BreastScreen NSW – Data Dictionary

ID	Variable	Description/ Notes	Data Values
Client Segment			
1	Year of Birth	The year of birth of the person.	YYYY
2	Month of Birth	The month of birth of the person.	MM
3	Year of Death	The year of death of the person.	YYYY
4	Month of Death	The month of death of the person.	MM
5	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)
6	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
7	Family History of Breast Cancer	Whether a first degree female relative of the woman has	Y=Yes N=No

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		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.	
8	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
9	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			
10	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
11	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
12	Family History of Breast Cancer— Laterality	Laterality of the breast cancer diagnosed in the client's family member.	1=Unilateral 2=Bilateral 3=Unknown

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		This does not correlate directly with data element Family history of breast cancer or relationship	
Client History of Breast Cancer Segment			
13	History of Breast Cancer - Year	The year in which the client's previous breast cancer was diagnosed	YYYY
14	History of Breast Cancer - Laterality	Laterality of previous breast cancer.	B=Both L=Left R=Right U=Unknown
Episode Segment			
15	Episode Number	The round number of the episode	NN
16	Date of First Attendance	The date the presenting woman first attended for screening, this episode.	DD/MM/YYYY
Screening Visit Segment			
17	Appointment Booking Date	The date an appointment was made by the client, or someone on her behalf.	DD/MM/YYYY
18	Attendance Number	The ordering of the attended appointments within an episode	N
19	Attendance Date	The date the client arrived for the attendance.	DD/MM/YYYY
20	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			
21	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	0=No symptoms reported 1=Lump 2=Nipple discharge—clear 3=Nipple discharge—blood stained 4=Other breast symptoms, please specify 5=Skin dimpling

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		which she reports at the time of screening.	6=Recent nipple inversion 9=Not stated
22	Symptom – Laterality	Laterality of symptom reported.	B=Both L=Left R=Right
Assessment Visit Segment			
23	Attendance Number	The ordering of the attendances within an episode	N
24	Attendance Date	The date the woman attended for a procedural visit during this assessment episode.	DD/MM/YYYY
25	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
26	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			
27	Attendance Number	The ordering of the attendances within an episode	N
28	Procedure Number	The ordering number of the procedure within the assessment.	N
29	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

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			5=Other 34=No– woman's decision 35=No– clinical decision 39=Unknown
30	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
31	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
32	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			
33	Attendance Number	The ordering of the attendances within an episode	N
34	Procedure Number	The ordering number of the procedure within the assessment.	N
35	Excision Performed	Whether or not an excision was performed for a woman recommended for diagnostic open biopsy or treatment.	Y=Yes N=No
36	Excision Performed Date	The date on which the excision was performed.	DD/MM/YYYY

ID	Variable	Description/ Notes	Data Values
37	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
38	Lesion identified in specimen	Whether or not the lesion was correctly identified in the specimen during surgical excision.	Y=Yes N=No
39	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
40	Date of definitive diagnosis	Date of histological diagnosis, or where histological diagnosis was not obtained, the date of the cytological diagnosis.	DD/MM/YYYY
41	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

ID	Variable	Description/ Notes	Data Values
			6=Further Assessment
Histopathology Segment			
42	Lesion Number	An identifier of the lesion within an episode.	N
43	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
44	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
45	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

ID	Variable	Description/ Notes	Data Values
			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).
Interval Cancer Segment			
46	Date of Detection	The date the interval cancer was detected.	DD/MM/YYYY
47	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
48	Breast Involved	Which breast was involved with the interval cancer.	L=Left R=Right
49	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

ID	Variable	Description/ Notes	Data Values
			12=Normal fibrocystic change 13=Columnar cell change
50	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).
51	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.	
52	Histological grade	The level of malignancy based on histological factors.	1=Grade 1 2=Grade 2 3=Grade 3
Primary Treatment Segment			
53	Date of commencement of treatment	The date on which primary treatment commenced.	DD/MM/YYYY
54	Side of malignancy	Whether the malignancy for which the woman was treated	1=Left 2=Right

ID	Variable	Description/ Notes	Data Values
		is in the left or the right breast, or whether both breasts are involved.	3=Both
55	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
56	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
57	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
58	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