Cancer (clinical) DSS

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List of metadata items

Data Element Technical Names

Metadata items

Cancer (clinical) DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 334019

Registration status: NHIG, Standard 07/12/2005

DSS type: Data Set Specification (DSS)

Scope: This Cancer (clinical) data set specification is not mandated for collection but is recommended as best practice if cancer clinical data are to be collected.

The Cancer (clinical) data set underpins the evaluation of cancer treatment services and this can occur at a number of levels; the individual clinician, the health care institution, at state or territory level and ultimately at a national level.

Clinicians use such data for ongoing patient management and the ability to link patient management to outcomes allows treatments or outcomes to be identified and assessed. Institutions can monitor through-put in their centres for planning and resource allocation purposes to obtain optimum return for cancer expenditure. End-points can be monitored to ensure that objectives are being met.

The principal aim of good-quality and consistent data is to provide information that can lead to improved quality and length of life for all patients by providing a systematic foundation for evidence-based medicine, informing quality assurance and improvement decisions and guiding successful planning and evaluation of cancer control activities.

Collection and usage attributes

Collection methods: This data set is primarily concerned with the clinical use of cancer data. It can also be used by a wider range of health and health-related establishments that create, use, or maintain records on health-care clients.

Source and reference attributes

Submitting organisation: National Cancer Control Initiative (NCCI)

Relational attributes

Related metadata references: Supersedes Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Has been superseded by Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Metadata items in this Data Set Specification

Seq No.	*Metadata item*	*Obligation*	*Max occurs*
-	Address line (person)	Mandatory	1
-	Cancer initial treatment completion date	Mandatory	1
-	Cancer initial treatment starting date	Mandatory	1
-	Cancer staging—M stage code	Mandatory	1
-	Cancer staging—N stage code	Mandatory	1
-	Cancer staging—T stage code	Mandatory	1

-	Cancer staging—TNM stage grouping code	Mandatory	1
-	Cancer treatment type	Mandatory	1
-	Cancer treatment—target site (ICD-10-AM)	Mandatory	1
-	Cancer treatment—target site (ICDO-3)	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of death	Mandatory	1
-	Date of diagnosis of cancer	Mandatory	1
-	Date of diagnosis of first recurrence	Mandatory	1
-	Date of surgical treatment for cancer	Mandatory	1
-	Establishment number	Mandatory	1
-	Family name	Mandatory	1
-	Given name(s)	Mandatory	1
-	Histopathological grade	Mandatory	1
-	Intention of treatment for cancer	Mandatory	1
-	Laterality of primary cancer	Conditional	1
-	Medicare card number	Mandatory	1
-	Morphology of cancer	Conditional	0
-	Most valid basis of diagnosis of cancer	Conditional	1
-	Oestrogen receptor assay status	Mandatory	1
-	Outcome of initial treatment	Mandatory	1
-	Person identifier	Mandatory	1
-	Primary site of cancer (ICD-10-AM code)	Mandatory	1
-	Primary site of cancer (ICDO-3 code)	Conditional	1
-	Progesterone receptor assay results	Conditional	1
-	Radiotherapy treatment type	Mandatory	1
-	Received radiation dose	Mandatory	1
-	Region of first recurrence	Mandatory	1
-	Regional lymph nodes examined	Mandatory	1
-	Regional lymph nodes positive	Conditional	1
-	Sex	Mandatory	1
-	Staging basis of cancer	Mandatory	1
-	Staging scheme source	Mandatory	1
-	Staging scheme source edition number	Mandatory	1
-	Surgical treatment procedure for cancer	Mandatory	1
-	Systemic therapy agent name	Mandatory	1
-	Tumour size at diagnosis (solid tumours)	Mandatory	1
-	Tumour thickness at diagnosis (melanoma)	Mandatory	1

Address line (person)

Identifying and definitional attributes

Technical name:	Person (address)—address line, text [X(180)]
METeOR identifier:	286620
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 30/09/2005
Definition:	A composite of one or more standard **address** components that describes a low level of geographical/physical description of a location, as represented by a text. Used in conjunction with the other high-level address components i.e. Suburb/town/locality, Postcode—Australian, Australian state/territory, and Country, forms a complete geographical/physical address of a person.

Data element concept attributes

Data element concept:	Person (address)—address line
Definition:	A composite of one or more standard address components that describes a low level of geographical/physical description of a location that, used in conjunction with the other high-level address components i.e. Suburb/town/locality, Postcode—Australian, Australian state/territory, and Country, forms a complete geographical/physical address of a person.
Object class:	Person
Property:	Address line

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(180)]
Maximum character length:	180

Data element attributes

Collection and usage attributes

Guide for use:	A high-level address component is defined as a broad geographical area that is capable of containing more than one specific physical location. Some examples of a broad geographical area are: - Suburb, town or locality - Postcode—Australian or international - State, Territory, local government area, electorate, statistical local area - Postal delivery point identifier - Countries, provinces, etc other than in Australia These components of a complete address do not form part of the Address line.

When addressing an Australian location, following are the standard address data elements that may be concatenated in the Address line:

- Building/complex sub-unit type
- Building/complex sub-unit number
- Building/property name
- Floor/level number
- Floor/level type
- House/property number
- Lot/section number
- Street name
- Street type code
- Street suffix code

One complete identification/description of a location/site of an address can comprise one or more than one instance of address line.

Instances of address lines are commonly identified in electronic information systems as Address-line 1, Address-line 2, etc.

The format of data collection is less important than consistent use of conventions in the recording of address data. Hence, address may be collected in an unstructured manner but should ideally be stored in a structured format.

Where Address line is collected as a stand-alone item, software may be used to parse the Address line details to separate the sub-components.

Multiple Address lines may be recorded as required.

Collection methods:

The following concatenation rules should be observed when collecting address lines addressing an Australian location.

- Building/complex sub-unit type is to be collected in conjunction with Building/complex sub-unit number and vice versa.
- Floor/level type is to be collected in conjunction with Floor/level number and vice versa.
- Street name is to be used in conjunction with Street type code and Street suffix code.
- Street type code is to be used in conjunction with Street name and Street suffix code.
- Street suffix code is to be used in conjunction with Street name and Street type code.
- House/property number is to be used in conjunction with Street name.

Source and reference attributes

Submitting organisation: Standards Australia

Origin: Health Data Standards Committee

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia.

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes Person (address)—health address line, text [X(180)] NHIG, Superseded 04/05/2005

Is formed using Person (address)—building/property name, text [X(30)] NHIG, Standard 01/03/2005, NCSIMG, Standard 30/09/2005

Is formed using Person (address)—building/complex sub-unit identifier, [X(7)] NHIG, Standard 01/03/2005, NCSIMG, Standard 30/09/2005

Is formed using Person (address)—building/complex sub-unit type, code A[AAA] NHIG, Standard 01/03/2005, NCSIMG, Standard 30/09/2005

Is formed using Person (address)—floor/level identifier, [NNNA] NHIG, Standard 01/03/2005, NCSIMG, Standard 30/09/2005

Is formed using Person (address)—floor/level type, code A[A] NHIG, Standard 01/03/2005, NCSIMG, Standard 30/09/2005

Is formed using Person (address)—house/property identifier, text [X(12)] NHIG, Standard 01/03/2005, NCSIMG, Standard 30/09/2005

Is formed using Person (address)—lot/section identifier, N[X(14)] NHIG, Standard 01/03/2005, NCSIMG, Standard 30/09/2005

Is formed using Person (address)—street name, text [A(30)] NHIG, Standard 01/03/2005, NCSIMG, Standard 30/09/2005

Is formed using Person (address)—street type, code A[AAA] NHIG, Standard 01/03/2005, NCSIMG, Standard 30/09/2005

Is formed using Person (address)—street suffix, code A[A] NHIG, Standard 01/03/2005, NCSIMG, Standard 30/09/2005

Implementation in Data Set Specifications:

Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Cervical Screening Standardised Data Set V3 *No registration status*

Health care client identification DSS NHIG, Standard 04/05/2005
NCSIMG, Standard 03/10/2006

Health care provider identification DSS NHIG, Standard 04/05/2005

Person usual physical address DSS *No registration status*

Data set specification specific attributes

Cancer initial treatment completion date

Identifying and definitional attributes

Technical name:	Cancer treatment—non-surgical cancer treatment completion date, DDMMYYYY
METeOR identifier:	288136
Registration status:	NHIG, Standard 04/06/2004
Definition:	The date on which the initial non-surgical treatment for cancer was completed.

Data element concept attributes

Data element concept:	Cancer treatment—non-surgical cancer treatment completion date
Definition:	The date on which the initial non-surgical treatment for cancer was completed.
Object class:	Cancer treatment
Property:	Non-surgical cancer treatment completion date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Collected for radiation therapy and systemic therapy.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Cancer initial treatment - completion date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set:

This field must:

- be greater than or equal to the date of initial cancer diagnosis, and
- be greater than or equal to the date of the initial course of treatment for cancer.

This item is collected for the analysis of outcome by treatment type.

Collecting dates for radiotherapy treatment and systemic therapy agent treatment will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Cancer initial treatment starting date

Identifying and definitional attributes

Technical name:	Cancer treatment—non-surgical cancer treatment start date, DDMMYYYY
METeOR identifier:	288103
Registration status:	NHIG, Standard 04/06/2004
Definition:	The start date of the initial course of non-surgical treatment for cancer.

Data element concept attributes

Data element concept:	Cancer treatment—non-surgical cancer treatment start date
Definition:	The start date of the initial course of non-surgical treatment for cancer.
Object class:	Cancer treatment
Property:	Non-surgical cancer treatment start date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The start date of the treatment is recorded regardless of whether treatment is completed as intended or not. Treatment subsequent to a recurrence will not be recorded. Collected for radiation therapy and systemic therapy. Date of surgical treatment is collected as a separate item.

Source and reference attributes

Submitting organisation:	National Cancer Control Institute
Origin:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references:	Supersedes Cancer initial treatment - starting date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set:

This field must:

- be greater than or equal to the date of initial cancer diagnosis, and
- be less than or equal to the date on which initial treatment for cancer was completed.

This metadata item is collected for the analysis of outcome by treatment type.

Collecting dates for radiotherapy treatment and systemic therapy agent treatment will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Cancer staging—M stage code

Identifying and definitional attributes

Technical name:	Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX
METeOR identifier:	293231
Registration status:	NHIG, Standard 13/06/2004
Definition:	Absence or presence of distant metastasis at the time of diagnosis of the primary cancer, as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—distant metastasis status
Definition:	M stage is the coding system used to record the absence or presence of distant metastases at the time of diagnosis of the primary cancer. It is part of the TNM cancer staging system.
Object class:	Person with cancer
Property:	Distant metastasis status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XX
Maximum character length:	2

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use:	Valid M codes from the current edition of the UICC TNM Classification of Malignant Tumours. Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules.

Data element attributes

Collection and usage attributes

Guide for use:	Choose the lower (less advanced) M category when there is any uncertainty.
Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.
Comments:	Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site. Staging systems seek to classify patients having a similar

prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

TNM staging applies to solid tumours excluding brain tumours.

Source and reference attributes

Origin: International Union Against Cancer (UICC)

Commission on Cancer, American College of Surgeons

Reference documents: UICC TNM Classification of Malignant Tumours (5th Edition) (1997)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references: Supersedes Cancer staging - M stage code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Has been superseded by Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX NHIG, Candidate 14/09/2006

Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX} NHIG, Standard 04/06/2004

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set: For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer staging—N stage code

Identifying and definitional attributes

Technical name:	Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX
METeOR identifier:	293254
Registration status:	NHIG, Standard 13/06/2004
Definition:	Extent of regional lymph node metastasis at the time of diagnosis of the primary cancer, as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—regional lymph node metastasis status
Definition:	N stage is the coding system used to denote the absence or presence of regional lymph node metastases. It classifies the extent of regional lymph node metastases at the time of diagnosis of the primary cancer. It is a part of the TNM cancer staging system.
Object class:	Person with cancer
Property:	Regional lymph node metastasis status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XX
Maximum character length:	2

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use:	Valid N codes from the current edition of the UICC TNM Classification of Malignant Tumours. Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules.

Data element attributes

Collection and usage attributes

Guide for use:	Choose the lower (less advanced) N category when there is any uncertainty.
Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.
Comments:	Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if

the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

TNM staging applies to solid tumours excluding brain tumours.

Source and reference attributes

Reference documents: Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references: Supersedes Cancer staging - N stage code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Has been superseded by Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX NHIG, Candidate 14/09/2006

Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX} NHIG, Standard 04/06/2004

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set: For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer staging—T stage code

Identifying and definitional attributes

Technical name:	Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX[X]
METeOR identifier:	293270
Registration status:	NHIG, Standard 13/06/2004
Definition:	Extent of primary cancer including tumour size, at the time of diagnosis, as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—primary tumour status
Definition:	T stage is the coding system used to identify the presence of primary tumour. It reflects the tumour size and extent of the primary cancer at the time of diagnosis. It is a part of the TNM cancer staging system.
Object class:	Person with cancer
Property:	Primary tumour status

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XX[X]
Maximum character length:	3

Supplementary values:

Value	Meaning
88	Not applicable

Collection and usage attributes

Guide for use:	Valid T codes from the current edition of the UICC TNM Classification of Malignant Tumours. Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules.

Data element attributes

Collection and usage attributes

Guide for use:	Choose the lower (less advanced) T category when there is any uncertainty.
Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.
Comments:	Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

TNM staging applies to solid tumours excluding brain tumours.

Source and reference attributes

Reference documents: Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references: Supersedes Cancer staging - T stage code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Has been superseded by Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX[X] NHIG, Candidate 14/09/2006

Is used in the formation of Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX} NHIG, Standard 04/06/2004

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set: For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer staging—TNM stage grouping code

Identifying and definitional attributes

Technical name:	Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours 5th ed) code XXXX{[X]XX}
METeOR identifier:	296925
Registration status:	NHIG, Standard 04/06/2004
Definition:	The anatomical extent of disease at diagnosis based on the previously coded T,N and M stage categories, as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—extent of primary cancer
Definition:	The stage grouping defines the anatomical extent of disease at diagnosis based on the previously coded T, N and M stage categories.
Object class:	Person with cancer
Property:	Extent of primary cancer

Value domain attributes

Representational attributes

Classification scheme:	International Union against Cancer TNM Classification of Malignant Tumours 5th edition
Representation class:	Code
Data type:	String
Format:	XXXX{[X]XX}
Maximum character length:	6

Supplementary values:

Value	Meaning
8888	Not applicable
9999	Unknown, Stage X

Collection and usage attributes

Guide for use:	Valid stage grouping codes from the current edition of the UICC TNM Classification of Malignant Tumours.

Data element attributes

Collection and usage attributes

Guide for use:	Refer to the UICC reference manual, TNM Classification of Malignant Tumours for coding rules. Choose the lower (less advanced) T category when there is any uncertainty.
Collection methods:	From information provided by the treating doctor and recorded on the patient's medical record.

Relational attributes

Related metadata references:	Supersedes Cancer staging - TNM stage grouping code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 Is formed using Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX NHIG, Standard 13/06/2004 Is formed using Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX NHIG, Standard 13/06/2004 Is formed using Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours 5th ed) code XX[X] NHIG, Standard 13/06/2004 Has been superseded by Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XXXX{[X]XX} NHIG, Candidate 14/09/2006
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set:	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.

Cancer treatment type

Identifying and definitional attributes

Technical name:	Cancer treatment—cancer treatment type, code N
METeOR identifier:	288185
Registration status:	NHIG, Standard 04/06/2004
Definition:	The type of treatment for cancer given as initial treatment for the particular patient, as represented by a code.

Data element concept attributes

Data element concept:	Cancer treatment—cancer treatment type
Definition:	The type of treatment for cancer given as initial treatment for the particular patient.
Context:	This item is collected for surgical treatment, radiation therapy and systemic therapy. It is used for correlating outcome with original intent of the treatment.
Object class:	Cancer treatment
Property:	Cancer treatment type

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	No treatment
1	Surgical treatment
2	Radiation therapy
3	Systemic agent therapy
4	Surgical and radiation treatment
5	Surgical treatment and systemic agent treatment
6	Radiation and systemic agent treatment
7	All three treatment types

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons. New South Wales Health Department.
Reference documents:	Commission on Cancer, Standards of the Commission on

Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references:	Supersedes Cancer treatment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Cancer treatment—target site (ICD-10-AM)

Identifying and definitional attributes

Technical name:	Cancer treatment—target site for cancer treatment, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333822
Registration status:	NHIG, Standard 07/12/2005
Definition:	The site or region which is the target of particular surgical or radiotherapy treatment, as represented by an ICD-10-AM code.

Data element concept attributes

Data element concept:	Cancer treatment—target site for cancer treatment
Definition:	The site or region of cancer which is the target of a particular surgical or radiotherapy treatment.
Object class:	Cancer treatment
Property:	Target site for cancer treatment

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Data element attributes

Collection and usage attributes

Guide for use:	This information is collected for surgical and radiotherapy treatments. Current edition of International Classification of Diseases (ICD-10-AM), Australian Modification, National Centre for Classification in Health, Sydney is used.

Relational attributes

Related metadata references:	Supersedes Cancer treatment—target site for cancer treatment, code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Data set specification specific attributes

Cancer treatment—target site (ICDO-3)

Identifying and definitional attributes

Technical name:	Cancer treatment—target site for cancer treatment, code (ICDO-3) ANN
METeOR identifier:	293161
Registration status:	NHIG, Standard 13/06/2004
Definition:	The site or region of cancer which is the target of a particular surgical or radiotherapy treatment, as represented by an ICDO-3 code.

Data element concept attributes

Data element concept:	Cancer treatment—target site for cancer treatment
Definition:	The site or region of cancer which is the target of a particular surgical or radiotherapy treatment.
Object class:	Cancer treatment
Property:	Target site for cancer treatment

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN
Maximum character length:	3

Data element attributes

Collection and usage attributes

Guide for use:	This information is collected for surgical and radiotherapy treatments. Current edition of International Classification of Diseases for Oncology (ICD-O), World Health Organisation is used. Major organ only - first 3 characters.

Relational attributes

Related metadata references:	Supersedes Cancer treatment - target site, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Date of birth

Identifying and definitional attributes

Technical name:	Person—date of birth, DDMMYYYY
METeOR identifier:	287007
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005 NHDAMG, Standard 20/06/2005
Definition:	The date of birth of the person.

Data element concept attributes

Data element concept:	Person—date of birth
Definition:	The date of birth of the person.
Context:	Required for a range of clinical and administrative purposes. Date of birth enables derivation of age for use in demographic analyses, assists in the unique identification of clients if other identifying information is missing or in question, and may be required for the derivation of other metadata items (e.g. the diagnosis related group for admitted patients).
Object class:	Person
Property:	Date of birth

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. Collected or estimated age would usually be in years for adults, and to the nearest three months (or less) for children aged less than two years. Additionally, an estimated date flag or a date accuracy indicator should be reported in conjunction with all estimated dates of birth. For data collections concerned with children's services, it is suggested that the estimated date of birth of children aged under 2 years should be reported to the nearest 3 month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child who is thought to be aged 18 months in October of one year would have his/her estimated date of birth reported as 0104 of the previous year. Again, an estimated date flag or date accuracy indicator should be reported in conjunction with all estimated dates of birth.

Collection methods:

Information on date of birth can be collected using the one question:

What is your/(the person's) date of birth?

In self-reported data collections, it is recommended that the following response format is used:

Date of birth: _ _ / _ _ / _ _ _ _

This enables easy conversion to the preferred representational layout (DDMMYYYY).

For record identification and/or the derivation of other metadata items that require accurate date of birth information, estimated dates of birth should be identified by a date accuracy indicator to prevent inappropriate use of date of birth data . The linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of an indicator of the accuracy of the date may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date—accuracy indicator, code AAA also be recorded at the time of record creation to flag the accuracy of the data.

Comments:

Privacy issues need to be taken into account in asking persons their date of birth.

Wherever possible and wherever appropriate, date of birth should be used rather than age because the actual date of birth allows a more precise calculation of age.

When date of birth is an estimated or default value, national health and community services collections typically use 0101 or 0107 or 3006 as the estimate or default for DDMM.

It is suggested that different rules for reporting data may apply when estimating the date of birth of children aged under 2 years because of the rapid growth and development of children within this age group which means that a child's development can vary considerably over the course of a year. Thus, more specific reporting of estimated age is suggested.

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes Person—date of birth, DDMMYYYY NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005

Is used in the formation of Record—linkage key, statistical code XXXXXDDMMYYYYN NCSIMG, Proposed 19/07/2006

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (postnatal), total N[NN]
No registration status

Is used in the formation of Episode of admitted patient care—length of stay (including leave days) (antenatal), total N[NN] *No registration status*

Is used in the formation of Person—statistical linkage key, XXXXXDDMMYYYYN NCSIMG, Proposed 19/07/2006

Is used in the formation of Major Diagnostic Category - supplied by hospital - code (AR-DRG v5.1) NN *No registration status*

Is used in the formation of Record—linkage key, statistical code XXXXXDDMMYYYYN *No registration status*

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN NHIG, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA NHIG, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care (postnatal)—length of stay (including leave days), total N[NN] NHIG, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care (antenatal)—length of stay (including leave days), total N[NN] NHIG, Standard 01/03/2005

Implementation in Data Set Specifications:

AROC inpatient data set specification NHIG, Recorded 24/08/2006

Acute coronary syndrome (clinical) DSS NHIG, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS *No registration status*

Acute coronary syndrome (clinical) DSS NHIG, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*

Admitted patient care NMDS NHIG, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 NHIG, Standard 07/12/2005

Admitted patient care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Admitted patient mental health care NMDS NHIG, Standard 07/12/2005

Admitted patient mental health care NMDS NHIG, Superseded 07/12/2005

Admitted patient mental health care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Admitted patient palliative care NMDS NHIG, Superseded 07/12/2005

Admitted patient palliative care NMDS 2006-2007 NHIG, Superseded 29/11/2006

Admitted patient palliative care NMDS 2007-08 NHIG, Standardisation pending 23/10/2006

Alcohol and other drug treatment services NMDS NHIG, Standard 21/03/2006

Alcohol and other drug treatment services NMDS NHIG, Superseded 21/03/2006

Alcohol and other drug treatment services NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS NHIG, Standard 01/03/2005

Cardiovascular disease (clinical) DSS - Demo for CPIC *No registration status*

Child protection NMDS *No registration status*

Commonwealth State/Territory Disability Agreement NMDS *No registration status*

Community mental health care 2004-2005 NHIG, Superseded 08/12/2004

Community mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005

Community mental health care NMDS 2006-2007 NHIG, Standard 07/12/2005

Community mental health care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Community-based palliative care client DSS *No registration status*

Computer Assisted Telephone Interview demographic module DSS *No registration status*

Computer Assisted Telephone Interview demographic module DSS NHIG, Standard 04/05/2005

Congenital anomalies NMDS (Under development by the NPSU September 2006) *No registration status*

Date of birth DSS *No registration status*

Dementia MDS *No registration status*

Diabetes (clinical) DSS NHIG, Superseded 21/09/2005

Diabetes (clinical) DSS NHIG, Standard 21/09/2005

Gambling Support Services *No registration status*

Health care client identification DSS NHIG, Standard 04/05/2005
NCSIMG, Standard 03/10/2006

Health care provider identification DSS NHIG, Standard 04/05/2005

Health labour force NMDS NHIG, Standard 01/03/2005

Juvenile Justice NMDS NCSIMG, Proposed 19/07/2006

Medical Indemnity DSS *No registration status*

National Bowel Screening Program NMDS *No registration status*

Non-admitted patient emergency department care NMDS NHIG, Standard 24/03/2006

Non-admitted patient emergency department care NMDS NHIG, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS NHIG, Superseded 24/03/2006

Non-admitted patient emergency department care NMDS *No registration status*

Organ and tissue donation *No registration status*

Outpatient care patient level DSS *No registration status*

Perinatal NMDS NHIG, Standard 06/09/2006

Perinatal NMDS NHIG, Superseded 07/12/2005

Perinatal NMDS NHIG, Superseded 06/09/2006

Residential mental health care NMDS NHIG, Proposed 15/08/2005

Residential mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005

Residential mental health care NMDS 2006-2007 NHIG, Standard 07/12/2005

Residential mental health care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

SAAP date of birth data cluster *No registration status*

Statistical linkage key DSS *No registration status*

Data set specification specific attributes

Date of death

Identifying and definitional attributes

Technical name:	Person—date of death, DDMMYYYY
METeOR identifier:	287305
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 30/09/2005
Definition:	The date of death of the person.

Data element concept attributes

Data element concept:	Person—date of death
Definition:	The date of death of the person.
Context:	Required for: • statistical survival analysis for derivation of the length of time between diagnosis with primary cancer and death • where it is necessary to identify that a person has died (eg in a longitudinal health record or provider index).
Object class:	Person
Property:	Date of death

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Recorded for persons who have died. Where Date of birth is collected, Date of death must be equal to or greater than Date of birth for the same person.
Collection methods:	It is recommended that in cases where all components of the date of death are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate. For record identification and/or the derivation of other metadata items that require accurate date of death information, estimated dates of death should be identified by a date accuracy indicator to prevent inappropriate use of date of death data . The linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is

critical. The collection of Date accuracy indicator may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date accuracy indicator also be recorded at the time of record creation to flag the accuracy of the data.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes Date of death, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Acute coronary syndrome (2nd tier data items) *No registration status*

Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Community-based palliative care client DSS *No registration status*

Health care provider identification DSS NHIG, Standard 04/05/2005

Organ and tissue donation *No registration status*

Data set specification specific attributes

Information specific to this data set: This field must be greater than or equal to Date of diagnosis of primary cancer.

Date of diagnosis of cancer

Identifying and definitional attributes

Technical name:	Patient—diagnosis date (cancer), DDMMYYYY
METeOR identifier:	270061
Registration status:	NHIG, Standard 01/03/2005
Definition:	The date when the cancer was first diagnosed (whether at its primary site or as a metastasis).
Context:	Patient administration system, cancer notification system, population cancer statistics, research.

Data element concept attributes

Data element concept:	Patient—diagnosis date
Definition:	The date on which a patient is diagnosed with a particular condition or disease.
Object class:	Patient
Property:	Diagnosis date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	Date of diagnosis must be: >= date of birth <= date of death Diagnosis of cancer after death: If the patient is first diagnosed with the cancer in an autopsy report the date of diagnosis is the date of death as stated on the patient's death certificate. Incidental diagnosis of cancer: If a patient is admitted for another condition (for example a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date the cancer was diagnostically determined, not the admission date.
Collection methods:	Reporting rules: The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence:

Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer.

Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital.

Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country).

If components of the date are not known, an estimate should be provided where possible with an estimated date flag to indicate that it is estimated. If an estimated date is not possible, a standard date of 15 June 1900 should be used with a flag to indicate the date is not known.

Source and reference attributes

Origin:	International agency for research on cancer World Health Organisation International Association of Cancer Registries
Reference documents:	Modified from the definition presented by the New South Wales Inpatient Statistics Collection Manual 2000/2001

Relational attributes

Related metadata references:	Supersedes Date of diagnosis of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Date of diagnosis of first recurrence

Identifying and definitional attributes

Technical name:	Patient—diagnosis date (first recurrence of cancer), DDMMYYYY
METeOR identifier:	288596
Registration status:	NHIG, Standard 04/06/2004
Definition:	The date a medical practitioner confirms the diagnosis of a recurrent or metastatic cancer of the same histology.

Data element concept attributes

Data element concept:	Patient—diagnosis date
Definition:	The date on which a patient is diagnosed with a particular condition or disease.
Object class:	Patient
Property:	Diagnosis date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The term `recurrence' defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.
Comments:	This item is collected for determining the time interval from diagnosis to recurrence, from treatment to recurrence and from recurrence to death.

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Date of diagnosis of first recurrence, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set: This field must:

- be greater than the date of diagnosis of cancer
- be greater than the cancer initial treatment - completion date (if less than cancer initial treatment - completion date, the patient was never disease-free)

Date of surgical treatment for cancer

Identifying and definitional attributes

Technical name:	Cancer treatment—surgical procedure date, DDMMYYYY
METeOR identifier:	288632
Registration status:	NHIG, Standard 04/06/2004
Definition:	The date on which the cancer-directed surgical treatment was performed.

Data element concept attributes

Data element concept:	Cancer treatment—surgical procedure date
Definition:	The date on which the cancer-directed surgical treatment was performed.
Object class:	Cancer treatment
Property:	Surgical procedure date

Value domain attributes

Representational attributes

Representation class:	Date
Data type:	Date/Time
Format:	DDMMYYYY
Maximum character length:	8

Data element attributes

Collection and usage attributes

Guide for use:	The date of each surgical treatment episode should be entered separately. Collected for curative and palliative surgery prior to the first recurrence.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Date of surgical treatment for cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set:

This field must be greater than or equal to the date of initial cancer diagnosis.

This item is collected for analyses of outcome by treatment type.

Establishment number

Identifying and definitional attributes

Technical name:	Establishment—organisation identifier (state/territory), NNNNN
METeOR identifier:	269975
Registration status:	NHIG, Standard 01/03/2005
Definition:	An identifier for an establishment, unique within the state or territory.

Data element concept attributes

Data element concept:	Establishment—organisation identifier (state/territory)
Definition:	An identifier for an establishment, unique within the state or territory.
Context:	All health services.
Object class:	Establishment
Property:	Organisation identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	NNNNN
Maximum character length:	5

Data element attributes

Collection and usage attributes

Comments:	Identifier should be a unique code for the health care establishment used in that state/territory.

Relational attributes

Related metadata references:	Supersedes Establishment number, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005 Is used in the formation of Establishment—organisation identifier (Australian), NNX[X]NNNNN NHIG, Standard 01/03/2005
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status* Admitted patient care NMDS NHIG, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 NHIG, Standard 07/12/2005 Admitted patient care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006 Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Community mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005

Community mental health care NMDS 2006-2007 NHIG, Standard 07/12/2005

Community mental health care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Health care client identification NHIG, Superseded 04/05/2005

Health care client identification DSS NHIG, Standard 04/05/2005
NCSIMG, Standard 03/10/2006

Mental health establishments NMDS 2005-2006 NHIG, Superseded 07/12/2005

Mental health establishments NMDS 2005-2006 NHIG, Superseded 21/03/2006

Mental health establishments NMDS 2006-2007 NHIG, Standard 21/03/2006

Mental health establishments NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Organ and tissue donation *No registration status*

Outpatient care patient level DSS *No registration status*

Residential mental health care NMDS NHIG, Proposed 15/08/2005

Residential mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005

Residential mental health care NMDS 2006-2007 NHIG, Standard 07/12/2005

Residential mental health care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Test Establishment identifier data cluster *No registration status*

Data set specification specific attributes

Family name

Identifying and definitional attributes

Technical name:	Person (name)—family name, text X[X(39)]
Synonymous names:	Surname; Last name
METeOR identifier:	286953
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005 NHDAMG, Standard 20/06/2005
Definition:	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text.

Data element concept attributes

Data element concept:	Person (name)—family name
Definition:	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names.
Context:	Administrative purposes and individual identification.
Object class:	Person
Property:	Family name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The agency or establishment should record the client's full **family** name on their information systems. National Community Services Data Dictionary specific: In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. Or, where proof of identity is required, as the name is recorded on a majority of the higher point scoring documents that are produced as proof of identity.
Collection methods:	This metadata item should be recorded for all persons who receive services from or are of interest to an organisation. For the purposes of positive identification, it may also be recorded for providers of those services who are individuals. Mixed case should be used. Family name should be recorded in the format preferred by the

person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one family name (e.g. formal name, birth name, married/maiden name, tribal name) depending on the circumstances. Each name should be recorded against the appropriate Name type (see Comments).

A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change his or her name under the Change of Name Act. Care should be taken when recording a change of name for a minor. Ideally, the name recorded for the minor should be known to both of his/her parents, so the minor's records can be retrieved and continuity of care maintained, regardless of which parent accompanies the minor to the agency or establishment.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be the name on their Medicare card. The Person name type metadata item can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection:

What is your family name?

_____

Are you known by any other family names that you would like recorded? If so, what are they

_____

Please indicate, for each name above, the 'type' of family name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by). Whenever a person informs the agency or establishment of a change of family name (e.g. following marriage or divorce), the former name should be recorded as an alias name. A full history of names should be retained. e.g. 'Mary Georgina Smith' informs the hospital that she has been married and changed her family name to 'Jones'. Record 'Jones' as her preferred family name and record 'Smith' as an alias name.

Hyphenated family names:

Sometimes persons with hyphenated family names use only one of the two hyphenated names. It is useful to record each of the hyphenated names as an alias. If the person has a hyphenated family name, e.g. 'Wilson-Phillips' record 'Wilson-Phillips' in the preferred family name field and record 'Wilson' and 'Phillips' separately as alias family names.

Punctuation:

If special characters form part of the family name they should be included, e.g. hyphenated names should be entered with a hyphen.

Examples:

- hyphen, e.g. Wilson-Phillips

Do not leave a space before or after a hyphen, i.e. between the last letter of 'Wilson' and the hyphen, nor a space between the

hyphen and the first letter of 'Phillips'.

- apostrophe, e.g. O'Brien, D'Agostino

Do not leave a space before or after the apostrophe, i.e. between the 'O' and the apostrophe, nor a space between the apostrophe and 'Brien'.

- full stop, e.g. St. John, St. George

Do not leave a space before a full stop, i.e. between 'St' and the full stop. Do leave a space between the full stop and 'John'.

- space, e.g. van der Humm, Le Brun, Mc Donald

If the health care client has recorded their family name as more than one word, displaying spaces in between the words, record their family name in the same way leaving one space between each word.

Registered unnamed newborn babies:

When registering a newborn, use the mother's family name as the baby's family name unless instructed otherwise by the mother. Record unnamed babies under the newborn Name type.

Persons with only one name:

Some people do not have a family name and a given name, they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' field blank.

Registering an unidentified person:

The default for unknown family name, should be unknown in all instances and the name recorded as an alias name. Don't create a 'fictitious' family name such as 'Doe' as this is an actual family name. When the person's name becomes known, record it as the preferred family name and do not overwrite the alias name of unknown.

Registering health care clients from disaster sites:

Persons treated from disaster sites should be recorded under the alias Name Type. Local business rules should be developed for consistent recording of disaster site person details.

Care should be taken not to use identical dummy data (family name, given name, date of birth, sex) for two or more persons from a disaster site.

If the family name needs to be shortened:

If the length of the family name exceeds the length of the field, truncate the family name from the right (that is, dropping the final letters). Also, the last character of the name should be a hash (#) to identify that the name has been truncated.

Use of incomplete names or fictitious names:

Some health care facilities permit persons to use a pseudonym (fictitious or partial name) in lieu of their full or actual name. It is recommended that the person be asked to record both the pseudonym (Alias name) in addition to the person's Medicare card name.

Baby for **adoption**:

The word adoption should not be used as the family name, given name or alias for a newborn baby. A newborn baby that is for adoption should be registered in the same way that other newborn babies are registered. However, if a baby born in the hospital is subsequently adopted, and is admitted for treatment as a child, the baby is registered under their adopted (current)

name, and the record should not be linked to the birth record. This should be the current practice. Any old references to adoption in client registers (for names) should also be changed to unknown. Contact your State or Territory adoption information service for further information.

Prefixes:

Where a family name contains a prefix, such as one to indicate that the person is a widow, this must be entered as part of the 'Family name' field. When widowed, some Hungarian women add 'Ozvegy' (abbreviation is 'Ozy') before their married family name, e.g. 'Mrs Szabo' would become 'Mrs Ozy Szabo'. That is, 'Mrs Szabo' becomes an alias name and 'Mrs Ozy Szabo' becomes the preferred name.

Ethnic Names:

The Centrelink publication, Naming Systems for Ethnic Groups, provides the correct coding for ethnic names.

Misspelled family name:

If the person's family name has been misspelled in error, update the family name with the correct spelling and record the misspelled family name as an alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the person's name. Discretion should be used regarding the degree of recording that is maintained.

Comments:

Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between MacIntosh and McIntosh - can make record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) 'Given name' and 'Family name'. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred names that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family name or surname separately. These should then be recorded as 'Given name' and 'Family name' as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the family name in combination with selected letters of the given name, date of birth and sex, may be used for record linkage for statistical purposes only.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare
Standards Australia

Origin: National Health Data Committee
National Community Services Data Committee
Commonwealth Department of Health and Family Services

	1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia
Reference documents:	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person (name)—family name, text X[X(39)] NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005
	See also Person (name)—given name, text [X(40)] NHIG, Standard 04/05/2005, NCSIMG, Standard 25/08/2005, NHDAMG, Standard 20/06/2005
	Is used in the formation of Person (name)—letters of name, text XXXXX NHIG, Proposed 17/06/2005, NCSIMG, Proposed 19/07/2006
Implementation in Data Set Specifications:	Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*
	Cancer (clinical) DSS NHIG, Standard 07/12/2005
	Cancer (clinical) DSS NHIG, Candidate 14/09/2006
	Cancer (clinical) DSS NHIG, Superseded 07/12/2005
	Health care client identification DSS NHIG, Standard 04/05/2005 NCSIMG, Standard 03/10/2006
	Health care provider identification DSS NHIG, Standard 04/05/2005
	National Bowel Screening Program NMDS *No registration status*
	Recommended Data Specifications for Community Care *No registration status*
	TEST sorting DSS *No registration status*
	TEST sorting DSS (no clusters) *No registration status*

Data set specification specific attributes

Given name(s)

Identifying and definitional attributes

Technical name:	Person (name)—given name, text [X(40)]
METeOR identifier:	287035
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005 NHDAMG, Standard 20/06/2005
Definition:	The person's identifying name within the family group or by which the person is socially identified, as represented by text.

Data element concept attributes

Data element concept:	Person (name)—given name
Definition:	The person's identifying name(s) within the **family** group or by which the person is socially identified.
Context:	Administrative purposes and individual identification.
Object class:	Person
Property:	Given name

Value domain attributes

Representational attributes

Representation class:	Text
Data type:	String
Format:	[X(40)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	A person may have more than one Given name. All given names should be recorded. The agency or establishment should record the client's full given name(s) on their information systems. National Community Services Data Dictionary specific: In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. In situations where proof of identity is required, the name is recorded on a majority of the higher point scoring documents that are produced as proof of identity. National Health Data Dictionary specific: Each individual Given name should have a Given name sequence number associated with it. Health care establishments may record given names (first and other given names) in one field or several fields. This metadata item definition applies regardless of the format of data recording. A full history of names is to be retained.

Collection methods:

This metadata item should be recorded for all clients.

Given name(s) should be recorded in the format preferred by the person. The format should be the same as that indicated by the person (eg written on a form) or in the same format as that printed on an identification card, such as Medicare card, to ensure consistent collection of name data.

It is acknowledged that some people use more than one given name (e.g. formal name, birth name, nick name or shortened name, or tribal name) depending on the circumstances. A person is able to change his or her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change his or her name under the Change of Name Act.

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be their legal (or Medicare card) name. The Person name type metadata item (see Comments) can be used to distinguish between the different types of names that may be used by the person.

The following format may assist with data collection:

What is the given name you would like to be known by?

_____

Are you known by any other given names that you would like recorded?

If so, what are they

_____

Please indicate the 'type' of given name that is to be recorded:

(a) Medicare card name (if different to preferred name).

(b) Alias (any other name that you are known by).

Whenever a person informs the agency or establishment of a change of given name (e.g. prefers to be know by their middle name), the former name should be recorded according to the appropriate name type. Do not delete or overwrite a previous given name e.g. 'Mary Georgina Smith' informs the hospital that she prefers to be known as 'Georgina'. Record 'Georgina' as her preferred given name and record 'Mary' as the Medicare card given name.

e.g. The establishment is informed that 'Baby of Louise Jones' has been named 'Mary Jones'. Retain 'Baby of Louise' as the newborn name and also record 'Mary' as the preferred 'Given name'.

Registering an unidentified health care client:

If the person is a health care client and her/his given name is not known record unknown in the 'Given name' field and use alias Name type. When the person's name becomes known, add the actual name as preferred Name type (or other as appropriate). Do not delete or overwrite the alias name of unknown.

Use of first initial:

If the person's given name is not known, but the first letter (initial) of the given name is known, record the first letter in the preferred 'Given name' field. Do not record a full stop following the initial.

Persons with only one name:

Some people do not have a **family** name and a given name: they have only one name by which they are known. If the person has only one name, record it in the 'Family name' field and leave the 'Given name' blank.

Record complete information:

All of the person's given names should be recorded.

Shortened or alternate first given name:

If the person uses a shortened version or an alternate version of their first given name, record their preferred name, the actual name as their Medicare card name and any alternative versions as alias names as appropriate.

Example - The person's given name is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred 'Given name' and 'Jennifer' as her Medicare card name.

Example - The person's given name is 'Giovanni' but he prefers to be called 'John'.

Record 'John' as the preferred 'Given name' and 'Giovanni' as the Medicare card name.

Punctuation:

If special characters form part of the given names they shall be included, e.g. hyphenated names shall be entered with the hyphen.

- Hyphen, e.g. Anne-Maree, Mary-Jane

Do not leave a space before or after the hyphen, i.e. between last letter of 'Anne' and the hyphen, nor a space between the hyphen and the first letter of 'Maree'.

- spaces, e.g. Jean Claude Carcel Moreaux

If the person has recorded their given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way (i.e. Jean Claude is one given name and Marcel is another given name).

Names not for continued use:

For cultural reasons, a person such as an Aboriginal or Torres Strait Islander may advise that they are no longer using the given name they previously used and are now using an alternative current name. Record their current name as their preferred given name and record their previously used name as an alias name (with a Name conditional use flag of ‘not for continued use’).

Composite name:

If a person identifies their first name as being a composite word, both parts should be recorded under the first Given Name (rather than the first and second Given Name).

e.g. ‘Anne Marie Walker’ notes her preferred Given Name to be ‘Anne Marie’, then ‘Anne Marie’ is recoded as (first) Given Name , and (second) Given Name is left blank.

Registering an unnamed newborn baby:

An unnamed (newborn) baby is to be registered using the mother's given name in conjunction with the prefix 'Baby of'. For example, if the baby's mother's given name is Fiona, then record 'Baby of Fiona' in the preferred 'Given name' field for the baby. This name is recorded under the newborn Name type. If a name is subsequently given, record the new name as the preferred given name and retain the newborn name.

Registering unnamed multiple births:

An unnamed (newborn) baby from a multiple birth should use their mother's given name plus a reference to the multiple births. For example, if the baby's mother's given name is 'Fiona' and a set of twins is to be registered, then record 'Twin 1 of Fiona' in the Given name field for the first born baby, and 'Twin 2 of Fiona' in the 'Given name' field of the second born baby. Arabic numbers (1, 2, 3 ...) are

used, not Roman Numerals (I, II, III .....).

In the case of triplets or other multiple births the same logic applies. The following terms should be use for recording multiple births:

- Twin:

use Twin i.e. Twin 1 of Fiona

- Triplet:

use Trip i.e. Trip 1 of Fiona

- Quadruplet:

use Quad i.e. Quad 1 of Fiona

- Quintuplet:

use Quin i.e. Quin 1 of Fiona

- Sextuplet:

use Sext i.e. Sext 1 of Fiona

- Septuplet:

use Sept i.e. Sept 1 of Fiona.

These names should be recorded under the newborn Person name type. When the babies are named, the actual names should be recorded as the preferred name. The newborn name is retained.

Aboriginal/Torres Strait Islander names not for continued use:

For cultural reasons, an Aboriginal or Torres Strait Islander may advise an agency or establishment that they are no longer using the given name that they had previously registered and are now using an alternative current name.

Record their current name as the preferred 'Given name' and record their previous used given name as an alias name.

Ethnic Names:

The Centrelink Naming Systems for Ethnic Groups publication provides the correct coding for ethnic names. Refer to Ethnic Names Condensed Guide for summary information.

Misspelled given names:

If the person's given name has been misspelled in error, update the Given name field with the correct spelling and record the misspelled given name as an Alias name. Recording misspelled names is important for filing documents that may be issued with previous versions of the client's name. Discretion should be used regarding the degree of recording that is maintained.

Comments:

Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between Thomas and Tom - can make Record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should ask the person for their full (formal) Given name and Family name. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family or surname separately. These should then be recorded as Given name and Family name as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the given name in combination with selected letters of the family name, date of birth and sex may be used for **record linkage** for statistical purposes only.

National Health Data Dictionary specific:

Health care provider identification DSS and Health care client identification DSS

For the purpose of positive identification or contact, agencies or establishments that collect Given name should also collect Given name sequence number. Given name sequence number is also a metadata item in Australian Standard AS4846-2004 Health care provider identification and is proposed for inclusion in the review of Australian Standard AS5017-2002 Health care client identification. AS5017 and AS4846 use alternative alphabetic codes for Given name sequence number. Refer to the current standards for more details.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Standards Australia

Origin: National Health Data Committee

National Community Services Data Committee

Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references: See also Person (name)—family name, text X[X(39)] NHIG, Standard 04/05/2005, NCSIMG, Standard 25/08/2005, NHDAMG, Standard 20/06/2005

Supersedes Person (name)—given name, text [X(40)] NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005

Is used in the formation of Person (name)—letters of name, text XXXXX NHIG, Proposed 17/06/2005, NCSIMG, Proposed 19/07/2006

Implementation in Data Set Specifications: Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*

Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Health care client identification DSS NHIG, Standard 04/05/2005 NCSIMG, Standard 03/10/2006

Health care provider identification DSS NHIG, Standard 04/05/2005

National Bowel Screening Program NMDS *No registration status*

Recommended Data Specifications for Community Care *No registration status*

Data set specification specific attributes

Histopathological grade

Identifying and definitional attributes

Technical name:	Person with cancer—histopathological grade, code N
METeOR identifier:	288663
Registration status:	NHIG, Standard 04/06/2004
Definition:	The histopathological grade, differentiation or phenotype describes how little the tumour resembles the normal tissue from which it arose, as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—histopathological grade
Definition:	The histopathological grade, differentiation or phenotype describes how little the tumour resembles the normal tissue from which it arose.
Object class:	Person with cancer
Property:	Histopathological grade

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Grade 1: Well differentiated, differentiated, NOS
2	Grade 2: Moderately differentiated, moderately well differentiated, intermediate differentiation
3	Grade 3: Poorly differentiated
4	Grade 4: Undifferentiated, anaplastic
5	T-cell: T-cell
6	B-cell: B-cell, Pre-B, B-Precursor
7	Null-cell: Null cell, Non T- non B
8	NK: Natural killer cell

Supplementary values:

9	Grade/differentiation unknown: Grade/cell type not determined, not stated or not applicable

Data element attributes

Collection and usage attributes

Guide for use:	Only one code can be recorded.

Source and reference attributes

Origin:	World Health Organisation

	Commission on Cancer American College of Surgeons
Reference documents:	World Health Organisation International Classification of Diseases Oncology, Third edition (ICD-O-3) (2000)
	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Histopathological grade, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005
	Cancer (clinical) DSS NHIG, Candidate 14/09/2006
	Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Intention of treatment for cancer

Identifying and definitional attributes

Technical name:	Cancer treatment—intention of treatment, code N
METeOR identifier:	288690
Registration status:	NHIG, Standard 04/06/2004
Definition:	The intention of the initial treatment for cancer for the particular patient, as represented by a code.

Data element concept attributes

Data element concept:	Cancer treatment—intention of treatment
Definition:	The intention of the initial treatment for cancer for the particular patient.
Object class:	Cancer treatment
Property:	Intention of treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Prophylactic
2	Curative
3	Non-curative or palliative

Supplementary values:

Value	Meaning
0	Did not have treatment
9	Not stated

Collection and usage attributes

Guide for use:

CODE 0 Did not have treatment

This code is used when the patient did not have treatment as part of the initial management plan

CODE 1 Prophylactic

This code is used when the cancer has not developed

CODE 2 Curative

This code is used when treatment is given for control of the disease

CODE 3 Non-curative or Palliative

This code is used when the cure is unlikely to be achieved and treatment is given primarily for the purpose of pain control. Other benefits of the treatment are considered secondary contributions to the patient's quality of life

CODE 9 Intention was not stated

Patient had treatment for cancer but the intention was not stated.

Data element attributes

Collection and usage attributes

Guide for use: This item is collected for surgical treatment, radiation therapy and systemic therapy agent treatment.

Source and reference attributes

Submitting organisation: National Cancer Control Initiative

Origin: Commission on Cancer, American College of Surgeons
New South Wales Health Department

Reference documents: Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)
Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references: Supersedes Intention of treatment for cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005
Cancer (clinical) DSS NHIG, Candidate 14/09/2006
Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set: It is used for correlating outcome with original intent of the treatment.

Laterality of primary cancer

Identifying and definitional attributes

Technical name:	Person with cancer—laterality of primary cancer, code [N]
METeOR identifier:	270177
Registration status:	NHIG, Standard 01/03/2005
Definition:	The side of a paired organ that is the origin of the primary cancer, as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—laterality of primary cancer
Definition:	Laterality describes which side of a paired organ is the origin of the primary cancer. Each side of a paired organ is considered separately and described as lateral when occurring unless a physician determines that it is bilateral. A paired organ is one in which there are two separate organs of the same kind, one on either side of the body (e.g. kidney, breast, ovary, testis and lung).
Context:	This information is collected for the purpose of differentiating the site of the primary cancer. For example, a woman may present with a primary cancer in the left breast. She may return at a later stage with a new primary cancer in the right breast.
Object class:	Person with cancer
Property:	Laterality of primary cancer

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Left
	2	Right
	3	Bilateral
Supplementary values:	9	Not known
	Null	Not applicable

Data element attributes

Collection and usage attributes

Guide for use:	The valid International Classification of Diseases for Oncology values for the variable are provided in the list below: CODE 1 Left Origin of primary site is on the left side of a paired organ. Paired organs are: Breast (C50), Lung (C34), Kidney (C64), Ovary (C56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1,

C40.0, C77.3,), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62), Parathyroid glands (C75.0), Adrenal glands (C74.9, C74.0, C74.1), Tonsils (C09.9, C02.4, C11.1, C09.0, C09.1, C03.9), Ureter (C66.9), Carotid body (C75.4), Vas deferens (C63.1), Optic nerve (C72.3)

CODE 2 Right

Origin of primary site is on the right side of a paired organ.

CODE 3 Bilateral

Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3)) Note: Bilateral cancers are very rare.

CODE 9 Unknown

It is unknown whether, for a paired organ the origin of the cancer was on the left or right side of the body.

Collection methods: This information should be obtained from the patient's pathology report, the patient's medical record, or the patient's medical practitioner/nursing staff.

Source and reference attributes

Origin: World Health Organization

Reference documents: Percy C, Van Holten V, Muir C (eds). International Classification of Diseases for Oncology, 2nd edition. Geneva: WHO, 1990

Relational attributes

Related metadata references: Supersedes Laterality of primary cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Medicare card number

Identifying and definitional attributes

Technical name:	Person—government funding identifier, Medicare card number N(11)
METeOR identifier:	270101
Registration status:	NHIG, Standard 01/03/2005
Definition:	Person identifier, allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.
Context:	Medicare utilisation statistics. Persons eligible for Medicare services.

Data element concept attributes

Data element concept:	Person—government funding identifier
Definition:	A personal identifier allocated by a government department for the purpose of identifying those eligible for specific services.
Object class:	Person
Property:	Government funding identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	Number
Format:	N(11)
Maximum character length:	11

Collection and usage attributes

Guide for use:	Full Medicare number for an individual (i.e. family number plus person (individual reference) number).
Comments:	The Medicare card number is printed on a Medicare card and is used to access Medicare records for an eligible person. Up to 9 persons can be included under the one Medicare card number with up to five persons appearing on one physical card. Persons grouped under one Medicare card number are often a family, however, there is no requirement for persons under the same Medicare card number to be related. A person may be shown under separate Medicare card numbers where, for example, a child needs to be included on separate Medicare cards held by their parents. As a person can be identified on more than one Medicare card this is not a unique identifier for a person.

Data element attributes

Collection and usage attributes

Guide for use:	The Medicare card number should only be collected from persons eligible to receive health services that are to be funded

	by the Commonwealth government. The number should be reported to the appropriate government agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any other purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.
Comments:	Note: Veterans may have a Medicare card number and a Department of Veterans' Affairs (DVA) number or only a DVA number.

Source and reference attributes

Submitting organisation:	Standards Australia
Origin:	AS5017 Health care client identification

Relational attributes

Related metadata references:	Supersedes Medicare card number, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005 Health care client identification NHIG, Superseded 04/05/2005 Health care client identification DSS NHIG, Standard 04/05/2005 NCSIMG, Standard 03/10/2006 National Bowel Screening Program NMDS *No registration status*

Data set specification specific attributes

Morphology of cancer

Identifying and definitional attributes

Technical name:	Person with cancer—morphology of cancer, code (ICDO-3) NNNN/N
METeOR identifier:	270179
Registration status:	NHIG, Standard 01/03/2005
Definition:	The histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour), as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—morphology of cancer
Definition:	The morphology of a cancer refers to the histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour). The designation is based on a microscopic diagnosis of morphology by the pathologist (Esteban, Whelan, Laudico & Parkin 1995).
Object class:	Person with cancer
Property:	Morphology of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	Number
Format:	NNNN/N
Maximum character length:	5

Collection and usage attributes

Guide for use:

ICDO morphology describes histology and behaviour as separate variables, recognising that there are a large number of possible combinations.

In ICDO, morphology is a 4-digit number ranging from 8000 to 9989, and behaviour is a single digit which can be 0, 1, 2, 3, 6 or 9.

Record morphology codes in accordance with ICDO coding standards. Use the 5th-digit to record behaviour. The 5th-digit behaviour code numbers used in ICDO are listed below:

0 Benign

1 Uncertain whether benign or malignant

- borderline malignancy
- low malignant potential

2 Carcinoma in situ

- intraepithelial
- non-infiltrating

- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site

- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Source and reference attributes

Origin: International Classification of Diseases for Oncology, Third Edition (ICDO-3)

Data element attributes

Collection and usage attributes

Collection methods: Cancer registry use:

In cancer registries morphology information should be obtained from a pathology report or pathology system, and recorded with/on the patient's medical record and/or the hospital's patient administration system. Additional information may also be sought from the patient's attending clinician or medical practitioner.

Hospital morbidity use:

In hospitals, the morphology code is modified for use with ICD-10-AM. The morphology code consists of histologic type (4 digits) and behaviour code (1 digit) ranging from 8000/0 to 9989/9. The '/' between the fourth and fifth digits is not supplied.

Source and reference attributes

Origin: World Health Organization

New South Wales Health Department

State and Territory Cancer Registries

Reference documents: New South Wales Inpatient Statistics Collection Manual, 2000/2001

Esteban D, Whelan S, Laudico A and Parkin DM editors. International Agency for Research on Cancer World Health Organization and International Association of Cancer Registries: Manual for cancer registry personnel. IARC Technical Report No 10. Lyon: IARC,1995

Relational attributes

Related metadata references: Supersedes Morphology of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set: This information is collected for the purpose of:

- classifying tumours into clinically relevant groupings on the basis of both their morphology (cell type) and their degree of invasion or malignancy as indicated by the behaviour code component (the last digit of the

morphology code);

- monitoring the number of new cases of cancer for planning treatment services.

Most valid basis of diagnosis of cancer

Identifying and definitional attributes

Technical name:	Person with cancer—most valid basis of diagnosis of a cancer, code N
METeOR identifier:	270181
Registration status:	NHIG, Standard 01/03/2005
Definition:	The most valid basis of diagnosis of cancer, as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—most valid basis of diagnosis of a cancer
Definition:	The basis of diagnosis of a cancer is the microscopic or non-microscopic or death certificate source of the diagnosis. The most valid basis of diagnosis is that accepted by the cancer registry as the most reliable diagnostic source of the death certificate, non-microscopic, and microscopic sources available.
Object class:	Person with cancer
Property:	Most valid basis of diagnosis of a cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
0	Death certificate only: Information provided is from a death certificate
1	Clinical: Diagnosis made before death, but without any of the following (codes 2-7)
2	Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis
4	Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site
5	Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates
6	Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens
7	Histology of a primary tumour: Histological

		examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour
	8	Histology: either unknown whether of primary or metastatic site, or not otherwise specified
Supplementary values:	9	Unknown.

Collection and usage attributes

Guide for use:

CODES 1 - 4

Non-microscopic.

CODES 5 - 8

Microscopic.

CODE 9

Other.

Comments:

In a hospital setting this metadata item should be collected on the most valid basis of diagnosis at this admission. If more than one diagnosis technique is used during an admission, select the higher code from 1 to 8.

Data element attributes

Collection and usage attributes

Guide for use:

The most valid basis of diagnosis may be the initial histological examination of the primary site, or it may be the post-mortem examination (sometimes corrected even at this point when histological results become available). In a cancer registry setting, this metadata item should be revised if later information allows its upgrading.

When considering the most valid basis of diagnosis, the minimum requirement of a cancer registry is differentiation between neoplasms that are verified microscopically and those that are not. To exclude the latter group means losing valuable information; the making of a morphological (histological) diagnosis is dependent upon a variety of factors, such as age, accessibility of the tumour, availability of medical services, and, last but not least, upon the beliefs of the patient.

A biopsy of the primary tumour should be distinguished from a biopsy of a metastasis, e.g., at laparotomy; a biopsy of cancer of the head of the pancreas versus a biopsy of a metastasis in the mesentery. However, when insufficient information is available, Code 8 should be used for any histological diagnosis. Cytological and histological diagnoses should be distinguished.

Morphological confirmation of the clinical diagnosis of malignancy depends on the successful removal of a piece of tissue that is cancerous. Especially when using endoscopic procedures (bronchoscopy, gastroscopy, laparoscopy, etc.), the clinician may miss the tumour with the biopsy forceps. These cases must be registered on the basis of endoscopic diagnosis and not excluded through lack of a morphological diagnosis.

Care must be taken in the interpretation and subsequent coding of autopsy findings, which may vary as follows:

a) the post-mortem report includes the post-mortem histological diagnosis (in which case, one of the Histology codes

should be recorded instead);

b) the autopsy is macroscopic only, histological investigations having been carried out only during life (in which case, one of the Histology codes should be recorded instead);

c) the autopsy findings are not supported by any histological diagnosis.

Source and reference attributes

Origin: International Agency for Research on Cancer
International Association of Cancer Registries

Relational attributes

Related metadata references: Supersedes Most valid basis of diagnosis of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005
Cancer (clinical) DSS NHIG, Candidate 14/09/2006
Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set: Knowledge of the basis of a diagnosis underlying a cancer code is one of the most important aids in assessing the reliability of cancer statistics.

Oestrogen receptor assay status

Identifying and definitional attributes

Technical name:	Person with cancer—oestrogen receptor assay results, code N
METeOR identifier:	291324
Registration status:	NHIG, Standard 13/06/2004
Definition:	The result of oestrogen receptor assay at the time of diagnosis of the primary breast tumour, as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—oestrogen receptor assay results
Definition:	The results of oestrogen receptor assay at the time of diagnosis of the primary breast tumour.
Context:	Collected for breast cancers.
Object class:	Person with cancer
Property:	Oestrogen receptor assay result

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Test done, results positive (oestrogen receptor positive)
2	Test done, results negative (oestrogen receptor negative)

Supplementary values:

Value	Meaning
0	Test not done (test not ordered or not performed)
8	Test done but results unknown

Data element attributes

Collection and usage attributes

Comments:

Hormone receptor status is an important prognostic indicator for breast cancer.

The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high) and
- a conclusion as to whether the assay is positive or negative.

Source and reference attributes

Origin:	Royal College of Pathologists of Australasia

	Australian Cancer Network
	Commission on Cancer American College of Surgeons
Reference documents:	Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001)
	Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)
	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Oestrogen receptor assay status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005
	Cancer (clinical) DSS NHIG, Candidate 14/09/2006
	Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Outcome of initial treatment

Identifying and definitional attributes

Technical name:	Cancer treatment—outcome of treatment, code N.N
METeOR identifier:	289304
Registration status:	NHIG, Standard 04/06/2004
Definition:	The response of the tumour at the completion of the initial treatment modalities, as represented by a code.

Data element concept attributes

Data element concept:	Cancer treatment—outcome of treatment
Definition:	The outcome of initial treatment describes the response of the tumour at the completion of the initial treatment modalities.
Object class:	Cancer treatment
Property:	Outcome of treatment

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N.N
Maximum character length:	2

Permissible values:

Value	Meaning
1.0	Complete response
2.1	Partial response
2.2	Stable or static disease
2.3	Progressive disease
2.9	Incomplete response

Supplementary values:

Value	Meaning
9.0	Not assessed or unable to be assessed

Collection and usage attributes

Guide for use:

CODE 1.0 Complete response

Complete disappearance of all measurable disease, including tumour markers, for at least four weeks. No new lesions or new evidence of disease.

CODE 2.1 Partial response

A decrease by at least 50% of the sum of the products of the maximum diameter and perpendicular diameter of all measurable lesions, for at least four weeks. No new lesions or worsening of disease.

CODE 2.2 Stable or static disease

No change in measurable lesions qualifying as partial response or progression and no evidence of new lesions.

CODE 2.3 Progressive disease

An increase by at least 25% of the sum of the products of the maximum diameter and a perpendicular diameter of any measurable lesion, or the appearance of new lesions.

Data element attributes

Source and reference attributes

Origin: New South Wales Health Department

Reference documents: Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references: Supersedes Outcome of initial treatment, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set: This item is collected for assessing disease status at the end of primary treatment.

Person identifier

Identifying and definitional attributes

Technical name:	Person—person identifier, XXXXXX[X(14)]
METeOR identifier:	290046
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005
Definition:	Person identifier unique within an establishment or agency.

Data element concept attributes

Data element concept:	Person—person identifier
Definition:	Person identifier unique within an establishment or agency.
Context:	This item could be used for editing at the agency, establishment or collection authority level and, potentially, for record linkage. There is no intention that this item would be available beyond collection authority level.
Object class:	Person
Property:	Person identifier

Value domain attributes

Representational attributes

Representation class:	Identifier
Data type:	String
Format:	XXXXXX[X(14)]
Maximum character length:	20

Data element attributes

Collection and usage attributes

Guide for use:	Individual agencies, establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems. Field cannot be blank.

Source and reference attributes

Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Person—person identifier (within establishment/agency), XXXXXX[X(14)] NHIG, Superseded 04/05/2005, NCSIMG, Superseded 25/08/2005
Implementation in Data Set Specifications:	AROC inpatient data set specification NHIG, Recorded 24/08/2006 Acute coronary syndrome (clinical) DSS NHIG, Standard

07/12/2005

Acute coronary syndrome (clinical) DSS *No registration status*

Acute coronary syndrome (clinical) DSS NHIG, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*

Admitted patient care NMDS NHIG, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 NHIG, Standard 07/12/2005

Admitted patient care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Admitted patient mental health care NMDS NHIG, Standard 07/12/2005

Admitted patient mental health care NMDS NHIG, Superseded 07/12/2005

Admitted patient mental health care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Admitted patient palliative care NMDS NHIG, Superseded 07/12/2005

Admitted patient palliative care NMDS 2006-2007 NHIG, Superseded 29/11/2006

Admitted patient palliative care NMDS 2007-08 NHIG, Standardisation pending 23/10/2006

Alcohol and other drug treatment services NMDS NHIG, Standard 21/03/2006

Alcohol and other drug treatment services NMDS NHIG, Superseded 21/03/2006

Alcohol and other drug treatment services NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS NHIG, Standard 01/03/2005

Cardiovascular disease (clinical) DSS - Demo for CPIC *No registration status*

Community mental health care 2004-2005 NHIG, Superseded 08/12/2004

Community mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005

Community mental health care NMDS 2006-2007 NHIG, Standard 07/12/2005

Community mental health care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Congenital anomalies NMDS (Under development by the NPSU September 2006) *No registration status*

Health care client identification DSS NHIG, Standard 04/05/2005
NCSIMG, Standard 03/10/2006

Health care provider identification DSS NHIG, Standard 04/05/2005

Intensive care DSS NHIG, Recorded 14/07/2006

Juvenile Justice NMDS NCSIMG, Proposed 19/07/2006

Non-admitted patient emergency department care NMDS NHIG, Standard 24/03/2006

Non-admitted patient emergency department care NMDS NHIG, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS NHIG, Superseded 24/03/2006

Non-admitted patient emergency department care NMDS *No registration status*

Outpatient care patient level DSS *No registration status*

Perinatal NMDS NHIG, Standard 06/09/2006

Perinatal NMDS NHIG, Superseded 07/12/2005

Perinatal NMDS NHIG, Superseded 06/09/2006

Residential mental health care NMDS NHIG, Proposed 15/08/2005

Residential mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005

Residential mental health care NMDS 2006-2007 NHIG, Standard 07/12/2005

Residential mental health care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Data set specification specific attributes

Primary site of cancer (ICD-10-AM code)

Identifying and definitional attributes

Technical name:	Person with cancer—primary site of cancer, code (ICD-10-AM 5th edn) ANN{.N[N]}
METeOR identifier:	333927
Registration status:	NHIG, Standard 07/12/2005
Definition:	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICD-10-AM code.

Data element concept attributes

Data element concept:	Person with cancer—primary site of cancer
Definition:	The primary site is the site of origin of the tumour, as opposed to the secondary or metastatic sites. It is described by reporting the anatomical position (topography) of the tumour.
Object class:	Person with cancer
Property:	Primary site of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 5th edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:	Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer. In ICD-10-AM (5th edition), primary site is identified using a single 4 digit code Cxx.x or Dxx.x.

Source and reference attributes

Reference documents:	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)

Data element attributes

Collection and usage attributes

Collection methods:	In a hospital setting, primary site of cancer should be recorded on the patient's medical record by the patient's attending clinician or medical practitioner, and coded by the hospital's medical records department. Hospitals use Diagnosis codes from ICD-10-AM (5th edition). Valid codes must start with C or D. In hospital reporting, the diagnosis code for each separate

primary site cancer will be reported as a Principal diagnosis or an Additional diagnosis as defined in the current edition of the Australian Coding Standards. In death reporting, the Australian Bureau of Statistics uses ICD-10.

Some ICD-10-AM (5th edition) diagnosis codes e.g. mesothelioma and Kaposi's sarcoma, are based on morphology and not site alone, and include tumours of these types even where the primary site is unknown.

Source and reference attributes

Origin: World Health Organization

Relational attributes

Related metadata references: Supersedes Person with cancer—primary site of cancer, code (ICD-10-AM 4th edn) ANN{.N[N]} NHIG, Superseded 07/12/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Data set specification specific attributes

Information specific to this data set: This information is collected for the purpose of:

- classifying tumours into clinically-relevant groupings on the basis of both their site of origin and their histological type
- monitoring the number of new cases of cancer for planning treatment services
- epidemiological studies.

Primary site of cancer (ICDO-3 code)

Identifying and definitional attributes

Technical name:	Person with cancer—primary site of cancer, code (ICDO-3) ANN{.N[N]}
METeOR identifier:	270178
Registration status:	NHIG, Standard 01/03/2005
Definition:	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICDO-3 code.

Data element concept attributes

Data element concept:	Person with cancer—primary site of cancer
Definition:	The primary site is the site of origin of the tumour, as opposed to the secondary or metastatic sites. It is described by reporting the anatomical position (topography) of the tumour.
Object class:	Person with cancer
Property:	Primary site of cancer

Value domain attributes

Representational attributes

Classification scheme:	International Classification of Diseases for Oncology 3rd edition
Representation class:	Code
Data type:	String
Format:	ANN{.N[N]}
Maximum character length:	6

Collection and usage attributes

Guide for use:

Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer.

In ICDO, primary site is identified using both the Cxx.x code identifying site and the behaviour code to identify whether the site is the primary site. The behaviour code numbers used in ICDO are listed below:

0 Benign

1 Uncertain whether benign or malignant

- borderline malignancy
- low malignant potential

2 Carcinoma in situ

- intraepithelial
- non-infiltrating
- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site

- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Data element attributes

Collection and usage attributes

Collection methods: Cancer registries use Site codes from ICDO 3rd edition.

Source and reference attributes

Origin: World Health Organization

Relational attributes

Related metadata references: Supersedes Primary site of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005
Cancer (clinical) DSS NHIG, Candidate 14/09/2006
Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set: This information is collected for the purpose of:

- classifying tumours into clinically-relevant groupings on the basis of both their site of origin and their histological type
- monitoring the number of new cases of cancer for planning treatment services
- epidemiological studies.

Progesterone receptor assay results

Identifying and definitional attributes

Technical name:	Person with cancer—progesterone receptor assay results, code N
METeOR identifier:	291341
Registration status:	NHIG, Standard 13/06/2004
Definition:	The results of progesterone receptor assay at the time or diagnosis of the primary breast tumour, as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—progesterone receptor assay results
Definition:	The results of progesterone receptor assay at the time of diagnosis of the primary breast tumour.
Object class:	Person with cancer
Property:	Progesterone receptor assay results

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Maximum character length:	1	
Permissible values:	Value	Meaning
	1	Test done, results positive (progesterone receptor positive)
	2	Test done, results negative (Progesterone receptor negative)
Supplementary values:	0	Test not done (test not ordered or not performed)
	8	Test done but results unknown
	9	Unknown

Data element attributes

Collection and usage attributes

Collection methods: The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include:

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high), and
- a conclusion as to whether the assay is positive or negative.

Source and reference attributes

Origin: Royal College of Pathologists of Australasia

	Australian Cancer Network
	Commission on Cancer American College of Surgeons
Reference documents:	Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001)
	Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)
	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Progesterone receptor assay status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005
	Cancer (clinical) DSS NHIG, Candidate 14/09/2006
	Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set:	Hormone receptor status is an important prognostic indicator for breast cancer.

Radiotherapy treatment type

Identifying and definitional attributes

Technical name:	Cancer treatment—radiotherapy treatment type, code N
METeOR identifier:	291438
Registration status:	NHIG, Standard 13/06/2004
Definition:	The type of radiation therapy used in initial treatment of the cancer, as represented by a code.

Data element concept attributes

Data element concept:	Cancer treatment—radiotherapy treatment type
Definition:	The type of radiation therapy used in initial treatment of the cancer.
Object class:	Cancer treatment
Property:	Radiotherapy treatment type

Value domain attributes

Representational attributes

Representation class:	Code	
Data type:	Number	
Format:	N	
Permissible values:	Value	Meaning
	1	External radiotherapy treatment given
	2	Brachytherapy (radioactive implants)
	3	Unsealed radioisotopes
Supplementary values:	0	No radiotherapy treatment given
	9	Radiotherapy was administered but method was not stated

Data element attributes

Collection and usage attributes

Collection methods:	If codes 1,2,3 or 9 are used, the amount of radiation received should also be collected. Most external beam radiotherapy is delivered on an outpatient basis. CODE 2 Brachytherapy (radioactive implants) This code is likely to be listed as a procedure for admitted patients.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons New South Wales Health Department
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS)

Volume II (1998)
Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references: See also Cancer treatment—radiation dose received, total Gray N[NNNN] NHIG, Standard 13/06/2004
Supersedes Radiotherapy treatment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005
Cancer (clinical) DSS NHIG, Candidate 14/09/2006
Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set: This metadata item is collected for the analysis of outcome by treatment type.

Received radiation dose

Identifying and definitional attributes

Technical name:	Cancer treatment—radiation dose received, total Gray N[NNNN]
METeOR identifier:	291472
Registration status:	NHIG, Standard 13/06/2004
Definition:	The received dose of radiation measured in Gray (Gy) - ICRU.

Data element concept attributes

Data element concept:	Cancer treatment—radiation dose received
Definition:	The amount of radiation a person receives for treatment of cancer.
Object class:	Cancer treatment
Property:	Radiation dose received

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[NNNN]
Maximum character length:	5

Supplementary values:

Value	Meaning
00000	No radiation therapy was administered
99999	Radiation therapy was administered but the dose is unknown

Unit of measure:	Gray (Gy)

Data element attributes

Collection and usage attributes

Guide for use:

The International Commission on Radiation Units (ICRU) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pairs and so on). The ICRU50 reference dose should be recorded for photon therapy if available, otherwise a description of the received dose at the centre of the planning target volume.

The ICRU58 should be recorded for brachytherapy.

For maximum consistency in this field the ICRU recommendations should be followed whenever possible.

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	Supersedes Received radiation dose, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set:	This item is collected for the analysis of outcome by treatment type.

Region of first recurrence

Identifying and definitional attributes

Technical name:	Person with cancer—region of first recurrence of cancer, code N
METeOR identifier:	289136
Registration status:	NHIG, Standard 04/06/2004
Definition:	The region of first recurrence of primary cancer after a disease free intermission or remission, as represented by a code.

Data element concept attributes

Data element concept:	Person with cancer—region of first recurrence of cancer
Definition:	The term recurrence refers to the return or reappearance of the primary cancer after a disease-free intermission or remission.
Object class:	Person with cancer
Property:	Region of first recurrence of cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Local
2	Regional
3	Both local and regional
4	Distant
5	Distant and either local or regional
6	Local, regional and distant

Supplementary values:

Value	Meaning
0	None, patient is disease-free
7	Patient was never disease-free
8	Recurred but site unknown
9	Unknown if recurred

Data element attributes

Collection and usage attributes

Guide for use:

The region of the first recurrence following the initial diagnosis should be recorded.

The record should not be updated with subsequent recurrences.

The cancer may recur in more than one site (e.g. both regional and distant metastases).

Record the highest numbered applicable response.

Source and reference attributes

Origin:	Commission on Cancer, American College of Surgeons
Reference documents:	Commission on Cancer, Standards of the Commission on Cancer Volume II Registry Operations and Data Standards (ROADS) (1998)

Relational attributes

Related metadata references:	Supersedes Region of first recurrence, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set:	This item is collected for the analysis of outcome by treatment type.

Regional lymph nodes examined

Identifying and definitional attributes

Technical name:	Person with cancer—number of regional lymph nodes examined, total N[N]
METeOR identifier:	289177
Registration status:	NHIG, Standard 04/06/2004
Definition:	The total number of regional lymph nodes examined by the pathologist.

Data element concept attributes

Data element concept:	Person with cancer—number of regional lymph nodes examined
Definition:	This records the total number outcome of regional lymph nodes examined by the pathologist.
Object class:	Person with cancer
Property:	Number of regional lymph nodes examined

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
0	No regional lymph nodes examined
90	Ninety or more regional lymph nodes examined
95	No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed
96	Regional lymph node removal documented as sampling but number unknown/not stated
97	Regional lymph nodes removal documented as dissection but number unknown/not stated
98	Regional lymph nodes removal but number unknown/not stated and not documented as sampling or dissection
99	Unknown; not stated; death certificate only

Collection and usage attributes

Guide for use:

CODE 95 No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed

No regional lymph node(s) removed, but aspiration of regional lymph node(s) was performed, is used for a lymph node aspiration when cytology or histology is positive for malignant cells.

CODE 99 Unknown; not stated; death certificate only

Unknown; not stated; death certificate only, is used if information about regional lymph nodes is unknown or if the field is not applicable for that site or histology.

Data element attributes

Source and reference attributes

Origin:

Australian Cancer Network

Commission on Cancer American College of Surgeons

Reference documents:

Australian Cancer Network The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)

Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:

See also Person with cancer—number of positive regional lymph nodes, total N[N] NHIG, Standard 04/06/2004

Supersedes Regional lymph nodes examined, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications:

Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Regional lymph nodes positive

Identifying and definitional attributes

Technical name:	Person with cancer—number of positive regional lymph nodes, total N[N]
METeOR identifier:	289205
Registration status:	NHIG, Standard 04/06/2004
Definition:	The total number of regional lymph nodes examined by a pathologist and reported as containing tumour.

Data element concept attributes

Data element concept:	Person with cancer—number of positive regional lymph nodes
Definition:	The number of regional lymph nodes examined by a pathologist and reported as containing tumour.
Object class:	Person with cancer
Property:	Number of positive regional lymph nodes

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	Number
Format:	N[N]
Maximum character length:	2

Supplementary values:

Value	Meaning
0	All nodes examined negative
96	Ninety-six or more lymph nodes positive
97	Positive nodes but number not specified
98	No nodes examined
99	Unknown if nodes are positive or negative; not applicable

Collection and usage attributes

Guide for use:

CODE 97 Positive nodes but number not specified

Positive nodes but number not specified, is used when the cytology or histology from a lymph node aspiration is positive for malignant cells.

CODE 98 No nodes examined

Positive nodes but number not specified, is used when no nodes are removed or examined.

CODE 99 Unknown if nodes are positive or negative; not applicable

Unknown if nodes are positive or negative, is used if information about regional lymph nodes is unknown or if it is not applicable for that site or histology.

Data element attributes

Source and reference attributes

Origin:	Australian Cancer Network Commission on Cancer American College of Surgeons
Reference documents:	Australian Cancer Network The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001) Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:	See also Person with cancer—number of regional lymph nodes examined, total N[N] NHIG, Standard 04/06/2004 Supersedes Regional lymph nodes positive, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Sex

Identifying and definitional attributes

Technical name:	Person—sex, code N
METeOR identifier:	287316
Registration status:	NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005 NHDAMG, Standard 10/02/2006
Definition:	The biological distinction between male and female, as represented by a code.

Data element concept attributes

Data element concept:	Person—sex
Definition:	Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.
Context:	Sex is a core metadata item in a wide range of social, labour and demographic statistics.
Object class:	Person
Property:	Sex

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	Male
2	Female
3	Intersex or indeterminate

Supplementary values:

Value	Meaning
9	Not stated/inadequately described

Collection and usage attributes

Guide for use:

Diagnosis and procedure codes should be checked against the national ICD-10-AM sex edits, unless the person is undergoing, or has undergone a sex change or has a genetic condition resulting in a conflict between sex and ICD-10-AM code.

CODE 3 Intersex or indeterminate

Intersex or indeterminate, refers to a person, who because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason.

Intersex or indeterminate, should be confirmed if reported for people aged 90 days or greater.

Comments: The definition for Intersex in Guide for use is sourced from the

ACT Legislation (Gay, Lesbian and Transgender) Amendment Act 2003.

Source and reference attributes

Origin: Australian Capital Territory 2003. Legislation (Gay, Lesbian and Transgender) Amendment Act 2003

Reference documents: Legislation (Gay, Lesbian and Transgender) Amendment Act 2003. See http://www.legislation.act.gov.au/a/2003-14/20030328-4969/pdf/2003-14.pdf.

Data element attributes

Collection and usage attributes

Collection methods: Operationally, sex is the distinction between male and female, as reported by a person or as determined by an interviewer.

When collecting data on sex by personal interview, asking the sex of the respondent is usually unnecessary and may be inappropriate, or even offensive. It is usually a simple matter to infer the sex of the respondent through observation, or from other cues such as the relationship of the person(s) accompanying the respondent, or first name. The interviewer may ask whether persons not present at the interview are male or female.

A person's sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment, transsexual surgery, transgender reassignment or sexual reassignment. Throughout this process, which may be over a considerable period of time, the person's sex could be recorded as either Male or Female.

In data collections that use the ICD-10-AM classification, where sex change is the reason for admission, diagnoses should include the appropriate ICD-10-AM code(s) that clearly identify that the person is undergoing such a process. This code(s) would also be applicable after the person has completed such a process, if they have a procedure involving an organ(s) specific to their previous sex (e.g. where the patient has prostate or ovarian cancer).

CODE 3 Intersex or indeterminate

Is normally used for babies for whom sex has not been determined for whatever reason.

Should not generally be used on data collection forms completed by the respondent.

Should only be used if the person or respondent volunteers that the person is intersex or where it otherwise becomes clear during the collection process that the individual is neither male nor female.

CODE 9 Not stated/inadequately described

Is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Origin: Australian Institute of Health and Welfare (AIHW) National Mortality Database 1997/98 AIHW 2001 National Diabetes Register, Statistical Profile, December 2000 (Diabetes Series No.

2.)

Reference documents:

Australian Bureau of Statistics

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

In AS4846 and AS5017 alternative codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references:

Supersedes Person—sex (housing assistance), code N NHDAMG, Superseded 10/02/2006

Supersedes Person—sex, code N NHIG, Superseded 04/05/2005, NCSIMG, Superseded 31/08/2005

Is used in the formation of Record—linkage key, statistical code XXXXXDDMMYYYYN NCSIMG, Proposed 19/07/2006

Is used in the formation of Person—statistical linkage key, XXXXXDDMMYYYYN NCSIMG, Proposed 19/07/2006

Is used in the formation of Major Diagnostic Category - supplied by hospital - code (AR-DRG v5.1) NN *No registration status*

Is used in the formation of Episode of admitted patient care—major diagnostic category, code (AR-DRG v5.1) NN NHIG, Standard 01/03/2005

Is used in the formation of Episode of admitted patient care—diagnosis related group, code (AR-DRG v5.1) ANNA NHIG, Standard 01/03/2005

Implementation in Data Set Specifications:

ACT Health Morbidity Data Collection Specification 2006-2007 *No registration status*

AROC inpatient data set specification NHIG, Recorded 24/08/2006

Acute coronary syndrome (clinical) DSS NHIG, Standard 07/12/2005

Acute coronary syndrome (clinical) DSS *No registration status*

Acute coronary syndrome (clinical) DSS NHIG, Superseded 07/12/2005

Acute coronary syndrome (clinical) DSS - Queensland Health CPIC *No registration status*

Admitted patient care NMDS NHIG, Superseded 07/12/2005

Admitted patient care NMDS 2006-2007 NHIG, Standard 07/12/2005

Admitted patient care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Admitted patient mental health care NMDS NHIG, Standard 07/12/2005

Admitted patient mental health care NMDS NHIG, Superseded 07/12/2005

Admitted patient mental health care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Admitted patient palliative care NMDS NHIG, Superseded 07/12/2005

Admitted patient palliative care NMDS 2006-2007 NHIG,

Superseded 29/11/2006

Admitted patient palliative care NMDS 2007-08 NHIG, Standardisation pending 23/10/2006

Alcohol and other drug treatment services NMDS NHIG, Standard 21/03/2006

Alcohol and other drug treatment services NMDS NHIG, Superseded 21/03/2006

Alcohol and other drug treatment services NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Cardiovascular disease (clinical) DSS NHIG, Standard 01/03/2005

Cardiovascular disease (clinical) DSS - Demo for CPIC *No registration status*

Child protection NMDS *No registration status*

Commonwealth State/Territory Disability Agreement NMDS *No registration status*

Community mental health care 2004-2005 NHIG, Superseded 08/12/2004

Community mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005

Community mental health care NMDS 2006-2007 NHIG, Standard 07/12/2005

Community mental health care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Community-based palliative care client DSS *No registration status*

Computer Assisted Telephone Interview demographic module DSS *No registration status*

Computer Assisted Telephone Interview demographic module DSS NHIG, Standard 04/05/2005

Congenital anomalies NMDS (Under development by the NPSU September 2006) *No registration status*

Dementia MDS *No registration status*

Diabetes (clinical) DSS NHIG, Superseded 21/09/2005

Diabetes (clinical) DSS NHIG, Standard 21/09/2005

Draft Needle and Syringe program client data dictionary *No registration status*

Gambling Support Services *No registration status*

Health care client identification DSS NHIG, Standard 04/05/2005

NCSIMG, Standard 03/10/2006

Health care provider identification DSS NHIG, Standard 04/05/2005

Intensive care DSS NHIG, Recorded 14/07/2006

Juvenile Justice NMDS NCSIMG, Proposed 19/07/2006

Medical Indemnity DSS *No registration status*

National Bowel Screening Program NMDS *No registration status*

National opioid pharmacotherapy statistics annual data *No registration status*

Non-admitted patient emergency department care NMDS

NHIG, Standard 24/03/2006

Non-admitted patient emergency department care NMDS NHIG, Superseded 07/12/2005

Non-admitted patient emergency department care NMDS NHIG, Superseded 24/03/2006

Non-admitted patient emergency department care NMDS *No registration status*

Organ and tissue donation *No registration status*

Outpatient care patient level DSS *No registration status*

Perinatal NMDS NHIG, Standard 06/09/2006

Perinatal NMDS NHIG, Superseded 07/12/2005

Perinatal NMDS NHIG, Superseded 06/09/2006

Recommended Data Specifications for Community Care *No registration status*

Residential mental health care NMDS NHIG, Proposed 15/08/2005

Residential mental health care NMDS 2005-2006 NHIG, Superseded 07/12/2005

Residential mental health care NMDS 2006-2007 NHIG, Standard 07/12/2005

Residential mental health care NMDS 2007-2008 NHIG, Standardisation pending 23/10/2006

Statistical linkage key DSS *No registration status*

Test DSS *No registration status*

Data set specification specific attributes

Staging basis of cancer

Identifying and definitional attributes

Technical name:	Cancer staging—staging basis of cancer, code A
METeOR identifier:	296981
Registration status:	NHIG, Standard 04/06/2004
Definition:	The timing and evidence for T, N and M cancer stage values, as represented by a code.

Data element concept attributes

Data element concept:	Cancer staging—staging basis of cancer
Definition:	The timing and evidence for T, N and M cancer stage values.
Context:	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.
Object class:	Cancer staging
Property:	Staging basis of cancer

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	String
Format:	A
Maximum character length:	1

Permissible values:

Value	Meaning
P	Pathological
C	Clinical

Collection and usage attributes

Guide for use:

CODE P Pathological

Pathological stage is based on histological evidence acquired before treatment, supplemented or modified by additional evidence acquired from surgery and from pathological examination.

CODE C Clinical

Clinical stage is based on evidence obtained prior to treatment from physical examination, imaging, endoscopy, biopsy, surgical exploration or other relevant examinations.

Refer to the latest edtion of the UICC reference manual TNM Classification of Malignant Tumours for coding rules.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods:	From information provided by the treating doctor and recorded

on the patient's medical record.

Relational attributes

Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Staging scheme source

Identifying and definitional attributes

Technical name:	Cancer staging—cancer staging scheme source, code N
METeOR identifier:	296988
Registration status:	NHIG, Standard 04/06/2004
Definition:	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer at the time of diagnosis, as represented by a code.

Data element concept attributes

Data element concept:	Cancer staging—cancer staging scheme source
Definition:	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer at the time of diagnosis.
Context:	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.
Object class:	Cancer staging
Property:	Cancer staging scheme source

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N
Maximum character length:	1

Permissible values:

Value	Meaning
1	TNM Classification of Malignant Tumours (UICC)
2	Durie & Salmon for multiple myeloma staging
3	FAB for leukaemia classification
4	Australian Clinico-Pathological Staging (ACPS) System
8	Other

Supplementary values:

Value	Meaning
9	Unknown

Source and reference attributes

Reference documents:

Durie BGM, Salmon SE. *A clinical staging system for multiple myeloma correlation of measured myeloma cell mass with presenting clinical features, response to treatment and survival.* Cancer 36:842-54 (1975).

Bennett JM, Catovsky D, Daniel MT, Flandrin G, Galton DA, Gralnick HR, Sultan C. *Proposed revised criteria for the classification of acute myeloid leukemia: a report of the French-American-British Cooperative Group.* Ann Intern Med 103(4): 620-625 (1985).

Cheson BD, Cassileth PA, Head DR, Schiffer CA, Bennett JM, Bloomfield CD, Brunning R, gale RP, Grever MR, Keating MJ, et al. *Report of the National Cancer Institute-sponsored workshop on definitions of diagnosis and response in acute myeloid leukemia.* J Clin Oncol 8(5): 813-819 (1990).

Davis NC, Newland RC. *The reporting of colorectal cancer: the Australian Clinicopathological Staging system.* Aust NZ J Surg 52:395-397 (1982).

Public Health Division *NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1* Sydney NSW Health Dept (2001).

NHMRC *Guidelines for the prevention, early detection and management of colorectal cancer (CRC)* (1999)).

Data element attributes

Collection and usage attributes

Guide for use:

It is recommended that the TNM Manual of the UICC be used whenever it is applicable. The classifications published in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual are identical to the TNM classifications of the UICC.

TNM is not applicable to all tumour sites. Staging is of limited use in acute leukaemias, although a staging system is used for chronic lymphocytic leukaemia. Separate staging systems exist for lymphomas and myeloma. The *NHMRC Guidelines for the prevention, early detection and management of colorectal cancer (CRC)* support the use of the Australian Clinico-Pathological Staging (ACPS) System. A table of correspondences between ACPS and TNM classifications is available.

The current edition of each staging scheme should be used.

Source and reference attributes

Origin:

International Union Against Cancer (UICC).

FAB (French-American-British) Group.

NSW Health Department.

National Health & Medical Research Council.

Clinical Oncological Society of Australia.

Australian Cancer Network.

Relational attributes

Related metadata references:

Supersedes Staging scheme source, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

See also Cancer staging—cancer staging scheme source edition number, code N[N] NHIG, Standard 04/06/2004

Implementation in Data Set Specifications:

Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Staging scheme source edition number

Identifying and definitional attributes

Technical name:	Cancer staging—cancer staging scheme source edition number, code N[N]
METeOR identifier:	297011
Registration status:	NHIG, Standard 04/06/2004
Definition:	The edition of the reference used for the purposes of staging the cancer, as represented by a code.

Data element concept attributes

Data element concept:	Cancer staging—cancer staging scheme source edition number
Definition:	The edition of the reference used for the purposes of staging the cancer.
Context:	For survival analysis adjusted by stage at diagnosis and distribution of cancer cases by type and stage.
Object class:	Cancer staging
Property:	Cancer staging scheme source edition number

Value domain attributes

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]

Supplementary values:

Value	Meaning
88	Not applicable (Cases that do not have a recommended staging scheme)
99	Unknown edition

Collection and usage attributes

Guide for use:	Record the edition number (i.e. 1 - 87).

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Origin:	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

Related metadata references:	Supersedes Staging scheme source edition number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Data set specification specific attributes

Surgical treatment procedure for cancer

Identifying and definitional attributes

Technical name:	Cancer treatment—surgical procedure for cancer, procedure code (ACHI 5th edn) NNNNN-NN
METeOR identifier:	333816
Registration status:	NHIG, Standard 07/12/2005
Definition:	The surgical procedure used in the primary treatment of the cancer, as represented by a code.

Data element concept attributes

Data element concept:	Cancer treatment—surgical procedure for cancer
Definition:	The surgical procedure used in the primary treatment of the cancer.
Object class:	Cancer treatment
Property:	Surgical procedure for cancer

Value domain attributes

Representational attributes

Classification scheme:	Australian Classification of Health Interventions (ACHI) 5th edition
Representation class:	Code
Data type:	Number
Format:	NNNNN-NN
Maximum character length:	7

Data element attributes

Collection and usage attributes

Guide for use:	Each surgical treatment procedure used in the initial treatment of the cancer should be recorded. Surgical procedures performed for palliative purposes only should not be included. For surgical procedures involved in the administration of another modality (eg., implantation of infusion pump, isolated limb parfusion/infusion, intra-operative radiotherapy) record both the surgery and the other modality. Any systemic treatment which can be coded as a procedure through ACHI should be so coded (eg., stem cell or bone marrow infusion).

Source and reference attributes

Submitting organisation:	National Cancer Control Initiative
Origin:	National Centre for Classification in Health New South Wales Department of Health, Public Health Division
Reference documents:	NSW Department of Health NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 (2001).

Relational attributes

Related metadata references:	Supersedes Cancer treatment—surgical procedure for cancer, procedure code (ICD-10-AM 4th edn) NNNNN-NN NHIG, Superseded 07/12/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Data set specification specific attributes

Information specific to this data set:	This item is collected for determining outcome by treatment type.

Systemic therapy agent name

Identifying and definitional attributes

Technical name:	Cancer treatment—systemic therapy agent name (primary cancer), antineoplastic drug code (Self-Instructional Manual for Tumour Registrars Book 8 3rd edn) X[X(39)]
METeOR identifier:	288446
Registration status:	NHIG, Standard 04/06/2004
Definition:	The chemotherapeutic agent or anti-cancer drug used for treatment of the primary cancer, as represented by a code.

Data element concept attributes

Data element concept:	Cancer treatment—systemic therapy agent name (primary cancer)
Definition:	The standard chemotherapeutic agent or anti-cancer drug used for treatment of the primary cancer.
Object class:	Cancer treatment
Property:	Systemic therapy agent name

Value domain attributes

Representational attributes

Classification scheme:	Self-Instructional Manual for Tumour Registrars Book 8 Antineoplastic Drugs, 3rd edition
Representation class:	Code
Data type:	String
Format:	X[X(39)]
Maximum character length:	40

Data element attributes

Collection and usage attributes

Guide for use:	The purpose of collecting specific treatment information is to account for all treatment types, which may assist in evaluation of effectiveness of different treatment patterns. The actual agents used will sometimes be of interest. Systemic therapy often involves treatment with a combination of agents. These may be known by acronyms but since details of drugs and acronyms may vary it is recommended that each agent be recorded separately. Oral chemotherapy normally given on an outpatient basis should also be included. New codes and names will need to be added as new agents become available for clinical use. Hormone therapy agents and immunotherapy agents should be recorded under this data element.
Collection methods:	The full name of the agent(s) should be recorded if the coding manual is not available.
Comments:	Collecting dates for systemic therapy will allow evaluation of

treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Source and reference attributes

Origin: National Cancer Institute Surveillance, Epidemiology and End Results (SEER) Program

Reference documents: Surveillance, Epidemiology and End Results (SEER) Program Self-instructional manual for tumour registrars: Book 8 - Antineoplastic drugs 3rd Edition National Cancer Institute.

Relational attributes

Related metadata references: Supersedes Systemic therapy agent name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005

Implementation in Data Set Specifications: Cancer (clinical) DSS NHIG, Standard 07/12/2005

Cancer (clinical) DSS NHIG, Candidate 14/09/2006

Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set: This item is collected for the analysis of outcome by treatment type.

Tumour size at diagnosis (solid tumours)

Identifying and definitional attributes

Technical name:	Person with cancer—solid tumour size (at diagnosis), total millimetres NNN
METeOR identifier:	270184
Registration status:	NHIG, Standard 01/03/2005
Definition:	The largest dimension of a solid tumour, measured in millimetres.

Data element concept attributes

Data element concept:	Person with cancer—solid tumour size
Definition:	The largest dimension of a solid tumour.
Object class:	Person with cancer
Property:	Solid tumour size

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN
Maximum character length:	3
Supplementary values:	Value: 999 — Meaning: Unknown
Unit of measure:	Millimetre (mm)

Collection and usage attributes

Guide for use:	Size in millimetres with valid values 001 to 997.

Data element attributes

Collection and usage attributes

Guide for use:	The reporting standard for the size of solid tumours is: Breast cancer or other solid neoplasms - the largest tumour dimension, measured to a precision of 1mm.

Relational attributes

Related metadata references:	Supersedes Tumour size at diagnosis - solid tumours, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Information specific to this data set:	This is used to measure the diameter of the largest dimension of breast cancers and other solid neoplasms for patient

management, population cancer statistics and research.

Tumour thickness at diagnosis (melanoma)

Identifying and definitional attributes

Technical name:	Person with cancer—melanoma thickness (at diagnosis), total millimetres NNN.NN
METeOR identifier:	270185
Registration status:	NHIG, Standard 01/03/2005
Definition:	The measured thickness of a melanoma in millimetres.

Data element concept attributes

Data element concept:	Person with cancer—melanoma thickness
Definition:	The thickness of a melanoma.
Context:	Patient management, population cancer statistics and research.
Object class:	Person with cancer
Property:	Melanoma thickness

Value domain attributes

Representational attributes

Representation class:	Total
Data type:	String
Format:	NNN.NN
Maximum character length:	5
Supplementary values:	Value — Meaning 999.99 — Unknown
Unit of measure:	Millimetre (mm)

Data element attributes

Collection and usage attributes

Guide for use:	The reporting standard for the thickness of melanoma is: Primary cutaneous melanoma - the depth of penetration of tumour cells below the basal layer of the skin; measured to a precision of 0.01mm. Size in millimetres - valid values are: 000.01 to 997.99

Relational attributes

Related metadata references:	Supersedes Tumour thickness at diagnosis - melanoma, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005
Implementation in Data Set Specifications:	Cancer (clinical) DSS NHIG, Standard 07/12/2005 Cancer (clinical) DSS NHIG, Candidate 14/09/2006 Cancer (clinical) DSS NHIG, Superseded 07/12/2005

Data set specification specific attributes

Glossary items

Address

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327278
Registration status:	NHIG, Standard 01/03/2005 NCSIMG, Standard 08/05/2006
Definition:	The referential description of a location where an entity is located or can be otherwise reached or found.

Collection and usage attributes

Comments:

Following are the attributes are commonly used in the formation of a full address:

- Address line; (address line is a composite data element containing many attributes of the specific location of a full address - see the current version of the Address line metadata item for further description and a list of its components for addresses located in Australia)
- Address type
- Australian state/territory identifier
- Country identifier
- Non-Australian State/province
- Postal delivery point identifier
- Postcode - Australian
- Postcode - international
- Suburb/town/locality

Some attributes of an address, located within Australia, also provide the elements to determine the **Statistical Local Are**a (SLA). This enables:

- comparison of the use of services by persons residing in different geographical areas,
- characterisation of catchment areas and populations for facilities for planning purposes, and
- documentation of provision of services to clients who reside in other states or territories. The address is also a relevant element in the unambiguous identification of a Health Care Client and a Health Care Provider.

Source and reference attributes

Submitting organisation:	Health Data Standards Committee
Reference documents:	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:	Supersedes Address, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005 Supersedes Address (community services) NCSIMG, Superseded 08/05/2006
Metadata items which use this	Person (address)—address line, text [X(180)] NHIG, Standard

glossary item:	04/05/2005 NCSIMG, Standard 30/09/2005
	Service provider organisation (address)—address line, text [X(180)] NHIG, Standard 04/05/2005 NCSIMG, Standard 30/09/2005

Adoption

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327208
Registration status:	NCSIMG, Standard 01/03/2005
Definition:	Adoption is the legal process by which a person legally becomes a child of the adoptive parents and legally ceases to be a child of his/her existing parents.
Context:	Children and family services.

Collection and usage attributes

Comments:	The adoption order severs the legal relationship between the biological parents and the child. A new birth certificate is issued to the child bearing the name(s) of his/her adoptive parent(s) as the natural parent(s) and the new name of the child, where a change has occurred.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare (AIHW)
Origin:	Adoptions Australia (AIHW). *Data collection standards, tables and counting rules*, 1998-99.

Relational attributes

Related metadata references:	Supersedes Adoption, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Household family NCSIMG, Standard 01/03/2005 Person (name)—family name, text X[X(39)] NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005 NHDAMG, Standard 20/06/2005 Person (name)—family name, text X[X(39)] NHIG, Superseded 04/05/2005 NCSIMG, Superseded 25/08/2005

Family

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327232
Registration status:	NCSIMG, Standard 01/03/2005 NHDAMG, Standard 01/03/2005
Definition:	Two or more people related by blood, marriage (including step-relations), adoption or fostering and who may or may not live together. They may form the central core of support networks for individuals.
Context:	Data on families are essential elements for the study of the well being of family groups and in this way for the study of the well being of individuals. They are a tool for assessing the type of and level of support to which a person has access. By defining the extended family as the central support network for individual, support which would not have been defined as accessible to the individual using the 'Household family' definition becomes apparent. It is important to recognise the 'family beyond the household' when examining types and levels of support available to individuals.

Collection and usage attributes

Comments:	The 'household family' has been traditionally viewed as a building block of society and it is the predominant unit reported statistically and historically. However, the 'household family', since it is tied to the idea of co-residence, forms only a snapshot in time and refers only to related people who live in the same household at a point in time. Related persons who leave the central household live in other households may still participate in the lives of other family members they do not live with in a variety of ways, including financial, material, physical, emotional, legal and spiritual. For instance, frail older people may receive help from their adult children even though they do not live in the same household. The definition for this glossary item differs from the Australian Bureau of Statistics (ABS) standard. This is necessary because the ABS standard is based on household collection, which is not suitable, in many community services' areas. The community service definition needs to be broader to incorporate families that exist outside of households.

Source and reference attributes

Submitting organisation:	Australian Institute of Family Studies
Origin:	McDonald, P. 1995. *Families in Australia: A Socio-Demographic Perspective*. Melbourne: Australian Institute of Family Studies.

Relational attributes

Related metadata references:	Supersedes Family, version 1, DEC, NHADD, NHDAMG, Superseded 01/03/2005 Supersedes Family, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005 Has been superseded by Family NCSIMG, Standardisation

pending 03/05/2007

Metadata items which use this glossary item:

Establishment—number of group session occasions of service for non-admitted patients NHIG, Standard 01/03/2005

Household—family type, code N NCSIMG, Standard 01/03/2005

Household—household composition, code N{.N} NHDAMG, Superseded 10/02/2006

Household—Indigenous status NHDAMG, Superseded 10/02/2006

Household—Indigenous status NHDAMG, Standard 10/02/2006

Living arrangement code N NCSIMG, Standard 01/03/2005

Person (name)—family name, text X[X(39)] NHIG, Standard 04/05/2005
NCSIMG, Standard 25/08/2005
NHDAMG, Standard 20/06/2005

Person (name)—family name, text X[X(39)] NHIG, Superseded 04/05/2005
NCSIMG, Superseded 25/08/2005

Person (name)—given name NHIG, Standard 01/03/2005
NCSIMG, Standard 01/03/2005
NHDAMG, Standard 01/08/2005

Person (name)—given name, text [X(40)] NHIG, Standard 04/05/2005
NCSIMG, Standard 25/08/2005
NHDAMG, Standard 20/06/2005

Person (name)—given name, text [X(40)] NHIG, Superseded 04/05/2005
NCSIMG, Superseded 25/08/2005

Person (requiring care)—carer availability status NHIG, Standard 01/03/2005
NCSIMG, Superseded 02/05/2006

Person (requiring care)—carer availability status, code N NHIG, Standard 01/03/2005
NCSIMG, Superseded 02/05/2006

Record linkage

Identifying and definitional attributes

Metadata item type:	Glossary Item
METeOR identifier:	327264
Registration status:	NCSIMG, Standard 01/03/2005
Definition:	A process, technique or method that enables the bringing together of two or more records that are believed to belong to the same individual.
Context:	Record linkage may facilitate improved service provision, treatment or case management to individual clients.

Collection and usage attributes

Comments:	Linkage can occur across data systems or within data systems and may be done by using a range of identifiers. For statistical purposes, including planning, research or the measurement of service or program outcomes, record linkage facilitates separating multiple items clustered around individuals from total counts (for example, double counting of clients can be reduced when calculating total numbers of clients across several agencies). The proposed use of a linkage key in the Home and Community Care program (HACC) Minimum Data Set is intended to make it possible to count the number of HACC clients (without counting clients more than once) and the services which they receive. The Commonwealth-State Territory Disability Agreement National Minimum Data Set is using the statistical linkage key based on that for the HACC Minimum Data Set.

Source and reference attributes

Submitting organisation:	Australian Institute of Health and Welfare
Origin:	Commonwealth Department of Health and Family Services 1998 Home and Community Care (HACC) Data Dictionary Version 1.0 Canberra: DHFS

Relational attributes

Related metadata references:	Supersedes Record linkage, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005
Metadata items which use this glossary item:	Estimated date flag code N NCSIMG, Standard 01/03/2005 Person (name)—family name, text X[X(39)] NHIG, Superseded 04/05/2005 NCSIMG, Superseded 25/08/2005 Person (name)—given name, text [X(40)] NHIG, Standard 04/05/2005 NCSIMG, Standard 25/08/2005 NHDAMG, Standard 20/06/2005 Person (name)—given name, text [X(40)] NHIG, Superseded 04/05/2005 NCSIMG, Superseded 25/08/2005