

DIAGNOSING CLEFT LIP PATHOLOGY IN 3D ULTRASOUND: A LANDMARKING-BASED APPROACH

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1 **DIAGNOSING CLEFT LIP PATHOLOGY IN 3D ULTRASOUND:**
2 **A LANDMARKING-BASED APPROACH**

3
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15ABSTRACT

16

17Aim of this work is to automatically diagnose and formalize prenatal cleft lip with
18representative key points and identify the type of defect (unilateral, bilateral, right, or
19left) in three-dimensional ultrasonography (3D US). Differential Geometry has been
20used as a framework for describing facial shapes and curvatures. Then, descriptors
21coming from this field are employed for identifying the typical key points of the defect
22and its dimensions. The descriptive accurateness of these descriptors have allowed us
23to automatically extract reference points, quantitative distances, labial profiles, and to
24provide information about facial asymmetry. Eighteen foetal faces, ten of healthy
25foetuses and eight with different types of cleft lips, have been obtained through a
26Voluson system and used for testing the algorithm. Cleft lip has been diagnosed and
27correctly characterized in all cases. Transverse and cranio-caudal length of the cleft
28have been computed and upper lip profile has been automatically extract to have a
29visual quantification of the overall labial defect. The asymmetry information obtained
30is consistent with the defect. This algorithm has been designed to support
31practitioners in identifying and classifying cleft lips. The gained results have shown
32that Differential Geometry might be a proper tool for describing faces and for
33diagnosis.

34

35Keywords: Cleft lip; dysmorphisms; landmarking; syndrome diagnosis; 3D ultrasound.

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39INTRODUCTION

40

41 Three-dimensional ultrasound (US) has been introduced more than twenty years
42ago into clinical practice (Riccabona *et al.*, 1997). Its applications on diagnosis of
43anomalies and diseases were a direct consequence of its use. In particular, cleft lip
44and palate (CLP) detection, whose incidence is 1/700 in United States (Tonni and
45Lituania, 2013), was widely addressed, as they could be difficult to be diagnosed with
46bi-dimensional US, especially in earlier gestational ages (Hata *et al.*, 1998). In the
47effort to quantify the performance of routine ultrasonographic screening on an
48unselected population, the Eurofetus study (Grandjean *et al.*, 1999) shows that CLP
49has the lowest rates of detection (18%) and it is diagnosed usually later in pregnancy
50(only 31.6% before 24 weeks). Furthermore, CLP is identified with a lower occurrence
51by prenatal US when the anomaly is isolated than in the cases where multiple

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52anomalies coexist, as frequently noticed during autopsies following termination of
53pregnancy of fetuses with diagnosed multiple diseases (Luck *et al.*, 1992).
54Complementarily, 3D, despite some criticisms (Maarse *et al.*, 2010), has been
55considered more accurate than bi-dimensional data in detecting unaffected lips at less
56than 24 weeks (Pretorius *et al.*, 1995).

57 In this work we will focus on cleft lip (CL) alone. CL, “both unilateral and
58bilateral, includes clefts involving the alveolus and hard palate anterior to the incisive
59foramen, namely the embryological primary palate” (Demircioglu *et al.*, 2008). The
60tested rates of antenatal detection of CL range 21-30% (Rotten and Levillant, 2004).

61 Cleft lip has been associated with more than one-hundred different
62chromosomal abnormalities and genetic syndromes (Jones, 1993), and sometimes may
63be the only sign of a chromosomal anomaly, as trisomy 18 (Carlson, 2000), trisomy 13,
64or syndromes such as Cornelia de Lange or Smith-Lemli-Opitz (Roelfsema *et al.*, 2007).
65Thus, an accurate scan searching for other foetal anomalies and a genetic counselling
66are paramount when a cleft lip is diagnosed. Cleft lip does not go with any palatal
67abnormality in 15-25% cases (Bäumler *et al.*, 2011, Offerdal *et al.*, 2008). More
68generally, if we consider CLP as a whole, the incidence of structural anomalies and
69syndromes accompanying cleft lip and palate ranges between 21% and 38%
70(Campbell *et al.*, 2005). But it is important to note that, although they often occur with
71each other, cleft lip and palate abnormalities are “developmentally distinct processes”
72(Lee *et al.*, 2000). In particular, the embryological origins of lips and alveolus clefts
73appear to be distinct from those of secondary palate cleft (Campbell *et al.*, 2005).

74 Lee *et al.* (2000) used three-dimensional ultrasonography to support cleft lip
75and palate detection. CL was identified by an examiner as “a loss of continuity of the
76orbicularis oris muscle from a coronal or axial view of the lips” (Lee *et al.*, 2000), so
77the diagnosis was not automatic. Campbell *et al.* (2005) assessed the clinical value of
78a three-dimensional US technique, the 'reverse face' view, in the prenatal
79categorization of orofacial clefts including CL. Then, Platt *et al.* (2006) proposed the
80'flipped face' view to diagnose lip and palate cleftings, relying on 3D US. When a static
81volume is acquired, it is rotated 90° so that the cut plane is directed in a chin-to-nose
82plane and scrolled to examine in sequential order different zones, including lips.
83Mailáth-Pokorny *et al.* (2010) investigated the role of foetal MRI in the antenatal
84diagnosis of facial clefts, including cleft lip, although no particular detection technique
85has been employed. Martinez-Ten *et al.* (2012) investigated whether systematic
86examination of primary and secondary palate supported the detection of face cleftings
87during first trimester. Gindes *et al.* (2013) studied the potential of three-dimensional
88US for palate view in fetuses at high risk for CLP. An in-depth palate assessment was
89made adopting both 2D and 3D US on the axial plane. Then, the outcoming prenatal
90diagnosis was compared to after-birth findings.

91 Some authors used landmarks as reference points. Johnson *et al.* (2000)
92assessed the advantages of three-dimensional US in diagnosing cleft lip. The volume
93data were displayed in two formats: three orthogonal planar images and a three-
94dimensional rendered image of the foetal facial surface. The planar images were
95“rotated with the interactive display into a standard anatomic orientation, so that the
96three planar images corresponded to the frontal, sagittal, and transverse facial planes”
97(Johnson *et al.*, 2000). The rendered image provided landmarks for the planar images.
98Roelfsema *et al.* (2007) used 3D US to perform foetal orofacial clefts examination and
99quantified the craniofacial variability index (CVI) in distinguishing between isolated

100 cleft lip/palate and cleft lip/palate in chromosomal abnormalities or syndromes. Facial
 101 landmarks such as tragus, nasion, gnathion, glabella, subnasion, and others were
 102 employed to extract sixteen craniofacial measurements for the evaluation of after-
 103 birth abnormal/regular orofacial development. Although none of the fetuses
 104 evaluated in their study was affected by cleft lip, Sepulveda *et al.* (2010) proposed a
 105 novel sonographic landmark typical of the first trimester, the 'retronasal triangle', to
 106 be adopted for the early screening of CP. This landmark has been termed this way
 107 because coronal plane displays three easily identifiable echogenic lines: the two
 108 maxilla frontal processes and the primary palate. Manganaro *et al.* (2011) studied CLP
 109 via MRI and ultrasound, although not 3D. Facial landmarks in the zones of forehead,
 110 occiput, orbits, nose, lips, chin, mandible were identified and analyzed for each fetus.
 111 Tonni and Lituania (2012) proposed a new three-dimensional sonographic software, the
 112 OmniView algorithm, and applied it to unilateral CL, bilateral CLP, and isolated CP. They
 113 showed that 3D imaging of the foetal hard and soft palates by OmniView was
 114 technically easier than with previously reported 3D techniques. OmniView allowed
 115 visualization of all anatomical landmarks of the specific targeted zone, i.e. labia,
 116 primary palate, alveolar ridge, posterior palate, uvula, velum, and tongue.

117 This work introduces a methodology for automatically diagnosing cleft lip and
 118 assessing specific information about the detected cleft, such as transverse and cranio-
 119 caudal lengths, upper lip outline, and a quantification of facial asymmetry.

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123 MATERIALS AND METHODS

124

125 During 2013, 38 3D volumes of 38 fetuses at 22-32 weeks' gestation were
 126 acquired. Eight of them were fetuses affected by cleft lip. Written informed consent
 127 was obtained from the parents for publication of clinical details, clinical images, and
 128 videos. Principles outlined in the Declaration of Helsinki have been followed.

129 Among these acquisitions, 18 were selected and processed for the purposes of
 130 the study, keeping all the eight faces with cleft lip. The leftover ones were excluded
 131 due to damages, acquisition inaccuracy, noise, and wrong or unusable fetus's
 132 position, such as hands on face or similar.

133 The US equipment was a Voluson system (GE Healthcare, Wauwatosa, WI, USA),
 134 with a RAB 4-8 (real time 4D convex transducer probe). The GE RAB 4-8 has a
 135 frequency range of 4 to 8 MHz and is used for OB applications (Footprint 63.6 x 37.8
 136 mm, FOV 70°, V 85°x70°). Table 1 shows data details and respective scan settings.

137

Ultrasound examination											
Volume Ultrasound: GE Voluson e - Transducer: RAB 4-8-RS/OB											
Foetus		Scan Setting									Defect
Name	Week	MI	Fr	TIs	Quality	Th	B(°)	V(°)	Mix	SR I	Cleft lip?
Anto	32	0,9	4,2/10,8 cm/51 Hz	0,1	max	30	52	65	40/60	II	no
Bart	32	0,9	3,7/11,0 cm/52 Hz	0,1	max	29	50	65	50/50	II	no
Lisa	32	1,	4,1/9,7 cm/54	0,	max	3	53	65	40/6	II	no

5

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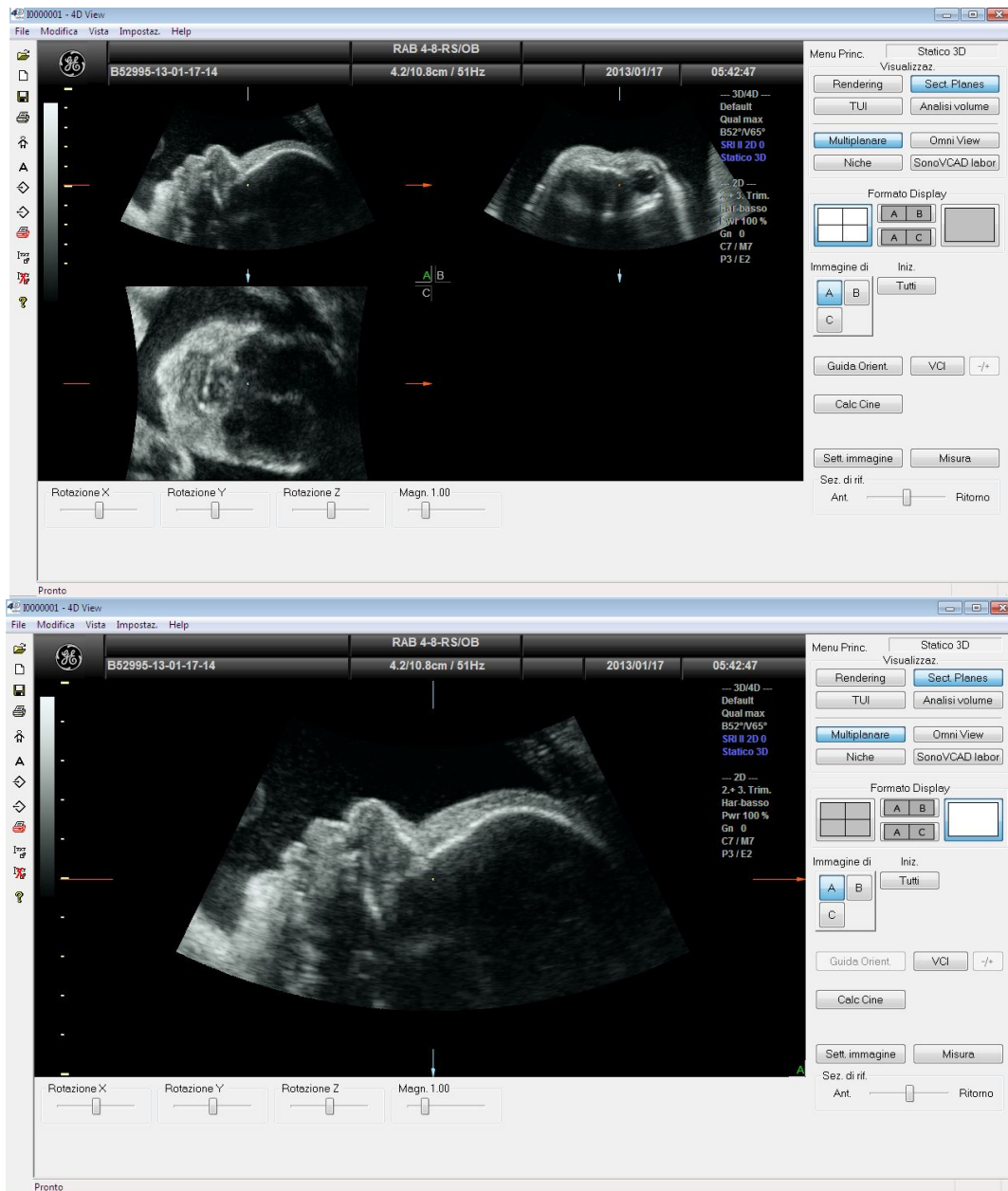
		1	Hz	1		0			0		
Gio	22	1,1	3,6/10,2 cm/58 Hz	0,1	max	30	47	65	40/60	II	no
Gian	22	1,0	3,6/8,1 cm/68 Hz	0,1	high 2	30	46	65	40/60	II	no
Paul	32	1,1	2,8/10,9 cm/49 Hz	0,2	max	30	54	65	40/60	II	no
Pie	32	1,1	1,7/8,1 cm/55 Hz	0,1	max	30	58	65	40/60	II	no
Elena	32	0,9	4,2/10,8 cm/47 Hz	0,1	max	30	56	65	40/60	II	no
Fede	32	0,9	4,4/11,1 cm/51 Hz	0,1	max	30	50	65	40/60	II	no
Simon	32	1,1	3,5/9,6 cm/56 Hz	0,1	max	30	50	65	40/60	II	no
A	32	0,9	4,2/10,8 cm/51 Hz	0,1	max	30	52	65	40/60	II	Unilateral complete
B	32	0,9	3,7/11,0 cm/52 Hz	0,1	max	29	50	65	50/50	II	Unilateral complete
C	32	0,9	4,2/10,8 cm/47 Hz	0,1	max	30	56	65	40/60	II	Bilateral complete
D	32	0,9	4,4/11,1 cm/51 Hz	0,1	max	30	50	65	40/60	II	Bilateral complete
E	22	1,0	3,6/8,1 cm/68 Hz	0,1	high 2	30	46	65	40/60	II	Unilateral incomplete
F	32	1,1	4,1/9,7 cm/54 Hz	0,1	max	30	53	65	40/60	II	Unilateral incomplete
G	32	1,1	2,8/10,9 cm/49 Hz	0,2	max	30	54	65	40/60	II	Unilateral complete
H	32	1,1	3,5/9,6 cm/56 Hz	0,1	max	30	50	65	40/60	II	Unilateral incomplete

138 **Table 1.** Weeks' gestation, scan settings, and eventual cleft lip features for each baby.

139
140 4D VIEW software allows to see the acquired images on three orthogonal planes: axial,
141 sagittal, and coronal (Fig. 1, above). The plane chosen for the facial shell modelling is
142 the midsagittal (Fig. 1, below).

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Figure 1. Multiplanar image (above) and midsagittal plane (below).

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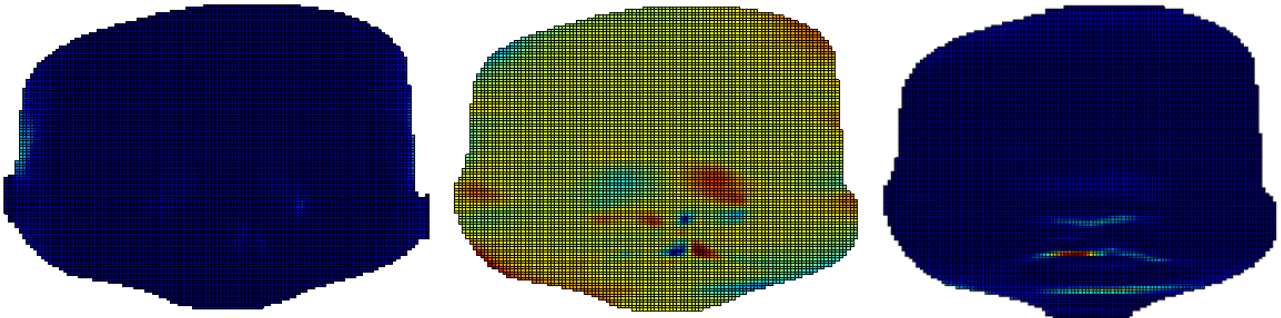
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Appendix. These descriptors rely on previous work of our research group (Calignano

161and Vezzetti, 2010; Vezzetti *et al.*, 2011-2014). Figures 2-8 show their behaviour on a
162facial shell with cleft lip.

163

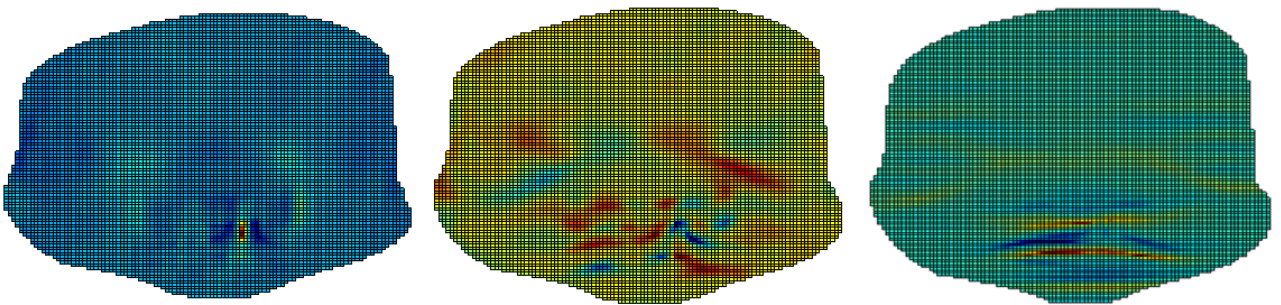
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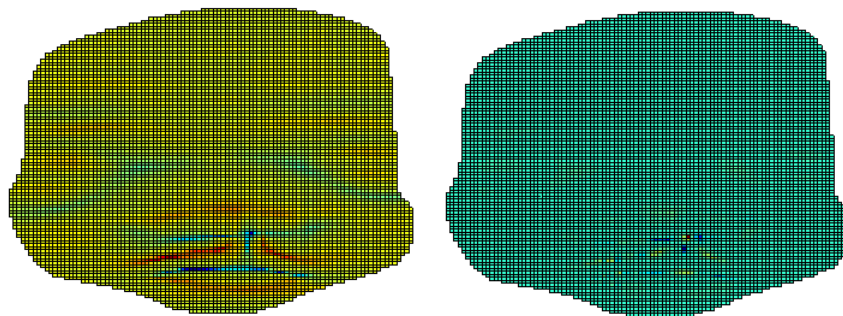
Figure 2. The coefficients of the first fundamental form E , F and G .



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168

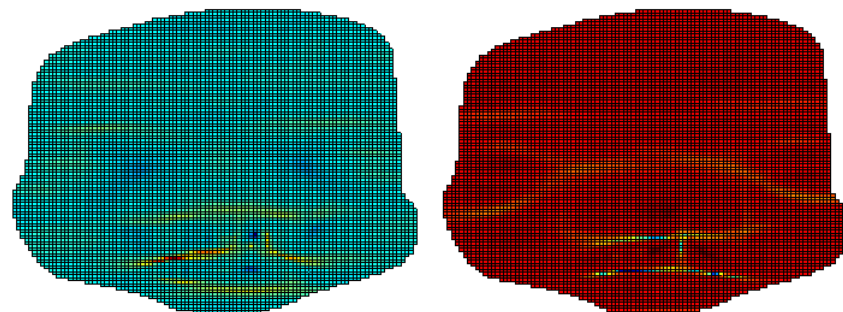
Figure 3. The coefficients of the second fundamental form e , f and g .



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Figure 4. The mean and Gaussian curvature H and K .



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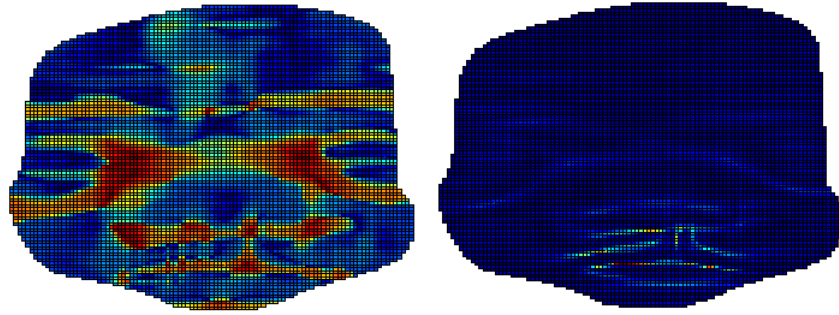
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173

Figure 5. The principal curvatures k_1 and k_2 .

11

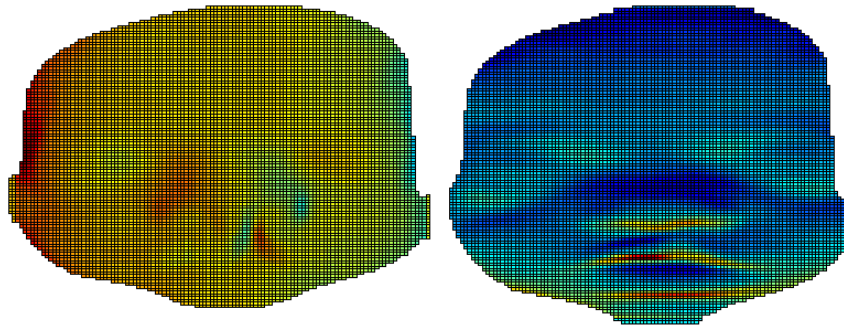
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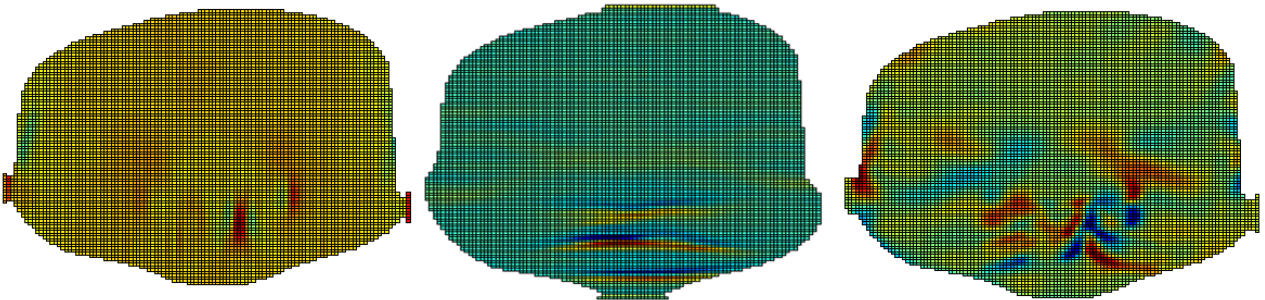
Figure 6. The Shape and Curvature Indexes S and C .



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177

Figure 7. The first derivatives D_x and D_y .



178

179

Figure 8. The second derivatives D_{xx} , D_{yy} and D_{xy} .

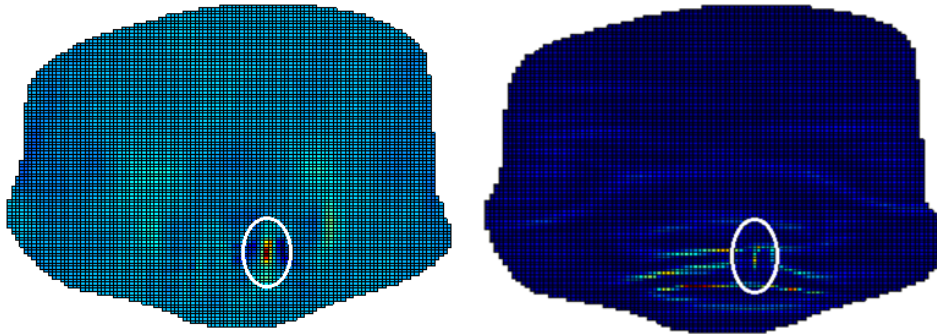
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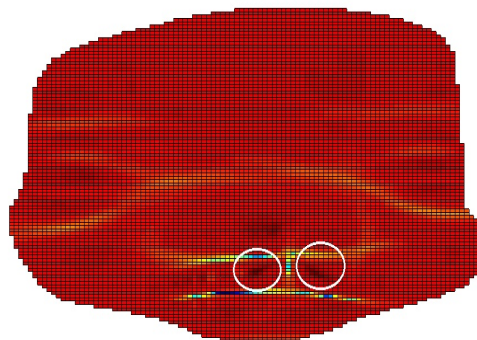
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183 DETECTION OF THE DEFORMITY

184
185 Cleft lip is a gap/indentation in the upper lip. The proposed algorithm
186 demonstrates that this defect could be detected via point-by-point mapping
187 geometrical descriptors on facial depth map. This indentation is characterized by high
188 numerical values of coefficient e and of Curvedness Index C in correspondence to the
189 zone of interest, as shown in Figure 9. Moreover, the two parts of the lip that are
190 located beside the indentation are characterized by two maximums of the principal
191 curvature k_2 , as can be seen in Figure 10.
192



193
194 **Figure 9.** The behaviour of the coefficient e (left) and of the Curvedness Index C (right) in a foetus with
195 cleft lip. The circle highlights the area of the gap.

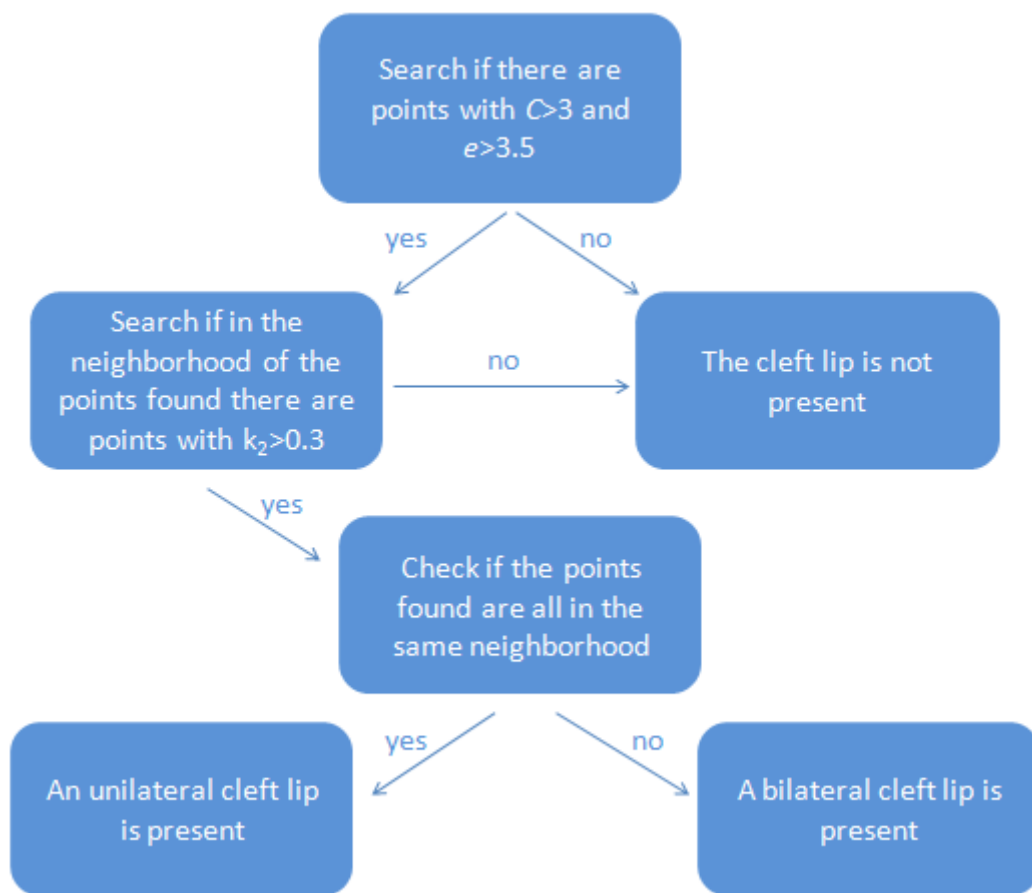


196
197 **Figure 10.** The behaviour of the principal curvature k_2 in a foetus with cleft lip. The two circles highlight
198 the areas of the lip beside the gap.
199

200 The designed algorithm adopts the previous geometrical features to detect
201 whether the cleft lip is present or not in a foetus's face. Moreover, this algorithm is
202 able to automatically distinguish between unilateral and bilateral cleft lip. It is
203 composed by the following steps.

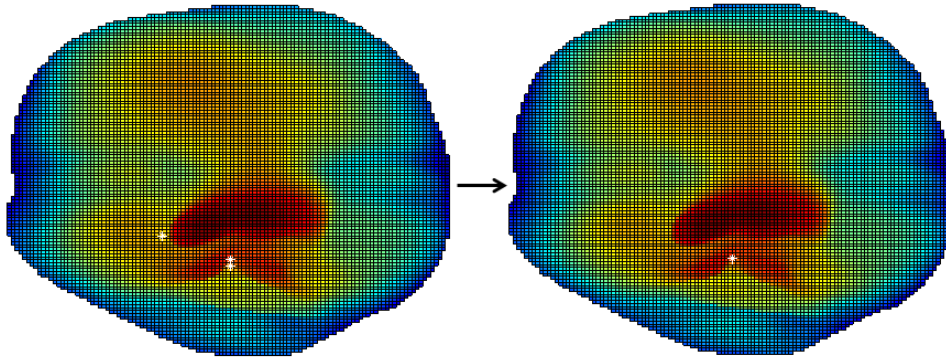
- 204 1. The algorithm searches if there are points whose coefficient e and Curvedness
205 Index C are greater than a threshold value ($C > 3$ and $e > 3.5$). These are the
206 geometrical features of the gap in the lip. Thresholds are set via
207 experimentation.
- 208 2. If the search of the step 1 gives no results, the cleft lip is not present.
209 Otherwise, another check is performed in order to verify that a cleft lip is really
210 present. For each point that satisfies the conditions of step 1, the algorithm
211 searches if in its neighbourhood there are points with a high value of the
212 principal curvature k_2 ($k_2 > 0.3$). These are the geometrical features of the two
213 parts of the lip beside the gap. This further condition is needed, as in some

214 cases the points close to the *a/ae* of the nose could have the same geometrical
 215 features searched in step 1.
 216 3. If the search of the previous step gives no results, the cleft lip is not present;
 217 otherwise it is.
 218 4. In order to verify if it is an unilateral or bilateral cleft lip, the algorithm checks if
 219 the points that satisfy the condition of step 1 and 2 are all in the same
 220 neighbourhood or not. If they do not belong to the same neighbourhood, the
 221 cleft lip is bilateral.
 222 The steps of the process are explained in the scheme of Figure 11.
 223 In Figure 12, the points found in step 1 and 2 are shown in a shell with an unilateral
 224 cleft lip.
 225 In Figure 13, the points found in step 1 and 2 are shown in a shell with a bilateral
 226 cleft lip.
 227

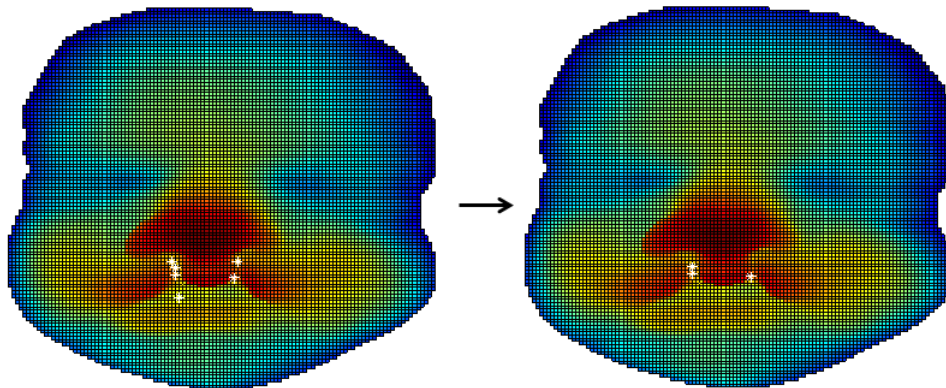


228
229

Figure 11. Scheme of the process for cleft lip diagnosis.



230
 231 **Figure 12.** On the left: the points found in the first step of the algorithm. On the right: the points found in
 232 the second step of the algorithm.



233
 234 **Figure 13.** On the left: the points found in the first step of the algorithm. On the right: the points found in
 235 the second step of the algorithm.

236

237 LOCALIZATION OF KEY POINTS

238

239 In order to quantify the deformation, four key points are automatically localized:
 240 the two points of the lip that are beside the cleft and the ending points of the cleft,
 241 shown in Figure 14.

242



Figure 14. The four key points of the cleft lip.

243
 244
 245

246 As mentioned above, the principal curvature k_2 has two maximums in the first
247 two points. The automatic localization algorithm:

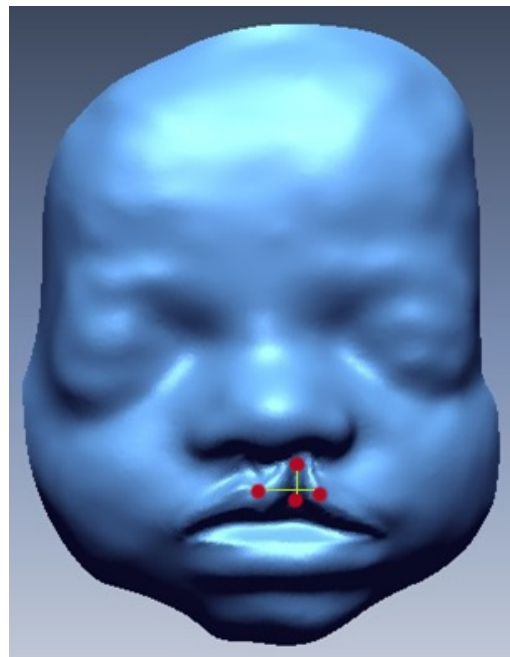
- 248 1. after deformity detection, identifies two regions in the neighbourhood of the
249 cleft, one on the right side and one on the left side;
- 250 2. in each region, selects the points with $D_y < 0$;
- 251 3. maximizes the principal curvature k_2 .

252 The other two points are located in the gap of the lip. As said above, this area is
253 characterized by high values of the Curvedness Index C and of coefficient e . To extract
254 these points, firstly the algorithm localizes the centre of the cleft maximizing the
255 coefficient e . Then, it analyzes the neighbourhood of this point, moving upwards from
256 the centre to the high ending point and downwards till the low ending point. The
257 algorithm, for each y value, maximizes the coefficient e in a neighbourhood of the cleft
258 lip. The ending points are the first two maximums that are lower than a proper
259 threshold value, established via experimentation.

260
261
262 MEASUREMENT OF THE DEFORMATION AND EXTRACTION OF THE UPPER LIP
263 OUTLINE

264
265 Transverse diameter of the cleft was evaluated by computing the Euclidean
266 distance between the first two points extracted; its cranio-caudal length by computing
267 the Euclidean distance between the last two points extracted. These two distances,
268 represented in Figure 15, are the most adopted in the estimation of cleft size.

269

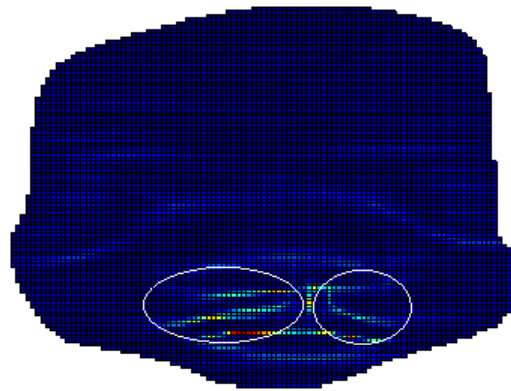


270
271 **Figure 15.** The transverse (horizontal) and cranio-caudal length (vertical) of the cleft.
272

273 The outline of the upper lip was also extracted, in order to provide an extra
274 information about its shape. The Curvedness Index was adopted, as it is one of the
275 geometrical descriptors that more accurately highlights upper lip surface behaviour. As
276 shown in Figure 16, the Curvedness Index has a maximum behaviour in
277 correspondence to the upper lip. To extract the outline, for each x value in the upper

278lip area, the Curvedness Index is maximized. This way, we obtain a sequence of
279points, namely a line, in the 3D space that describes the upper lip area.
280

281



282 **Figure 16.** The Curvedness Index. The two circles highlight the upper lip area.
283
284

282

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285

286 EVALUATION OF FACE ASYMMETRY

287

288 Facial asymmetry was also evaluated in the cases of unilateral cleft lip. To
289 perform this evaluation, the mean of the absolute value of the coefficient e was
290 computed in both left and right parts of the mouth. By comparing these two mean
291 values, we obtain an useful information about the asymmetry of the face. Coefficient e
292 is chosen and its absolute value is taken, as in correspondence of the cleft lip two
293 minimums and a maximum are present (as it was previously shown in Figure 8); the
294 absolute value will avoid that the minimum and maximum behaviour will annul each
295 other when the mean area is computed.

296

297

298

299 RESULTS AND DISCUSSION

300

301 The algorithm for the diagnosis of cleft lip was tested on the eighteen
302 ultrasounds (eight with cleft lip and ten without). In all these cases, the algorithm
303 correctly detected the presence/absence of the cleft and, in the two shells with
304 bilateral cleft lip, the algorithm detected both the clefts.

305 In the eight ultrasounds with cleft lip, the four key points were localized. In
306 Figure 17 the resulting four key points are shown for each shell.

307

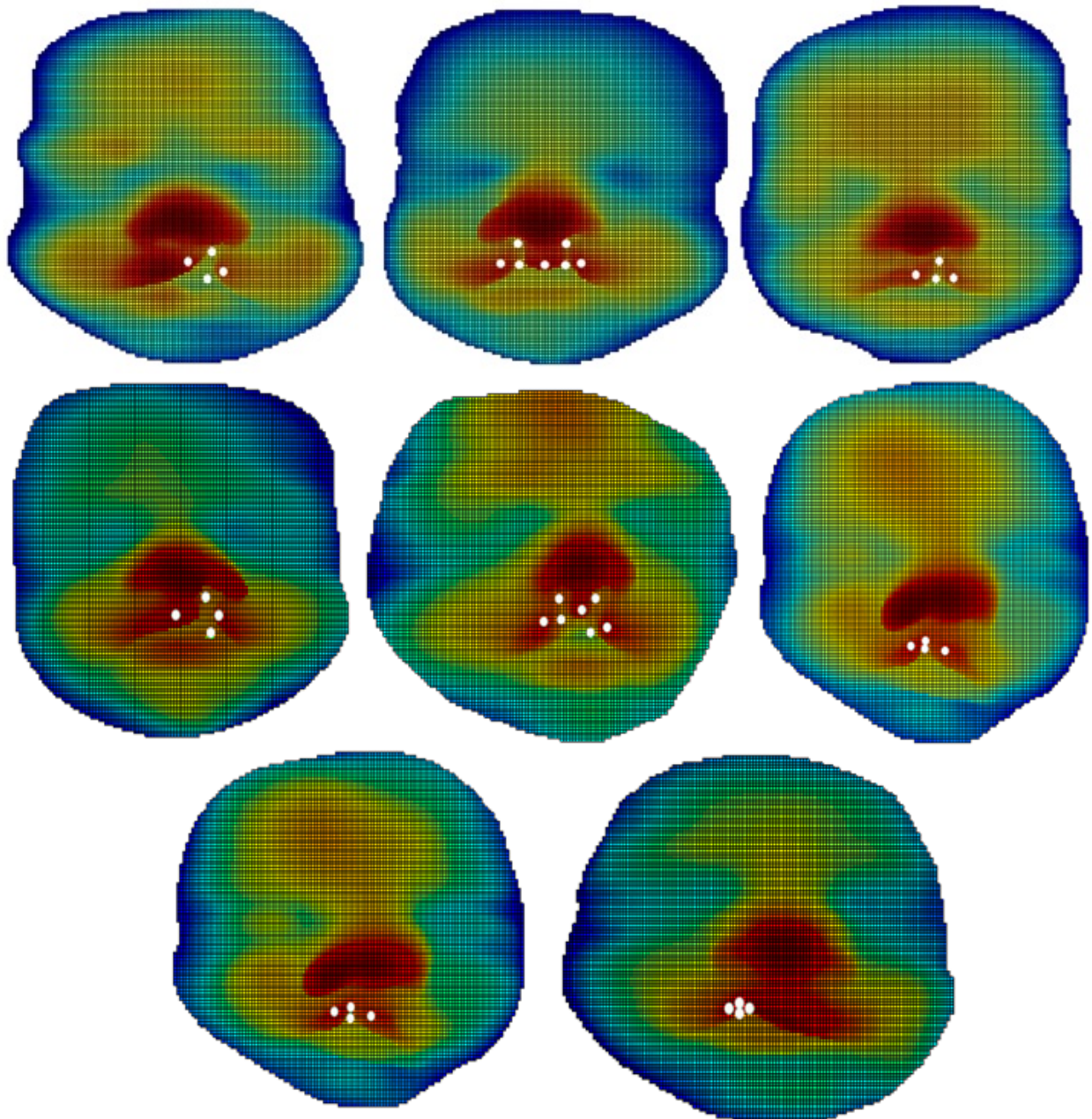


Figure 17. The resulting four key points for each shell with cleft lip.

308
 309
 310
 311 After having localized the four key points, transverse and the cranio-caudal length are
 312 computed. In Table 2, the values of these distances for each shell are shown. The unit
 313 of measurement is the millimetre. As can be seen, the shells that present the lowest
 314 cranio-caudal length are the ones with an incomplete cleft.

315
 316

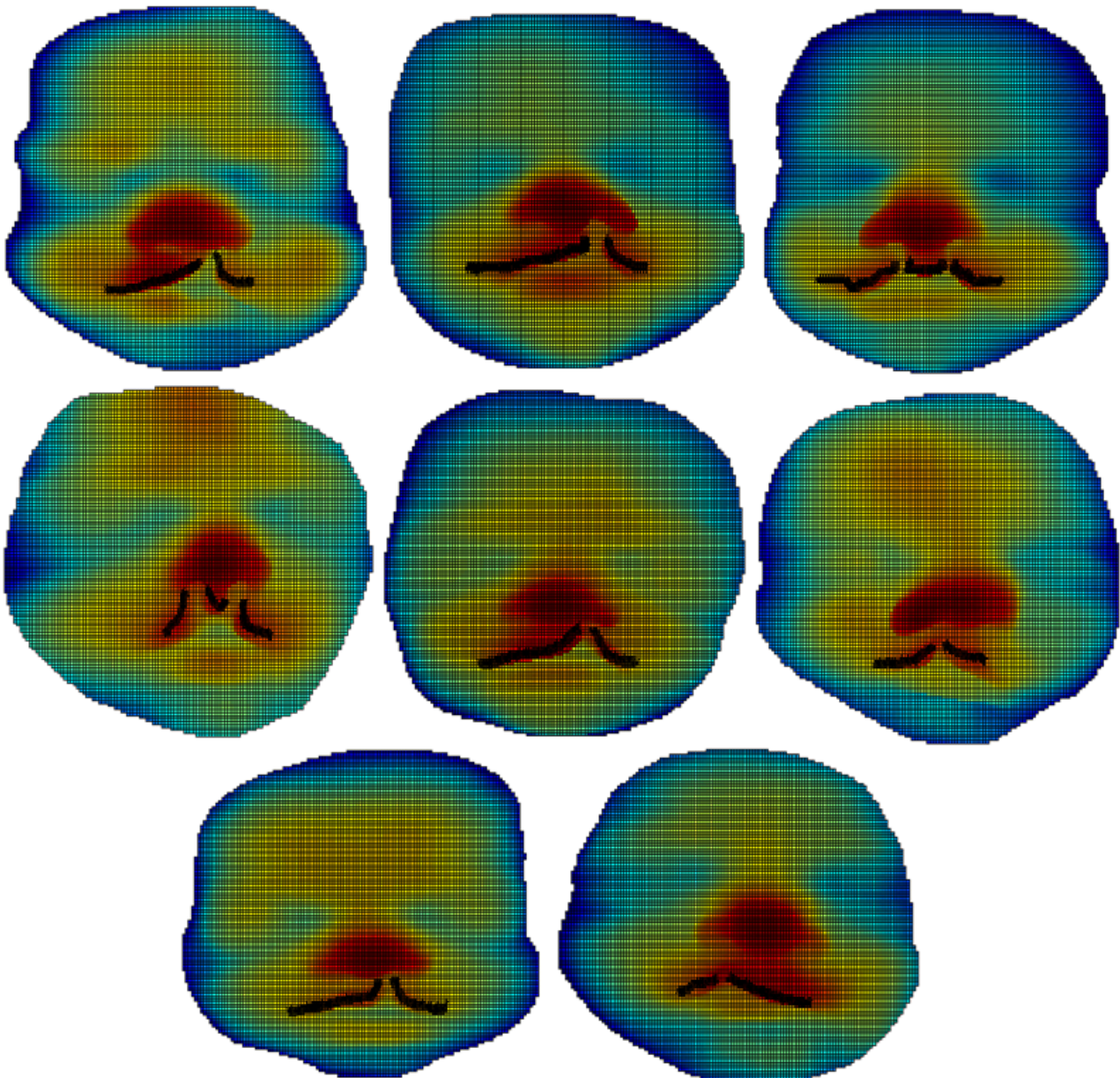
A	7.19	6.78
B	8.31	9.59
C (left cleft)	15.08	7.00
C (right cleft)	12.04	7.06
D (left cleft)	12.65	6.09
D (right cleft)	10.01	12.34

E	6.69	1.81
F	6.67	1.64
G	6.19	4.34
H	3.17	0.62

317 **Table 2.** Computed distances for each shell.

318 For each shell with cleft lip, upper lip outline was extracted. Results are shown in
319 Figure 18.

320



321
322
323

Figure 18. The resulting upper lip outline for each shell with cleft lip.

324 We computed facial asymmetry in the six shells with unilateral cleft lip and on the ten
325 shells without cleft lip; the evaluation was not performed on the two shells with
326 bilateral cleft lip. The results are shown in Table 3 (shells with unilateral cleft lip) and 4
327 (shells without cleft lip).

328

A	1.08	0.41	0.68
B	1.34	0.4	0.94
E	1.10	0.36	0.74
F	0.82	0.60	0.22
G	1.09	0.33	0.76
H	0.44	0.28	0.16

329 **Table 3.** Results of asymmetry evaluation for shells with unilateral cleft lip.

Anto	0.28	0.33	0.05
Bart	0.30	0.48	0.18
Elena	0.16	0.27	0.11
Fede	0.33	0.30	0.03
Gian	0.22	0.33	0.11
Gio	0.16	0.24	0.08
Lisa	0.36	0.21	0.14
Paul	0.17	0.22	0.05
Pie	0.15	0.20	0.05
Simon	0.18	0.25	0.07

330 **Table 4.** Results of asymmetry evaluation for shells without cleft lip.

331 As can be seen in Tables 3 and 4, the difference between the two sides of the
332face is usually higher in the shells with cleft lip. The mean difference value is 0.58 mm
333in shells with cleft lip instead it is 0.09 mm in shells without cleft lip, i.e. about six
334times smaller. The shell with cleft lip with the lowest difference value is H, where an
335incomplete cleft lip is present. Probably in this case the asymmetry was not high
336because the cleft lip was not accentuated, as can be verified in Table 2, where the
337shell H has the lowest cranio-caudal length. Also, the other shell with a low difference
338value, namely shell E, presents an incomplete cleft lip. Instead, in the shells without
339cleft lip the difference between the two face sides is usually low, with values ranging
340between 0.05 and 0.18 millimetres. The highest values (Bart and Lisa) are probably
341due to the quality of the ultrasound.

342

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344

345 CONCLUSIONS

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347 This work presents a new algorithm for diagnosing cleft lip on 3D ultrasound.
348The proposed algorithm was developed with Matlab® and tested on eighteen fetuses'
349faces (eight with cleft lip and ten healthy). The algorithm automatically states whether
350the defect is present or not, classifies it (unilateral, bilateral, right, left), extracts four
351key points, transverse and cranio-caudal length of the cleft, and upper lip outline, and
352provides information on the facial asymmetry. The defect has been correctly
353diagnosed and classified for all the fetuses.

354 Differential Geometry provided us with a set of descriptors leading this research
355activity. The result is that these descriptors are suitable to describe facial shape and
356curvedness, allowing an accurate extraction of the interested facial features.

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362

363The authors declare that they have no conflicts of interest to disclose.

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473

474

475APPENDIX

476

477The First and Second Fundamental Forms are used to measure distance on surfaces
478and are defined by

479

$$480 \quad Edu^2 + 2Fdudv + Gdv^2, \quad (1)$$

481

$$482 \quad ed u^2 + 2fdudv + gd v^2, \quad (2)$$

483

484respectively, where E, F, G, e, f and g are their Coefficients. Curvatures are used to
485measure how a regular surface x bends in R^3 . If D is the differential and N is the

486normal plane of a surface, then the determinant of DN is the product

487 $(-k_1)(-k_2) = k_1k_2$ of the Principal Curvatures, and the trace of DN is the negative

488 $-(k_1+k_2)$ of the sum of Principal Curvatures. In point P , the determinant of DN_P is

489the *Gaussian Curvature* K of x at P . The negative of half of the trace of DN is called the
490*Mean Curvature* H of x at P . In terms of the principal curvatures can be written

491

$$492 \quad K = k_1k_2, \quad (3)$$

493

$$494 \quad H = \frac{k_1+k_2}{2}.$$

$$495 \quad (4)$$

496

497 Some definitions of these descriptors are given. These are the forms implemented in
498 the algorithm:

499
500 $E = 1 + h_x^2$, (5)

501
502 $F = h_x h_y$, (6)

503
504 $G = 1 + h_y^2$, (7)

505
506 $e = \frac{h_{xx}}{\sqrt{1 + h_x^2 + h_y^2}}$,
507 (8)

508
509 $f = \frac{-h_{xy}}{\sqrt{1 + h_x^2 + h_y^2}}$,
510 (9)

511
512 $g = \frac{-h_{yy}}{\sqrt{1 + h_x^2 + h_y^2}}$,
513 (10)

514
515 $K = \frac{h_{xx} h_{yy} - h_{xy}^2}{(1 + h_x^2 + h_y^2)^2}$,
516 (11)

517
518 $H = \frac{(1 + h_x^2) h_{yy} - 2 h_x h_y h_{xy} + (1 + h_y^2) h_{xx}}{(1 + h_x^2 + h_y^2)^{3/2}}$,
519 (12)

520
521 $k_1 = H + \sqrt{H^2 - K}$,
522 (13)

523
524 $k_2 = H - \sqrt{H^2 - K}$,
525 (14)

526
 527 where h is a differentiable function $z=h(x,y)$. It is, therefore, convenient to have at
 528 hand formulas for the relevant concepts in this case. To obtain such formulas let us
 529 parametrize the surface by

530
 531 $x(u,v)=(u,v,h(u,v))$, $(u,v) \in U$,
 532 (15)

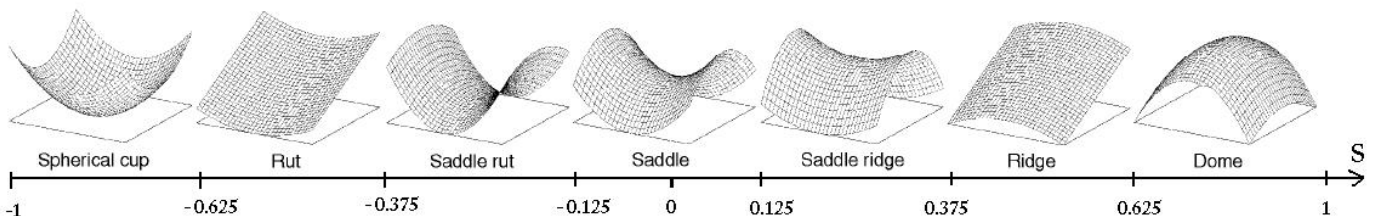
533
 534 where $u = x, v = y$.

535
 536 The most used descriptors are surely the Shape and Curvedness Indexes S and C ,
 537 introduced by Koenderink *et al.*¹:

538
 539 $S = \frac{-2}{\pi} \arctan \frac{k_1+k_2}{k_1-k_2}$, $S \in [-1,1]$, $k_1 \geq k_2$,
 540 (16)

541
 542 $C = \sqrt{\frac{k_1^2+k_2^2}{2}}$.
 543 (17)

544
 545 For the role they play in the work, a little digression about their significance is needed.
 546 Their meaning is shown in Figures 19-21 and in Table 5.



547
 548 **Figure 19.** Illustration of Shape Index scale divided into seven categories. Different
 549 subintervals of its range $[-1,1]$ correspond to seven geometric surfaces.

550

Class	S	Type	H	K
cup/pit	$[-1,-0.625)$	elliptical convex	+	+
rut/valley	$[-0.625,-0.375)$	cylindrical convex	+	0
saddle rut/saddle valley	$[-0.375,-0.125)$	hyperbolic convex	+	-
saddle	$[-0.125,0.125)$	hyperbolic symmetric	0	-
saddle ridge	$[0.125,0.375)$	hyperbolic concave	-	-
ridge	$[0.375,0.625)$	cylindrical concave	-	0
dome/peak	$[0.625,1)$	elliptical concave	-	+

551 **Table 5.** Topographic classes.
 552

431 Koenderink, J.J. and van Doorn, A.J., 1992. Surface shape and curvature scales.
 44 Image and Vision Computing 10(8), 557-564.

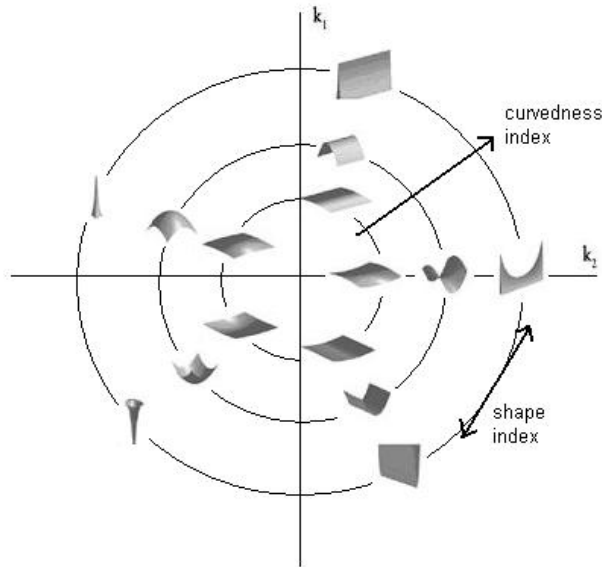


553

554

555

Figure 20. Curvedness Index scale, whose range is $(-\infty, \infty)$.



556

557

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560

561

Figure 21. Indexes (S,C) are viewed as polar coordinates in the (k_1, k_2) -plane, with planar points mapped to the origin. The effects on surface structure from variations in the curvedness (radial coordinate) and Shape Index (angular coordinate) parameters of curvature, and the relation of these components to the principal curvatures (k_1 and k_2). The degree of curvature increases radially from the centre.