## BreastScreen NSW – Data Dictionary

| ID | | Variable | | Description/ Notes | Data Values |
| --- | --- | --- | --- | --- | --- |
| Client Segment | | | | | |
|  | Date of Birth | | The date of birth of the person. | | DD/MM/YYYY |
|  | Year of Birth | | The year of birth of the person. | | YYYY |
|  | Month of Birth | | The month of birth of the person. | | MM |
|  | Date of Death | | The date of death of the person. | | DD/MM/YYYY |
|  | Year of Death | | The year of death of the person. | | YYYY |
|  | Month of Death | | The month of death of the person. | | MM |
|  | Postcode of Usual Residence | | Postcode of usual residence is a four digit numeric code used by Australia  Post to define a postal delivery area. | | Valid Australia Post postal code.  9999 = Unknown |
|  | Main Language Other Than English Spoken at Home | | The language reported by a person as the main language other than English spoken by a person in his/her home (or most recent private residential setting occupied by the person) on a regular basis, to communicate with other residents of the home or setting and regular visitors. | | 1=English Only  2=Arabic  3=Cantonese  4=Croatian  5=French  6=German  7=Greek  8=Hindi  9=Indonesian  10=Italian  11=Korean  12=Macedonian  13=Maltese  14=Mandarin  15=Serbian  16=Spanish  17=Tagalog (Filipino)  18=Tamil  19=Turkish  20=Vietnamese  99=Other (please specify) |
|  | Indigenous Status | | Whether a woman identifies as being of Aboriginal or Torres Strait Islander descent. This is in accord with the first two of three components of the Commonwealth definition. | | 1=Aboriginal  2=Torres Strait Islander  3=Aboriginal and Torres Strait Islander  4=Non-indigenous  8=Declines to Respond  9=Not stated |
|  | Family History of Breast Cancer | | Whether a first degree female relative of the woman has had a diagnosis of breast cancer.  If multiple first degree female relatives of the women had a diagnosis of breast cancer, the value will be derived as ‘yes’, without associated to any given relative.  A first degree female relative is a mother, sister or daughter. | | Y=Yes  N=No |
|  | Previous History of Breast Cancer | | Whether or not the client has had a previous diagnosis of breast cancer, including ductal carcinoma in situ. This information is based on the client’s self-report at each visit and is retained for each visit. | | Y=Yes  N=No |
|  | Round Number - State | | The number of the most recent screening round for a particular presenting woman, within the State/Territory BreastScreen Program. | | NN |
| Client Family History Segment | | | | | |
|  | Family History of Breast Cancer - Relationship | | The relationship of the client’s family member who has had a diagnosis of breast cancer to the client.  This does not correlate directly with data element Family history of breast cancer | | 1=Mother  2=Daughter  3=Sister  4=Other  5=Ovarian Cancer  6=Genetic Test  7=Jewish Descent |
|  | Family History of Breast Cancer—Age at Diagnosis | | Age (when diagnosed) of the person in the client’s family who has had a diagnosis of breast cancer. | | 9999=Unknown age |
|  | Family History of Breast Cancer—Laterality | | Laterality of the breast cancer diagnosed in the client’s family member.  This does not correlate directly with data element Family history of breast cancer or relationship | | 1=Unilateral  2=Bilateral  3=Unknown |
| Client History of Breast Cancer Segment | | | | | |
|  | History of Breast Cancer - Year | | The year in which the client’s previous breast cancer was diagnosed | | YYYY |
|  | History of Breast Cancer - Laterality | | Laterality of previous breast cancer. | | B=Both  L=Left  R=Right  U=Unknown |
| Episode Segment | | | | | |
|  | Episode Number | | The round number of the episode | | NN |
|  | Date of First Attendance | | The date the presenting woman first attended for screening, this episode. | | DD/MM/YYYY |
| Screening Visit Segment | | | | | |
|  | Appointment Booking Date | | The date an appointment was made by the client, or someone on her behalf. | | DD/MM/YYYY |
|  | Attendance Number | | The ordering of the attended appointments within an episode | | N |
|  | Attendance Date | | The date the client arrived for the attendance. | | DD/MM/YYYY |
|  | Screening Recommendation | | The recommended action following the client’s visit(s) to the screening unit for this episode. | | 1=Return to routine screening  2=Technical recall  3=Recall for assessment |
| Screening Visit Symptom Segment | | | | | |
|  | Symptom Status | | Self-reported breast lump or nipple discharge (clear or blood stained) or other breast symptoms (for example dimpling of the skin of the breast) of which the woman is aware prior to screening and which she reports at the time of screening. | | 0=No symptoms reported  1=Lump  2=Nipple discharge—clear  3=Nipple discharge—blood stained  4=Other breast symptoms, please specify  5=Skin dimpling  6=Recent nipple inversion  9=Not stated |
|  | Symptom – Laterality | | Laterality of symptom reported. | | B=Both  L=Left  R=Right |
| Assessment Visit Segment | | | | | |
|  | Attendance Number | | The ordering of the attendances within an episode | | N |
|  | Attendance Date | | The date the woman attended for a procedural visit during this assessment episode. | | DD/MM/YYYY |
|  | Final Result of Assessment | | The combined result of all procedures carried out during the assessment of a woman. | | 0=Incomplete assessment  1=No significant abnormality  2=Benign lesion  3=Equivocal lesion  4=Suspicious lesion  5=Malignant lesion  9=Unknown |
|  | Assessment Recommendation | | The recommended action following the assessment workup for this screening episode. | | 0=In Progress  1=Routine rescreen at 2 years  2=Routine rescreen at 1 year  3=Early review  4=Treatment  5=Diagnostic open biopsy  6=Further Assessment |
| Needle Biopsy Segment | | | | | |
|  | Attendance Number | | The ordering of the attendances within an episode | | N |
|  | Procedure Number | | The ordering number of the procedure within the assessment. | | N |
|  | Percutaneous needle biopsy performed | | Whether or not a percutaneous needle biopsy was performed, including details of the type of needle biopsy performed or the reason why a needle biopsy was not performed. | | 1=Yes, fine needle aspiration  2=Yes, core biopsy, non-vacuum assisted  3=Yes, core biopsy, vacuum assisted  4=Cyst Aspiration - no cytology  5=Other  34=No– woman’s decision  35=No– clinical decision  39=Unknown |
|  | Percutaneous needle biopsy guidance method | | The method used to direct needle position for percutaneous needle biopsy. | | 1=Not done - refused  2=Not done - other reason  3=Palpation  4=Ultrasound  5=Mammographic – stereotactic  9=Unknown  10=Mammographic - tomosynthesis |
|  | Percutaneous needle biopsy result - cytology | | The cytology result of the percutaneous needle biopsy. | | 1=Inadequate specimen  2=Benign  3=Atypical/equivocal  4=Suspicious  5=Malignant  9=Unknown |
|  | Percutaneous needle biopsy result - histology | | The histology result of the percutaneous needle biopsy. | | 1=Inadequate specimen (specify reason)  2=Benign  3=Atypical/equivocal  4=Suspicious  5=Malignant – Invasive  6=Malignant - Non-Invasive  7=Malignant - Unknown  9=Unknown |
| Local Excision Segment | | | | | |
|  | Attendance Number | | The ordering of the attendances within an episode | | N |
|  | Procedure Number | | The ordering number of the procedure within the assessment. | | N |
|  | Excision Performed | | Whether or not an excision was performed for a woman recommended for diagnostic open biopsy or treatment. | | Y=Yes  N=No |
|  | Excision Performed Date | | The date on which the excision was performed. | | DD/MM/YYYY |
|  | Marking method | | The marking method used to localise the lesion during surgical excision. | | 1=None (palpation)  2=Hookwire/needle  3=Carbon  4=Radioisotope Local Injection  5=Unknown  6=Radioactive seeds |
|  | Lesion identified in specimen | | Whether or not the lesion was correctly identified in the specimen during surgical excision. | | Y=Yes  N=No |
|  | Local excision result | | Whether lesion(s) for which a woman underwent excision was/were malignant or non-malignant. | | 1=Malignant - Invasive  2=Malignant - Non-Invasive  3=Malignant - Unknown  4=Non-Malignant (True benign/Normal)  5=No definitive result  6=Malignant – Non-Breast Cancer  7=Non-Malignant - Malignancy removed at assessment needle biopsy  8=Non-Malignant - Cancer resolved following neoadjuvant chemotherapy  9=Non-Malignant - False positive assessment needle biopsy |
|  | Date of definitive diagnosis | | Date of histological diagnosis, or where histological diagnosis was not obtained, the date of the cytological diagnosis. | | DD/MM/YYYY |
|  | Recommendation—definitive | | The definitive recommendation given to the woman, following excision of lesion(s). | | 0=In Progress  1=Routine rescreen at 2 years  2=Routine rescreen at 1 year  3=Early review  4=Treatment  5=Diagnostic open biopsy  6=Further Assessment |
| Histopathology Segment | | | | | |
|  | Lesion Number | | An identifier of the lesion within an episode. | | N |
|  | Reason for histopathology | | Whether histopathology relates to cancer diagnosed after completion of the last screening episode in the Program or lesion(s) detected as part of the current screening episode. | | 1=Interval cancer or cancer in a non-attender for rescreen  2=Lesion detected as part of the current screening episode |
|  | Histopathology of non-malignant lesions | | The type of non-malignant lesion identified during histopathology. | | 1=Lobular carcinoma in situ  2=Atypical lobular hyperplasia  3=Ductal hyperplasia with atypia  4=Phyllodes tumour (benign)  5=Ductal hyperplasia without atypia  6=Fibroadenoma  7=Radial scar/complex sclerosing lesion  8=Sclerosing adenosis  9=Cyst  10=Other, please specify  11=Papilloma  12=Normal fibrocystic change  13=Columnar cell change |
|  | Histopathology of Malignant Lesions | | Histopathology information used in relation to monitoring breast cancer detection, small invasive breast cancer detection, interval breast cancers | | 1.1=Invasive ductal N.O.S  1.2=Tubular  1.3=Cribriform  1.4=Mucinous (colloid)  1.5=Medullary  1.6=Lobular classical  1.7=Lobular variant  1.8=Mixed ductal/lobular  1.9=Phyllodes tumour (malignant subtype only—not borderline or benign  variants)  1.10=Other, primary invasive breast malignancy (specify)  1.11=Other, primary malignancy, not defined as breast cancer (specify)  1.12=Other, secondary malignancy (specify). |
|  | Size of tumour | | Histopathology information used in relation to monitoring breast cancer detection, small invasive breast cancer detection, and interval breast cancers. The size, in millimetres, of the malignant tumour. | |  |
|  | Histological grade | | The level of malignancy based on histological factors. | | 1=Grade 1  2=Grade 2  3=Grade 3 |
| Interval Cancer Segment | | | | | |
|  | Date of Detection | | The date the interval cancer was detected. | | DD/MM/YYYY |
|  | Reason For Histopathology | | Whether histopathology relates to cancer diagnosed after completion of the last screening episode in the Program or lesion(s) detected as part of the current screening episode. | | 1=Interval cancer or cancer in a non-attender for rescreen  2=Lesion detected as part of the current screening episode |
|  | Breast Involved | | Which breast was involved with the interval cancer. | | L=Left  R=Right |
|  | Histopathology of non-malignant lesions | | The type of non-malignant lesion identified during histopathology. | | 1=Lobular carcinoma in situ  2=Atypical lobular hyperplasia  3=Ductal hyperplasia with atypia  4=Phyllodes tumour (benign)  5=Ductal hyperplasia without atypia  6=Fibroadenoma  7=Radial scar/complex sclerosing lesion  8=Sclerosing adenosis  9=Cyst  10=Other, please specify  11=Papilloma  12=Normal fibrocystic change  13=Columnar cell change |
|  | Histopathology of Malignant Lesions | | Histopathology information used in relation to monitoring breast cancer detection, small invasive breast cancer detection, interval breast cancers | | 1.1=Invasive ductal N.O.S  1.2=Tubular  1.3=Cribriform  1.4=Mucinous (colloid)  1.5=Medullary  1.6=Lobular classical  1.7=Lobular variant  1.8=Mixed ductal/lobular  1.9=Phyllodes tumour (malignant subtype only—not borderline or benign  variants)  1.10=Other, primary invasive breast malignancy (specify)  1.11=Other, primary malignancy, not defined as breast cancer (specify)  1.12=Other, secondary malignancy (specify). |
|  | Size of tumour | | Histopathology information used in relation to monitoring breast cancer detection, small invasive breast cancer detection, and interval breast cancers. The size, in millimetres, of the malignant tumour. | |  |
|  | Histological grade | | The level of malignancy based on histological factors. | | 1=Grade 1  2=Grade 2  3=Grade 3 |
| Primary Treatment Segment | | | | | |
|  | Date of commencement of treatment | | The date on which primary treatment commenced. | | DD/MM/YYYY |
|  | Side of malignancy | | Whether the malignancy for which the woman was treated is in the left or the right breast, or whether both breasts are involved. | | 1=Left  2=Right  3=Both |
|  | Surgical treatment | | The definitive outcome of the surgical treatment. Unknown (code 9) is to be used only after attempts to seek a result have failed. | | 1=No surgery—woman’s decision  2=No surgery—surgeon’s decision  7=Complete excision  8=Total mastectomy  9=Unknown |
|  | Radiotherapy | | Whether or not radiotherapy was given as a part of the treatment regime. Unknown (code 9) is to be used only after attempts to seek a result have failed. | | 1=Yes  2=No  9=Unknown  31=Yes, primary  32=Yes, adjuvant |
|  | Chemotherapy | | Whether or not chemotherapy was given as a part of the treatment regime. Unknown (code 9) is to be used only after attempts to seek a result have failed. | | Y=Yes  N=No  U=Unknown |
|  | Metastasis—distant | | Whether or not there was evidence of distant metastasis at the time of primary treatment. Unknown (code 9) is to be used only after attempts to seek a result have failed. | | 1=Present  2=Not present  9=Unknown |