BreastScreen NSW – Data Dictionary

For information on the BreastScreen NSW program please see:
https://www.cancerinstitute.org.au/data-research/data-held-by-cinsw/breastscreen-nsw

ID	Variable	Description/ Notes	Data Values
Client Segment			
1	Date of Birth	The date of birth of the person.	DD/MM/YYYY
2	Address	Address of usual residence.	
3	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
4	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)
5	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

ID	Variable	Description/ Notes	Data Values
			4=Non-indigenous 8=Declines to Respond 9=Not stated
6	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.	1=Yes 2=No
7	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=Sister 3=Daughter
8	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
9	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
10	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.	1=Yes 2=No
11	Previous history of breast cancer—year	The year in which the client's previous breast cancer was diagnosed	YYYY
12	Round number	The number of the most recent screening round for a particular presenting woman, within the State/Territory BreastScreen Program.	NN

ID	Variable	Description/ Notes	Data Values
13	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 9=Not stated
Screening Visit Segment			
14	Appointment Booking Date	The date an appointment was made by the woman, or someone on her behalf.	DD/MM/YYYY
15	Date of first attendance for this episode	The date the presenting woman first attended for screening, this episode.	DD/MM/YYYY
16	Recommendation—screening	The recommended action following the client's visit(s) to the screening unit for this episode.	1=Routine rescreen 2 years 2=Routine rescreen 1 year 3=To assessment centre for mammographic recall only 4=To assessment centre for other reasons (non-mammographic) 5=To assessment centre for combined recall
Assessment Visit Segment			
17	Date of first attendance for assessment	The date the woman first attended for assessment, for this episode.	DD/MM/YYYY
18	Percutaneous needle biopsy performed	Whether or not a percutaneous needle biopsy was performed, including details of the type of needle biopsy performed or the	1=Yes, fine needle aspiration 2=Yes, core biopsy, non-vacuum assisted

ID	Variable	Description/ Notes	Data Values
		reason why a needle biopsy was not performed.	3=Yes, core biopsy, vacuum assisted 4=No– woman's decision 5=No– clinical decision 9=Unknown
19	Percutaneous needle biopsy guidance method	The method used to direct needle position for percutaneous needle biopsy.	1=Palpation 2=Ultrasound 3=Mammographic—stereotactic 9=Unknown
20	Percutaneous needle biopsy result	The result of the percutaneous needle biopsy.	1=Inadequate specimen (specify reason) 2=Benign 3=Atypical/equivocal 4=Suspicious 5=Malignant 9=Unknown
21	Final result of assessment visit	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
22	Recommendation—assessment	The recommended action following the assessment workup for this screening episode.	1=Routine rescreen at 2 years 2=Routine rescreen at 1 year 3=Early review 4=Definitive treatment for cancer 5=Diagnostic open biopsy

ID	Variable	Description/ Notes	Data Values
23	Assessment visit—date	The date the woman attended for a procedural visit during this assessment episode.	DD/MM/YYYY
Local Excision of Lesion Segment			
24	Local excision performed	Whether or not a local excision was performed for a woman recommended for diagnostic open biopsy or treatment.	1=Yes 2=No
25	Date excision performed	The date on which the local excision was performed.	DD/MM/YYYY
26	Marking method	The marking method used to localise the lesion during surgical excision.	1=None (palpation) 2=Hookwire/needle 3=Carbon
27	Lesion removal	Whether the screen detected lesion has been removed through needle biopsy or surgery.	1=Yes 2=No
28	Local excision result	Whether lesion(s) for which a woman underwent local excision was/were malignant or non-malignant.	1=Malignant 2=Non malignant 3=No definitive result
29	Date of definitive diagnosis	Date of histological diagnosis, or where histological diagnosis was not obtained, the date of the cytological diagnosis.	DD/MM/YYYY
30	Recommendation—definitive	The definitive recommendation given to the woman, following excision of lesion(s).	1=Routine rescreen 2 years 2=Routine rescreen 1 year 3=Early review 4=Referral for treatment
Histopathology Segment			
31	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
32	Date of diagnosis of interval cancer	The date on which an interval cancer or cancer in a non-attender for rescreen was diagnosed. That is, a cancer diagnosed	DD/MM/YYYY

ID	Variable	Description/ Notes	Data Values
		after completion of the last screening episode.	
33	Histopathology of non-malignant lesions	The type of non-malignant lesion identified during histopathology.	1=Lobular carcinoma in situ 1.1=Classical lobular carcinoma in situ 1.2=Pleomorphic 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
34	Histopathology of Malignant Lesions	Histopathology information used in relation to monitoring breast cancer detection, small invasive breast cancer detection, interval breast cancers	**Invasive breast malignancies** 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

ID	Variable	Description/ Notes	Data Values
			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). **Non-invasive breast malignancies** 2.1=DCIS, High Grade 2.2=DCIS, Intermediate Grade 2.3=DCIS, Low Grade 2.4=Other DCIS (specify)
35	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.	NNNN
36	Histological grade	The level of malignancy based on histological factors.	1=Grade 1 2=Grade 2 3=Grade 3
Primary Treatment Segment			
37	Nature of primary treatment	The nature of primary treatment.	1=Surgical 2=Radiotherapy 3=Chemotherapy 4=No treatment 9=Unknown

ID	Variable	Description/ Notes	Data Values
38	Date of commencement of treatment	The date on which primary treatment commenced.	DD/MM/YYYY
39	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
40	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 3=Level II/III Axillary Dissection 4=Level I Axillary Dissection 5=Axillary Node Sampling (non-directed) 6=Sentinel Node Biopsy 7=Complete local excision 8=Total mastectomy 9=Unknown
41	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, primary 2=Yes, adjuvant 3=No 9=Unknown
42	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.	1=Yes, primary 2=Yes, adjuvant 3=No 9=Unknown
43	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
Death segment			
44	Date of Death	Death segment	DD/MM/YYYY

ID	Variable	Description/ Notes	Data Values
45	Underlying cause of death	The underlying cause of death of the woman. **Caveat:** due to the lack of information provided by ABS/RBDM, this information has not been populated since 2013.	1=Breast cancer 2=Other