## 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 AustraliaPost 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 Only2=Arabic3=Cantonese4=Croatian5=French6=German7=Greek8=Hindi9=Indonesian10=Italian11=Korean12=Macedonian13=Maltese14=Mandarin15=Serbian16=Spanish17=Tagalog (Filipino)18=Tamil19=Turkish20=Vietnamese99=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=Aboriginal2=Torres Strait Islander3=Aboriginal and Torres Strait Islander4=Non-indigenous8=Declines to Respond9=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=YesN=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=YesN=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=Mother2=Daughter3=Sister4=Other5=Ovarian Cancer6=Genetic Test7=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=Unilateral2=Bilateral3=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=BothL=LeftR=RightU=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 screening2=Technical recall3=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 reported1=Lump2=Nipple discharge—clear3=Nipple discharge—blood stained4=Other breast symptoms, please specify5=Skin dimpling6=Recent nipple inversion9=Not stated |
|  | Symptom – Laterality | Laterality of symptom reported. | B=BothL=LeftR=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 assessment1=No significant abnormality2=Benign lesion3=Equivocal lesion4=Suspicious lesion5=Malignant lesion9=Unknown |
|  | Assessment Recommendation | The recommended action following the assessment workup for this screening episode. | 0=In Progress1=Routine rescreen at 2 years2=Routine rescreen at 1 year3=Early review4=Treatment5=Diagnostic open biopsy6=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 aspiration2=Yes, core biopsy, non-vacuum assisted3=Yes, core biopsy, vacuum assisted4=Cyst Aspiration - no cytology5=Other34=No– woman’s decision35=No– clinical decision39=Unknown |
|  | Percutaneous needle biopsy guidance method | The method used to direct needle position for percutaneous needle biopsy. | 1=Not done - refused2=Not done - other reason3=Palpation4=Ultrasound5=Mammographic – stereotactic9=Unknown10=Mammographic - tomosynthesis |
|  | Percutaneous needle biopsy result - cytology | The cytology result of the percutaneous needle biopsy. | 1=Inadequate specimen2=Benign3=Atypical/equivocal4=Suspicious5=Malignant9=Unknown |
|  | Percutaneous needle biopsy result - histology | The histology result of the percutaneous needle biopsy. | 1=Inadequate specimen (specify reason)2=Benign3=Atypical/equivocal4=Suspicious5=Malignant – Invasive6=Malignant - Non-Invasive7=Malignant - Unknown9=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=YesN=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/needle3=Carbon4=Radioisotope Local Injection5=Unknown6=Radioactive seeds |
|  | Lesion identified in specimen | Whether or not the lesion was correctly identified in the specimen during surgical excision. | Y=YesN=No |
|  | Local excision result | Whether lesion(s) for which a woman underwent excision was/were malignant or non-malignant. | 1=Malignant - Invasive2=Malignant - Non-Invasive3=Malignant - Unknown4=Non-Malignant (True benign/Normal)5=No definitive result6=Malignant – Non-Breast Cancer7=Non-Malignant - Malignancy removed at assessment needle biopsy8=Non-Malignant - Cancer resolved following neoadjuvant chemotherapy9=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 Progress1=Routine rescreen at 2 years2=Routine rescreen at 1 year3=Early review4=Treatment5=Diagnostic open biopsy6=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 rescreen2=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 situ2=Atypical lobular hyperplasia3=Ductal hyperplasia with atypia4=Phyllodes tumour (benign)5=Ductal hyperplasia without atypia6=Fibroadenoma7=Radial scar/complex sclerosing lesion8=Sclerosing adenosis9=Cyst10=Other, please specify11=Papilloma12=Normal fibrocystic change13=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.S1.2=Tubular1.3=Cribriform1.4=Mucinous (colloid)1.5=Medullary1.6=Lobular classical1.7=Lobular variant1.8=Mixed ductal/lobular1.9=Phyllodes tumour (malignant subtype only—not borderline or benignvariants)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 12=Grade 23=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 rescreen2=Lesion detected as part of the current screening episode |
|  | Breast Involved | Which breast was involved with the interval cancer. | L=LeftR=Right |
|  | Histopathology of non-malignant lesions | The type of non-malignant lesion identified during histopathology. | 1=Lobular carcinoma in situ2=Atypical lobular hyperplasia3=Ductal hyperplasia with atypia4=Phyllodes tumour (benign)5=Ductal hyperplasia without atypia6=Fibroadenoma7=Radial scar/complex sclerosing lesion8=Sclerosing adenosis9=Cyst10=Other, please specify11=Papilloma12=Normal fibrocystic change13=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.S1.2=Tubular1.3=Cribriform1.4=Mucinous (colloid)1.5=Medullary1.6=Lobular classical1.7=Lobular variant1.8=Mixed ductal/lobular1.9=Phyllodes tumour (malignant subtype only—not borderline or benignvariants)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 12=Grade 23=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=Left2=Right3=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 decision2=No surgery—surgeon’s decision7=Complete excision8=Total mastectomy9=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=Yes2=No9=Unknown31=Yes, primary32=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=YesN=NoU=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=Present2=Not present9=Unknown |