LIEGE Iniversité Use of Principal Component and Cluster Analysis to **Describe Phenotypes in COPD**

H. Nekoee Zahraei^{1,2}, Françoise Guissard², Virginie Paulus², Monique Henket², Anne-Françoise Donneau¹, Renaud Louis² ^{1.}Department of Public Health, Bstat, University of Liège, Belgium, ^{2.}Department of Pneumology, GIGA, University of Liège, Belgium

Introduction

Objective

Chronic obstructive pulmonary disease (COPD) is a complex, multidimensional and heterogeneous disease with a large number of subtypes and multifactorial background. It may be caused by different pathophysiologic mechanisms (sometimes referred to as endotypes) but may share similar observed characteristics (phenotypes). These phenotypes divide all patients into several groups with common features which helps patients to receive effective care and achieve better clinical results.

The main purpose of this study is, through the development of statistical methods, to

Statistical Analysis

Three different phenotypes were defined in COPD. All variables were compared between three clusters by using Kruskal-Wallis and Chi-squared tests for quantitative and qualitative variables, respectively.

Table. Characteristics of patients with COPD according to variable groups after imputation, Median(IQR)/Percentage(frequency)

Var	Variable		Cluster 1 (n=39)	Cluster 2 (n=72)	Cluster 3 (n=67)	P - value
			Women, Severe COPD with			-
			Emphysema Exacerbation-			
			prone, Bacterial	Males, Moderate COPD	Women, Moderate COPD	
			Colonization, Neutrophilic	with Emphysema		
			Airway and Systemic			
	1		Inflammation			
hic	Age (year)		69 (62 - 75)	63.5 (57 - 71.25)	64 (56 - 71)	0.059
	Sex (Female)		79.49% (31)	1.39% (1)	97.01% (65)	< 0.0001
	Height (cm)		169 (163.5 - 175)	160.55 (155 - 165)	174 (169 - 178)	< 0.0001
	Weight (kg)		67 (56 - 77)	60 (52.75 - 66.12)	78 (67 - 90)	< 0.0001
	$BVII (kg/m^2)$		23.18 (20.49 - 25.08)	23.16 (20.06 - 24.91)	25.88 (22.13 - 30.08)	0.0002
	Cigarette Packs (year)		3/./(20.8/-50)	38 (21.45 - 46)	37.5(27.75-51)	0.385
	Cigarettes (day)		19.14 (10 - 20)	20(10-20)	20 (11.5 - 25)	0.072
	Smoking Duration(year)	2	45 (30 - 50)	44 (30 - 49) 61 110/ (44)	41(32.5 - 50)	0.432
)	20.51% (8)	01.11% (44)	82.09% (55)	<0.0001
raț	OCS Course	1	46.15% (18)	26.39% (19)	11.94% (8)	<0.0001
60		<u>≥</u> 2	33.33% (13)	12.5% (9)	5.97% (4)	
Dem	(C	20.51% (8)	31.94% (23)	50.75% (34)	0.000
	Antibiotic Course	1	58.97% (23)	58.33% (42)	47.79% (28)	0.003
		<u>≥</u> 2	20.51% (8)	9.72% (7)	7.46% (5)	
	Emergency Room (C	66.67% (26)	87.5% (63)	92.54% (62)	
	Admission for asthma	1	30.77% (12)	12.5% (9)	7.46% (5)	0.001
	or COPD	<u>></u> 2	2.56% (1)	0% (0)	0% (0)	
	Number of (C	66.67% (26)	87.5% (63)	95.52% (64)	
	hospitalizations for	1	30.77% (12)	11.11% (8)	2.98% (2)	< 0.0001
	asthma or COPD	>2	2.56%(1)	1.39% (1)	1.49% (1)	
	FeNO (ppb)		20 (11.15 - 26)	14 (9.75 - 19.89)	17 (11 - 29.5)	0.051
	FEV1 predicted (mL)		1050 (780 - 1315)	1295 (987.5 - 1505)	1840 (1475 - 2175)	< 0.0001
	FEV1 predicted (%)		36 (30 - 48)	57 (47.75 - 68)	57 (48 - 68)	< 0.0001
	FEV1 PD (mL)		1110 (825 - 1380)	1330 (1082.5 - 1595)	1970 (1660 - 2350)	< 0.0001
	FEV1 PD (%)		38 (31 - 51.5)	61 (51.75 - 71.25)	63 (53 - 74)	< 0.0001
	Reversibility (%)		7 (1 - 13)	6.5 (2 - 13)	7 (0.5 - 11)	0.982
	FVC predicted (mL)		2250 (1760 - 2750)	2150 (1710 - 2442.5)	3200 (2650 - 3825)	< 0.0001
	FVC predicted (%)		62 (52.5 - 73.5)	78.5 (66.5 - 90.25)	82 (70.5 - 90.5)	< 0.0001
Pulmonary	FVC post (mL)		2340 (1795 - 2835)	2190 (1850 - 2555)	3390 (2890 - 3900)	< 0.0001
	FVC post (%)		69 (56 - 77)	80.5 (69.75 - 94)	88 (73.5 - 97)	< 0.0001
	FEV1/FVC pre (%)		47.2 (43.25 - 50.45)	61.85 (54.37 - 66.85)	57.5 (50.05 - 64.25)	< 0.0001
	FEV1/FVC post (%)		47.5 (42.7 - 53.2)	63 (55.42 - 69.4)	58.6 (52.75 - 66.2)	< 0.0001
	DEM 25/75 (mL)		470 (355 - 643.06)	726.52 (530.64 - 831.40)	881.38 (769.3 - 1020.3)	< 0.0001
	DEM 25/75 (%)		17 (13.45 - 22.58)	26.01 (20.27 - 31)	29 (24.71 - 33.25)	< 0.0001
	TLC (mL)		6899.66 (6127.1 - 7762.4)	5625.33 (5090 - 5960)	6911.76 (6630 - 7192)	< 0.0001
	TLC predicted (%)		114.17 (108.08 - 120.5)	114.54 (109 - 124.03)	105.85 (97 - 108.82)	< 0.0001
	RV (mL)		4624.24 (4028.1 - 5237.1)	3334.51 (2940 - 3690.69)	3796.9 (3320 - 4191.8)	< 0.0001
	RV (%)		193 (183.98 - 218)	172.37 (156.15 - 188.5)	161.76 (138.5 - 179.6)	< 0.0001
	RV/TLC (%) DLCO (1/1 D 1)		66 (61.35 - 68.41)	58.27 (54.95 - 63.64)	54.06 (49.5 - 58.85)	<0.0001
	DLCO (mmol/kPa.min)		3.4(2.75 - 4.27)	3.46 (2.98 - 3.94)	4.91 (4.44 - 5.57)	< 0.0001
	DLCO predicted (%)		43.48 (33 - 30.33)	4/(43 - 31.13)	30.14(32.13 - 01) 1.01(0.06 - 1.1)	<0.0001 0.0004
	DLCU/AV DLCO/AV predicted (0/)		0.95 (0.77 - 0.99) 70 32 (50 06 - 77 42)	0.95 (0.05 - 1.02) 65 01 (55 67 68 22)	$1.01 (0.90 - 1.1) \\ 75 70 (71 64 - 82)$	0.0004 <0.0001
	sGaw (1/kPa*son)		0.32 (0.36 - 0.46)	0.55 (0.38 - 0.64)	0.52 (0.44 - 0.65)	<0.0001
	FRC PL (L)		5 49 (4 99 - 6 19)	4 22 (3 90 - 4 64)	5 12 (4 86 - 5 47)	<0.0001
	FRC PL predicted (%)		172.44 (162.16 - 181.70)	158.06 (149 47 - 169 8)	149(1405 - 15792)	<0.0001
			262(104-212)	24.4(17.5, 20.4)	$\frac{11}{225(144,20)}$	0.0001

20.2(1).7 = 31.2

 $\Delta \tau, \tau (1 / ... - \Delta / ...)$

22.3(17.7 - 30)

 \mathbf{U}

identify clinical phenotypes among adults suffering from COPD. This problem of grouping objects may be solved by cluster analysis. Clustering was applied to understand, manage and better predict future risks and optimize treatment selection based on the new groupings of patients. Furthermore, in this study, missing data and dimensionreduction, which are present in any large dataset of observational data, were handled.

Cluster Analysis

In this application, 178 patients were described by 85 multiple and huge sets of variables that structured into seven groups. This study was conducted by the Pneumology Department of the University Hospital of Liege. At the first step, the missing values were imputed by multiple factor analysis (MFA). After single imputation, MFA was applied for reducing the complexity of high-dimensional data. After this step, hierarchical clustering was performed using Ward's criterion on the selected principal components. In this step, the optimal number of clusters was selected based on the hierarchical tree, total within-cluster sum of square and silhouette method. In the final step, K-means was performed to improve the initial partition obtained from hierarchical clustering. All statistical analyses were performed using R software.



Emphyseina Exacerdation-prone,
Bacterial Colonization, Neutrophilic
Airway and Systemic Inflammation

In the past years, classification methods in COPD have been applied based on ignoring missing values with limited or selected number of variables which have missed more complex phenotypes. In this study, these two issues are solved. Then, with advanced statistical methods, patients are divided into three distinct clusters. These clinically meaningful clusters of patients with common characteristics can be used to predict outcomes of patients with COPD, to aid in the development of personalized therapy.

Haldar P., Pavord I.D., Shaw D.E., et al (2008). Cluster analysis and clinical asthma phenotypes. American Journal of Respiratory and Critical Care Medicine, 178: 218–224.

Husson F., Josse J., Pagès J. (2010). Principal Component Methods-Hierarchical ClusteringPartitional Clustering: Why Would we Need to Choose for Visualizing Data?, Technical Report-Agrocampus, Applied Mathematics Department, 1-17.

