ATTACHMENT 3a

MDE Data Items and Definitions Required for Reporting

OMB Control No. 0920-0571
Expiration Date: 10/31/2015

DATA USER'S MANUAL

for the

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

MDE Version 6.0
Effective Date 01/01/2009

Division of Cancer Prevention and Control
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

National Breast and Cervical Cancer Early Detection Program
Minimum Data Elements (MDE) Data Definition

Table of Contents:

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
All Patients Section: This section must be completed for each MDE record when NBCCEDP funds are used to pay for all or part of at least one of the screening or diagnostic procedure(s).							
1. Screening Location							
1.01	1a	State, Territorial, or Tribal Program	2	1	2	FIPS Code, **Right Justify** (i.e. California = □6 and Texas = 48, where □ = a blank character.	Valid code for your program.
1.02	1b	County	3	3	5	FIPS Code, **Right Justify**.	Valid codes for your program. This is the county of the primary B&C provider.
1.03	1d	Enrollment Site	5	6	10	**Right Justify.** This should be the point of enrollment of the woman to the program. The intent is to identify the center that is administratively responsible for the care and tracking of the woman.	Valid codes for your sites.
2. Patient and Record Identification							
2.01	2a	Unique Patient ID Number	15	11	25	If Social Security Number (SSN) is used, it must be encoded. The ID number should be unique and constant for each patient in order to track the patient over time. This field should not contain any identifiable information, including partial names or dates. **Alphanumeric (no special symbols), left justify.** **Alphabetic characters must be entered consistently in uppercase or lowercase for all records for each patient.**	
2.02	2b	Record Identifier	8	26	33	**Right Justify.** This field will be used to uniquely identify one record among many for a woman. This could be a cycle number, a visit date, or a record number. In this context, record and screening cycle have the same meaning.	

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
3. Patient Demographic Information							
3.01	3a	County of Residence	3	34	36	FIPS Code, **Right Justify**. (If unknown, blank fill.) Not required if Zip Code of residence is reported.	Valid FIPS code for the county.
3.02	3b	State or Territory of Residence	2	37	38	FIPS Code, **Right Justify**. (If unknown, blank fill.)	Valid FIPS code for the state or territory.
3.03	3c	ZIP Code of Residence	5	39	43	**Right Justify**. (If unknown, blank fill) Not required if county of residence is reported.	Valid 5 digit numeric zip code.
3.04	3d	Date of Birth	8	44	51	MMDDYYYY (i.e. Jan 3, 1942 = 01031942). If unknown, blank fill.	Check for validity, i.e. no one too old or too young at date of enrollment. See edit guidelines for dates at the end of this document.
3.05	3f	Hispanic or Latino Origin (self reported)	1	52	52	1. Yes 2. No 3. Unknown	Range check.
3.06. 1	3g.1	Race 1 (self reported)	1	53	53	1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 7. Unknown 8. Asian/Pacific Islander (v4.1 only)* *8 - Asian/Pacific Islander (v4.1 only) may only be reported for data collected prior to 10/01/2002.	Range check. This race field should be populated first. If a woman self identifies more than one race, then each race identified should be reported in a separate race field. Report up to five (5) separate races. It is recommended that your Program no longer collect 'Other' race on your data collection forms. However, if your Program collects 'Other' as a race category, please export this to '7' (Unknown) in the MDEs.
3.06.2	3g.2	Race 2 (self reported)	1	54	54	1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 7. Unknown	This field should be left blank, unless the woman reports more than one race.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
3.06.3	3g.3	Race 3 (self reported)	1	55	55	1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 7. Unknown	This field should be left blank, unless the woman reports more than two races.
3.06.4	3g.4	Race 4 (self reported)	1	56	56	1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 7. Unknown	This field should be left blank, unless the woman reports more than three races.
3.06.5	3g.5	Race 5 (self reported)	1	57	57	1. White 2. Black or African American 3. Asian 4. Native Hawaiian or Other Pacific Islander 5. American Indian or Alaska Native 7. Unknown	This field should be left blank, unless the woman reports more than four races.
4. CBE Screening Information							
4.01	4c	Breast Symptoms (self reported)	1	58	58	1. Yes 2. No 3. Unknown	Range check.
4.02	4d	Clinical Breast Exam	1	59	59	1. Normal/Benign findings - schedule for routine CBE in one year 2. Abnormality suspicious for cancer - diagnostic evaluation needed 3. Not needed 4. Needed but not performed at this visit (includes refused)	Range check. If the result of this clinical breast exam is ‘2’, the Additional Breast Procedures Section should be completed and "Additional Procedures Needed to Complete Breast Cycle" (6.08) should be ‘1’. Reference Model Clinical Guidelines in MDE Data User's Manual, Section 2.
4.03	4e	Date of Clinical Breast Exam	8	60	67	If "Clinical Breast Exam" = ‘1’ or ‘2’, enter MMDDYYYY If "Clinical Breast Exam" = ‘3’ or ‘4’, blank fill.	If not blank, must be a valid date. Check the skip pattern. See edit guidelines for skip patterns at the end of this document.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
4.04	4e.1	Clinical Breast Exam Paid by NBCCEDP Funds	1	68	68	1. Yes 2. No 3. Unknown If ”Clinical Breast Exam” = ‘3’ or ‘4’, blank fill.	Range and skip pattern check. If office visit (which includes Clinical Breast Exam) was paid by NBCCEDP funds, then this field should be set to ‘1’.
5. Pap Test Screening Information							
5.01	4f	Previous Pap Test	1	69	69	1. Yes 2. No 3. Unknown	Range check.
5.02	4f.1	Date of Previous Pap Test	6	70	75	If "Previous Pap Test" = ‘1’ then enter MMYYYY (if known) or blank fill (if unknown). If "Previous Pap Test" = ‘2’ or ‘3’, blank fill.	If not blank, must be a valid date. Check the skip pattern.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
5.03		Indication for Pap Test	1	76	76	1. Routine Pap test 2. Patient under surveillance for a previous abnormal test. 3. Pap test done by a non-program funded provider, patient referred in for diagnostic evaluation. 4. Pap test not done. Patient proceeded directly for diagnostic work-up or HPV test. 5. Breast record only, cervical services not done. 9. Unknown	Range and skip pattern check. Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. '1' (Routine) should be reported for a Pap test performed as part of a routine screening schedule. Items 5.05 – 5.16 should be reported as appropriate. Item 5.04 should be blank. '2' (Surveillance) should be reported for a Pap test performed on a woman under management for a cervical abnormality detected prior to this cycle. Items 5.05 – 5.16 should be reported as appropriate. Item 5.04 should be blank. '3' (Referred) should be reported when a patient has had a Pap test performed outside of the Program, and is referred to the Program for diagnostic work-up. Referral Date (5.04) must be completed, and a valid Pap test Result should be provided: (5.08) "Bethesda 1991" = 1-8, 12 or 14; or (5.09) "Bethesda 2001" = 1-8 or 12. '4' (Not Done) should be reported when the patient does not have a Pap test and goes directly to HPV testing or Diagnostic Work-up. Items 5.04 – 5.12 should be blank. '5' (Breast record only) should be reported when no cervical services are provided or reported in this record, only breast services. Items 5.04 – 5.16 should be blank.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
5.04		Cervical Diagnostic Referral Date	8	77	84	If “Indication for Pap Test” = “3”, enter MMDDYYYY; otherwise leave blank	Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. If not blank, must be a valid date. Check the skip pattern. See edit guidelines for skip patterns at the end of this document. This field should indicate the enrollment date for a patient referred in to the program for diagnostic evaluation following an abnormal Pap test provided outside of the program.
5.05	4g	Bethesda System Used	1	85	85	1. Bethesda 1991 2. Bethesda 2001	Range check. This field should indicate which Bethesda System was used to report the Pap test result. If system used is ‘1', then “Bethesda ’91 Pap test Result” (5.08) should be completed. If system used is ’2', then “Bethesda ’01 Pap test Result” (5.09) should be completed. This field should be left blank if “Indication for Pap Test” (5.03) is ‘4’ or ‘5’.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
5.06	4g.1	Specimen Adequacy of Pap Test (For both 1991 and 2001 Bethesda Systems)	1	86	86	1. Satisfactory 2. Satisfactory for evaluation but limited by... (for Bethesda 1991 results only) 3. Unsatisfactory 4. Unknown	Range check. This field should be left blank if “Indication for Pap Test” (5.03) is ‘4’ or ‘5’. For data where Pap test was done prior to 10/01/2002, this field may be blank. For Pap tests performed after 10/01/2002, this field MUST be completed. If “Bethesda System Used” (5.05) is ’1' and Specimen Adequacy is ‘1’, ‘2’ or ‘4’ then “Bethesda ’91 Pap test Result” (5.08) must be completed. If Specimen Adequacy is ’3', then “Bethesda ’91 Pap test Result” (5.08) must be ‘8’ (Unsatisfactory). If “Bethesda System Used” (5.05) is ’2' and Specimen Adequacy is ‘1’ or ‘4’, then” Bethesda ’01 Pap test Result” (5.09) must be completed. If Specimen Adequacy is ’3', then “Bethesda ’01 Pap test Result” (5.09) must be left blank. A specimen adequacy result of ’2' is NOT VALID for Bethesda 2001.
5.07	4g.3	Specimen Type for Pap Test	1	87	87	1. Conventional smear 2. Liquid Based 3. Other 4. Unknown	Range check. This field should be left blank if “Indication for Pap Test” (5.03) is ‘4’ or ‘5’.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
5.08	4g.2	Result of Pap Test Categories from the Bethesda 1991 Reporting System	2	88	89	**Right Justify** 1. Negative (within normal limits) 2. Infection/Inflammation/Reactive Changes 3. Atypical squamous cells of undetermined significance (ASCUS) 4. Low grade SIL (including HPV changes) 5. High grade SIL 6. Squamous Cell Cancer 7. Other 8. Unsatisfactory 11. Result pending 12. Result unknown, presumed abnormal, Pap test from non-program funded source 14. Abnormal Glandular Cells (including Atypical Glandular Cells of Undetermined Significance (AGUS) and Adenocarcinoma)	Range check. This field should be left blank if “Bethesda System Used” (5.05) is '2'. This field should be left blank if “Indication for Pap Test” (5.03) is ‘4’ or ‘5’. If the result of this screening Pap test is a ‘5’, ‘6’, ‘12’, or ‘14’ the Additional Cervical Procedures Section MUST be completed and "Diagnostic work-up planned for cervical dysplasia or cancer“ (5.16) set to ‘1’. If the result is a ‘3’ or ‘4’ and the clinician chooses to do a diagnostic work-up, the Additional Cervical Procedures Section MUST also be completed and "Diagnostic work-up planned for cervical dysplasia or cancer" (5.16) set to ‘1’.
5.09	4g.4	Result of Pap Test Categories from the Bethesda 2001 Reporting System	2	90	91	**Right Justify** 1. Negative for intraepithelial lesion or malignancy 2. Atypical squamous cells of undetermined significance (ASC-US) 3. Low grade SIL (including HPV changes) 4. Atypical squamous cells cannot exclude HSIL (ASC-H) 5. High grade SIL 6. Squamous Cell Carcinoma 7. Abnormal Glandular Cells (including Atypical, Endocervical adenocarcinoma in situ and adenocarcinoma) 8. Other 11. Result pending 12. Result unknown, presumed abnormal, Pap test from non-program funded source.	Range check. This field should be left blank if “Bethesda System Used” (5.05) is '1'. This field should be left blank if “Indication for Pap Test” (5.03) is ‘4’ or ‘5’. If the result of this Pap test is a ‘4’, ’5’, ‘6’, ‘7’, or ‘12’ the Additional Cervical Procedures Section MUST be completed and "Diagnostic work-up planned for cervical dysplasia or cancer“ (5.16) set to ‘1’. If the result is a ‘1’, ‘2’ or ‘3’ and the clinician chooses to do a diagnostic work-up, the Additional Cervical Procedures Section MUST also be completed and "Diagnostic work-up planned for cervical dysplasia or cancer" (5.16) set to ‘1’.
5.10	4g.5	Other Pap Test Result	20	92	111	If "Result of Pap Test" = ‘7’ from the 1991 Bethesda, or ‘8’ from the 2001 Bethesda, enter "Result" in free text format.	Check the skip pattern. This field should be left blank if “Indication for Pap Test” (5.03) is ‘4’ or ‘5’.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
5.11	4h	Date of Pap Test	8	112	119	<u>For Bethesda 1991</u>: If "Result of Pap Test" ≤ '8' or '14', enter MMDDYYYY. If you know the date for '11' or '12', enter MMDDYYYY, otherwise blank fill. <u>For Bethesda 2001:</u> If "Result of Pap Test" ≤ '8', enter MMDDYYYY. If you know the date for '11' or '12', enter MMDDYYYY, otherwise blank fill.	If not blank, must be a valid date and > "Date of Previous Pap test" (5.02), if known. Check the skip pattern. This field should be left blank if "Indication for Pap Test" (5.03) is '4' or '5'.
5.12	4i	Pap Test Paid by NBCCEDP Funds	1	120	120	1. Yes 2. No 3. Unknown If "Result of Pap Test" = '11', and paid data are known, then enter '1' or '2'. Otherwise blank fill. If "Result of Pap Test" = '12', this field should be set to '2'.	Range and skip pattern check. If the Pap test, laboratory services, or pelvic exam were paid by NBCCEDP funds, then this field should be set to '1' (Yes). This field should be left blank if "Indication for Pap Test" (5.03) is '4' or '5'.
5.13		HPV Test Result	1	121	121	1. Positive 2. Negative 3. Test Not Done 9. Unknown	Range check. Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. This field should be left blank if "Indication for Pap Test" (5.03) is '5'.
5.14		Date of HPV Test	8	122	129	If "HPV Test Result" = '1', '2' or '9', then enter MMDDYYYY If "HPV Test Result" = '3', blank fill. Date of HPV Test is the date of the sample collection.	If not blank, must be a valid date. Check the skip pattern. Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. This field should be left blank if "Indication for Pap Test" (5.03) is '5'.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
5.15		HPV Test Paid by NBCCEDP Funds	1	130	130	1. Yes 2. No 3. Unknown Complete this field if “HPV Test Result” = ‘1’, ‘2’, or ‘9’. If “HPV Test Result” = ‘3’, blank fill.	Range and skip pattern check. Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. This field should be left blank if “Indication for Pap Test” (5.03) is ‘5’.
5.16	4g.6	Diagnostic Work-up Planned for Cervical Dysplasia or Cancer	1	131	131	1. Diagnostic work-up planned on basis of abnormal Pap test or pelvic exam 2. Diagnostic work-up not planned 3. Diagnostic work-up plan not yet determined	If “Indication for Pap Test” (5.03) is ‘1’, ‘2’, ‘3’, ‘4’, or ‘9’ this field must be completed; otherwise, leave blank. . The purpose of this field is to indicate the need for immediate diagnostic work-up. In the vast majority of cases an abnormal Pap test (defined in 5.08 or 5.09) or pelvic exam (not collected) will indicate that a diagnostic work-up is necessary. However, in a small number of cases a diagnostic work-up will be performed in the absence of an abnormal Pap test or pelvic exam. If this field is coded as ‘1’, the Additional Cervical Procedures Section must be completed. If this field is coded as ‘2’ or ‘3’, the Additional Cervical Procedures Section must be blank.
6. Initial Mammography Information							
6.01	4j	Previous Mammogram	1	132	132	1. Yes 2. No 3. Unknown	Range check.
6.02	4j.1	Date of Previous Mammogram	6	133	138	If "Previous Mammogram" = ‘1’ then enter MMYYYY (if known) or blank fill (if unknown). If "Previous Mammogram" = ‘2’ or ‘3’ blank fill.	If not blank, must be a valid date. Check the skip pattern.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
6.03		Indication for Initial Mammogram	1	139	139	1. Routine screening mammogram 2. Initial mammogram performed to evaluate symptoms, positive CBE result, or previous abnormal mammogram result 3. Initial mammogram done by a non-program funded provider, patient referred in for diagnostic evaluation. 4. Initial mammogram not done. Patient only received CBE, or proceeded directly for other imaging or diagnostic work-up. 5. Cervical record only, breast services not done. 9. Unknown	Range and skip pattern check. Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. '1' (Screening) should be reported for an initial mammogram performed as part of a routine or annual screening schedule and in the absence of symptoms or a recent positive CBE. Items 6.05 through 6.08 should be completed as appropriate. Item 6.04 should be blank. '2' (Evaluate symptoms) should be reported for an initial mammogram performed as additional evaluation of a recent mammogram prior to this cycle, evaluation of current symptoms or abnormal CBE finding. Items 6.05 through 6.08 should be completed as appropriate. Item 6.04 should be blank. '3' (Referred) should be reported when a patient has had a mammogram performed outside of the Program, and is referred to the Program for diagnostic work-up. Referral Date (6.04) must be completed, and a valid Mammogram Result (6.05) of 1 – 7, or 11 should be reported. '4' (Not Done) should be reported when the patient only received a CBE; or when the patient does not have an initial mammogram performed and goes directly to Diagnostic Work-up. Items 6.05 – 6.07 should be blank. '5' (Cervical record only) should be reported when no breast services are provided or reported in this record, only cervical services. Initial Mammogram Result (6.05) should be left blank. Additionally, items 6.04, 6.06 – 6.08 should be blank.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
6.04		Breast Diagnostic Referral Date	8	140	147	If “Indication for Initial Mammogram” = “3”, enter MMDDYYYY; otherwise leave blank	Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. If not blank, must be a valid date. Check the skip pattern. See edit guidelines for skip patterns at the end of this document. This field should indicate the enrollment date for a patient referred in to the program for diagnostic evaluation following an abnormal mammogram provided outside of the program.
6.05	4k	Initial Mammography Test Result (includes **all** mammograms which were the first mammogram of a screening cycle) Categories from the American College of Radiology Breast Imaging Reporting and Database System	2	148	149	1. Negative (BI-RADS 1) 2. Benign Finding (BI-RADS 2) 3. *Probably Benign – Initial short interval follow-up suggested (Bi-RADS 3) 4. Suspicious Abnormality - Biopsy should be considered (BI-RADS 4) 5. Highly Suggestive of Malignancy - Appropriate action should be taken (BI-RADS 5) 6. Assessment is Incomplete - Need additional imaging evaluation (BI-RADS 0) 7. Unsatisfactory - This applies if the mammogram was technically unsatisfactory and could not be interpreted by radiologist. 10. Result pending 11. Result unknown, presumed abnormal, mammogram from non-program funded source 13. Film comparison required (BI-RADS 0) *Based on new BI-RADS guidance from the Fourth Edition 2003, (3) Probably Benign should not be reported as the initial mammogram result unless a complete work-up was performed prior to the screening cycle either within or outside of the program. Please refer to the Field Description in the Data User’s Manual for further details.	Range check. This field should be left blank if “Indication for Mammogram” (6.03) is ‘4’ or ‘5’. If the result of the initial mammogram is ‘4’, ‘5’, ‘6’, ‘11’ or ‘13’, the Additional Breast Procedures Section must be completed and ”Additional procedures needed to complete breast cycle“ (6.08) should = ‘1’. A result of ‘7’ (Unsatisfactory) indicates that the cycle should be considered complete, and a new cycle will begin with the repeat mammogram. This variable should be the initial result of the first mammographic film only. If any additional imaging is needed, to obtain a final imaging result, then report ‘6’. If a film comparison is necessary to obtain a final imaging result, then report ‘13’.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
6.06	4l	Date of Initial Mammogram	8	150	157	If "Initial Mammography Test Result" ≤ '7' or '13' enter MMDDYYYY. If you know the date for '10' or '11', enter MMDDYYYY, otherwise blank fill.	If not blank, must be a valid date and > "Date of Previous Mammogram" (6.02), if known. Check the skip pattern. This field should be left blank if "Indication for Mammogram" (6.03) is '4' or '5'.
6.07	4m	Initial Mammogram Paid by NBCCEDP Funds	1	158	158	1. Yes 2. No 3. Unknown If "Initial Mammography Test Result" = '10' and paid data are known, then enter a '1' or '2'; otherwise blank fill. If "Initial Mammography Test Result" = '11', then this field should be set to '2'.	Range and skip pattern check. This field should be left blank if "Indication for Mammogram" (6.03) is '4' or '5'.
6.08	4k.1	Additional Procedures Needed to Complete Breast Cycle	1	159	159	1. Additional procedures needed or planned. 2. Additional procedures not needed or planned. 3. Need or plan for additional procedures not yet determined	If "Indication for Mammogram" (6.03) is '1', '2', '3' or '4' this field must be completed; otherwise, leave blank. The purpose of this field is to indicate the need or plan for immediate additional imaging or diagnostic work-up. In most cases a positive mammogram (defined in 6.05) or CBE (4.02) will indicate that a diagnostic work-up is necessary. However, in some cases additional procedures will be planned in the absence of an abnormal mammogram or CBE. If this field is coded as '1', the Additional Breast Procedures Section must be completed. If this field is coded as '2' or '3', the Additional Breast Procedures Section must be blank.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
6.09	4n	MDE Version Number	2	160	161	21. For data collected through 9/30/1994 22. For data collected beginning 10/01/1994 23. For data collected beginning 10/01/1995 24. For data collected beginning 10/01/1996 30. For data collected beginning 10/01/1997 40. For data collected beginning 10/01/1998 41. For data collected beginning 10/01/1999 50. For data collected beginning 10/01/2002 60. For data collected beginning 01/01/2009	The version number is indicated as a footnote to this document. Note that the period in the version number is not included. For example, version 5.0 will be submitted as '50', version 6.0 as '60'.
	4o	Reserved	5	162	166	Reserved for future use.	This field should be blank filled.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
Additional Cervical Procedures Section - This section must be completed if Diagnostic Work-up Planned for Cervical Dysplasia or Cancer (5.16) = '1' (planned), otherwise leave blank.							
7. Cervical Diagnostic Procedures							
7.01	1a.1	Colposcopy without Biopsy	1	167	167	1. Yes 2. No	Range check. See edit guideline for range checks at the end of this document.
7.02	1a.2	Colposcopy with Biopsy and/or ECC	1	168	168	1. Yes 2. No	Range check.
7.03		Loop Electrosurgical Excision Procedure (LEEP)	1	169	169	1. Yes 2. No	Range check. Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank.
7.04		Cold Knife Cone (CKC)	1	170	170	1. Yes 2. No	Range check. Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank.
7.05		Endocervical Curettage *alone* (ECC)	1	171	171	1. Yes 2. No	Range check. Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank.
7.06	1a.3	Other Cervical Procedures Performed	1	172	172	1. Yes 2. No	Range check.
7.07	1a.3	Other Cervical Procedures Performed Description (from 7.06)	40	173	212	Free text format, description of "Other Cervical Procedures Performed".	Check the skip pattern. See edit guideline for skip pattern checks at the end of this document.
7.08	1a.4	Cervical Diagnostic Procedures Paid by NBCCEDP Funds	1	213	213	1. Yes 2. No 3. Unknown	If at least one cervical diagnostic procedure was paid by NBCCEDP Funds, then this field should be set to '1'.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
8. Cervical Diagnosis Information							
8.01	1c	Status of Final Diagnosis	1	214	214	1. Work-up complete 2. Work-up pending 3. Lost to follow-up 4. Work-up refused 9. Irreconcilable A response of "9" will be used for those records, which after clinical review; it was determined that there was no sufficient way to translate the clinical scenario into the MDE data record. An example would be: If the clinician refers the woman for short-term follow-up instead of following the guideline for immediate diagnostic work-up, enter a '9' to indicate a closed cycle with an irreconcilable status.	Range check. A status of "Work-up complete" means that the diagnostic testing is complete, and that "Final Diagnosis" (8.02) and "Date of Final Diagnosis" (8.04) are known.
8.02	1b	Final Diagnosis	1	215	215	1. Normal/Benign reaction/inflammation 2. HPV/Condylomata/Atypia 3. CINI/mild dysplasia (biopsy diagnosis) 4. CINII/moderate dysplasia (biopsy diagnosis) 5. CINIII/severe dysplasia/Carcinoma in situ (Stage 0) or Adenocarcinoma In Situ of the cervix (AIS) (biopsy diagnosis) 6. Invasive Cervical Carcinoma (biopsy diagnosis) 7. Other 8. Low grade SIL (biopsy diagnosis) 9. High grade SIL (biopsy diagnosis)	Range check. Low grade SIL and High grade SIL are provided as alternatives to diagnoses 2-5 and only one diagnosis should be submitted. Invasive Adenocarcinoma of the cervix should be coded as a '6' (Invasive Cervical Carcinoma). Adenocarcinoma In Situ (AIS) of the cervix should be coded as '5' (CIN3/severe dysplasia/CIS/AIS).
8.03	1b.7	Final Diagnosis - Other	20	216	235	Free text format, Description of "Final Diagnosis - Other".	Check the skip pattern.
8.04	1d	Date of Final Diagnosis	8	236	243	If Status of Final Diagnosis (8.01) = '1' enter MMDDYYYY, the date of diagnosis of cancer or precancerous lesion or date the decision made that no cancer present. If Status of Final Diagnosis (8.01) = '2' then blank fill. If Status of Final Diagnosis (8.01) = '3', '4' or '9' then enter MMDDYYYY, the date of administrative closeout.	Check the skip pattern. If not blank, should be ≥ "Date of Pap Test" (5.11) in All Patients Section. See edit guidelines for dates at the end of this document.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
8.05	1b6a	Stage at Diagnosis **LEGACY DATA ONLY. This section is used to report stage data on all cancer records with initial screens prior to 1/1/2004; or stage data not acquired through state cancer registries.** **Use Section 14 to report cancer data acquired through state cancer registries for screens dating from 1/1/2004.**	1	244	244	If Final Diagnosis (8.02) is a '6' then enter one of the following: 1. Stage I 2. Stage II 3. Stage III 4. Stage IV 5. Summary Local 6. Summary Regional 7. Summary Distant 8. Unknown/Unstaged If "Final Diagnosis" is NOT a '6', blank fill.	Range and skip pattern check. This field is not intended for use for cervical screens beginning 01/01/2009 when it is superseded by Registry Data fields (14.01 – 14.11). However, it may be optionally reported, in addition to required registry fields, for data collected from providers. If clinical stage is available, report using International Federation of Gynecology and Obstetrics (FIGO)/American Joint Committee on Cancer (AJCC), Fifth Edition, 1997. FIGO/AJCC stage can be reported as pathological or clinical. FIGO/AJCC clinical stage is preferred over pathological stage which is preferred over summary stage.
9. Cervical Cancer Treatment Information – This section is completed based on the results of MDE Item 8.02 (Final Diagnosis).							
9.01	2a	Status of Treatment	1	245	245	If Final Diagnosis (8.02) = '4', '5', '6', or '9' then complete 9.01 and 9.02. If Final Diagnosis (8.02) = '2', '3', '7', or '8' then 9.01 and 9.02 MAY be completed. If Final Diagnosis (8.02) = '1', then 9.01 and 9.02 should be left blank. 1. Treatment started 2. Treatment pending 3. Lost to follow-up 4. Treatment refused 5. Treatment not needed If a woman dies before treatment has started, enter a '3' (Lost to follow-up).	A woman should be classified as having started treatment when the Program has confirmed that a plan for treatment of the cancer or precancerous lesion has been developed and started. Range and skip pattern check.
9.02	2b	Date of Treatment Status	8	246	253	If Status of Treatment (9.01) = '1' enter MMDDYYYY, the date that treatment of cancer or precancerous lesion began. If Status of Treatment (9.01) = '2' then blank fill. If Status of Treatment (9.01) = '3', '4', or '5' then enter MMDDYYYY, the date of administrative closeout.	Check the skip pattern. If not blank, should be ≥ "Date of Final Diagnosis" (8.04).
	2c	Reserved	5	254	258	Reserved for future use.	This field should be blank filled.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
Additional Breast Procedures Section: This section must be completed if Additional Procedures Needed (6.08) = '1' (Needed/Planned). Otherwise, leave blank.							
10. Breast Imaging Procedures							
10.01	1a.1	Additional Mammographic Views	1	259	259	1. Yes 2. No	Range check. See edit guideline for range checks at the end of this document.
10.02	1a3	Ultrasound	1	260	260	1. Yes 2. No	Range check.
10.03		Film Comparison to evaluate an Assessment Incomplete	1	261	261	1. Yes 2. No/Not Applicable	Range check. Code '1' (Yes) if film comparison was done when required to further evaluate an Initial Mammogram Test Result as Assessment Incomplete (6.05 = 6 or 13); otherwise, code '2' (No/Not Applicable) if film comparison was not done or done as part of standard imaging evaluation. Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
10.04		Final Imaging Outcome	1	262	262	1. Negative (BI-RADS 1) 2. Benign Finding (BI-RADS 2) 3. Probably Benign - Short interval follow-up indicated (BI-RADS 3) 4. Suspicious Abnormality - Biopsy should be considered (BI-RADS 4) 5. Highly Suggestive of Malignancy - Appropriate action should be taken (BI-RADS 5) 7. Unsatisfactory - This applies if the additional imaging result was technically unsatisfactory and final assessment could not be made. 8. Additional imaging pending	Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. This is the assessment from all imaging procedures, including comparison with previous films, needed to arrive at a final outcome. Assessment incomplete is NOT an option; however, if programs experience a delay in receiving comparison films or additional imaging results they should report '8' (Additional imaging pending). If no additional breast imaging procedures (10.01 through 10.03) were performed, this field should be left blank. If at least one procedure was planned, but patient refused the procedure, or was lost to follow-up prior to its completion, please indicate this in "Status of Final Diagnosis/Imaging" (12.01).
10.05		Date of Final Imaging Outcome	8	263	270	If Final Imaging Outcome (10.04) ≤ '5' or '7', enter MMDDYYYY. If Final Imaging Outcome (10.04) = '8' blank fill.	Data collection for this field is effective 01/01/2009. Historical data can be reported if accurately collected; otherwise, leave blank. If not blank, must be a valid date and ≥ the "Date of Initial Mammogram" (6.06) if known. Check the skip pattern. If additional imaging is performed on more than one date, report the date of the last procedure used to determine a final imaging outcome.
11. Breast Diagnostic Procedures							
11.01	1a.2	Repeat Breast Exam/ Surgical Consultation	1	271	271	1. Yes 2. No	Range check.
11.02	1a.4	Biopsy/Lumpectomy	1	272	272	1. Yes 2. No	Range check.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
11.03	1a.5	Fine Needle/Cyst Aspiration	1	273	273	1. Yes 2. No	Range check.
11.04	1a.6	Other Breast Procedures Performed	1	274	274	1. Yes 2. No	Range check.
11.05	1a.6	Other Breast Procedures Performed Description (from 11.04)	40	275	314	Free text format, Description of "Other Breast Procedures Performed"	Check the skip pattern. See edit guideline for skip patterns at the end of this document.
11.06	1a.7	Additional Breast Procedures Paid by NBCCEDP Funds	1	315	315	1. Yes 2. No 3. Unknown	If at least one of the additional breast procedures was paid by NBCCEDP Funds, then this field should be set to '1' (Yes).
12. Breast Final Diagnosis Information							
12.01	1c	Status of Final Diagnosis / Imaging	1	316	316	1. Work-up complete 2. Work-up pending 3. Lost to follow-up 4. Work-up refused 9. Irreconcilable A response of '9' will be used for those records, which after clinical review; it was determined that there was no sufficient way to translate the clinical scenario into the MDE data record. An example would be: If the clinician refers the woman for short-term follow-up instead of following the guideline for immediate diagnostic work-up, enter a '9' to indicate a closed cycle with an irreconcilable status.	Range check. A status of "Work-up complete" means that all additional imaging and diagnostic testing (if applicable) is complete, and that the "Final Diagnosis" (12.02) and "Date of Final Diagnosis" (12.03) are known.
12.02	1b	Final Diagnosis	1	317	317	1. Carcinoma In Situ, Other* 2. Invasive Breast Cancer 3. Breast Cancer Not Diagnosed 4. Lobular Carcinoma In Situ (LCIS) - (Stage 0) 5. Ductal Carcinoma In Situ (DCIS) - (Stage 0) *Category (1) - CIS, Other is not a current reporting option for Final Diagnosis. It was used to report CIS diagnoses prior to 10/01/1999.	Range check. If a patient gets additional imaging procedures and a Final Imaging Outcome that requires no further diagnostic procedures, then this field should be coded as '3' (Breast Cancer Not Diagnosed).

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
12.03	1d	Date of Final Diagnosis / Imaging	8	318	325	If Status of Final Diagnosis/Imaging = '1', then enter MMDDYYYY, the date of diagnosis of cancer or date that decision made that no cancer present. If Status of Final Diagnosis/Imaging = '2', then blank fill. If Status of Final Diagnosis/Imaging = '3', '4' or '9' then enter MMDDYYYY, the administrative date of closeout of this episode.	Check the skip pattern. If not blank, should be ≥ "Date of Initial Mammogram" (6.06) or "Clinical Breast Exam Date" (4.03) in All Patients Section. See edit guidelines for dates at the end of this document. If only additional imaging was performed [10.01, 10.02, or 10.03 = '1' (Yes)] then this date should be the same as "Date of Final Imaging Outcome" (10.05). If any additional "non-imaging" procedures were performed, the "Date of Final Diagnosis/Imaging" (10.05) should be the date of the definitive procedure indicating cancer or not cancer.
12.04	1b2a	Stage at Diagnosis **LEGACY DATA ONLY. This section is used to report stage data on all cancer records with initial screens prior to 1/1/2004; or stage data not acquired through state cancer registries.** **Use Section 15 to report cancer data acquired through state cancer registries for screens dating from 1/1/2004.**	1	326	326	If Final Diagnosis is a '2' (Invasive Breast Cancer) then enter one of the following: 1. AJCC Stage I 2. AJCC Stage II 3. AJCC Stage III 4. AJCC Stage IV 5. Summary Local 6. Summary Regional 7. Summary Distant 8. Unknown/Unstaged If Final Diagnosis is a '1', '3', '4' or '5' then blank fill.	Range and skip pattern check. This field is not intended for use for breast screens beginning 01/01/2009 when it is superseded by Registry Data fields (15.01 – 15.11). However, it may be optionally reported, in addition to required registry fields, for data collected from providers. The staging data should be reported using pathological stage, which includes clinical staging information, according to AJCC, Fifth Edition, 1997. AJCC staging may be reported as pathological or clinical stage. AJCC stage (pathological or clinical) is preferred over summary stage.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
12.05	1b2b	Tumor Size **LEGACY DATA ONLY. This section is used to report stage data on all cancer records with initial screens prior to 1/1/2004; or stage data not acquired through state cancer registries.** **Use Section 15 to report cancer data acquired through state cancer registries for screens dating from 1/1/2004.**	1	327	327	If Final Diagnosis is a '2' (Invasive Breast Cancer) then enter one of the following: 1. 0 to ≤1 cm 2. > 1 to ≤ 2 cm 3. > 2 to ≤ 5 cm 4. > 5 cm 5. Unknown If Final Diagnosis is a '1', '3', '4' or '5' then blank fill.	Range and skip pattern check. This field is not intended for use for breast screens beginning 01/01/2009 when it is superseded by Registry Data fields (15.01 – 15.11). However, it may be optionally reported, in addition to required registry fields, for data collected from providers.
13. Breast Cancer Treatment Information – This section is completed based on the results of Final Diagnosis (12.02).							
13.01	2a	Status of Treatment	1	328	328	If Final Diagnosis (12.02) = '1', '2' or '5' then complete 13.01 and 13.02. If Final Diagnosis (12.02) = '4', then 13.01 and 13.02 MAY be completed. If Final Diagnosis (12.02) = '3', then 13.01 and 13.02 should be blank. 1. Treatment started 2. Treatment pending 3. Lost to follow-up 4. Treatment refused 5. Treatment not needed If a woman dies before treatment has started, enter a '3' (Lost to follow-up).	Range and skip pattern check. A woman should be classified as having started treatment when the Program has confirmed that a plan for treatment of the cancer or precancerous lesion has been developed and started.
13.02	2b	Date of Treatment Status	8	329	336	If Status of Treatment (13.01) = '1', then enter MMDDYYYY, the date that treatment for cancer began. If Status of Treatment (13.01) = '2', then blank fill. If Status of Treatment (13.01) = '3', '4', or '5' then enter MMDDYYYY, the date of administrative closeout.	Check the skip pattern. If not blank, should be ≥ "Date of Final Diagnosis" (12.03).
	2c	Reserved	5	337	341	Reserved for future use.	This field should be blank filled.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
14. Cervical Cancer Registry Data – If Final Diagnosis (8.02) is a '6' (Invasive Cervical Carcinoma) and the patient was screened as of January 1, 2004, then this section must be completed. This section is reserved for data acquired through a State Central Cancer Registry or an equivalent data source approved by CDC/IMS. **NAACCR Record Data Standards and Data Dictionary are available at www.naaccr.org.**							
14.01		Registry Linkage Status	1	342	342	1. Linkage process pending 2. Linkage process complete, record matched 3. Linkage process attempted, record not matched	Range check.
14.02		Registry Date of Diagnosis [NAACCR data item #390]	8	343	350	MMDDYYYY	Leave blank if 14.01 = 1, 3. If not blank, must be a valid date.
14.03		Registry Histologic Type [NAACCR data item #522]	4	351	354	Range: 8000-9989 *A complete list of valid values/labels will be provided for reference in Chapter 3 of the Data User's Manual.*	Range check. Leave blank if 14.01 = 1, 3.
14.04		Registry Behavior [NAACCR data item #523]	1	355	355	0. Benign 1. Uncertain whether benign or malignant/Borderline malignancy 2. Carcinoma In Situ 3. Malignant	Range check. Leave blank if 14.01 = 1, 3.
14.05		Registry Summary Stage [NAACCR data item: #3020 When 14.02 ≥ 1/1/2004 #759 When 14.02 = 1/1/2001 – 12/31/2003 #760 When 14.02 ≤ 12/31/2000]	1	356	356	0. In situ (IS) 1. Localized (L) 2. Regional, direct extension only (RE) 3. Regional, regional lymph nodes only (RN) 4. Regional, extension and nodes (RE+RN) 5. Regional, NOS (RNOS) 7. Distant (D) 8. Not Applicable (NA) 9. Unknown/unstaged (U)	Range check. Leave blank if 14.01 = 1, 3. Note: These NAACCR data items are specific to definitions in place for the calendar year of the Registry Date of Diagnosis (14.02).

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
14.06		Registry Collaborative Stage (CS) – Derived AJCC Stage Group [NAACCR data item #3000]	2	357	358	Range: 00-99 *Valid values for CS-derived AJCC stage include: 00-02, 10-24, 30-43, 50-63, 70-74, 88, 90, 99.* *A complete list of valid values/labels will be provided for reference in Chapter 3 of the Data User's Manual.*	Range check. Leave blank if 14.01 = 1, 3. Complete only if Registry Date of Diagnosis (14.02) ≥ 01/01/2004; otherwise leave blank.
14.07		Registry Collaborative Stage (CS) Tumor Size [NAACCR data item #2800]	3	359	361	If Final Diagnosis is a '6' (Invasive Cervical Carcinoma) then enter one of the following: 001-988 Exact size in millimeters 989. ≥ 989 millimeters 990. Microscopic focus or foci only; no size of focus is given 991. Described as less than 1 cm 992. Described as less than 2 cm 993. Described as less than 3 cm 994. Described as less than 4 cm 995. Described as less than 5 cm 999. Unknown; size not stated In the event that the NBCCEDP diagnosis is confirmed by the cancer registry to be a Lymphoma diagnosis (Item 14.03 = 9590-9699, 9702-9729, 9823, 9827), the following value should be used to report CS – Tumor Size: 888 = Not applicable. If Final Diagnosis is '1', '2', '3', '4', '5', '7', '8' or '9', leave blank. *See most current version of the CS Staging Manual:* *http://www.cancerstaging.org/cstage/manuals.html* *v01.03.00 (Sept 2006), Part I, pg 25*	Range check. Leave blank if 14.01 = 1, 3. Complete only if Registry Date of Diagnosis (14.02) ≥ 01/01/2004; otherwise leave blank.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
14.08		Registry Collaborative Stage (CS) Extension [NAACCR data item #2810]	2	362	363	Range: 00 – 99 *Valid values for CS extension include: 00, 01, 11-12, 20, 25, 30-31, 35- 40, 50, 60, 62-63, 65, 68, 70, 80, 95, 99.* In the event that the NBCCEDP diagnosis is confirmed by the cancer registry to be a Lymphoma diagnosis (14.03 = 9590-9699, 9702-9729, 9823, 9827), the following values should be used to report CS - Extension: 10-12, 20-23, 30-33, 80, and 99. These values will have different definitions than those listed above for cervical cancer. *A complete list of valid values/labels will be provided for reference in Chapter 3 of the Data User's Manual.* *See most current version of the CS Staging Manual:* *http://www.cancerstaging.org/cstage/manuals.html* *v01.03.00 (Sept 2006), Part II, pg 389*	Range check. Leave blank if 14.01 = 1, 3. Complete only if Registry Date of Diagnosis (14.02) ≥ 01/01/2004; otherwise leave blank.
14.09		Registry Collaborative Stage (CS) Lymph Nodes [NAACCR data item #2830]	2	364	365	Range 00 – 99 *Valid values for CS lymph nodes include: 00, 10, 80, 99.* In the event that the NBCCEDP diagnosis is confirmed by the cancer registry to be a Lymphoma diagnosis (14.03 = 9590-9699, 9702-9729, 9823, 9827), the following value should be used to report CS – Lymph Nodes: 88 = Not applicable. *A complete list of valid values/labels will be provided for reference in Chapter 3 of the Data User's Manual.* *See most current version of the CS Staging Manual:* *http://www.cancerstaging.org/cstage/manuals.html* *v01.03.00 (Sept 2006), Part II, pg 391*	Range check. Leave blank if 14.01 = 1, 3. Complete only if Registry Date of Diagnosis (14.02) ≥ 01/01/2004; otherwise leave blank.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
14.10		Registry Collaborative Stage (CS) Mets at Diagnosis [NAACCR data item #2850]	2	366	367	Range 00 – 99 *Valid values for CS mets at diagnosis include: 00, 10, 40, 50, 99.* In the event that the NBCCEDP diagnosis is confirmed by the cancer registry to be a Lymphoma diagnosis (14.03 = 9590-9699, 9702-9729, 9823, 9827), the following value should be used to report CS – Mets at Diagnosis: 88 = Not applicable for this site. *A complete list of valid values/labels will be provided for reference in Chapter 3 of the Data User's Manual.* *See most current version of the CS Staging Manual:* *http://www.cancerstaging.org/cstage/manuals.html* *v01.03.00 (Sept 2006), Part II, pg 392*	Range check. Leave blank if 14.01 = 1, 3. Complete only if Registry Date of Diagnosis (14.02) ≥01/01/2004; otherwise leave blank.
14.11		Registry Primary Site [NAACCR data item #400]	4	368	371	C000 – C999 NOTE: The 'C' must be included as part of the variable response in the MDE file. For example, Endocervix = C530. A complete list of valid values/labels for this item will be provided for reference in the Data User's Manual.	Range check. Leave blank if 14.01 = 1, 3. Complete only if Registry Date of Diagnosis (14.02) ≥ 01/01/2004; otherwise leave blank.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
15. Breast Cancer Registry Data – If Final Diagnosis (12.02) is a '1' (Carcinoma In Situ, Other), '2' (Invasive Breast Cancer), '4' (Lobular Carcinoma In Situ) or '5' (Ductal Carcinoma In Situ) and the patient was screened as of January 1, 2004, then this section must be completed. This section is reserved for data acquired through a State Central Cancer Registry or an equivalent data source approved by CDC/IMS. **NAACCR Record Data Standards and Data Dictionary are available at www.naaccr.org.**							
15.01		Registry Linkage Status	1	372	372	1. Pending linkage 2. Linked, matched 3. Linked, not matched	Range check.
15.02		Registry Date of Diagnosis [NAACCR data item #390]	8	373	380	MMDDYYYY	Leave blank if 15.01 = 1, 3. If not blank, must be a valid date.
15.03		Registry Histologic Type [NAACCR data item #522]	4	381	384	Range: 8000-9989 *A complete list of valid values/labels will be provided for reference in Chapter 3 of the Data User's Manual.*	Range check. Leave blank if 15.01 = 1, 3.
15.04		Registry Behavior [NAACCR data item #523]	1	385	385	0. Benign 1. Uncertain whether benign or malignant/Borderline malignancy 2. Carcinoma In Situ 3. Malignant	Range check. Leave blank if 15.01 = 1, 3.
15.05		Registry Summary Stage [NAACCR data item: #3020 When 15.02 ≥ 1/1/2004 #759 When 15.02 = 1/1/01- 12/31/03 #760 When 15.02 ≤ 12/31/2000]	1	386	386	0. In situ (IS) 1. Localized (L) 2. Regional, direct extension only (RE) 3. Regional, regional lymph nodes only (RN) 4. Regional, extension and nodes (RE+RN) 5. Regional, NOS (RNOS) 7. Distant (D) 8. Not Applicable (NA) 9. Unknown/unstaged (U)	Range check. Leave blank if 15.01 = 1, 3. Note: These NAACCR data items are specific to definitions in place for the calendar year of the Registry Date of Diagnosis (15.02).

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
15.06		Registry Collaborative Stage (CS) – Derived AJCC Stage group [NAACCR data item #3000]	2	387	388	Range: 00-99 *Valid values for CS-derived AJCC stage include: 00-02, 10-24, 30-43, 50-63, 70-74, 88, 90, 99.* *A complete list of valid values/labels will be provided for reference in Chapter 3 of the Data User's Manual.*	Range check. Leave blank if 15.01 = 1, 3. Complete only if Registry Date of Diagnosis (15.02) ≥ 01/01/2004; otherwise leave blank.
15.07		Registry Collaborative Stage (CS) Tumor Size [NAACCR data item #2800]	3	389	391	If Final Diagnosis is a '1' (Carcinoma In Situ, Other), '2' (Invasive Breast Cancer), '4' (Lobular Carcinoma In Situ) or '5' (Ductal Carcinoma In Situ) then enter one of the following: 001-988 Exact size in millimeters 989. ≥ 989 millimeters 990. Microscopic focus or foci only; no size of focus is given 991. Described as less than 1 cm 992. Described as between 1 cm and 2 cm 993. Described as between 2 cm and 3 cm 994. Described as between 3 cm and 4 cm 995. Described as between 4 cm and 5 cm 996. Mammographic/xerographic diagnosis only, no size given; clinically not palpable 997. Paget's Disease of nipple with no demonstrable tumor 998. Diffuse 999. Unknown; size not stated In the event that the NBCCEDP diagnosis is confirmed by the cancer registry to be a Lymphoma diagnosis (15.03 = 9590-9699, 9702-9729, 9823, 9827), the following value should be used to report CS - Tumor Size: 888 = Not applicable. If Final Diagnosis is a '3' then blank fill. *See most current version of the CS Staging Manual:* *http://www.cancerstaging.org/cstage/manuals.html* *v01.03.00 (Sept 2006), Part II, pg 371*	Range check and skip pattern check. Leave blank if 15.01 = 1, 3. Complete only if Registry Date of Diagnosis (15.02) ≥ 01/01/2004; otherwise leave blank.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
15.08		Registry Collaborative Stage (CS) Extension [NAACCR data item #2810]	2	392	393	Range: 00 – 99 *Valid values for CS extension include: 00, 05, 07, 10, 20,30, 40, 51-52, 61-62, 71- 73, 95, 99* In the event that the NBCCEDP diagnosis is confirmed by the cancer registry to be a Lymphoma diagnosis (15.03 = 9590-9699, 9702-9729, 9823, 9827), the following values should be used to report CS - Extension: 10-12, 20-23, 30-33, 80, and 99. These values will have different definitions than those listed above for breast cancer. *A complete list of valid values/labels will be provided for reference in Chapter 3 of the Data User's Manual.* *See most current version of the CS Staging Manual:* *http://www.cancerstaging.org/cstage/manuals.html* *v01.03.00 (Sept 2006), Part II, pg 372*	Range check. Leave blank if 15.01 = 1, 3. Complete only if Date of Diagnosis (15.02) ≥ 01/01/2004; otherwise leave blank.
15.09		Registry Collaborative Stage (CS) Lymph Nodes [NAACCR data item #2830]	2	394	395	Range 00 – 99 *Valid values for CS lymph nodes include: 00, 05, 13, 15, 25-26, 28-30, 50- 52, 60, 71- 80, 99.* In the event that the NBCCEDP diagnosis is confirmed by the cancer registry to be a Lymphoma diagnosis (15.03 = 9590-9699, 9702-9729, 9823, 9827), the following value should be used to report CS – Lymph Nodes: 88 = Not applicable. *A complete list of valid values/labels will be provided for reference in Chapter 3 of the Data User's Manual.* *See most current version of the CS Staging Manual:* *http://www.cancerstaging.org/cstage/manuals.html* *v01.03.00 (Sept 2006), Part II, pg 374*	Range check. Leave blank if 15.01 = 1, 3. Complete only if Registry Date of Diagnosis (15.02) ≥ 01/01/2004; otherwise leave blank.

Item Number		Variable Name	Column			Codes / Format / Comments	Edit Checks/Skip Patterns
New	Old		Length	Begin	End		
15.10		Registry Collaborative Stage (CS) Mets at Diagnosis [NAACCR data item #2850]	2	396	397	Range 00 – 99 *Valid values for CS mets at diagnosis include: 00, 10, 40, 42, 44, 50, 99.* In the event that the NBCCEDP diagnosis is confirmed by the cancer registry to be a Lymphoma diagnosis (15.03 = 9590-9699, 9702-9729, 9823, 9827), the following value should be used to report CS – Mets at Diagnosis: 88 = Not applicable for this site. *A complete list of valid values/labels will be provided for reference in Chapter 3 of the Data User's Manual.* *See most current version of the CS Staging Manual:* *http://www.cancerstaging.org/cstage/manuals.html* *v01.03.00 (Sept 2006), Part II, pg 376*	Range check. Leave blank if 15.01 = 1, 3. Complete only if Registry Date of Diagnosis (15.02) ≥ 01/01/2004; otherwise leave blank.
15.11		Registry Primary Site [NAACCR data item #400]	4	398	401	C000 – C999 NOTE: The 'C' must be included as part of the variable response in the MDE file. For example, Breast NOS = C509. A complete list of valid values/labels for this item will be provided for reference in the Data User's Manual.	Range check. Leave blank if 15.01 = 1, 3. Complete only if Registry Date of Diagnosis (15.02) ≥ 01/01/2004; otherwise leave blank.
99. End of Record Mark – Completed for each MDE record							
		End of Record/Newline	1	402	402	Character that ends the current record and begins a new line of text.	Example: Carriage Return-Line Feed

General edit guidelines for:

Dates: If your data processing system does not store dates as complete dates (i.e. they are separate month, day, and year fields), you need to verify the individual fields. The month needs to be between 1 and 12 and the day, if specified, between 1 and 31 and appropriate for the month (i.e. no June 31). A common situation for some dates could be that the year is known, but the month or day is not. If this occurs, please blank fill only the unknown fields.

Correct date sequences: A correct sequence of dates that track screening, diagnosis, and treatment is very important. These relationships have been specified in the edit section above. Please check these date relationships to ensure that the date sequences are reasonable.

Range checks: These are performed on fields like Hispanic Origin (3.05), Race (3.06.x), Breast Symptoms (4.01), etc. where specific values are requested. A simple check of these data before they are submitted will ensure that, for example, Hispanic Origin only has values of '1' to '3' as specified in the MDE documentation.

Skip patterns: There are fields in the MDEs that are supposed to be completed under certain circumstances and left blank in others. For example, Clinical Breast Exam Date (4.03) should only be completed if Clinical Breast Exam (4.02) is a '1' or '2'. Thus please check to see that if, for example, 10 women have a '1' or a '2' for Clinical Breast Exam, that there are no more than 10 Clinical Breast Exam Dates (4.03).