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Public Adventures in Diabetes: Personal Activity in a Modern Science Center

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ABSTRACT

About 100 million Americans visit science centers each year to participate in experiential science and technology activities. There is great potential for diabetes awareness and education via the several hundreds of science centers in the United States. Most science centers tend to avoid medically related topics in part because of the difficulty in meeting the interactive goals of science center activities. The Utah Science Center (USC) is addressing these difficulties by creating environments for personal interactive activities in a range of medically related topics, including diabetes. The USC will open in early 2005 in Salt Lake City. The design of diabetes activities for the USC is reviewed: (1) activities (aims, description, stages of development, and partnerships); (2) specific stage I activities (body mass index, "feeling" hypoglycemia, and urine chemistry); and (3) conclusion.

INTRODUCTION

DIABETES HAS CLEARLY become prevalent in the United States. There are approximately six individuals with prediabetes, four diagnosed with diabetes, and two with undiagnosed diabetes among every 100 Americans. Moreover, there is a 6% yearly increase in diabetes incidence in the United States. The cost of treating diabetes and its complications is over \$130 billion per year in the United States.¹ Public awareness of diabetes is needed to encourage prevention, create a supportive atmosphere for disease management, and hopefully counter the rising expenditures for diabetes care.

The Utah Science Center (USC) will be a new center for health awareness and health education in an objective, informal, non-threatening,

open, and free environment. The USC sees itself as the first "third generation" science center² in that it will take visitor interactivity to entirely new levels. It has three main themes: (1) **You** are the experiment; where visitors will have the opportunity to make measurements of their own physiologic parameters; (2) **Energy**; from solar energy to personal bioenergetics, including nutrition, exercise, obesity, and diabetes; and (3) **Home**—Planet Earth and its resources, environments, and changes. In addition, the USC will likely become a center for networking communications, including an extensive database, which will provide unique opportunities for researchers, health care providers, and patients. The USC will open in early 2005 in Salt Lake City, and expects about 400,000 visitors a year (<http://www.utah-sciencecenter.org>).

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ACTIVITIES

Our objective is to help develop more aware, educated, empowered citizens, particularly in relation to health awareness and education. Diabetes risk factors, prevention and control, the seriousness of having diabetes, and the promotion and support of diabetes self-management will all be emphasized. Given the growth in the incidence of type II diabetes and the national concern with diabetes education and awareness, we are developing a cluster of interactive exhibits related to diabetes. We are in the design, prototype, and testing phase (2003–2004). Prototype exhibits will be tested in different public settings.

We presented, discussed, and tested two prototypes at the Diabetes Science and Technology Conference, held in San Francisco, CA, in November 2003.³

Activities in the USC will consist of main floor interactive exhibits; main floor demonstration carts and small “theatre” demonstrations; and special supervised activities in basement laboratories, shops, and classrooms. In addition, the USC will also develop a range of online activities for its website.

Stage I activities (2005)

- *Body measurements*: weight, height, heart rate, and blood pressure; compare personal data with general public data, with an emphasis on populations, statistics, and distributions
- *“Feeling” hypoglycemia*: activities that enable visitors to “feel” the physical effects of being hypoglycemic
- *Simulation*: games and related computer-based activities, which incorporate multiple parameters, blood glucose levels, insulin dosing, food intake, and physical activity in the management of diabetes
- *Diabetes chemistry cart*: demonstrations of simulated blood and urine chemistry measurements

Stage II activities (2006)

- *Bioenergetics*: nutrition, food as fuel, exercise, conservation of mass and energy, and energy utilization—all personal and highly interactive

- *Smart toilet*: interactive toilet measuring the user’s urine glucose, pH, and density via visual colorimetric and fluorescent qualitative assays
- *Sensations*: what you can and cannot sense with your fingers—the role of peripheral nerve issues in chronic diabetes
- *Games*: where do you stand among the public in terms of diabetes awareness?

Stage III activities (2007)

- *Modern noninvasive glucose measurement technologies*
- *Diabetes and the eye*: vision issues associated with chronic diabetes
- *Diabetes story room*: watch and listen to the personal stories of individuals with diabetes
- *Database*: a collection of personal measurements and other input from the interactive exhibits—a potential resource for researchers, health providers, and students in the fields of diabetes prevention and therapy

Partnerships

We are establishing partnerships with diabetes-related organizations to deliver additional activities by their professionals. Partners will regularly operate screening stations and related activities. USC laboratories and classrooms will be used by health partners to present demonstrations of new methods and technologies for the management of diabetes.

SPECIFIC STAGE I ACTIVITIES (FIG. 1)



- *Pseudo-body mass index*. The visitor steps on a force plate, facing a height detector. Each visitor’s mass and height are obtained in units of kilograms and meters, respectively. Measurements for every visitor are voluntarily entered into a software program, which presents a histogram of population measurements, generating pseudo-body mass index measures (an approximation to the formula used in calculating the body mass index: weight in kilograms divided by squared height in meters), and the data are correlated with diabetes risk factors. The histograms and

STAGE I ACTIVITIES OF THE DIABETES EXHIBIT

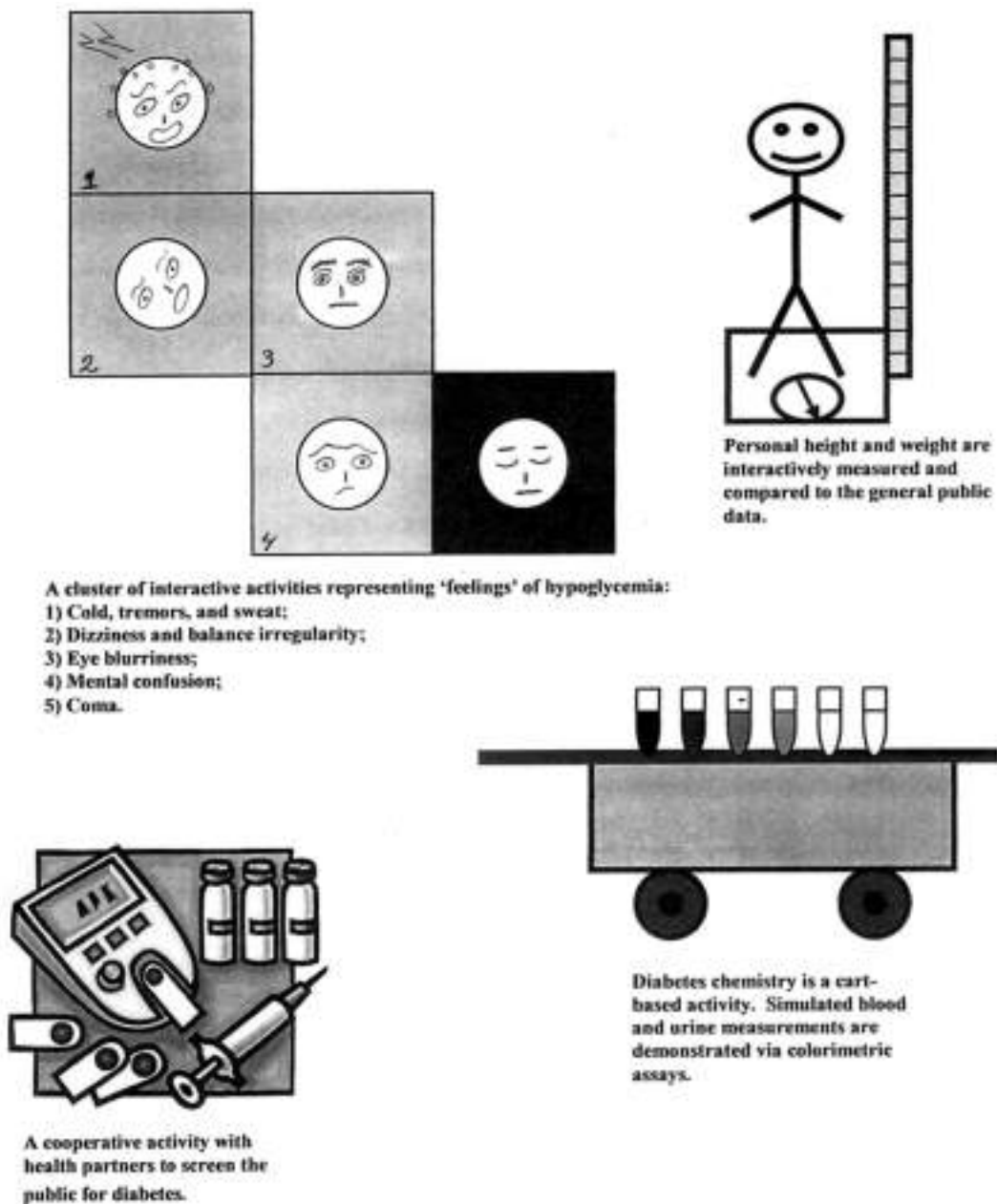


FIG. 1. Schematic presentation of stage I activities. Height and weight, "feeling" hypoglycemia, simulations, and public screening for diabetes are distributed over four zones: personal data, experience of persons with diabetes, awareness, and partnerships, respectively. In addition, there will be a diabetes chemistry demonstration cart.

other information are dynamically projected for the visitors to view.

- *"Feeling" hypoglycemia.* The visitor "enters" the world of a patient with diabetes by "feeling" certain hypoglycemic symptoms, including cold, tremors, sweating, dizziness, vision blurriness, mental confusion, and

sense of balance irregularities. Although it is chemistry that is largely responsible for these feelings in individuals with diabetes, visitors without diabetes will "feel" hypoglycemia by means of changes in their physical environment. The visitor will enter the first segment of the activity, where he will

feel cold, start to sweat, and probably shake. This will be achieved by generating cold and humid air, along with spraying drops of water on the visitor. The next zone will involve rotation and vibration of the walls and floor to simulate dizziness. Balance irregularities are felt and measured by standing on a mechanical table. Looking at hazy mirrors, lenses, and glass plates simulates vision blurriness. Mental confusion is encountered when the visitor experiences unfamiliar sounds and visions that he cannot interpret. Finally, the visitor enters a dark room, where he recognizes flashes and audio alarms warning him that he is reaching the stage of hypoglycemic coma.

- *Diabetes chemistry.* Cart-based demonstrations include measurement of blood glucose and of urine ketones and other urine analytes using a GlucoWatch® (Cygnum, Inc., Redwood City, CA) and urine dipsticks, respectively. Urine will provide a medium to show food and drug metabolism in the body. The demonstration will also allow the exploration of urine drug screening, including the technology related to drug screening in competitive sports. Specific urine metabolites will be included and examined in test tubes, containing artificial urine. Charts of urine color in various physiological conditions will also be demonstrated to the visitor.

CONCLUSION

The purpose of this brief paper is to inform the reader of the potential for enhancing the public's awareness and education regarding diabetes, using science centers and museums available throughout the country. We also solicit your feedback on the design of activities, exhibits, and demonstrations. We would like to exchange experience and form links with other science centers and health-related institutions. Your participation and input are especially needed in the following topics:

1. What noninvasive blood glucose measurement technologies are likely to be available

by 2007, and which one of them would be most applicable in a public science center environment?

2. What activities could most effectively demonstrate the links between lifestyle and diabetes?
3. Are there existing diabetes activities similar to what we are developing?
4. What diabetes-related activities should be presented to elementary and high school children?
5. What other diabetes issues or concerns should be included?
6. Are you interested in being a partner?

Send your input to Joseph Andrade or Youssef Al-sheikh at the addresses given below.

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**Review of Designing an Information Processing Ware for a Diabetic Chip
“diabetiChip”**

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Abbreviations: (4M Lab) laboratory for monitoring, measurement, and
management of the metabolome; (ChemChip) clinical chemistry chip;
(diabetiChip) diabetic chip; (ATP) adenosine triphosphate; (NAD) nicotinamide
adenine dinucleotide; (NADH) reduced nicotinamide adenine dinucleotide;
(NADPH) phosphorylated reduced nicotinamide adenine dinucleotide; (FFL)

firefly luciferase; (ChipWare) chip ware; (SampleWare) sample ware;
(ChemWare) chemistry ware; (LightWare) light detection ware; (InfoWare)
information processing ware; (MetaWare) metabolic assays ware; (DataWare)
data analysis ware; (VisWare) data visualization ware; (PMT) photomultiplier
tube; (ChemCD) clinical chemistry CD; (CoA) coenzyme A; (CO₂) carbon
dioxide; (FAD) flavin adenine dinucleotide; (FADH₂) reduced flavin adenine
dinucleotide; (FMN) flavin mononucleotide; (FMNH₂) reduced flavin
mononucleotide; (RLU) relative light units

Key Words: bioluminescence, light emission, assay calibration, simulation,
central nodes of metabolism, visual display, GlucoFaces™, Diabetes Info Portal,
Diabetic Chip

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Abstract

Miniaturization of clinical chemistry analyzers can empower research conducted to better understand, diagnose, manage, and cure diseases such as diabetes. For the last decade, we have been working on the design and development of miniaturized clinical chemistry devices (ChemChips), including the Diabetic Chip (diabetiChip), which measure a small array of analytes, are small, portable, fast, easy-to-operate, and inexpensive. The chosen analytical method for the diabetiChip uses bioluminescence, which is highly sensitive and specific, and is based on photon counting and specific enzymatic reactions. Bioluminescent reactions were intentionally chosen for analyzing metabolic reactions due to them utilizing some of the central nodes of metabolism, such as adenosine triphosphate (ATP). The analytical processes of the diabetiChip are carried out within a chip ware by four operational wares: sample ware; chemistry ware; light ware; and information processing ware “InfoWare” (further divided into metabolic reactions ware, data analysis ware, and data visualization ware). InfoWare is the focus of this paper; we show the feasibility of using a set of kinase-utilized enzymatic reactions of a firefly bioluminescence-coupled glucose assay in designing a diabetic chip. We also present the concept of GlucoFacesTM in visualizing measurements of the diabetiChip.

Introduction

Miniaturization of clinical chemistry analyzers can empower ongoing research in better understanding, diagnosing, managing, preventing, and curing diseases such as diabetes. For the last decade, we have been working on the design and development of miniaturized multianalytical clinical chemistry devices (ChemChips), including the Diabetic Chip (diabetiChip), that measure a small array of analytes, are small, portable, fast, easy-to-operate, and inexpensive. The analytical principle of the diabetiChip is the measurement of the number of photons emitted from the coupling of an enzymatic reaction specific to the metabolite of concern with a bioluminescent chemical reaction. Bioluminescent reactions were intentionally chosen for analyzing metabolic reactions due to them utilizing some of the central nodes of metabolism, such as adenosine triphosphate (ATP). Also, due to the high sensitivity and specificity of bioluminescent reactions, the diabetiChip can ‘cheaply’ analyze multiple metabolites from a small sample volume in a relatively short time (few minutes).

Analytical processes of the diabetiChip are carried out within a micro-scale, multi-well chip (ChipWare) by four operational wares (Figure 1): sample processing ware (SampleWare) for processing and transporting the sample; chemistry ware (ChemWare), which constitutes the various chemical assays, deposited in specific analytical wells; light detection ware (LightWare) for detecting and reporting photon counts; and information processing ware

(InfoWare), which correlates the signal to metabolite concentration, performs calibration, estimates analytical error, and displays the relevant information in simple visual patterns.

ChipWare, SampleWare, and LightWare

Chemistry chips can be manufactured in large quantities with relatively low cost. A variety of microfabrication techniques can be used to build arrays of detection wells, where each well contains an independent bioluminescence-based analytical assay.^{1,2} Each unique assay is deposited and stabilized in small quantities in individual detection wells. Commercially available silicon photodiodes, avalanche photodiodes, and photomultiplier tube (PMT) arrays designed for low-light detection are ideal for producing small size-detectors to simultaneously measure signals from multiple analytical channels. Our group has focused on PMT-based detectors during chip development processes. We also examined various sample processing methods, such as top-loading, through-flow, hydrogel, plasma separation membrane, and microfluidic channels. However, we developed a total chemistry micro-analytical system (ChemCD), which integrates all wares.³ The general concept of the ChemCD is to distribute the biological sample from a single sample acquisition chamber to multiple sample-metering chambers via a distribution channel. Each sample-metering chamber would have a passive valve from which the metered sample volume would travel through burst valves and mixing channels, and enter the analytical wells. Since centrifugal pumping can only move the fluid radially outward, the sample chamber has to be facing the

CD's center, and the distribution channel has to spiral outward. Basic design and an advanced design (involving high speed blood separation unit) are illustrated in Figures 2 and 3, respectively. ChemCD can empower the clinical chemistry chip in measuring analyte concentrations in different biological samples and beyond the analytical detectable limit via the automatic filtering and diluting of biological samples.

ChemWare

A reaction that produces photons has many advantages: the problems associated with color perception or wavelength separation are eliminated, as in the case of reflectance colorimetry; no light source is needed, as in the case of fluorescence spectroscopy; no usage of electrodes susceptible to contamination, as in the case of electrochemical analyzers; and less sample volume, a major concern for the patient. Bioluminescence is light produced by compounds undergoing specific oxidation reactions catalyzed by enzymes. Bioluminescence-based measurements are efficient for analyzing metabolites in the micro to sub-microMolar concentration range due to its high sensitivity (generally 100 to 1,000 times more sensitive than common spectroscopic or colorimetric methods). Bioluminescence occurs naturally in some organisms, such as firefly, bacteria, fish, and fungi. Generally, bioluminescent reactions employ an enzyme called "luciferase," which facilitates the oxidation of an energetic substrate, called "luciferin," into an excited state, where it emits a photon. There are many different luciferases and luciferins with at least 30 different known bioluminescent reactions in nature. The

yellow-green (580 nm wavelength) bioluminescence of fireflies (FFL) is based on the enzyme-catalyzed oxidation of firefly luciferin utilizing adenosine triphosphate (ATP) as a highly specific co-reactant (key light inducer). Interactions between the reactants and ATP result in light emission. Moreover, a calibration curve can be obtained for various ATP initial concentrations or any metabolite coupled to ATP via an enzymatic reaction.^{4,5}

InfoWare

InfoWare refers to mathematical models and simulation tools for analyzing metabolic networks, including calibration, data analysis, estimation of analytical error, and simple means of presenting multianalytical data in simple visual patterns that are easily interpretable.⁶⁻⁸ InfoWare is further divided into three complementary units:

1. MetaWare: Analytes appropriate to diagnosing or managing a metabolic disorder (e.g., diabetes), organ dysfunction (e.g., kidney dysfunction), or physiological condition (e.g., lactation, aging, stress, starvation) are selected. Next, biochemical pathways are explored for reaction(s) utilizing each metabolite of interest and can be coupled to one of the bioluminescence analytical platforms. In general, any reaction utilizing a kinase or a dehydrogenase enzyme could be used to couple an analyte to the ATP or NADH/NADPH “NAD(P)H” platform, respectively. If more than one reaction is available, then the most suitable reaction is chosen based on enzyme availability and assay cost.

2. DataWare: First, configured assays are simulated to examine assay feasibility and optimal physical and chemical parameters such as medium acidity and enzyme concentration. Also, mathematical and statistical methods for design of experiments are used to minimize number of required experiments in assay validation. Then, experimental data and calibration curves are analyzed for optimal assay calibration. Finally, a general analytical calibration curve that encompasses the effects of other metabolites is created with the aim of minimizing the number of experiments required to validate and implement assays of related metabolites onboard the chip.
3. VisWare: Metabolic networking features, mentioned above, are further utilized to visually represent data from a collection of analyzed metabolites via simple, but significantly informative, visual patterns. These visual patterns can ease interpretation and provide new insights for understanding disease etiology and pathophysiology.

MetaWare

Metabolism refers to the highly integrated network of chemical reactions that carries out the cellular processes of extracting and controlling energy from the environment and the synthesis of biochemicals and macromolecules. More than a thousand chemical reactions take place in *Escherichia coli* (a single cell-organism).⁹⁻¹⁷ Though this array of reactions may seem overwhelming at first glance, its coherent design and its many common motifs show metabolism to be

much simpler. In different words, the number of reactions in metabolism is large but the number of kinds of reactions is relatively small, and the mechanisms of these reactions are usually simple. Furthermore, a group of about a hundred molecules plays a central role in the metabolism of all forms of life; these are often called the central nodes of metabolism.¹⁰ Utilizing the motifs and central nodes to simulate and analyze the metabolic mesh may hold the key to uncover or better understand disease etiology, improve disease treatment or management, or prevent disease.

Most interchanges of activated groups in metabolism are accomplished by a small set of carriers, some water-soluble vitamins, and some key bioenergetic molecules that collectively form the central nodes of metabolism: ATP (phosphoryl carrier); NADH, NADPH, FADH₂, and FMNH₂ (electron carriers); CoA and lipoamide (acyl carriers); Thiamine pyrophosphate (aldehyde carrier); Biotin (CO₂ carrier); Tetrahydrofolate (1-carbon units-carrier); Adenosylmethionine (methyl carrier); Cytidine diphosphate diacylglycerol (phosphatidate carrier); Nucleoside triphosphates (nucleotides carriers); Ascorbate, the ionized form of vitamin C (a reducing agent); Vitamin B₂ (a precursor of FAD and FMN); Niacin (a precursor of NAD); Pantothenate (a component of CoA); and Glucose (a universal energy currency) along with the carrier uridine diphosphate glucose.

Human disease phenotypes are controlled not only by genes but also by self-organizing networks; including metabolic, regulatory, and signal transduction

networks, which all display system dynamics. These networks can be divided further into sub-networks. For example, the metabolic network can be viewed as two complementary networks; the metabolite network and the enzyme network. When perturbed, these networks alter their output of matter and energy, and can produce either a pathological or a normal phenotype; depending on the environmental context. Study of the dynamics of these networks by approaches such as metabolic control analysis may provide new insights into the pathogenesis and treatment of complex diseases such as diabetes.¹⁸⁻²²

Most diseases have metabolic origins; which necessitates analyzing certain metabolites to diagnose, manage, or prevent disease.^{16,23-65} Moreover, increasing the number of analyzed metabolites is needed to better understand the biochemical basis of disease.⁶⁶⁻⁸¹ This necessitates simultaneous analyses of multiple analytes and requires an analytical methodology capable of performing such analyses at relatively low cost.⁸²⁻⁸⁴ Bioluminescence-based analyses can be coupled to a large number of metabolic reactions.⁸⁴ The high sensitivity of bioluminescence-based analyses significantly reduces the needed volumes of sample and chemical reagents needed, and thus reduces cost.⁸⁴⁻⁸⁷

Since the central metabolite ATP is a key analyte in the FFL bioluminescent platform, a large number of metabolites can be measured by coupling a metabolite-specific reaction that also involves ATP (usually enzymatic reactions utilizing kinase) to the FFL bioluminescence platform. In such coupled reactions,

light emission will also depend on the type of the kinase-utilized enzymatic reaction; whether produces ATP or competes for ATP. In any case (whether ATP is consumed or produced), the amount of emitted light (or photons) can be correlated to the metabolite concentration via generating a calibration curve for the coupled assay.^{4,5}

Glucose Assay

Diabetes is a complex metabolic syndrome that is divided further in multiple sub-disease classes. In general, diabetes is characterized by absolute insulin deficiency in the case of type I diabetes, or partial insulin deficiency or insulin resistance in the case of type II diabetes. Insulin can be described as the shuttle that performs and regulates glucose transport into cells. When insulin is deficient, glucose cannot be well utilized. Knowing that glucose is a universal currency for energy exchange within the human body makes diabetes an energy disease affecting functions of the whole body.⁸⁸⁻¹⁰³ Thus, tight control of blood glucose levels close to normoglycemia is necessary for reducing the frequency of diabetes short-term complications (hypoglycemia and hyperglycemia) and delaying long-term complications. Therefore, developing a glucose assay is the cornerstone for the diabetiChip. Establishing the glucose analytical assay began with searching the metabolic pathways for enzymatic reaction(s) utilizing glucose, which can be coupled to the FFL bioluminescence platform via ATP. Then, preliminary assay protocols were obtained from the literature.¹⁰⁴⁻¹¹⁶

DataWare

FFL Bioluminescence-Coupled Glucose Analytical Assay (Dry)

We refer to the simulation of FFL bioluminescent reaction (ATP assay) and FFL bioluminescence-kinase coupled glucose reactions (glucose assay) of the diabetiChip as the dry assay. The main goals of simulation are examining assay feasibility and estimating optimal concentrations for reagents. FFL bioluminescence reaction requires firefly luciferase (FFL), luciferin (LH₂), oxygen (O₂), and ATP in the presence of magnesium ions (Mg²⁺). ATP utilizes Mg²⁺ and binds rapidly and reversibly on LH₂ to form the complex luciferase-luciferyl-adenylate “FFL-LH₂-AMP” (steps 1-2 in Figure 4). Molecular oxygen oxidizes the complex to produce oxyluciferin (L_{oxy}), AMP, carbon dioxide (CO₂), and light (step 6 in Figure 4). The light emitting reaction is limited by three steps; the first two occur before oxidation:

1. A proton abstraction from luciferin (step 4 in Figure 4).
2. A conformational change of luciferase (step 5 in Figure 4).
3. Dissociation of the luciferase-oxyluciferin complex “FFL-L_{oxy}” (step 7 in Figure 4).^{4-5,7}

After a rapid mixing of the reaction’s reagents for about 5 milliseconds (ms), a lag phase of 25 ms occurs before light is emitted (Figure 5). The two limiting steps preceding oxidation, mentioned above, are responsible for this delay. Maximum intensity of the emitted light (I_{\max}); which is proportional to the ATP

concentration for values lower than 1 micro-Molar, is reached in less than 1 second, but the time necessary to reach half of this value ($I_{\max}/2$) is constant (about 100 ms) and independent of the ATP concentration. A steady-state light signal is obtained only for ATP concentrations lower than 10 nanoMolar. As the ATP concentration is increased beyond this value, the peak light intensity increases. Light's decay rate also increases due to the noncompetitive inhibition of luciferase by oxyluciferin; the concentration of which increases when ATP concentration is raised. A nonsteady state kinetics model proposed by Deluca and McElroy, and modified by Gandelman, is used in simulating the ATP assay with *Gepasi Biochemical Simulation* (Figure 6, Table 1).^{4-5,7,117} We had prior knowledge of the FFL bioluminescent assay, which is widely used in different analytical fields. Thus, the aim of simulation was verification rather than proving. Based on simulation, optimal concentrations for ATP, luciferin, and firefly luciferase (FFL) were about 650, 1000-3000, and 400-500 μM (Figure 7).

The enzymatic reactions involving glucose utilize the conversion of glucose and ATP to glucose-6-phosphate and ADP via the glucose kinase enzyme (Figure 8). In Figure 9, we present the general kinetic model “YTAL-sheikh’s Kinase-Kinetic Model” for the enzymatic reactions that utilize the conversion of an analyte (denoted by i) and ATP to another analyte (denoted by j) and ADP via a kinase enzyme (denoted by ij). These kinase-utilized reactions can be coupled with the FFL bioluminescent reaction’s model, discussed above, in simulating the bioluminescence-kinase coupled reactions.

FFL Bioluminescence-Coupled Glucose Analytical Assay (Wet)

ATP and glucose assays were examined experimentally; used assay protocols are listed in Table 2. In each experiment, five assays for each analyte concentration were run for 60 seconds using a TD 20/20 Luminometer. Data points of the ATP and glucose assays were normalized by dividing each data point by the maximal value of the data set. Assays data points at each second were averaged. Each experiment was repeated three times. We present here results of one experiment performed to validate each of the ATP and glucose assays (Figures 10, 11, and 12).

Assay Calibration

A measurement is a set of operations performed to determine the value of a quantity, such as the concentration of blood glucose. Calibration is a comparative measurement aimed toward comparing an analyte concentration from a patient sample with a calibrant that has a known value for the same analyte. Calibrants are either directly prepared from a pure substance via simple procedures or indirectly via a series of comparative procedures when the substance is impure. Thus, the measurement procedure on the patient sample constitutes the last step in a series of comparisons, in which each comparative step adds to the uncertainty of the final result.

Analyte concentration is usually correlated to the level of signal detected by a clinical laboratory analyzer; the signal is scaled by calibration parameters for conversion into concentration units. In the case of POC devices, such as the glucometer, each batch of testing strips has a calibration code that adjusts the scaling parameters to account for variation among batches. However, calibration codes do not account for variation among testing strips within a batch, changes due to storage conditions, or changes in the sensor's accuracy. Measuring the signals from analytical calibrants (or standards) can account for these variations.

Onboard calibration engages treatment of the unknown, unaccounted for random interferences attributable to the patient sample (or biomatrix effects), validation of the chip analytical performance, and estimation of total analytical error (TAE). Onboard calibration incorporates a number of analytical standards to optimize calibration constants. The more calibration constants in the mathematical equation describing the calibration curve(s), the more standards are required. For the purpose of onboard calibration, we make use of one of the advantages of microarrays; availability of a large number of analytical wells. Also, we make use of microfluidics to treat and distribute biological samples to certain wells, and not to distribute them to other wells.

There are various means for assay calibration such as internal standards, standard additions, and spikes. However, via utilizing multianalytical arrays and microfluidic systems (such as the ones discussed above), we are able to employ

the analytical calibration technique “standard additions” for onboard calibration. In addition to the blank, standards with known analyte concentration are mixed with patient sample (Figure 11). By this, most of the interferences and systematic errors, such as biomatrix effects, inter-batch variability, and signal to concentration correlations, are being accounted for.

Different methods can be used for generating calibration curves; integrating total or partial area under the curve, slope determination, and end-point value (Figure 13). An off-board calibration curve for the glucose assay, discussed above, was generated via integrating the area under the curve of normalized relative light units (RLUs) (Figure 14). The calibration curve was fitted using the *Matlab-Curve Fitting Toolbox*¹¹⁸ (Figures 15, Tables 3).

We have previously studied and tested onboard calibration on the ATP assay. We present here results of this study to show the feasibility of the clinical chemistry chip’s onboard calibration methodology: ATP assay was deposited within wells of chips from different batches, light emission was detected using a CCD camera; images were processed using the software program *ImageJ*, and data were analyzed using *Microsoft Excel* and *Matlab*, and calibration curves were generated. Tested detectable ATP assay’s linear range was 1-100 μM . Average concentration measurement error was 19%.

No matter what level of success we achieve in accounting for many of the sources of systematic variation, the main challenge we still face is the end-user error. If the end-user has difficulty in following the operational instructions of the device, the user may obtain inaccurate results even if the analytical assays and signal detector were optimal. Likewise, if the end-user has difficulty in interpreting the results, he/she will not be capable of making use of the results in disease diagnosis or management. Therefore, easy operational instructions and simple data visual patterns are necessary for optimal utilization of the clinical chemistry chip. These issues are discussed in the VisWare section of this paper.

VisWare

Multianalytical clinical chemistry data can be displayed via simple patterns, providing ease of interpretation and enabling fast treatment decision-making by the healthcare provider or patient. High-dimensional data visualization presents a large number of dimensions or parameters of the data on a display surface (soft or hardcopy). High dimensional data visualization projects n dimensional data onto a 2D physical medium. Examples of high dimensional data visualization are illustrated in Table 4.¹¹⁹⁻¹²⁵ Consider a 3D scatterplot. Here the data is n -dimensional, 3 axes are selected and laid out on the plane (the physical medium). The n dimensional points are projected on the 2D surface. Hence this is a 3D visualization on the 2D surface. By coloring and shaping the data points, we could argue that a 3D scatterplot is a 5D representation of n -dimensional data on a 2D

surface. Thus, visualizations can be classified based on the intrinsic dimensionality of the logical representation as well as its potential dimensionality by adding in additional data attributes.¹²⁵

Simple visual displays have been the major theme of our philosophy regarding data representation.¹²⁶⁻¹²⁷ The first author has emphasized the idea of representing diabetes states, symptoms, and measurements via simple facial and iconic data displays in his other publications, such as the paper titled “Public Adventures in Diabetes: Personal Interactivity in a Modern Science Center.”¹²⁶⁻¹²⁸ We have designed a grid or a set of iconic facial displays to represent the diabetiChip’s glucose measurements “YTAL-sheikh’s GlucoFaces™” along with interactive, educational manual for data visualization and interpretation that will be available soon on the Diabetes Info Portal <<http://www.DiabetesInfoPortal.org>> (Figure 16).¹²⁶⁻¹²⁹ The concept of the GlucoFaces™ is simply correlating glucose measurements with facial features. For example, low glucose values can be represented via the degree of tilting the head, high blood glucose values can be represented via the amount of shading pupils of the eyes, normal glucose values by the width of upward lips, which refer to happiness. Also, all glucose measurement are represented on the nose (a longitudinal bar scaled from 0 to 600 mg/dl glucose concentration). Color attributes were also added to the bar to alarm the patient of diabetes state via the conventional alarming colors (green for normal range, yellow for hyperglycemic range, and red for hypoglycemic range). Only the general frame of the GlucoFaces™ and the three fundamental

GlucoFacesTM (normal, hypoglycemic, and hyperglycemic) are shown in Figure 16. All glucose measurements are variations of the three fundamental GlucoFacesTM.

In summary, we have demonstrated throughout this paper the processes of developing the diabetic chip, in general, and an information processing ware (InfoWare) for the Diabetic Chip (diabetiChip), in particular. Bioluminescent chemical reactions are highly sensitive and can be coupled with many metabolic reactions via one of the central nodes of metabolism, such as ATP. Assay simulation, experiments, and calibration proved the feasibility of using FFL Bioluminescent-kinase coupled glucose assay in designing a diabetic chip that is highly sensitive, small, portable, disposable, and cheap. Easing data interpretation and glucose monitoring brought about by designing a set of GlucoFacesTM.

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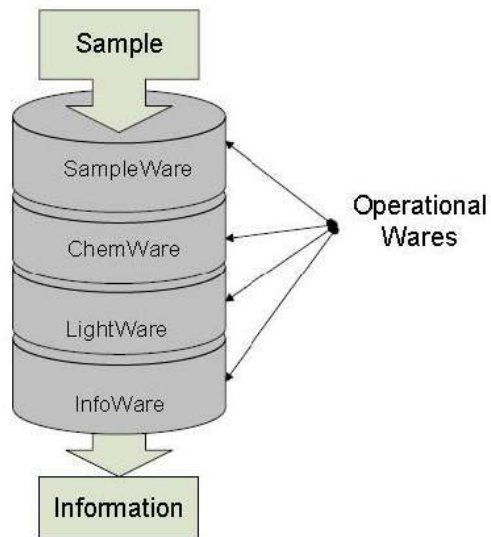


Figure 1: Schematic Representation of the Diabetes Chip's Operational Wares: A biological sample is first processed and distributed to the analytical wells via a SampleWare. Each analytical well contains analyte-specific enzymatic reactions coupled to a bioluminescent reaction. Light signals emitted by reactions from the analytical wells are detected by light-detection elements (LightWare). InfoWare correlates the light signal to analyte concentration and reports results via simple visual patterns.

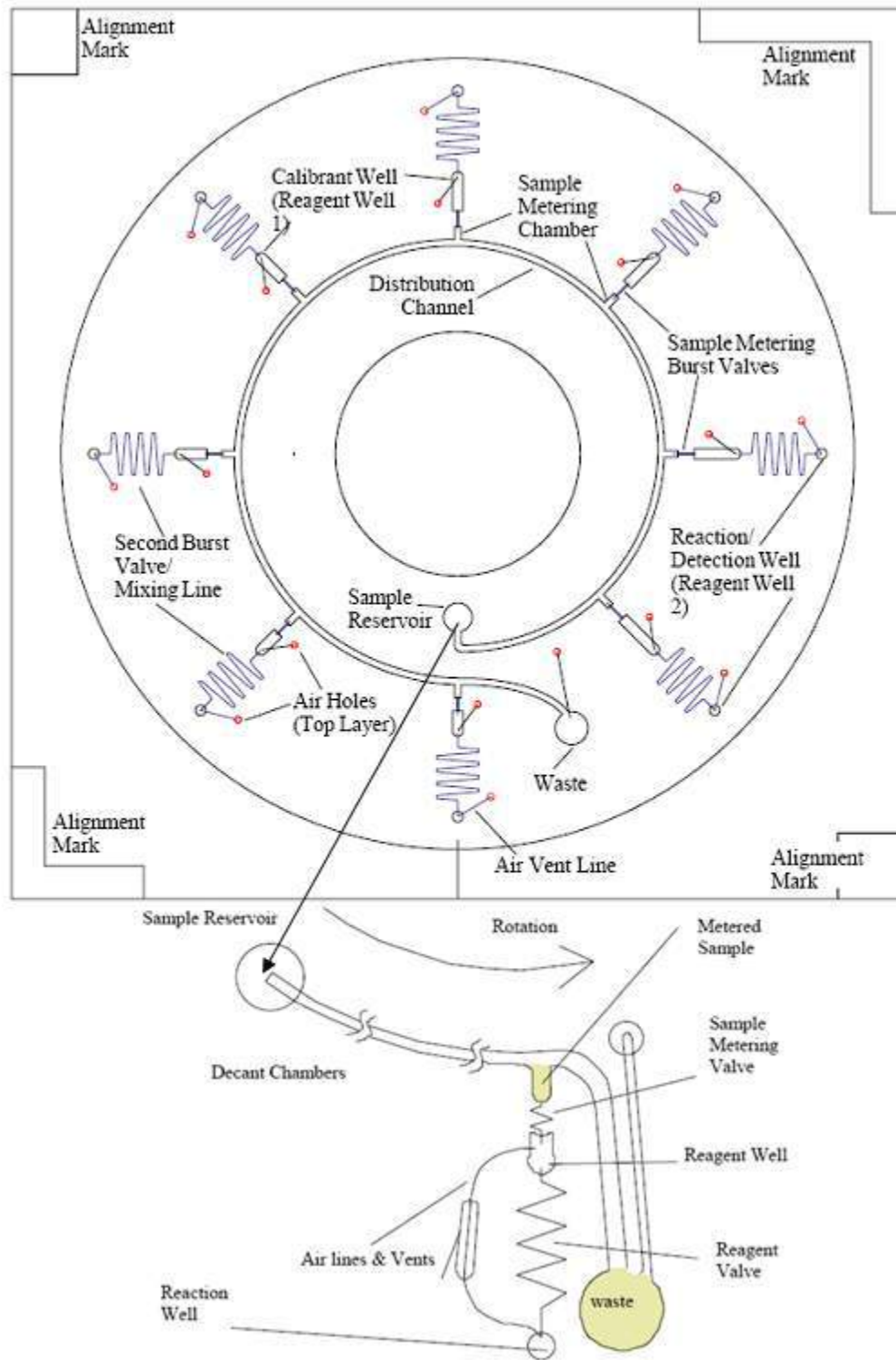


Figure 2: ChemCD Basic Design: Operation of the sample reservoir unit is magnified and detailed.³

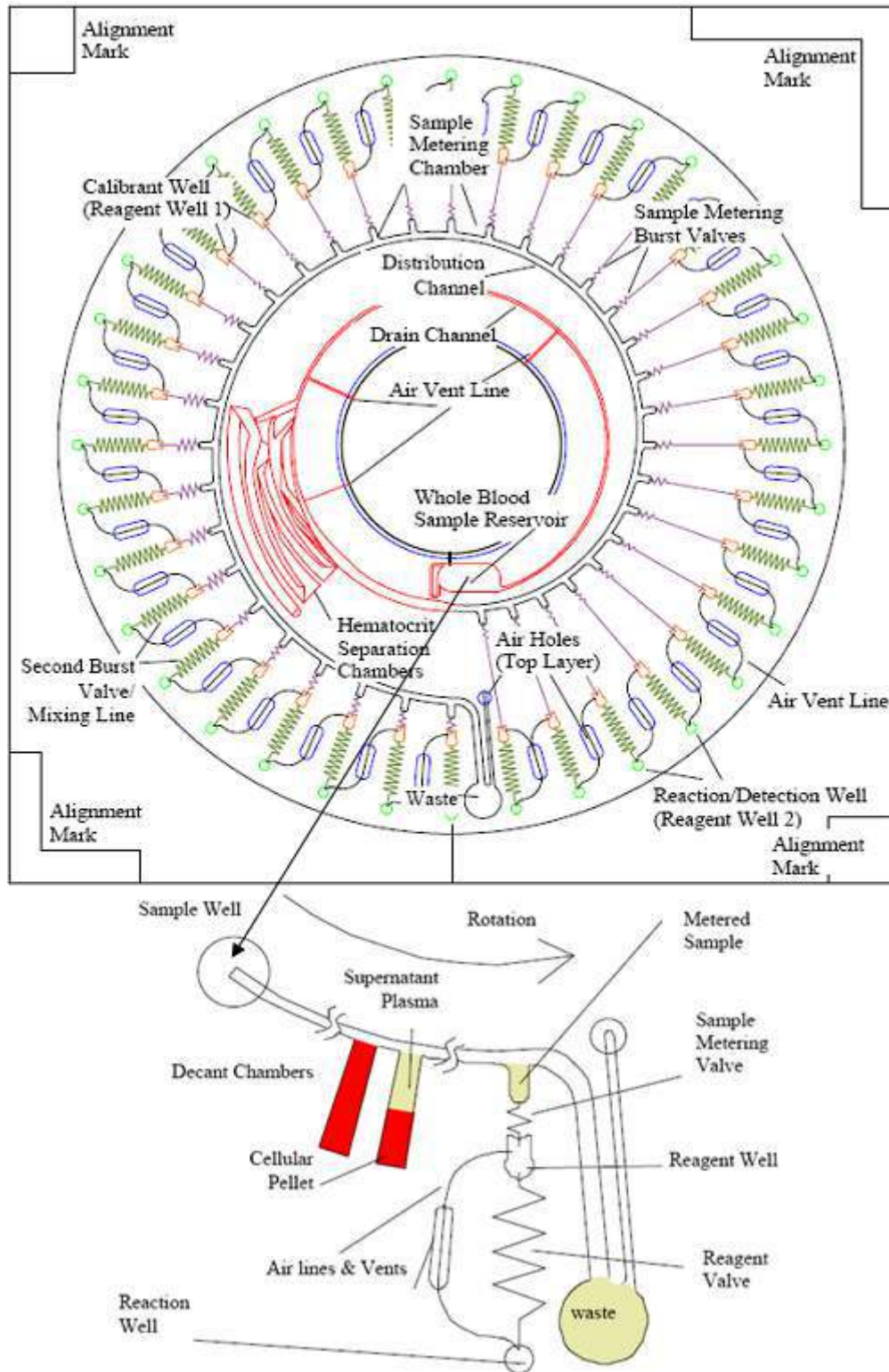


Figure 3: ChemCD Advanced Design: The advanced ChemCD design utilizes a high speed blood separation unit. Operation of the sample reservoir unit is magnified and detailed.³

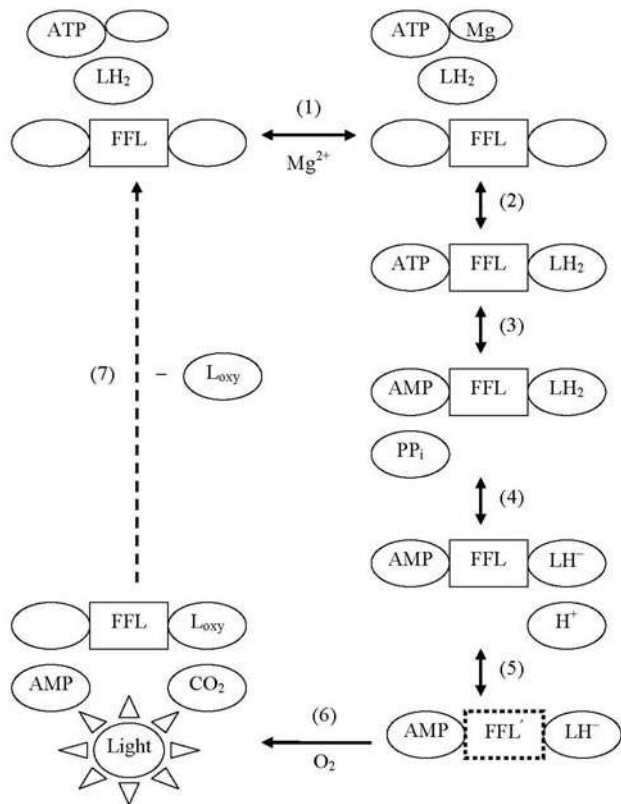


Figure 4: Schematic Representation of the Detailed Steps in a FFL Bioluminescence Reaction.¹⁻³ ATP firsts bind magnesium ions, which facilitates binding on the enzyme firefly luciferase ‘FFL’ (Step 1). ATP and luciferin ‘ LH_2 ’ gets bound to FFL (Step 2). ATP loses orthophosphate and turns into AMP (Step 3). A proton is abstracted from luciferin and conformational change in FFL occurs (Steps 4-5). Steps four and five are responsible for the 25 milliseconds lag phase in light emission. Oxidation of the deprotonized luciferin leads to releasing carbon dioxide (CO_2), AMP, the complex FFL-oxyluciferin, and light (Step 6). Steps six and seven contribute to additional another limitation to light emission; the more oxyluciferin (an inhibitor) is released, the less light is emitted.

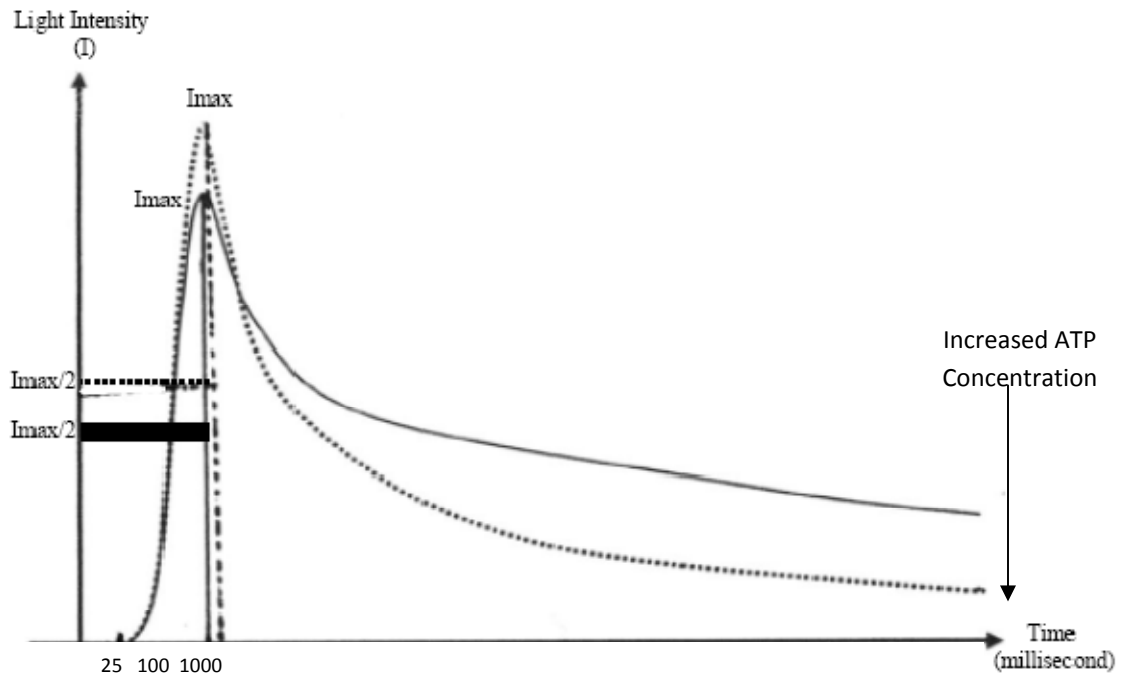


Figure 5: Light Emission Profiles of the FFL Bioluminescent Reaction: The solid curve corresponds to ATP concentrations less than 10 nM. The dotted curve corresponds to ATP concentrations higher than 10 nM. A one half of light intensity is independent of ATP concentration and is always reached after about 100 ms. On the other hand, maximal light intensity depends on ATP concentration. There is a lag phase of about 25 ms in emitting light. The lag phase is mostly due to conformational change in the firefly luciferase enzyme. The light emission decay rate also depends on the concentration of the reaction product oxyluciferin, which is a noncompetitive inhibitor and its concentration is directly correlated with ATP concentration.

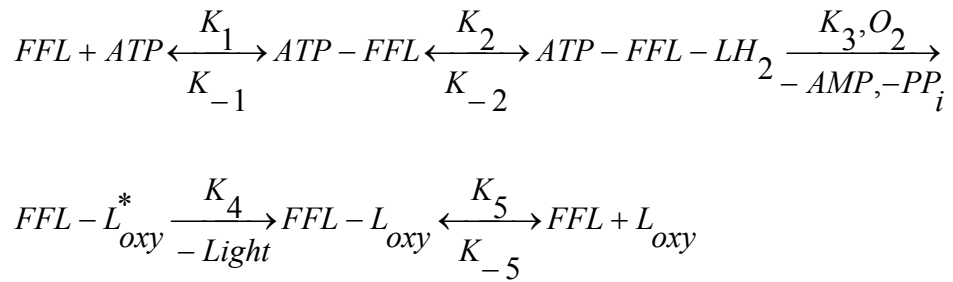


Figure 6: The kinetic Model for the FFL Bioluminescence Platform (or ATP assay):¹⁻³ The first two steps and the last step are reversible and rapid. Rate constants for backward reactions are denoted by minus signs. ATP binds to the enzyme firefly luciferase (FFL) in the first step. FFL binds luciferin (LH₂) in the second step. Luciferin is oxidized and converted to the energetically excited oxyluciferin, and AMP and oxygen are released in the third step. The energetically excited oxyluciferin becomes energetically unexcited and releases the excitation energy in the form of light in the fourth step. Finally, oxyluciferin is dissociated from FFL in the fifth step.

Table 1: Values of the Kinetic Rate Constants Used in Simulating the FFL Bioluminescent Reaction and Bioluminescence-Kinase Coupled Reactions:¹⁻³ Rows above the double line represent kinetic rate constants of the kinase-specific reaction that is coupled to the FFL bioluminescence reaction, whereas, the rows below the double line corresponds to the kinetic rate constants of the FFL bioluminescent reaction.

Kinetic Rate Constant	Value	Unit
$K_{m(\text{Analyte})}$	Specific to the Metabolic	Molar
K_{cat}	Kinase Specific Activity	$\mu\text{mole}\cdot\text{mg}^{-1}\cdot\text{minute}^{-1}$
K_m (ATP)	250×10^{-6}	Molar
K_m (Luciferin)	2×10^{-6}	Molar
K_i (Oxyluciferin)	$\pm 23 \times 10^{-8}$	Molar
K_1	$(10 - 30) \times 10^3$	$\text{Molar}^{-1}\cdot\text{second}^{-1}$
K_{-1}	$(4 - 8) \times 10^1$	Second^{-1}
K_2	$(5 - 15) \times 10^5$	$\text{Molar}^{-1}\cdot\text{second}^{-1}$
K_{-2}	$(5 - 15) \times 10^1$	Second^{-1}
K_3	$(20 - 40) \times 10^1$	Second^{-1}
K_4	$(7 - 13) \times 10^1$	Second^{-1}
K_5	$(7 - 13) \times 10^{-2}$	Second^{-1}
K_{-5}	$(8 - 12) \times 10^5$	$\text{Molar}^{-1}\cdot\text{second}^{-1}$

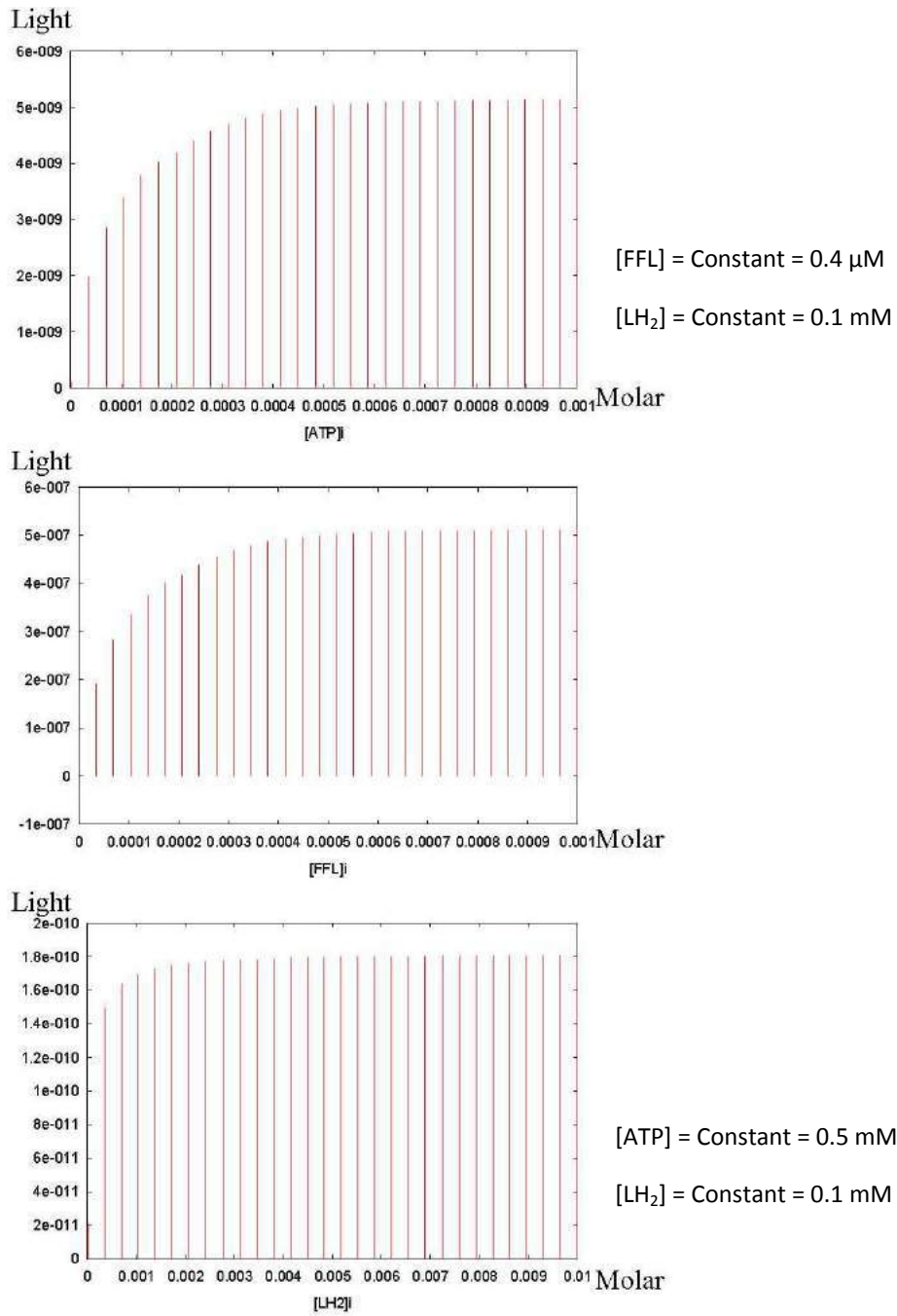


Figure 7: Optimal Concentrations of ATP, FFL, and Luciferin (LH₂) for the FFL Bioluminescence Platform Found from Reactions Simulation.

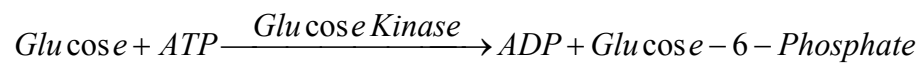
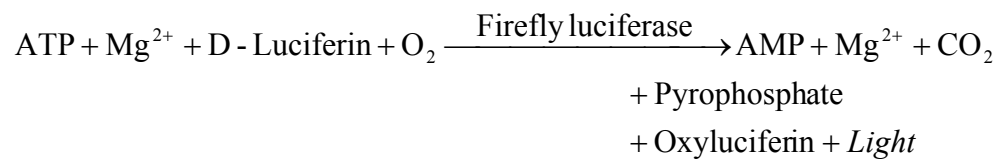


Figure 8: Reactions of the Glucose Assay.

$$\begin{aligned}
& (Kinase)_{ij} + (Analyte)_i \xleftarrow{k_{-1}, k_1} (Kinase)_{ij} - (Analyte)_i \\
& K_{ij} + x_i \xleftarrow{k_{-1}, k_1} (K_{ij} - x_i) \\
& (K_{ij} - x_i) + ATP \xleftarrow{k_{-2}, k_2} (K_{ij} - x_i) - ATP \\
& (K_{ij} - Analyte_i) - ATP \xleftarrow{k_{-3}, k_3} (K_{ij} - Analyte_j) - ADP \\
& (K_{ij} - x_i) - ATP \xleftarrow{k_{-3}, k_3} (K_{ij} - x_j) - ADP \\
& (K_{ij} - x_j) - ADP \xleftarrow{k_{-4}, k_4} (K_{ij} - x_j) + ADP \\
& (K_{ij} - x_j) \xleftarrow{k_{-5}, k_5} K_{ij} + x_j \\
& \text{-----} \\
& (K_{ij} - x_i) + ATP \xleftarrow{k_{-2}, k_2} (K_{ij} - x_i) - ATP \xrightarrow{k_3} (K_{ij} - Analyte_j) - ADP \\
& I\alpha([ATP]_0 - [ATP]) \\
& \frac{d[ATP]}{dt} = -k_2[(K_{ij} - x_i)].[ATP] + k_{-2}[(K_{ij} - x_i) - ATP] \\
& \frac{d[(K_{ij} - x_i) - ATP]}{dt} = k_2[(K_{ij} - x_i)].[ATP] - (k_{-2} + k_3).[(K_{ij} - x_i) - ATP] \\
& [(K_{ij} - x_i) - ATP] = \frac{k_2}{k_{-2} + k_3} [(K_{ij} - x_i)].[ATP] \\
& \frac{d[ATP]}{dt} = -k_2[(K_{ij} - x_i)].[ATP] + \frac{k_{-2}k_2}{k_{-2} + k_3} [(K_{ij} - x_i)].[ATP] \\
& \frac{d[ATP]}{dt} = \left\langle \left[-k_2 + \frac{k_{-2}k_2}{k_{-2} + k_3} \right] (K_{ij} - x_i) \right\rangle [ATP] \\
& \frac{d[ATP]}{dt} = \left\langle \left[-\frac{k_2k_3}{k_{-2} + k_3} \right] (K_{ij} - x_i) \right\rangle [ATP] \\
& \frac{d[ATP]}{[ATP]} = \left\langle \left[-\frac{k_2k_3}{k_{-2} + k_3} \right] (K_{ij} - x_i) \right\rangle .dt \\
& [ATP] = [ATP]_0 e^{\left[\frac{-k_2k_3}{k_{-2} + k_3} \right] (K_{ij} - x_i).t} \\
& I\alpha \left([ATP]_0 - [ATP]_0 e^{\left[\frac{-k_2k_3}{k_{-2} + k_3} \right] (K_{ij} - x_i).t} \right) \\
& I\alpha \left(1 - e^{\left[\frac{-k_2k_3}{k_{-2} + k_3} \right] (K_{ij} - x_i).t} \right) . [ATP]_0
\end{aligned}$$

Figure 9: YTAL-sheikh's General Kinase-Kinetic Model for Kinase-Utilized Reactions that can be Coupled to the FFL Bioluminescent Reaction.

Table 2: Chemistry Protocols for ATP and Glucose Assays.

Reagent	ATP	Glucose	Glycerol
Glycine-Glycine Buffer	pH = 7.8	pH = 7.8	pH = 7.8
Firefly Luciferase	0.4 μ M	0.4 μ M	0.4 μ M
Magnesium Sulphate	5 μ M	5 μ M	5 μ M
Luciferin	100 μ M	100 μ M	100 μ M
ATP	0, 0.1, 1, 10, 100 μ M	500 μ M	500 μ M
Glucose		0, 25, 100, 200 μ M	
Glucose Kinase		2 μ M	

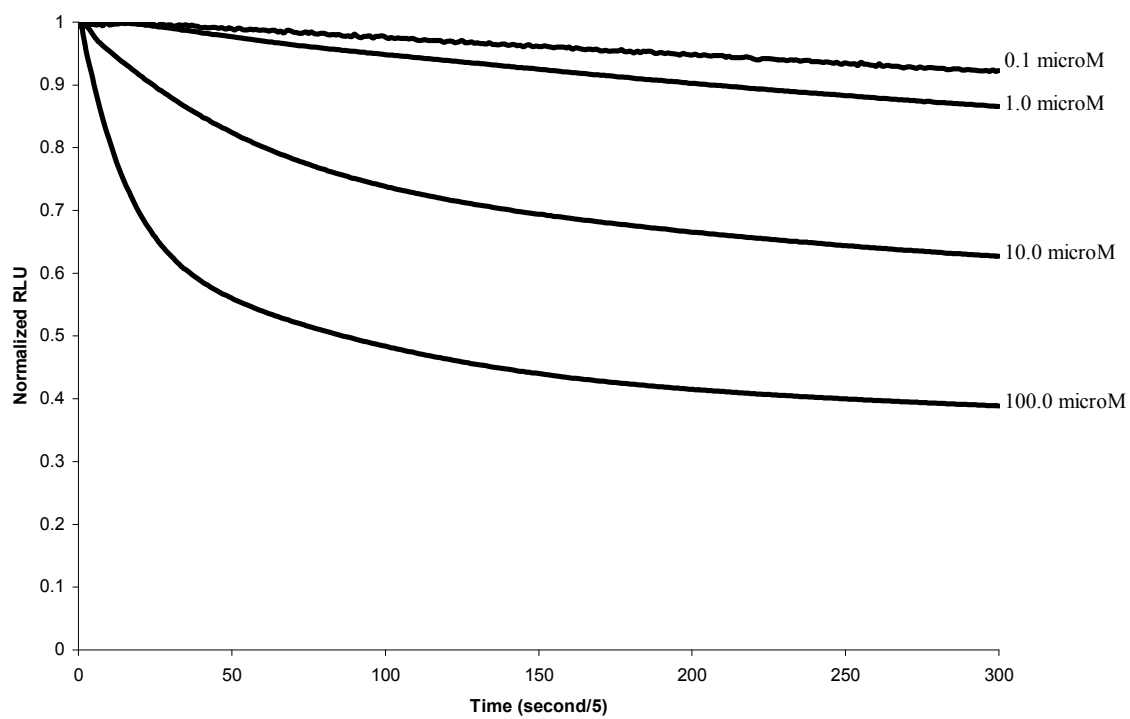


Figure 10: ATP Assay's Light Emission Profiles.

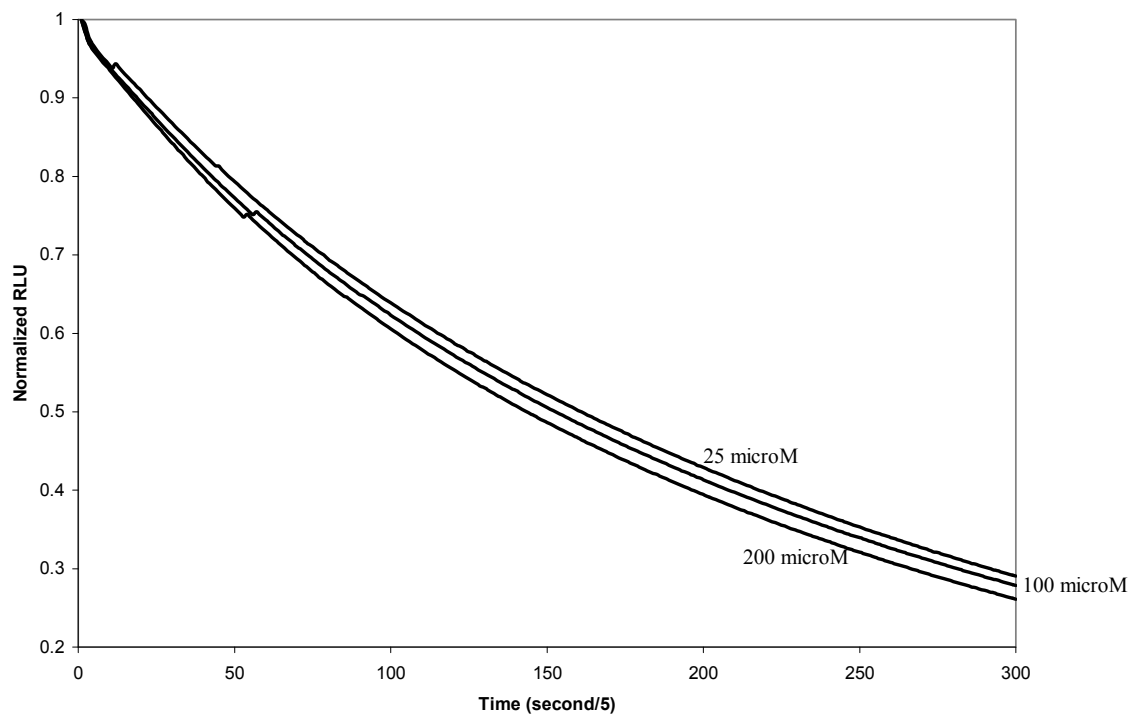


Figure 11: Normalized Light Emission Profiles of the Glucose Assay: Top curve corresponds to 25 micromolar of glucose, middle curve to 100 micromolar glucose, and lowest curve to 200 micromolar glucose.

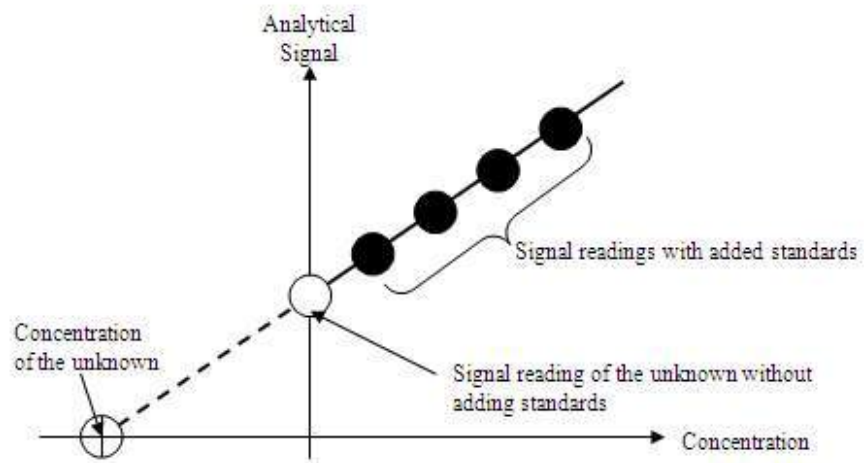
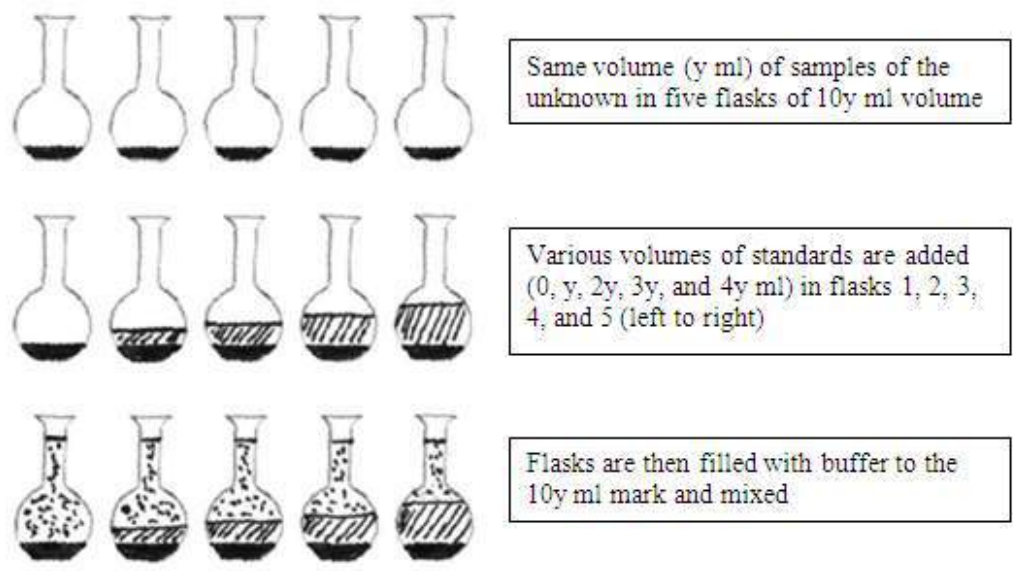


Figure 12: Demonstration of the Standard Additions Assay Calibration Method.

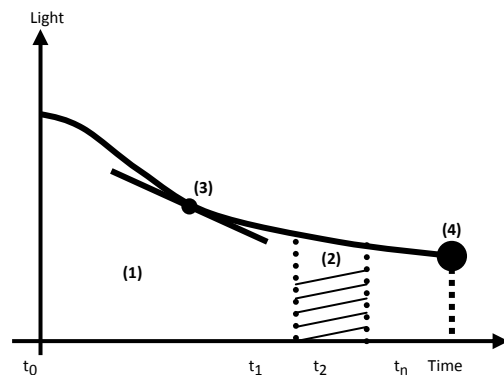


Figure 13: Different Methods for Calibration Curve Analysis and Parameterization: Four methods are shown: Total area under the curve (1), area under the curve between two time points (2), slope value (3), and end point value (4). Method (1) is the easiest as the number of emitted photons, which constitute the area under the curve, can be directly obtained from the light detector. However, if the calibration curve was not graphically examined, potential systematic errors may not be revealed, and thus, total number of emitted photons may not be a valid means for assay calibration. Method (2) can solve ambiguities of method (1); a certain area (between two time points) under the curve is considered instead. Method (3) may be useful if change in analyte concentration can result in noticeable change in the light emission profile. Method (4) resembles method (1) in ease (the last signal reading of the instrument is considered) and also in not recognizing systematic errors. Taking in consideration the pros and cons of these methods, and that experimental light emission profiles agreed with the kinetic model and that no significant systematic errors were noticed, we used the easiest methods (integrating total area under the curve and end point analyses).

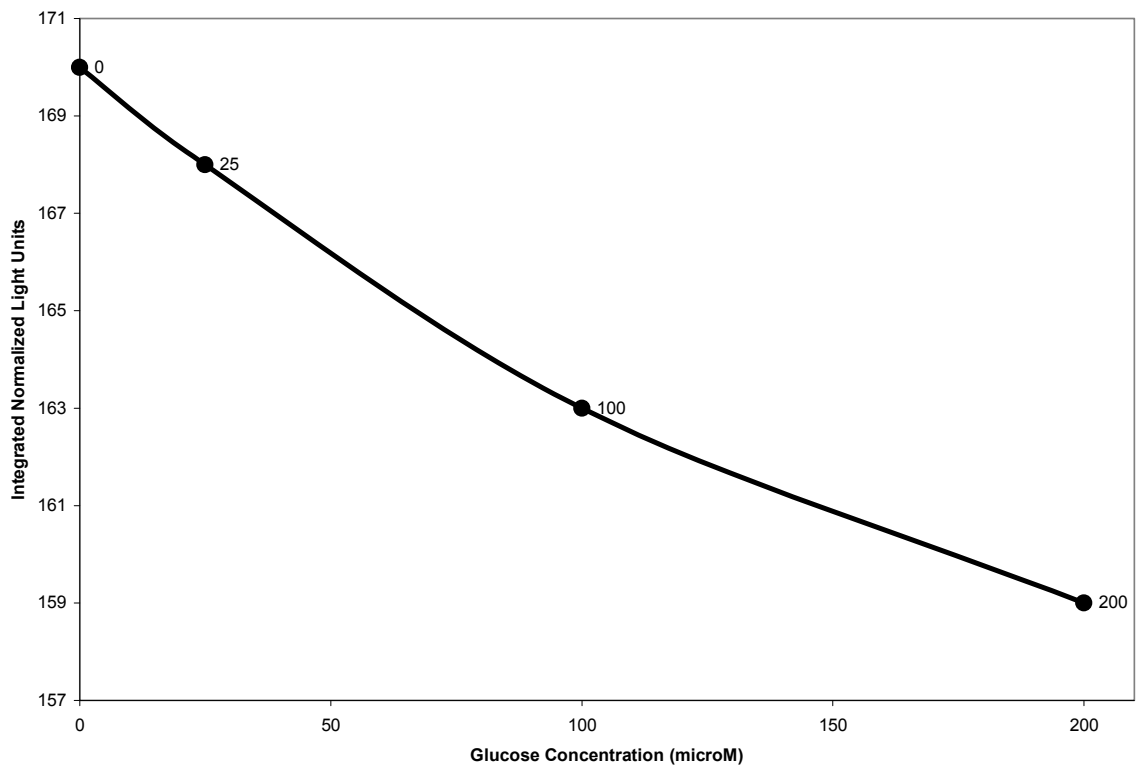


Figure 14: Glucose Assay Calibration Curve.

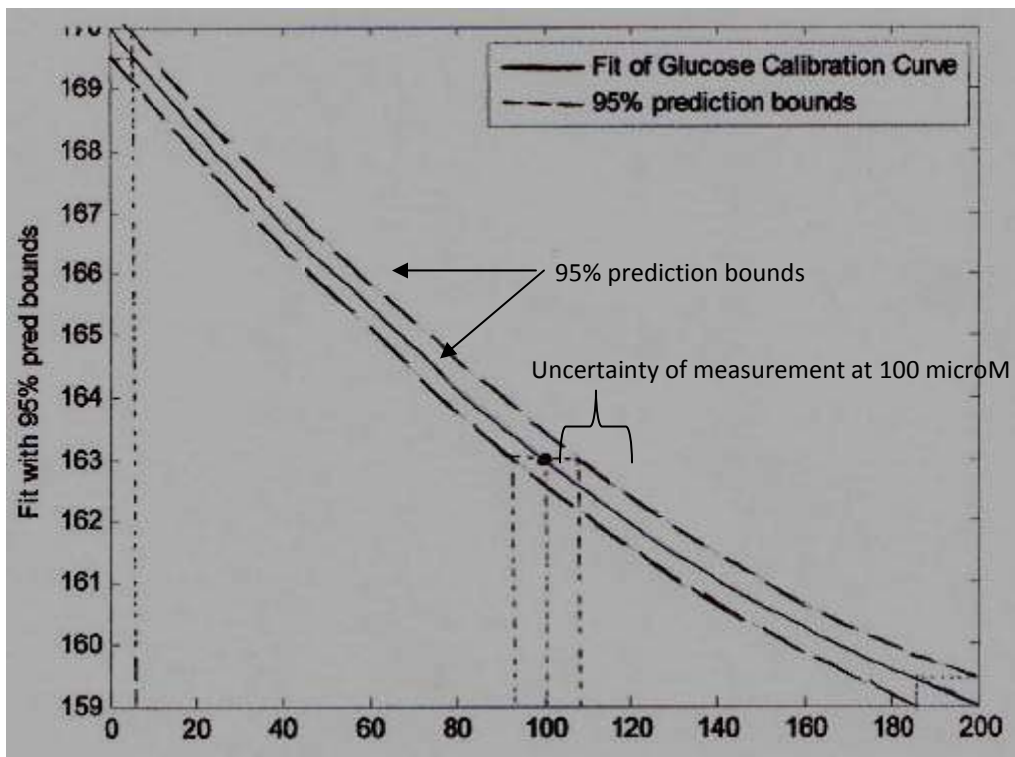


Figure 15: Fitted Glucose Assay Calibration Curve: Assay's analytical detection limits (5–185) micromolar. Uncertainty associated with reporting a 100 micromolar concentration is about ± 5 micromolar.

Table 3: Fitting Model and Parameters, and Goodness of Fit for the Glucose Assay

Calibration Curve.

Fitting Model	Quadratic Polynomial $f(x) = p1*x^2 + p2*x + p3$	x is normalized by mean 81.25 and std 89.85
Fitting Parameters	Coefficients (95% confidence) p1 p2 p3	1.209 (0.9026, 1.514) -5.453 (-5.678, -5.227) 164.1 (163.8, 164.4)
Goodness of Fit	SSE R-square Adjusted R-square RMSE	0.0005988 0.9998 0.9999 0.02447

Table 4: Some Methods of High-Dimensional Data Visualization.¹⁻⁷

Method	Description
2-D or 3-D Scatterplot	A point projection of the data onto a 2D or 3D space. The displayed points can have numerous attributes such as color, size, shape, texture, motion and even sound; when interacted with.
Scatterplot Matrix	An array of scatterplots displaying all possible pairwise combinations of dimensions or coordinates. For n dimensional data this yields $n(n - 1)2$ scatterplots with shared scales.
Heat Map	An array of cells where each cell is colored based on some data value or function on the data.
Height Map	An extension of the heat map with the grid represented as a height field instead of color.
Iconic Display	Each coordinate represents a parameter or attribute of an entity (pixel, icon or glyph) and entities (records) are displayed at once on the screen. There are two types; dimensions of the n-dimensional data set are mapped to certain features of the icon, such as Chernoff faces, where data dimensions are mapped to facial features, or star plots, where the dimensions are represented as equal angular spokes radiating from the center of a circle.
Pixel Technique	An arrangement of the data into an area, starting from some origin, according to the size and number of dimensions, using various techniques including recursive, spiral, and circle segments. The interpretation of the (X, Y) position of the cell depends on the mapping.
Sammon Plot	A non-linear analytic or graphical representation that projects a data set onto a space of lower dimensionality.
Polar Chart	A circular graph for plotting polar coordinates. Polar coordinates map data onto a 2D surface using the angle and radius, creating a wrap-around version of a line graph.
Kohonen Self-Organizing Map (SOM)	A summarization technique that attempts to reduce the complexity of the data set by displaying clusters of the data in a grid. The Kohonen SOM is similar to a k-means clustering algorithm, extending it by providing a topological structure and placing similar objects in neighboring clusters.

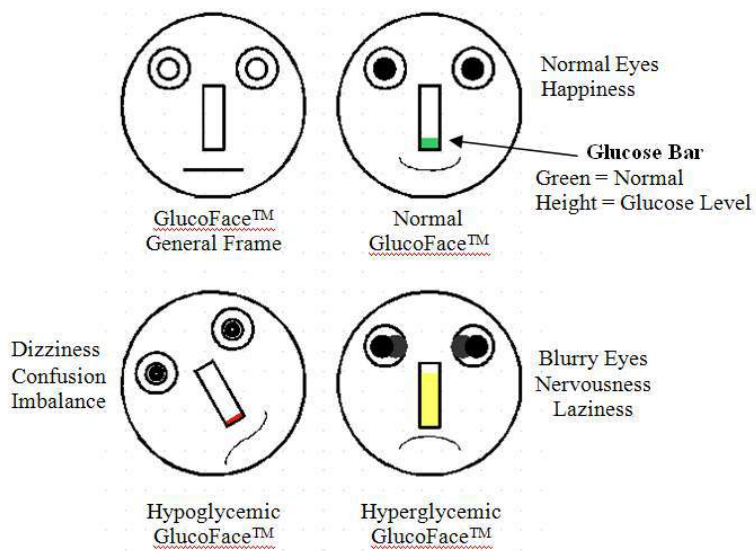


Figure 16: Using Simple Visual Displays (YTAL-sheikh's GlucoFaces™) to Present Results of the diabetiChip.¹²⁶⁻¹²⁸



Visualizing Multi-Analytical Clinical Diagnostic Data via Simple Patterns

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Visualizing Multi-Analytical Clinical Diagnostic Data via Simple Patterns

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Abstract

Multi-analytical clinical data can be displayed via simple patterns to ease interpretation and enable fast diagnostic decision-making. We developed and employed a software program "MACROPatterns" (Multi-Analytical Chemistry-Recognizer of Optical Patterns) for this purpose. MACROPatterns is a multi-dimensional visualization program that enables simultaneous interpretation of measurements along with the recognition of correlated or uncorrelated patterns. Employing visualization concepts and approaches in MACROPatterns required knowledge in various fields, including visual cognition and recognition, art, scientific visualization, and software design. MACROPatterns provides easy navigation through different pathologic panels and various patterns of each panel. This could be very useful especially in clinical education and training. MACROPatterns can be utilized in different analytical fields that require interpretation of multiple measurements along with the recognition of correlated or uncorrelated patterns. Multi-analytical clinical chemistry data visualization via simple iconic displays is demonstrated in the diagnosis of galactosemia and hyperlipoproteinemia.

Introduction

High-dimensional data visualization presents a large number of dimensions or parameters of the data on a display surface (soft or hardcopy). High dimensional data visualization projects n dimensional data onto a 2D physical medium.¹⁻⁶ Multi-analytical clinical data can be displayed via simple patterns to ease interpretation and enable fast diagnostic decision-making.⁷⁻¹² Wolfgang Vogt is one of the pioneers in clinical data display. Diagnosing hyperthyroid disease is a good example of his work.¹³⁻¹⁵ In the example of diagnosing hyperthyroidism, after the tentative diagnosis of a hyperthyroid situation has been made, free thyroxine (FT₄) and free triiodothyronine (FT₃) are investigated and one (or both) of these clinical chemical parameters is supposed to be elevated. Hence a diagnostic model can be formulated:

- Grave's Disease \Leftrightarrow {High FT₄ & High FT₃};
where & refers to a joint state
- Thyroiditis \Leftrightarrow {High FT₄ & High FT₃}

- T₄ Thyrotoxicosis \Leftrightarrow {High FT₄}
- T₃ Thyrotoxicosis \Leftrightarrow {High FT₃}
- Increased Thyroxine-Binding Globulin (TBG) \Leftrightarrow {High FT₄ & High FT₃}

Clearly, a definite diagnosis is impossible because the attributes in the premise are not sufficient. Therefore, further attributes like FT₃ fraction-uptake by analytical method, thyroid-stimulating hormone (TSH), and FT₄ index (FT₄I) have to be added and the process has to be repeated for further clarification. Junctions of such attributes may be called a pattern. Of course, such patterns can also be put into premises. The maximum information content can be achieved if every clinical chemical parameter is determined. This corresponds to an exhaustive procedure with high redundancy and cost. Further, it is impossible simultaneously to detect interrelationships between more than 3D to 5D data. The information from a single value of a parameter can be clearly realized, but the information due to a combination of different quantitative values cannot. Therefore, it is important first to find procedures that help the physician to choose suitable clinical chemical parameters for the solution of a certain diagnostic problem, and second to transform information contained in the single values into general information on one visual display.¹³⁻¹⁵

Stimulated by Vogt's work, we hoped to find appropriate means to represent data generated from a clinical chemistry chip via simple, yet powerful visual patterns. Thus, we developed a software program capable of mathematically and graphically transforming the clinical chemistry chip's data into simple, recognizable visual diagnostic patterns. We called this program MACROPatterns (Multi-Analytical Chemistry-Recognizer of Optical Patterns).

MACROPatterns

MACROPatterns is a multi-dimensional visualization program that enables simultaneous interpretation of measurements along with the recognition of correlated or uncorrelated patterns. Employing visualization concepts and approaches in MACROPatterns required knowledge in various fields, including visual cognition and recognition, art,

scientific visualization, and software design. Visualization concepts and approaches include:

- 1) Visual perception; human visual perception performs best at one-dimensional space, and the larger the dimensionality of space is, the weaker human visual perception becomes,
- 2) Visual recognition; displaying and adding attributes to useful data, and
- 3) MACROPatterns functionality; projecting useful data onto a two-dimensional physical medium, clustering data into simple visual patterns, adding attributes (color, brightness, transparency, or shape distortion) to patterns, and displaying multiple patterns on one screen to ease comparative interpretation.⁷

MACROPatterns provides easy navigation through different pathologic panels and various patterns of each panel. This could be very useful especially in clinical education and training. It assigns the term “Panel” to all analytes related to a clinical condition, and assigns the term “Patterns” to comparative displays (or maps) of the panel’s measurement results “Pathological (or the name of the corresponding sub-disorder)” versus (vs. or v.) normal values “Reference” and a cluster of sub-disorder “Diagnostic”: Reference vs. Diagnostic (R v. D); Diagnostic vs. Pathological (D v. P); Reference vs. Pathological (R v. P); and Reference vs. Diagnostic vs. Pathological (All). Using MACROPatterns to

display multi-analytical clinical data is demonstrated in two cases: galactosemia and hyperlipoproteinemia.

MACROPatterns Demonstrated

Galactosemia: Galactosemia is an inherited disease in which galactose (Gal) and the derived toxic products galactose-1-phosphate (Gal-1-P), galactitol, and galactonate accumulate in the blood due to enzymatic deficiency. The severe form (classical galactosemia) is a life threatening disease resulting from lack of Gal-1-P uridyltransferase (GalT) caused by genetic mutation. Classical galactosemia is suspected when the initial screening shows a galactose value higher than 20 mg/dl and/or GalT absence. Galactosemia may also be caused by a deficiency of UDP-Galactose-4'-epimerase (GalE) associated with increased levels of galactose and Gal-1-P, or a deficiency of galactokinase (GalK) associated with increased levels of galactose, Gal-1-P, galactitol, and galactonate, see Table 1.^{11-12, 16-21}

MACROPatterns can be used to display patterns of a galactosemia panel consisting of galactose, GalK, GalT, GalE, and Gal-1-P along with a map of all the patterns of classical galactosemia (see Figures 1 and 2).

Table 1. Galactosemia Diagnosing Panel⁷

	Gal	GalK	GalT	GalE	Gal-1-P	Galactitol	Galactonate
Galaktokinase-deficient galactosemia	+++	---	Normal	Normal	++	+++	+++
G-1-P uridyltransferase-deficient galactosemia	++	Normal	---	Normal	+++	+++	+++
UDP-galactose-4'-epimerase-deficient galactosemia	++	Normal	Normal	---	++		

Hyperlipoproteinemia: Hyperlipoproteinemia is abnormally high levels of lipids (cholesterol, triglycerides, or both) carried by lipoproteins in blood; low density lipoprotein (LDL) cholesterol, very low density lipoprotein (VLDL) cholesterol, and chylomicrons. However, a high level of the high density lipoprotein (HDL) cholesterol “the good cholesterol” is beneficial and is not considered a

disorder. Levels of lipoproteins increase slightly as people age. Also, they are normally slightly higher in men than in women, but increase in women after menopause. The increase in levels of lipoproteins occurring along with aging can result in hyperlipoproteinemia and increase the risk of atherosclerosis.^{16, 22}

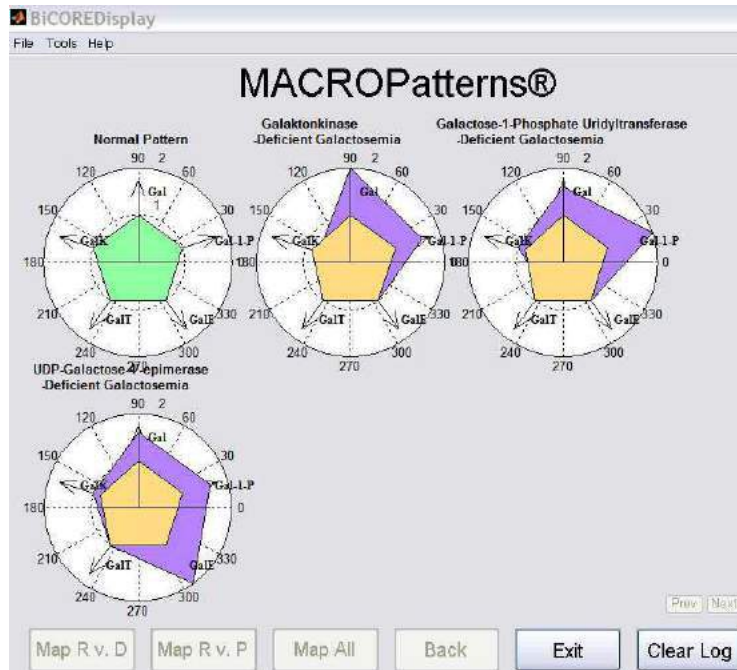


Figure 1. Four iconic displays for the patterns associated with galactosemia: The upper left display is the reference pattern, the other three displays show diagnostic patterns imposed on top of the pathological patterns of patients.⁷



Figure 2. A comparative display of patterns related to galactokinase-deficient galactosemia: The small polygon refers to the typical diagnostic pattern of galactokinase-deficient galactosemia. The pentagon refers to the reference pattern of the extended galactosemia panel. The big polygon is the patient's pattern.⁷

Columns of Table 2 represent the hyperlipoproteinemia panel, whereas the rows represent the diagnostic patterns. This case is uniquely processed in MACROPatterns; unlike the other analytes of the hyperlipoproteinemia panel, chylomicrons are qualitatively analyzed in urine samples. Typically, chylomicrons are reported either as negative (clear urine) or positive (creamy urine).

Thus, MACROPatterns assigns chylomicrons an axis with 0 or 1 values. Also a color dimming attribute is added to the diagnostic and patient patterns to reflect the positive (or creamy) values of chylomicrons. Therefore, when chylomicrons exist (positive result) the corresponding diagnostic pattern would appear dimmer towards the 1 value on the chylomicrons axis (see Figures 3 and 4).

Table 2. Hyperlipoproteinemia diagnosing panel⁷

	Chylomicrons	LDL	VLDL	Cholesterol	Triglycerides
Hyperchylomicronemia	++	Normal	Normal	Normal or +	+++
Hyperbetalipoproteinemia	Normal	+++	Normal	+++	Normal
Combined Hyperlipoproteinemia	Normal	+++	+	+++	+
Hyperprebetalipoproteinemia	Normal	Normal	+++	Normal or +	+++
Mixed Hyperlipoproteinemia	++	Normal	+++	+++	++

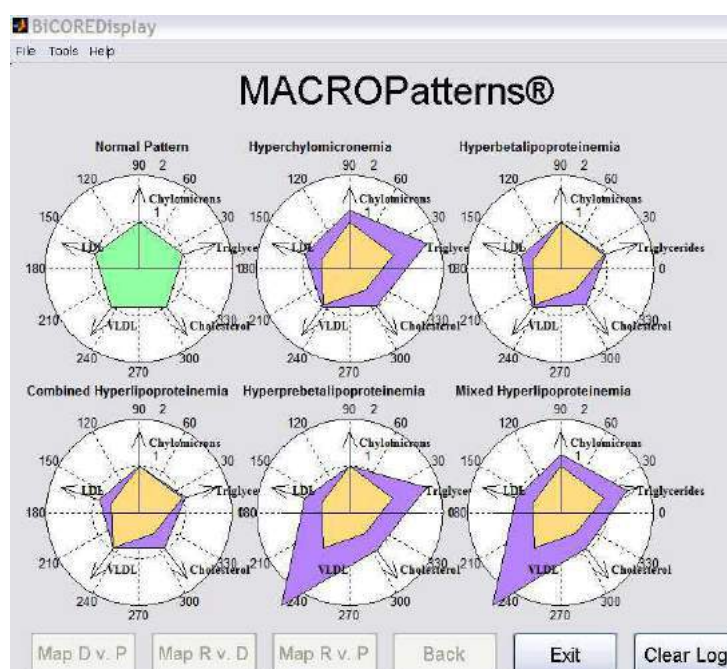


Figure 3. Six iconic displays for the patterns associated with the hyperlipoproteinemia: The upper left display is the reference pattern, the other five displays show diagnostic patterns imposed on top of patients' pathological patterns.⁷

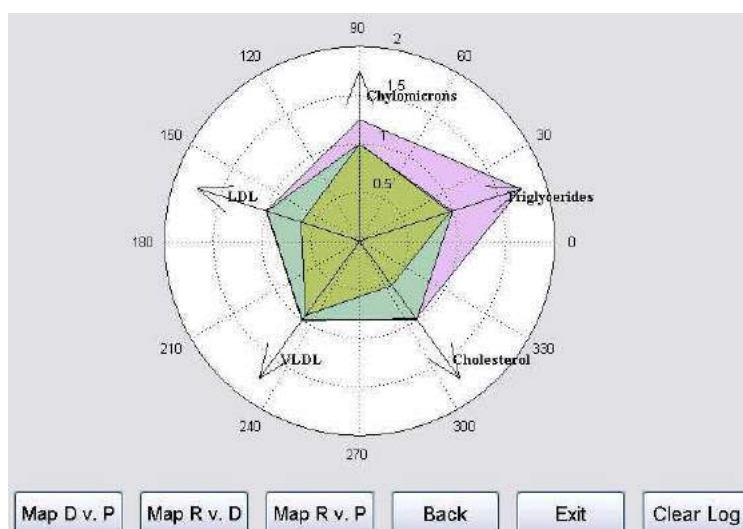


Figure 4. A comparative display of patterns related to hyperchylomicronemia: The small polygon refers to the typical diagnostic pattern of hyperchylomicronemia. The pentagon refers to the reference pattern of the extended hyperlipoproteinemia panel. The big polygon is the patient's pattern.⁷

The existing version of MACROPatterns and its documentation are available on AL-sheikh's webpage:

(<http://informatics.bmi.utah.edu/wiki/index.php/User:YTAL>). The program is not being improved or supported.

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Visualizing Multi-Analytical Clinical Chemistry Data via Simple Patterns

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Abstract

Multi-analytical clinical chemistry data can be displayed via simple patterns to ease interpretation and enable fast diagnostic decision making. We developed and employed a software program "MACROPatterns" (Multi-Analytical Chemistry-Recognizer of Optical Patterns) for this purpose. MACROPatterns is a multidimensional visualization program that enables simultaneous interpretation of

measurements along with the recognition of correlated or uncorrelated patterns. Employing visualization concepts and approaches in MACROPatterns required knowledge in various fields, including visual cognition and recognition, art and scientific visualization, and software design. MACROPatterns provides easy navigation through different pathologic panels and various patterns of each panel. This could be very useful, especially in clinical laboratory

education and training. MACROPatterns can be utilized in different analytical fields that require interpretation of multiple measurements along with the recognition of correlated or uncorrelated patterns. Multi-analytical clinical chemistry data visualization via simple iconic displays is demonstrated in the diagnosis of galactosemia and hyperlipoproteinemia.

High-dimensional data visualization presents a large number of dimensions or parameters of the data on a display surface (soft or hardcopy). High dimensional data visualization projects n dimensional data onto a 2D physical medium.¹⁻⁶ Multi-analytical clinical data can be displayed via simple patterns to ease interpretation and enable fast diagnostic decision making.⁷⁻¹⁴ Wolfgang Vogt is one of the pioneers in clinical data display. Diagnosing hyperthyroid disease is a good example of his work.¹⁵⁻¹⁷ In the example of diagnosing hyperthyroidism, after the tentative diagnosis of a hyperthyroid situation has been made, free thyroxine (FT4) and free triiodothyronine (FT3) are investigated and one (or both) of these clinical chemical parameters is supposed to be elevated. Hence a diagnostic model can be formulated:

- Grave's Disease; {High FT4 & High FT3}; where "&" refers to a joint state.
- Hashimoto's Disease; {High FT4 & High FT3}.
- T4 thyrotoxicosis; {High FT4}.
- T3 thyrotoxicosis; {High FT3}.
- Increased thyroxine-binding globulin (TBG); {High FT4 & High FT3}.

Clearly, a definite diagnosis is impossible because the attributes in the premise are not sufficient. Therefore, further attributes like FT3 fraction-uptake by analytical method, thyroid-stimulating hormone (TSH), and FT4 index (FT4I) have to be added and the process has to be repeated for further clarification. Junctions of such attributes may be called a pattern. Of course, such patterns can also be put into premises. The maximum information content can be achieved if every clinical chemical parameter is

determined. This corresponds to an exhaustive procedure with high redundancy and cost. Further, it is impossible simultaneously to detect interrelationships between more than 3D to 5D data. The information from a single value of a parameter can be clearly realized, but the information, due to a combination of different quantitative values, cannot. Therefore, it is important first to find procedures that help the physician to choose suitable clinical chemical parameters for the solution of a certain diagnostic problem, and second to transform information contained in the single values into general information on one visual display.¹⁵⁻¹⁷

Stimulated by Vogt's work, we hoped to find appropriate means to represent data generated from a clinical chemistry chip via simple, yet powerful, visual patterns. Thus, we developed a software program capable of mathematically and graphically transforming the clinical chemistry chip's data into simple, recognizable visual diagnostic patterns. We called this program MACROPatterns (multi-analytical chemistry-recognizer of optical patterns).

MACROPatterns

MACROPatterns is a multi-dimensional visualization program that enables simultaneous interpretation of measurements along with the recognition of correlated or uncorrelated patterns. Employing visualization concepts and approaches in MACROPatterns required knowledge in various fields, including visual cognition and recognition, art and scientific visualization, and software design.

Table 1_Galactosemia Diagnosing Panel⁷⁻⁹

	Gal	GalK	GalT	GalE	Gal-1-P	Galactitol	Galactonate
Galaktokinase-deficient galactosemia	+++	---	Normal	Normal	++	+++	+++
G-1-P uridytransferase-deficient galactosemia	++	Normal	---	Normal	+++	+++	+++
UDP-galactose-4'-epimerase-deficient galactosemia	++	Normal	Normal	---	++		

Concepts: MACROPatterns visualization concepts and approaches include:

- 1) Visual perception: human visual perception performs best at 1-dimensional space, and the larger the dimensionality of space is, the weaker human visual perception becomes;
- 2) visual recognition: displaying and adding attributes to useful data; and
- 3) MACROPatterns functionality: projecting useful data onto a 2-dimensional physical medium, clustering data into simple visual patterns, adding attributes (color, brightness, transparency, or shape distortion) to patterns, and displaying multiple patterns on 1 screen to ease comparative interpretation.⁷⁻⁹

Environment: MACROPatterns provides easy navigation through different pathologic panels and various patterns of each panel. This could be very useful, especially in clinical education and training. It assigns the term “Panel” to all analytes related to a clinical condition, and assigns the term “Patterns” to comparative displays (or maps) of the panel’s measurement results “Pathological (or the name of the corresponding sub-disorder)” versus (vs. or v.) normal values “Reference” and a cluster of sub-disorder “Diagnostic”:

- Reference vs. Diagnostic (R v. D);
- Diagnostic vs. Pathological (D v. P);
- Reference vs. Pathological (R v. P); and
- Reference vs. Diagnostic vs. Pathological (All).

Using MACROPatterns to display multi-analytical clinical data is demonstrated in 2 cases: galactosemia and hyperlipoproteinemia.

Clinical Examples

Galactosemia

Galactosemia is an inherited disease in which galactose (Gal) and the derived toxic products galactose-1-phosphate (Gal-1-P), galactitol, and galactonate accumulate in the blood due to enzymatic deficiency. The severe form (classical galactosemia) is a life threatening disease resulting from lack of Gal-1-P uridytransferase (GalT) caused by genetic mutation. Classical galactosemia is suspected when the initial screening shows a galactose value higher than 20 mg/dL and/or GalT absence. Galactosemia may also be caused by a deficiency of UDP-Galactose-4'-epimerase (GalE) associated with increased levels of galactose and Gal-1-P, or a deficiency of galactokinase (GalK) associated with increased levels of galactose, Gal-1-P, galactitol, and galactonate (Table 1).^{13-14,18-23} MACROPatterns can be used to display patterns of a galactosemia panel consisting of galactose, GalK, GalT, GalE, and Gal-1-P along with a map of all the patterns of classical galactosemia (Figures 1 and 2).

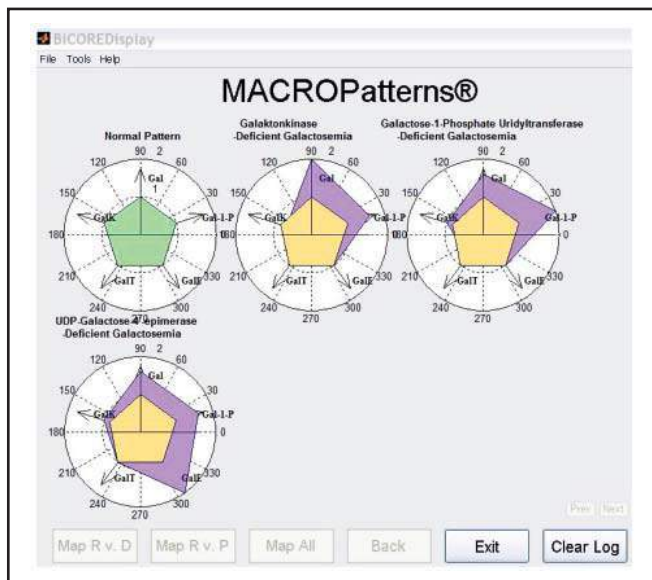


Figure 1_Four iconic displays for the patterns associated with galactosemia. The upper left display is the reference pattern; the other 3 displays show diagnostic patterns imposed on top of the pathological patterns of patients.⁷⁻⁹



Figure 2 A comparative display of patterns related to galactokinase-deficient galactosemia. The small polygon refers to the typical diagnostic pattern of galactokinase-deficient galactosemia. The pentagon refers to the reference pattern of the extended galactosemia panel. The big polygon is the patient's pattern.⁷⁻⁹

Table 2_Hyperlipoproteinemia Diagnosing Panel⁷⁻⁹

	Chylomicrons	LDL	VLDL	Cholesterol	Triglycerides
Hyperchylomicronemia	++	Normal	Normal	Normal or +	+++
Hyperbetalipoproteinemia	Normal	+++	Normal	+++	Normal
Combined hyperlipoproteinemia	Normal	+++	+	+++	+
Hyperprebetalipoproteinemia	Normal	Normal	+++	Normal or +	+++
Mixed hyperlipoproteinemia	++	Normal	+++	+++	++

LDL, low-density lipoprotein; VLDL, very-low-density lipoprotein

Hyperlipoproteinemia

Hyperlipoproteinemia is abnormally high levels of lipids (cholesterol, triglycerides, or both) carried by lipoproteins in blood; low-density lipoprotein (LDL) cholesterol, very-low-density lipoprotein (VLDL) cholesterol, and chylomicrons. However, a high level of the high-density lipoprotein (HDL) cholesterol, the “good cholesterol,” is beneficial and is not considered a disorder. Levels of lipoproteins increase slightly as people age. Also, they are normally slightly higher in men than in women, but increase in women after menopause. The increase in levels of lipoproteins occurring along with aging can result in hyperlipoproteinemia and increase the risk of atherosclerosis.^{18,24}

Columns in **Table 2** represent the hyperlipoproteinemia panel, whereas the rows represent the diagnostic patterns. This case is uniquely processed in MACROPatterns; unlike the other analytes of the hyperlipoproteinemia panel, chylomicrons are qualitatively analyzed in urine samples. Typically, chylomicrons are reported either as negative (clear urine) or positive (creamy urine). Thus, MACROPatterns assigns chylomicrons an axis with 0 or 1 values. Also a color-dimming attribute is added to the diagnostic and patient patterns to reflect the positive (or creamy) values of chylomicrons. Therefore, when chylomicrons exist (positive result) the corresponding diagnostic pattern

would appear dimmer towards the 1 value on the chylomicrons axis (**Figures 3 and 4**).

If further developed to visualize measurements of other clinical measurements, MACROPatterns may be a useful software program aimed towards enabling differential diagnoses of complex diseases and in training clinicians. The reader is referred to a Web site (www.DiabetesInfoPortal.org) for further details on the design and development of MACROPatterns, and for downloading version 1.0 of the software program and the associated user manual. LM

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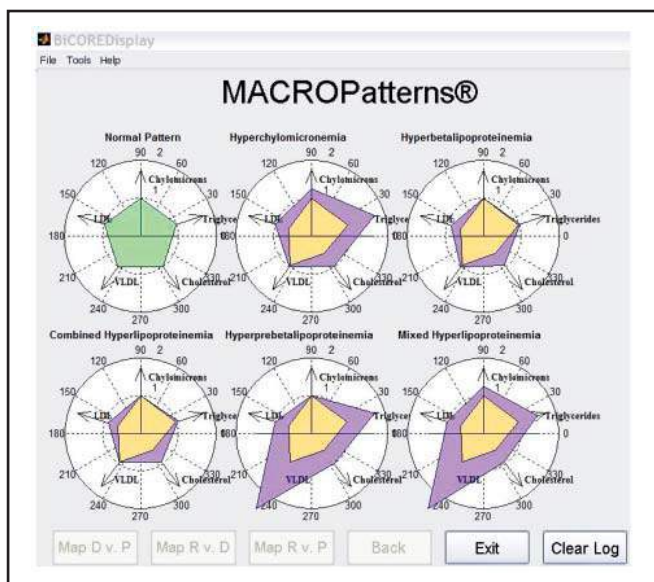


Figure 3 Six iconic displays for the patterns associated with the hyperlipoproteinemia. The upper left display is the reference pattern; the other 5 displays show diagnostic patterns imposed on top of patients' pathological patterns.⁷⁻⁹



Figure 4 A comparative display of patterns related to hyperchylomicronemia. The small polygon refers to the typical diagnostic pattern of hyperchylomicronemia. The pentagon refers to the reference pattern of the extended hyperlipoproteinemia panel. The big polygon is the patient's pattern.⁷⁻⁹

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