






# A Novel Approach for Modelling the Relationship between Blood Pressure and ECG by using Time-series Feature Extraction

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**Abstract:** This paper addresses the ECG-blood pressure relationship - a fact that physicians have discussed for years. The hypothesis set in the paper is that blood pressure is related to electrocardiogram (ECG) and that the systolic blood pressure (SBP) and diastolic blood pressure (DBP) values can be predicted by using information only from a given ECG signal. Therefore, we established a protocol for creating a database considering measurements from real patients in ambulance environment, and consequently developed methodology for analysing the collected measurements. The proposed methodology follows two steps: i) first the signals are considered as time series data, and ii) a time series feature extraction method is applied to extract the important features from the ECG signals. Hereafter, a novel Machine learning method is applied (CLUS) that produced best results among the traditionally-used Machine learning methods. The best results obtained are  $12.81 \pm 2.66$  mmHg for SBP and  $8.12 \pm 1.80$  mmHg for DBP. After introducing calibration method the obtained mean absolute errors (MAEs) reduced to  $6.93 \pm 4.70$  mmHg for SBP, and  $7.13 \pm 4.48$  mmHg for DBP. Given the latest literature, the results are appropriately compared and confirm the relation between the ECG signal and the blood pressure.


## 1 INTRODUCTION


Cardiovascular diseases (CVDs) are among the top five causes of death worldwide according to World Health Organization research (Organization et al., 2016). Ischemic heart disease and stroke are at the top of this list. This fact indicates the particular importance of prevention as well as early diagnosis and treatment of CVDs. Blood pressure (BP) is one of the vital signs used to diagnose these diseases. Regular BP monitoring is especially important to detect possible changes in the functioning of the cardiovascular system.


Recently, there is an expansion of wearable de-


vices equipped with biosensors designed to monitor the activity of the human body by measuring some of the vital signs. They come in the form of smart watches, smart hand bracelets, belts, rings, smart glasses, etc. Usually, smart watches are equipped with motion detection sensors and Photoplethysmography (PPG) sensors. Detailed analysis of these measurements can provide important information to physicians about the functioning of the cardiovascular system of the patients. Even though the smart watches and the wearable sensors are still not equipped with BP sensors, the newest generation of smart watches provides dual-electrode ECG sensors, e.g. the famous Apple Watch in the latest two versions (fourth and fifth), is equipped with ECG functionality (Hernando et al., 2018). This is very important for the research presented in this paper, since the main goal is to leverage the ECG signal in order to estimate the BP condition of the patient.

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Several studies have been performed on the relationship between blood pressure and morphological characteristics of the ECG, which confirm that there is no strong relationship between the morphological characteristics of the signal and hypertension (Schroeder et al., 2003; Hassan et al., 2008). However, in the most recent research (Mousavi et al., 2019a), this hypothesis is rejected since the results clearly show ECG-BP relation based on the morphological characteristics of the ECG signal.

In this paper, a new approach for exploring the ECG-BP relationship is proposed. The core of the new approach is in the feature engineering phase. The ECG signal is considered as time series data and Machine Learning models have been trained, which use a space of 794 discriminatory time series features.

The paper is organized as follows. Section 2 presents the most reliable work related to the research presented in this paper. The related work is organized in a table, which also encompasses our results, to make it easily comparable with the literature. Since we follow the regular procedure for biomedical signal processing proposed in (Najarian and Splinter, 2005), the first step to describe the biological system of interest in the paper is described in Section 3. The sensors used, the database, the preprocessing, the features selection, and the complete Machine learning approach are described in Section 4. Section 5 presents the results and the discussion, whereas the final conclusions are presented in Section 6.

## 2 RELATED WORK

More attempts have been made to establish the relationship between BP and some parameters that can be measured with wearable devices, such as PPG sensor. However, the majority of them have used a combination of multiple sensors and vital signs information, which requires an installation of additional measurement devices. Only a few papers are studying the relationship between the BP and the ECG only.

Given the published results in the literature, in Table 1 we present many of the achievements evaluated in the literature by the mean absolute error and standard deviation, MAE ± SD. The second cluster of results in the same table relate to the latest research published in 2018 and 2019. In the third cluster, found in the table, the results published in this paper are isolated so that they can be easily compared with the results published in the literature.

From the related literature, we have identified only four other studies in which ECG has been used to assess BP. However, the methods in two of the studies

use an additional sensor (PPG sensor).

All the errors are measured in mmHg unit.

## 3 THE BIOLOGICAL SYSTEM

Electrocardiography is a standard method of recording the impulses of electrical activity of the heart muscle. The graphical representation of the heart's electrical bio-potentials is called an electrocardiogram (ECG). Deviations from the normal ECG shape occur at numerous cardiac abnormalities, including changes in rhythm (such as atrial fibrillation and ventricular

Table 1: Related work comparison.

| Research                       | Source              | Num. subjects                 | sub-jects | Age    | Records | Method                                    | MAE SBP            | MAE DBP            | MAE MAP      |
|--------------------------------|---------------------|-------------------------------|-----------|--------|---------|-------------------------------------------|--------------------|--------------------|--------------|
| (Gao et al., 2016)             | PPG                 | 65                            |           | 22-65  | 78      | Wavelet, SVM                              | 5.1 ± 4.3          | 4.6 ± 4.3          | N/A          |
| (Ahmad et al., 2012)           | ECG, PTT            | 10                            |           | 24-63  | 150     | Numerical solution                        | ±5.93              | ±4.76              | ±4.23        |
| (Chen et al., 2015)            | BCG, ECG            | 5                             |           | /      | /       | Analytical solution                       | 1.8 ± 1.3          | 1.8 ± 1.3          | N/A          |
| (Daimiwal et al., 2014)        | PPG                 | 16                            |           | 18-48  | /       | Frequency analysis                        | 0.8 ± 0.7          | 0.9 ± 0.6          | N/A          |
| (Chan et al., 2001)            | ECG, PPG, PAT       | /                             |           | /      | /       | Analytical solution                       | 7.49 ± 8.8         | 4.07 ± 5.6         | N/A          |
| (Kachuee et al., 2015)         | PPG                 | MIMIC II (Saeed et al., 2011) |           | adults | 4254    | Linear regression, SVM                    | 13.84 ± 17.56      | 6.96 ± 9.16        | 8.54 ± 10.87 |
| (Yamanaka et al., 2016)        | PTT, PPG            | 127                           |           | /      | /       | Wavelet                                   | ±7.63              | H/B                | H/B          |
| (Ding et al., 2016)            | ECG + PPG           | 27                            |           | 21-29  | /       | Analytical solution                       | -0.37 ± 5.21       | -0.08 ± 4.06       | -0.18 ± 4.13 |
| (Su et al., 2018)              | FBG sensor          | 84                            |           | /      | /       | Deep RNN                                  | [3.84-5.81] (RMSE) | [1.80-5.21] (RMSE) |              |
| (Katayama et al., 2018)        | Ultrasound (images) | 77                            |           | 21-87  | 132     | PLSR, ANN                                 | Unknown: 12 ± 17   | 8.23               |              |
| (Zakrzewski and Anthony, 2018) | Ultrasound (images) | 24                            |           | /      | /       | Regression, Bland-Altman                  | 10.21              |                    |              |
| (Mousavi et al., 2019b)        | PCG                 | 400                           |           | /      | 1323    | DL:SVR, ABR:RFR                           | [4.17-7.51] (SD)   | [8.90-18.54] (SD)  |              |
| (Wu et al., 2018)              | ECG + PPG           | 85                            |           | /      | /       | DNN                                       | 3.63               | 2.45               |              |
| (Fan et al., 2018)             | PCG                 | 6                             |           | 20-35  | /       | Gaussian model                            | 8.42 ± 8.81        | 12.34 ± 7.10       |              |
| (Mousavi et al., 2019a)        | ECG                 | 7                             |           | 50-81  | 7       | morphological features, McSharry's method | 1.125 ± 3.125      | N/A                | N/A          |
| (Yang et al., 2018)            | ECG, PPG            | 14                            |           | N/A    | N/A     | Lasso regression, SVM                     | 12.38 ± 16.17      | 6.34 ± 8.45        | N/A          |
| (Sirjanoska et al., 2018)      | ECG                 | 72                            |           | 16-83  | 1253    | Complexity analysis                       | 7.93 ± 8.16        | 6.41 ± 7.5         | 5.72 ± 6.69  |
| Our approach                   | ECG                 | 69                            |           | 18-89  | 2073    | tsfresh + CLUS                            | 12.81 ± 2.66       | 8.12 ± 1.80        | N/A          |
| Our approach (calibrated)      | ECG                 | 69                            |           | 18-89  | 2073    | tsfresh + CLUS                            | 6.93 ± 4.70        | 7.13 ± 4.48        | N/A          |

tachycardia), inadequate blood flow to the coronary artery, and electrolyte disturbances.

Blood pressure is defined as the force by which blood presses on the walls of the arteries at different stages of a cardiac cycle, and is measured in millimeters of mercury (mmHg). Usually BP is presented as two values, that is, systolic and diastolic blood pressure. Systolic blood pressure (SBP) is the pressure at which the blood presses on the walls of the arteries when the heart is pumped, i.e., the highest pressure in a heart cycle (known as a pumping phase). Diastolic blood pressure (DBP) is the pressure on the walls of the arteries in the phase of filling the heart with blood, that is, when the heart rests between two beats (or the lowest blood pressure between two beats). Usually greater attention is given to SBP as a major factor for CVDs. According to recent studies, the risk of death from ischemic heart disease and stroke is doubled with every rise of 20 mmHg of systolic and 10 mmHg of DBP for people from 40 to 89 years (Association et al., 2014).

## 4 METHODOLOGY

To develop models that can be used for predicting blood pressure using ECG time series, we propose our own methodology that consists of four main steps:

- Data collection;
- Preprocessing of ECG signals;
- Training regression models for blood pressure prediction;
- Methodology evaluation.

The methodology flowchart is presented in Figure 1. Further, each step is described in detail.

### 4.1 Data Collection

The data collected in our study consists of 69 participants, who agreed to be a part of the study. For the data collection process, we established a protocol for creating a data set that considers patients' measurements obtained in an ambulance environment.

The reason for creating the de novo database, instead of using publicly available resources as Physionet's Charis database, is the fact that the participants involved in the Charis database suffered traumatic brain injuries (Kim et al., 2016). Considering such brain injuries, all of those patients would exhibit a special case of hypertension, referred to as isolated systolic hypertension, thus obtaining SBP of  $\geq 140$  and DBP of  $< 90$  (Simjanoska et al., 2018). This

makes Charis database unacceptable for our study since we would lack patients with normal blood pressure values. In addition to this reason is the fact that we want to prove the usefulness of the biosensors technology in a case when there is a lack of medical equipment.

Before the ECG signal and BP measurements were collected, we obtained a study approval from the Ethics committee, which is a part from the Faculty of Medicine within "Ss. Cyril and Methodius" University in Skopje. Additionally, each participant signed an agreement that their information can be used for the purpose of the research study. The participants data is anonymized.

The measurements were collected in a clinical conditions with a help of physician. The physician helped preparing the participant before measurements start, by setting participants in the appropriate seating position, way of breathing and their posture. After that, the ECG signal is measured for three minutes using a commercially available ECG device, known as Zephyr ECG (Zephyr Technology, 2017). The reliability of the device is previously confirmed in other studies (Hailstone and Kilding, 2011). Additionally, at the beginning and at the end of the ECG measurement, the physician measured the SBP and DBP for every participant by using a standardized device for blood pressure (i.e. the traditional cuff-based method). The data is taken into consideration only if the two (consecutive) pairs of BP measurements are in the range of  $\pm 5$  mmHg. The average of the two pairs is taken as a final BP reading, assigned to the 3 minutes long ECG.

### 4.2 ECG Signals Preprocessing

After the data is collected, the next step is to preprocess the data in order to create a training corpus that will be used to train regression models for BP prediction. The preprocessing step consists of several sub-steps:

- Segmentation;
- Noise removal;
- Feature engineering.

#### 4.2.1 Segmentation

Since we are working with ECG signals that are time series from three minutes, we segmented each signal into segments with a signal length of 10 s. Additionally, to each segment we assigned the SBP and DBP real values from the whole ECG signal.

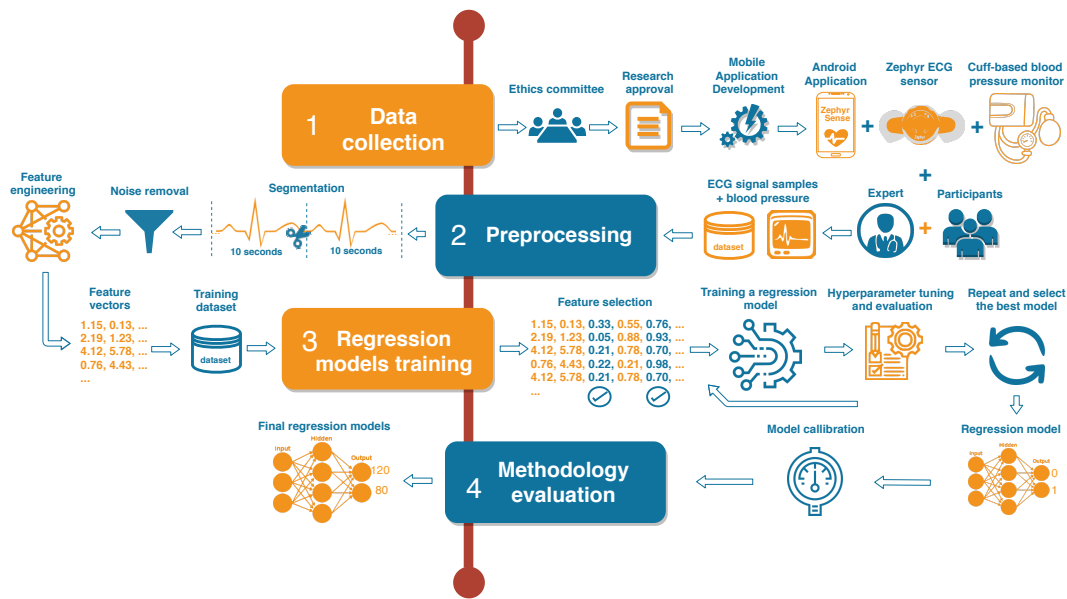


Figure 1: Methodology flowchart.

#### 4.2.2 Noise Removal

When measuring ECG signals, the signal obtained contains a noise, that can be caused either by the device, or the environment where the measurements are performed. For this reason, bandpass filters can be used for noise removal. In this research, Butterworth bandpass filter is selected that can be used with cut-off frequency between 0.05 Hz and 100 Hz. The selection of the frequencies is supported by the results published in (Simjanoska et al., 2018; Simjanoska et al., 2019).

#### 4.2.3 Feature Engineering

In order to extract useful information from the ECG signal, we have come up with a new form of representing the ECG signal data in terms of time-series features.

Manual definition and computation of an ECG time series features is a time-consuming process which requires an expert knowledge. An approach of manual definition and computation of ECG features has been already studied in a previous research (Simjanoska et al., 2018; Simjanoska et al., 2019). The new approach proposed in this paper deals with automation of the feature engineering step, utilizing the **tsfresh** library for ECG feature extraction (Christ et al., 2018).

**TSFRESH** is a python library that deals with automatic feature extraction for representing a time series data. Utilizing this library, 794 features can be

extracted for every 10s-long segment. There are 65 unique features, described in the documentation of the **tsfresh** library (TSFRESH, 2016). The number of 794 features for every segment is a result of computing many of these features with different parameter settings. Some of the features computed by the **tsfresh** library are: absolute energy, absolute sum of changes, autocorrelation, entropy, binned entropy, number of values above and below the average, friedrich coefficients, skewness, symmetry looking, etc.

#### 4.3 Regression Models Creation

The next challenge was creating regression models that will be able to predict the real SBP and DBP values. For this reason, the training corpus that is described by the **tsfresh** features is used again. In order to shrink the feature space consisting of 794 features, feature selection techniques are applied. Two different approaches are used to train regression models. In the first scenario, two different single linear regression models are trained (one for SBP and the other for DBP). In this scenario, the SBP and DBP values are assumed to be independent. To create the models we evaluate Random Forest (Liaw et al., 2002), Gradient Boosting (Friedman, 2002), Bagging (Sutton, 2005), and XGBoost (Chen et al., 2015) methods. In the second scenario, one multi-target linear regression model is trained by using Clus Random Forest (Kocev et al., 2013). In this scenario, the SBP and DBP values are assumed to be dependent.

### 4.3.1 Calibration

Since we are working with sensors that measure vital signs and also moving in the direction of personalized medicine, in most cases we should adapt the models with regard to the user. In our approach, we propose a calibration which includes several user's segments in the training set used to train the regression models. This is motivated from the reason that on that way the model can learn the specific relations that exist between the ECG and BP for the specific user. It can be used as online learning approach, where at the beginning, a pretrained model is provided, and after receiving several segments from the user, the model will start to adapt.

### 4.4 Methodology Evaluation

In order to evaluate the regression models, and eliminate the possibility of overfitting, a *Leave-one-participant-out* validation is used. Again, all the segments from one participant are used for testing, and the segments from the other participants are used to train a model. After applying the trained model, mean absolute error (MAE) is calculated for each segment from the testing participant. Eventually, the average MAE is calculated considering all the segments from the testing participant. In addition to MAE, the standard deviation (SD) is also calculated. This process is repeated for every participant, and finally, the average MAE and SD from the values associated to every participant, are reported.

## 5 RESULTS AND DISCUSSION

In this section we describe the data set used for our experiments, as well as the obtained results from the regression models, followed by a discussion.

### 5.1 Data

The data set consists of ECG signals and BP measurements for each of the 69 participants, including 43 men and 26 women of age in range 18-89. The ECG signal is acquired using the Zephyr ECG device. Systolic and diastolic BP readings, acquired with a standard cuff-based BP device, are assigned to each ECG signal.

For 55 of the participants, an ECG signal of 3 minutes length is measured. The sampling frequency of the Zephyr ECG device is 250Hz, providing a signal of 45,000 points in length (3min x 60sec x 250Hz = 45,000 ECG signal points). For 5 of the participants,

an ECG of different length is measured. For the rest of 9 participants, several distinct ECG signals of different length, accompanied with BP readings, have been acquired.

The segmentation step results in total of 2073 segments with a signal length of 10 seconds. This includes 990 ECG segments for 55 of the participants with 3 minutes long ECG signal and 1083 segments for the rest of 14 participants for which several ECG signals of different length have been acquired.

### 5.2 Feature Selection

The "curse of dimensionality" is a problem that typically arises when analyzing a data in high-dimensional feature space. The feature space of 794 attributes is a high-dimensional space, and as it turns out, many of these features are correlated. To reduce the number of features, correlation analysis is performed (Ji et al., 2001), followed by removing features with a Pearson's correlation greater than 0.75. After that, a model-based feature selection is used, removing the least significant features, with respect to the feature weights computed by the Gradient Boosting model (Xu et al., 2014). It is important to be mentioned that the final set of features depends on the training data used in each iteration (according to the leave-one-participant out rules), since the training data is used for the correlation analysis and the model-based selection of features.

In most cases, the combination of these two approaches results in a feature space of around 450 features and better regression models as explained in the following steps.

### 5.3 Regression

To predict the SBP and DBP value, five different regression algorithms are applied: i) Random Forest, ii) Gradient Boosting, iii) Bagging Regressor, iv) XG-Boost Regressor, and v) CLUS. As evaluation metric mean absolute error (MAE) is selected together with the standard deviation (SD) averaged across all patients, as reported in Table 2.

Using the table, it can be seen that CLUS provided most promising results that are also in the range of state-of-the-art approaches used for the same problem. In this case, only one multi-target regression model is trained. It achieved an average error of  $12.81 \pm 2.66$  mmHg for the SBP and  $8.12 \pm 1.80$  mmHg for the DBP. The other models that learn separate linear regression models for SBP and DBP, and therefore, treating them as two independent problems, provide larger errors.

### 5.3.1 Calibration

The proposed calibration method can be evaluated with nine of the participants, as only for these participants several distinct measurements (ECG signal + BP readings) have been taken. The distinct measurements for one participant are taken during several days. The BP values vary for each of the measurements. To show the calibration process, in Table 3, we presented the calibration results for these nine participants. In that case, one participant’s measurement is included in the training phase, while the testing is done on the other participant’s measurements.

Considering the calibration results provided in the table, it can be seen that it really helps the model to adapt the relations between the ECG signal and BP of a specific user, which results in smaller errors, even though only one participant’s measurement is used in the training set. Taking into account the results in Table 2, it can be concluded that the model performs very well even without calibration applied, meaning at most of the cases (except for patient 5 at the SBP case, and patients 6 and 7 at DBP case), the errors are near or even less than those reported in the same table. However, when the calibration is applied, those errors are reduced and meet the expectations from the model.

When compared to the results in the literature where the authors used distribution-based calibration methodology (Simjanoska et al., 2018), and obtained MAEs of 7.72 mmHg for SBP, 9.45 mmHg for DBP and 8.13 mmHg for MAP, our results showing MAEs of  $6.93 \pm 4.70$  mmHg for SBP and  $7.13 \pm 4.48$  mmHg for DBP, indicate that the proposed methodology is competitive to those presented in state-of-the-art literature.

Even though the calibration can be considered as limitation and this problem should be addressed in the future work, however, many smart devices applications nowadays require personal information before they can be accurately used.

## 6 CONCLUSION

This paper presents a novel methodology for BP prediction by using information only from ECG signal. The methodology addresses the hypothesis whether the BP is related and can be predicted from ECG. For the goal to accept the hypothesis, we performed experiment in which we developed a procedure for collecting ECG signals measured at patients in ambulance environment, by using commercial and reliable biosensor (Zephyr), as well as a certified cuff-based device for measuring the reference BP values. The methodology developed consists of multiple steps including preprocessing the signals, feature extraction and Machine learning methods to build the models for the BP prediction given the ECG signal. The core of importance of the proposed methodology is in the feature extraction process at which a suitable time-series method is applied to form the reliable feature space.

The best results obtained are  $12.81 \pm 2.66$  mmHg for SBP and  $8.12 \pm 1.80$  mmHg for DBP. After introducing calibration method the results significantly improved, and the obtained MAEs reduced to  $6.93 \pm 4.70$  mmHg for SBP, and  $7.13 \pm 4.48$  mmHg for DBP. Given the latest literature, the results obtained from the proposed methodology confirm the relation between the ECG signal and the blood pressure.

Table 2: Regression models evaluation metrics.

|   | Algorithm         | Systolic MAE | Systolic SD | Diastolic MAE | Diastolic SD |
|---|-------------------|--------------|-------------|---------------|--------------|
| 1 | Random Forest     | 13.99        | 4.13        | 8.65          | 2.71         |
| 2 | Gradient Boosting | 13.68        | 3.88        | 8.97          | 2.48         |
| 3 | Bagging Regressor | 13.62        | 3.86        | 8.87          | 2.91         |
| 4 | XGBoost Regressor | 13.71        | 3.81        | 8.95          | 2.47         |
| 5 | CLUS              | 12.81        | 2.66        | 8.12          | 1.80         |

Table 3: Calibration evaluation on distinct testing set.

| part. ID | Systolic MAE | Diastolic MAE | Calibrated Systolic MAE | Calibrated Diastolic MAE |
|----------|--------------|---------------|-------------------------|--------------------------|
| 1        | 7.51 ± 5.25  | 6.35 ± 4.82   | 5.86 ± 3.62             | 4.05 ± 4.81              |
| 2        | 8.71 ± 4.87  | 8.11 ± 5.63   | 5.72 ± 3.93             | 5.88 ± 4.61              |
| 3        | 4.05 ± 3.54  | 8.11 ± 3.92   | 3.81 ± 3.53             | 7.55 ± 3.97              |
| 4        | 11.64 ± 6.37 | 6.96 ± 4.35   | 11.25 ± 6.21            | 6.84 ± 4.34              |
| 5        | 13.72 ± 6.65 | 6.55 ± 4.12   | 7.22 ± 4.59             | 6.40 ± 4.01              |
| 6        | 6.31 ± 3.16  | 21.82 ± 6.31  | 6.15 ± 4.04             | 17.41 ± 7.36             |
| 7        | 7.97 ± 3.54  | 17.11 ± 4.83  | 6.77 ± 3.66             | 5.61 ± 2.72              |
| 8        | 12.02 ± 7.62 | 6.26 ± 6.84   | 10.14 ± 6.32            | 5.44 ± 5.09              |
| 9        | 6.69 ± 6.70  | 6.93 ± 4.06   | 5.44 ± 6.39             | 5.02 ± 3.12              |

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