NBSS User Guide

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Document Update History:

Version Number	Issue date	Updated by	Description of changes
1.0 draft 1	18 May 2004	JKO	Version sent to Margot to create her own user guide. Based on DS0024 Ad Hoc Reporting Technical Specification, v0.6
1.0 draft 2	30 Sep 2005	JKO	Updated to reflect fields added to DS0024.
1.0 draft 3	28 Mar 2006	JKO	Updated Client and Episode descriptions for new fields, added ProcedureSide. Added SNOMED fields to BiopsyProcedure for scope change SC0048.
1.1	Not issued	JKO	Added pathology data to BiopsyProcedure & WbnProcedure (SC0066). Added note to ClinicalTeam re open episodes.
2.0	9 Nov 2007	JKO	Updated and renamed after Clinical Module redevelopment (the Rel801003A release notes describe the changes). Updated EpisodeAuthorityEndCode derivation notes after scope change SC0096 to force codes to "WO".
3.0	7 May 2009	JKO	Added Accession Number and other PACS-related fields Added ClientTrial table for CADET2 Added Table Note 4 to Episode and updated Note 3
		SLT	Changed Batch and Episode for age extension trial
		ADG	Changed GpDetails
3.1	Not issued	SLT	Added a field to Episode for Cancer Registry Extract
4.0	9 Apr 2010	JKO	Updated after Higher Risk development. "Rel902001A Crystal Reports Release Notes.doc" describes the changes. Updated Table Diagrams appendix.
4.1	17 Jun 2010	JKO	Added Partial Mammography fields to Episode
		JKO	Added BasoBenignCandidate to Episode
		ADG	Added ScreeningEquipmentType to Episode
		JKO	Updated for PACS Phase 2. Dropped AccessionNumber from Appointment, OtherImaging and ScreeningProcedure. Added tables AppointmentPacsExam, EpisodePacsExam and OtherImagingPacsExam. Updated Table Diagrams.
4.2	15 Jun 2012	GSK	Changed AxillaNormal to AxillaOpinion in tables ClinicalExamProcedure and ImagingProcedure
		GSK	Added FilmTracking table

		GSK	Changed AssessmentMri opinion codes G1-5 to MRI1-5
		JKO	Changed AssessmentMri to match NHSBSP Publication 68. Corrected OPINION names in Code Lists appendix.
		ADG	Added EquipmentMakeModel and EquipmentType to ScreeningMri, ScreeningProcedure, ScreeningUltrasound
		GSK	Updated Episode, added IntervalCancerScrFilmReview and IntervalCancerSymptomatic. Added “Interval Cancer Tables” to diagrams section.
		JKO	Dropped obsolete table BasoDownload
		GSK	Updated ImagingProcedure
4.3	4 Apr 2013	JKO	Updated ScreeningProcedure for trainee film readers
		JKO	Added ReverseReadingTrial and updated Client table
		JKO	Added ImagedBothSides to Episode
		JKO	Added interval cancer record types to ProcedureSide
		JKO	Added table ProcedureLesion (was BasoDownload)
		JKO	Added table Letter
		JKO	Added SpecialAppointmentReason to Client
4.4	8 Nov 2013	JKO	Updated Appointment fields for second timed appointments
		JKO	Updated Episode fields for partial mammography
4.5	21 May 2014	JKO	Updated Appointment fields for smart clinics
		JKO	Added table UTIL.LetterEmbeddedFields in an appendix
4.6	24 Jul 2015	JKO	Updated ScreeningProcedure with film reading lesion data
		JKO	Added DateOfFirstOfferedMRI to Episode
		JKO	Updated ScreeningProcedure for films pending priors
		JKO	Updated WbnProcedure with new pathology fields
		JKO	Updated GpDetails. Renamed PCT fields as CCG.
		JKO	Updated Episode explanation of “previous episode”
4.7	14 Oct 2016	ADG	Added Eklund View to ScreeningProcedure
		JKO	Increased ReaderAlertMessage length from 80 to 100
		JKO	Increased GpSurname length from 20 to 40 Increased GpName length from 30 to 40 Increased AssociatedGpName length from 30 to 63
4.8	9 Dec 2016	JKO	Added ResponsibleAssessor to Episode
4.9	19 Oct 2017	SSS	Replaced SpecialAppointmentReason with a list of SpecialAppointmentReasons in Client
		JKO	Increased Appointment ClinicianComment from 20 to 60
		SCD	Added SpecialCorrespondence to Client
4.10	22 Jan 2018	SCD	Added National People Code fields
		JKO	Updated description of EpisodeAuthorityEndCode
5.0	19 Jun 2018	JKO	Added VaeProcedure, updated Table Diagrams appendix. Update Episode fields to take account of VAE. Made other minor updates for new record type VAE.
		JKO	Updated table Episode and table ScreeningMri fields for high risk clients.
		DGS	Reviewed by DGS as Development TL
5.1	9 Jan 2019	JKO	Added MalignancyType to VaeProcedure

		JKO	Added LesionType, LesionTypeTxt to Lesion
		JKO	Renamed LymphNode fields as PossibleLymphNode fields in tables ClinicalExamProcedure, ImagingProcedure, IntervalCancerScrFilmReview, IntervalCancerSymptomatic, VaeProcedure and WbnProcedure
		DGS	Reviewed by DGS as Development TL
5.2	7 Jun 2019	JKO	Added reasons for assessment to ScreeningProcedure and added table ReasonForAssessmentAnalysis
		LAW	Added DateOfMriInitialCommunication to Episode
		DGS	Reviewed by DGS as Development TL
5.3	19 Aug 2019	SCD	Added NationalIncidentStatus to Episode table
5.4	31 Mar 2020	JKO	Added fields to ClientProtocol and Episode tables to indicate whether higher risk episodes are Invitation or Self-Referral
		SCD	Added fields to Episode table for Diagnosis Communicated
		DGS	Reviewed by DGS as Development TL

Contents

Introduction

This document describes the NBSS data fields that are available in Crystal Reports via ODBC.

Key to Columns

K	Field	Format	Description
"K" indicates a key field "*" indicates a lesion or side-specific field. The first field marked with "*" is also a key field.	Field Name in Crystal Reports or Microsoft Access. "→" indicates a field that can be used to link to another table	C(max) = Character DATE NUM = Number NUM(decimals) TIME YN = 'Y', 'N' or null	Field description and list of values

Number (format "NUM") fields have a maximum size of 15.

Field Naming Conventions

Field-naming conventions are as follows:

- Field names consist of an upper case letter followed by mixed case letters and digits. They never contain spaces or underscores.
- Descriptions of code fields end in "Txt", for example, "CancellationTypeTxt" is the description for a code value in "CancellationType"

Field Order

The "Description" notes on the right of the following example explain how fields are ordered:

K	Field	Format	Description
K	SxNumber →	NUM	1. Key fields: Most important fields come first
K	ScreeningProcedureRecordId	NUM	
	ScreeningRecordId →	NUM	2. Links. These fields can be used to link this table to other tables when designing a report in Crystal.
	AgeAtScreening	NUM	3. Main fields in alphabetical order
	Comment	C(66)	
	etc…		
*	LesionId →	NUM	4. LesionId, SideCode or just SideCode: The start of any lesion-dependent or side-dependent fields
*	SideCode	C(1)	
*	AnySignificantFindings	YN	5. Lesion-dependent or side-dependent fields in alphabetical order
*	Appearance	C(7)	
*	AppearanceTxt	C(100)	
*	etc…		

Table Definitions

Appointment

Contains appointments and their associated timeslot, session, date and clinic information.

K	Field	Format	Description
K	ClinicCode	C(5)	
K	DateOfClinic	DATE	Appointment Date
K	Clinician	C(3)	
K	SessionCode	C(2)	
K	Timeslot	C(6)	Code such as “T1415” for 2:15 pm
K	AppointmentNumber	NUM	
	SxNumber →	NUM	Link to Client
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	AppointmentComment	C(30)	
	AppointmentStatus	C(1)	One of the following codes (no code list): A = Attended B = Booked C = Cancelled by Hospital D = DNA - No Notice Given L = Late Booking (obsolete) N = DNA - Notice Given (ie. cancelled by client)
	AppointmentStatusTxt	C(21)	
	AttendanceProbability	NUM(2)	The probability of a screening appointment being attended. This is between 0.01 and 0.99 where 0.01 is a 1% chance of attendance and 0.99 is a 99% chance. It is blank for screening appointments created before Smart Clinics was released and for assessment appointments.
	AttendanceProbabilityTxt	C(10)	AttendanceProbability as 1-10 vertical bars.
	BookingOrCancelDate	DATE	
	BookingOrCancelTime	TIME	
	CancellationPhoneNumber	C(15)	
	CancellationType	C(2)	A code from code list CTYPE (CancellationType, pg 125)
	CancellationTypeTxt	C(25)	
	ClientCategory	C(1)	One of the following codes (no code list): 1 = NHS 2 = Private 3 = Amenity
	ClientCategoryTxt	C(25)	
	ClinicConsultant	C(4)	A code from code list CON
	ClinicConsultantName	C(50)	
	ClinicianComment	C(60)	

K	Field	Format	Description
	ClinicianStatusFlag	C(1)	One of the following codes (no code list): C = Cancelled F = Full P = Closed S = Stopped
	ClinicianStatusTxt	C(9)	Description for ClinicianStatusFlag
	ClinicianTotalClients	NUM	
	ClinicIsSmart	YN	Y if the appointment is in a smart screening clinic, N if it is in an ordinary screening clinic or assessment clinic.
	ClinicNameOnLetters	C(50)	
	ClinicNameOnListings	C(30)	
	ClinicSubspec	C(5)	
	DateRequestReceived	DATE	
	DayComment	C(20)	
	DayName	C(9)	
	DayNumber	C(1)	1 = Monday, 2 = Tuesday etc
	DayStatusFlag	C(1)	One of the following codes (no code list): C = Cancelled F = Full P = Closed S = Stopped
	DayStatusTxt	C(9)	Description for DayStatusFlag
	DayTotalClients	NUM	
	GpLetterComment	C(20)	
	GpLetterFlag	C(1)	One of the following codes (no code list): L = Letter Received N = No Letter P = Patient Bringing Letter
	GpLetterTxt	C(15)	Description for GpLetterFlag
	HospitalClientBooked	C(1)	C if the appointment was booked as a result of the client contacting the screening office. H (hospital) if the screening office initiated the booking.
	MethodOfCancellation	C(50)	
	NotScreened	YN	Y if attended but not screened
	NotScreenedComment	C(50)	Reason not screened
	OperatorsInitials	C(12)	
	OverbookAuthority	C(20)	
	PathologyFlag	YN	No longer used.
	ReasonForCancellation	C(30)	
	ReferredBy	C(20)	
	ReferredTo	C(20)	

K	Field	Format	Description
	ResultsEntryIsBlind	YN	Y if session is flagged for blind film reader data entry, N if visible, Null if ResultsEntryIsPaper is Y
	ResultsEntryIsPaper	YN	Y if session flagged as paper, N if direct
	ResultsEntryMethod	C(1)	REM code (if ResultsEntryIsPaper is N)
	ResultsEntryMethodTxt	C(30)	REM title (“Paper” if ResultsEntryIsPaper is Y)
	ResultsEntryMinReaders	NUM	Number of readers (if ResultsEntryIsPaper is N)
	ScreeningAppointmentNumber	NUM	Indicates a screening appointment’s sequence within its episode. The first Booked, Attended or DNA screening appointment is 1; the second is 2 etc. This is blank for assessment appointments, cancelled appointments and appointments that are not linked to episodes.
	SessionComment	C(25)	
	SessionPrintFlag	C(1)	No longer used.
	SessionStatusFlag	C(1)	One of the following codes (no code list): C = Cancelled F = Full P = Closed S = Stopped
	SessionStatusTxt	C(9)	Description for SessionStatusFlag
	SessionStopped	YN	Y if the session has been stopped/cancelled using option ALL, otherwise N
	TimeslotCategory	C(5)	
	TimeslotComment	C(25)	
	TimeslotStatusFlag	C(1)	One of the following codes (no code list): C = Cancelled F = Full P = Closed S = Stopped
	TimeslotStatusTxt	C(9)	Description for TimeslotStatusFlag
	TimeslotTime	TIME	A time such as “14:15”
	TimeslotTotalBooked	NUM	The number of booked, attended and DNA’d appointments in the timeslot.
	TimeslotTotalCapacity	NUM	The maximum number of Booked, Attended and DNA appointments the timeslot can hold without being overbooked. Normally 1 but can be more for special “DNA clinics”. The value is blank if ClinicIsSmart = Y
	TimeslotTotalClients	NUM	
	TransportFlag	YN	
	TypeOfLetterSent	C(6)	BOOK, FVRC, EPNA etc
	XRayAppointmentText	C(20)	
	XRayComment	C(20)	
	XrayFlag	YN	Y if had X-ray previously, N if not

History

09/11/07	JKO	Added field AccessionNumber for PACS
01/03/11	JKO	Dropped field AccessionNumber for PACS Phase 2
18/06/13	JKO	Added ScreeningAppointmentNumber and TimeslotTotalCapacity and amended AppointmentStatus and TimeslotTotalBooked for second timed appointments.
24/01/14	JKO	Added AttendanceProbability, ClinicIsSmart and HospitalClientBooked and dropped SessionTotalClients for smart clinics.
27/06/17	JKO	Increased ClinicianComment length from 20 to 60

AppointmentPacsExam

Contains the PACS exams associated with a row in the Appointment table. A screening appointment has one AppointmentPacsExam row with a Procedure of XSCMB. An assessment appointment can have several rows in AppointmentPacsExam.

K	Field	Format	Description
K	ClinicCode	C(5)	
K	DateOfClinic	DATE	Appointment and PACS Exam Date
K	Clinician	C(3)	
K	SessionCode	C(2)	
K	Timeslot	C(6)	
K	AppointmentNumber →	NUM	Link to Appointment when used with the keys above
K	AccessionNumber	C(16)	PACS examination ID
	SxNumber →	NUM	Link to Client
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	ExamStatus	C(1)	One of the following codes (no code list): A = Arrived C = Cancelled S = Scheduled
	ExamStatusTxt	C(10)	
	ExamTime	TIME	Same as Appointment field TimeslotTime
	IsReported	YN	Y if "reported", N if not "reported"
	ProcedureCode	C(6)	Code from list PEPR (PACS Exam Procedure, pg 130)
	ProcedureTxt	C(40)	Description from PEPR (PACS Exam Procedure, pg 130)
	ProcedureModalityType	C(2)	Modality from PEPR (PACS Exam Procedure, pg 130)
	ProcedureScreenOrAssess	C(1)	S/A code from PEPR (PACS Exam Procedure, pg 130): S = Screening A = Assessment

History

01/03/11 JKO Created for PACS Phase 2

AssessmentMri

Contains Assessment MRI procedure and lesion information. A procedure with no lesion records has nulls in LesionId, SideCode etc.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	AssessmentMriRecordId	NUM	Internal Record ID
	ImagingDSRecordId →	NUM	Link to ImagingDS when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	BackgroundEnhancement	C(1)	A code from code list MRBCK: 0 = None 1 = Minimal 2 = Mild 3 = Moderate 4 = Marked This is null if LesionId is null.
	BackgroundEnhancementTxt	C(12)	
	Clinician	C(4)	Who is responsible for the overall imaging opinion. A code from code list PEPL
	ClinicianNational	C(8)	National People Code
	ClinicianTxt	C(27)	Clinician name
	DatePerformed	DATE	
	HospitalCode	C(6)	A code from code list HOSP
	HospitalCodeTxt	C(30)	
	HospitalNumber	C(11)	
	LeftAxillaOpinion	C(1)	A code from code list AXOPN: A = Abnormal N = Normal X = Not Assessed
	LeftAxillaOpinionTxt	C(12)	
	LeftSideAssessed	YN	
	Location	C(5)	A code from code list LOC
	LocationTxt	C(25)	
	RightAxillaOpinion	C(1)	See LeftAxillaOpinion
	RightAxillaOpinionTxt	C(12)	
	RightSideAssessed	YN	
	TimeOrder	NUM	See *TimeOrder*, page 121
*	LesionId →	NUM	Link to Lesion when used with SxNumber and EpisodeRecordId. This is null if the procedure has no lesion records.
*	SideCode	C(1)	R for right or L for left

K	Field	Format	Description
*	AreaEnhancement	C(1)	A code from code list MRARE: F = Focal L = Linear P = Stippled S = Segmental
*	AreaEnhancementTxt	C(12)	
*	EnhancementCurve	C(2)	A code from code list MRCRV: T1 = Type I T2 = Type II T3 = Type III
*	EnhancementCurveTxt	C(12)	
*	LesionCategory	C(1)	A code from code list MRCAT: A = Non-mass-like enhancement F = Focus (<5 mm) M = Mass
*	LesionCategoryName	C(8)	Focus, Mass or Non-mass
*	LesionCategoryTxt	C(25)	
*	MassEnhancement	C(2)	A code from code list MRMEN: ER = Rim HE = Heterogeneous HO = Homogenous
*	MassEnhancementTxt	C(13)	
*	MassMorphology	C(2)	A code from code list MRMOR: IR = Irregular LB = Lobulated SM = Smooth SP = Spiculated
*	MassMorphology Txt	C(20)	
*	Opinion	C(4)	A code (MRI1-MRI5) from code list OPINION (Opinion after a procedure, pg 128)
*	OpinionTxt	C(25)	
*	PreviousOpinions	C(20)	
*	ProcedureLesionDescription	C(30)	MRI Lesion Description
*	ProcedureLesionNotes	C(4000)	MRI Lesion Notes. Multiple lines.
*	SizeMm	NUM	
*	WorstLesion	YN	See *WorstLesion*, page 121

History

23/03/10	JKO	Table created for Higher Risk Screening
02/12/11	GSK	Changed opinion codes G1-G5 to MRI1-MRI5 for scope change SCO168
03/02/12	JKO	Changed to match NHSBSP Publication 68 (SC0169): BackgroundEnhancement moved from lesion to procedure. LesionCategory and MassEnhancement added; Morphology now MassMorphology; TypeOfMass dropped; AreaEnhancement replaced SegmentalEnhancement. Several code lists changed.
20/09/17	SCD	Added National People Code for Clinician

AuditTrailValue

Contains a field value from the audit trail.

- Contains field values from the database audit trail.
- Shows "old" and "new" values for each field in a record from a table.
- Excludes fields where both "old" and "new" values are blank.
- Fields BatchId…UserName relate to the update of one record.
- Fields from FieldName onwards relate to a single field on the database.

K	Field	Format	Description
K	AuditRef	NUM	Sequential number that identifies a set of records related to one table update.
K	FieldId	NUM	A field number within a database update.
	BatchId →	C(11)	Batch ID (no "-" or letter suffix) that the entry relates to. Usually blank.
	ClinicCode →	C(5)	Clinic Code the entry relates to. Usually blank.
	DateOfClinic →	DATE	Clinic Date the entry relates to. Usually blank.
	SxNumber →	NUM	SX Number (no "-") that the entry relates to. Usually blank.
	AuditDate	DATE	Date the entry was written to the audit trail.
	AuditTime	TIME	Time the entry was written to the audit trail.
	FunctionCode	C(10)	The function that updated the database.
	FunctionName	C(50)	
	TableName	C(60)	The database table that was updated
	TableReference	C(40)	
	UpdateAction	C(8)	Description for UpdateCode
	UpdateCode	C(1)	What happened to the record. Values: A = Amended D = Deleted N = Inserted R = Read U = Amended Most reports will want to exclude "Read" operations.
	UserId	C(12)	User who requested the function that updated the database.
	UserName	C(50)	
	FieldName	C(50)	Field-specific data start here.
	FieldUpdated	YN	Indicates whether Old and New values are the same or not. This is N if UpdateAction is "Read" and Y if action is "Inserted" or "Deleted". Values: Y New and Old values are different N New and Old values are the same

K	Field	Format	Description
	NewValue	C(255)	Value after update, only the first 255 characters are shown
	OldValue	C(255)	Value before update, only the first 255 characters are shown

Here are some examples of rows from this table:

	Example 1	Example 2
AuditRef	1252894	1253867
FieldId	16	31
BatchId		KKE000621
ClinicCode	AC001	
DateOfClinic	25/10/2003	
SxNumber		10806
AuditDate	07/11/2003	12/11/2003
AuditTime	13:45:05	02/02/2004 11:35:13
FunctionCode	SIP	SIBX
FunctionName	Privileged Client Options	Results Entry
TableName	APP.SAAAppointment	Batch Complete Client Record
TableReference	APP.SAAAppointment	APP.SBBatchCompleteClientRcd
UpdateAction	Amended	Amended
UserId	WOLTER	WOLTER
UserName	Wolter Visscher	Wolter Visscher
FieldName	Timeslot	RecordTransmission
FieldUpdated	Y	Y
NewValue	T1100	U
OldValue	T1015	NO/9601

Crystal Reports Hints

- Fields BatchId, ClinicCode, DateOfClinic and SxNumber can be used to easily select a set of records
- Be aware that linking to a table like “Client” (on SxNumber) can be slow. Reports tend to run a lot quicker if they only use AuditTrailValue
- Reports should select records based on TableReference rather than TableName as this is less likely to change
- To select on a field other than BatchId, ClinicCode, DateOfClinic or SxNumber you can create conditions on FieldName = the name of the field you want to check and NewValue (or OldValue) = the value you are looking for.

Authority

Contains the old FHSA and FPC codes and names. Only contains addresses and phone numbers for the authorities associated with this screening office.

This view allows name lookups for the various “Authority” fields on records such as “Client” and “Episode”.

K	Field	Format	Description
K	Authority	C(3)	Eg COV, NN, GG etc
	Active	YN	
	AuthorityAddressLine1	C(30)	
	AuthorityAddressLine2	C(30)	
	AuthorityAddressLine3	C(30)	
	AuthorityAddressLine4	C(20)	
	AuthorityAddressMemo	C(140)	
	AuthorityContact	C(30)	
	AuthorityLinkMedium	C(10)	One of the following codes (no code list): E = Electronic N = Network P = Paper
	AuthorityLinkMediumTxt	C(10)	
	AuthorityName	C(55)	
	AuthorityPostcode	C(9)	
	AuthorityRCN	YN	
	AuthorityTelephoneNumber	C(30)	

Batch

Contains screening batch and NBR batch information.

K	Field	Format	Description
K	BatchId	C(9)	Batch ID (no "-" or letter suffix)
	Authority →	C(3)	Link to Authority
	AgeIntervalRandomisation	YN	
	AgeLimitExcluded	C(1)	One of the following: L = Excluded Lower Age Group U = Excluded Upper Age Group This is NULL if there was no randomisation
	AgeLowerLimit	NUM	See **Table Notes** item 1
	AgeUpperLimit	NUM	See **Table Notes** item 1
	AuthorityBatchId	C(6)	
	BatchIdFull	C(12)	Batch ID with "-" and letter suffix
	BatchStatus	C(1)	One of the following codes (no code list): B = Being Processed C = Completed D = Deleted S = Specified
	BatchStatusTxt	C(15)	
	Clients	NUM	Number of clients in batch
	ClientsAvailableCall	NUM	Number of clients available (call)
	ClientsAvailableRecall	NUM	Number of clients available (recall)
	ClientsBeingScreenedCall	NUM	Number of clients being screened (call)
	ClientsBeingScreenedRecall	NUM	Number of clients being screened (recall)
	ClientsCeasedCall	NUM	Number of clients ceased (call)
	ClientsCeasedRecall	NUM	Number of clients ceased (recall)
	ClientsMissingDetails	NUM	Number of clients missing details
	DateBatchCompleted	DATE	
	DateBatchSpecified	DATE	
	DateScreeningSessionEnds	DATE	
	DateScreeningSessionStarts	DATE	
	NBRBatch	YN	
	SpecificationSent	YN	
	TransmissionStatus	C(11)	Transfer reference of last results transfer to authority or "U" if awaiting transfer

Table Notes

1. If AgeLimitExcluded is “U”, women older than AgeUpperLimit are not invited for screening. If AgeLimitExcluded is “L”, women younger than AgeLowerLimit are not invited.

History

05/05/09	SLT	Made these changes for the Age Extension 2009 Trial: o Added AgeLimitExcluded., AgeLowerLimit and AgeUpperLimit o Changed Randomised to AgeIntervalRandomisation to reduce ambiguity

BatchClient

Batch client details record.

K	Field	Format	Description
K	BatchId →	C(9)	Link to Batch
K	BatchSet	C(2)	One of the following codes (from code list CAT): AC = Available (Call) AR = Available (Recall) BC = Being screened (Call) BR = Being screened (Recall) CC = Ceased (Call) CR = Ceased (Recall) E = Exceptions (now obsolete) MM = Details missing SC = Suspended (Call) SR = Suspended (Recall)
K	NhsNumber →	C(14)	Link to Client if client has been imported
	GpAuthority →	C(3)	Link to Authority
	GpCode →	C(10)	Link to GpDetails when used with GpAuthority if client has been imported
	AddressOneLine	C(200)	
	AppointmentMade	YN	
	AuthorityEndCode	C(3)	One of the following codes (from code list FEC): DNA = Did not attend DNR = Did not respond PC = Premature closure SC = Screening complete WB = W'drawn-being screened WC = Withdrawn - ceased WD = Withdrawn - died WF = Withdrawn - FP69 WM = Withdrawn - moved WO = Withdrawn - other WS = Withdrawn - suspend
	AuthorityEndCodeTxt	C(25)	
	BatchSetTxt	C(23)	
	CallRecallStatus	C(1)	One of the following codes (from code list CRS): C = Ceased N = Normal S = Suspended (not in use)
	CallRecallStatusTxt	C(10)	
	CeasedBy	C(2)	SO = Screening Office GP = General Practitioner WO = Woman's own choice
	CeasedOnDate	DATE	
	ClientIsException	YN	
	DateOfBirth	DATE	

K	Field	Format	Description
	Dha	C(3)	For example M17, M09 etc
	EpisodeType	C(1)	One of the following codes (no code list): C = Call R = Recall
	EpisodeTypeTxt	C(6)	
	Forenames	C(30)	
	GpInitials	C(3)	
	GpSurname	C(20)	
	LastScreeningDate	DATE	
	LastSO	C(3)	
	Postcode	C(8)	
	PreviousForenames	C(22)	
	PreviousSurname	C(20)	
	ResearchTrialArm	C(3)	
	ResearchTrialCode	C(1)	
	ResearchTrialRandomised	DATE	
	Surname	C(20)	
	Title	C(4)	

Client

Contains client demographic information. Only includes clients who are not flagged as “Deleted”.

K	Field	Format	Description
K	SxNumber	NUM	Number that identifies a client
	GpAuthority →	C(3)	Link to Authority
	GpCode →	C(6)	Link to GpDetails when used with GpAuthority
	AddressLine1	C(30)	
	AddressLine2	C(30)	
	AddressLine3	C(30)	
	AddressLine4	C(30)	
	AddressLine5	C(30)	
	AddressMemo	C(200)	
	AddressOneLine	C(200)	
	Age	NUM	Current age (blank if deceased)
	AgeBand	C(7)	"0-4", "5-9", "10-14" etc
	Authority	C(3)	A code from code list HA
	AuthorityTxt	C(35)	
	BcaContribCauseOfDeath	C(1)	One of the following codes (no code list): N = No U = Unknown Y = Yes NULL if the value has not been entered
	BcaContribCauseOfDeathTxt	C(7)	
	BcaMainCauseOfDeath	C(1)	One of the following codes (no code list): N = No U = Unknown Y = Yes NULL if the value has not been entered
	BcaMainCauseOfDeathTxt	C(7)	
	CallRecallStatus	C(1)	One of the following codes (from code list CRS): C = Ceased N = Normal S = Suspended
	CallRecallStatusTxt	C(10)	
	CaseNotes	YN	
	CeasedBy	C(2)	
	CeasedOnDate	DATE	
	CeasedReason	C(4)	A code from code list CRCSREAS
	CeasedReasonTxt	C(30)	
	CivilStatus	C(1)	Not generally in use now

K	Field	Format	Description
	DateBcaDiagnosed	DATE	
	DateOfBirth	DATE	
	DateOfDeath	DATE	
	DeathFlag	YN	Y if has a DateOfDeath.
	DeathFurtherDetails	C(66)	
	Dha	C(3)	A code from code list DHA
	DhaTxt	C(20)	
	EthnicOrigin	C(2)	A code from code list ETH2001
	EthnicOriginTxt	C(60)	
	EthnicOriginOld	C(2)	A code from code list ETHOLD
	EthnicOriginOldTxt	C(20)	
	FirstLanguage	C(3)	A code from code list FIRSTLAN
	FirstLanguageTxt	C(25)	
	Forenames	C(22)	
	FullName	C(50)	Client full name with title
	GpFullCode	C(10)	Format is AAA/GGGG where AAA is an authority code such as COV and GGGG is a number or combination of letters and numbers
	HistoryComments	C(133)	History comment lines 1 and 2 with a space between
	HrAgeAtNextTestDue	NUM	Client or diagnosis age at HrNextTestDueDate for the client's current protocol
	HrNextTestDueDate	DATE	Date next higher risk screening is due
	HrReasonWithdrawn	C(4)	A code from code list HRWR (Higher Risk Withdrawal Reason, pg 127) if HrStatus is W
	HrReasonWithdrawnTxt	C(40)	
	HrStatus	C(1)	One of the following Higher Risk Status codes: N = Normal W = Withdrawn Blank if the client is not in table ClientProtocol
	HrStatusTxt	C(9)	
	HrStatusComment	C(66)	Higher risk status comment
	Initials	C(5)	Derived from Forenames
	LastAuthority	C(3)	Link to Authority
	LastScreeningOffice	C(3)	A code from code list SO, from Exeter system
	LastScreeningOfficeTxt	C(20)	
	LastScreeningOfficeDate	DATE	"Date of last complete screening" as imported from authority Exeter system
	NextAuthority	C(3)	Link to Authority
	NextScreeningOffice	C(3)	A code from code list SO
	NextScreeningOfficeTxt	C(20)	

K	Field	Format	Description
	NextScreeningOfficeDate	DATE	Date of change of SO as entered into NBSS
	NhsNumber	C(14)	
	NhsNumberCryptic	C(11)	Research projects that need to identify clients registered at more than one screening office can extract NhsNumberCryptic rather than NhsNumber to ensure confidentiality. See **Table Notes** item 1
	NhsNumberPacs	C(16)	NhsNumber in the format it is sent to a PACS
	Notepad	C(16320)	Details contained in the Notepad. Multiple lines
	Postcode	C(8)	Full postcode
	PostcodeArea	C(4)	First part of Postcode
	PreviousNhsNumber	C(14)	
	PreviousSurname	C(20)	
	RegistrationComments	C(121)	
	ResearchTrialActive	YN	
	ResearchTrialArm	C(1)	
	ResearchTrialCode	C(1)	
	ResearchTrialRandomised	DATE	
	Sex	C(1)	M, F, N, or O
	SpecialAppointmentIndicator	YN	Y or N or blank
	SpecialAppointmentReasons	C(500)	List of the special appointment reasons separated by commas. For example, “Implants, Other.”. The special appointment reasons are: Agoraphobia Implants Learning Difficulties Physical Restriction Registered disabled Social Reasons Wheelchair User Other Blank if SpecialAppointmentIndicator is N or blank, or if no reason has been entered.
	SpecialCorrespondence	C(1)	Y or N
	Surname	C(20)	
	SxNumberAndName	C(50)	SxNumber and name as one field
	SxNumberFull	C(11)	SxNumber with leading zeroes and the SO code on the front
	SxNumberPacs	C(16)	SxNumber in the format it is sent to a PACS
	TelephoneNo1	C(30)	
	TelephoneNo2	C(30)	
	Title	C(4)	

Table Notes

1. NhsNumberCryptic is a pseudonymised client ID of format Nxxx or Sxxx where xxx consists of characters A-Z and 2-9. The value is Nxxx (national) if the client's NHS Number is valid (10 digits with a valid check digit). If a client has the same valid NHS Number at several screening offices, NhsNumberCryptic is the same at all the offices. The value is Sxxx (site-specific) if the NHS Number is invalid. In this case, the Sxxx value is derived from the office cipher and SX Number and is different at each office.

History

09/11/07	JKO	Added field SxNumberPacs for PACS
15/07/08	JKO	Added field NhsNumberPacs for PACS
23/03/10	JKO	Added higher risk fields HrAgeAtNextTestDue…HrWithdrawalReasonTxt
13/09/12	JKO	Added field NhsNumberCryptic for Reverse Reading Trial
23/01/13	JKO	Added field SpecialAppointmentReason
27/06/17	SSS	Replaced SpecialAppointmentReason with SpecialAppointmentReasons
25/07/17	SCD	Added SpecialCorrespondence

ClientProtocol

Contains Higher Risk Screening client protocol records.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	ClientProtocolRecordId	NUM	
	ReferringClinician →	C(8)	Link to ReferrerDetails
	AgeAtNTD	NUM	The client age at the NTD. The NTD is in field HrNextTestDueDate of table Client.
	AuthorisedBy	C(4)	A code from code list PEPL
	AuthorisedByNational	C(7)	National People Code
	AuthorisedByTxt	C(25)	
	NextScreening	C(2)	A code from code list HRNXT (Higher Risk Next Screening, pg 127) indicating what type of higher risk episode will be created for this ClientProtocol and AgeAtNTD.
	NextScreeningTxt	C(13)	
	OtherGeneCodes	C(20)	A code or codes separated by commas. A code consists of characters A-Z and 0-9 and is at least 4 characters long but is otherwise unvalidated. Only valued if ReferralReasons includes OTHR.
	ProtocolDate	DATE	The date the protocol starts
	ProtocolDateStatus	C(1)	One of the following: 1 = Superseded (client has a later protocol) 2 = Current You can use this to restrict a report to protocols that are active today (ProtocolDateStatus=2)
	ReferralReasons	C(35)	List of reason codes separated by spaces
	ScreeningProtocol	C(35)	Protocol name
	ScreeningProtocolAgeFrom	NUM	Minimum age for the ScreeningProtocol
	ScreeningProtocolAgeTo	NUM	Maximum age for the ScreeningProtocol

History

23/03/10	JKO	Table created for Higher Risk Screening
20/09/17	SCD	Added National People Code for AuthorisedBy
06/02/20	JKO	Updated for higher risk RFC0124122. Added NextScreening, NextScreeningTxt and OtherGeneCodes. Removed ScreeningProtocolAgeCalc and DiagnosisDate because NBSS no longer supports annual follow-up. Removed “3=Future date (not started yet)” from ProtocolDateStatus because NBSS no longer allows a future ProtocolDate.

ClientTrial

Identifies clients who consented to take part in clinical trials. There is a row in this table if the client has consented to participate. There is no entry if the client refused to participate or withdrew consent.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	TrialCode	C(6)	Identifies a trial that the client is participating in. Currently one of the following codes from code list TRIALC but the list is likely to expand in future: C2 = Cadet II SLN = Sloane
	TrialName	C(10)	
	DateEntered	DATE	The date the client consent was recorded in NBSS
	UserId	C(12)	The user who recorded client consent in NBSS
	UserName	C(50)	

Table Notes

1. The *Client* table (page 20) contains "ResearchTrial" fields that indicate participation in the Age and Interval trials. The SurgeryProcedure table (page 104) contains fields that indicate participation in surgical trials.

History

02/01/08	JKO	Table created for CADET2
01/09/08	JKO	Added TrialName, changed TrialCode to a lookup and increased length to 6

ClinicalExamDS

Contains clinical examination diagnostic set information.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	ClinicalExamDSRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Comments	C(133)	Comment lines 1 and 2 with a space between
	DiagnosticSetOutcome	C(4)	
	EventType	C(3)	Always “ASS”
	LeftOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	LeftOpinionTxt	C(16)	
	OverallAction	C(2)	A code from code list ACT: Action (pg 122)
	OverallActionTxt	C(16)	
	OverallDate	DATE	
	Responsibility	C(4)	A code from code list PEPL
	ResponsibilityNational	C(7)	National People Code
	ResponsibilityTxt	C(25)	
	RightOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	RightOpinionTxt	C(16)	

History

13/04/07	JKO	Dropped Clinic, ReasonForClinic, ReasonForClinicTxt, WeeksInterval (obsolete)
20/09/17	SCD	Added National People Code for Responsibility

ClinicalExamProcedure

Contains clinical examination ("Clinical Findings") procedure and lesion information. A procedure with no lesion records has nulls in LesionId, SideCode etc.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	ClinicalExamProcedureRecordId	NUM	Internal Record ID
	ClinicalExamDSRecordId →	NUM	Link to ClinicalExamDS when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Clinician	C(4)	A code from code list PEPL
	ClinicianNational	C(7)	National People Code
	ClinicianTxt	C(27)	
	DatePerformed	DATE	
	LeftAxillaOpinion	C(1)	A code from code list AXOPN: A = Abnormal N = Normal X = Not Assessed
	LeftAxillaOpinionTxt	C(12)	
	LeftSideAssessed	YN	
	Location	C(5)	A code from code list LOC
	LocationTxt	C(25)	
	RightAxillaOpinion	C(1)	See LeftAxillaOpinion
	RightAxillaOpinionTxt	C(12)	
	RightSideAssessed	YN	
	TimeOrder	NUM	See *TimeOrder*, page 121
*	LesionId →	NUM	Link to Lesion when used with SxNumber and EpisodeRecordId. This is null if the procedure has no lesion records.
*	SideCode	C(1)	R for right or L for left
*	DiscreteMass	YN	
*	NippleChanges	YN	
*	NippleDischarge	C(1)	One of the following (from code list NIPDIS): B = Bloodstained N = None X = Other (not bloodstained)
*	NippleDischargeTxt	C(25)	
*	Nodularity	YN	
*	Opinion	C(2)	A code (P1-P5) from code list OPINION (Opinion after a procedure, pg 128)
*	OpinionTxt	C(25)	
*	PossibleLymphNode	YN	
*	PreviousOpinions	C(20)	

*	SizeMm	NUM	
*	SkinChanges	YN	
*	WorstLesion	YN	See *WorstLesion*, page 121

History

13/04/07	JKO	Rewritten for new Clinical Module
16/11/11	GSK	Replaced {Side}AxillaNormal with {Side}AxillaOpinion (SC0139)
20/09/17	SCD	Added National People Code for Clinician
09/01/19	JKO	Renamed column LymphNode as PossibleLymphNode

ClinicDay

Has a row for each clinic session date. The "daybook" values are blank unless details have been received from a mobile unit and uploaded to the NBSS database.

K	Field	Format	Description
K	ClinicCode	C(5)	Could link to "clinic" in the future
K	DateOfClinic	DATE	Session date
	DateDaybookCopied	DATE	Date copied to server, never null if has daybook
	DateDaybookImported	DATE	Null until imported
	DaybookStatus	C(1)	A, F or I
	DaybookStatusTxt	C(20)	Awaiting Importation, Failed Import or Imported
	NumberOfDaybookWomen	NUM	Number of client record received from the mobile unit

Notes

1. A DaybookStatus of NULL means a daybook has not been loaded.

2. Other clinic records could be added in the future for the ID, Session, Clinician, Timeslot etc. At the moment everything is on the Appointment table.

CurrentRecord

Contains episode side-dependent information. An episode can only have one CurrentRecord per side.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	CurrentRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Comments	C(133)	Comment lines 1 and 2 with a space between
	MonthlyBse	YN	
	PeriodInLast12Months	YN	
	TrainedByHealthProf	YN	
*	SideCode	C(1)	R for right or L for left
*	BreastLump	C(2)	One of the following codes (from code list PRDSCV): N = Not Present PD = Present, discovered by a doctor PS = Present, discovered by self PU = Present, discovered by an unknown person PX = Present, discovered by another person
*	BreastLumpTxt	C(40)	
*	BreastNippleDistortion	C(2)	A code from code list PRDSCV, as BreastLump above
*	BreastNippleDistortionTxt	C(40)	
*	BreastSymptoms	C(1)	A code from code list PRE (Present, Yes or No, pg 130)
*	NippleDischarge	C(1)	One of the following codes (from code list NIPDIS): B = Bloodstained N = None X = Other (not bloodstained)
*	NippleDischargeTxt	C(25)	
*	PainDiscomfort	C(1)	A code from code list PRE (Present, Yes or No, pg 130)
*	ReaderAlertCode	C(2)	Values: BL = Recent lump BS = Distortion or change in shape of breast ND = Nipple discharge NE = Nipple eczema NI = Recent nipple inversion ST = Skin tethering or dimpling XX = Other/Custom
*	ReaderAlertMessage	C(100)	Standard or custom alert text

Notes

1. Most of the fields are obsolete and only filled in for historical records. The only relevant fields for recent records are SxNumber, CurrentRecordId, EpisodeRecordId, SideCode, ReaderAlertCode and ReaderAlertMessage.

History

24/08/16	JKO	Increased length of ReaderAlertMessage from 80 to 100

Episode

Contains episode information.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	EpisodeRecordId	NUM	Internal Record ID
	BatchId →	C(11)	Link to Batch
	AgeAtFoa	NUM	Age at DateOfFirstOfferedAppointment
	AgeExtension2009Status	C(1)	This can be one of the following: 0 = Not in Trial 1 = Randomised In 2 = Randomise Out This is 1 if the woman was in the upper or lower age group and batch randomisation included that group in screening. It is 2 if she was in the upper or lower age group and batch randomisation excluded that group from screening.
	AgeExtension2009StatusTxt	C(25)	
	AssessmentToCytoWeeks	NUM(2)	Weeks from first assessment to FNA. **Table Notes** item 2 describes the field derivation in detail.
	AssessmentToEpisodeCloseWeeks	NUM(2)	Weeks from first assessment to episode close. **Table Notes** item 2 describes the field derivation in detail.
	AssessmentToSurgeryWeeks	NUM(2)	Weeks from first assessment to BT. **Table Notes** item 2 describes the field derivation in detail.
	AssessmentToWbnWeeks	NUM(2)	Weeks from first assessment to WBN. **Table Notes** item 2 describes the field derivation in detail.
	AssociatedAuthority	C(3)	Link to Authority
	AssociatedGpAuthority	C(3)	Link to Authority of GP
	AssociatedGpCode	C(6)	Link to GpDetails when used with GpAuthority
	AssociatedGpFullCode	C(10)	Format is AAA/GGGG where AAA is an authority code such as COV and GGGG is a number or combination of letters and numbers
	AssociatedGpName	C(63)	
	AttendedAppointment	YN	Y if attended an appointment in this episode, otherwise N
	BasoBenignCandidate	YN	Y if this is a benign episode as defined by BASO, otherwise N. **Table Notes** item 3 describes the field derivation in detail.

K	Field	Format	Description
	BasoCancerCandidate	YN	Y if this is a cancer episode as defined by BASO, otherwise N. **Table Notes** item 4 describes the field derivation in detail.
	BatchIdFull	C(12)	Batch ID with "-" and letter suffix
	CancerRegistryCandidate	YN	Y if this is a cancer episode as defined by Cancer Registry, otherwise N. **Table Notes** item 5 describes the field derivation in detail.
	ClinicalTeam	C(10)	A code from code list CLT (eg MCO1). Contains the default ClinicalTeam if the episode is still open and has not had a team assigned explictly.
	ClinicalTeamTxt	C(55)	
	ClosedBy	C(15)	
	ClosureResponsibility	C(4)	A code from code list PEPL
	ClosureResponsibilityTxt	C(25)	
	ClosureResponsibilityNat	C(8)	National People Code
	CurrentComment	C(66)	First comment line of the "current" record.
	DateApptFirstMade	DATE	
	DateOfFirstAssessment	DATE	Earliest "Date Performed" or "Date Reported" in any of the following assessment procedure types: AssessmentMri (AMR) ClinicalExamProcedure (CE) ImagingProcedure (IMP) FnaProcedure (FNA) SurgeryProcedure (BT, Event "ASS" only) VaeProcedure (VAE) WbnProcedure (WBN)
	DateOfFirstOfferedAppointment	DATE	The earlier of these two dates: 1. The first appointment offered in a screening or assessment clinic 2. DateOfFirstOfferedMRI
	DateOfFirstOfferedAssessment	DATE	This field is similar to "Date of First Offered Appointment" but only records the date of the first *assessment* appointment offered. An "assessment" appointment is an appointment at a clinic with a sub-speciality of "RC" (Review Clinic).
	DateOfFirstOfferedMRI	DATE	The date of the first MRI appointment offered for screening or assessment. Blank if the client was not offered MRI. **Table Notes** item 9 describes the field derivation in detail.
	DateOfFOAorFirstAssessment	DATE	Same as DateOfFirstOfferedAppointment if present, or DateOfFirstAssessment if DateOfFirstOfferedAppointment is blank.

K	Field	Format	Description
	DateOfMriInitialCommunication	DATE	The date of Initial Communication for MRI procedures. Only populated if screning MRI procedures are present.
	DateOfLastDiagnosis	DATE	Same derivation as DateOfFirstAssessment but finds the most recent date.
	DiagCommDate	DATE	Date an assessment diagnosis result was communicated to the client
	DiagCommMethod	C(3)	One of the following cancer waiting times codes indicating how the client was told: 01 = Face to face 02 = Telephone call 03 = Email 04 = Letter 98 = Other
	DiagCommMethodTxt	C(30)	
	DiagCommPerson	C(4)	The PEPL code of the person who gave the result
	DiagCommPersonTxt	C(25)	
	DiagCommProfession	C(4)	One of the following cancer waiting times dataset care profession codes: 060 = Consultant 180 = Nurse 310 = Radiographer XXX = Other
	DiagCommProfessionTxt	C(30)	
	DirectToAssessment	YN	Y if assessed but not screened, otherwise N (a TR does not count as a screening)
	EpisodeAuthorityEndCode	C(3)	Value such as “SC” or “PC” from code list FEC. See field AuthorityEndCode on BatchClient starting on page 18 for codes. **Table Notes** item 1 describes the field derivation in detail.
	EpisodeCharacter	C(2)	One of the following codes (from code list EPC): CA = Continued Assessment CD = Delayed Treatment CF = Follow-up after treatment CI = Interval case CR = Local Recurrence F = First Call G = GP Referral H = Higher Risk N = Non-rout Recall R = Routine Recall S = Self Referral X = Other
	EpisodeCharacterTxt	C(25)	
	EpisodeClosedDate	DATE	

K	Field	Format	Description
	EpisodeEndPoint	C(24)	Procedure outcomes separated by commas, for example “S+,Aabn,H-”
	EpisodeIsClosed	YN	Y or N
	EpisodeOpenedDate	DATE	Date batch completion run in SB
	FinalActionInEpisode	C(2)	A code from code list ACT: Action (pg 122)
	FinalActionInEpisodeTxt	C(16)	
	FirstAssessApptDnaDate	DATE	The earliest non-cancelled assessment clinic appointment’s date if this appointment’s status is DNA. Null if the earliest non-cancelled assessment clinic appointment status is Attended or Booked.
	FnaCytologicalOpinionC5	YN	Y if episode has one or more FnaProcedure records with Opinion C5 (Malignant). Otherwise N.
	HighRiskShortTermRecall	YN	For a high risk episode (EpisodeCharacter is H), this is Y if the episode is the result of a short-term recall, N if it is not from short-term recall or Null if it was created before the “Sort Term Recall” option was introduced for high risk episodes in 2012. The field is always null if this is not a high risk episode (EpisodeCharacter is not H).
	ImagedBothSides	YN	Y if the ImagingDS table has an opinion for each breast that was present at the start of the episode (a breast was present if the History table MastectomyForBca year is after the EpisodeOpenedDate year). N if the episode has no ImagingDS record or a breast that was present at the start of the episode was not assessed by imaging.
	IntervalCancerDateOfDiagnosis	DATE	Date the interval cancer was diagnosed.
	IntervalCancerDateOfReview	DATE	Date the interval cancer review took place.
	IntervalCancerDateOfRegional	DATE	Date the regional review took place.
	IntervalCancerRegionalRvwrs	C(50)	Attendees at the regional review. Free text.
	IntervalCancerRegionalRvwCom	C(4000)	Notes from the regional review. Multiple lines.
	IntervalCancerReviewers	C(50)	A list of PEPL codes separated by spaces.
	IntervalCancerReviewersN	C(90)	List of National People codes separated by spaces. A minus “-” appears in place of a national code if there is no national code assigned to a local person code.
	IntervalCancerReviewComment	C(4000)	Notes from the interval cancer review. Multiple lines.

K	Field	Format	Description
	IntervalCancerSizeMm	NUM	Size of the lesion identified in the previous screening mammogram if the interval cancer type is 3 – Suspicious.
	IntervalCancerType	C(2)	One of the following codes (from code list ICT): 0 = Unclassifiable 1 = Normal/benign 2 = Uncertain 3 = Suspicous
	IntervalCancerTypeTxt	C(30)	
	NationalIncidentStatus	YN	Y if the episode is a National Incident batch. N if for a normal BAU batch.
	NoOfScreeningApptsMissed	NUM	
	OnKC62	YN	Y if the client is a candidate for the KC62 report, N if KC62 reports will ignore them (ignored if sex is not female, DOB is blank, died before DOFOA or episode character is not F, G, N, R or S)
	PartialMammography	YN	Y if mammography was partial.
	PartialMammographyReasonCode	C(2)	A code from code list PARTR (Partial Mammography Reason, pg 130)
	PartialMammographyReason	C(66)	Description of why mammography was partial. As entered by the mammographer if reason code is XX. From list PARTR (Partial Mammography Reason, pg 130) if reason code is not XX. Blank if PartialMammography is N.
	PrevalentIncidentStatus	C(2)	One of the following codes (from code list PRVI): I = Incident P = Prevalent XI = X-Incident XP = X-Prevalent
	PreviousAppointmentDate	DATE	The first value from the following list that is not blank: 1. Date of last "other mammogram" if more recent than the previous episode 2. DateOfFirstOfferedAppointment of previous episode 3. DateOfFirstAssessment of previous episode 4. Blank if all of the above are blank **Table Notes** item 6 explains the term “previous episode”.

K	Field	Format	Description
	PreviousFoaToFoaWeeks	NUM(2)	Difference in weeks between PreviousAppointmentDate and the equivalent date on the current episode. The equivalent is the first of the following dates that is not blank: 1. DateOfFirstOfferedAppointment 2. DateOfFirstAssessment
	PreviousScreeningDate	DATE	The first value from the following list that is not blank: 1. Date of last "other mammogram" if more recent than the previous episode 2. ScreeningDate of previous episode 3. DateOfFirstOfferedAppointment of previous episode 4. DateOfFirstAssessment of previous episode 5. Blank if all of the above are blank **Table Notes** item 6 explains the term “previous episode”.
	PreviousScreeningToFoaDays	NUM	Difference between PreviousScreeningDate and the first of these dates that is not blank: 1. DateOfFirstOfferedAppointment 2. DateOfFirstAssessment
	PreviousScreeningToFoaWeeks	NUM(2)	Same as PreviousScreeningToFoaDays but in weeks (days divided by 7)
	ReasonEpisodeClosed	C(2)	A code from code list EPRC (Reason for Episode Closure, pg 126)
	ReasonEpisodeClosedTxt	C(25)	
	RecallDueDate	DATE	
	ResponsibleAssessor	C(4)	A code from code list PEPL
	ResponsibleAssessorNat	C(8)	National People Code
	ResponsibleAssessorTxt	C(25)	
	ScreeningDate	DATE	Date of first screening procedure, ignoring any that resulted in a technical repeat or are not finalised
	ScreeningDateMammo	DATE	Date of first ScreeningProcedure, ignoring any that resulted in a technical repeat or are not finalised
	ScreeningDateMRI	DATE	Date of first ScreeningMri, ignoring any that resulted in a technical repeat or are not finalised

K	Field	Format	Description
	ScreeningDateUSS	DATE	Date of first ScreeningUltrasound, ignoring any that resulted in a technical repeat or are not finalised
	ScreeningEquipmentType	C(1)	One of the following codes (no code list): A = Analogue D = Digital **Table Notes** item 8 describes the field derivation in detail.
	ScreeningInterval	NUM	Interval in days between the earliest and latest ScreeningDateMammo, ScreeningDateMRI, ScreeningDateUSS. Zero if only one contains a date. Null if none contain a date.
	ScreeningProtocol	C(35)	Higher risk protocol at episode creation. Only applies to EpisodeCharacter H.
	ScreeningProtocolAge	NUM	Age at NTD at episode creation. Only applies to EpisodeCharacter H.
	ScreeningProtocolEpiType	C(1)	Higher risk episode subtype: I = Invitation S = Self-Referral Only applies to EpisodeCharacter H.
	ScreeningProtocolEpiTypeTxt	C(13)	Null if EpisodeCharacter is not H.
	ScreeningReportedDate	DATE	This is the same as OverallDate from table ScreeningDS.
	ScreeningToAssessmentWeeks	NUM(2)	Weeks from first screening to first assessment. **Table Notes** item 2 describes the field derivation in detail.
	ScreeningToCytoWeeks	NUM(2)	Weeks from first screening to FNA. **Table Notes** item 2 describes the field derivation in detail.
	ScreeningToDOFOAssWeeks	NUM(2)	Weeks from ScreeningDate to DateOfFirstOfferedAssessment.
	ScreeningToEpisodeCloseWeeks	NUM(2)	Weeks from first screening to episode close. **Table Notes** item 2 describes the field derivation in detail.
	ScreeningToSurgeryWeeks	NUM(2)	Weeks from first screening to BT. **Table Notes** item 2 describes the field derivation in detail.
	ScreeningToWbnWeeks	NUM(2)	Weeks from first screening to WBN. **Table Notes** item 2 describes the field derivation in detail.
	SurgeryHistologicalDiagnosisH5	YN	Y if the episode has one or more SurgeryProcedure records with Opinion H5 (Malignant). Otherwise N.
	TechnicalRepeatDate	DATE	Date of last screening procedure in the episode with action TR. Blank if last screening procedure was not TR.

K	Field	Format	Description
	VaeOpinionE5	YN	Y if the episode has one or more VaeProcedure records with Opinion E5 (Malignant). Otherwise N.
	WbnOpinionB5	YN	Y if the episode has one or more WbnProcedure records with Opinion B5 (Malignant). Otherwise N.
	WideOpinion5	YN	Y if the episode has any WbnProcedure or VaeProcedure records with Opinion B5 or E5 (Malignant). Otherwise N.

Table Notes

1. EpisodeAuthorityEndCode is derived as follows:

    1. The code is blank if the episode is open (i.e. ReasonEpisodeClosed is blank)

    2. EpisodeAuthorityEndCode is SC (has been screened) if EpisodeEndPoint is not blank

    3. For all other cases, EpisodeAuthorityEndCode is determined by ReasonEpisodeClosed (code list EPRC (Reason for Episode Closure, pg 126)). The following table shows the EpisodeAuthorityEndCode for every ReasonEpisodeClosed SO code.

End Code	End Code Text	SO Code	SO Text
DNA	Did not attend	HR	On higher risk
		NA	Non-attender
DNR	Did not respond	NR	Non-Responder
PC or WO [1]	Premature closure or Withdrawn – other	BS	Being Screened
		CP	Under care; perm
		CT	Under care; temp
		DD	Died
		FP	FPC closed; prem
		NS	Atten'd not screened
		NT	No Transport to Unit
		OP	Opted out; Permanent
		OT	Opted out; temporary
		RS	Recently Screened
		X	Other;see C/R status
SC	Screening complete	DE	Defaulted
		DU	Further Dtls Unavail
		R	Routine Closure
WB	W'drawn-being screened	FB	FPC closed; being Sx
WC	Withdrawn - ceased	FC	FPC closed; ceased
WD	Withdrawn - died	FD	FPC closed; Died
WF	Withdrawn - FP69	FF	FPC closed; FP69
		MV	Moved Away
		NK	Not Known at address
WM	Withdrawn - moved	FM	FPC closed; Moved
WO	Withdrawn - other	FX	FPC closed; Other
WS	Withdrawn - suspend	AR	Randomised Out
		FS	FPC closed;suspended
null		I	Interval case

[1] The end code is PC (Premature Closure) if the episode has at least one screening clinic appointment that is not AppointmentStatus “C” (Cancelled by Hospital). If the episode does not meet this condition, the end code is WO (Withdrawn - other). This rule was introduced in scope change SC0096 to ensure that women who have not been offered screening will still appear in future failsafe batches.

2. AssessmentToXxx and ScreeningToXxx

AssessmentToXxxWeeks is the number of weeks between the following events:

Field	From	To
AssessmentToCytoWeeks	First Assessment	First FNA record
AssessmentToEpisodeCloseWeeks	First Assessment	Episode closure date
AssessmentToSurgeryWeeks	First Assessment	First BT record
AssessmentToWbnWeeks	First Assessment	First WBN record

ScreeningToXxx Weeks is the number of weeks between the following events:

Field	From	To
ScreeningToAssessmentWeeks	First Screening	First Assessment
ScreeningToCytoWeeks	First Screening	First FNA record
ScreeningToEpisodeCloseWeeks	First Screening	Episode closure date
ScreeningToSurgeryWeeks	First Screening	First BT record
ScreeningToWbnWeeks	First Screening	First WBN record

The computer gets a procedure's date from "Date Performed" if present or "Date Reported" if there isn't one. It ignores screening and assessment procedures where both dates are blank.

To get the "First Screening" date the computer finds the episode's first screening procedure. It does not matter whether this screening resulted in a technical recall or not, it will still be used.

To get the "First Assessment" date the computer uses the date from the first non-screening procedure on or after the "First Screening" date. If the "First Screening" date was blank, the "First Assessment" date will also be blank.

3. BasoBenignCandidate

The computer applies the following rules to decide if "BasoBenignCandidate" is Y or N. It stops looking through the rules as soon as it finds a rule that is true.

The descriptions use "diagnostic surgery" as shorthand for a SurgeryProcedure with Event "ASS" and "surgical treatment" as shorthand for a SurgeryProcedure with Event "PTR".

No.	Rule Description	Result
1	OnKC62 is "N"	N
2	Has diagnostic surgery Opinion "H2" and no later diagnostic surgery Opinion is "H3", "H4" or "H5"	Y
3	No FnaProcedure.Opinion is "C1" or "C2" and no WbnProcedure.Opinion is "B1" or "B2" and no VaeProcedure.Opinion is "E1" or "E2"	N
4	Has surgical treatment TreatmentProcedure "EXP", "Excision of benign lesion (patient choice)"	Y
5	All other situations	N

4. BasoCancerCandidate

The computer applies the following rules to decide if "BasoCancerCandidate" is Y or N. It stops looking through the rules as soon as it finds a rule that is true.

No.	Rule Description	Result
1	EpisodeCharacter is "CI"	N
2	OnKC62 is "N"	N
3	Has SurgeryProcedure.Opinion "H5"	Y
4	Has SurgeryProcedure.CancerOnKC62 "Y"	Y
5	Has FnaProcedure.Opinion "C5"	Y
6	Has WbnProcedure.Opinion "B5"	Y
7	Has VaeProcedure.Opinion "E5"	Y
8	All other situations	N

5. CancerRegistryCandidate

The computer applies the following rules to decide if "CancerRegistryCandidate" is Y or N. It stops looking through the rules as soon as it finds a rule that is true.

No.	Rule Description	Result
1	EpisodeCharacter is not F,R,N,G,S,H or CI	N
2	Has SurgeryProcedure.Opinion "H5"	Y
3	Has SurgeryProcedure.CancerOnKC62 "Y"	Y
4	Has FnaProcedure.Opinion "C5"	Y
5	Has WbnProcedure.Opinion "B5"	Y
6	Has VaeProcedure.Opinion "E5"	Y
7	All other situations	N

6. "Previous Episode"

When the system is determining the "previous episode", it only looks at episodes that have a ScreeningDate or DateOfFOAorFirstAssessment.

7. ScreeningProtocol

ScreeningProtocol and ScreeningProtocolAge are the protocol and age values used to determine the expected screening procedures and recall interval for a higher risk episode.

8. ScreeningEquipmentType

This comes from the A/D flag associated with the EquipmentUsed field of the first finalised ScreeningProcedure, ScreeningMri or ScreeningUltrasound record on the ScreeningDate.

9. DateOfFirstOfferedMRI

The computer uses the date that the office recorded in the episode's "First Offered MRI" date if one was entered. If no date is recorded, it uses the earliest of the following:

- Screening MRI Appointment Date of appointments not cancelled by SO
- Screening MRI Date Taken
- Assessment MRI Date Performed

History

13/04/07	JKO	Updated for new Clinical Module
11/09/07	JKO	Updated notes on EpisodeAuthorityEndCode derivation following SC0096
08/06/08	JKO	Added note 4 following a small change for round length calculation
04/07/08	JKO	Changed rules for BasoCancerCandidate derivation (note 3)
17/04/09	SLT	Created AgeExtension2009Status
08/01/10	SLT	Added field CancerRegistryCandidate and associated note
23/03/10	JKO	Added fields ScreeningProtocol and ScreeningProtocolAge and note 7. Changed fields DirectToAssessment and ScreeningDate to treat screening film, screening MRI and screening ultrasound as equivalent.
31/08/10	JKO	Added fields PartialMammography and PartialMammographyReason
18/11/10	JKO	Added field BasoBenignCandidate and associated note
09/02/11	ADG	Added field ScreeningEquipmentType and associated note
04/02/12	GSK	Added IntervalCancer- fields. Updated code table ICT (IntervalCancerType)
07/11/12	JKO	Added ImagedBothSides for scope change SC0146
06/11/13	JKO	Added PartialMammographyReasonCode, updated PartialMammographyReason
23/10/14	JKO	Added DateOfFirstOfferedMRI
24/07/15	JKO	Removed DateOfFirstOfferedAppointment comment "blank for episodes before 1995" and DateOfFirstOfferedAssessment comment "blank prior to Jan/Feb 2006" because NBSS release 9.08 populates these dates for old episodes. Removed the "diagnostic set" check from note 6 "Previous Episode": an episode is no longer considered a previous episode if it has a diagnostic set but has blanks in DateOfFOAorFirstAssessment and ScreeningDate.
14/10/15	JKO	Increased length of AssociatedGpName from 30 to 63
09/12/16	JKO	Added ResponsibleAssessor
20/09/17	SCD	Added National People Codes for Closure Responsibility, Interval Cancer Reviewers and Responsible Assessor
22/02/18	JKO	Updated description of EpisodeAuthorityEndCode. Added closure reason HR and removed the conversion to end code WO for end codes other than PC
12/04/18	JKO	Added VaeOpinionE5 and WideOpinion5. Renamed WbnHistologicalOpinionB5 as WbnOpinionB5 to deliberately "break" reports that refer to it. This was done to encourage re-evaluation of reports that might need to also take account of VAE opinion E5. Also updated DateOfFirstAssessment, BasoBenignCandidate, BasoCancerCandidate and CancerRegistryCandidate to consider VAE.
30/04/18	JKO	Added HighRiskShortTermRecall, ScreeningDateMammo, ScreeningDateMRI, ScreeningDateUSS and ScreeningInterval. Changed the derivation of column DateOfFirstOfferedAppointment to include MRI appointments and added Table Notes 9 to explain the derivation of DateOfFirstOfferedMRI.
07/06/19	LAW	Added DateOfMriInitialCommunication.
19/08/19	SCD	Added National Incident Status
06/02/20	JKO	Updated for higher risk RFC0124122. Added ScreeningProtocolEpiType, ScreeningProtocolEpiTypeTxt.
27/03/20	SCD	Updated for Date Assessment Result Given FS109885. Added DiagCommDate, DiagCommMethod, DiagCommMethodTxt, DiagCommPerson, DiagCommPersonTxt, DiagCommProfession, DiagCommProfessionTxt, FirstAssessApptDnaDate, ScreeningReportedDate.

EpisodePacsExam

Contains the PACS exams associated with a row in the Episode table. The PACS exams associated with episode appointments are in table AppointmentPacsExam.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
K	AccessionNumber	C(16)	PACS examination ID
	ExamDate	DATE	
	ProcedureCode	C(6)	Code from list PEPR (PACS Exam Procedure, pg 130)
	ProcedureTxt	C(40)	Description from PEPR (PACS Exam Procedure, pg 130)
	ProcedureModalityType	C(2)	Modality from PEPR (PACS Exam Procedure, pg 130)
	ProcedureScreenOrAssess	C(1)	S/A code from PEPR (PACS Exam Procedure, pg 130): S = Screening A = Assessment

History

01/03/11	JKO	Created for PACS Phase 2

FilmTracking

Contains the current Film Tracking information for a client's films.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
	CurrentLocationCode	C(5)	
	CurrentLocationDescription	C(50)	
	CurrentStatusCode	C(3)	
	CurrentStatusDescription	C(50)	
	DateLastUpdated	DATE	Date the film status was last updated
	DateRequested	DATE	Date the last request was made
	DateRequired	DATE	Date the films are required by the requestor
	DateTracked	DATE	Date the current location was last changed
	RequestComment	C(4000)	Comment when the last request was made
	RequestedByUserId	C(12)	
	RequestedByUserName	C(50)	
	RequestedLocationCode	C(5)	
	RequestedLocationDescription	C(50)	
	StatusComment	C(4000)	Comment when the film status was last updated
	TrackedByUserId	C(12)	
	TrackedByUserName	C(50)	
	TrackingComment	C(4000)	Comment when the current location was last changed
	UpdatedByUserId	C(12)	
	UpdatedByUserName	C(50)	

History

13/01/12 GSK Created for SC0164 Include Film Tracking in ODBC views

FnaDS

Contains Cytology (Fine Needle Aspiration) diagnostic set information.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	FnaDSRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Comments	C(133)	Comment lines 1 and 2 with a space between
	DiagnosticSetOutcome	C(4)	
	EventType	C(3)	Always “ASS”
	LeftOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	LeftOpinionTxt	C(16)	
	OverallAction	C(2)	A code from code list ACT: Action (pg 122)
	OverallActionTxt	C(16)	
	OverallDate	DATE	
	Responsibility	C(4)	A code from code list PEPL
	ResponsibilityNational	C(7)	National People code
	ResponsibilityTxt	C(25)	
	RightOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	RightOpinionTxt	C(16)	

History

13/04/07	JKO	Dropped Clinic, ReasonForClinic, ReasonForClinicTxt, WeeksInterval (obsolete)
20/09/17	SCD	Added National People Code for Responsibility

FnaProcedure

Contains Cytology (Fine Needle Aspirate) procedure and lesion information. A procedure with no lesion records has nulls in LesionId, SideCode etc.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	FnaProcedureRecordId	NUM	Internal Record ID
	FnaDSRecordId →	NUM	Link to FnaDS when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Clinician	C(4)	A code from code list PEPL
	ClinicianNational	C(7)	National people code
	ClinicianTxt	C(27)	Clinician name
	DatePerformed	DATE	
	HospitalCode	C(6)	A code from code list HOSP
	HospitalCodeTxt	C(30)	
	HospitalNumber	C(10)	
	LeftSideAssessed	YN	
	Location	C(5)	A code from code list LOC
	LocationTxt	C(25)	
	RightSideAssessed	YN	
	TimeOrder	NUM	See *TimeOrder*, page 121
	TimePerformed	TIME	
*	LesionId →	NUM	Link to Lesion when used with SxNumber and EpisodeRecordId. This is null if the procedure has no lesion records.
*	SideCode	C(1)	R for right or L for left
*	ClinicianComment	C(66)	
*	DateReported	DATE	
*	Laboratory	C(5)	A code from code list LAB
*	LaboratoryTxt	C(30)	
*	LocalisationType	C(1)	A code from code list LOCTYP (Localisation Type, pg 128)
*	LocalisationTypeTxt	C(18)	
*	Opinion	C(2)	A code (C1-C5) from code list OPINION (Opinion after a procedure, pg 128)
*	OpinionTxt	C(25)	
*	Pathologist	C(4)	A code from code list PEPL
*	PathologistComments	C(4000)	Multiple lines
*	PathologistNational	C(7)	National people code
*	PathologistTxt	C(27)	Pathologist name

K	Field	Format	Description
*	PreviousOpinions	C(20)	
*	ReportNumber	C(12)	
*	SpecimenType	C(3)	One of the following codes (from code list SPTYP): AC = FNA cyst AS = FNA solid LA = Node aspirate ND = Nipple discharge NS = Nipple/skin scrape
*	SpecimenTypeTxt	C(20)	
*	WorstLesion	YN	See *WorstLesion*, page 121

History

13/04/07	JKO	Rewritten for new Clinical Module
23/10/07	JKO	Added TimePerformed
20/09/17	SCD	Added National People Code for Clinician and Pathologist

FumBiopsy

Contains follow-up surgery (biopsy & treatment) side-dependent information. Some of the fields are similar to SurgeryProcedure.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	FumBiopsyRecordId	NUM	Internal Record ID
	Consultant	C(4)	A code from code list PEPL
	ConsultantNational	C(8)	National People Code
	ConsultantTxt	C(27)	Consultant name
	DatePerformed	DATE	
	DateReported	DATE	
	EnteredIntoNationalTrial	YN	
	Event	C(3)	
	Hospital	C(6)	A code from code list HOSP
	HospitalNumber	C(30)	
	HospitalTxt	C(10)	Description for Hospital
	HrTherapy	C(2)	
	LocalTrial	C(3)	A code from code list TRIAL (not RTRIAL)
	LocalTrialTxt	C(25)	
	Location	C(5)	A code from code list LOC
	LocationTxt	C(40)	
	NationalTrial	C(6)	A code from code list TRIALNS. Called "WhichTrial" on screens.
	NationalTrialTxt	C(60)	
	Surgeon	C(4)	A code from code list PEPL
	SurgeonNational	C(8)	National People Code
	SurgeonTxt	C(27)	
*	SideCode	C(1)	R for right or L for left
*	AdditionalBiopsyProcs	C(26)	List of codes separated by spaces. Values from code list BIADD (Biopsy Additional Procedure , pg 123)
*	AdditionalBiopsyProcsTxt	C(120)	
*	AdditionalTreatmentProcs	C(26)	List of codes separated by spaces. Values from code list BIADD1 (Additional Treatment Procedures, pg 123)
*	AdditionalTreatmentProcsTxt	C(120)	
*	AxillaryNodesNumberPositive	NUM	
*	AxillaryNodesPresent	YN	
*	AxillaryNodesTotalNumber	NUM	

K	Field	Format	Description
*	BenignLesions	C(35)	List of codes separated by spaces. Values from code list BENL (Benign Lesions on WBN, pg 122)
*	BenignLesionsSeen	YN	
*	BenignLesionsTxt	C(120)	Descriptions for BenignLesions
*	BiopsyProcs	C(3)	A code from code list BIPRE (Pre-diagnostic Surgical Procedure, pg 125)
*	BiopsyProcsTxt	C(120)	
*	CaseReviewed	YN	
*	CellTypeOrPattern	C(40)	
*	Comments	C(133)	Comment lines 1 and 2 with a space between
*	DiseaseExtent	C(3)	A code from code list BIMNAT (Disease extent, pg 124)
*	DiseaseExtentTxt	C(25)	
*	DiseaseGrade	C(2)	A code from code list BIMHG (Histological Grade, pg 123)
*	DiseaseGradeTxt	C(14)	
*	EpithelialProliferation	C(7)	List of codes separated by spaces. A code from code list EPIP (Epithelial Proliferation, pg 126)
*	EpithelialProliferationTxt	C(120)	
*	ExcisionMarginDistance	NUM(1)	
*	ExcisionMargins	C(2)	One of the following codes (from code list EXCN): ED = Not to mar ER = Reach marg EU = Uncertain
*	ExcisionMarginsTxt	C(25)	
*	ExcisionSite	C(3)	A code from code list BRSITE (Site Within Breast, pg 125)
*	ExcisionSiteTxt	C(25)	
*	GrowthPatterns	C(40)	
*	HistologicalCalcification	C(1)	A code from code list BICAL (Histological Calcification, pg 123)
*	HistologicalCalcificationTxt	C(10)	
*	HistologicalDiagnosis	C(2)	A code (H0-H2, H5) from code list OPINION (Opinion after a procedure, pg 128)
*	HistologicalDiagnosisTxt	C(20)	
*	Invasive	C(27)	List of codes separated by spaces. Values from code list BIMI (see appendix)
*	InvasiveComment	C(40)	
*	InvasiveTxt	C(70)	Description for Invasive
*	LesionNumber	NUM	

K	Field	Format	Description
*	MalignantLesionsSeen	YN	
*	MammographicAbnormality	YN	
*	MaxDiameterInvasiveCompo	NUM(1)	Maximum diameter of invasive component
*	Microinvasion	C(3)	A code from code list BIMMIF (Microinvasion, pg 124)
*	MicroinvasionTxt	C(15)	
*	NonInvasive	C(15)	List of codes separated by spaces. Values from code list BIMNI (Non-invasive, pg 124)
*	NonInvasiveTxt	C(70)	
*	OtherNodesNumberPositive	NUM	
*	OtherNodesPresent	YN	
*	OtherNodesTotalNumber	NUM	
*	Pathologist	C(4)	A code from code list PEPL
*	PathologistNational	C(8)	National People Code
*	PathologistTxt	C(25)	Pathologist name
*	PathologyFindings	YN	
*	ProcedureComment	C(66)	
*	RadiotherapySites	C(5)	List of codes separated by spaces. Values (from code list BIRYSIT): B = Breast L = Lymph nodes X = Other
*	RadiotherapySitesTxt	C(70)	
*	ReportNumber	C(12)	
*	SiteOfOtherNodes	C(40)	
*	SizeDuctalOnly	NUM(1)	
*	SpecimenRadiographSeen	YN	
*	SpecimenWeight	NUM	
*	TreatmentProcedure	C(3)	A code from code list BIPOST (Post-diagnostic Surgical Procedure, pg 124)
*	TreatmentProcedureTxt	C(70)	
*	VascularInvasion	C(3)	One of the following codes (from code list BIMVI): VNS = Not present VPO = Possible VPR = Present
*	VascularInvasionTxt	C(11)	
*	WholeSizeOfTumour	NUM	

History

20/01/15	JKO	Corrected VascularInvasion codes and descriptions
20/09/17	SCD	Added National People Code for Consultant, Surgeon and Pathologist

FumDetail

Contains follow-up side-dependent information.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	FumDetailRecordId	NUM	Internal Record ID
	Consultant	C(4)	A code from code list PEPL
	ConsultantNational	C(8)	National People Code
	ConsultantTxt	C(27)	
	DeceasedOrMoved	YN	Y or N
	Hospital	C(6)	A code from code list HOSP
	HospitalNumber	C(10)	
	HospitalTxt	C(30)	Description for Hospital
	Radiotherapist	C(4)	A code from code list PEPL
	RadiotherapistNational	C(8)	National People Code
	RadiotherapistTxt	C(27)	
	Surgeon	C(4)	A code from code list PEPL
	SurgeonNational	C(8)	National People Code
	SurgeonTxt	C(27)	
*	SideCode	C(1)	R for right or L for left
*	AppointmentType	C(1)	One of the following codes (from code list TAPP): 1 = Routine Follow-up 2 = Radiotherapy 3 = Oncology
*	AppointmentTypeTxt	C(20)	
*	Chemotherapy	C(30)	
*	Clinician	C(4)	A code from code list PEPL
*	ClinicianNational	C(8)	National People Code
*	ClinicianTxt	C(27)	
*	Comments	C(66)	
*	Confirmed	YN	
*	CurrentStatus	C(1)	One of the following codes (from code list TVISITYP): 1 = Disease Free 2 = New Recurrence (This Side) 3 = New Disease (Other side) 4 = Previously Diagnosed 5 = Non-Attender
*	CurrentStatusTxt	C(20)	
*	DateOfFollowUp	DATE	
*	ExtentOfDisease	C(1)	One of the following codes (from code list EXTDIS):

K	Field	Format	Description
			L = Local M = Metastatic R = Regional
*	ExtentOfDiseaseTxt	C(20)	
*	LocalTrialCode	C(3)	A code from code list TRIAL (not RTRIAL)
*	LocalTrialTxt	C(25)	
*	NewTreatments	C(23)	List of codes separated by spaces. Values (from code list TREAT): AS = Ablative Surgery C = Systemic Chemo H = Systemic Hormone LS = Local Surgery R = Radiotherapy SM = Salvage Mastectomy
*	NewTreatmentsTxt	C(63)	
*	NextAppointment	NUM	
*	Radiotherapy	C(30)	
*	Surgery	C(30)	

History

20/09/17	SCD	Added National People Code for Consultant, Radiotherapist, Surgeon and Clinician

FumFna

Contains follow-up FNA cytology side-dependent information. Similar fields exist in FnaProcedure.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	FumFnaRecordId	NUM	Internal Record ID
	DateOfVisit	DATE	
	DatePerformed	DATE	
	DateReported	DATE	
	Location	C(5)	A code from code list LOC
	LocationTxt	C(40)	
	Pathologist	C(4)	A code from code list PEPL
	PathologistNational	C(8)	National People Code
	PathologistTxt	C(27)	
*	SideCode	C(1)	R for right or L for left
*	Aspirator	C(4)	A code from code list PEPL
*	AspiratorNational	C(8)	National People Code
*	AspiratorTxt	C(27)	
*	Comment	C(66)	
*	CystAspirWithoutCytolology	YN	
*	CytologicalOpinion	C(2)	A code (C1-C5) from code list OPINION (Opinion after a procedure, pg 128)
*	CytologicalOpinionTxt	C(20)	
*	Kv	NUM	
*	LocalisationMammographer	C(10)	A code from code list PEPL
*	LocalisationMammographerNat	C(8)	National People Code
*	LocalisationMammographerTxt	C(27)	
*	LocalisationType	C(1)	A code from code list LOCTYP (Localisation Type, pg 128)
*	LocalisationTypeTxt	C(18)	
*	SpecimenNumber	C(12)	
*	SpecimenType	C(2)	One of the following codes (from code list SPTYP): AC = FNA (cyst) AS = FNA (solid lesion) ND = Nipple discharge NS = Nipple or skin scraping
*	SpecimenTypeTxt	C(24)	
*	TotalExposures	NUM	
*	TotalFilms	NUM	
*	TotalMas	NUM	Total milliamps used during the procedure

K	Field	Format	Description
*	VisitComments	C(133)	Visit comment lines 1 and 2 with a space between

History

20/09/17	SCD	Added National People Code for Aspirator, Localisation Mammographer and Pathologist

FumWbn

Contains follow-up WBN side-dependent information. Similar fields exist in WbnProcedure.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	FumWbnRecordId	NUM	Internal Record ID
	DatePerformed	DATE	
	DateReported	DATE	
	Hospital	C(6)	A code from code list HOSP
	HospitalNumber	C(10)	
	HospitalTxt	C(30)	Description for Hospital
	Location	C(5)	A code from code list LOC
	LocationTxt	C(40)	
	Pathologist	C(4)	A code from code list PEPL
	PathologistNational	C(8)	National People Code
	PathologistTxt	C(27)	
*	SideCode	C(1)	R for right or L for left
*	CalcificationOnSpecimen	C(1)	One of the following codes (from code list CPOSX): N = No U = Radiograph Not Seen Y = Yes
*	CalcificationOnSpecimenTxt	C(19)	
*	Comment	C(66)	
*	HistologicalComments	C(133)	Histological comment lines 1 and 2 with a space between
*	HistologicalCalcification	C(1)	A code from code list BICAL (Histological Calcification, pg 123)
*	HistologicalCalcificationTxt	C(10)	
*	HistologicalOpinion	C(2)	A code (B1-B5) from code list OPINION (Opinion after a procedure, pg 128)
*	HistologicalOpinionTxt	C(20)	
*	Kv	NUM	
*	LocalisationMammographer	C(10)	A code from code list PEPL
*	LocalisationMammographerNat	C(8)	National People Code
*	LocalisationMammographerTxt	C(27)	
*	LocalisationType	C(1)	A code from code list LOCTYP (Localisation Type, pg 128)
*	LocalisationTypeTxt	C(18)	

K	Field	Format	Description
*	MalignancyType	C(1)	One of the following codes (from code list MALTYPE): a = In-situ b = Invasive c = Not assessable
*	MalignancyTypeTxt	C(14)	
*	NumberOfCores	NUM	
*	Operator	C(4)	A code from code list PEPL
*	OperatorNational	C(8)	National People Code
*	OperatorTxt	C(27)	Operator name
*	ReportNumber	C(12)	
*	TotalExposures	NUM	
*	TotalFilms	NUM	
*	TotalMas	NUM	Total milliamps used during the procedure

History

20/09/17	SCD	Added National People Code for Operator, Localisation Mammographer and Pathologist

GpDetails

Contains GP and GP Practice information.

K	Field	Format	Description
K	GpAuthority	C(3)	Link to Authority
K	GpCode	C(6)	
	GpFullCode	C(10)	Format is AAA/GGGG where AAA is an authority code such as COV and GGGG is a number or combination of letters and numbers
	Active	YN	Y or N
	AuthorityAddressLine1	C(30)	
	AuthorityAddressLine2	C(30)	
	AuthorityAddressLine3	C(30)	
	AuthorityAddressLine4	C(20)	
	AuthorityAddressMemo	C(140)	
	AuthorityContact	C(30)	
	AuthorityLinkMedium	C(1)	One of the following codes (no code list): E = Electronic N = Network P = Paper
	AuthorityLinkMediumTxt	C(10)	
	AuthorityName	C(40)	
	AuthorityPostcode	C(9)	
	AuthorityRCN	YN	Y or N
	AuthorityTelephoneNumber	C(30)	
	Ccg	C(3)	A code from code list PCT. Specifies an England CCG (Clinical Commissioning Group), Wales LHB (Local Health Board), Northern Ireland LCG (Local Commissioning Group) or Isle of Man PHD (Primary Healthcare Directorate).
	CcgTxt	C(60)	
	GpAddressLine1	C(40)	
	GpAddressLine2	C(40)	
	GpAddressLine3	C(40)	
	GpAddressLine4	C(40)	
	GpAddressLine5	C(40)	
	GpAddressMemo	C(220)	
	GpDha	C(3)	A code from code list DHA
	GpDhaTxt	C(30)	
	GpEmail	C(40)	
	GpFax	C(30)	

K	Field	Format	Description
	GpForenames	C(22)	
	GpFullName	C(75)	GpSurname, GpForenames, GpTitle
	GpInitials	C(3)	
	GpPostcode	C(8)	
	GpSurname	C(40)	
	GpTelephoneNumber	C(30)	
	GpTitle	C(10)	
	PracticeAddressLine1	C(40)	
	PracticeAddressLine2	C(40)	
	PracticeAddressLine3	C(40)	
	PracticeAddressLine4	C(40)	
	PracticeAddressLine5	C(40)	
	PracticeAddressMemo	C(220)	
	PracticeCode	C(6)	Practice Code is “0” for “Unattached” GPs
	PracticeEmail	C(40)	
	PracticeFax	C(30)	
	PracticeName	C(40)	
	PracticePostcode	C(20)	
	PracticeTelephone	C(30)	

History

23/04/09	ADG	Added GpAddressLine5, GpFax, GpEmail, PracticeAddressLine5, PracticeFax, PracticeEmail. Changed PracticeName, GpAddressLines and PracticeAddressLines field length from 30 to 40, PracticeAddressMemo from 120 to 220 and GPAddressMemo from 200 to 220.
07/05/15	JKO	Replaced Pct with Ccg and added to description. Replaced PctTxt with CcgTxt and increased its length from 30 to 60.
14/10/15	JKO	Increased length of GpSurname from 20 to 40 and GpFullName from 50 to 75

History

Contains historical side-dependent information.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	HistoryRecordId	NUM	Internal Record ID
	AgeAtEndOfFTEducation	C(2)	No longer used. The "Ages" are usually numbers but some BSS databases contain non-numeric values such as "N" or "U"
	AgeAtFirstBirth	C(2)	No longer used.
	AgeAtMenarche	C(2)	No longer used.
	AgeOfMother	C(2)	No longer used.
	AgesOfSisters	C(11)	No longer used.
	Comments	C(133)	Comment lines 1 and 2 with a space between
	DateBcaDiagnosed	DATE	
	EthnicOrigin	C(2)	A code from code list ETH2001
	EthnicOriginTxt	C(60)	
	EthnicOriginOld	C(2)	No longer used. A code from code list ETHOLD
	EthnicOriginOldTxt	C(20)	No longer used.
	FamilyHistoryOfBca	YN	No longer used.
	NoOfLiveBirths	NUM	No longer used.
	TypeOfAccommodation	C(2)	No longer used. A code from code list ACC
	TypeOfAccommodationTxt	C(15)	No longer used.
*	SideCode	C(1)	R for right or L for left
*	CystAspiration	C(19)	Previous cyst aspiration
*	ExcisionOfBenignLump	C(19)	Previous excision of benign lump
*	HistoryOfBreastDisease	C(1)	A code from code list PRE (Present, Yes or No, pg 130)
*	HistoryOfBreastDiseaseTxt	C(11)	
*	MastectomyForBca	C(4)	
*	OtherBreastSurgery	YN	
*	OtherSurgeryForBca	C(19)	
*	RadiotherapyForBca	C(4)	

ImagingDS

Contains imaging assessment diagnostic set information.

K	Field	Format	Description
K	SxNumber→	NUM	Link to Client
K	ImagingDSRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Comments	C(133)	Comment lines 1 and 2 with a space between
	DiagnosticSetOutcome	C(4)	
	EventType	C(3)	Always “ASS”
	LeftOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	LeftOpinionTxt	C(16)	
	OverallAction	C(2)	A code from code list ACT: Action (pg 122)
	OverallActionTxt	C(16)	
	OverallDate	DATE	
	Responsibility	C(4)	A code from code list PEPL
	ResponsibilityNational	C(8)	National People Code
	ResponsibilityTxt	C(25)	
	RightOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	RightOpinionTxt	C(16)	

History

13/04/07	JKO	Renamed, was ImagingAssessmentDS. ImagingAssessmentRecordId changed to ImagingDSRecordId Dropped Clinic, ReasonForClinic, ReasonForClinicTxt, WeeksInterval (obsolete)
20/09/17	SCD	Added National People Code for Responsibility

ImagingProcedure

Contains imaging assessment procedure and lesion information for mammograms and ultrasound. A procedure with no lesion records has nulls in LesionId, SideCode etc.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	ImagingProcedureRecordId	NUM	Internal Record ID
	ImagingDSRecordId →	NUM	Link to ImagingDS when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Clinicians	C(14)	Who is responsible for the overall imaging opinion. A list of PEPL codes separated by spaces.
	CliniciansNational	C(50)	List of National People codes separated by spaces. A minus "-" appears in place of a national code if there is no national code assigned to a local person code.
	CliniciansTxt	C(500)	
	DatePerformed	DATE	
	LeftAxillaOpinion	C(1)	A code from code list AXOPN: A = Abnormal N = Normal X = Not Assessed
	LeftAxillaOpinionTxt	C(12)	
	LeftSideAssessed	YN	
	Location	C(5)	A code from code list LOC
	LocationTxt	C(25)	
	RightAxillaOpinion	C(1)	See LeftAxillaOpinion
	RightAxillaOpinionTxt	C(12)	
	RightSideAssessed	YN	
	TimeOrder	NUM	See *TimeOrder*, page 121
*	LesionId →	NUM	Link to Lesion when used with SxNumber and EpisodeRecordId. This is null if the procedure has no lesion records.
*	SideCode	C(1)	R for right or L for left
*	Mammo	YN	Y if the lesion procedure includes mammography
*	MammoAdditionalViews	YN	
*	MammoAttributes	C(11)	List of codes separated by spaces. Values (from code list MAMFT): AD = Architectural Deformity AS = Asymmetry LY = Lymphoedema ST = Skin Thickening

*	MammoCalcification	C(1)	A code from code list CALCM: B = Benign C = Casting G = Granular N = None P = Punctate X = Other
*	MammoCalcificationTxt	C(12)	
*	MammoClinicians	C(14)	Who is responsible for the mammography opinion. A list of PEPL codes separated by spaces.
*	MammoCliniciansNat	C(50)	List of National People codes separated by spaces. A minus "-" appears in place of a national code if there is no national code assigned to a local person code.
*	MammoCliniciansTxt	C(500)	
*	MammoFocus	C(1)	A code from code list MASFOC: M = Multiple S = Single U = Uncertain
*	MammoFocusTxt	C(12)	
*	MammoMass	C(1)	A code from code list MASSM: I = Ill Defined N = None S = Spiculate W = Well Defined X = Other
*	MammoMassTxt	C(30)	
*	MammoOpinion	C(2)	A code (R1-R5) from code list OPINION (Opinion after a procedure, pg 128)
*	MammoOpinionTxt	C(25)	
*	MammoPossibleLymphNode	YN	
*	MammoSizeMm	NUM	
*	MammoSizeMm90	NUM	
*	MammoSizeProduct	NUM	MammoSizeMm x MammoSizeMm90
*	Opinion	C(2)	A code (I1-I5) from code list OPINION (Opinion after a procedure, pg 128)
*	OpinionTxt	C(25)	
*	PreviousOpinions	C(20)	
*	Uss	YN	Y if the lesion procedure includes ultrasound
*	UssAttributes	C(5)	List of codes separated by spaces. Values (from code list USSFT): CA = Calcification DA = Diffuse Abnormality
*	UssClinicians	C(14)	Who is responsible for the ultrasound opinion. A list of PEPL codes separated by spaces.

	UssCliniciansNat	C(50)	List of National People codes separated by spaces. A minus "-" appears in place of a national code if there is no national code assigned to a local person code.
*	UssCliniciansTxt	C(500)	
*	UssCyst	YN	
*	UssFocus	C(1)	A code from the same list as MammoFocus
*	UssFocusTxt	C(12)	
*	UssMass	C(1)	A code from code list MASSU: C = Cystic/Solid E = Echogenic I = Irregular N = None W = Well Defined X = Other
*	UssMassTxt	C(30)	
*	UssOpinion	C(2)	A code (U1-U5) from code list OPINION (Opinion after a procedure, pg 128)
*	UssOpinionTxt	C(25)	
*	UssPossibleLymphNode	YN	
*	UssSizeMm	NUM	
*	WorstLesion	YN	See *WorstLesion*, page 121

History

13/04/07	JKO	Created to replace AssessmentFilmProcedure and UltrasoundProcedure
24/10/07	JKO	Added MammoClinician, MammoClinicianTxt, UssClinician, UssClinicianTxt
16/11/11	GSK	Replaced {Side}AxillaNormal with {Side}AxillaOpinion (SC0139)
15/05/12	GSK	Replaced Clinician/MamClinician/UssClinician with Clinicians/MamClinicians/UssClinicians (SC0156)
20/09/17	SCD	Added National People Code Lists for Clinicians, MammoClinicians and USSClinicians
09/01/19	JKO	Renamed column MammoLymphNode as MammoPossibleLymphNode and column UssLymphNode as UssPossibleLymphNode

IntervalCancerScrFilmReview

Contains interval cancer screening film review procedure and lesion information. A procedure with no lesion records has nulls in LesionId, SideCode etc.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	IntScrFilmRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	BreastDensity	C(1)	A code from code list BRDEN: D = Dense F = Fatty M = Mixed
	BreastDensityTxt	C(12)	
	ClinicalSymptoms	C(1)	A code from code list PRE: N = No U = Unknown Y = Yes
	ClinicalSymptomsTxt	C(12)	
	DateReviewed	DATE	Date the screening mammogram review took place.
	LeftSideAssessed	YN	
	PreviousAssessment	YN	Y if the lesion that became cancer was identifed at previous screening and caused the woman to be recalled for assessment.
	RightSideAssessed	YN	
	TimeOrder	NUM	See *TimeOrder*, page 121
*	LesionId →	NUM	Link to Lesion when used with SxNumber and EpisodeRecordId. This is null if the procedure has no lesion records.
*	SideCode	C(1)	R for right or L for left
*	Mammo	YN	Y if the lesion procedure includes mammography
*	MammoAttributes	C(11)	List of codes separated by spaces. Values (from code list MAMFT): AD = Architectural Deformity AS = Asymmetry LY = Lymphoedema ST = Skin Thickening
*	MammoCalcification	C(1)	A code from code list CALCM: B = Benign C = Casting G = Granular N = None P = Punctate X = Other

*	MammoCalcificationTxt	C(12)	
*	MammoMass	C(1)	A code from code list MASSM: I = Ill Defined N = None S = Spiculate W = Well Defined X = Other
*	MammoMassTxt	C(30)	
*	MammoPossibleLymphNode	YN	
*	WouldYouHaveRecalled	YN	

History

02/04/12	GSK	Created
09/01/19	JKO	Renamed MammoLymphNode as MammoPossibleLymphNode

IntervalCancerSymptomatic

Contains interval cancer symptomatic procedure and lesion information for mammogram and ultrasound. A procedure with no lesion records has nulls in LesionId, SideCode etc.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	IntSymptoRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	HospitalCode	C(6)	A code from code list HOSP
	HospitalCodeTxt	C(30)	
	HospitalNumber	C(11)	
	LeftAxillaOpinion	C(1)	A code from code list AXOPN: A = Abnormal N = Normal X = Not Assessed
	LeftAxillaOpinionTxt	C(12)	
	LeftSideAssessed	YN	
	Location	C(5)	A code from code list LOC
	LocationTxt	C(25)	
	RightAxillaOpinion	C(1)	See LeftAxillaOpinion
	RightAxillaOpinionTxt	C(12)	
	RightSideAssessed	YN	
	SymptomaticNumber	C(11)	
	TimeOrder	NUM	See *TimeOrder*, page 121
*	LesionId →	NUM	Link to Lesion when used with SxNumber and EpisodeRecordId. This is null if the procedure has no lesion records.
*	SideCode	C(1)	R for right or L for left
*	Mammo	YN	Y if the lesion procedure includes mammography
*	MammoAttributes	C(11)	List of codes separated by spaces. Values (from code list MAMFT): AD = Architectural Deformity AS = Asymmetry LY = Lymphoedema ST = Skin Thickening
*	MammoCalcification	C(1)	A code from code list CALCM: B = Benign C = Casting G = Granular N = None P = Punctate X = Other
*	MammoCalcificationTxt	C(12)	
*	MammoFocus	C(1)	A code from code list MASFOC:

			M = Multiple S = Single U = Uncertain
*	MammoFocusTxt	C(12)	
*	MammoMass	C(1)	A code from code list MASSM: I = Ill Defined N = None S = Spiculate W = Well Defined X = Other
*	MammoMassTxt	C(30)	
*	MammoOpinion	C(2)	A code (R1-R5) from code list OPINION (Opinion after a procedure, pg 128)
*	MammoOpinionTxt	C(25)	
*	MammoPossibleLymphNode	YN	
*	MammoSizeMm	NUM	
*	MammoSizeMm90	NUM	
*	MammoSizeProduct	NUM	MammoSizeMm x MammoSizeMm90
*	Opinion	C(2)	A code (I1-I5) from code list OPINION (Opinion after a procedure, pg 128)
*	OpinionTxt	C(25)	
*	PreviousOpinions	C(20)	
*	Uss	YN	Y if the lesion procedure includes ultrasound
*	UssAttributes	C(5)	List of codes separated by spaces. Values (from code list USSFT): CA = Calcification DA = Diffuse Abnormality
*	UssCyst	YN	
*	UssFocus	C(1)	A code from the same list as MammoFocus
*	UssFocusTxt	C(12)	
*	UssMass	C(1)	A code from code list MASSU: C = Cystic/Solid E = Echogenic I = Irregular N = None W = Well Defined X = Other
*	UssMassTxt	C(30)	
*	UssOpinion	C(2)	A code (U1-U5) from code list OPINION (Opinion after a procedure, pg 128)
*	UssOpinionTxt	C(25)	
*	UssPossibleLymphNode	YN	
*	UssSizeMm	NUM	
*	WorstLesion	YN	See *WorstLesion*, page 121

History

02/04/12	GSK	Created
09/01/19	JKO	Renamed column MammoLymphNode as MammoPossibleLymphNode and column UssLymphNode as UssPossibleLymphNode

Lesion

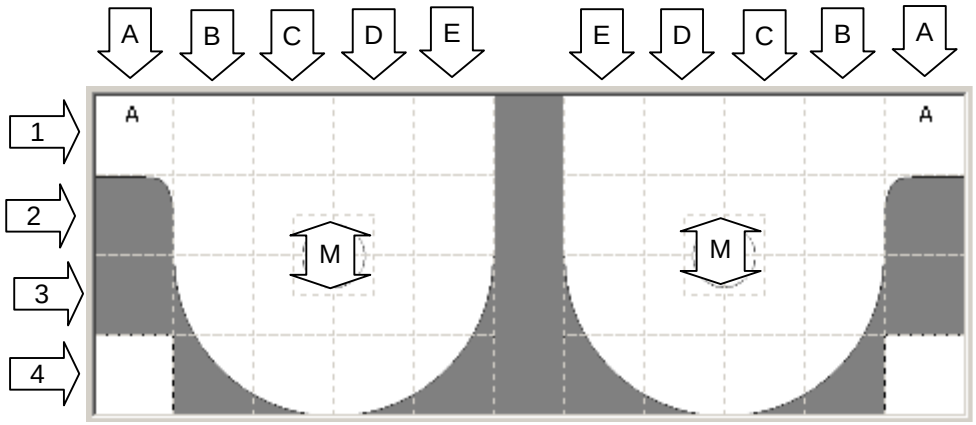
Contains general lesion information. The information applies across all procedures in the episode.

K	Field	Format	Description
K	SxNumber	NUM	Link to Client
K	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
K	LesionId	NUM	Lesion number in the episode (1, 2, 3…)
	CystAspirated	YN	
	CystAspiratedBy	C(4)	A code from code list PEPL
	CystAspiratedByNational	C(8)	National People Code
	CystAspiratedByTxt	C(27)	
	CystAspiratedDate	DATE	
	LesionDescription	C(30)	
	LesionDescriptionCode	C(2)	One of the following codes from code list LESDES, or null if the description is not a standard one: AS = Asymmetry CA = Calcification only CY = Cyst DS = Distortion LN = Lymph node MA = Mass MC = Mass with calcification NA = No significant abnormality ZZ = Clinical abnormality
	LesionDistanceFromNipple	NUM	Depth
	LesionNotes	C(4000)	Multiple lines
	LesionPosition	C(3)	A code indicating roughly where the lesion is – see **Table Notes**
	LesionType	C(2)	One of the following codes (from code list LESTYPE): BB = Breast Tissue LA = Axillary Lymph Node LO = Other Lymph Node
	LesionTypeTxt	C(20)	
	LocalisationNeeded	YN	
	LocalisationType	C(1)	One of the following codes (from code list LESLOCT): S = Skin Marker U = Ultrasound Guidance X = X-Ray Guidance
	LocalisationTypeTxt	C(30)	
	SideCode	C(1)	R for Right or L for Left
	SideText	C(5)	

	SiteIndicator	C(1)	One of the following codes (from code list LESSITE): M = Multiple S = Single
	SiteIndicatorTxt	C(10)	

Table Notes

1. LesionPosition is a code that is similar to a spreadsheet cell address. The columns are A to E and the rows are 1 to 4 with special address "M" for the middle cell (areola/nipple).



Examples:

RA1	Right axilla
LA1	Left axilla
RA4	Right bottom corner (position not specified)
LA4	Left bottom corner (position not specified)
RE1	Right upper inner cell
LE1	Left upper inner cell
RM	Right middle (areola/nipple)
LM	Left middle (areola/nipple)

History

13/04/07	JKO	Created for new Clinical Module
20/09/17	SCD	Added National People Code Lists for CystAspiratedBy
09/01/19	JKO	Added LesionType, LesionTypeTxt

Letter

Contains client letters.

K	Field	Format	Description
K	SxNumber	NUM	Link to Client
K	LetterRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber. Can be null. See **Table Notes** item 2.
	AppointmentClinicCode	C(5)	See **Table Notes** item 1.
	AppointmentDateOfClinic	DATE	See **Table Notes** item 1.
	AppointmentClinician	C(3)	See **Table Notes** item 1.
	AppointmentSessionCode	C(2)	See **Table Notes** item 1.
	AppointmentTimeslot →	C(6)	Links to Appointment when used with other fields. See **Table Notes** item 1.
	CreatedBy	C(12)	Operator's NBSS username
	CreatedByTxt	C(61)	Operator's full name
	DateCreated	DATE	
	DatePrinted	DATE	
	EpisodeIdStatus	C(30)	This classifies the EpisodeRecordId value. It can be: OK Missing Ambiguous {ID1/ID2…} See **Table Notes** item 2.
	LetterStatus	C(1)	One of the following codes (no code list): A = Awaiting Reprint D = Deleted P = Printed R = Re-Printed W = Waiting to be printed
	LetterStatusTxt	C(21)	
	LetterType	C(6)	A code such as ASSRR or BOOK.
	LetterTypeTxt	C(50)	
	LinkedLetter	C(99)	The legacy letter code or Crystal Reports template that was used to print the letter. Null if not printed.
	PreviousClinicCode	C(5)	See **Table Notes** item 1.
	PreviousDateOfClinic	DATE	See **Table Notes** item 1.
	PreviousClinician	C(3)	See **Table Notes** item 1.
	PreviousSessionCode	C(2)	See **Table Notes** item 1.
	PreviousTimeslot →	C(6)	Links to Appointment when used with other fields. See **Table Notes** item 1.
	PrintedBy	C(12)	Operator's NBSS username
	PrintedByTxt	C(61)	Operator's full name

Table Notes

1. Appointment and Previous Fields

   The SxNumber, EpisodeRecordId and "Appointment…" or "Previous…" fields can be used to link a letter to rows in the Appointment table.

   Appointment booking letters should have details of the booked appointment in the following fields, but these fields can be blank if the letter was created before an appointment was made.

   - AppointmentClinicCode
   - AppointmentDateOfClinic
   - AppointmentClinician
   - AppointmentSessionCode
   - AppointmentTimeslot

   Appointment booking letters created since NBSS release 9.05 can have details of the previous appointment in the following fields.

   - PreviousClinicCode
   - Previous DateOfClinic
   - PreviousClinician
   - PreviousSessionCode
   - PreviousTimeslot

   Letters that are not for appointment booking or rebooking, such as EPNA and RR letters, can have values in the "Appointment…" or "Previous…" fields or the values can be null.

2. EpisodeRecordId and EpisodeIdStatus

   The vast majority of letters are associated with a single episode. These letters have a value in EpisodeRecordId and an EpisodeIdStatus of "OK". A small number of letters are not associated with any episode or are associated with more than one overlapping episode. These letters have null in EpisodeRecordId and a value in EpisodeIdStatus that indicates why EpisodeRecordId is null. The following grid shows the possible values of EpisodeRecordId and EpisodeIdStatus and the situations that give rise to them.

EpisodeRecordId	EpisodeIdStatus	Situation
Valued	OK	Normal situation. The letter is for an appointment or has a DateCreated that falls in one episode's opened/closed dates.
Null	OK	The letter type is not for a particular episode (applies to letter types PROTO1, RCNGP and RCNHA)
Null	Missing	The letter should have an episode ID but it does not (eg. the letter's appointment has a blank EpisodeRecordId).
Null	Ambiguous ID1/ID2…	The letter is not for an appointment and DateCreated falls in more than one episode's opened/closed dates. ID1/ID2… are the possible EpisodeRecordId values separated by /.

History

02/01/13 JKO Created

MeetingDecision

Contains an MDM decision about the woman's assessment (MDM=**M**ulti-**D**isciplinary Team **M**eeting).

K	Field	Format	Description
K	SxNumber	NUM	Link to Client
K	MeetingDecisionRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Attendees	C(50)	A list of PEPL codes separated by spaces
	AttendeesNational	C(150)	List of National People codes separated by spaces. A minus "-" appears in place of a national code if there is no national code assigned to a local person code.
	AttendeesTxt	C(500)	
	DateOfMeeting	DATE	
	LeftSideAssessed	YN	
	MeetingNotes	C(4000)	Multiple lines
	OutcomeCategory	C(1)	A code (from code list MDMA): C = Discharge D = Further Diagnosis T = Treatment
	OutcomeCategoryTxt	C(20)	
	OutcomeSubcategory	C(41)	If OutcomeCategory is C (Discharge) this contains a code from the following list: EC = Short Term Recall RR = Routine Recall If OutcomeCategory is D (Further Diagnosis) this contains a code from the following list: AI = Additional Imaging DS = Diagnostic Surgery NB = Needle Biopsy VA = VAE If OutcomeCategory is T (Treatment) this contains a list of codes from code list MDMAT (MDM Action Treatment, pg 128) separated by spaces.
	OutcomeSubcategoryTxt	C(250)	
	Place	C(5)	A code from code list PLACE
	PlaceTxt	C(30)	
	RightSideAssessed	YN	
	TimeOrder	NUM	See *TimeOrder*, page 121

History

13/04/07	JKO	Created for new Clinical Module
20/09/17	SCD	Added National People Code Lists for Attendees
12/04/18	JKO	Added VA (VAE) to OutcomeSubcategory

Office

Contains information about the current screening office. Does not have any key fields.

K	Field	Format	Description
	Environment	C(20)	eg. NBSS_LIV
	OfficeAddressMemo	C(200)	Screening office address lines as a memo
	OfficeCode	C(3)	
	OfficeDHA	C(3)	
	OfficeName	C(15)	
	OfficePostcode	C(8)	
	OfficeTelephone1	C(32)	
	OfficeTelephone2	C(32)	
	OfficeTelephone3	C(32)	
	OfficeTitle	C(25)	

OtherImaging

Contains data from Other Imaging records.

K	Field	Format	Description
K	SxNumber	NUM	Link to Client
K	OtherImagingRecordId	NUM	Internal Record ID
	Comments	C(133)	Comment lines 1 and 2 with a space between
	DatePerformed	DATE	
	ImagingType	C(1)	One of the following codes (from code list LMT): N = Non-symptomatic S = Symptomatic U = type uncertain or unknown
	ImagingTypeTxt	C(30)	
	Location	C(1)	One of the following codes (from code list LML): A = Under another SO N = NHS but not a SO P = Private (but not at workplace) T = Under this SO W = Workplace
	LocationTxt	C(38)	
	Outcome	C(1)	One of the following codes (from code list LMOU): F = Further action taken N = No further action taken
	OutcomeTxt	C(30)	
	PIStatus	C(2)	One of the following codes (from code list PRVI): I = Incident P = Prevalent XI = X-Incident XP = X-Prevalent
	PIStatusTxt	C(15)	

History

09/11/07	JKO	Added field AccessionNumber for PACS
23/03/10	JKO	Table and fields renamed. Changed “Mammogram” to “Imaging”. Changed field PIStatusTxt so descriptions no longer have a space at the start.
01/03/11	JKO	Dropped field AccessionNumber for PACS Phase 2

OtherImagingPacsExam

Contains the PACS exams associated with a row in the OtherImaging table.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	OtherImagingRecordId →	NUM	Link to OtherImaging when used with SxNumber
K	AccessionNumber	C(16)	PACS examination ID
	ExamDate	DATE	
	ProcedureCode	C(6)	Code from list PEPR (PACS Exam Procedure, pg 130)
	ProcedureTxt	C(40)	Description from PEPR (PACS Exam Procedure, pg 130)
	ProcedureModalityType	C(2)	Modality from PEPR (PACS Exam Procedure, pg 130)
	ProcedureScreenOrAssess	C(1)	S/A code from PEPR (PACS Exam Procedure, pg 130): S = Screening A = Assessment

History

01/03/11 JKO Created for PACS Phase 2

ProcedureLesion

Combines important episode clinical procedure fields in a single record. The table only contains procedures that have lesions.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	RecordId →	NUM	Link to the XxxProcedure table when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	RecordType	C(6)	One of the following codes: AMR = Assessment MRI BT = Surgery CE = Clinical Findings FNA = Cytology (FNA) IMP = Imaging Assessment VAE = Histology (VAE) WBN = Histology (WBN)
*	LesionId →	NUM	Link to Lesion when used with SxNumber and EpisodeRecordId
*	SideCode	C(1)	R or L – from the Lesion record
*	ClinexamDatePerformed	DATE	ClinicalExamProcedure.DatePerformed
*	ClinexamOpinion	C(2)	ClinicalExamProcedure.Opinion
*	FnaCytologicalOpinion	C(2)	FnaProcedure.CytologicalOpinion
*	FnaDatePerformed	DATE	FnaProcedure.DatePerformed
*	ImagingDatePerformed	DATE	ImagingProcedure.DatePerformed
*	ImagingMammoOpinion	C(2)	ImagingProcedure.MammoOpinion
*	ImagingUssOpinion	C(2)	ImagingProcedure.UssOpinion
*	MriDatePerformed	DATE	AssessmentMri.DatePerformed
*	MriOpinion	C(4)	AssessmentMri.Opinion
*	SurgeryAxillaryNodesPositive	NUM	SurgeryProcedure.AxillaryNodesPositive
*	SurgeryAxillaryNodesPresent	YN	SurgeryProcedure.AxillaryNodesPresent
*	SurgeryAxillaryNodesTotal	NUM	SurgeryProcedure.AxillaryNodesTotal
*	SurgeryCancerOnKC62	YN	SurgeryProcedure.CancerOnKC62
*	SurgeryChemotherapy	YN	Surgery Procedure.Chemotherapy
*	SurgeryDatePerformed	DATE	SurgeryProcedure.DatePerformed
*	SurgeryDcisGradeTxt	C(15)	SurgeryProcedure.DcisGradeTxt
*	SurgeryDiagnosticProcedureTxt	C(30)	SurgeryProcedure.DiagnosticProcedureTxt
*	SurgeryDiseaseExtentTxt	C(25)	SurgeryProcedure.DiseaseExtentTxt
*	SurgeryDiseaseGradeTxt	C(14)	SurgeryProcedure.DiseaseGradeTxt
*	SurgeryHistologicalOpinion	C(2)	SurgeryProcedure.Opinion
*	SurgeryHormoneTherapy	YN	SurgeryProcedure.HormoneTherapy
*	SurgeryHospitalNumber	C(10)	SurgeryProcedure.HospitalNumber

K	Field	Format	Description
*	SurgeryInSituComponentsTxt	C(25)	SurgeryProcedure.InSituComponentsTxt
*	SurgeryInvasiveComponentsTxt	C(100)	SurgeryProcedure.InvasiveComponentsTxt
*	SurgeryInvasiveTypeTxt	C(20)	SurgeryProcedure.InvasiveTypeTxt
*	SurgeryMaxDiameterInvasiveCompo	NUM(1)	SurgeryProcedure.MaxDiameterInvasiveCompo
*	SurgeryMicroinvasionTxt	C(15)	SurgeryProcedure.MicroinvasionTxt
*	SurgeryRadiotherapyDateStarted	DATE	SurgeryProcedure.RadiotherapyDateStarted
*	SurgerySizeDuctalOnly	NUM(1)	SurgeryProcedure.SizeDuctalOnly
*	SurgerySurgeonTxt	C(27)	SurgeryProcedure.SurgeonTxt
*	SurgeryTreatmentProcedureTxt	C(45)	SurgeryProcedure.TreatmentProcedureTxt
*	SurgeryWholeSizeOfTumour	NUM(1)	SurgeryProcedure.WholeSizeOfTumour
*	VaeDatePerformed	DATE	VaeProcedure.DatePerformed
*	VaeHistologicalOpinion	C(2)	VaeProcedure.Opinion
*	WbnDatePerformed	DATE	WbnProcedure.DatePerformed
*	WbnHistologicalOpinion	C(2)	WbnProcedure.Opinion
*	WbnMalignancyType	C(1)	WbnProcedure.MalignancyType
*	WorstLesion	YN	See *WorstLesion*, page 121

Table Notes

1. A row contains the fields from one type of procedure and fields for other types are null (for example, fields for clinical examination, surgery etc are null if imaging fields are not null).

Sx Number	RecordId	Episode RecordId	Record Type	Lesion Id	Side Code	Clinexam Date Performed	Clinexam Opinion	Fna Cytological Opinion	Fna Date Performed	…
304	9978	9985	CE	1	R	20/10/1992	P5			
304	9975	9985	FNA	1	R			C5	20/10/1992	

2. The table only contains a subset of procedure fields. If you need more fields you may be able to use ProcedureSide (pg 80) instead.

3. The "DatePerformed" fields are often blank for records that were created before migration to the Windows-based NBSS.

History

30/06/05	JKO	Created as “EpisodeProcedure” at request of the Programme Board (document "CRS001 Running BASO reports from crystal in different datasources.doc").
13/04/07	JKO	Renamed (was “EpisodeProcedure”). Renamed many fields. Added SurgeryCancerOnKC62 and SurgeryHospitalNumber. Improved performance.
15/06/12	JKO	Dropped table BasoDownload. It is obsolete now there is a dedicated BASO data extraction function in NBSS.
04/12/12	JKO	Reinstated table BasoDownload as ProcedureLesion. Added MRI fields.
12/04/18	JKO	Added VAE to RecordType. Added VaeDatePerformed, VaeHistologicalOpinion

ProcedureSide

Contains a record for every clinical procedure side that was "assessed". It can be useful to advanced users creating reports that include several types of procedure.

K	Field	Format	Description
K	SxNumber →	NUM	
K	RecordId	NUM	Link to a procedure when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	DatePerformed	DATE	The date the procedure took place
	RecordType	C(6)	Values: AMR = ASS-MRI (AssessmentMri) BT = SURGERY (SurgeryProcedure) CE = CLINEXAM (ClinicalExamProcedure) FNA = FNA (FnaProcedure) IMP = IMAGING (ImagingProcedure) INTSCR = CI-REVIEW (IntervalCancerScrFilmReview) INTSYM = CI-SYMPTO (IntervalCancerSymptomatic) MDM = MDM (MeetingDecision) RVW = REV-ONLY (ReviewProcedure) SCREEN = SCR-FILM (ScreeningProcedure) SMR = SCR-MRI (ScreeningMri) SUS = SCR-USS (ScreeningUltrasound) VAE = VAE (VaeProcedure) WBN = WBN (WbnProcedure)
	RecordTypeTxt	C(10)	ASS-MRI , SURGERY etc.
*	SideCode	C(1)	R for right or L for left

Table Notes

1. Each record in the table has corresponding records in one of the other procedure tables such as SurgeryProcedure (RecordType BT) or ScreeningProcedure (RecordType SCREEN). ProcedureSide is linked to the corresponding procedures by matching on SxNumber, RecordId and SideCode. The ProcedureSide "RecordId" has to link to the equivalent ID in the procedure table (SurgeryProcedureRecordId, ScreeningMriRecordId etc). The ProcedureSide table is normally linked to a procedure table using a "left outer join". Figure 1 below shows the relationship between Episode, this table and the procedures.

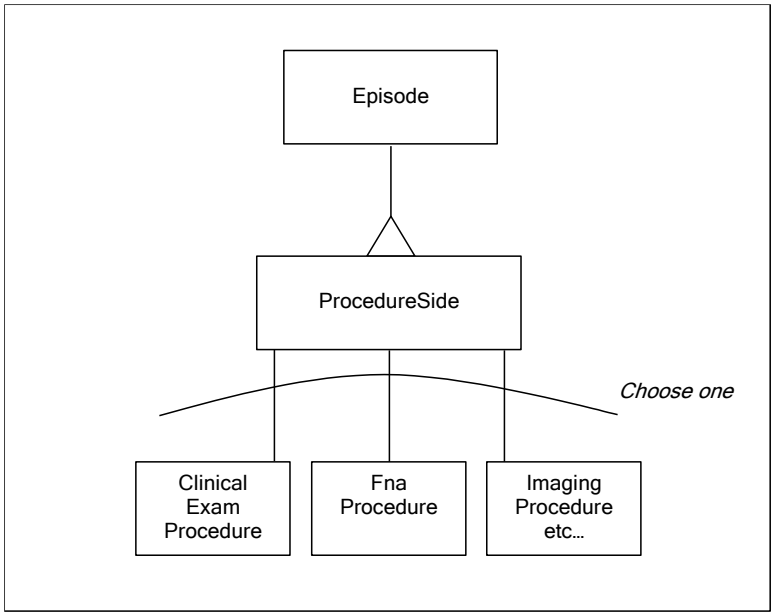
2. The table only includes procedures that have "Side Assessed" of "Yes", or for RVW and SCREEN, have ProcedureRequested "Yes" or ProcedureRequested of null but an opinion for the side.

3. **YOU MUST SPECIFY "DISTINCT" IF YOU CREATE A REPORT THAT LINKS THIS TABLE TO OTHER PROCEDURES**.

To do this in Crystal Reports 9, tick “Select Distinct Records” in the “Database” menu. In Microsoft Access, add DISTINCTROW to the SQL view of the query or change “Unique Records” to “Yes” in the query properties. If you do not do this, Caché will generate an error[1].

4. Reports that use this table will usually check the procedure type. The report should be a bit quicker if RecordType is used rather than RecordTypeTxt.

Figure 1: How ProcedureSide relates to episode procedures



- One row in the Episode table can have zero, one or more rows in the ProcedureSide table.
- Each ProcedureSide row has zero, one or more matching rows in a procedure table:

Table	Matching Rows
AssessmentMri	One per lesion
ClinicalExamProcedure	One per lesion
FnaProcedure	One per lesion
ImagingProcedure	One per lesion
IntervalCancerScrFilmReview	One per lesion
IntervalCancerSymptomatic	One per lesion
MeetingDecision	One per side assessed
ReviewProcedure	One per side assessed
ScreeningProcedure	One per side assessed
ScreeningMri	One per side assessed
ScreeningUltrasound	One per side assessed
SurgeryProcedure	One per lesion
VaeProcedure	One per lesion
WbnProcedure	One per lesion

History

04/12/12	JKO	Added CI-REVIEW and CI-SYMPTO record types
12/04/18	JKO	Added VAE

[1] Technical Note: The error occurs in Caché 5.0.2 when left joining to a column that is calculated in a view - it may be fixed in a later version. The error can be avoided by adding “DISTINCT” to the SELECT statement of the ProcedureSide view itself but this greatly increases the time required to run queries based on the view.

ReasonForAssessmentAnalysis

This table is to allow the comparison of the reasons for recall to assessment identified on film reading with the assessment procedures subsequently performed.

K	Field	Format	Description
K	SxNumber →	NUM	
K	ScreeningProcedureRecordId →	NUM	Link to ScreeningProcedure when used with SxNumber
K	SideCode	C(1)	R for right or L for left
K	ReasonForAssessment	C(6)	One of the following codes: ARCDIS = Architectural Distortion ASYMD = Asymmetric Density CALCS = Microcalcification Outside a Mass CLABN = Clinical Abnormality LYMABN = Lymph Node Abnormality MILL = Mass Ill Defined (+/-calc.) MWELL = Mass Well Defined (+/-calc.)
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	AssessmentMRIPerformed	YN	Y if any AssessmentMri has SideAssessed Y
	AssessmentMammoPerformed	YN	Y if Mammo is Y in any ImagingProcedure
	AssessmentUssPerformed	YN	Y if.Uss is Y in any ImagingProcedure
	ClinicalExamPerformed	YN	Y if any ClinicalExamProcedure has SideAssessed Y
	FNALocalisedByMRI	YN	Y if any FnaProcedure has LocalisationType N
	FNALocalisedByPalpation	YN	Y if any FnaProcedure has LocalisationType P
	FNALocalisedByProneStereo	YN	Y if any FnaProcedure has LocalisationType R
	FNALocalisedByStereo	YN	Y if any FnaProcedure has LocalisationType S
	FNALocalisedByUltrasound	YN	Y if any FnaProcedure has LocalisationType U
	FNALocalisedByXRay	YN	Y if any FnaProcedure has LocalisationType X
	FNAPerformed	YN	Y if any FnaProcedure has SideAssessed Y
	VAELocalisedByMRI	YN	Y if any VaeProcedure has LocalisationType N
	VAELocalisedByPalpation	YN	Y if any VaeProcedure has LocalisationType P
	VAELocalisedByProneStereo	YN	Y if any VaeProcedure has LocalisationType R
	VAELocalisedByStereo	YN	Y if any VaeProcedure has LocalisationType S
	VAELocalisedByUltrasound	YN	Y if any VaeProcedure has LocalisationType U
	VAELocalisedByXRay	YN	Y if any VaeProcedure has LocalisationType X
	VAEPerformed	YN	Y if any VaeProcedure has SideAssessed Y
	WBNLocalisedByMRI	YN	Y if any WbnProcedure has LocalisationType N
	WBNLocalisedByPalpation	YN	Y if any WbnProcedure has LocalisationType P
	WBNLocalisedByProneStereo	YN	Y if any WbnProcedure has LocalisationType R
	WBNLocalisedByStereo	YN	Y if any WbnProcedure has LocalisationType S
	WBNLocalisedByUltrasound	YN	Y if any WbnProcedure has LocalisationType U

K	Field	Format	Description
	WBNLocalisedByXRay	YN	Y if any WbnProcedure has LocalisationType X
	WBNPerformed	YN	Y if any WbnProcedure has SideAssessed Y

Table Notes

1. The table contains a row for every "reason for assessment" that film readers have ticked if:

   - The screening film is in an episode that is closed
   - The episode is not an interval cancer or an episode with episode character "X"
   - The screening film has action "RC" (Recall to Assessment) or "FV" (Further Views) [2].
   - The screening film overall opinion for the side is Abnormal or Clinical

2. The Y/N values are determined by the episode's procedures and lesions for the side. The same Y/N values apear for each ReasonForAssessment with the same combination of SxNumber, ScreeningProcedureRecordId and SideCode.

History

08/03/19	JKO	Table created after introduction of film reader categorisation of reason for recall

[2] If an episode has more than one screening film with action "RC" or "FV", only the most recent screening film is included in the table

ReferrerDetails

Contains referring clinician and referring service information.

K	Field	Format	Description
K	ReferringClinician	C(8)	Referring clinician code
	ReferrerActive	YN	Y or N
	ReferrerAddressLine1	C(40)	
	ReferrerAddressLine2	C(40)	
	ReferrerAddressLine3	C(40)	
	ReferrerAddressLine4	C(40)	
	ReferrerAddressLine5	C(40)	
	ReferrerAddressMemo	C(250)	Address Lines 1 to 5 and Postcode
	ReferrerEmail	C(40)	
	ReferrerFax	C(30)	
	ReferrerName	C(40)	
	ReferrerPostcode	C(8)	
	ReferrerTelephone	C(30)	
	ReferringService	C(8)	Referring service code
	ServiceActive	YN	Y or N
	ServiceAddressLine1	C(40)	
	ServiceAddressLine2	C(40)	
	ServiceAddressLine3	C(40)	
	ServiceAddressLine4	C(40)	
	ServiceAddressLine5	C(40)	
	ServiceAddressMemo	C(250)	Address Lines 1 to 5 and Postcode
	ServiceEmail	C(40)	
	ServiceFax	C(30)	
	ServiceName	C(40)	
	ServicePostcode	C(8)	
	ServiceTelephone	C(30)	

History

23/03/10 JKO Table created for Higher Risk Screening

RegistrationChange

Contains information relating to any registration changes that have been made to the client.

K	Field	Format	Description
K	SxNumber	NUM	Link to Client
K	RecordId	NUM	Internal Record ID
	ChangedItem	C(20)	
	ChangerInitials	C(12)	
	DateChanged	DATE	
	DateFpcGpNotified	DATE	
	NewValue	C(78)	
	OldValue	C(78)	
	RejectedValue	C(78)	
	SourceOfRejectedValue	C(20)	

ReverseReadingTrial

This table is used to extract data for the Reverse Reading Trial. The table is documented in NBSS functional specification “FS4172 Reverse Reading Trial”.

History

13/09/12	JKO	Added for Reverse Reading Trial

ReviewDS

Contains assessment review diagnostic set information.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	ReviewDSRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Comments	C(133)	Comment lines 1 and 2 with a space between
	DiagnosticSetOutcome	C(4)	
	EventType	C(3)	Always “ASS”
	LeftOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	LeftOpinionTxt	C(16)	
	OverallAction	C(2)	A code from code list ACT: Action (pg 122)
	OverallActionTxt	C(16)	
	OverallDate	DATE	
	Responsibility	C(4)	A code from code list PEPL
	ResponsibilityNational	C(8)	National People Code
	ResponsibilityTxt	C(25)	
	RightOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	RightOpinionTxt	C(16)	

History

13/04/07	JKO	Renamed (was “AssessmentReviewDS”) Dropped Clinic, ReasonForClinic, ReasonForClinicTxt, WeeksInterval (obsolete)
20/09/17	SCD	Added National People Code for Responsibility

ReviewProcedure

Contains assessment review side-dependent information.

K	Field	Format	Description
K	SxNumber→	NUM	Link to Client
K	ReviewProcedureRecordId	NUM	Internal Record ID
	ReviewDSRecordId →	NUM	Link to ReviewDS when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	DateOfReview	DATE	
	DatePerformed	DATE	
	Location	C(5)	
	LocationTxt	C(25)	A code from code list LOC
	ResponsibilityForOpinion	C(4)	A code from code list PEPL
	ResponsibilityForOpinionNat	C(8)	National People Code
	ResponsibilityForOpinionTxt	C(25)	
	ReviewComments	C(133)	Review comment lines 1 and 2 with a space between
*	SideCode	C(1)	R for right or L for left
*	Opinion	C(2)	A code (A1-A5) from code list OPINION (Opinion after a procedure, pg 128)
*	OpinionTxt	C(16)	
*	ProcedureRequested	YN	

History

13/04/07	JKO	Renamed (was “AssessmentReviewProcedure”) and dropped obsolete fields
20/09/17	SCD	Added National People Code for ResponsibilityForOpinion

ScreeningDS

Contains screening mammogram diagnostic set information.

K	Field	Format	Description
K	SxNumber→	NUM	Link to Client
K	ScreeningDSRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Comments	C(133)	Comment lines 1 and 2 with a space between
	DiagnosticSetOutcome	C(4)	
	EventType	C(3)	Always “SCR”
	LeftOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	LeftOpinionTxt	C(16)	
	OverallAction	C(2)	A code from code list ACT: Action (pg 122)
	OverallActionTxt	C(16)	
	OverallDate	DATE	By default, this is the latest DateReported of all ScreeningProcedure records in the diagnostic set’s episode that do not have FinalAction “TR”. Users can override this default if necessary.
	Responsibility	C(4)	A code from code list PEPL
	ResponsibilityNational	C(8)	National People Code
	ResponsibilityTxt	C(25)	
	RightOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	RightOpinionTxt	C(16)	

History

13/04/07	JKO	Dropped Clinic, ReasonForClinic, ReasonForClinicTxt, WeeksInterval (obsolete). Renamed field ScreeningRecordId as ScreeningDSRecordId.
20/09/17	SCD	Added National People Code for Responsibility
30/03/20	JKO	Added a description for OverallDate

ScreeningMri

Contains screening MRI side-dependent information.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	ScreeningMriRecordId	NUM	Internal Record ID
	ScreeningDSRecordId →	NUM	Link to ScreeningDS when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	AppointmentComment	C(80)	See **Table Notes** item 1
	AppointmentDate	DATE	
	AppointmentStatus	C(2)	A code from code list MRST: A = Attended B = Booked NA = Not Attended NS = Attended Not Screened XC = Cancelled by Client XS = Cancelled by Screening Office
	AppointmentStatusTxt	C(30)	
	AppointmentTime	TIME	
	DateReported	DATE	
	DateTaken	DATE	
	EquipmentUsed	C(5)	Equipment code from SACMN
	EquipmentUsedTxt	C(40)	Description from SACMN
	EquipmentMakeModel	C(50)	Manufacturer and Model
	EquipmentType		Analogue or Digital
	FinalAction	C(2)	The overall action. A code from code list ACT: Action (pg 122)
	FinalActionTxt	C(16)	
	FinalActionInterval	NUM	Days between DateTaken and DateReported (0 if same day).
	Finalised	YN	
	HospitalCode	C(6)	A code from code list HOSP
	HospitalCodeTxt	C(30)	
	HospitalNumber	C(11)	
	Location	C(5)	A code from code list LOC
	LocationTxt	C(25)	
	Notes	C(80)	
	Reader1	C(4)	First entry in Readers
	Reader1National	C(8)	National People Code
	Reader1Action	C(2)	First entry in RecommendedActions
	Reader1DateReported	DATE	

K	Field	Format	Description
	Reader2	C(4)	Second entry in Readers
	Reader2National	C(8)	National People Code
	Reader2Action	C(2)	Second entry in RecommendedActions
	Reader2DateReported	DATE	
	Readers	C(25)	List of clinician codes separated by spaces, one per reader. Values from code list PEPL.
	ReadersTxt	C(100)	Names of Readers
	ReadersNational	C(75)	List of National People Codes separated by Commas
	Reason	C(2)	One of the following codes (from code list RFF): S1 = Initial Screen (this episode) TC = Technical Recall
	ReasonTxt	C(30)	
	RecommendedActions	C(25)	A list of codes separated by spaces, one per reader. Values from ACT: Action (pg 122).
	RecommendedActionsTxt	C(160)	Descriptions for RecommendedActions. Only lists unique values.
	ResponsibilityForOpinion	C(4)	Clinician responsible for the FinalAction. A code from code list PEPL
	ResponsibilityForOpinionNat	C(8)	National People Code
	ResponsibilityForOpinionTxt	C(25)	
*	SideCode	C(1)	R for right or L for left
*	ClinicalFindingsCode	C(2)	See ReaderAlertCode in CurrentRecord
*	ClinicalFindingsMessage	C(80)	Standard or custom alert text
*	Opinion	C(2)	Overall opinion for the side. One of the following codes: BA = Clinical RO = Unreported RU = Abnormal RN = Normal blank = X (not applicable) These are the same as the codes used to record opinions in table ScreeningProcedure
*	OpinionTxt	C(16)	
*	ProcedureRequested	YN	Always Y for MRI
*	Reader1Opinion	C(1)	Opinion code as entered (A=Abnormal, N=Normal, C=Clinical, T=Tech Recall, X=Not applicable)
*	Reader2Opinion	C(1)	
*	ReaderOpinions	C(9)	Consolidated list of opinion codes as entered
*	ReaderOpinionsTxt	C(100)	Consolidated list of opinion descriptions

K	Field	Format	Description
*	RepeatReason	C(3)	A code from code list MRIRR (MRI Repeat Reason, pg 128)
*	RepeatReasonTxt	C(30)	

Table Notes

1. Appointment Columns

   Columns named "Appointment…" show values from the Screening MRI appointment that is status Booked or Attended, if there is one. If there is no Booked or Attended appointment, the columns show values from the most recent appointment with an AppointmentDate of today or earlier. A Screening MRI can only have one appointment with status Booked or Attended.

History

23/03/10	JKO	Table created for Higher Risk Screening
23/02/12	ADG	Added EquipmentMakeModel and EquipmentType
20/09/17	SCD	Added National People Code for Readers and ResponsibilityForOpinion
30/04/18	JKO	Added Reader1DateReported, Reader2DateReported, Reason, ReasonTxt, RepeatReason and RepeatReasonTxt. Renamed existing fields to match NBSS Screening MRI record maintenance in SS/SIP: AppointmentNote became Notes, Status became AppointmentStatus, StatusTxt became AppointmentStatusTxt and StatusComment became AppointmentComment. Updated descriptions of fields AppointmentStatus, Finalised, Opinion and Reader1Opinion. Added Table Notes 1 explaining which appointment is reported in fields named "Appointment…".

ScreeningProcedure

Contains screening film side-dependent information.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	ScreeningProcedureRecordId	NUM	Internal Record ID
	ScreeningDSRecordId →	NUM	Link to ScreeningDS when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	AgeAtScreening	NUM	Age at the time of the procedure
	AssessmentComment	C(150)	Film readers' comments about why client needs assessment
	Comment	C(66)	
	DateReported	DATE	
	DateTaken	DATE	
	EquipmentUsed	C(5)	Equipment code from SACMM
	EquipmentUsedTxt	C(40)	Description from SACMM
	EquipmentMakeModel	C(50)	Manufacturer and Model
	EquipmentType		Analogue or Digital
	FilmReaders	C(25)	List of codes separated by spaces, one per film reader. Values from code list PEPL.
	FilmReadersTxt	C(100)	Names of FilmReaders
	FilmReadersNational	C(75)	List of National People Codes separated by commas
	FilmReader1	C(4)	First entry in FilmReaders
	FilmReader1National	C(8)	National People Code
	FilmReader1Interval	NUM	Days between DateTaken and film reading (0 if same day). Only known if FinalActionSource is "A" or "D".
	FilmReader1RecAction	C(2)	First entry in FilmRecommendedActions
	FilmReader1ResultNumber	C(1)	"T" if the reader was a trainee; a number if they were not. See **Table Notes** item 1.
	FilmReader2	C(4)	Second entry in FilmReaders
	FilmReader2National	C(8)	National People Code
	FilmReader2Interval	NUM	As FilmReader1Interval
	FilmReader2RecAction	C(2)	Second entry in FilmRecommendedActions
	FilmReader2ResultNumber	C(1)	"T" if the reader was a trainee; a number if they were not. See **Table Notes** item 1.
	FilmReader3	C(4)	Third entry in FilmReaders
	FilmReader3National	C(8)	National People Code
	FilmReader3Interval	NUM	As FilmReader1Interval

K	Field	Format	Description
	FilmReader3RecAction	C(2)	Third entry in FilmRecommendedActions
	FilmReader3ResultNumber	C(1)	"T" if the reader was a trainee; a number if they were not. See **Table Notes** item 1.
	FilmReader4	C(4)	Fourth entry in FilmReaders
	FilmReader4National	C(8)	National People Code
	FilmReader4Interval	NUM	As FilmReader1Interval
	FilmReader4RecAction	C(2)	Fourth entry in FilmRecommendedActions
	FilmReader4ResultNumber	C(1)	"T" if the reader was a trainee; a number if they were not. See **Table Notes** item 1.
	FilmReader5	C(4)	Fifth entry in FilmReaders
	FilmReader5National	C(8)	National People Code
	FilmReader5Interval	NUM	As FilmReader1Interval
	FilmReader5RecAction	C(2)	Fifth entry in FilmRecommendedActions
	FilmReader5ResultNumber	C(1)	"T" if the reader was a trainee; a number if they were not. See **Table Notes** item 1.
	FilmRecommendedActions	C(25)	A list of codes separated by spaces, one per film reader. Values from code list ACT: Action (pg 122).
	FilmRecommendedActionsTxt	C(160)	Descriptions for FilmRecommendedActions. Only lists unique values.
	FinalAction	C(2)	A code from code list ACT: Action (pg 122)
	FinalActionTxt	C(16)	
	FinalActionInterval	NUM	Days between DateTaken and DateReported (0 if same day). Known if FinalActionSource is "A", "D" or "P"
	FinalActionSource	C(1)	How final action was updated: Null if no final action, "A" if automatic arbitration, "D" if direct (human arbitration), "P" if entered from paper
	FinalActionSourceTxt	C(9)	Null, "Automatic", "Direct" or "Paper"
	Finalised	YN	Y if film finalised, N if not
	Location	C(5)	A code from code list LOC
	LocationTxt	C(25)	
	Mammographer	C(4)	A code from code list PEPL
	MammographerNat	C(8)	National People Code
	MammographerTxt	C(25)	
	NoMoreReaders	YN	Y if film reader has indicated there will be no more film readers for this film record (because the film has been unloaded from the viewer). N if expect all readers to give an opinion.

K	Field	Format	Description
	PendingPriors	YN	Y if film reading was delayed by the need to retrieve prior images, N if not delayed.
	PendingPriorsDate	DATE	The date the film was flagged as pending priors. Null if PendingPriors is N.
	PendingPriorsReader	C(4)	A film reader code from code list PEPL that identifies the film reader who flagged the film as pending priors. Null if PendingPriors is N.
	Reason	C(2)	One of the following codes (from code list RFF): AS = Post screen assessment S1 = Initial Screen (this episode) TC = Technical Recall TP = Technical Repeat TR = Repeat Film (technical) X = Other; specify in comment area
	ReasonTxt	C(30)	
	ResponsibilityForOpinion	C(4)	A code from code list PEPL
	ResponsibilityForOpinionNat	C(8)	National People Code
	ResponsibilityForOpinionTxt	C(25)	
	ResultComments	C(133)	Result comment lines 1 and 2 with a space between
*	SideCode	C(1)	R for right or L for left
*	AnySignificantFindings	YN	
*	Appearance	C(7)	A list of codes separated by spaces. One of the following codes (from code list MICAPP): B = Benign C = Casting I = Irregular/coral-shaped L = Linear P = Punctate R = Ring(s)/periductal V = Variable (polymorph/polydense) X = Other Y = Branching
*	AppearanceTxt	C(100)	
*	AssessForDistortion	YN	Y if side is abnormal or clinical and recall to assessment due to Architectural Distortion
*	AssessForAsymmetricDensity	YN	Y if side is abnormal or clinical and recall to assessment due to Asymmetric Density
*	AssessForClinicalAbnormality	YN	Y if side is abnormal or clinical and recall to assessment due to Clinical Abnormality
*	AssessForLymphNodeAbnormality	YN	Y if side is abnormal or clinical and recall to assessment due to Lymph Node Abnormality

K	Field	Format	Description
*	AssessForMassIllDefined	YN	Y if side is abnormal or clinical and recall to assessment due to Mass Ill Defined (+/- calc.)
*	AssessForMassWellDefined	YN	Y if side is abnormal or clinical and recall to assessment due to Mass Well Defined (+/- calc.)
*	AssessForMicrocalcifications	YN	Y if side is abnormal or clinical and recall to assessment due to Microcalcifications Outside a Mass
*	AsymmetricalDensity	C(1)	A code from code list PRE (Present, Yes or No, pg 130)
*	AsymmetricalDensityTxt	C(7)	
*	Density	C(1)	One of the following codes (from code list MASDEN): H = High I = Intermediate L = Low (fat)
*	DensityTxt	C(12)	
*	Distribution	C(1)	One of the following codes (from code list MICDIS): C = Cluster D = Diffuse L = Localised S = Segmental
*	DistributionTxt	C(10)	
*	FilmReader1Opinion	C(1)	Opinion code in SIRE/SIRO format (A=Abnormal, C=Clinical, N=Normal, T=Tech Recall, X=Not applicable)
*	FilmReader2Opinion	C(1)	
*	FilmReader3Opinion	C(1)	
*	FilmReader4Opinion	C(1)	
*	FilmReader5Opinion	C(1)	
*	FilmReaderOpinions	C(9)	Consolidated list of SIRE/SIRO opinion codes
*	FilmReaderOpinionsTxt	C(100)	Consolidated list of SIRE/SIRO opinion descriptions
*	Focus	C(1)	One of the following codes (from code list MASFOC): M = Multiple S = Single U = Uncertain
*	FocusTxt	C(12)	

K	Field	Format	Description
*	Halo	C(1)	One of the following codes (from code list MASHAL): C = Corona (malignant) N = Not present T = Thin
*	HaloTxt	C(12)	
*	Kv	NUM	
*	LesionAssessmentNotes	C(80)	Film reader notes for assessment
*	LesionDescription	C(30)	
*	LesionDescriptionCode	C(2)	One of the following codes from code list LESDES, or null if the description is not a standard one: AS = Asymmetry CA = Calcification only CY = Cyst DS = Distortion LN = Lymph node MA = Mass MC = Mass with calcification NA = No significant abnormality ZZ = Clinical abnormality
*	LesionPosition	C(3)	A code from code list BRSITE (Site Within Breast, pg 125)
*	LesionPositionTxt	C(25)	
*	Margin	C(3)	A list of codes separated by spaces. Values (from code list MASMAR): C = Spiculated I = Irregular L = Lobulated R = Regular S = Smooth U = Uncertain W = Well-defined
*	MarginTxt	C(30)	
*	Mass	C(1)	A code from code list PRE (Present, Yes or No, pg 130)
*	MassTxt	C(7)	
*	MicrocalcWithMass	YN	
*	Microcalcification	C(1)	A code from code list PRE (Present, Yes or No, pg 130)
*	MicrocalcificationTxt	C(7)	
*	NumberOfRepeats	NUM	Number of films that had to be repeated
*	Opinion	C(2)	A code (R1-R5 and others) from code list OPINION (Opinion after a procedure, pg 128)

K	Field	Format	Description
*	OpinionTxt	C(16)	
*	PathologicalNodes	YN	
*	ProcedureRequested	YN	Y or N
*	RepeatReason	C(3)	A code from code list RETAKE (Repeat Reason for Film, pg 131)
*	RepeatReasonTxt	C(25)	
*	SiteOfMass	C(3)	A code from code list BRSITE (Site Within Breast, pg 125)
*	SiteOfMassTxt	C(25)	
*	SiteOfMicrocalc	C(3)	A code from code list BRSITE (Site Within Breast, pg 125)
*	SiteOfMicrocalcTxt	C(25)	
*	SizeMm	NUM	
*	SkinChanges	YN	
*	StromalDeformity	C(1)	A code from code list PRE (Present, Yes or No, pg 130)
*	StromalDeformityTxt	C(7)	
*	TotalExposures	NUM	
*	TotalMas	NUM	Total milliamps used during the procedure
*	ViewsProcedures	C(24)	List of "View/Procedure" values separated by spaces (for example, "L L/M C/M"): One of the following codes (code list VIEW): C = Cranio-caudal D = Dutch oblique (for Nijmegen oblique) E = Extended cranio-caudal EK = Eklund L = Lateral M = Mastectomy N = None taken O = Standard oblique One of the following codes (code list VPROC): C = Coned down G = Grid M = Magnification
*	ViewsProceduresTxt	C(120)	

Table Notes

1. FilmReaderXResultNumber

   FilmReader1ResultNumber, FilmReader2ResultNumber etc contain "T" if the film reader was a trainee when they first reported the films. If the reader was not a trainee, the field contains a sequential result number. For example:

Event	FilmReaderXResultNumber	=
Qualified reader reports films	FilmReader1ResultNumber	1
Trainee reader reports films	FilmReader2ResultNumber	T
Qualified reader reports films	FilmReader3ResultNumber	2
Arbitration reader reports films	FilmReader4ResultNumber	3

2. Lesion fields

   LesionAssessmentNotes, LesionDescription, LesionDescriptionCode, LesionPosition and LesionPositionTxt are NULL at most screening offices. They are only populated at screening offices that piloted scope change SC0159 Reason for Recall to Assessment in 2014.

History

13/04/07	JKO	Renamed field ScreeningRecordId as ScreeningDSRecordId.
09/11/07	JKO	Added fields AccessionNumber and AccessionNumberSource for PACS
23/03/10	JKO	Dropped WeeksBetweenScreenings because (a) it was already unreliable and (b) it did not take account of MRI and ultrasound screening procedures. The table was renamed "ScreeningMammogram" as part of the Higher Risk changes but this was withdrawn on pilot because it required changes to too many reports.
01/03/11	JKO	Dropped AccessionNumber and AccessionNumberSource for PACS Phase 2
23/02/12	ADG	Added EquipmentMakeModel and EquipmentType
08/06/12	JKO	Added FilmReaderXResultNumber for trainee film readers
21/03/14	JKO	Added LesionAssessmentNotes, LesionDescription and LesionPosition
10/12/14	JKO	Added PendingPriors, PendingPriorsDate, PendingPriorsReader
23/03/16	ADG	Added Eklund view to ViewsProcedures
20/09/17	SCD	Added National People Codes for FilmReaders, Mammographer and ResponsibilityForOpinion
08/03/19	JKO	Added AssessmentComment, AssessForArchitecturalDistortion, AssessForAsymmetricDensity, AssessForClinicalAbnormality, AssessForLymphNodeAbnormality, AssessForMassIllDefined, AssessForMassWellDefined, AssessForMicrocalcifications

ScreeningUltrasound

Contains screening ultrasound side-dependent information.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	ScreeningUltrasoundRecordId	NUM	Internal Record ID
	ScreeningDSRecordId →	NUM	Link to ScreeningDS when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	DateReported	DATE	
	DateTaken	DATE	
	EquipmentUsed	C(5)	Equipment code from SACMU
	EquipmentUsedTxt	C(40)	Description from SACMU
	EquipmentMakeModel	C(50)	Manufacturer and Model
	EquipmentType	C(8)	Analogue or Digital
	FinalAction	C(2)	The overall action. A code from code list ACT: Action (pg 122)
	FinalActionTxt	C(16)	
	FinalActionInterval	NUM	Days between DateTaken and DateReported (0 if same day).
	Finalised	YN	Always Y for ultrasound
	Location	C(5)	A code from code list LOC
	LocationTxt	C(25)	
	ResponsibilityForOpinion	C(4)	Clinician responsible for the Opinion and FinalAction. A code from code list PEPL
	ResponsibilityForOpinionNat	C(8)	National People Code
	ResponsibilityForOpinionTxt	C(25)	
*	SideCode	C(1)	R for right or L for left
*	ClinicalFindingsCode	C(2)	See ReaderAlertCode in CurrentRecord
*	ClinicalFindingsMessage	C(80)	Standard or custom alert text
*	Opinion	C(2)	One of the following codes: BA = Clinical RU = Abnormal RN = Normal blank = X (not applicable) These are the same as the codes used to record opinions in table ScreeningProcedure
*	OpinionTxt	C(16)	
*	ProcedureRequested	YN	Always Y for ultrasound
*	ReaderOpinions	C(9)	Opinion code as entered (A=Abnormal, N=Normal, C=Clinical, X=Not applicable)
*	ReaderOpinionsTxt	C(100)	

History

23/03/10	JKO	Table created for Higher Risk Screening
23/02/12	ADG	Added EquipmentMakeModel and EquipmentType
20/09/17	SCD	Added National People Code for ResponsibilityForOpinion

Settings

Contains miscellaneous report settings.

K	Field	Format	Description
	Box0	C(1)	Wingdings character for empty tickbox (☐)
	Box1	C(1)	Wingdings character for filled tickbox (☑)
	Circle0	C(1)	Wingdings character for empty radio button (○)
	Circle1	C(1)	Wingdings character for filled radio button (⦿)

Table Notes

1. Box0, Box1, Circle0 and Circle1 mimic the widgets on data entry forms. If you include one of these in a report you need to change the font to “Wingdings” to see the widget.

History

13/04/07	JKO	Created for client forms

SurgeryDS

Contains surgery ("biopsy & treatment") diagnostic set information.

K	Field	Format	Description
K	SxNumber→	NUM	Link to Client
K	SurgeryDSRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Comments	C(133)	Comment lines 1 and 2 with a space between
	DiagnosticSetOutcome	C(4)	
	EventType	C(3)	"ASS" if only contains Diagnostic Surgery "PTR" if only contains Surgical Treatment "ASS PTR" if contains both
	LeftOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	LeftOpinionTxt	C(16)	
	OverallAction	C(2)	A code from code list ACT: Action (pg 122)
	OverallActionTxt	C(16)	
	OverallDate	DATE	
	Responsibility	C(4)	A code from code list PEPL
	ResponsibilityNational	C(8)	National People Code
	ResponsibilityTxt	C(25)	
	RightOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	RightOpinionTxt	C(16)	

History

13/04/07	JKO	Renamed (was "BiopsyDS") Dropped Clinic, ReasonForClinic, ReasonForClinicTxt, WeeksInterval (obsolete)
20/09/17	SCD	Added National People Code for Responsibility

SurgeryProcedure

Contains surgery ("biopsy and treatment") procedure lesion information. A procedure with no lesion records has nulls in LesionId, SideCode etc.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	SurgeryProcedureRecordId	NUM	Internal Record ID
	SurgeryDSRecordId →	NUM	Link to SurgeryDS when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Consultant	C(4)	A code from code list PEPL
	ConsultantNational	C(8)	National People Code
	ConsultantTxt	C(27)	Consultant name
	DatePerformed	DATE	
	EnteredIntoNationalTrial	YN	
	Event	C(3)	ASS or PTR
	HospitalCode	C(6)	A code from code list HOSP
	HospitalCodeTxt	C(30)	
	HospitalNumber	C(10)	
	LeftSideAssessed	YN	
	LocalTrialCode	C(3)	A code from code list TRIAL (not RTRIAL)
	LocalTrialTxt	C(25)	
	Location	C(5)	A code from code list LOC
	LocationTxt	C(25)	
	NationalTrial	C(6)	A code from code list TRIALNS. Called "Which Trial" on screens.
	NationalTrialTxt	C(60)	
	RightSideAssessed	YN	
	Surgeon	C(4)	A code from code list PEPL
	SurgeonNational	C(8)	National people code
	SurgeonTxt	C(27)	Surgeon name
	TimeOrder	NUM	See *TimeOrder*, page 121
*	LesionId →	NUM	Link to Lesion when used with SxNumber and EpisodeRecordId. This is null if the procedure has no lesion records.
*	SideCode	C(1)	R for right or L for left
*	AdditionalDiagnosticProcs	C(20)	List of codes separated by spaces. Values from code list SASS2 (Additional Diagnostic Procedure, pg 131)
*	AdditionalDiagnosticProcsSnomed	C(120)	
*	AdditionalDiagnosticProcsTxt	C(250)	

K	Field	Format	Description
*	AdditionalTreatmentProcs	C(11)	List of codes separated by spaces. Values from code list SPTR2 (Additional Treatment Procedure, pg 131)
*	AdditionalTreatmentProcsSnomed	C(120)	
*	AdditionalTreatmentProcsTxt	C(250)	
*	AppliesToAllLesions	YN	Y if the histology results apply to the whole side, N if just applies to this lesion
*	AxillaryMetsType	C(3)	A code from code list AXMET (Axillary Node Metastatis Type, pg 122). Only recorded if AxillaryNodesNumberPositive is 1 (metastases) or 0 (ITC)
*	AxillaryMetsTypeTxt	C(25)	
*	AxillaryNodesNumberPositive	NUM	
*	AxillaryNodesPresent	YN	
*	AxillaryNodesTotalNumber	NUM	
*	AxillarySpecimenTypes	C(8)	Codes separated by spaces. Values (from code list BIAP) are: NP No Lymph Node Procedure SB Sentinel Node Biopsy AS Axillary Node Sample AC Axillary Node Clearance
*	AxillarySpecimenTypesTxt	C(120)	
*	BenignLesions	C(39)	List of codes separated by spaces. Values from code list BENL2 (Benign Lesions on VAE and Surgery, pg 122)
*	BenignLesionsOther	C(40)	BenignLesionsOther is the text that is entered in “Other Benign Lesion” when someone includes benign lesion code “BXX” to signify “Other”.
*	BenignLesionsSeen	YN	
*	BenignLesionsSnomed	C(120)	
*	BenignLesionsTxt	C(300)	Descriptions for BenignLesions codes
*	BiopsySpecimenType	C(3)	One of the following codes (from list BIST): LB Localisation Biopsy OB Open Biopsy WX Wide Local Excision SX Segmental Excision MS Mastectomy
*	BiopsySpecimenTypeTxt	C(25)	
*	CancerOnKC62	YN	
*	Chemotherapy	YN	Y if NonsurgicalTreatments contains CA or CB N if NonsurgicalTreatments does not contain any of those codes and is not null Null if NonsurgicalTreatments is null
*	DateReported	DATE	

K	Field	Format	Description
*	DiagnosticProcedure	C(3)	A code from code list SASS1 (Main Diagnostic Procedure, pg 131). This is the main diagnostic (biopsy) procedure.
*	DiagnosticProcedureSnomed	C(50)	
*	DiagnosticProcedureTxt	C(30)	
*	DcisGrade	C(3)	A code from code list DCISG (DCIS Grade, pg 126)
*	DcisGradeSnomed	C(50)	
*	DcisGradeTxt	C(15)	
*	DcisGrowthPatterns	C(27)	List of codes separated by spaces. Values from code list DCISP (DCIS Growth Pattern, pg 126)
*	DcisGrowthPatternsTxt	C(100)	
*	DcisOtherGrowthPattern	C(40)	Text describing the DCIS growth pattern if DcisPatterns include GO (“Other”).
*	DiseaseExtent	C(3)	List of codes separated by spaces. Values from code list BIMNAT (Disease extent, pg 124)
*	DiseaseExtentTxt	C(25)	
*	DiseaseGrade	C(2)	A code from code list BIMHG (Histological Grade, pg 123)
*	DiseaseGradeTxt	C(14)	
*	EpithelialProliferation	C(11)	List of codes separated by spaces. Values from code list EPIP (Epithelial Proliferation, pg 126)
*	EpithelialProliferationSnomed	C(120)	
*	EpithelialProliferationTxt	C(120)	
*	ExcisionMarginDistance	NUM(1)	
*	ExcisionMargins	C(2)	One of the following codes (from code list EXCN): ED = Not to mar ER = Reach marg EU = Uncertain
*	ExcisionMarginsTxt	C(25)	
*	HER2ReceptorScore	C(4)	0, 1+, 2+ or 3+ for immunohistochemistry ISH- or ISH+ for In Situ Hybridization tests
*	HER2ReceptorStatus	C(2)	A code from code list HER2ST (HER2 Status, pg 127)
*	HER2ReceptorStatusTxt	C(15)	
*	HistologicalCalcification	C(1)	A code from code list BICAL (Histological Calcification, pg 123)
*	HistologicalCalcificationTxt	C(10)	
*	HormoneERScore	C(1)	ER (Oestrogen) Allred Score of 0-8
*	HormoneERStatus	C(2)	A code from code list HORRS (Hormone Receptor Status, pg 127)

K	Field	Format	Description
*	HormoneERStatusTxt	C(15)	
*	HormonePRScore	C(1)	PR (Progesterone) Allred Score of 0-8
*	HormonePRStatus	C(2)	A code from code list HORRS (Hormone Receptor Status, pg 127)
*	HormonePRStatusTxt	C(15)	
*	HormoneTherapy	YN	Y if NonsurgicalTreatments contains EA, EB, HA or HB N if NonsurgicalTreatments does not contain any of those codes and is not null Null if NonsurgicalTreatments is null
*	InSituComponents	C(11)	List of codes separated by spaces. Values from code list ISCC (In Situ Carcinoma Component, pg 127)
*	InSituComponentsSnomed	C(152)	
*	InSituComponentsTxt	C(25)	
*	InSituPresent	YN	
*	InvasiveComponentOther	C(40)	Text describing the invasive component if InvasiveComponents include IPX (“Other”).
*	InvasiveComponents	C(23)	A list of codes separated by spaces. Values from code list INVCC (Invasive Carcinoma Component, pg 127)
*	InvasiveComponentsSnomed	C(407)	
*	InvasiveComponentsTxt	C(100)	
*	InvasivePresent	YN	
*	InvasiveType	C(2)	A code from code list INVCT (Invasive Carcinoma Type, pg 127)
*	InvasiveTypeOther	C(40)	Text describing the type of invasive cancer if InvasiveType is IO (“Other”).
*	InvasiveTypeSnomed	C(50)	
*	InvasiveTypeTxt	C(20)	
*	Laboratory	C(5)	A code from code list LAB
*	LaboratoryTxt	C(30)	
*	MalignantLesionsSeen	YN	
*	MammographicAbnormality	C(1)	Values: N = No U = Unsure Y = Yes
*	MammographicAbnormalityTxt	C(6)	
*	MaxDiameterInvasiveCompo	NUM(1)	Maximum diameter of invasive component
*	Microinvasion	C(3)	A code from code list BIMMIF (Microinvasion, pg 124)
*	MicroinvasionTxt	C(15)	

K	Field	Format	Description
*	NonsurgicalTreatments	C(41)	A list of codes separated by spaces. Values from code list NONSURG (Non-Surgical Treatment, pg 128)
*	NonsurgicalTreatmentsSnomed	C(250)	
*	NonsurgicalTreatmentsTxt	C(300)	
*	Opinion	C(2)	A code (H0-H5) from code list OPINION (Opinion after a procedure, pg 128)
*	OpinionTxt	C(25)	
*	OtherNodesNumberPositive	NUM	
*	OtherNodesPresent	YN	
*	OtherNodesTotalNumber	NUM	
*	Pathologist	C(4)	A code from code list PEPL
*	PathologistComments	C(4000)	Multiple lines
*	PathologistNational	C(8)	National People Code
*	PathologistTxt	C(27)	Pathologist name
*	PreviousOpinions	C(20)	
*	ProcedureComment	C(66)	
*	RadiotherapyDateStarted	DATE	
*	ReconstructiveProcedure	C(2)	A code from code list BRCON (Breast Reconstructive Procedures, pg 125)
*	ReconstructiveProcedureSnomed	C(50)	
*	ReconstructiveProcedureTxt	C(30)	
*	ReportNumber	C(12)	
*	SiteOfOtherNodes	C(40)	
*	SizeDuctalOnly	NUM(1)	
*	SpecimenRadiographSeen	YN	
*	SpecimenWeight	NUM	
*	TherapeuticProcedures	C(29)	Values from code list THERP (Therapeutic Procedure, pg 132)
*	TherapeuticProceduresSnomed	C(100)	
*	TherapeuticProceduresTxt	C(250)	
*	TreatmentProcedure	C(3)	A code from code list SPTR1 (Main Treatment Procedure, pg 131)
*	TreatmentProcedureSnomed	C(50)	
*	TreatmentProcedureTxt	C(45)	
*	VascularInvasion	C(3)	One of the following codes (from code list BIMVI): VNS = Not present VPO = Possible VPR = Present
*	VascularInvasionTxt	C(11)	

K	Field	Format	Description
*	WholeSizeOfTumour	NUM(1)	
*	WorstLesion	YN	See *WorstLesion*, page 121

Table Notes

1. The “Snomed” fields show the SNOMED equivalents to NBSS codes. A “-” appears in place of a SNOMED code if there is no SNOMED equivalent to the NBSS code.

History

28/03/06	JKO	Added SNOMED fields for scope change SC0048
13/05/06	JKO	Dropped Invasive, NonInvasive as part of scope change SC0066
13/04/07	JKO	Several changes for new Clinical Module
20/01/15	JKO	Corrected VascularInvasion codes and descriptions
20/09/17	SCD	Added National People Code for Consultant, Surgeon and Pathologist
12/04/18	JKO	Changed BenignLesions list from BENL to BENL2 as part of VAE changes

VaeProcedure

Contains VAE (Vacuum-Assisted Excision) procedure lesion information. A procedure with no lesion records has nulls in LesionId, SideCode etc.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	VaeProcedureRecordId	NUM	Internal Record ID
	WbnDSRecordId →	NUM	Link to WbnDS when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Clinician	C(4)	A code from code list PEPL
	ClinicianNational	C(8)	National People Code
	ClinicianTxt	C(27)	Clinician name
	DatePerformed	DATE	
	HospitalCode	C(6)	A code from code list HOSP
	HospitalCodeTxt	C(30)	
	HospitalNumber	C(10)	
	LeftSideAssessed	YN	
	Location	C(5)	A code from code list LOC
	LocationTxt	C(25)	
	RightSideAssessed	YN	
	TimeOrder	NUM	See *TimeOrder*, page 121
	TimePerformed	TIME	
*	LesionId →	NUM	Link to Lesion when used with SxNumber and EpisodeRecordId. This is null if the procedure has no lesion records.
*	SideCode	C(1)	R for right or L for left
*	BenignLesions	C(39)	List of codes separated by spaces. Values from code list BENL2 (Benign Lesions on VAE and Surgery, pg 122)
*	BenignLesionsOther	C(40)	BenignLesionsOther is the text that is entered in “Other Benign Lesion” when someone includes benign lesion code “BXX” to signify “Other”.
*	BenignLesionsSeen	YN	
*	BenignLesionsSnomed	C(120)	
*	BenignLesionsTxt	C(300)	Descriptions for BenignLesions codes
*	BiopsySpecimenType	C(3)	Always the following code (from list BIST): LB Localisation Biopsy
*	BiopsySpecimenTypeTxt	C(25)	Always “Localisation Biopsy”
*	CalcificationOnSpecimen	C(1)	One of the following codes (from code list CPOSX): N = No U = Radiograph Not Seen Y = Yes

K	Field	Format	Description
*	CalcificationOnSpecimenTxt	C(19)	
*	ClinicianComment	C(66)	
*	DateReported	DATE	
*	DcisGrade	C(3)	A code from code list DCISG (DCIS Grade, pg 126)
*	DcisGradeSnomed	C(50)	
*	DcisGradeTxt	C(15)	
*	DcisGrowthPatterns	C(27)	List of codes separated by spaces. Values from code list DCISP (DCIS Growth Pattern, pg 126)
*	DcisGrowthPatternsTxt	C(100)	
*	DcisOtherGrowthPattern	C(40)	Text describing the DCIS growth pattern if DcisPatterns include GO (“Other”).
*	DiseaseGrade	C(2)	A code from code list BIMHG (Histological Grade, pg 123)
*	DiseaseGradeTxt	C(14)	
*	EpithelialProliferation	C(11)	List of codes separated by spaces. Values from code list EPIP (Epithelial Proliferation, pg 126)
*	EpithelialProliferationSnomed	C(120)	
*	EpithelialProliferationTxt	C(120)	
*	HER2ReceptorScore	C(4)	0, 1+, 2+ or 3+ for immunohistochemistry ISH- or ISH+ for In Situ Hybridization tests
*	HER2ReceptorStatus	C(2)	A code from code list HER2ST (HER2 Status, pg 127)
*	HER2ReceptorStatusTxt	C(15)	
*	HistologicalCalcification	C(1)	A code from code list BICAL (Histological Calcification, pg 123)
*	HistologicalCalcificationTxt	C(10)	
*	HormoneERScore	C(1)	ER (Oestrogen) Allred Score of 0-8
*	HormoneERStatus	C(2)	A code from code list HORRS (Hormone Receptor Status, pg 127)
*	HormoneERStatusTxt	C(15)	
*	HormonePRScore	C(1)	PR (Progesterone) Allred Score of 0-8
*	HormonePRStatus	C(2)	A code from code list HORRS (Hormone Receptor Status, pg 127)
*	HormonePRStatusTxt	C(15)	
*	InSituComponents	C(11)	List of codes separated by spaces. Values from code list ISCC (In Situ Carcinoma Component, pg 127)
*	InSituComponentsSnomed	C(152)	
*	InSituComponentsTxt	C(25)	
*	InSituPresent	YN	

K	Field	Format	Description
*	InvasiveComponentOther	C(40)	Text describing the invasive component if InvasiveComponents include IPX (“Other”).
*	InvasiveComponents	C(23)	A list of codes separated by spaces. Values from code list INVCC (Invasive Carcinoma Component, pg 127)
*	InvasiveComponentsSnomed	C(407)	
*	InvasiveComponentsTxt	C(100)	
*	InvasivePresent	YN	
*	InvasiveType	C(2)	A code from code list INVCT (Invasive Carcinoma Type, pg 127)
*	InvasiveTypeOther	C(40)	Text describing the type of invasive cancer if InvasiveType is IO (“Other”).
*	InvasiveTypeSnomed	C(50)	
*	InvasiveTypeTxt	C(20)	
*	Laboratory	C(5)	A code from code list LAB
*	LaboratoryTxt	C(30)	
*	LocalisationMarkerUsed	YN	Indicates whether left in a clip/gel marker
*	LocalisationType	C(1)	A code from code list LOCTYP (Localisation Type, pg 128)
*	LocalisationTypeTxt	C(18)	
*	MalignancyType	C(1)	One of the following codes (from code list MALTYPE): a = In-situ b = Invasive c = Not assessable The value is derived from other fields. See **Table Notes** item 2.
*	MalignancyTypeTxt	C(20)	
*	MalignantLesionsSeen	YN	
*	MammographicAbnormality	C(1)	Values: N = No U = Unsure Y = Yes
*	MammographicAbnormalityTxt	C(6)	
*	MaxDiameterInvasiveCompo	NUM(1)	Maximum diameter of invasive component
*	Microinvasion	C(3)	A code from code list BIMMIF (Microinvasion, pg 124)
*	MicroinvasionTxt	C(15)	
*	NeedleSpecimenType	C(3)	Always the following code (from list WBNST): VAE = Vacuum excision
*	NeedleSpecimenTypeTxt	C(20)	Always “Vacuum excision”
*	NumberOfCores	NUM	

K	Field	Format	Description
*	Opinion	C(2)	A code (E0-E2, E5) from code list OPINION (Opinion after a procedure, pg 128)
*	OpinionTxt	C(25)	
*	Pathologist	C(4)	A code from code list PEPL
*	PathologistComments	C(4000)	Multiple lines
*	PathologistNational	C(8)	National People Code
*	PathologistTxt	C(27)	
*	PossibleLymphNode	YN	
*	PreviousOpinions	C(20)	
*	ReportNumber	C(12)	
*	SizeDuctalOnly	NUM(1)	
*	SpecimenRadiographSeen	YN	
*	SpecimenWeight	NUM	
*	VascularInvasion	C(3)	One of the following codes (from code list BIMVI): VNS = Not present VPO = Possible VPR = Present
*	VascularInvasionTxt	C(11)	
*	WholeSizeOfTumour	NUM(1)	
*	WorstLesion	YN	See *WorstLesion*, page 121

Table Notes

1. The "Snomed" fields show the SNOMED equivalents to NBSS codes. A "-" appears in place of a SNOMED code if there is no SNOMED equivalent to the NBSS code.

2. MalignancyType is derived by applying the following rules in the order listed:

    1. Blank/null if Opinion is not "E5"
    2. "b" if InvasivePresent is "Y"
    3. "a" if InSituPresent is "Y"
    4. "c" if none of the above apply

History

12/04/18	JKO	Created table VaeProcedure when VAE recording introduced to NBSS
30/10/18	JKO	Added MalignancyType and MalignancyTypeTxt and Table Notes 2
09/01/19	JKO	Renamed column LymphNode as PossibleLymphNode

WbnDS

Contains Histology (Wide Bore Needle) diagnostic set information.

K	Field	Format	Description
K	SxNumber→	NUM	Link to Client
K	WbnDSRecordId	NUM	Internal Record ID
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Comments	C(133)	Comment lines 1 and 2 with a space between
	DiagnosticSetOutcome	C(4)	
	EventType	C(3)	Always “ASS”
	LeftOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	LeftOpinionTxt	C(16)	
	OverallAction	C(2)	A code from code list ACT: Action (pg 122)
	OverallActionTxt	C(16)	
	OverallDate	DATE	
	Responsibility	C(4)	A code from code list PEPL
	ResponsibilityNational	C(8)	National People Code
	ResponsibilityTxt	C(25)	
	RightOpinion	C(2)	A code (OB-OU) from code list OPINION (Opinion after a procedure, pg 128)
	RightOpinionTxt	C(16)	

History

13/04/07	JKO	Dropped Clinic, ReasonForClinic, ReasonForClinicTxt, WeeksInterval (obsolete)
20/09/17	SCD	Added National People Code for Responsibility

WbnProcedure

Contains Histology (Wide Bore Needle) procedure and lesion information. A procedure with no lesion records has nulls in LesionId, SideCode etc.

K	Field	Format	Description
K	SxNumber →	NUM	Link to Client
K	WbnProcedureRecordId	NUM	Internal Record ID
	WbnDSRecordId →	NUM	Link to WbnDS when used with SxNumber
	EpisodeRecordId →	NUM	Link to Episode when used with SxNumber
	Clinician	C(4)	A code from code list PEPL
	ClinicianNational	C(8)	National people code
	ClinicianTxt	C(27)	Clinician name
	DatePerformed	DATE	
	HospitalCode	C(6)	A code from code list HOSP
	HospitalCodeTxt	C(30)	
	HospitalNumber	C(10)	
	LeftSideAssessed	YN	
	Location	C(5)	A code from code list LOC
	LocationTxt	C(25)	
	RightSideAssessed	YN	
	TimeOrder	NUM	See *TimeOrder*, page 121
	TimePerformed	TIME	
*	LesionId →	NUM	Link to Lesion when used with SxNumber and EpisodeRecordId. This is null if the procedure has no lesion records.
*	SideCode	C(1)	R for right or L for left
*	BenignLesions	C(39)	List of codes separated by spaces. Values from code list BENL (Benign Lesions on WBN, pg 122)
*	BenignLesionsOther	C(40)	BenignLesionsOther is the text that is entered in "Other Benign Lesion" when someone includes benign lesion code "BXX" to signify "Other".
*	BenignLesionsSnomed	C(120)	
*	BenignLesionsTxt	C(300)	Descriptions for BenignLesions codes
*	CalcificationOnSpecimen	C(1)	One of the following codes (from code list CPOSX): N = No U = Radiograph Not Seen Y = Yes
*	CalcificationOnSpecimenTxt	C(19)	
*	ClinicianComment	C(66)	
*	DateReported	DATE	
*	DcisGrade	C(3)	A code from code list DCISG (DCIS Grade, pg 126)
*	DcisGradeSnomed	C(50)	

K	Field	Format	Description
*	DcisGradeTxt	C(15)	
*	DiseaseGrade	C(2)	A code from code list BIMHG (Histological Grade, pg 123)
*	DiseaseGradeTxt	C(14)	
*	EpithelialAtypia	C(1)	One of the following codes (from code list EPIAT): A = Absent P = Present
*	EpithelialAtypiaSnomed	C(50)	
*	EpithelialAtypiaTxt	C(7)	
*	EpithelialProliferation	C(11)	List of codes separated by spaces. Values from code list EPIP (Epithelial Proliferation, pg 126)
*	EpithelialProliferationSnomed	C(120)	
*	EpithelialProliferationTxt	C(120)	
*	HER2ReceptorScore	C(4)	0, 1+, 2+ or 3+ for immunohistochemistry ISH- or ISH+ for In Situ Hybridization tests
*	HER2ReceptorStatus	C(2)	A code from code list HER2ST (HER2 Status, pg 127)
*	HER2ReceptorStatusTxt	C(15)	
*	HistologicalCalcification	C(1)	A code from code list BICAL (Histological Calcification, pg 123)
*	HistologicalCalcificationTxt	C(10)	
*	HormoneERScore	C(1)	ER (Oestrogen) Allred Score of 0-8
*	HormoneERStatus	C(2)	A code from code list HORRS (Hormone Receptor Status, pg 127)
*	HormoneERStatusTxt	C(15)	
*	HormonePRScore	C(1)	PR (Progesterone) Allred Score of 0-8
*	HormonePRStatus	C(2)	A code from code list HORRS (Hormone Receptor Status, pg 127)
*	HormonePRStatusTxt	C(15)	
*	InSituComponents	C(11)	List of codes separated by spaces. Values from code list ISCC (In Situ Carcinoma Component, pg 127)
*	InSituComponentsSnomed	C(152)	
*	InSituComponentsTxt	C(25)	
*	InSituPresent	YN	
*	InvasiveComponentOther	C(40)	Text describing the invasive component if InvasiveComponents include IPX (“Other”).
*	InvasiveComponents	C(23)	List of codes separated by spaces. Values from code list INVCC (Invasive Carcinoma Component, pg 127)
*	InvasiveComponentsSnomed	C(407)	
*	InvasiveComponentsTxt	C(100)	
*	InvasivePresent	YN	

K	Field	Format	Description
*	InvasiveType	C(2)	A code from code list INVCT (Invasive Carcinoma Type, pg 127)
*	InvasiveTypeOther	C(40)	Text describing the type of invasive cancer if InvasiveType is IO (“Other”).
*	InvasiveTypeSnomed	C(50)	
*	InvasiveTypeTxt	C(20)	
*	Laboratory	C(5)	A code from code list LAB
*	LaboratoryTxt	C(30)	
*	LocalisationMarkerUsed	YN	Indicates whether left in a clip/gel marker
*	LocalisationType	C(1)	A code from code list LOCTYP (Localisation Type, pg 128)
*	LocalisationTypeTxt	C(18)	
*	MalignancyType	C(1)	One of the following codes (from code list MALTYPE): a = In-situ b = Invasive c = Not assessable
*	MalignancyTypeTxt	C(20)	
*	MaxDiameterInvasiveCompo	NUM(1)	Maximum diameter of invasive component
*	NeedleSpecimenType	C(3)	One of the following codes (from list WBNST): WBN = Core Biopsy VAD = Vacuum diagnostic VAE = Vacuum excision VAU = Vacuum unspecified SKP = Nipple/Skin Biopsy (skin punch)
*	NeedleSpecimenTypeTxt	C(20)	
*	NumberOfCores	NUM	
*	Opinion	C(2)	A code (B1-B5) from code list OPINION (Opinion after a procedure, pg 128)
*	OpinionTxt	C(25)	
*	Pathologist	C(4)	A code from code list PEPL
*	PathologistComments	C(4000)	Multiple lines
*	PathologistNational	C(8)	National people code
*	PathologistTxt	C(27)	Pathologist name
*	PossibleLymphNode	YN	
*	PreviousOpinions	C(20)	
*	ReportNumber	C(12)	
*	UncertainLesions	C(51)	List of codes separated by spaces. Values from code list UNCL (Uncertain Lesions, pg 132)
*	UncertainLesionsOther	C(40)	UncertainLesionsOther is the text that is entered in “Other Uncertain Lesion” when someone includes lesion code “UXX” to signify “Other”.

K	Field	Format	Description
*	UncertainLesionsSnomed	C(120)	
*	UncertainLesionsTxt	C(400)	Descriptions for UncertainLesions codes
*	VascularInvasion	C(3)	One of the following codes (from code list BIMVI): VNS = Not present VPO = Possible VPR = Present
*	VascularInvasionTxt	C(11)	
*	WorstLesion	YN	See *WorstLesion*, page 121

Table Notes

1. The "Snomed" fields show the SNOMED equivalents to NBSS codes. A "-" appears in place of a SNOMED code if there is no SNOMED equivalent to the NBSS code.

History

28/03/06	JKO	Added SNOMED fields for scope change SC0048
13/04/07	JKO	Changed for new Clinical Module
23/10/07	JKO	Added TimePerformed
20/01/15	JKO	Added VascularInvasion, VascularInvasionTxt
10/03/15	JKO	Added EpithelialAtypia, EpithelialAtypiaSnomed, EpithelialAtypiaTxt, UncertainLesions, UncertainLesionsOther, UncertainLesionsSnomed, UncertainLesionsTxt
20/09/17	SCD	Added National People Code for Clinician and Pathologist
09/01/19	JKO	Renamed column LymphNode as PossibleLymphNode

Appendices

Table UTIL.LetterEmbeddedFields

Values from table UTIL.LetterEmbeddedFields can be included in NBSS letters and labels that are written in Crystal Reports and linked to NBSS reporting tasks using menu options SLL ("Link Letter Text to Task") or SLBL ("Link Label Text to Task").

The following columns are shown for each field in UTIL.LetterEmbeddedFields.

Field	C	Len	Description
Field Name in Crystal Reports or Microsoft Access. There are no "→" arrows: none of the fields can be used to link to other tables.	The embedded field code in legacy letters and labels or "-" if the field cannot be included in legacy letters and labels.	The maximum length. All field values are format C (Character).	A short description.

The table does not have key any fields: NBSS retrieves the values when it prints a letter or label.

Field	C	Len	Description
AppointmentDate	V	29	Appointment date, eg. "Monday 19th May 2014"
AppointmentShortDate	z	11	Short appointment date, eg. "19 May 2014"
AppointmentShortDayOfWeek	x	3	Appointment day of week (short), eg. "Mon"
AppointmentTime	W	10	Appointment time, eg. "2:24 p.m."
BlankFlag	-	0	A dummy field with a null value.
CaseNotes	Y	3	Case notes present: "(Y)" or "(N)"
ClientAddressLine1	C	30	Client address line 1
ClientAddressLine2	D	30	Client address line 2
ClientAddressLine3	E	30	Client address line 3
ClientAddressLine4	F	30	Client address line 4
ClientAddressLine5	G	20	Client address line 5
ClientDateOfBirth	L	11	Client date of birth
ClientForenames	J	22	Client forenames
ClientFullName	-	50	ClientTitle, ClientInitial and ClientSurname
ClientInitial	K	2	Client initial
ClientPostcode	H	8	Client postcode
ClientSurname	B	20	Client surname
ClientTitle	I	4	Client title
ClinicAddressLine1	N	30	Clinic address line 1
ClinicAddressLine2	O	30	Clinic address line 2
ClinicAddressLine3	P	30	Clinic address line 3
ClinicAddressLine4	Q	30	Clinic address line 4
ClinicAddressLine5	R	20	Clinic address line 5
ClinicCode	n	5	Clinic code
ClinicConsultant	o	25	Clinic consultant's name
ClinicName	M	50	Clinic name

Field	C	Len	Description
ClinicPostcode	S	8	Clinic postcode
ClinicReceptionPoint	U	25	Clinic reception point
ClinicTelephoneNumber	T	27	Clinic telephone number
DateTaken	a	11	Date of screening procedure
EarlyRecallDueDate	b	14	Early Recall Due, eg. “April 2015”
EthnicOrigin	p	2	Ethnic origin code, eg. “CA”
FirstLanguage	l	3	First language code, eg. “POR”
GPAddressLine1	g	30	GP address line 1
GPAddressLine2	h	30	GP address line 2
GPAddressLine3	i	30	GP address line 3
GPAddressLine4	j	20	GP address line 4
GPName	f	40	GP name
GPPostcode	k	8	GP postcode
Info	-	255	Header/trailer lines on printing labels
LetterReferenceCode	X	10	Letter reference code
LocnOfPersonPatientReferredTo	d	50	Location of person patient referred to
NHSNumber	s	14	NHS Number
NhsNoBarcodePACS	-	16	NhsNumberPACS for barcode font printing
NhsNumberPACS	r	16	NHSNumber as formatted for PACS
OldAppointmentDate	v	29	Old appointment date
OldClinicName	m	30	Old clinic name
PersonPatientReferredTo	c	35	Person patient referred to
ProtocolText	-	500	Higher risk protocol description (memo)
ReferrerAddress	-	500	Higher risk referrer full address (memo)
ReferrerAddressLine1	-	30	Higher risk referrer address line 1
ReferrerAddressLine2	-	30	Higher risk referrer address line 2
ReferrerAddressLine3	-	30	Higher risk referrer address line 3
ReferrerAddressLine4	-	20	Higher risk referrer address line 4
ReferrerAddressLine5	-	20	Higher risk referrer address line 5
ReferrerName	-	30	Higher risk referrer name
ReferrerPostcode	-	8	Higher risk referrer postcode
SxBarcode	-	11	SxNumber for barcode font printing
SxBarcodePACS	-	16	SxNumberPACS for barcode font printing
SxNumber	A	9	Client SX Number, eg. “KKE000123”
SxNumberPACS	q	16	SxNumber as formatted for PACS
SxNumberWithCommas	t	11	SxNumber with commas (labels only)
SxNumberWithHyphen	u	10	SxNumber with a hyphen
TelNoOfPersonPatientReferredTo	e	30	Telephone number of person patient referred to
TodaysDate	Z	11	Today's date
WatermarkText	-	50	Text to print as a watermark on example letters

Special Fields

TimeOrder

Procedures contain a date field (usually “DatePerformed”) and a “TimeOrder” field. TimeOrder is a number that indicates the order of the procedure within the date: the earlier the procedure, the lower theTimeOrder value. The combination of date and TimeOrder can be used to order records by procedure date and time.

WorstLesion

Lesion-based views contain a field called “WorstLesion”. This is “Y” if the lesion is the “worst” on the side for this procedure, or “N” if another lesion is “worse” than this one. The “worst” lesion is the lesion with the highest opinion code on the side within the procedure. If two lesion have the same opinion, it is the one with the earlier “date reported”. If two lesions have the same opinion and date, it the one with the lower LesionId.

Example:

SxNumber	SurgeryProcedureRecordId	LesionId	SideCode	DateReported	Opinion	WorstLesion
13262	9935	1	R	20/03/2007	H5	N
13262	9935	2	R	19/03/2007	H5	Y
13262	9935	4	L	20/03/2007	H2	Y

In this example, lesions “1” and “2” are both on the right and are both “H5”. Lesion “3” is on the left. Lesion “2” is the “worst” on the right because its “DateReported” is earlier than that of lesion “1”.

Code Lists

This section contains code lists for codes that occur in several tables. The section presents the lists alphabetically by code table identifier. Some old codes can no longer be selected in screens but may still exist in the database. These codes have "(obsolete)" after their description.

ACT: Action (pg 122)

EC = For Early Recall for Clinic
ES = For Early Recall for Screening
FN = For Fine Needle Aspiration
FP = For Follow-up (Post-treatment)
FV = For Further X-ray views
IP = For Inpatient biopsy
MT = For Medical Treatment
NA = No Action from this procedure
R2 = Routine second film opinion (obsolete)
RC = For Review in clinic
RF = For referral to consultant/GP
RR = Routine recall for screening
ST = For Surgical Treatment
TR = For Repeat Film (technical)
WB = For Wide Bore Needle

AXMET (Axillary Node Metastatis Type, pg 122)

MET = Metastasis (> 2 mm)
MIM = Micrometastasis (<= 2 mm to > 0.2 mm)
ITC = Isolated tumour cells (<= 0.2 mm)

BENL (Benign Lesions on WBN, pg 122)

BCC = Columnar cell change
BCR = Complex sclerosing lesion/radial scar
BDE = Periductal mastitis/duct ectasia
BFA = Fibroadenoma
BFC = Fibrocystic change
BPM = Multiple papilloma
BPS = Solitary papilloma
BSA = Sclerosing adenosis
BSC = Solitary cyst
BXX = Other

BENL2 (Benign Lesions on VAE and Surgery, pg 122)

BBP = Borderline Phyllodes Tumour
BCC = Columnar cell change
BCF = Cellular Fibroepithelial Lesion/Benign Phyllodes
BCR = Complex sclerosing lesion/radial scar
BDE = Periductal mastitis/duct ectasia
BFA = Fibroadenoma
BFC = Fibrocystic change
BML = Mucocele-like Lesion
BPM = Multiple papilloma
BPS = Solitary papilloma
BSA = Sclerosing adenosis
BSC = Solitary cyst

BST = Stromal lesion of uncertain significance
BXX = Other

BIADD (Biopsy Additional Procedure , pg 123)

AX = Axillary node sampling
FB = Frozen section - benign
FD = Frozen section - diag deferred
FM = Frozen section - malignant
GU = Guidance by ultrasound
GX = Guidance by X-ray
SB = Sentinel node biopsy
SX = Specimen X-rayed

BIADD1 (Additional Treatment Procedures, pg 123)

A1 = Axillary Clearance - Level 1
A2 = Axillary Clearance - Level 2
AC = Axillary Clearance - Total
AX = Axillary node sampling
CA = Pre-operative chemotherapy
CB = Post-operative chemotherapy
CH = Chemotherapy (obsolete)
EN = Endocrine
GU = Guidance by ultrasound
GX = Guidance by X-ray
IM = Internal mammary node sampling
NL = No lymph node procedures
NO = No additional treatment procs.
OT = Other nodes biopsied
RA = Radiotherapy
SB = Sentinel node biopsy
SX = Specimen X-rayed

BICAL (Histological Calcification, pg 123)

A = Absent
B = Benign
M = Malignant
N = Not present
T = Both

BIMHG (Histological Grade, pg 123)

1 = I (obsolete)
2 = II (obsolete)
3 = III (obsolete)
4 = not done (obsolete)
G1 = I
G2 = II
G3 = III
NA = Not assessable

BIMI (Invasive, pg 123)

C = Cribriform (obsolete)
D = Ductol n.o.s. (obsolete)
IDC = 'Ductal' / no specific type (NST)

ILC = Lobular carcinoma
IMC = Medullary carcinoma
IMD = Mixed
IMU = Mucinous carcinoma
IMX = Other malignant tumour
INA = Not assessable
INP = Not present
IPX = Other primary carcinoma
ITC = Tubular carcinoma
L = Lobular (obsolete)
MD = Medullary (obsolete)
MU = Mucoid (obsolete)
N = Not present (obsolete)
P = Papillary (obsolete)
T = Tubular (obsolete)
X = Other (obsolete)

BIMMIF (Microinvasion, pg 124)

MNP = Not present
MPR = Present
MPS = Possible
N = Not present (obsolete)
P = Definitely present (obsolete)
U = Uncertain (obsolete)

BIMNAT (Disease extent, pg 124)

DEL = Localised
DEM = Multiple
DEN = Not assessable
DES = Ill-defined (obsolete)
M = Multiquadrant (obsolete)
S = Single quadrant (obsolete)
U = Uncertain (obsolete)

BIMNI (Non-invasive, pg 124)

D = Ductal in situ (obsolete)
L = Lobular in situ (obsolete)
N = Not present (obsolete)
NDH = Ductal, high grade
NDO = Ductal, other
NID = Ductal (obsolete)
NIL = Lobular
NIN = Not present
NIP = Paget's
P = Paget's disease (obsolete)
X = Other (obsolete)

BIPOST (Post-diagnostic Surgical Procedure, pg 124)

IBT = Initial biopsy was treatment
NON = None
OTH = Other
PMX = Patey (modified radical mastectomy)
RLE = Repeat WLE to clear margins

RMX = Radical mastectomy
SCI = Subcut. mastectomy/immediate implant
SCM = Subcutaneous mastectomy
SEG = Segmentectomy or quadrantectomy
SMX = Simple mastectomy
TM = Total mastectomy (obsolete)
UMX = Mastectomy - type unknown
WLE = Wide local excision (quadrantectomy)

BIPRE (Pre-diagnostic Surgical Procedure, pg 125)

CA = Cyst aspiration (obsolete)
EXB = Excision biopsy palpable
EXI = Excisn. biopsy impalpable
FNA = Fine needle aspirn. biop (obsolete)
WBN = Wide bore needle biopsy (obsolete)
WLE = Wide local excisn.(quad) (obsolete)
XLU = Localisation ultrasound
XLX = Excn Bx Impalp Locn Xray

BRCON (Breast Reconstructive Procedures, pg 125)

DP = DIEP flap
LD = LD flap with implant
LN = LD flap without implant
NO = No reconstructive procedures
OT = Other
SP = Subpectoral implant
TR = TRAM flap

BRDEN (Breast Density, pg 125)

D = Dense
F = Fatty
M = Mixed

BRSITE (Site Within Breast, pg 125)

AX = Axillary tail
C = Central
ECT = Ectopic (obsolete)
IH = Inner half
LH = Lower half
LIQ = Lower inner quadrant
LOQ = Lower outer quadrant
OH = Outer half
SAR = Subareolar region
UH = Upper half
UIQ = Upper inner quadrant
UOQ = Upper outer quadrant

CTYPE (CancellationType, pg 125)

AW = Adverse weather
CA = Card (obsolete)
DE = Declined
EA = Equipment availability
HO = Holiday

IC = Inconvenient
ME = Moving/Emigrating
PP = Postal problems
RS = Recently screened
SI = Sickness
ST = Staffing issues
TA = Transport/Accessibility
WC = Work commitments
ZO = Other

DCISG (DCIS Grade, pg 126)

NDH = High
NDI = Intermediate
NDL = Low
NDN = Not assessable
NDO = Other (obsolete)

DCISP (DCIS Growth Pattern, pg 126)

GA = Apocrine
GC = Cribriform
GF = Flat
GM = Micropapillary
GO = Other
GP = Papillary
GS = Solid

EPIP (Epithelial Proliferation, pg 126)

EAD = Present with atypia (ductal)
EAF = Present with atypia (FEA)
EAL = Present with atypia (lobular)
EAX = Present with atypia(unspecifd) (obsolete)
ENP = Not present
EPW = Present without atypia

EPRC (Reason for Episode Closure, pg 126)

AR = Randomised Out
BS = Being Screened
CP = Under care; perm
CT = Under care; temp
DD = Died
DE = Defaulted
DU = Further Dtls Unavail
FB = FPC closed; being Sx
FC = FPC closed; ceased
FD = FPC closed; Died
FF = FPC closed; FP69
FM = FPC closed; Moved
FP = FPC closed; prem
FS = FPC closed;suspended
FX = FPC closed; Other
HR = On higher risk
I = Interval case
MV = Moved Away

NA = Non-attender
NK = Not Known at address
NR = Non-Responder
NS = Atten'd not screened
NT = No Transport to Unit
OP = Opted out; Permanent
OT = Opted out; temporary
R = Routine Closure
RS = Recently Screened
X = Other;see C/R status

HER2ST (HER2 Status, pg 127)

RP = Positive
RN = Negative
RB = Borderline
RU = Not Performed

HORRS (Hormone Receptor Status, pg 127)

RP = Positive
RN = Negative
RU = Not Performed

HRNXT (Higher Risk Next Screening, pg 127)

I = Invitation
S = Self-Referral
TO = Too Old for protocol
TY = Too Young for protocol

HRWR (Higher Risk Withdrawal Reason, pg 127)

BMAS = Bilateral mastectomy
LOW = No longer at higher risk
MCA = Mental Capacity Act
OTHR = Other
WITH = Woman's choice
XFER = Transferred to triennial screening

INVCC (Invasive Carcinoma Component, pg 127)

IDC = Ductal/NST
ILC = Lobular
IMC = Medullary like
IMU = Mucinous
IPX = Other component
ITC = Tubular/cribriform

INVCT (Invasive Carcinoma Type, pg 127)

IN = Ductal/NST
IP = Pure Special Type
IM = Mixed
IO = Other

ISCC (In Situ Carcinoma Component, pg 127)

NID = Ductal

NIL = Lobular
NIP = Paget's

LOCTYP (Localisation Type, pg 128)

M = Mammotome (obsolete)
N = MRI
P = Palpation
R = Prone stereo
S = Stereotactic
U = Ultrasound
X = X-ray

MRIRR (MRI Repeat Reason, pg 128)

BT = Excision of benign lesion (patient choice)
CA = Pre-op chemotherapy
CB = Post-op chemotherapy
EA = Pre-op endocrine
EB = Post-op endocrine
GA = Other pre-op growth factor
GB = Other post-op growth factor
HA = Other pre-op hormone therapy
HB = Other post-op hormone therapy
OA = Other pre-op non-surgical treatments
OB = Other post-op non-surgical treatments
RB = Post-op radiotherapy
ST = Surgery
TA = Pre-op Herceptin (Trastuzumab)
TB = Post-op Herceptin (Trastuzumab)

MDMAT (MDM Action Treatment, pg 128)

BT = Excision of benign lesion (patient choice)
CA = Pre-op chemotherapy
CB = Post-op chemotherapy

NONSURG (Non-Surgical Treatment, pg 128)

CA = Pre-op chemotherapy
CB = Post-op chemotherapy
EA = Pre-op endocrine
EB = Post-op endocrine
GA = Other pre-op growth factor
GB = Other post-op growth factor
HA = Other pre-op hormone therapy
HB = Other post-op hormone therapy
NO = No non-surgical treatments
OA = Other pre-op non-surgical treatments
OB = Other post-op non-surgical treatments
RB = Post-op radiotherapy
TA = Pre-op Herceptin (Trastuzumab)
TB = Post-op Herceptin (Trastuzumab)

OPINION (Opinion after a procedure, pg 128)

0 = Cyto normal (obsolete)
1 = Cyto inadequate (obsolete)

2 = Cyto benign (obsolete)
3 = Cyto suspicious (obsolete)
4 = Cyto malig (obsolete)

A1 = Assess normal
A2 = Assess benign
A3 = Assess uncert'n
A4 = Assess suspic
A5 = Assess malig

B1 = Unsatis/Normal
B2 = Benign
B3 = Benign unc mal
B4 = Susp of malig
B5 = Malignant

BA = Clinical
BH = Per History BCa (obsolete)

C1 = Cyt unsatis
C2 = Cyt benign
C3 = Cyt atypia
C4 = Cyt susp, malig
C5 = Cyt malig

CB = Clin benign (obsolete)
CM = Clin malig (obsolete)
CN = Clin normal (obsolete)
CS = Clin suspicious (obsolete)

E0 = Hist unreported
E1 = Histol normal
E2 = Histol benign
E5 = Hist malignant

FH = Fam history BCa (obsolete)

H0 = Hist unreported
H1 = Histol normal
H2 = Histol benign
H5 = Hist malignant
HE = Histo equivocal (obsolete)
HI = Hist malig inv (obsolete)

I1 = Imaging normal
I2 = Imaging benign
I3 = Imaging uncertain
I4 = Imaging suspicious
I5 = Imaging malig

MRI1 = MRI normal
MRI2 = MRI benign
MRI3 = MRI indeterminate
MRI4 = MRI suspicious
MRI5 = MRI malig

OB = Benign
OM = Malignant
ON = Normal
OS = Suspicious

OU = Uncertain

P1 = Clin normal
P2 = Clin benign
P3 = Clin uncertain
P4 = Clin suspicious
P5 = Clin malignant

QU = Unsure (obsolete) - was used for CADET2

R1 = Rad normal
R2 = Rad benign
R3 = Rad uncertain
R4 = Rad suspicious
R5 = Rad malig

RB = Benign
RM = Malignant
RN = Normal
RO = Unreported
RS = Suspicious
RU = Uncertain

SH = History suspic

U1 = USS normal
U2 = USS benign
U3 = USS uncertain
U4 = USS suspicious
U5 = USS malig

PARTR (Partial Mammography Reason, pg 130)

CD = Exam limited due to chronic disease condition
CW = Withdrew consent
LU = Unable to co-operate due to limited understanding of the procedure
PH = Exam limited due to pacemaker, Hickman line, or loop recorder
RM = Unable to attain/maintain position due to restricted mobility
WC = Exam performed in a wheelchair which restricted positioning
XX = Other (free-text)

PEPR (PACS Exam Procedure, pg 130)

		Modality	S/A
MMAMB	= MRI Breast Both	MR	A
UMAMB	= US Breast Both	US	A
XMAMB	= XR Mammogram Both	MG	A
XPATH	= XR Pathological specimen	DX	A
XSCMB	= XR Screening mammogram Both	MG	S

PRE (Present, Yes or No, pg 130)

N = No
P = Present (obsolete)
U = Unknown
Y = Yes

REASON (Reason for Referral/Review, pg 130)

AFM = All Further Management

FU = Post Treatment Follow Up
INV = Investigation Only (obsolete)
ITR = Investigation and Treatment (obsolete)
PTR = Primary Treatment (obsolete)
STR = Secondary Treatment (obsolete)
X = Other reason

RETAKE (Repeat Reason for Film, pg 131)

C = Client difficulty (obsolete)
E1 = X-Ray machine malfunction
E2 = Film processor sys. fault
E3 = Film handling system fault
E4 = ID marker fault
E5 = Cassette fault
E6 = Film manufacturers faults
M = Machine or power supply (obsolete)
P = Processing problem (obsolete)
R = Radiographer or positioning (obsolete)
R1A = Inadequate posn-Rad'grphr
R1B = Inadequate posn-Client
R2 = Inadequate compression
R3 = Incorrect exposure
R4 = Incorrect processing
R5 = Artefacts obscuring image
X = Other (obsolete)

SASS1 (Main Diagnostic Procedure, pg 131)

EXB = Excision biopsy palpable
EXI = Excision biopsy impalpable
EXU = Excision biopsy

SASS2 (Additional Diagnostic Procedure, pg 131)

AX = Axillary node sampling
FB = Frozen section - benign
FD = Frozen section - diag deferred
FM = Frozen section - malignant
GU = Guidance by ultrasound
GX = Guidance by X-ray
SX = Specimen X-rayed

SPTR1 (Main Treatment Procedure, pg 131)

EXP = Excision of benign lesion (patient choice)
IBT = Initial biopsy was treatment
NON = No surgical procedures
OTH = Other
RLE = Repeat WLE to clear margins
SCM = Subcutaneous mastectomy
TMX = Total mastectomy
WLE = Wide local excision/seg/quad

SPTR2 (Additional Treatment Procedure, pg 131)

GU = Guidance by ultrasound
GX = Guidance by X-ray

NO = No additional treatment procs
SX = Specimen X-rayed

THERP (Therapeutic Procedure, pg 132)

AC = Axillary lymph node clearance
AX = Four node axillary sampling
AY = Four node axillary sampling blue dye
IM = Internal thoracic node sampling
NL = No lymph node procedures
OT = Other nodes biopsied
SB = Sentinel node biopsy
SD = Sentinel node biopsy blue dye
SI = Sentinel node biopsy radioisotope
SX = Sentinel node biopsy dye and isotope

UNCL (Uncertain Lesions, pg 132)

UAD = AIDEP/ADH
UAX = At least AIDEP/ADH
UBP = Borderline Phyllodes Tumour
UCF = Cellular Fibroepithelial Lesion/Benign Phyllodes
UFE = Flat Epithelial Atypia
ULH = Lobular Neoplasia (ALH)
ULI = Lobular Neoplasia (LCIS)
ULX = Lobular Neoplasia (ALH/LCIS)
UML = Mucocele-like Lesion
UPA = Papillary Lesion
URS = Radial Scar/Complex Sclerosing Lesion
UST = Stromal lesion of uncertain significance
UXX = Other uncertain malignant potential

Table Diagrams

Key

repeating record

R | L

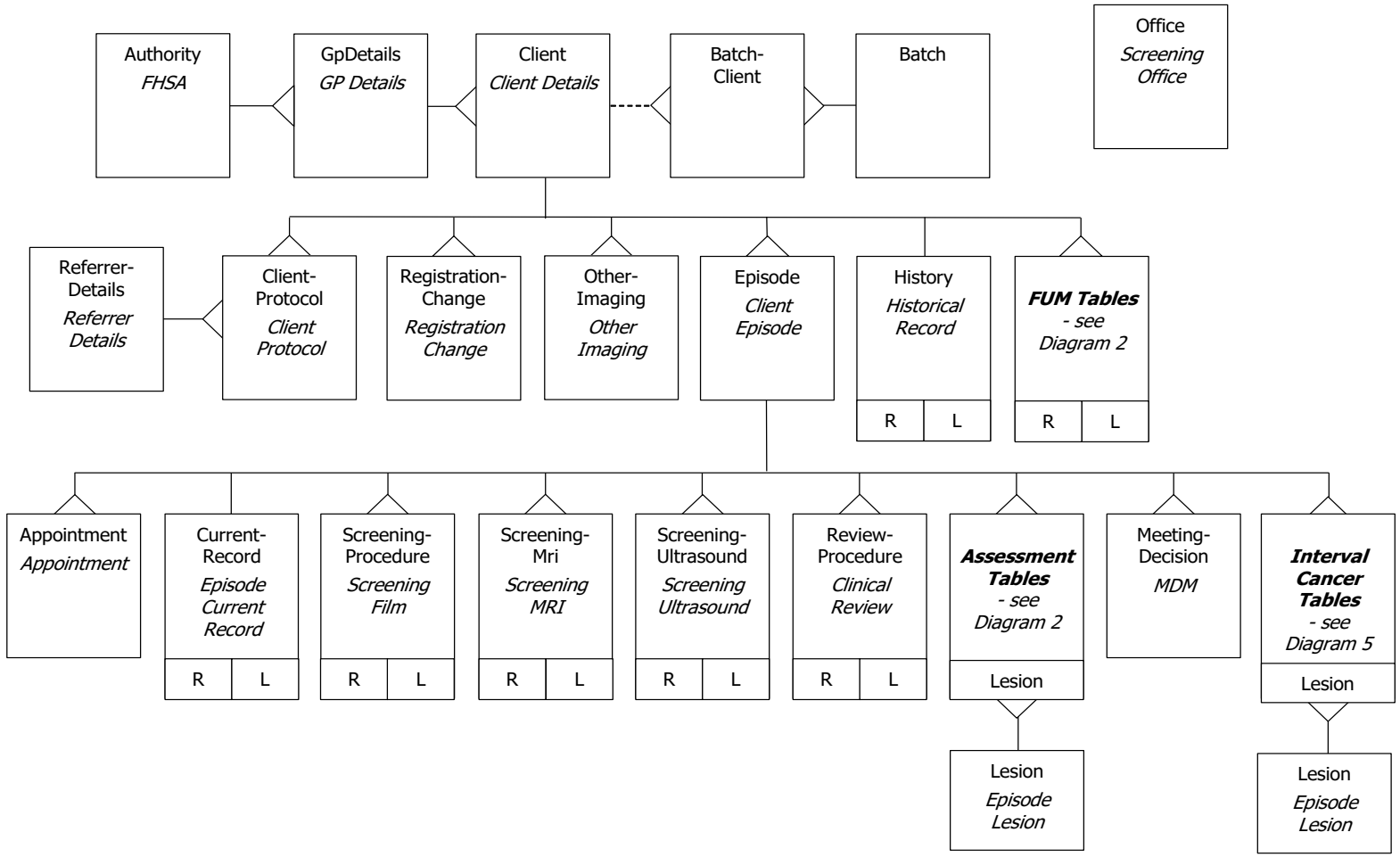
side records

The next page identifies ***FUM Tables*** and ***Assessment Tables***

"-" in a table name denotes a line break and should be ignored

eg. "Batch-Client" = "BatchClient"

NBSS Table Diagram 1 · Overview



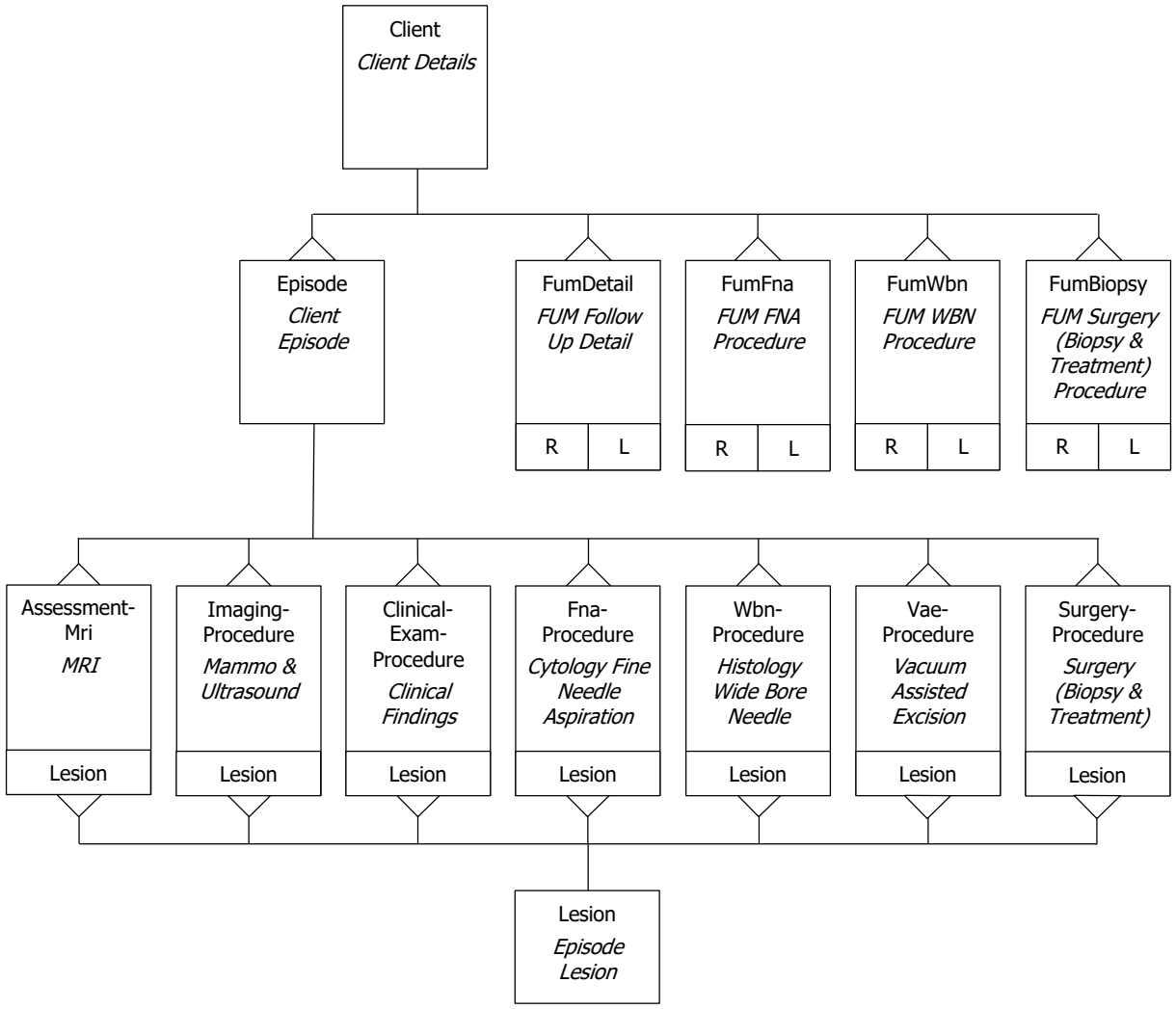
Key

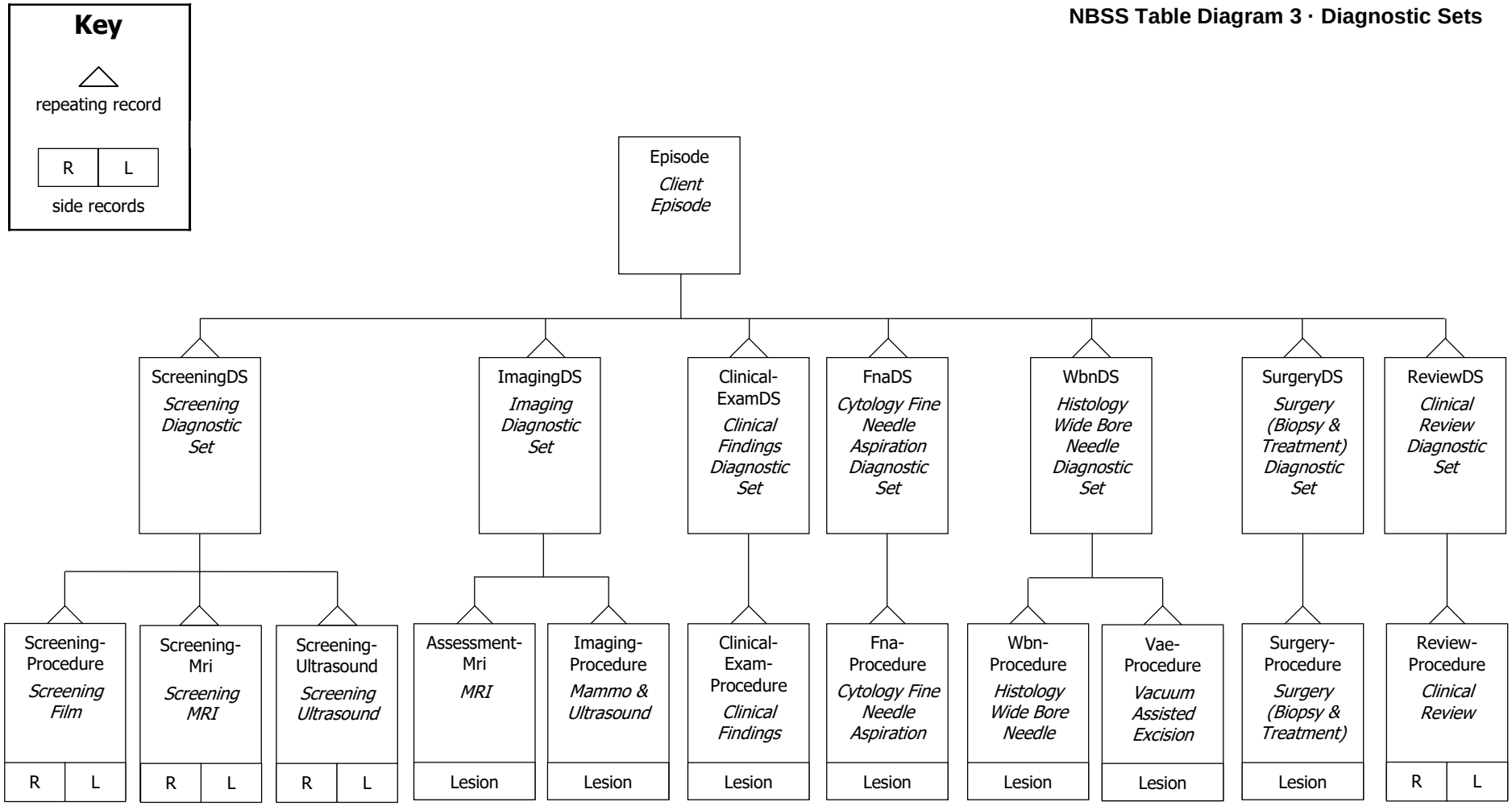
△ repeating record

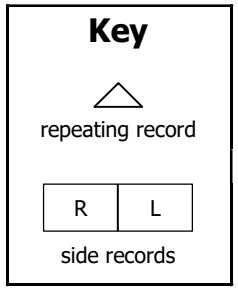
R | L side records

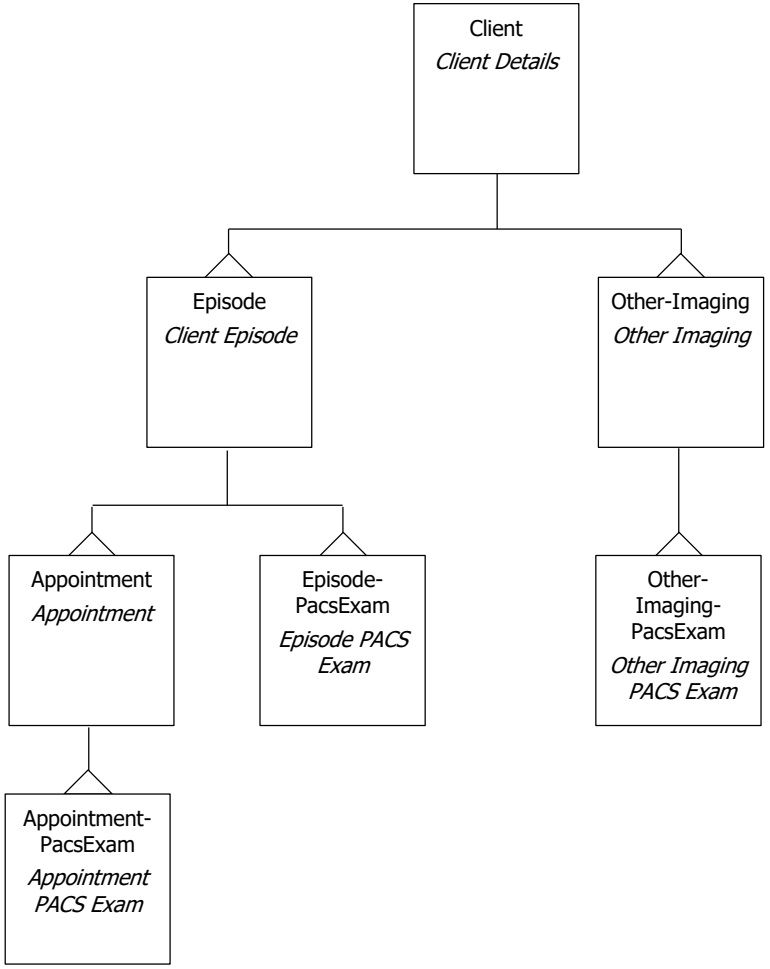
"-" in a table name denotes a line break and should be ignored

eg. "Batch-Client" = "BatchClient"




Key
repeating record
R
L
side records
Episode
Client Episode
ScreeningDS
Screening Diagnostic Set
ImagingDS
Imaging Diagnostic Set
Clinical-ExamDS
Clinical Findings Diagnostic Set
FnaDS
Cytology Fine Needle Aspiration Diagnostic Set
WbnDS
Histology Wide Bore Needle Diagnostic Set
SurgeryDS
Surgery (Biopsy & Treatment) Diagnostic Set
ReviewDS
Clinical Review Diagnostic Set
Screening-Procedure
Screening Film
Screening-Mri
Screening MRI
Screening-Ultrasound
Screening Ultrasound
Assessment-Mri
MRI
Imaging-Procedure
Mammo & Ultrasound
Clinical-Exam-Procedure
Clinical Findings
Fna-Procedure
Cytology Fine Needle Aspiration
Wbn-Procedure
Histology Wide Bore Needle
Vae-Procedure
Vacuum Assisted Excision
Surgery-Procedure
Surgery (Biopsy & Treatment)
Review-Procedure
Clinical Review
Lesion


Key
repeating record
R
L
side records


Client
Client Details
Episode
Client Episode
Other-Imaging
Other Imaging
Appointment
Appointment
Episode-PacsExam
Episode PACS Exam
Other-Imaging-PacsExam
Other Imaging PACS Exam
Appointment-PacsExam
Appointment PACS Exam

Key

△ repeating record

R	L

side records

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