realistic difference [47,48].

Cohort description

On review cohort descriptions were mostly conform to contemporary standards on demographic characteristics. Cohort descriptions are relevant for AI, and will

also greatly limit/determine the usability of the system. This reinforces the need to build on successful initiatives such as the established Consolidated Standards of Reporting Trials of Electronic and Mobile Health Applications and online TeleHealth (CONSORT-EHEALTH) [49] and the CONSORT-AI guidelines [50]. Documentation of developmental changes is also relevant throughout pediatric care and at the transition to adult care. A novel source of potential biases related to the disease diagnostic criteria used. For many of the conditions of interest to retinal OCT, subsequent diagnostic criteria were published over the past decades. Whilst generally aimed at improving practicability, sensitivity and specificity, this bears the risk that cohorts which are supposed to have the same disease can be quite different in their composition. For example, subsequent diagnostic criteria for MS, AD, PD have profoundly reshaped the patient base for clinical research over time. Contemporary cohorts tend to be milder than historical cohorts [51]. Clinical trial populations are different from observational studies. The co-morbidity burden is relevant. Relevant items for the pooling of big data are: reporting of the exact diagnostic criteria, a detailed listing of all inclusion and exclusion criteria, recruitment, referrals and capability of individuals to comply with the examinations. Minimization of the risk of systematic bias will ensure that validation of AI in other cohorts will be comparable.

Validation

For all AI algorithm development efforts, data used for this purpose should be clearly described for discovery and replication analyses. To avoid obtaining a distorted/biased view on performance, data that is used for validation (for example to assess performance) should not have been used during algorithm development. There is a real risk for over-fitting the AI models. It was recommended to perform a validation of the algorithm with the aid of a comparable out-of-sample population. Each AI classification scheme should be rated to whether or not an **external validation** was performed. This can be supported by publishing details on the building blocks of the AI. Relevant are precise and meaningful definitions on a functional and performance level. This entails a detailed description of the AI architecture, hyper-parameters, as well as details on how the available data were used to train such systems, preferably via open access code repositories. One of the challenges with AI at regulatory level but also at the clinical level found was the fact that neural networks can learn with data and improve their performance. For this reason, it was suggested to define in advance which type of learning is allowed without requiring validation, approval or lack clinical risks.

Human versus machine and human with machine

It was reported that AI might improve over human performance in terms of accuracy and speed [52]. For this 'machine versus human' approach reporting

included data on sensitivity, specificity, positive and negative predictive values including the 95% confidence intervals (CI) and the numbers on which the calculations were based. These data permit to answer the question if AI can outperform humans not only as seen with Chess and 'Go' games [53,54], but also for classification of retinal appearances [55].

There is a second, equally important question to be answered. **How can AI be used to enhance human performance [56]?** Therefore, it was recommended to test if there is a synergistic effect if the AI and human approach are combined. This is typically referred to as human-AI symbiont/symbiotic [57].

Clinical practice

The relevance of potential clinical downstream effects has been recognized [58-60]. The big chances are to reduce the burdens on physicians and help with service capacity issues. It was recommended to indicate if an algorithm is useful for clinical practice. This requires to test the algorithm in clinical routine. There were different levels at which algorithms added information: on an individual level, on a cohort level or for screening purposes. There can be important consequences for daily clinical care and health systems. Concerns reported related to misdiagnosis and practicability. This has implications for disease classification [61].

Guidelines

At the time of the review the following guidelines were relevant, APOSTEL,
TRIPOD-AI, CONSORT-AI [50], SPIRIT-AI, STROBE [62] guidelines. They are regularly
updated and latest information can be found on the equator network website at
www.equator-network.org/.

Open access

Open access and data sharing were found to be essential for accountability and
reproducibility. The classified sample dataset is just as valuable as the
developed algorithm. Datasets can potentially be used by other groups, to
facilitate even greater improvements. Accordingly, data availability may
accelerate development in the field. Algorithms can also be transferable and
codes can be shared.

Black box

On review there is a need to understand on what basis an algorithm came to a
particular conclusion.

Review of the black box of OCT in neurology

There are a few careful predictions one can make regarding the "black box" for
neurodegeneration based on anatomy and progression pattern.

Firstly, anatomically each area in the retina is connected by axons with a corresponding area in the brain because of the hard-wired retino-cortical projections [3,5]. The location of damage to the brain will determine the location of expected OCT changes in a determined area of the retina, a "Region of Interest" (ROI). It has been shown that an ROI based approach to quantification of inner retinal layer atrophy is superior to occasionally performed sector analysis [5-7] or the generally adopted global averaged approach because it can mask small areas of atrophy [63,64].

Secondly, the progression pattern is determined by location and size of a lesion damaging the retino-cortical projections [64-66]. The speed of progression is highest and the area of inner retinal atrophy most extensive with direct retrograde axonal degeneration as seen with optic nerve damage. More distal brain damage will still cause localized atrophy in the retina by a mechanism called retrograde trans-synaptic axonal degeneration [65,67]. On sequential OCT imaging the time course of atrophy is shorter with small brain lesions compared to larger brain lesions [64]. It can be anticipated that a smoldering, slowly enlarging brain lesion will continue to drive the expansion of OCT detectable retinal atrophy [68].

Thirdly, inflammatory activity in demyelinating disease has been related to transient increase of the inner nuclear layer (INL) volume [69-73]. Part of this INL thickening is related to the development of microcystic macular edema (MME) [69,70,74]. Vitreous traction had been implicated, but is not required for the development of MMO [75]. In most (>80%) cases, MMO is a transient

phenomenon [74]. In the remainder, it remains static over the years [74,76] and is considered by some to represent a retrograde maculopathy [77] due to axonotmesis in the anterior visual pathways as known from experimental models [78].

Fourthly, there are qualitative observations on the OCT images which have not yet been translated into automated forms of quantification. One example is the presence of hyper-reflective spots [74]. There are two types of these hyper-reflective spots on OCT, and one is static and particularly visible at the upper and lower border of the INL. With the advent of OCT-Angiography (OCTA) and adaptive optics, it has become clear that they represent reflectivity changes from the inner retinal vasculature [79]. There is at least another type of hyper-reflective spot noticed on serial OCT images, which migrates vertically through the retina.

Fifthly, the vitreous has specific OCT signal characteristics which can reliably quantified from the raw image data [80,81]. The technique is useful in neurological disease affecting younger adults where the vitreous body still adheres to the retina such as the majority of people with MS [82]. The evaluation of the raw OCT data, rather than analysis of an already post-processed screen image is required due to signal changes.

Sixth, advanced image shape analyses now permit for quantitative data on qualitative characteristics of the optic disc. The technique has proved valuable in idiopathic intracranial hypertension [83,84] and possibly also idiopathic moyamoya angiopathy [85]. Similarly, the presence of peripapillary hyper-

reflective ovoid mass like structures (PHOMS) are a novel OCT finding [86], which akin to MMO remained undetectable on conventional funduscopic examination. Likewise shape analysis of the fovea has become possible [87][87,88] .

Sevenths, functional assessment of individual retinal layers by OCT is possible using for example a dark adaptation [79]. One can anticipate that with the availability of OCTA the retinal equivalent of a blood-oxygen-level-dependent (BOLD) signal for the brain will emerge [89]. Increased, localized retinal metabolic activity will demand increased oxygen supply and cause elevated perfusion of the microvasculature [79]. Pioneering data on OCTA in MS imply that there is a need for AI-supported QC to exclude artifacts [90-92]. This will be relevant for reliable quantitative OCTA data on the retinal microvasculature which may help to differentiate between disease entities such as MS and NMOSD [93].

Eighth, inter-eye differences of individual retinal layers are an attractive and highly sensitive method to screen for optic neuritis and MS [43,94-101]. Expanding on these findings there is a field for AI-based analyses of patterns of retinal asymmetry in MS [43].

Lastly, reflectivity changes of individual layers can be interrogated to estimate tissue properties indirectly [102,103].

Based on the above combination of numerous quantitative and qualitative changes in retinal (neural and non-neural tissue) architecture in neurological disease, there are promising avenues for a supervised ML approach to the analysis and interpretation of OCT data. Equally, for researchers who prefer to follow a non-supervised ML approach, the committee recommends checking if

findings may be explainable, at least in part, by the above summary of anatomically, biologically and pathologically plausible observations.

Summary

In summary, we reviewed several levels of AI-based OCT research in neurology. The main points arising from this review are summarized in Table 3 and based on five pillars (RASCO). The practical conclusions from the multiple levels of evidence reviewed and the summary table may be found helpful on a practical level for future research in the field.

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Conflict of Interest Statement

A.Petzold is part of the steering committee of the ANGI network which is sponsored by ZEISS, steering committee of the OCTiMS study which is sponsored by Novartis and reports speaker fees from Heidelberg-Engineering.

P. Albrecht reports consulting fees, research grants and non-financial support from Allergan, Biogen, Celgene, Ipsen, Merck Serono, Merz Pharmaceuticals, Novartis, and Roche, consulting fees and non-financial support from Bayer Healthcare, and Sanofi-Aventis/Genzyme, outside the submitted work.

L. Balcer reports personal fees from Biogen; she is editor in chief of the Journal of Neuro-Ophthalmology.

E. Bekkers has nothing to disclose

A. Brandt is cofounder and shareholder of startups Motognosis and Nocturne. He is named as inventor on several patent applications description MS serum biomarkers, perceptive visual computing and retinal image analysis.

R. Bremel has served as a consultant for Biogen, EMD Serono, Genzyme/Sanofi, Genentech/Roche, Novartis, and Viela Bio. He receives ongoing research support directed to his institution from Biogen, Genentech, and Novartis.

P.A. Calabresi has received consulting fees for serving on scientific advisory boards for Biogen and Disarm Therapeutics, and is PI on grants to Johns Hopkins from Biogen, Gentech, and Annexon.

O. Galvin has nothing to disclose

J.S. Graves has grant/contract research support from the National MS Society, Biogen, and Octave Biosciences. She serves on a steering committee for a trial supported by Novartis. She has received honoraria for a non-promotional, educational activity for Sanofi-Genzyme. She has received speaker fees from Alexion and BMS and served on an advisory board for Genentech.

A. Green reports grants and other support from Inception Biosciences;

Guthy-Jackson Foundation. She has served on a scientific advisory panel for Hoffman-Laroche and Biogen and has received speaker's honoraria from Novartis, CMSC, MS at the Limits, Canadian Rheumatological Association.

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Table 1: *Expertise of the literature review committees.*

Expertise	Members
Patient voice	Nils Wiegerink (patient), Russel Wheeler (patient advocate), Christiaan Waters (President of patient organisation), Avril Daily (Retina International, ERN-EYE), Christina Fasser (Retina International, ERN-EYE), Orla Galvin Deborah (Retina International, ERN-EYE) Oshakuade (Retina International, ERN-EYE)
AI	Erik Bekkers, Siegfried Wagner, Pearse Keane
Public relation & Media	Avril Daily
ALS	Philip Albrecht, Orhan Atkas
Alzheimer disease	Thomas Wisnewski
Epilepsy	Josemir W. Sander
Parkinson disease	Alexander Brandt, Philipp Albrecht, Orhan Atkas
Stroke	Shadi Yaghi, Arvind Chandratheva
Multiple Sclerosis	Alexander Brandt, Peter Calabresi, Laura Balcer, Elliot & Tree Frohman, Friedeman Paul, Ari Green, Pablo Villoslada, Axel Petzold, Philipp Albrecht, Orhan Aktas, E. Ann Yeh, Bernardo Sanchez-Dalmau, Jen Graves, Shiv Saidha, Robert Bermel, IMSVISUAL, ERN-EYE
Rare Diseases	Alexander Brandt, Philipp Albrecht, Orhan Atkas, Axel Petzold, Friedeman Paul, Frederike Oertel, Alexander Brandt, E. Ann Yeh, Avril Daily (Retina International, ERN-EYE), Christina Fasser (Retina International, ERN-EYE), Orla Galvin Deborah (Retina International, ERN-EYE) Oshakuade (Retina International, ERN-EYE), Bernardo Sanchez-Dalmau, ERN-EYE
Ophthalmology	Bernardo Sanchez-Dalmau, Pearse Keane, Siegfried Wagner
Neuro-ophthalmology	Fiona Costello, Ari Green, Axel Petzold, Laura Balcer, Bernardo Sanchez-Dalmau, Jen Graves, ERN-EYE
OCT	Alexander Brandt, Frederike Oertel, Hannah Zimmerman, Philipp Albrecht, Orhan Atkas, Peter Calabresi, Axel Petzold, Jen Graves,

	Rachel Nolan-Kennedy, Laura Balcer, Shiv Saidha, Bernardo Sanchez-Dalmau, Pablo Villoslada, Robert Bermel
OCTA	Benjamin Knier, Shiv Saidha, Axel Petzold
Clinical trials OCT QC	Alexander Brandt, Friedeman Paul, Sven Schippling, Axel Petzold, Robert Bermel, Laura Balcer
Statistics and epidemiology	David Crabb, Gary Cutter, Laura Balcer, Jen Graves, Rachel Nolan-Kennedy, Kathryn Fitzgerald, Zhaoxia Yu

Table 2: *Terminology and basic concepts*

Artificial Intelligence (AI)	Computer or machine-based intelligence which enables "learning" and "problem solving"
Machine learning (ML)	One subset of AI. Typically algorithms improve automatically through experience after training on a dataset. ML can be supervised or unsupervised
Deep learning	One subset of ML essentially based on artificial neuronal networks. Very efficient and the basis of most contemporary AI-based studies on image recognition
Supervised	Supervised ML works on a labelled training dataset (for example OSCAR-IB OCT scans) and reproduces the desired outcome
Unsupervised	Unsupervised ML tries to discover previously undetected patterns in a dataset
Over fitting	Over fitting can be a problem with ML, a source of over-enthusiastic reporting and reason for lack of reproducibility

Table 3: *Summary of key points from the literature review on OCT and AI research in neurology. The categories are based on the mnemonic "RASCO". This table may be found helpful in guiding future use of the reported data for AI-based studies.*

Question	Answer
REPRODUCIBLITY	
OSCAR-IB OCT quality control compliant ?	Yes / No
APOSTEL OCT reporting guideline compliant ?	Yes / No
TRIPOD-AI compliant ?	Yes / No
CONSORT-AI compliant ?	Yes / No
SPIRIT-AI compliant ?	Yes / No
STROBE compliant ?	Yes / No
ACCOUNTABILITY	
Training, test & validation sets explained ?	Yes / No
Potential for bias[14] in big data addressed ?	Yes / No
Ground truth explicitly stated ?	Yes / No
Statement on proportional bias given ?	Yes / No
Precision recall curves provided ?	Yes / No
Power calculations included ?	Yes / No
SUPPORTS PATIENT DOCTOR RELATIONSHIP	
Patient voice included ?	Yes / No
Conflicts of interest, including political, explained ?	Yes / No
Shows how AI is used to enhance human performance ?	Yes / No

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14   Sources of bias can be analytical, clinical, statistical, imbalance in populations or centres where the original research was conducted.

Tested in clinical practise ?	Yes / No
CAPABILITY OF ALGORITHM	
Unsupervised AI[15] ?	Yes / No
Has QC capabilities[16] ?	Yes / No
Provides a glimpse into the black box[17] ?	Yes / No
Vulnerabilities of AI explained[18] ?	Yes / No
External Validation ?	Yes / No
OPENNESS	
Data availability statement ?	Yes / No
Data deposited in repository ?	Yes / No
AI deposited in open access code repository ?	Yes / No

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15 See Table 2

16 See Figure 2

17 See Figure 3

18 Vulnerabilities to artefacts, use of different devices, hard- or software updates of the OCT device.

Figure legends

Figure 1: **The goal of quality control in Artificial Intelligence (AI) rests on five pillars: RASCO.** (1) **O**penness with and trust in the public opinion, (2) to be **s**upportive for the patient-physician relationship, (3) **C**apability ranging from machine learning (ML) supported OCT quality control assessment to time and resource-efficient decision making, (4) **A**ccountability for decisions made, (5) **R**eproducibility (**RASCO**).
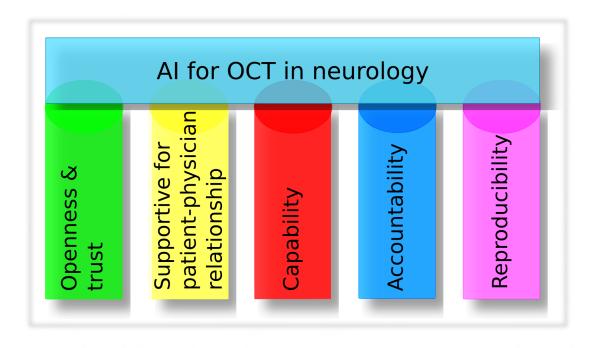
Figure 2: The capability of AI to contribute interpreting OCT images depends on the optimization of each step contributing to the decision tree. The first step relates to the quality of the raw data. Validated QC criteria for OCT image have been summarised as OSCAR-IB [2]. The ground truth of whether or not an OCT passes QC is based on human assessment. The seven OSCAR-IB criteria for QC rejection by a human assessor can directly be used to train AI. Annotation of corrupted OCT scans permit for two outcomes (1) image post-processing and repair of artefacts or (2) complete rejection and (if feasible) recall of patient and OCT rescan. Only a dataset that passed OCT image QC should be used for further AI interpretation.