Consistency and precision of landmark identification in three-dimensional cone beam computed tomography scans

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SUMMARY The purpose of this study was to quantify the consistency and precision of locating three-dimensional (3D) anatomic landmarks. The hypotheses tested are that these landmarks have characteristic and variable error patterns associated with their type and location. The consistency and precision of nine orthodontists identifying 32 landmarks of 19 patients were quantified. The cone beam computed tomography (CBCT) data were acquired using a Hitachi CB MercuRay system. Prior to the study, all examiners were calibrated with respect to the definitions of the landmarks and on the use of the software program (Dolphin) for identifying the landmarks. In addition, a reference guide was provided that had the definitions and sample images of the landmarks. Data were collected in spreadsheets as x, y, and z co-ordinates and statistically analysed to determine the mean and standard deviation (SD). The mean location for a given landmark on a given patient served as the reference point. The mean of the distances from the reference point was used as the consistency, while the SD of this mean was used as a measure of precision. The error in the x, y, and z planes was calculated in order to determine the specific characteristics of each landmark.

The consistency in landmark location and precision did not differ significantly among the nine examiners. Sella turcica was the most consistently (0.50 mm) and most precisely (0.23 mm) identified anatomic landmark. The most inconsistent landmark was porion-right (2.72 mm) and the most imprecise landmark was orbitale-right (1.81 mm). Due to the lack of even distribution of the errors, careful use of these landmarks for analysis purposes is needed.

Introduction

The capability to view the craniofacial complex in three-dimensions has made cone beam computed tomography (CBCT) an invaluable tool for clinicians and researchers. While three-dimensional (3D) superimpositions, visual treatment objectives, and facial analyses may, in the future, obviate the need for precise landmark location, at the present time, they are critical to the process of quantifying the size, position, and shape of the cranium, maxilla, mandible, and dentition. This conversion from the two-dimensional (2D) image to three dimensions raises the question of how well individuals can locate many of the same conventional landmarks used in standard cephalometric analysis when given access to a 3D digital representation of their patients (Lou et al., 2007; de Oliveira et al., 2009).

Landmark error

Landmark identification error is an important question that numerous authors have attempted to answer since cephalometric analysis was introduced in orthodontics by Broadbent (1931). Baumrind and Frantz (1971a,b) reported the distribution of landmark selection by nine orthodontic residents. Three conclusions by these authors are important issues that need resolution in an era of 3D data: the errors in landmark identification are too great to ignore, the magnitude of error varies greatly from landmark to landmark, and the distribution of errors for most landmarks is not an error per se but, rather, demonstrates the difficulty in precisely locating the particular landmark. Other studies have also found that there are characteristic patterns of landmark identification distribution (Stabrun and Danielsen, 1982; Tng et al., 1994; Trpkova et al., 1997) and errors that cannot be ignored (Richardson, 1966; Stabrun and Danielsen, 1982; Haynes and Chau, 1993; Tng et al., 1994; Trpkova et al., 1997; Perillo et al., 2000).

A number of studies have reported on the intra- and inter-observer variations in landmark locations. A meta-analysis of six studies on landmark identification error concluded that errors in the x-axis of 0.59 mm and in the y-axis of 0.56 mm are ‘acceptable levels of accuracy’ (Trpkova et al., 1997). The conclusion is that significant variation exists around each of the commonly used landmarks in
cephalometrics. In order to best control the error, the characteristic patterns of error need to be better understood so that the analysis does not depend upon the specific landmark, which may introduce clinically significant errors.

Error in postero-anterior cephalometrics

The same study designs that considered error in landmark identification in lateral headfilms have been used on postero-anterior (PA) headfilms (Leonardi et al., 2008). One such study that evaluated landmark error was undertaken by Major et al. (1994). Using 33 dry skulls and 25 patients without noticeable asymmetries, they studied 52 landmarks and found inter-examiner reliability to be between 0.31 and 4.70 mm. There were four examiners, and the skull and patient data were never combined into one data set. In this case, 0.31 mm was the error in the transverse/horizontal axis for the landmark IPL (i.e. the crest of the alveolus between the mandibular central incisors) while the 4.70 mm of error was in the vertical axis for the landmark CS (i.e. the most superior aspect of the condyle). Although they reported the data for the x and y co-ordinates, no attempt was made to quantify the 2D distance using the Pythagorean theorem. If this had been done for IPL and CS, then the true error in landmark identification among all examiners was actually 0.83 and 4.98 mm, respectively. A final finding by Major et al. (1994) was that certain landmarks possess significantly different amounts of error when skull and patient landmark errors are compared. Studies that look only at skulls do not represent the error that could be expected clinically since the soft tissue affects the contrast of the image.

CBCT craniofacial analysis

A basic way of approaching a 3D analysis is to propose a reference structure as the means of comparing distances of landmarks from this reference point among patients. Lagravere and Major (2005) and Lagravere et al. (2008) proposed a point midway between the foramen spinosum on the floor of the cranium. This point was found to be reliably located. An initial attempt by Park et al. (2006) at skeletal analysis using 3D analysis was based upon relationships between various planes. While Park et al. (2006) also suggested a number of simple linear and angular measurements, without established 3D norms, these values are of limited diagnostic value. Cephalometrics has progressed since 1931, and CBCT provides information that requires studies to test the various hypotheses (Kumar et al., 2007, 2008; Periago et al., 2008; Stratemann et al., 2008; Moerenhout et al., 2009). The primary aim of the present research was to quantify the consistency and precision of locating 3D anatomic landmarks using CBCT-generated volumetric images and slices.
transverse, and vertical; Figure 1). The software continually updated the location of the landmark in the other three views as it was moved in any single view. This feature allowed refined placement of landmarks so that each dimension was accounted for prior to moving on to the next landmark (Figures 1 and 2). The views that displayed the three planes each showed a 0.3 mm thick slice, which offers a significant advantage over 2D films that superimpose the entire craniofacial complex. The examiners all began with the same patient and followed the same order of patients. Once they completed locating the 32 landmarks, the co-ordinate data were copied into Excel (Microsoft, Redmond, Washington, USA) spreadsheets and saved using a specific file name: all files included the patient number and examiner’s name.

Examiners
The nine examiners were second- and third-year orthodontic residents. All examiners attended two 1 hour training sessions. In the two sessions, they were taught how to navigate through the Dolphin Imaging 3D module and how to place the landmarks. They were also given the opportunity to locate each of the landmarks and ask questions regarding their interpretation of the definitions provided. By the end of the second session, all examiners had found each landmark at least once. They were then given 6 months to locate the landmarks on the 19 patient files. At all times, the examiners had access to a manual with directions for opening patient images, landmark definitions, and captured screenshots of the landmarks (Schlicher, 2008).

Landmarks
Definitions for 3D anatomic landmarks are few since orthodontists have classically utilized the 2D headfilm. Many of the definitions were first defined by Solow (1966). In all cases, the definitions were checked with the 3D images, and, if needed, one author (WS) added the definition describing the transverse dimension. The final definitions were edited and confirmed with another investigator (IN; Tables 1 and 2).

Statistics
In order to assess landmark identification consistency and precision, there must be a point about which all others are compared. Because there was no gold standard for identifying the absolute position of each landmark in live patients (i.e. directly identifying a site on the bone), the average co-ordinates of all the examiners for each landmark served as the centroid for each particular landmark. From this centroid, the distribution of examiners’ landmarks was assessed. Firstly, the distances from the centroid were calculated using the Pythagorean theorem that included all three dimensions in the $x$, $y$, and $z$ planes. For a given patient

Figure 1 Example of the views seen when identifying sella using the Dolphin Imaging program.
and landmark, a mean distance from the centroid for that specific landmark was calculated to assess how well examiners agreed upon the location of that landmark. If a gold standard were available as the true location of the landmarks, then this study would be about accuracy and precision. Due to the impossibility of a gold standard for an anatomical location on a live patient (Stratemann et al., 2008; Brown et al., 2009), this study actually quantified the consistency and precision of landmark identification by multiple examiners. The consistency for a landmark was the mean of the measurements (total of all measurements/number of observations) of how far the landmarks were from the centroid by all the examiners. The SD of these distances was used to assess the precision of landmark identification. In essence, the inter-observer error of the method of using CBCT planes and volumetric images was measured simultaneously to define a landmark position. The study used the mean and SD to define the central tendency of this data.

For each landmark, the variation in each plane (i.e. x, y, and z) was calculated in a similar manner. For each dimension, the centroid co-ordinate value was compared with the values of the examiners. In order to assess changes in consistency and precision throughout the study, trend lines with accompanying correlation coefficients were drawn through scatterplots. These scatterplots had the patient number on the x-axis and the amount of consistency or precision on the y-axis.

Results

Individual inter-examiner performance

Prior to calculating the consistency and precision of landmark identification, an examination of the raw data and inter-examiner performance were evaluated. Before pooling all the data for analysis of individual landmark consistency and precision, it was important to know if the examiners performed equally. To do this, their consistencies for each patient were compared. Once the mean location was calculated in the x, y, and z planes for all examiners, the overall distance from that mean could be determined for each examiner. The mean ‘distance from mean’ across all 32 landmarks for a given patient represented the examiner’s performance for that patient. These data, plotted to visualize each examiner’s performance throughout the study across 19 patients, showed that the residents’ performances were similar, allowing pooling of the data for subsequent analysis (Figure 3). The examiners differed for three of the 19 patients primarily due to some of the examiners having a few landmarks that were markedly different from the mean for all the examiners for that patient.

In evaluating the raw data, the decision was made to remove from the data set outliers and any identified landmarks that were technical errors (i.e. choosing the next
was that large outliers were not due to a misunderstanding of the landmark definition or an inability to locate the landmark within the 3D image but rather a technical error in the use of the Dolphin Imaging 3D module. Justification for this decision came not only from looking at the millimetric deviation from the mean location but also from keeping track of those errors that were greater than 2 SDs from the mean. This decision allowed the study of the precision and consistency of defining the landmarks based on the examiners trying to define the actual position than on a study determining how the examiners used the Dolphin program.

How identifying landmarks changed as the study progressed was also evaluated. If gross errors greater than 2 SDs were the result of lapses in utilization of all the benefits offered by Dolphin Imaging, then tracking the number of these errors as the study progressed would give an idea of how well the residents began to understand and utilize the program’s features. While the trend in Figure 4 shows a slight negative correlation and, thus, suggests an improvement in the use of the program, the Pearson’s correlation coefficient was only \( r = 0.068 \) which is weak, suggesting that the errors did not change with use of the program. The outliers of patients 1 and 12 helped to make the trend with a negative slope.

**Landmark consistency and precision**

The average consistency across all landmarks (32), patients (19), and examiners (nine) was 1.64 mm (Figure 5). Thus, for 5472 data points, the examiners were, on average, only 1.64 mm from the mean location of a given landmark. The

### Table 1  Order of landmark identification. L, left; R, right.

<table>
<thead>
<tr>
<th>Order of landmark identification</th>
<th>Landmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sella</td>
</tr>
<tr>
<td>2</td>
<td>Basion</td>
</tr>
<tr>
<td>3</td>
<td>Articulare</td>
</tr>
<tr>
<td>4</td>
<td>Nasion</td>
</tr>
<tr>
<td>5</td>
<td>ANS</td>
</tr>
<tr>
<td>6</td>
<td>Point A</td>
</tr>
<tr>
<td>7</td>
<td>Point B</td>
</tr>
<tr>
<td>8</td>
<td>Pogonion</td>
</tr>
<tr>
<td>9</td>
<td>Gnathion</td>
</tr>
<tr>
<td>10</td>
<td>Menton</td>
</tr>
<tr>
<td>11</td>
<td>L-glenoid fossa</td>
</tr>
<tr>
<td>12</td>
<td>L-condylion</td>
</tr>
<tr>
<td>13</td>
<td>L-condylion</td>
</tr>
<tr>
<td>14</td>
<td>L-gnion</td>
</tr>
<tr>
<td>15</td>
<td>L-orbitale</td>
</tr>
<tr>
<td>16</td>
<td>L-infraorbital foramen</td>
</tr>
<tr>
<td>17</td>
<td>R-infraorbital foramen</td>
</tr>
<tr>
<td>18</td>
<td>L-maxillary central incisor crown tip</td>
</tr>
<tr>
<td>19</td>
<td>L-maxillary central incisor root apex</td>
</tr>
<tr>
<td>20</td>
<td>R-maxillary central incisor root apex</td>
</tr>
<tr>
<td>21</td>
<td>L-mandibular central incisor crown tip</td>
</tr>
<tr>
<td>22</td>
<td>L-mandibular central incisor root apex</td>
</tr>
<tr>
<td>23</td>
<td>R-mandibular central incisor crown tip</td>
</tr>
<tr>
<td>24</td>
<td>R-mandibular central incisor root apex</td>
</tr>
<tr>
<td>25</td>
<td>L-maxillary cant point</td>
</tr>
<tr>
<td>26</td>
<td>R-orbitale</td>
</tr>
<tr>
<td>27</td>
<td>R-gnion</td>
</tr>
<tr>
<td>28</td>
<td>R-porion</td>
</tr>
<tr>
<td>29</td>
<td>R-condylion</td>
</tr>
<tr>
<td>30</td>
<td>R-glenoid fossa</td>
</tr>
<tr>
<td>31</td>
<td>R-maxillary cant point</td>
</tr>
<tr>
<td>32</td>
<td>L-maxillary cant point</td>
</tr>
</tbody>
</table>

### Table 2  Three-dimensional landmark definitions.

<table>
<thead>
<tr>
<th>Landmark</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sella</td>
<td>The geometric centre of the sella turcica (Solow, 1966)</td>
</tr>
<tr>
<td>Nasion</td>
<td>The most anterior and median point along the frontonasal suture (Solow, 1966)</td>
</tr>
<tr>
<td>Articulare</td>
<td>A constructed point at the predicted intersection of the inferior surface of the sphenoid bone (cranial base) with the posterior border of the mandible when the patient is viewed from the side (Solow, 1966)</td>
</tr>
<tr>
<td>Basion</td>
<td>The most inferior point on the anterior border of the foramen magnum; the most postero-inferior point on the clivus (Solow, 1966)</td>
</tr>
<tr>
<td>ANS</td>
<td>The apex of anterior nasal spine (Solow, 1966)</td>
</tr>
<tr>
<td>Point A</td>
<td>A midline point in the deepest concavity along the anterior contour of the maxilla (Solow, 1966)</td>
</tr>
<tr>
<td>Point B</td>
<td>The deepest point on the anterior contour of the lower alveolar arch (Solow, 1966)</td>
</tr>
<tr>
<td>Glenoid fossa (right and left)</td>
<td>The most superior point of the glenoid fossa</td>
</tr>
<tr>
<td>Condylion (right and left)</td>
<td>The most supero-posterior point on the condylar head (Solow, 1966)</td>
</tr>
<tr>
<td>Porion (right and left)</td>
<td>The most superior point of the external acoustic meatus located laterally at the point when the meatus is entirely encircled in bone (Solow, 1966)</td>
</tr>
<tr>
<td>Gonion (right and left)</td>
<td>A point at the intersection of the mandibular plane and the ramus plane; a point on the bony contour of the gonial angle determined by bisecting the tangent angle (Solow, 1966)</td>
</tr>
<tr>
<td>Orbitale (right and left)</td>
<td>The deepest point of the infraorbital margin (Solow, 1966)</td>
</tr>
<tr>
<td>Infraorbital foramen (right and left)</td>
<td>The anterior opening of the foramen (Solow, 1966)</td>
</tr>
<tr>
<td>Pogonion</td>
<td>The most prominent point of the chin (Solow, 1966)</td>
</tr>
<tr>
<td>Menton</td>
<td>The lowest point on the symphysis (Solow, 1966)</td>
</tr>
<tr>
<td>Gnathion</td>
<td>A point at the intersection of the facial and mandibular planes (Solow, 1966)</td>
</tr>
<tr>
<td>Maxillary cant point (right and left)</td>
<td>The most superior and lateral point along the oral surface of the palatine bones at the antero-posterior position of the maxillary first molars (Solow, 1966)</td>
</tr>
</tbody>
</table>
average precision (SD of the deviation) about these 5472
data points was 0.87 mm. Therefore, 66 per cent (1 SD)
of all landmarks fell within 0.87 mm of one another.
When consistency was tracked throughout the study, there
was no significant improvement in how well landmarks
were identified. The mean consistency and precision were
oversimplifications of the data. The differences between
the landmarks began to reveal potential explanations for the
variations. In general, midline structures and landmarks
formed by acute angles were more consistently identified
than bilateral structures and landmarks along broad curves
(Figure 5).

Individual landmark

Since landmark identification in this study was in three
dimensions, consistency can be described not only by the
total distance from the mean but also by the x, y, and z
distances from the mean landmark. By breaking down the
overall consistency into its three component axes, a more
thorough evaluation could be carried out (Table 3). Ranking
the landmarks by how consistent they were
identified overall as well as by their component axis
provided an analysis of the effect of three dimensions.
Generally speaking, a landmark that was ranked highly
among one axis was also ranked highly among the others.
There were a number of landmarks that did not follow
this trend. For example, left glenoid fossa was ranked
27th (x-axis), 7th (y-axis), and 21st (z-axis). This type
of distribution suggests that the definition and/or the
anatomy are partially at fault for the poor ranking in two
of the three axes. Table 3 shows that midline structures
and landmarks formed by acute angles were more easily
identified.

Sella

Sella was the most consistently identified landmark with
an overall consistency of 0.50 mm. Figure 6a follows the
performance of the examiners throughout the study and
allows closer examination of which dimension(s) most
affected any inconsistencies. In the case of sella, while there
was slight improvement in the overall consistency (light
trend line: 0.0092 mm per patient), this was due to the more
significant improvement in the consistency in the x-axis
(dark trend line: 0.196 mm per patient; \( r = 0.60 \)). This
improvement is not likely to be clinically significant, but
does show that, as a group, the examiners were better able
to centre the landmark transversely in the sella tursica at the
end of the study.

Basion

The overall consistency for basion was 0.85 mm (rank =
4th) and similar to sella. While the improvement was not
clinically significant, the reason for the alteration in
overall consistency was due to a change in the x-axis.
There was not a strong correlation coefficient for any of
the trend lines.

Articulare

Articulare is an unusual 3D landmark due to its previous
definition in lateral cephalometrics. The steps required
to locate the new definition required utilizing all four
visualization windows in the computer display. In most
instances, the landmark was first located using a lateral
view of the reconstructed volumetric image and placing
the landmark at the intersection of the posterior border
of the mandible and the cranial base. The landmark was
then dragged to the midline so that there would be
consistency in all three dimensions. The landmark’s overall
consistency suffered (1.81 mm; rank = 20th) as a result of
the multistep process. When the consistency was broken
down into its component axes, there were discrepancies
in the ranks (x = 13th, y = 25th, and z = 23rd). The location
of the landmark in the y- and z-axes required more
manipulation of the images than the x-axis, which only
required the operator to place the landmark in the midline. Although there were only weak correlations (0.34–0.50), there was improvement in the consistency in all dimensions.

Nasion

Nasion, along with most of the other midline structures in this study, had an overall consistency of 1.02 mm (rank = 6th). The $y$-axis (vertical) was the most difficult axis for the examiners to agree upon (Figure 6b). Although the $y$-axis rank was 16th, the consistency was only 0.62 mm and, thus, not likely to be clinically significant. The good consistency was due to nasion being located at the intersection of two clearly identifiable structures located along the patient’s midline.

Anterior nasal spine

In a typical lateral headfilm, anterior nasal spine (ANS) can be difficult to identify since the X-rays easily penetrate the thin and pointy structure leaving that area of the film exposed. With an overall consistency of 1.15 mm (rank = 9th), ANS is a structure that is much easier to identify with CBCT imaging. While the identification error was low, the distribution of the error was in keeping with previous research on landmarks. The $x$- and $y$-axes were consistently identified (0.47 and 0.36 mm) while the $z$-axis was consistently ranked 17th (0.76 mm). The difficulty with this landmark was not in the vertical or transverse dimensions but in the sagittal dimension. Even with CBCT technology, there appears still to be some blurring of the very tip of ANS, which leads to greater error. The improvement in overall consistency during the study was due solely to improvement in $z$-axis consistency. While the improvement in overall accuracy had a weak correlation, the $z$-axis improvement of 0.023 mm per patient had a moderate correlation ($r = 0.57$).

Point A

As a curved structure, the largest amount of error came from the axis parallel to the broadest curve. The large difference in consistency between the three axes illustrates this point. The consistency in the vertical dimension was ranked 27th (1.02 mm) while that of the $x$- and $z$-axes were ranked 5th (0.47 mm) and 6th (0.34 mm), respectively. These results are in keeping with the hypothesis that curved structures are more difficult to consistently identify.

Point B

Similar to point A, point B lies along a broad curve without clear anatomic boundaries. All measurements were less consistent than point A with the greatest error also in the $y$-axis (0.87 mm; rank = 23rd). There was no improvement in landmark identification, which indicates that the error was not due to misunderstanding of the definition or technical difficulty in locating the landmark.

Chin points—pogonion, gnathion, menton

Pogonion, gnathion, and menton are all located very close to one another along the anterior, antero-inferior, and
inferior surfaces of the chin, respectively. The pattern of error distribution seen with points A and B was also evident with these landmarks. The point on the most anterior surface of the chin, pogonion had less error in the x- and z-axes (0.70 and 0.50 mm) than in the y-axis (1.23 mm). Although the trend line correlation coefficients were weak to moderate ($r = 0.22–0.60$), there was a slight tendency for pogonion to be identified with less consistency as the study progressed. Gnathion, just inferior to pogonion, was the most consistently identified of the three points along the chin (1.35 mm; rank = 12th). The error among the axes was evenly distributed. As the most antero-inferior point of the anterior mandible, the definition and anatomy of gnathion leaves little room for interpretation. The same cannot be said for menton where again one axis was identified with less consistency than the others. Whereas points A and B and pogonion are along curves that are orientated vertically, menton is along a curve on the inferior surface of the anterior mandible. Thus, the dimension with the greatest error was the z-axis (1.20 mm; rank = 29th).

### Glenoid fossa

The glenoid fossa was never part of lateral cephalometric analysis due to the inability to visualize it on a 2D film. As a potential landmark for analysing cranial base asymmetries, the glenoid fossa consistency was in the middle of the 32 landmarks. The right and left consistency did not differ significantly (1.59 and 1.66 mm). Identifying the most superior point was not a problem for the examiners as evidenced by the good y-axis ranking of 3rd (right) and 7th (left). There was less agreement as to the transverse and sagittal locations of the most superior point of the fossa.

### Condylion

Without the problem of superimposition of multiple structures on a classic 2D film, condylion was thought to be a landmark that would be much easier to identify using CBCT. The most superior point on a structure that is not a perfectly rounded dome proved to be difficult to consistently identify. There was a better consistency on the left...
(2.06 mm; rank 23rd) than on the right (2.42 mm; rank 27th) side. Similar to glenoid fossa, the $y$-axis was the source of the least amount of error (left: 0.52 mm and right: 0.46 mm). Even when outliers were removed from the sample, there continued to be significant variation in the consistency from patient to patient. There was no significant

Figure 6 Examination of consistency for each of the three axes, as well as the overall change, with lines indicating trends in consistency for a given axis as the nine examiners’ values were combined for each successively completed patient proceeding from patient 1 to patient 19. (a) sella and (b) nasion.
improvement or worsening of how consistently condylion was indentified.

**Porion**

The definition of porion did not include a description of its transverse location within the external auditory meatus. This proved to cause significant identification difficulty. Overall, porion appeared to have significant identification error (left: 2.33 mm; rank 26th and right: 2.68 mm; rank 30th). This is one point where the vast majority of the overall inconsistency was due to errors in one axis. The vertical and sagittal axes showed consistency while the transverse axis was ranked 30th on the left side and 32nd on the right side. The effect of the $x$-axis error on the overall consistency was noted. These results suggest that porion should be used for analysis of vertical and sagittal measurements (cants, Frankfort horizontal, etc.) but not for any analysis in the transverse dimension (left versus right asymmetries).

**Gonion**

Gonion is located along a broad curve on the posterior mandible, and its location is open to interpretation. This landmark is easily identified on a traditional lateral headfilm so the only advantage with 3D imaging is that the left and right gonial angles can be both identified and used for new analyses. The vertical dimension was ranked the lowest at 31 (left: 1.37 mm) and 32 (right: 1.78 mm). This bilateral similarity further suggests that the reason for the inconsistency in the $y$-axis was due to either the lack of clarity in the definition and/or the anatomy of the landmark. Of all landmarks located along curves, orbitale and gonion were on the broadest curves.

**Orbitale**

Orbitale has traditionally been a landmark used to establish the Frankfort horizontal reference line. A number of measurements are made from angles formed by Frankfort horizontal and other dental and skeletal lines. With the addition of the transverse dimension, this landmark also has the potential to be used for analysing canting of the orbits. The $x$-axis was largely responsible for its poor ranking among the other landmarks (left: 28th and right: 31st). The consistency for the $y$- and $z$-axes was less than 1 mm suggesting that orbitale is suitable for establishing Frankfort horizontal and also for evaluating canting of the orbits. However, the significant transverse inconsistency prevents its use for analysing differences in the transverse position of the orbits (i.e. hyper- and hypotelorism).

**Infraorbital foramen (infraorbitale)**

Fine structures that are difficult or impossible to visualize on lateral headfilms are now visible with CBCT images. Foramens are one such anatomic feature that could be used in craniofacial analysis. The reason for studying the consistency of infraorbital foramen was that it could be an alternative for orbitale. While the consistency was in the lower third (left: 1.83 mm, rank 21st and right: 2.19 mm, rank 24th), the axes all contributed equally. As a discrete anatomic point, the errors were similar in each dimension. This landmark was identified with greater consistency than the traditional orbitale landmark.

**Maxillary cant points/palatal recess**

The orientation and width of the palate are often difficult to assess on PA lateral headfilms. A common method to analyse transverse discrepancies between the maxilla and mandible has been to compare the position of the maxillary J-points with the mandibular antegonion notches. The J-points are a part of a complex 3D structure that would be very difficult to consistently identify using CBCT imaging. The maxillary cant points allow measurement of the width of the maxillary arch while providing a means to analyse canting. Unfortunately, they were inconsistently identified (left: 2.70 mm, rank 32nd and right: 2.67 mm, rank 29th). The $x$- and $y$-axes are the critical dimensions if these points are to be used for transverse measurements and canting analysis. Within these dimensions, the consistency was ranked poorly (22nd–28th) but measured between 1.00 and 1.08 mm. There was an insignificant change in the consistency overall and also for each axis throughout the study. With the SD in the $x$-axis of 0.70 mm, the width of the palate could be measured 95 per cent of the time to within 2.80 mm.

**Dental landmarks**

The midpoints along the incisal edges and root apices of the maxillary and mandibular incisors were identified. The root apex of the mandibular incisors is often difficult to identify on a traditional headfilm due to superimposition of the canine, lateral incisor, and central root apices. In addition, since the most prominent incisor is measured on a lateral headfilm, it is difficult to know which root apex belongs to the most prominent incisal edge. A third source of error when identifying incisors on lateral headfilms is that rotated incisors can appear more proclined since the mesial or distal surface is more anterior than the middle of the incisal edge. CBCT imaging allows unaltered views of these structures.

For a given tooth, the incisal edge was always identified more consistently than its respective root apex. The maxillary incisal edge and root apex measurements were all less than the similar mandibular measurements. Among the incisal edge measurements, the $x$-axis had the most variation. The variation was more evenly distributed among the root apices.
**Discussion**

CBCT imaging allows full examination of the craniofacial complex without superimposition of complex structures on a traditional 2D film (van Vlijmen et al., 2009). A systematic review of landmarks used data from spiral CT scans (Kragskov et al., 1997). This present study using CBCT demonstrated some additional factors. While certain landmarks exhibited some improvement throughout the present study, the general trend did not show significant improvement in landmark identification. The amount of time required to locate the 32 landmarks decreased from approximately 25 minutes to approximately 10 minutes. A possible reason for the lack of improvement is that while the examiners’ speed increased, it was to the detriment of their identification consistency. Another likely possibility is that the definitions and anatomy leave a certain amount of interpretation that will always result in differences among individuals. A more recent study evaluating landmark identification from CBCT-generated data of 12 subjects prior to surgery showed that three judges, evaluating the same patient three times, demonstrated excellent intra- and inter-observer reliability with correct training and calibration (de Oliveira et al., 2009).

**Anatomy and landmark consistency**

The primary aim of this research was to quantify the consistency of landmark identification using CBCT image sets. As in previous investigations using 2D lateral headfilms, the findings showed that each landmark has a unique quantity and distribution of error. While the specifics for each landmark have been presented above, some general trends were evident.

**Midline landmarks**

Except for pogonion and articulare, every midline landmark was identified with greater consistency than all bilateral skeletal structures. One possible reason for this difference is familiarity with the sagittal slice window in the 3D module. The window in the 3D module that displays the sagittal plane appears similar to a lateral headfilm once the midline of a patient is identified. In fact, the midline structures are clear in the sagittal plane window because the display is that of a 0.3 mm thick slice without the superimposition of multiple structures on to a single 2D film.

Another possible explanation for the consistency and precision among midline landmarks is the order of landmark identification. Midline structures were grouped together, which may have artificially improved the consistency and precision. The reason is that once sella was identified, the x-axis did not need to be drastically adjusted for subsequent landmarks. Therefore, the examiners were able to identify the other midline landmarks by only working with the other two axes. While the calibration training stressed the importance of checking all three dimensions prior to moving on to the next landmark, follow-up discussions with the examiners and evaluation of the raw data showed that many did not adjust the x-axis after identifying sella.

A third explanation is how the patient files were loaded into Dolphin Imaging’s 3D module. The windows that display the sagittal, coronal, and transverse planes depend upon how the patient is orientated prior to identifying landmarks. So that the examiners would have windows that were accurate representations of the these planes, all patients were orientated so that as the examiners worked their way through the landmarks there would be little required change in the x-axis. How orientation affects landmark identification is an interesting question in the age of 3D data but was not an aim of this study. The likely reality regarding midline structure consistency is that all three of these explanations were involved but to different degrees for each resident.

**Bilateral landmarks**

Familiarity and anatomy are responsible for the poorer performance in locating bilateral landmarks. While many of the bilateral landmarks in this study are routinely identified on a lateral headfilm, the average clinician is not acutely aware of each landmark’s 3D location. For example, orbitale has been classically defined as the most inferior point along the orbital rim when viewed on a lateral headfilm. The problem is that the definition lacks a transverse component. The definition in this study had the landmark placed on the most antero-inferior border of the orbit. Because orbital is roughly circular, once the most inferior point of the orbit is located, there can only be one transverse location. The combination of ‘most anterior and most inferior’ in the definition ensures that only one transverse location is the true landmark position. The complexity of redefining landmarks and changing the way clinicians view radiographs is more significant for bilateral landmarks. In contrast with midline landmarks, unfamiliarity with the radiographic appearance of bilateral landmarks made them less consistently located. Another explanation is that the bilateral landmarks are located along broad curves. Quite simply, the more broad the curve, the more difficult it is for the eye to capture this most prominent point or depression. For these reasons and possibly others, as a group, the bilateral landmarks showed less overall consistency than the midline landmarks.

**Left versus right**

An unanticipated finding was that landmarks on the left side were identified with greater consistency and precision than the same landmarks on the right side. Except for the glenoid fossa and palatal recess, all other bilateral skeletal structures showed this left–right difference. This study
involved a time commitment of roughly 20–30 minutes per patient from each assessor. To accurately identify the landmarks, the examiners had to concentrate not only on each patient’s image but also on a new definition of many of the landmarks. That being said, the most likely reason for this left–right difference was frustration with the amount of time spent identifying 32 landmarks. Another reason suggested by one resident was that time was limited during clinical hours to complete these tasks. If they were near the end of a landmark set when a patient arrived, they would end up hurrying to finish which would lead to less consistent landmark identification. The combination of impatience with attempts to find time during busy clinical hours to complete the 19 patients may have caused the slight but consistent differences between left and right landmarks.

Discordant axes

The characteristic \( x \), \( y \), and \( z \) patterns should have implications in their uses in 3D analyses. Every landmark with very different \( x \), \( y \), and \( z \) rankings were found along curves. The dimension that showed the greatest error was parallel to the curve. For example, menton is located on the most inferior point along the inferior surface of the anterior mandible. The consistency in the vertical plane was excellent while the assessors had difficulty agreeing upon the antero-posterior location of the landmark. The same principle can be illustrated by pogonion. The curvature on the anterior surface of the mandible is broad in the vertical and transverse planes. The deepest point along this surface (\( z \)-axis) is relatively easy to identify while the vertical (\( y \)-axis) position is open to interpretation. Because pogonion is a midline structure, there was a relatively good consistency in the transverse plane (\( x \)-axis). The principle whereby the greatest error is in the dimension with the broadest curves holds for all the landmarks that had differences in the \( x \)-, \( y \)-, and \( z \)-axes rankings: points A and B, menton, right/left glenoid fossa, pogonion, articular, right/left gonial angle, right/left porion, right/left condyliion, and right/left orbitale.

Applications of findings

The major weakness of this study was that there was no comparison of 3D CBCT landmark identification and 2D lateral cephalometric landmark identification (Lagranere and Major, 2005; de Oliveira et al., 2009). Only general comparisons with previous research can be made given the uniqueness of this study. One such comparison is the identification error of dental landmarks. The incisal edges of the incisors continue to be consistently identified. However, CBCT appears to offer a significant advantage when it comes to identifying the incisor root apices. Baumrind and Frantz (1971b) reported the 2D mean error for the lower incisor root apex to be \( 1.74 \pm 0.59 \) mm while in the present study, the 3D mean error for the lower incisor root apices was \( 1.50 \pm 0.73 \) and \( 1.60 \pm 0.71 \) mm. While there was slightly less precision, the present study included four more examiners than that of Baumrind and Frantz (1971a,b). For the question of which method is a better choice for landmark identification to be answered, a study using both methods needs to be conducted. From the findings of the present research, landmark identification in three dimensions was excellent considering the worst performing landmarks had overall consistency of less than 3 mm after being identified as much as 171 times.

The most tangible findings in this study relate to the development of 3D analyses (Cevitades et al., 2005, 2006, 2007; Haney et al., 2010; Stratemann et al., 2010). If a landmark is to be used to evaluate a certain dimension, then it should be shown to have relatively good consistency and precision (Schlicher, 2008). Therefore, when planning which landmarks are to be used to analyse a certain dimension, the consistency should be known for that dimension. A simple first step towards deciding on landmarks would be to organize the landmarks by rank and then decide the amount of consistency to be tolerated for analysis. In the near future, 3D superimpositions will require landmarks for aligning of structures, and only the most accurate should be used. Structural superimpositions, similar to that currently used with lateral headfilms, will be developed. Subsequent studies should include direct comparison between lateral cephalometrics and 3D landmark identification, evaluation of the effect that 3D landmark identification error has on standard cephalometric measurements, and development of novel analyses that comprehensively evaluate the craniofacial complex (measurements and superimpositions).

Conclusions

1. There was no significant improvement in the overall consistency or precision in landmark identification as the examiners completed 19 patients.
2. Sella was the landmark with the best consistency at \( 0.50 \pm 0.23 \) mm.
3. Left maxillary cant/palatal recess was the landmark with poorest consistency at \( 2.70 \pm 1.51 \) mm.
4. Landmarks on curves continue to have more errors than those with clear anatomic delineations.
5. While overall consistency is important in understanding the general error in a landmark’s identification error, an understanding of the individual axis consistency is essential for appreciating how error can affect craniofacial measurements in three dimensions.
6. Utilization of landmarks should take into account the distribution of error in each dimension so that the most accurate measurements can be made.
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