Australian Government
Australian Institute of Health and Welfare

National cervical cancer prevention data dictionary

Working paper

National Cervical Screening Program

A joint Australian, State and Territory Government initiative

CANCER SERIES NO. 88

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Authoritative information and statistics to promote better health and wellbeing

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National cervical cancer prevention data dictionary

Version 1

Working paper

Australian Institute of Health and Welfare
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Contents

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Abbreviations

ABS	Australian Bureau of Statistics
ACD	Australian Cancer Database
AIHW	Australian Institute of Health and Welfare
AIS	adenocarcinoma in situ
CIN	cervical intraepithelial lesion
HPV	human papillomavirus
HSIL	high-grade squamous intraepithelial lesion
LSIL	low-grade squamous intraepithelial lesion
NCSP	National Cervical Screening Program
NHMRC	National Health and Medical Research Council

Summary

Cervical cancer is the 12th most common cancer affecting Australian women. In 2010, 818 women were diagnosed with cervical cancer, and in 2011 there were 229 deaths from this disease. A screening program introduced in Australia in 1991—the National Cervical Screening Program (NCSP)—has been effective at reducing cases of cervical cancer to these current levels, in line with its aim to reduce incidence, morbidity and mortality from cervical cancer.

Reporting statistics about the NCSP in a standardised way is vital to ensure that governments, researchers and health workers have access to relevant and reliable statistics about the performance of the program over time, and how changes to the cervical screening environment—such as the introduction of the National HPV Vaccination Program in 2007—may affect it.

The *National cervical cancer prevention data dictionary version 1* is an assemblage of data elements developed by the Australian Institute of Health and Welfare (AIHW) to support the program's aim of achieving national consistency in data reporting through promoting standardisation and comparability of data across state and territory jurisdictions.

The objectives of the *National cervical cancer prevention data dictionary version 1* are to:

- support operation and monitoring of the National Cervical Screening Program
- establish uniform definitions for the National Cervical Screening Program
- facilitate consistency across jurisdictions in national reporting, including the national reporting of performance indicators for the publication *Cervical Screening in Australia*
- promote uniformity, reliability, validity, consistency and completeness in the data
- support future linkages between the state and territory cervical screening registers and the National HPV Vaccination Program Register
- support potential future directions of the National Cervical Screening Program.

The *National cervical cancer prevention data dictionary version 1* was developed in partnership with state and territory and Commonwealth components of the NCSP, and was endorsed by the Standing Committee on Screening for the Community Care and Population Health Principal Committee on 27 March 2014.

It comprises a comprehensive set of data elements covering the woman, HPV vaccination, provider and cervical tests (cytology, histology and HPV DNA), as well as detailed data specifications for the performance indicators of the NCSP.

1 What is the National cervical cancer prevention data dictionary version 1?

1.1 Development and objectives

The *National cervical cancer prevention data dictionary version 1* is an assemblage of data elements used by the National Cervical Screening Program (NCSP). This *data dictionary* was developed by the Australian Institute of Health and Welfare (AIHW) to support the program's aim of achieving national consistency in data reporting through promoting standardisation and comparability of data across the jurisdictions.

The development process started when NCSP program managers and data managers saw the implementation of *Screening to prevent cervical cancer: guidelines for the management of asymptomatic women with screen-detected abnormalities* as an opportunity to standardise data collections across jurisdictions through the development of a national cervical screening data dictionary.

The then-called *Standardised cervical screening data dictionary* was originally developed as 3 subsets: the first subset comprised data items related to demographic information for program participants, practitioners and laboratories, as well as cytology and human papillomavirus (HPV) testing results, and was published on the Department of Health (Health) website in April 2007. The second subset comprised data items for procedures for obtaining histology specimens and reporting of histology codes. The third subset was developed concurrently with the incorporation of the 3 subsets into a single document, and comprised definitions and algorithms for the performance indicators reported nationally in the annual publication *Cervical screening in Australia.*

At an NCSP program managers meeting held in June 2008, it was decided that the dictionary should be further developed into a comprehensive document, comprising *Essential*, *Desirable* and *Aspirational* data elements to support the NCSP as a whole. The original dictionary was expanded into the *National cervical cancer prevention data dictionary version 1* in July 2008, and continues to be developed to accommodate changes that impact on the NCSP.

The objectives of the *National cervical cancer prevention data dictionary version 1* are to:

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- facilitate consistency across jurisdictions in national reporting, including the national reporting of performance indicators for the publication *Cervical Screening in Australia*
- promote uniformity, reliability, validity, consistency and completeness of data
- support future linkages between the state and territory cervical screening registers and the National HPV Vaccination Program Register.
- support potential future directions of the National Cervical Screening Program.

The development of the *National cervical cancer prevention data dictionary version 1* is an ongoing process, reliant on the support and professional input of the state and territory cervical screening programs.

1.2 Endorsement

The *National cervical cancer prevention data dictionary version 1* was endorsed by the NCSP (through state and territory program managers and the Screening Section (Population Health Division) of Health), and was subsequently endorsed by the Standing Committee on Screening for the Community Care and Population Health Principal Committee on 27 March 2014.

The roles of the *National cervical cancer prevention data dictionary version 1* dictated the endorsement protocol adopted for this document. In order for the *National cervical cancer prevention data dictionary version 1* to support the uniform collection of data, the document and the data elements within need to remain static; however, to support potential future directions of the NCSP, this document needs to be able to change and grow along with new developments and requirements.

Thus, although the *National cervical cancer prevention data dictionary version 1* was officially endorsed as described above, there is a change management protocol to allow individual data elements to be introduced or changed on an ad hoc basis, without the requirement for all data elements to be subsequently reviewed or endorsed.

1.3 Change management protocol

A change to the *National cervical cancer prevention data dictionary version 1* may be initiated by a state or territory cervical screening program (this should occur through the program manager, but may also occur through a data manager or another staff member associated with the program such as a medical advisor or laboratory liaison), the Screening Section of Health, or by the Cancer and Screening Unit of the AIHW itself (the AIHW may also initiate a change on behalf of a third party if required).

A change may be initiated for a variety of reasons, such as to meet updated definitions, e-health requirements, or to provide data elements and definitions to support an initiative of the program at the national level.

Initiation of a change should use the table provided in Appendix E in the first instance, with this forwarded to the Cancer and Screening Unit of the AIHW on completion. This will then be considered through the change management protocol.

Note that any change to the *National cervical cancer prevention data dictionary version 1* that results from this process requires official endorsement through the NCSP and the Standing Committee on Screening for the Community Care and Population Health Principal Committee, and the assignment of a revised official endorsement date for the altered *data dictionary.*

1.4 Structure and scope

The *National cervical cancer prevention data dictionary version 1* is comprised of 4 chapters and Appendices. Chapters 1 and 2 are introductory and provide general information about the *data dictionary*, its structure, and its use. Chapter 3 contains data elements used by the National Cervical Screening Program, arranged in sections that reflect the way that these data elements are used. Chapter 4 defines the Performance Indicators used for national monitoring of the program in the annual *Cervical screening in Australia* report. Appendices

include histology codes for each jurisdiction mapped to the higher level histology codes used in the *National cervical cancer prevention data dictionary version 1*.

It should be noted that the contents of this *data dictionary* have not been assessed for inclusion in the National Health Data Dictionary and may not be comparable with existing national standards.

2 Technical aspects of the National cervical cancer prevention data dictionary version 1

2.1 Data elements

The data elements in the *National cervical cancer prevention data dictionary version 1* are described and defined using a standard format endorsed by the National Health Data Committee. This standard format is based on the first edition of the ISO/IEC 11179–2:2000 Specification and Standardization of Data Elements—the International Standard for defining data elements issued by the International Organization for Standardization and the International Electrotechnical Commission. The current standard used by the AIHW's metadata registry (METeOR) is ISO/IEC 11179-2003 second edition.

The standard rules applied to each data element definition are designed to ensure that each is clear, concise, unambiguous, comprehensive and provide sufficient information to ensure all those who collect, provide, analyse and use the data clearly understand its meaning. These rules describe the data. In technical terms, these rules are called metadata, or data about data.

It should be noted that the fields that describe the representational form of the data element are not meant to prescribe how the state and territory database systems should store the information. The layout in the dictionary describes how the data element should be represented for national reporting purposes. The information may be stored differently in each state and territory's computer system as long as the information required can be extracted and mapped to the format required.

2.2 How to use the information on data elements

Identifying and definitional attributes

The name of the data element is a multi-word designation assigned to a data element. This appears in the heading for each unique data definition in the dictionary. The technical name of the data element is made up of an object class, a property and a value domain, and describes how the value for that data element should appear; for example, A4 Woman—family name, text X[X(39)]. Identifying and definitional attributes include the common name and sometimes a synonymous name or context for the data element, a definition, and collection status within the Program.

Value domain representational attributes

Representation class refers to the form of the data element, such as identifier, text, date or code. The data type refers to the type of symbol, character or other designation used to represent the data element (e.g. string, date/time, number, text), and the format and character length describe how the value should appear for that data element.

Formats can be alphabetic character (denoted by the letter A), numeric (denoted by the letter N) alphanumeric (denoted by the letter X), or specific to dates (D for day, M for month, Y for year). Characters that are not in brackets denote a value that must be represented. Round brackets are used to indicate the number of repeats if a character is repeated more than 6

times in succession (X(9) indicates 9 alphanumeric characters). Square brackets are used to indicate that characters are optional in any ordered combination ([XXX] indicates 0, 1, 2 or 3 alphanumeric characters). Curly brackets are used to indicate that characters are entirely optional (X{XX} indicates 1 or 3 alphanumeric characters) (see Tables 2.1 and 2.2 for examples).

Table 2.1: Data element format—codes

Code	Definition	Description	Example
A	Alphabetic	Supports letter characters (including punctuation) only (i.e. no numbers)	AAA = ABC not A1C
N	Numeric	Supports numeric digits only (i.e. no alphabetic characters)	NNN = 123 not 1B3
X	Alphanumeric	Supports both alphabetic characters (including punctuation) and numeric digits	XXX = ABC or 123 or A1C or 1B3
D	Day	Date specific: day number within a month. Represented as DD in DDMMYYYY date format	23rd day of August 2013 23082013
M	Month	Date specific: month number within a year. Represented as MM in DDMMYYYY date format	8th month of 2013 23082013
Y	Year	Date specific: year number. Represented as YYYY in DDMMYYYY date format.	2013th year 23082013

Table 2.2: Data element format—use of brackets

Bracket type	Description	Example	Notes
No square or curly brackets	Characters must be entered in the format presented. *Note*: number in round brackets ( ) represents characters repeated 7 or more times in succession.	AAA NN X(8)	Exactly 3 alphabetic characters Exactly 2 numeric characters Exactly 8 alphanumeric characters
Curly brackets /braces { }	Characters are optional, but if entered, they are fixed in length and must match exactly the format presented.	{AAA} {NN} {X(8)}	0 or exactly 3 alphabetic characters 0 or exactly 2 numeric characters 0 or exactly 8 alphanumeric characters
Square brackets [ ]	Characters are optional, but if entered are variable in length up to the maximum length designated	[AAA] [NN] [N(8)]	Either 0, 1, 2 or 3 alphabetic characters Either 0, 1 or 2 numeric characters Either 0, 1, 2, 3, 4, 5, 6, 7 or 8 numeric characters

Value domain format examples

- X(10)—No square/curly brackets, therefore exactly 10 alphanumeric characters must be entered.
- {X(10)}—Curly brackets, therefore optional with fixed length. Either 0 or exactly 10 alphanumeric characters must be entered.
- [X(10)]—Square brackets, therefore optional with variable length—either 0 or between 1 to 10 alphanumeric characters entered.
- X[X(39)]—At least 1 alphanumeric character is required (an X is outside any square/curly brackets) and optionally supports an additional 0 to 39 alphanumeric characters, which means the maximum total length is 40 alphanumeric characters.
- {N(10)[N]}—Curly brackets, therefore optional with fixed length. Either 0 or 10 numeric characters with a further optional single numeric character entered. This allows for 0, 10 or a maximum of 11 numeric characters.
- {AAX[XXX]}—Curly brackets, therefore optional with fixed length. Either 0 or 2 alphabetic characters followed by a single alphanumeric character with a further optional 0 to 3 alphanumeric characters allowed. This allows for 0, 3, 4, 5 or a maximum of 6 characters (2 alphabetic, and 4 alphanumeric). If only 3 characters are entered, then they must be 2 alphabetic followed by 1 alphanumeric.

Collection and usage attributes may be included to ensure that data are captured correctly and to aid in the correct interpretation of permissible values.

Data element attributes

This section of the data element may also include:

- a guide for use, which takes the form of additional comments or advice on interpretation or application
- collection methods, which are comments and advice concerning the capture of data for a particular data element, including guidelines on the design of questions for use in collecting information, and treatment of 'not stated' or non-response.

Additional information relates to source, and related metadata, and reference documents.

3 Data elements of the National cervical cancer prevention data dictionary version 1

3.1 Source of cervical screening data elements

The cervical screening register in each of the 8 states and territories of Australia are the repositories of cervical screening data for the NCSP. Pathology laboratories are the primary source of data for cervical screening registers, which are in turn the primary source of cervical screening data—a relationship that is illustrated in Appendix A.

Laboratories reporting cervical cytology in Australia are required to send information to the cervical cytology registries in each state and territory on a regular and timely basis, depending on each jurisdiction's legislative requirements.

The registries operate on an opt-off basis and are required to send reminder letters to women overdue for a Pap test, follow up cervical abnormalities, send screening histories to laboratories for reporting of cervical cytology, and also provide data for the purposes of monitoring and evaluating the National Cervical Screening program. These functions are critically dependent on timely data provided from the laboratories.

Laboratories are required to send the following information to the cervical screening register in the woman's jurisdiction of residence:

- demographic information, including name, address, Aboriginal and Torres Strait Islander status (when the clinician has provided this information and the register is capable of receiving it), date of birth, Medicare number
- Pap test provider demographics, including name, address, provider number
- cervical cytology result and recommendation, coded according to the 2006 Cytology Coding Schedule
- histology results relevant to the cervix
- HPV test results.

The data should ideally be sent electronically from the laboratory to the register on a regular basis (this would usually be daily or weekly depending on the volume of tests), but other arrangements may be in place.

Box 3.1

Data elements have been arranged to reflect an entire record that may be sent from a pathology laboratory to the cervical screening register, since a woman's record on the cervical screening register is updated on a test by test basis.

In this context, it is useful to consider data elements at the time of test'.

This means that if a woman has a cervical cytology test, histology test or HPV DNA test, all other data elements relate to that test through the date of that test, since this is the date at which other data elements will also be collected and sent through from the pathology laboratory.

3.2 Organisation of data elements

Data elements have been organised into the following sections:

A Woman data elements—these are the details for each woman on the cervical screening register

V HPV vaccination data elements—these are details of HPV vaccinations from the National HPV Vaccination Program Register

B Provider data elements—these are the details of the provider requesting and collecting specimen/s

L Laboratory data elements—these are the details of the laboratory analysing the specimen/s

T Test type data element—this section contains a single data element that determines the type of test performed (cytology, histology or HPV DNA)

C Cytology test data elements—these are the details of a cytology test if the specimen was collected by way of a Pap test (Pap smear)

H Histology test data elements—these are the details of a histology test if the specimen was collected by way of a biopsy

D HPV DNA test data elements—these are the details of an HPV DNA test

F Follow-up data elements—this section contains 2 elements that allow information about the 27-month cervical screening register reminder letter to be collected.

These sections reflect the way in which the data elements are used in the cervical cytology registries that support the state and territory cervical screening programs.

It should be noted that differences exist in the way that each jurisdiction reports and records data, and this is therefore not reflective of all cervical screening registers, but aims to capture the main elements of all registers, and therefore present a 'generic' model that is applicable to all.

Box 3.2

Although the first subset of the *Standardised cervical screening data dictionary* was published in April 2007, the development of this document into the more comprehensive *National cervical cancer prevention data dictionary* identified many data elements that needed to be either added or altered.

Therefore differences exist between the data elements in the first subset and this document.

Another important change is the organisation of data elements into sections to increase the ease of use of the *data dictionary*, which means the numbering system used in the first and second subsets has been abolished.

To allow transition between the published first subset of the Dictionary and this *data dictionary*, any data elements that existed in the first subset have their previous number and technical name included in the related metadata references section of the relational attributes for these data elements.

3.3 Data element status

The current status of each data element in the *National cervical cancer prevention data dictionary version 1* is identified by its collection status.

Data elements currently used by cervical screening registers:

- **Essential** status indicates that this data element is required for cervical screening registers to conduct their core business, although the data may be collected and stored differently to the way in which the data element is described here.
- **Desirable** status indicates that, although desirable, this data element is not essential for cervical screening registers to collect. There may also be differences in the way in which the data items are collected and stored on the registers.
- **Conditional status** indicates that the recording of this data element is conditional on the defining event having occurred. For example, A25 Woman—date of death is conditional (nullable) until such time as the woman is confirmed as deceased by the cervical screening register. A further example is F2 Follow-up-date letter sent, which is conditional on whether a 27-month reminder letter is considered to have been sent.

Data elements not currently collected routinely by cervical screening registers:

- **Potential** status indicates that this data element is feasibly able to be collected, although there may be barriers to this at present. This status is used for data elements such as HPV vaccination status, for which a route for collection has been identified, in anticipation that in the near future these may be able to be used.
- **Aspirational** status indicates that this data element has been identified as one that would be required to support directions to which the program aspires, but which may never be realised. Data elements of this status include HPV genotyping information, which may never be able to be collected by cervical screening registers.

Since the *National cervical cancer prevention data dictionary version 1* aims, in addition to supporting current data collection and reporting of the National Cervical Screening Program, to support potential future aspirations that may never be realised, there are a number of 'potential' and 'aspirational' data elements in this document.

Potential and aspirational data elements are likely to require further development if they were to be collected by cervical screening registers (this is particularly the case for aspirational data elements, many of which are skeletal and only indicative of what may be collected in the future).

It should be noted that potential and aspirational data elements may not reflect the directions of all state and territory cervical screening programs, and in some cases may be in direct conflict with current legislation. These are considered important to include in this document, however, so that if states and territories chooses to incorporate these data into their cervical screening register in the future, they can do so within a framework that will allow national consistency. This is particularly important for the potential data elements that have general support, if not appropriate legislation, at this time.

It should be noted that, regardless of the status, these data elements are intended to support the state and territory cervical screening programs in achieving national consistency and validity in data rather than to prescribe how data should be collected or stored in each cervical screening register.

3.4 Data elements

Woman data elements

A1 Woman—client identifier, identifier X[X(19)]

Identifying and definitional attributes

Data element name	Client identifier
Definition	Client identifier unique within state or territory cervical screening registry.
Collection status	Essential

Value domain representational attributes

Representation class	Identifier
Data type	String
Format	X [X(19)]
Maximum character length	20

Collection and usage attributes

Guide for use

Data element attributes

Source and reference attributes

Origin	State and Territory cervical screening registers

A2 Woman—Medicare card number, identifier {N(10)[N]}

Identifying and definitional attributes

Data element name	Medicare card number
Synonymous names	Medicare number
Definition	A numeric number on a medical card allocated by Medicare Australia for the purpose of identifying those people eligible for specific services.
Collection status	Desirable

Value domain representational attributes

Representation class	Identifier
Data type	Number
Format	{N(10)[N]}
Maximum character length	11

Collection and usage attributes

Guide for use	This data item is desirable, as it is not currently collected by all cervical screening registries. Format allows the collection of full Medicare number for an individual (i.e. family number plus person (individual reference) number), or truncated Medicare 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

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 9 Person—government funding identifier, Medicare card number identifier N(11)

A3 Woman—individual healthcare identifier, identifier {N(16)}

Identifying and definitional attributes

Data element name	Individual healthcare identifier
Synonymous names	IHI
Definition	An individual healthcare identifier (IHI) is a unique 16 digit number that will be allocated to each Australian resident and others seeking healthcare in Australia.
Collection status	Aspirational

Value domain representational attributes

Representation class	Identifier
Data type	Number
Format	{N(16)}
Maximum character length	16

Collection and usage attributes

Guide for use	An individual healthcare identifier (IHI) is allocated to all individuals enrolled in the Medicare program or those who are issued with a Department of Veterans' Affairs (DVA) treatment card, and others who seek healthcare in Australia.

Data element attributes

Source and reference attributes

Origin	National E-Health Transition Authority (NEHTA)

A4 Woman—family name, text X[X(39)]

Identifying and definitional attributes

Data element name	Family name
Definition	The text that represents the part of a name a woman usually has in common with some other members of her family, as distinguished from her given names
Collection status	Essential

Value domain 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. This metadata item should be recorded for all clients. A full history of names is to be retained.
Collection methods	***Note that the following collection methods are not intended to be prescriptive, but rather are intended as a resource that cervical screening registries may find useful.*** Family name should be recorded in the format preferred by the person. The format should be the same as that indicated by the person (e.g. 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 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/her name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change his/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 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:

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 people 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.

People 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 health care client:

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:

People 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 people 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 females 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.

Prefixes:

Where a family name contains a prefix, such as one to indicate that the person is a widower/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.

Source and reference attributes

Origin

State and Territory cervical screening registers

Reference documents

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

Relational attributes

Related metadata references

Supersedes Standardised cervical screening data dictionary Cytology (first) sub-set data element 1 Person—family name, text X[X(39)]

A5 Woman—given names, text X[X(39)]

Identifying and definitional attributes

Data element name	Given names
Definition	The woman's identifying name(s) within the family group or by which the woman is socially identified.
Collection status	Essential

Value domain 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 full given name(s) of the client on their information systems. 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. This metadata item should be recorded for all clients. A full history of names is to be retained.
Collection methods	***Note that the following collection methods are not intended to be prescriptive, but rather are intended as resource that cervical screening registries may find useful.*** 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 (e.g. written on a form) or 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 their name by usage in all States and Territories of Australia with the exception of Western Australia, where a person may only change their name under the Change of Name Act. The person should generally be registered using their preferred name as it is more likely to be used in common usage. The preferred name of the person may in fact be their legal (or Medicare card) name. Use of first initial: If the given name of the person 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. Registers may be able to enter a full stop (.) into the given names if one is not provided. For example this would allow letters to be

printed as Ms . Robertson.

This assists Registers to format letter labels correctly and avoids confusion for data processing officers who may be unable to leave the data field blank.

The person 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.

Multiple given names (middle, second, third etc. names):

All of the given names of the person should be recorded in the 'Given name' field, leaving a space between each name.

Record complete information:

If the person has many given names and all of them cannot fit in the field, record as many names in full as possible, in preference to recording initials.

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.

e.g. The given name of the person is Jennifer but she prefers to be called Jenny. Record 'Jenny' as the preferred 'Given name' and 'Jennifer' as her 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'.

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.

e.g. Wendy Hilda

Leave a single space between the person’s first name and each of their middle names.

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 given name of the person 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 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.

Source and reference attributes

Origin	State and Territory cervical screening registers
Reference documents	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 2 Person—given names, text X[X(40)]

A6 Woman—other family name, text [X(40)]

Identifying and definitional attributes

Data element name	Other family name
Definition	That part of a name a woman has or had in common with some other members of her other or previous family(s), as distinguished from her other or previous given names.
Collection status	Desirable

Value domain 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	The agency or establishment should record the client's full other or previous family name on their information systems. A full history of names is to be retained.
Collection methods	*As for **A4 Woman—family name, text X[X(39)].***

Source and reference attributes

Origin	State and Territory cervical screening registers
Reference documents	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 3 Person—other family name, text X[X(39)]

A7 Woman—date of birth, date DDMMYYYY

Identifying and definitional attributes

Data element name	Date of birth
Definition	The date on which a woman was born.
Collection status	Essential

Value domain 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.
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).
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.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 10 Person—date of birth, date DDMMYYYY

A8 Woman—Indigenous status, code N

Identifying and definitional attributes

Data element name	Indigenous status
Definition	Whether a woman identifies as being of Aboriginal or Torres Strait Islander descent. This is in accord with the first two of three components of the Commonwealth definition.
Collection status	Essential where it is possible to be collected, and where the cervical screening register is capable of receiving it.

Value domain representational attributes

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

Permissible values

Value	Meaning
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin

Supplementary codes

9	Not stated/inadequately described

Collection and usage attributes

Context

Australia's Aboriginal and Torres Strait Islander peoples occupy a unique place in Australian society and culture. In the current climate of reconciliation, accurate and consistent statistics about Aboriginal and Torres Strait Islander peoples are needed in order to plan, promote and deliver essential services, to monitor changes in wellbeing and to account for government expenditure in this area. The purpose of this metadata item is to provide information about people who identify as being of Aboriginal or Torres Strait Islander origin. Agencies or establishments wishing to determine the eligibility of individuals for particular benefits, services or rights will need to make their own judgments about the suitability of the standard measure for these purposes, having regard to the specific eligibility criteria for the program concerned.

Guide for use

The collection of Aboriginal and Torres Strait Islander status is necessary for the government and other services to plan and deliver appropriate health services for all Australians, to assess the impact of services on particular groups in the community and to improve health care and to monitor changes in health and wellbeing over time (AIHW 2010).

Aboriginal and Torres Strait Islander status is not routinely collected by the cervical screening registries, but where it is collected by the practitioner collecting the cervical cytology sample, and where this is transmitted to the pathology laboratory on the request form (or electronically), and where the cervical screening register is capable of receiving it, it is essential that Aboriginal and Torres Strait Islander status be provided to the cervical screening registries.

This metadata item is based on the Australian Bureau of Statistics (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS Website as indicated in the Reference documents.

The classification for Indigenous status has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:

Indigenous:

- Aboriginal but not Torres Strait Islander origin.
- Torres Strait Islander but not Aboriginal origin.
- Both Aboriginal and Torres Strait Islander origin.

Non-indigenous:

- Neither Aboriginal nor Torres Strait Islander origin.

Not stated/ inadequately described:

This category is not to be available as a valid answer to the questions but is intended for use:

- Primarily when importing data from other data collections that do not contain mappable data.
- Where an answer was refused.
- Where the question was not able to be asked prior to completion of assistance because the client was unable to communicate or a person who knows the client was not available.

Only in the last two situations may the tick boxes on the questionnaire be left blank.

Collection methods

It is anticipated that collection of Aboriginal and Torres Strait Islander status will be collected through the inclusion of this field on pathology forms that accompany the cervical cytology sample to the laboratory.

Laboratories reporting cervical cytology in Australia are required to send information to the cervical screening registries in each state and territory on a regular and timely basis, depending on each jurisdiction's legislative requirements.

In addition to the information that laboratories are currently required to send to the cervical screening registry in the woman's jurisdiction of residence (including demographic information on the woman and cervical cytology test provider, cervical cytology results and recommendation, cervical histology results and HPV test results), Aboriginal and Torres Strait Islander status is also required to be sent to the cervical screening registry, where Aboriginal and Torres Strait Islander status is collected and transmitted to the pathology laboratory on the request form (or electronically), and where is legislatively permitted, possible and available to be collected, the cervical screening register is capable of receiving it and the cervical cytology screening register is able to store it.

Data element attributes

Collection and usage attributes

Collection methods

The standard question for Indigenous Status is as follows:

[Are you] [Is the person] [Is (name)] of Aboriginal or Torres Strait

Islander origin?

(For women of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.)

No.....

Yes, Aboriginal.....

Yes, Torres Strait Islander.....

This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend, or another member of the household is answering on behalf of the subject. It is strongly recommended that this question be asked directly wherever possible.

When someone is not present, the person answering for them should be in a position to do so, i.e. this person must know well the person about whom the question is being asked and feel confident to provide accurate information about them.

This question must always be asked regardless of data collectors' perceptions based on appearance or other factors.

The Indigenous status question allows for more than one response. The procedure for coding multiple responses is as follows:

If the respondent marks 'No' and either 'Aboriginal' or 'Torres Strait Islander', then the response should be coded to either Aboriginal or Torres Strait Islander as indicated (i.e. disregard the 'No' response).

If the respondent marks both the 'Aboriginal' and 'Torres Strait Islander' boxes, then their response should be coded to 'Both Aboriginal and Torres Strait Islander origin.

If the respondent marks all three boxes ('No', 'Aboriginal' and 'Torres Strait Islander'), then the response should be coded to 'Both Aboriginal and Torres Strait Islander Descent' (i.e. disregard the 'No' response).

This approach may be problematical in some data collections, for example when data are collected by interview or using screen based data capture systems. An additional response category

Yes, both Aboriginal and Torres Strait Islander...

may be included if this better suits the data collection practices of the agency or establishment concerned.

Comments

The following definition, commonly known as 'The Commonwealth Definition', was given in a High Court judgement in the case of Commonwealth v Tasmania (1983) 46 ALR 625.

'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'.

There are three components to the Commonwealth definition:

- descent;
- self-identification; and
- community acceptance.

In practice, it is not feasible to collect information on the community acceptance part of this definition in general purpose statistical and administrative collections and therefore standard questions on Indigenous status relate to descent and self-identification only.

Source and reference attributes

Origin

National Health Data Committee

National Community Services Data Committee

Reference documents	Australian Bureau of Statistics 1999. Standards for Social, Labour and Demographic Variables. Cultural Diversity Variables, Canberra. Viewed 3 August 2005. Australian Institute of Health and Welfare 2010. National best practice guidelines for collecting Indigenous status in health data sets. Cat. no. IHW 29. Canberra: AIHW.

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 11 Person—Indigenous status, code N

A9 Woman—main language other than English spoken at home, code (ASCL 2011) {NN{NN}}

Identifying and definitional attributes

Data element name	Main language other than English spoken at home
Registration status	Community Services, Superseded 13/10/2011 Housing assistance, Standard 10/02/2006 Health, Superseded 13/10/2011
Definition	The language reported by a person as the main language other than English spoken by that person in his/her home (or most recent private residential setting occupied by the person) to communicate with other residents of the home or setting and regular visitors, as represented by a code.
Collection status	Aspirational

Value domain representational attributes

Classification scheme	Australian Standard Classification of Languages 2011
Data type	Number
Format	{NN{NN}}
Maximum character length	4

Collection and usage attributes

Guide for use	Not currently able to be collected routinely by cervical screening registers. The Australian Standard Classification of Languages (ASCL) has a three- level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow Group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad Group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages. For example, the Lithuanian language has a code of 3102. In this case 3 denote that it is an Eastern European language, while 31 denote that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denote that it is an Australian Indigenous language and 87 denote that the language is Western Desert language. Language data may be output at the Broad Group level, Narrow Group level or base level of the classification. If necessary significant Languages within a Narrow Group can be presented separately while the remaining Languages in the Narrow Group are aggregated. The same principle can be adopted to highlight significant Narrow Groups within a Broad Group.

Data element attributes

Collection and usage attributes

Collection methods

Recommended question:

Do you/Does the person/Does (name) speak a language other than English at home? (If more than one language, indicate the one that is spoken most often.)

Response options for detailed data:

Alternative 1

No, (English only) []

Yes, Mandarin []

Yes, Italian []

Yes, Arabic []

Yes, Cantonese []

Yes, Greek []

Yes, Vietnamese []

Yes, Spanish []

Yes, Hindi []

Yes, Tagalog []

Yes, Other (please specify) _____

The above list includes languages based on their statistical significance in the Australian context. The list is reviewed when data indicate that different languages have been more or less frequently reported in the Census.

Alternative 2

No, English only []

Yes, Other - please specify _____

Response option for minimum data:

No, English only []

Yes, Other []

Comments

This metadata item is consistent with that used in the Australian Census of Population and Housing and is recommended for use whenever there is a requirement for comparison with Census data.

This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties. In conjunction with Indigenous status, Proficiency in spoken English and Country of birth this data element forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics (ABS).

Data on main language other than English spoken at home are regarded as an indicator of 'active' ethnicity and also as useful for the study of inter-generational language retention. The availability of such data may help providers of health and community services to effectively target the geographic areas or population groups that need those services. It may be used for the investigation and development of language services such as interpreter/ translation services.

The ABS Language Standards, 2012, Version 1.1 (cat. no. 1200.0.55.005) was released in September 2012. The recommended question recognises children under two years of age.

Source and reference attributes

Origin

Health Data Standards Committee

National Community Services Data Committee

Australian Bureau of Statistics 2011. Australian Standard Classification of Languages (ASCL) 2011. Canberra: ABS. 16/8/2011.

Reference documents

Australian Bureau of Statistics 2012. Language Standards, 2012, Version 1.1. Cat. no. 1200.0.55.05. Canberra: ABS.

A10 Woman—country of birth, code (SACC 2011) {NNNN}

Identifying and definitional attributes

Data element name	Country of birth
Registration status	Community Services, Standard 13/10/2011 Housing assistance, Standard 13/10/2011 Health, Standard 13/10/2011 Homelessness, Standard 13/10/2011 WA Health, Draft 23/08/2012 Independent Hospital Pricing Authority, Recorded 22/08/2012
Definition	The country in which the person was born, as represented by a code.
Collection status	Aspirational

Value domain representational attributes

Classification scheme	Standard Australian Classification of Countries 2011
Representation class	Code
Data type	Number
Format	{NNNN}
Maximum character length	4

Collection and usage attributes

Guide for use	Not currently able to be collected routinely by cervical screening registers. The Standard Australian Classification of Countries 2011 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country. A country, even if it comprises other discrete political entities such as states, is treated as a single unit for all data domain purposes. Parts of a political entity are not included in different groups. Thus, Hawaii is included in Northern America (as part of the identified country United States of America), despite being geographically close to and having similar social and cultural characteristics as the units classified to Polynesia.

Data element attributes

Collection and usage attributes

Collection methods	Some data collections ask respondents to specify their country of birth. In others, a pre-determined set of countries is specified as part of the question, usually accompanied by an 'other (please specify)' category. Recommended questions are: In which country were you/was the person/was (name) born? Australia Other (please specify) Alternatively, a list of countries may be used based on, for example common Census responses. In which country were you/was the person/was (name) born?

	Australia England New Zealand Italy Viet Nam India Scotland Philippines Greece Germany Other (please specify) In either case coding of data should conform to the SACC. Sometimes respondents are simply asked to specify whether they were born in either 'English speaking' or 'non-English speaking' countries but this question is of limited use and this method of collection is not recommended.
Comments	This metadata item is consistent with that used in the ABS collection methods and is recommended for use whenever there is a requirement for comparison with ABS data (last viewed 2/6/2008).

A11 Woman—residential address, text [X(180)]

Identifying and definitional attributes

Data element name	Residential address
Definition	The address where a woman usually resides.
Collection status	Desirable

Value domain 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	Address is a composite of one or more standard address components that describes a low level of geographical/physical description of a location. 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 woman. Residential or a postal (mailing) address should be provided for a woman.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 4 Person (address)—address line, text X[X(180)]

A12 Woman—residential suburb/town/locality name, text [A(50)]

Identifying and definitional attributes

Data element name	Residential suburb/town/locality name
Definition	The suburb/town/locality where a woman usually resides.
Collection status	Desirable

Value domain representational attributes

Representation class	Text
Data type	String
Format	[A(50)]
Maximum character length	50

Data element attributes

Collection and usage attributes

Guide for use	Suburb/town/locality is the text that represents the full name of the locality contained within the specific address of a woman. The suburb/town/locality name, may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names. This metadata item may be used to describe the location of woman, organisation or event. It can be a component of a street or postal address. If there is no data for this item please refer to 'Woman—alternative or other names for suburb/town/locality' as this may contain an alternative name the locality can be known by. Residential or a postal (mailing) address should be provided for a woman.
Collection methods	Enter 'Unknown' when the locality name or geographic area for a woman or event is not known. Enter 'No fixed address' when a woman has no fixed address or is homeless.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 5 Person (address)—suburb/town/locality name, text [A(50)]

A13 Woman—residential alternative or other names for suburb/town/locality, text [A(50)]

Identifying and definitional attributes

Data element name	Residential alternative or other names for suburb/town/locality
Definition	The alternative name or other name of the suburb/town/locality (for example an Indigenous name or a colloquial name for a locality that is different to the official or commonly used name) where a woman usually resides.
Collection status	Desirable

Value domain representational attributes

Representation class	Text
Data type	String
Format	[A(50)]
Maximum character length	50

Data element attributes

Collection and usage attributes

Guide for use	The alternative name or other name of the suburb/town/locality is, for example, an Indigenous name or a colloquial name for a locality that is different to the official or commonly used name, that is contained within the specific address of a woman. The alternative or other name for a suburb/town/locality may be used instead of, or in addition to, the official or commonly used name of the locality.
Collection methods	If there is not an alternative or other name for a locality other than the official or commonly used name, then do not enter any data for this item.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 6 Person—alternative or other names for suburb/town/locality, text [A(50)]

A14 Woman—residential Australian state/territory name, code {AA[A]}

Identifying and definitional attributes

Data element name	Residential Australian state/territory name
Definition	The name of the Australian state or territory for the address where a woman usually resides.
Collection status	Desirable

Value domain representational attributes

Representation class	Code	
Data type	Text	
Format	**{AA[A]}**	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	NSW	New South Wales
	VIC	Victoria
	QLD	Queensland
	WA	Western Australia
	SA	South Australia
	TAS	Tasmania
	ACT	Australian Capital Territory
	NT	Northern Territory

Data element attributes

Collection and usage attributes

Guide for use

This data element is important for national reporting by the Australian Institute of Health and Welfare, but is not mandatory for collection by state and territory cervical screening registers.

Where it is collected, it is preferable if this is known to be the state or territory of residence, rather than derived from the residential postcode alone, although this may not be possible.

Although the definition states that this is the state or territory in which a woman usually resides, this may alternatively be used by the AIHW to represent the state or territory that supplied the woman's data, which may be different to that in which the woman usually resides. This needs to be clearly defined in the documentation of AIHW databases that use this date element.

The order presented here is the standard for the Australian Institute of Health and Welfare, and reflects the current order of states and then territories in order of most populated to least populated.

Residential or a postal (mailing) address should be provided for a woman.

A15 Woman—residential Australian postcode, {NNNN}

Identifying and definitional attributes

Data element name	Residential Australian postcode
Definition	The code that represents a postal delivery area, aligned with locality, suburb or place for the address where a woman usually resides.
Collection status	Desirable

Value domain representational attributes

Representation class	Code
Data type	Number
Format	{NNNN}
Maximum character length	4

Collection and usage attributes

Comments	Must accept zero as the leading digit to accommodate all Australian postcodes. Australian Postcode may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators is not always possible. When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Statistical Geography Standard codes using an ABS concordance. The mailing postcode should only be used for correspondence purposes, and not for the calculation of geographic region or socioeconomic status in Indicators 1.2 and 1.3, unless there is no other postcode information stored for the woman. The postcode associated with the woman's usual residence provides a more accurate indication of the geographic region and socioeconomic status in Indicators 1.2 and 1.3, since the denominator populations are derived from place of usual residence.
Guide for use	When used to supply data to the AIHW, it is preferable for the residential postcode to be "at the time of test".

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 8 Person (address)—Australian postcode, {NNNN}

A16 Woman—mailing address, text [X(180)]

Identifying and definitional attributes

Data element name	Mailing address
Definition	The address where a woman prefers all correspondence to be delivered.
Collection status	Desirable

Value domain 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	This should be collected if a woman has a different address to which she would prefer correspondence sent. Address is a composite of one or more standard address components that describes a low level of geographical/physical description of a location. 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 woman. Residential or a postal (mailing) address should be provided for a woman.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references

A17 Woman—mailing suburb/town/locality name, text [A(50)]

Identifying and definitional attributes

Data element name	Mailing suburb/town/locality name
Definition	The suburb/town/locality where a woman prefers all correspondence to be delivered.
Collection status	Desirable

Value domain representational attributes

Representation class	Text
Data type	String
Format	[A(50)]
Maximum character length	50

Data element attributes

Collection and usage attributes

Guide for use	This should be collected if a woman has a different address to which she would prefer correspondence sent. Suburb/town/locality is the text that represents the full name of the locality contained within the specific address of a woman. The suburb/town/locality name, may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community. The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names. This metadata item may be used to describe the location of woman, organisation or event. It can be a component of a street or postal address. If there is no data for this item please refer to 'Woman—alternative or other names for suburb/town/locality' as this may contain an alternative name the locality can be known by. Residential or a postal (mailing) address should be provided for a woman.
Collection methods	Enter 'Unknown' when the locality name or geographic area for a woman or event is not known. Enter 'No fixed address' when a woman has no fixed address or is homeless.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 5 Person (address)—suburb/town/locality name, text [A(50)]

A18 Woman—mailing alternative or other names for suburb/town/locality, text [A(50)]

Identifying and definitional attributes

Data element name	Mailing alternative or other names for suburb/town/locality
Definition	The alternative name or other name of the suburb/town/locality (for example an Indigenous name or a colloquial name for a locality that is different to the official or commonly used name) where a woman prefers all correspondence to be delivered.
Collection status	Desirable

Value domain representational attributes

Representation class	Text
Data type	String
Format	[A(50)]
Maximum character length	50

Data element attributes

Collection and usage attributes

Guide for use	The alternative name or other name of the suburb/town/locality is, for example, an Indigenous name or a colloquial name for a locality that is different to the official or commonly used name, that is contained within the specific address of a woman. The alternative or other name for a suburb/town/locality may be used instead of, or in addition to, the official or commonly used name of the locality.
Collection methods	If there is not an alternative or other name for a locality other than the official or commonly used name, then do not enter any data for this item.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 6 Person—alternative or other names for suburb/town/locality, text [A(50)]

A19 Woman—mailing Australian state/territory name, code {AA[A]}

Identifying and definitional attributes

Data element name	Mailing Australian state/territory name
Definition	The name of the Australian state or territory for the address where a woman prefers all correspondence to be delivered.
Collection status	Desirable

Value domain representational attributes

Representation class	Code	
Data type	Text	
Format	{AA[A]}	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	NSW	New South Wales
	VIC	Victoria
	QLD	Queensland
	WA	Western Australia
	SA	South Australia
	TAS	Tasmania
	ACT	Australian Capital Territory
	NT	Northern Territory

Data element attributes

Collection and usage attributes

Guide for use	This data element is not mandatory for collection by state and territory cervical screening registers. Where it is collected, it is preferable if this is known to be the state or territory of the mailing address, rather than derived from the mailing address postcode alone, although this may not be possible. The order presented here is the standard for the Australian Institute of Health and Welfare, and reflects the current order of states and then territories in order of most populated to least populated. Residential or a postal (mailing) address should be provided for a woman.

A20 Woman—mailing Australian postcode, code {NNNN}

Identifying and definitional attributes

Data element name	Mailing Australian postcode
Definition	The code that represents a postal delivery area, aligned with locality, suburb or place for the address where a woman prefers all correspondence to be delivered.
Collection status	Desirable

Value domain representational attributes

Representation class	Code
Data type	Number
Format	{NNNN}
Maximum character length	4

Collection and usage attributes

Comments	Must accept zero as the leading digit to accommodate all Australian postcodes. The mailing postcode should only be used for correspondence purposes, and not for the calculation of geographic region or socioeconomic status in Indicators 1.2 and 1.3, unless there is no other postcode information stored for the woman. The postcode associated with the woman's usual residence provides a more accurate indication of the geographic region and socioeconomic status in Indicators 1.2 and 1.3, since the denominator populations are derived from place of usual residence. Residential or a postal (mailing) address should be provided for a woman.

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 8 Person (address)—Australian postcode, {NNNN}

A21 Woman—hysterectomy status, code N

Identifying and definitional attributes

Data element name	Hysterectomy status
Definition	An indication as to whether a woman has had a total hysterectomy (removal of uterus and cervix).
Collection status	Essential

Value domain representational attributes

Representation class	Code	
Data type	Number	
Format	N	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	0	No hysterectomy reported
	1	Hysterectomy reported

Collection and usage attributes

Business rule	If A22 is populated, A21 must equal 1.

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 13 Person—Hysterectomy status, code N

A22 Woman—date of hysterectomy, date {DDMMYYYY}

Identifying and definitional attributes

Data element name	Date of hysterectomy
Definition	The date a woman underwent a total hysterectomy (removal of uterus and cervix).
Collection status	Conditional

Value domain representational attributes

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

Collection and usage attributes

Guide for use	While it is preferable that this be an accurate date of a reported hysterectomy, part of the date may need to be estimated.
Collection methods	The collection of data for this data element is conditional on a woman having had a total hysterectomy.

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 14 Person—date of hysterectomy, date DDMMYYYY

A23 Woman—active status, code A

Identifying and definitional attributes

Data element name	Active status
Definition	An indication as to whether a woman record is active or inactive
Collection status	Essential

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	A	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	A	Active
	I	Inactive

Collection and usage attributes

Guide for use	Active status is to be used to reflect whether a woman's record on the register is active or inactive. An 'inactive' record may be for any of a number of reasons, such as a request from the woman to not be contacted by the register, or because she has 'opted off' the register. 'Inactive' will only indicate that a woman has 'opted off' the register in the states and territories in which test results for these woman are kept on the register; in those states and territories who remove all records for the woman, their inactive status will be removed along with all other details (see Appendix B for the different data implications for 'opt off' for states and territories).

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 35 Person—registry contact suspension flag, code N

A24 Woman—vital status, code [N]

Identifying and definitional attributes

Data element name	Vital status
Definition	An indication as to whether a woman is alive or deceased.
Context	These data are essential to ensure that correspondence is not sent to deceased people to avoid potential distress for the woman's family or friends.
Collection status	Desirable

Value domain representational attributes

Representation class	Code	
Data type	Number	
Format	[N]	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	0	Alive
	1	Deceased

Collection and usage attributes

Guide for use	Most cervical screening registries record status and vital status as separate data elements.
Business rule	If A25 is populated, A24 must equal 1.

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references:	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 36 Person—vital status, code N

A25 Woman—date of death, date {DDMMYYYY}

Identifying and definitional attributes

Data element name	Date of death
Definition	The date of death of the woman.
Context	Required to prevent screening reminder letters or other correspondence being sent to people.
Collection status	Conditional

Value domain representational attributes

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

Collection and usage attributes

Guide for use	Record the date of death. This data element should always be recorded as an 8-digit valid date comprising day, month and year. Year should always be recorded in its full 4 digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example if the woman dies on 1 July 2005 the Date of death should be recorded as 01072005 as specified in the representational layout.
Collection methods	If an accurate date of death cannot be recorded then do not enter any data, the completion of 'Person—vital status' will be sufficient.

Data element attributes

Collection and usage attributes

Guide for use	This item should only be recorded if notification of a death is received by the cervical screening registries.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 37 Woman—date of death, DDMMYYYY

Vaccination data elements

V1 Vaccination —HPV vaccine type, code N

Identifying and definitional attributes

Data element name	HPV vaccine type
Definition	The specific HPV vaccine used.
Collection status	Potential (requires development)

Value domain representational attributes

Representation class	Code	
Data type	Number	
Format	N	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	1	Gardasil
	2	Cervarix
	8	Other
	9	Unknown

Collection and usage attributes

Guide for use

Data element attributes

Collection and usage attributes

Guide for use

Source and reference attributes

Origin	National HPV Vaccination Program Register

Relational attributes

Related metadata references

V2 Vaccination—HPV vaccination status, code N

Identifying and definitional attributes

Data element name	HPV vaccination status
Definition	An indication as to whether a woman is vaccinated against HPV.
Collection status	Potential (requires development)

Value domain representational attributes

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

Permissible values

Value	Meaning
0	Unvaccinated
1	Complete
2	Incomplete
3	Too close
9	Unknown

Collection and usage attributes

Guide for use

Vaccination status is according to clinical completion status, which is determined by the National HPV Vaccination Program Register (NHVPR), based on an algorithm that considers number of doses and length of time between doses.

Definition of ‘unvaccinated’ refers to girls or women who have never received a dose of HPV vaccine, and as such, will not appear on the NHVPR.

‘Complete’ refers to girls or women who received a full course of HPV vaccine at adequate intervals; ‘incomplete’ refers to girls or women who received only one or two doses of HPV vaccine rather than the currently recommended three doses; ‘too close’ refers to girls or women who received their HPV vaccine doses too close together, and as such their clinical status is uncertain.

Definitions of ‘complete’, ‘incomplete’ and ‘too close’ are subject to change based on future research findings.

A vaccination status of ‘unknown’ is to be used for girls or women who are on the NHVPR, but do not have a valid clinical completion status. These girls or women should not be interpreted as ‘unvaccinated’, which is to be reserved for girls or women who have never received a dose of HPV vaccine, and therefore do not appear on the NHVPR.

Data element attributes

Collection and usage attributes

Guide for use

Source and reference attributes

Origin National HPV Vaccination Program Register

V3 Vaccination—HPV vaccination completion date, date {DDMMYYYY}

Identifying and definitional attributes

Data element name	HPV vaccination completion date
Definition	The date on which a woman is considered completely vaccinated with HPV vaccine.
Context	
Collection status	Potential (requires development)

Value domain representational attributes

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

Collection and usage attributes

Guide for use	Record the date that a girl or woman received an HPV vaccine dose that changed her status to 'complete' according to her clinical completion status, as shown in 'V2 Woman—HPV vaccination status, code N'. This data element should always be recorded as an 8-digit valid date comprising day, month and year. Year should always be recorded in its full 4 digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example 1 July 2007 should be recorded as 01072007 as specified in the representational layout.
Business rule	If V2 equals 1 ('complete'), V3 must be populated.

Data element attributes

Collection and usage attributes

Guide for use

Source and reference attributes

Origin	National HPV Vaccination Program Register

Relational attributes

Related metadata references

V4 Vaccination—HPV vaccination episode date, date DDMMYYYY

Identifying and definitional attributes

Data element name	HPV vaccination episode date
Definition	The date on which a woman receives an HPV vaccine dose.
Context	
Collection status	Potential (requires development)

Value domain representational attributes

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

Collection and usage attributes

Guide for use	Record the date of a woman's vaccination episode. A separate episode date should be recorded for each dose a girl or woman receives. This can be any number one to many. This data element should always be recorded as an 8-digit valid date comprising day, month and year. Year should always be recorded in its full 4 digit format. For days and months with a numeric value of less than 10, zeros should be used to ensure that the date contains the required 8 digits. For example 1 July 2007 should be recorded as 01072007 as specified in the representational layout.
Collection methods	

Data element attributes

Collection and usage attributes

Guide for use

Source and reference attributes

Origin	National HPV Vaccination Program Register

Relational attributes

Related metadata references

V5 Vaccination—HPV vaccine dose number, code [NN]

Identifying and definitional attributes

Data element name	HPV vaccine dose number
Definition	The dose of HPV vaccine
Collection status	Potential (requires development)

Value domain representational attributes

Representation class	Code
Data type	Number
Format	[NN]
Maximum character length	2

Collection and usage attributes

Guide for use	Most girls and women receive either 1, 2 or 3 doses, but there can be more doses given under particular circumstances, and it is not yet known whether booster doses will need to be administered.

Data element attributes

Collection and usage attributes

Guide for use

Source and reference attributes

Origin	National HPV Vaccination Program Register

Relational attributes

Related metadata references

Provider data elements

B1 Provider requesting test—Medicare provider number, Identifier X[X(7)]

Identifying and definitional attributes

Data element name	Medicare provider number
Synonymous names	Provider number
Definition	The Medicare provider number of the provider requesting a test.
Collection status	Essential

Value domain representational attributes

Representation class	Identifier
Data type	String
Format	**X[X(7)]**
Maximum character length	8

Collection and usage attributes

Guide for use	Provider requesting test is the provider who is responsible for the test. Of the occupations of providers who collect specimens listed in B12, only general practitioners, nurse practitioners and specialists have a Medicare provider number, and can therefore be considered responsible for the test. However, the provider requesting the test is not necessarily the provider who collects the specimen; for example a person without a provider number (such as a registered nurse) may collect the sample in which case the provider number will be the provider number of the person who is considered responsible for the test (B12, B13, B14 and B15 are data items specific for provider collecting specimen if different to provider requesting the test). The Medicare-issued provider number is not always known or available. In these cases, a dummy provider number unique to the practitioner may be used. A generic dummy value of 0000000Y may also be used, if there is no requirement for the dummy number to be unique to the practitioner.
Comments	Medicare provider numbers are allocated to individual providers and organisations to support payments and claims through government schemes such as Medicare Benefits and Pharmaceutical Benefits Schemes.

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 15 Provider taking specimen—provider identifier, Identifier N[N(11)] A

B2 Provider requesting test—healthcare provider identifier – individual (HPI-I), identifier {N(16)}

Identifying and definitional attributes

Data element name	Requesting healthcare provider identifier – individual (HPI-I)
Synonymous names	Requesting HPI-I
Definition	The healthcare provider identifier - individual (HPI-I) of the provider requesting a test. A healthcare provider identifier - individual (HPI-I) is a unique 16 digit number that will be allocated to healthcare providers involved in providing patient care.
Collection status	Aspirational

Value domain representational attributes

Representation class	Identifier
Data type	Number
Format	{N(16)}
Maximum character length	16

Collection and usage attributes

Guide for use

Data element attributes

Collection and usage attributes

Origin	National E-Health Transition Authority (NEHTA)

B3 Provider requesting test—healthcare provider identifier – organisation (HPI-O), identifier {N(16)}

Identifying and definitional attributes

Data element name	Requesting healthcare provider identifier – organisation (HPI-O)
Synonymous names	Requesting HPI-O
Definition	The healthcare provider identifier – organisation (HPI-O) of the provider requesting a test. A healthcare provider identifier – organisation (HPI-O) is a unique 16 digit number that will be allocated to organisations (such as a hospital or medical clinic) where healthcare is provided.
Collection status	Aspirational

Value domain representational attributes

Representation class	Identifier
Data type	Number
Format	{N(16)}
Maximum character length	16

Collection and usage attributes

Guide for use

Data element attributes

Collection and usage attributes

Origin	National E-Health Transition Authority (NEHTA)

B4 Provider requesting test—family name, text X[X(39)]

Identifying and definitional attributes

Data element name	Provider family name
Definition	The part of a name a provider requesting a test usually has in common with some other members of his/her family(s), as distinguished from his/her given names.
Context	Administrative purposes and individual identification.
Collection status	Essential

Value domain representational attributes

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

Collection and usage attributes

Guide for use

Data element attributes

Collection and usage attributes

Guide for use	The agency or establishment should record the full family name of a person requesting a test on their information systems.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 16 Provider taking specimen—family name, text X[X(39)]

B5 Provider requesting test—given names, text X[X(39)]

Identifying and definitional attributes

Data element name	Provider given names
Definition	The given names or initial(s) of a provider requesting a test.
Context	Administrative purposes and individual identification.
Collection status	Essential

Value domain 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 full given name(s) of a person requesting a test on their information systems.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 17 Provider taking specimen—given names, text [X(40)]

B6 Provider requesting test—name of practice or medical centre, text [X(200)]

Identifying and definitional attributes

Data element name	Name of practice or medical centre
Definition	The name of the practice or medical centre of the provider requesting a test.
Collection status	Desirable

Value domain representational attributes

Representation class	Text
Data type	String
Format	[X(200)]
Maximum character length	200

Data element attributes

Collection and usage attributes

Guide for use	The practice or medical centre should relate to the practice or medical centre at which the requesting provider is located.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes Standardised cervical screening data dictionary Cytology (first) sub-set data element 18 Provider taking specimen–name of practice or medical centre, text [X(200)]

B7 Provider requesting test—practice address, text X[X(179)]

Identifying and definitional attributes

Data element name	Practice address
Definition	The address where the practice of the provider requesting a test is located.
Collection status	Essential

Value domain representational attributes

Representation class	Text
Data type	String
Format	X[X(179)]
Maximum character length	180

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 19 Provider taking specimen (practice address)—address line, text [X(180)]

B8 Provider requesting test—practice suburb/town/locality name, text A[A(49)]

Identifying and definitional attributes

Data element name	Practice suburb/town/locality name
Definition	The suburb/town/locality where the practice of the provider requesting a test is located.
Collection status	Essential

Value domain representational attributes

Representation class	Text
Data type	String
Format	A[A(49)]
Maximum character length	50

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 20 Provider taking specimen (practice address)—practice suburb/town/locality name, text [A(50)]

B9 Provider requesting test—alternative or other names for suburb/town/locality, text [A(50)]

Identifying and definitional attributes

Data element name	Practice alternative or other names for suburb/town/locality
Definition	The alternative name or other name of the suburb/town/locality (for example an Indigenous name or a colloquial name for a locality that is different to the official or commonly used name) where the practice of the provider requesting a test is located.
Collection status	Desirable

Value domain representational attributes

Representation class	Text
Data type	String
Format	[A(50)]
Maximum character length	50

Data element attributes

Collection and usage attributes

Guide for use	The alternative or other name for a suburb/town/locality, may be used instead of, or in addition to, the official or commonly used name of the locality.
Collection methods	If there is not an alternative or other name for a locality other than the official or commonly used name, then do not enter any data for this item.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 21 Provider taking specimen (practice address)—alternative or other names for suburb/town/locality, text [A(50)]

B10 Provider requesting test—Australian state/territory name, code AA{A}

Identifying and definitional attributes

Data element name	Australian state/territory name
Definition	The name of the Australian state or territory in which the provider requesting a test is located.
Collection status	Essential

Value domain representational attributes

Representation class	Code	
Data type	Text	
Format	AA{A}	
Maximum character length	3	
Permissible values	**Value**	**Meaning**
	NSW	New South Wales
	VIC	Victoria
	QLD	Queensland
	WA	Western Australia
	SA	South Australia
	TAS	Tasmania
	ACT	Australian Capital Territory
	NT	Northern Territory

Data element attributes

Collection and usage attributes

Guide for use	The order presented here is the standard for the Australian Institute of Health and Welfare, and reflects the current order of states and then territories in order of most populated to least populated.

B11 Provider requesting test—Australian postcode, code NNNN

Identifying and definitional attributes

Data element name	Practice postcode
Definition	The code that represents a postal delivery area, aligned with locality, suburb or place for the practice where a provider requesting a test is located.
Collection status	Essential

Value domain representational attributes

Representation class	Code
Data type	Number
Format	NNNN
Maximum character length	4

Collection and usage attributes

Comments	Must accept zero as the leading digit to accommodate all Australian postcodes. Australian Postcode may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators is not always possible. When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Statistical Geography Standard codes using an ABS concordance

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 22 Provider taking specimen (practice address)—postcode, code {NNNN}

B12 Provider collecting specimen—occupation of person collecting specimen, code {A}

Identifying and definitional attributes

Data element name	Collecting provider occupation
Definition	The occupation of the person who collects a specimen.
Context	Administrative purposes.
Collection status	Aspirational

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	{A}	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	G	General practitioner
	N	Nurse Practitioner
	R	Registered Nurse/Midwife
	E	Enrolled Nurse
	S	Specialists (Obstetricians and gynaecologists)
	A	Aboriginal and Torres Strait Islander health care worker
	O	Other
	U	Unassigned

Collection and usage attributes

Guide for use	The occupation needs to reflect the occupation of the person who collected the specimen, not on the occupation of the provider number under which the specimen was collected (i.e. if a registered nurse collects the specimen under a GP's provider number, the occupation needs to be recorded as nurse, not GP).

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 23 Provider taking specimen—occupation of person taking specimen, code A

B13 Provider collecting specimen—identifier, identifier [X(20)]

Identifying and definitional attributes

Data element name	Collecting provider identifier
Definition	Identifier number of the provider collecting specimen.
Collection status	Desirable

Value domain representational attributes

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

Collection and usage attributes

Guide for use	This identifier allows for the collection of a number allocated to a provider collecting specimen that is not a Medicare provider number; for example registered nurse Pap test providers do not have a Medicare provider number (the provider number of the general practitioner or specialist responsible for the test will be used), but may have an identifying number.

Data element attributes

Collection and usage attributes

Origin	State and Territory cervical screening registers

B14 Provider collecting specimen—healthcare provider identifier – individual (HPI-I), identifier {N(16)}

Identifying and definitional attributes

Data element name	Collecting healthcare provider identifier – individual (HPI-I)
Synonymous names	Collecting HPI-I
Definition	A healthcare provider identifier - individual (HPI-I) is a unique 16 digit number that will be allocated to healthcare providers involved in providing patient care.
Collection status	Aspirational

Value domain representational attributes

Representation class	Identifier
Data type	Number
Format	{N(16)}
Maximum character length	16

Collection and usage attributes

Guide for use

Data element attributes

Collection and usage attributes

Origin	National E-Health Transition Authority (NEHTA)

B15 Provider collecting specimen—healthcare provider identifier – organisation (HPI-O), identifier {N(16)}

Identifying and definitional attributes

Data element name	Collecting healthcare provider identifier – organisation (HPI-O)
Synonymous names	Collecting HPI-O
Definition	The healthcare provider identifier – organisation (HPI-O) of the provider collecting specimen. A healthcare provider identifier – organisation (HPI-O) is a unique 16 digit number that will be allocated to organisations (such as a hospital or medical clinic) where healthcare is provided.
Collection status	Aspirational

Value domain representational attributes

Representation class	Identifier
Data type	Number
Format	{N(16)}
Maximum character length	16

Collection and usage attributes

Guide for use

Data element attributes

Collection and usage attributes

Origin	National E-Health Transition Authority (NEHTA)

Laboratory data elements

L1 Laboratory—pathology laboratory identifier, identifier XXX

Identifying and definitional attributes

Data element name	Pathology laboratory identifier
Synonymous names	Lab code
Definition	A unique identification that cervical screening registers allocate to the laboratories that perform analyses on cervical screening tests.
Collection status	Essential

Value domain representational attributes

Representation class	Identifier
Data type	String
Format	XXX
Maximum character length	3

Data element attributes

Collection and usage attributes

Collection methods	Provided by pathology laboratories.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 24 Pathology laboratory—laboratory, identifier X(3)

L2 Laboratory—laboratory receipt date, date DDMMYYYY

Identifying and definitional attributes

Data element name	Laboratory receipt date.
Definition	The date when a specimen was received by the laboratory.
Context	Used in reporting *Part A Lab Performance Measures for the RCPA QAP for Laboratories Reporting Cytology*.
Collection status	Desirable

Value domain representational attributes

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

Data element attributes

Collection and usage attributes

Collection methods	Provided by pathology laboratories.

Test type data element

T1 Type of test—code A

Identifying and definitional attributes

Data element name	Type of test
Definition	Whether a specimen is sent to the laboratory for cytological examination, histological examination, or for detection of Human Papillomavirus (HPV) DNA.
Collection status	Essential

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	A	
Maximum character length	1	
Permissible values	**Value**	**Meaning**
	C	Cytology
	H	Histology
	V	HPV test

Data element attributes

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 26 Pathology laboratory—test type, code AN

Cytology test data elements

C1 Cytology test—laboratory accession number, identifier X[X(19)]

Identifying and definitional attributes

Data element name	Laboratory accession number for cytology test
Synonymous names	Cytology lab specimen ID Cytology lab record ID
Definition	A unique record identifier allocated by the cervical screening laboratory to a cervical specimen to distinguish it from all other specimens analysed by the laboratory.
Collection status	Essential

Value domain representational attributes

Representation class	Identifier
Data type	String
Format	X[X(19)]
Maximum character length	20

Data element attributes

Collection and usage attributes

Collection methods	Provided by pathology laboratories.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 25 Pathology laboratory—cervical cytology accession number X(20)

C2 Cytology test—date of cytology test, date DDMMYYYY

Identifying and definitional attributes

Data element name	Date of cytology test
Synonymous names	Cytology collection date
Definition	The date when a specimen was collected.
Collection status	Essential

Value domain representational attributes

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

Collection and usage attributes

Guide for use	Laboratory receipt date (L2) can be used instead of test date (C2), if date of cytology test is not known

Data element attributes

Collection and usage attributes

Collection methods	Provided by pathology laboratories.

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 12 Person—date of cervical cytology screening specimen, date DDMMYYYY

C3 Cytology test—cytology specimen site, code AN

Identifying and definitional attributes

Data element name	Cytology specimen site
Definition	The site from where a specimen of cells has been collected for the purpose of screening for cancer or pre-cancerous changes.
Collection status	Essential

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	B1	Cervical
	B2	Vaginal *(with or without an intact cervix)*
	B3	Other gynaecological site
	B0	Not stated

Collection and usage attributes

Guide for use

B2 when T1 *Type of test* is C (cytological specimen):

A vaginal sample can be collected whether or not a woman has an intact cervix; this item is meant to represent only an anatomical description of the origin of the specimen. It is the supplementary use of E- in item *'C6 Cytology test—endocervical (glandular) cell analysis, cytology code XX'* that indicates a vault smear, not the anatomical site sampled.

To code a vault smear: record B2 for item *'C3 Cytology test—specimen site, cytology code AN'* **and** E- for item *'C6 Cytology test—endocervical (glandular) cell analysis, cytology code XX'.*

(NOTE: The use of B2 will be almost exclusively indicative of vault samples because 'vaginal only' smears in women with intact cervices are uncommon; however it is important to be able to distinguish whether a specimen is a vault smear or not for accurate reporting purposes.)

Data element attributes

Collection and usage attributes

Collection methods	Provided by pathology laboratories.

Source and reference attributes

Origin	State and Territory cervical screening registers
Reference documents	National Cervical Cytology Coding Sheet, For Use by the Cervical Cytology Registries, Edition Date: 9 September 2005

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 30 Person—cervical cytology specimen site, cervical cytology screening code, AN

C4 Cytology test—cytology specimen type, code AN

Identifying and definitional attributes

Data element name	Cytology specimen type
Definition	The type of specimen collected for the purpose of screening for cancer or pre-cancerous changes.
Collection status	Essential

Value domain representational attributes

Representation class	Code
Data type	String
Format	AN
Maximum character length	2

Permissible values

Value	Meaning
A1	Conventional smear
A2	Liquid based specimen
A3	Conventional and liquid based specimen
A0	Not stated

Collection and usage attributes

Guide for use

A1 Conventional smear

The Pap smear is a test whereby exfoliated cells are collected from the cervix and are transferred to a slide for staining and microscopic evaluation by a pathologist, cytologist or specially trained technician.

A2 Liquid based specimen

A liquid based specimen is where the sampling instrument/s is rinsed in a vial of fluid fixative which is processed to produce a 'monolayer' of cells on the slide. This facilitates reading of the slide either by cytotechnologist or by machine.

A3 Conventional *and* liquid based specimen

When both a liquid based specimen and a conventional (Pap) smear are obtained for examination.

A0 Not stated

This code should be used when there is no information on the type of screening test provided.

Data element attributes

Collection and usage attributes

Collection methods	As provided by laboratories.

Source and reference attributes

Origin	State and Territory cervical screening registers
Reference documents	National Cervical Cytology Coding Sheet, For Use by the Cervical Cytology Registries, Edition Date: 9 September 2005.

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 29 Person—cervical cytology specimen type, cervical cytology screening code AN

C5 Cytology test—squamous cytology cell analysis, code AX

Identifying and definitional attributes

Data element name	Squamous cytology cell analysis
Definition	The cytological analysis of squamous cells from the ectocervix obtained from a specimen for the purpose of screening for cancer or pre-cancerous changes to the cervix.
Collection status	Essential

Value domain representational attributes

Representation class	Code
Data type	String
Format	AX
Maximum character length	2

Permissible values

Value	Meaning
S1	Cell numbers and preservation satisfactory. No abnormality or only reactive changes
S2	Possible low-grade squamous intraepithelial lesion (LSIL)
S3	Low-grade squamous intraepithelial lesion (LSIL) (HPV and/or CIN I)
S4	Possible high-grade squamous intraepithelial lesion (HSIL)
S5	High-grade squamous intraepithelial lesion (HSIL) (CIN II/CIN III)
S6	High-grade squamous intraepithelial lesion (HSIL) with possible microinvasion/ invasion
S7	Squamous carcinoma
SU	Unsatisfactory for evaluation

Collection and usage attributes

Guide for use

S1 Cell numbers and preservation satisfactory. No abnormality or only reactive changes

Record this code where there is no abnormality detected and cell numbers and preservation is satisfactory.

S2 Possible low-grade squamous intraepithelial lesion (LSIL)

This code encompasses changes in squamous cells where the reporting cytologist/pathologist believes the changes may represent a low grade squamous intraepithelial lesion but no definitive changes are present.

S3 Low grade squamous intraepithelial lesion (LSIL)

Record this code where the cytologist/pathologist observes changes

which would have been described as HPV effect or CIN I (i.e. incorporates HPV effect and/or CIN I).

S4 Possible high grade squamous intraepithelial lesion (HSIL)

Record this code when the presence of a high grade squamous abnormality such as CIN II, CIN III or SCC is suspected but the changes are insufficient to justify a confident cytological prediction of a high grade lesion.

S5 High grade squamous intraepithelial lesion (HSIL)

Record this code where the changes observed would have previously been described as CIN II or CIN III (i.e. code S5 incorporates CIN II & CIN III.)

S6 High grade squamous intraepithelial lesion (HSIL) with possible invasion

Record this code when a definite HSIL is present, but the possibility of invasion cannot be excluded.

S7 Squamous carcinoma

Record this when squamous carcinoma is present.

SU Unsatisfactory for evaluation

Record this code if the specimen is unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by inflammation/blood/degenerate cells.

Data element attributes

Collection and usage attributes

Collection methods — As provided by laboratories.

Source and reference attributes

Origin — State and Territory cervical screening registers

Reference documents — National Cervical Cytology Coding Sheet, For Use by the Cervical Cytology Registries, Edition Date: 9 September 2005.

Relational attributes

Related metadata references — Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 31 Person— squamous cell analysis, cervical cytology screening code XX

C6 Cytology test—endocervical (glandular) cytology cell analysis, code AX

Identifying and definitional attributes

Data element name	Endocervical (glandular) cytology cell analysis
Definition	The cytological analysis of endocervical (glandular) cells obtained from a specimen for the purpose of screening for cancer or pre-cancerous changes to the cervix.
Collection status	Essential

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	AX	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	E0	No endocervical component
	E-	Not applicable: vault smear/previous hysterectomy
	E1	Endocervical component present. No abnormality or only reactive changes
	E2	Atypical endocervical cells of uncertain significance
	E3	Possible high-grade endocervical glandular lesion
	E4	Adenocarcinoma-in-situ
	E5	Adenocarcinoma-in-situ with possible microinvasion/invasion
	E6	Adenocarcinoma
	EU	Due to unsatisfactory nature of the smear, no assessment has been made

Collection and usage attributes

Guide for use

E0 No endocervical component

Record this when there is no endocervical component.

E- Not applicable: vault smear/previous hysterectomy

Record this when it is a vault smear or there has been a previous total hysterectomy.

E1 Endocervical component present. No abnormality or only reactive changes

Record if no abnormality is detected & cell numbers & preservation is satisfactory.

E2 Atypical endocervical cells of uncertain significance

Record where abnormal glandular cells are identified in a cervical cytology sample, but where the degree of abnormality is not

sufficient for a diagnosis of adenocarcinoma in situ to be made.

E3 Possible high grade endocervical glandular lesion

Record if adenocarcinoma in situ is suspected but a confident prediction is not possible.

E4 Endocervical adenocarcinoma in situ

Record when the reporting cytologist/pathologist is confident of the presence of an adenocarcinoma in situ.

E5 Endocervical adenocarcinoma in situ with possible invasion

Record this when a definite adenocarcinoma in situ is present, but the possibility of invasion cannot be excluded.

E6 Endocervical adenocarcinoma

Record this when a definite adenocarcinoma is present.

EU Due to the unsatisfactory nature of the smear, no assessment has been made.

Unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by blood/inflammation/degenerate cells. If a smear is sub optimal but atypical/abnormal cells are detected, the abnormality overrides the unsatisfactory coding & should be coded to reflect the abnormality detected.

Data element attributes

Collection and usage attributes

Collection methods As provided by laboratories.

Source and reference attributes

Origin State and Territory cervical screening registers

Reference documents National Cervical Cytology Coding Sheet, For Use by the Cervical Cytology Registries, Edition Date: 9 September 2005.

Relational attributes

Related metadata references Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 32 Person— endocervical cell analysis, cervical cytology screening code XX

C7 Cytology test—other/non-cervical cytology cell analysis, code AX

Identifying and definitional attributes

Data element name	Other/non-cervical cytology cell analysis
Definition	The cytological analysis of other/non-cervical cells (cells from areas of the woman's genital tract other than the cervix) obtained from a specimen for the purpose of screening for cancer or pre-cancerous changes.
Collection status	Essential

Value domain representational attributes

Representation class	Code
Data type	String
Format	AX
Maximum character length	2

Permissible values

Value	Meaning
O1	No other abnormal cells.
O2	Atypical endometrial cells of uncertain significance
O3	Atypical glandular cells of uncertain significance—site unknown
O4	Possible endometrial adenocarcinoma
O5	Possible high-grade lesion—non-cervical
O6	Malignant cells—uterine body
O7	Malignant cells—vagina
O8	Malignant cells—ovary
O9	Malignant cells—other
OU	Due to the unsatisfactory nature of the smear, no assessment has been made

Collection and usage attributes

Guide for use

O1 No other abnormal cells

Record this where there is no abnormality detected & cell numbers & preservation is satisfactory.

O2 Atypical endometrial cells of uncertain significance

Record this where there are changes in endometrial cells, but insufficient to raise the possibility of an endometrial carcinoma.

O3 Atypical glandular cells of uncertain significance—site unknown

Record this where there is uncertainty about whether the abnormal cells were endocervical or endometrial in origin. Use where changes are insufficient to raise the possibility of a neoplasm but are beyond a reactive process.

O4 Possible endometrial adenocarcinoma

Record this if endometrial adenocarcinoma is suspected, but a confident prediction is not possible.

O5 Possible high grade lesion— non cervical

Record if abnormal cells are present but do not appear to be cervical, endometrial or vaginal in origin.

O6 Malignant cells—uterine body

Record when malignant endometrial cells are present.

O7 Malignant cells—vagina

Record if malignant cells are present in a vaginal or vault smear.

O8 Malignant cells—ovary

Record if malignant ovarian cells are present.

O9 Malignant cells—other

Record if malignant cells are present which belong to none of the above categories.

OU Due to the unsatisfactory nature of the smear, no assessment has been made

Record this code when smear is unable to be assessed due to poor cellularity, poor preservation, cell detail obscured by blood/inflammation/degenerate cells. If a smear is sub optimal but atypical/abnormal cells are detected, the abnormality overrides the unsatisfactory coding & should be coded to reflect the abnormality detected.

Data element attributes

Collection and usage attributes

Collection methods — As provided by laboratories.

Source and reference attributes

Origin — State and Territory cervical screening registers

Reference documents — National Cervical Cytology Coding Sheet, For Use by the Cervical Cytology Registries, Edition Date: 9 September 2005.

Relational attributes

Related metadata references — Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 33 Person—other/non-cervical cell analysis, cervical cytology screening code XX

C8 Cytology test—follow-up recommendation, code AX

Identifying and definitional attributes

Data element name	Follow-up recommendation
Definition	The recommended assessment action (as per NHMRC guidelines) based on the cytological analysis of cells for the purpose of screening for cancer or pre-cancerous changes to the cervix.
Collection status	Essential

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	AX	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	R0	No recommendation
	R1	Repeat smear 3 years
	R2	Repeat smear 2 years
	R3	Repeat smear 12 months
	R4	Repeat smear 6 months
	R5	Repeat smear 6–12 weeks
	R6	Colposcopy/biopsy recommended
	R7	Already under gynaecological management
	R8	Referral to specialist
	R9	Other management recommended
	RS	Symptomatic - Clinical management required

Data element attributes

Collection and usage attributes

Collection methods	As provided by laboratories. Note that it is the practice in some registries to base follow-up recommendation on an internal recommendation code which generates follow-up protocols that comply with the recommended follow-up as laid out in the NHMRC guidelines. However, laboratory recommendation codes should still be stored using this data element regardless of any further internal coding that takes place.

Source and reference attributes

Origin	State and Territory cervical screening registers
Reference documents	National Cervical Cytology Coding Sheet, For Use by the Cervical Cytology Registries, Edition Date: 9 September 2005.

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Cytology (first) sub-set data element 34 Person—follow-up recommendation, cervical cytology screening code XX

C9 Cytology test—cytology result, code {AA}

Identifying and definitional attributes

Data element name	Cytology result (AIHW-derived)
Definition	Cervical cytology result based on S and E codes as defined by the Australian Institute of Health and Welfare for national reporting purposes.
Collection status	Desirable

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	{AA}	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	CU	Unsatisfactory
	CN	Negative
	CL	Low-grade
	CH	High-grade
	CC	Cancer

Collection and usage attributes

Guide for use

Note that for the purposes of national reporting of cervical cytology to the Australian Institute of Health and Welfare, categories are based only on S and E codes, and disregards O codes (the exception to this is that a negative result cannot include an O code of O3, as this could signify an endocervical abnormality).

CU Unsatisfactory

An unsatisfactory cytology result is defined as
(C5 = SU & C6 = EU) or (C5 = SU & C6 = (E0 or E1)).

CN Negative

A negative cytology result is defined as
C5 = S1 and C6 = (E0 or E1) and C7 $\neq$ O3.

CL Low-grade

A low-grade cytology result is defined as
C5 = (S2 or S3) or C6 =E2 (C5 cannot be >S3 and C6 cannot be >E2).

CH High-grade

A high-grade cytology result is defined as
C5 = (S4 or S5 or S6) or C6 = (E3 or E4 or E5) (C5 cannot be >S6 and C6 cannot be >E5)*.

CC Cervical cancer

A cervical cancer cytology result is defined as C5 = S7 or C6 = E6.

* this differs from how a high-grade cytology result is defined for follow-up purposes.

Note, too, that while S6 and E5 are included as high-grade for AIHW reporting, these codes are excluded from high-grade for NPAAC reporting. See *Cervical screening in Australia 2009–2010* (AIHW 2012) for further details.

Data element attributes

Collection and usage attributes

Collection methods

State and Territory cervical screening registers.

These are AIHW-derived definitions used for reporting purposes only and may differ from definitions used for other purposes. Further, these differ from the cytology summary codes used by State and territory cervical screening registries, which may incorporate O codes into the category definitions. For the purposes of national reporting of cervical cytology to the Australian Institute of Health and Welfare, categories are based only on S and E codes, and disregards O codes (the exception to this is that a negative result cannot include an O code of O3, as this could signify an endocervical abnormality).

Source and reference attributes

Origin

Australian Institute of Health and Welfare

Reference documents

National Cervical Cytology Coding Sheet, For Use by the Cervical Cytology Registries, Edition Date: 9 September 2005

Histology test data elements

H1 Histology test—laboratory accession number, identifier X[X(19)]

Identifying and definitional attributes

Data element name	Laboratory accession number for histology test
Synonymous names	Histology specimen ID Histology lab record ID
Definition	A unique record identifier allocated by the cervical screening laboratory to a cervical specimen to distinguish it from all other specimens analysed by the laboratory.
Collection status	Essential

Value domain representational attributes

Representation class	Identifier
Data type	String
Format	X[X(19)]
Maximum character length	20

Data element attributes

Collection and usage attributes

Collection methods	Provided by Pathology Laboratories

Source and reference attributes

Origin	State and Territory cervical screening registers

H2 Histology test—date of histology test, date DDMMYYYY

Identifying and definitional attributes

Data element name	Date of histology test
Synonymous names	Histology collection date
Definition	The date when a specimen was collected .
Collection status	Essential

Value domain representational attributes

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

Collection and usage attributes

Guide for use	Laboratory receipt date (L2) can be used instead of test date (H2), if date of histology test is not known

Data element attributes

Source and reference attributes

Origin	State and Territory cervical screening registers

H3 Histology test—histology specimen site, code AN

Identifying and definitional attributes

Data element name	Histology specimen site
Definition	The site from where a specimen has been collected.
Collection status	Essential

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	B1	Cervical
	B2	Vaginal *(with or without an intact cervix)*
	B3	Other gynaecological site
	B0	Not stated

Collection and usage attributes

Guide for use	Cervical specimen includes all cervical histology including cervical polyps and cervical samples obtained during hysterectomies for benign conditions. If both cervical and non-cervical tissues are sampled, use cervical report.

Data element attributes

Source and reference attributes

Origin	State and Territory cervical screening registers
Reference documents	Cytology Codes for use by the Cervical Screening Registries, Edition Date: 6 October 2004.

H4 Histology—procedure used for obtaining specimen for histological analysis, code AANN

Identifying and definitional attributes

Data element name	Procedure for histology specimen
Definition	The type of procedure used to collect a gynaecological specimen for histological analysis for the purpose of assessment of cancer or pre-cancerous changes.
Collection status	Essential

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	AANN	
Maximum character length	4	
Permissible values	Value	Meaning
	HP01	Biopsy (includes directed punch and random punch)
	HP02	Endocervical curettage (includes endocervical tissue obtained during D&C)
	HP03	LLETZ/LEEP loop biopsy
	HP04	Cone biopsy
	HP05	Polypectomy
	HP06	Subtotal hysterectomy
	HP07	Hysterectomy
	HP09	Amputated cervix
	HP99	Not disclosed

Data element attributes

Source and reference attributes

Origin	Australian Institute of Health and Welfare
Reference documents	State and Territory cervical cytology registers

H5 Histology—squamous histology cell analysis, code AAX[XXX]

Identifying and definitional attributes

Data element name	Cervical histology result (AIHW-derived data element)
Definition	The histological analysis of a cervical specimen (squamous cells of the ectocervix) for the purpose of assessment of cancer or pre-cancerous changes.
Collection status	Essential

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	AAX[XXX]	
Maximum character length	6	
Permissible values	Value	Meaning
	HS01	Negative
	HS02	Low-grade squamous abnormality
	HS03	High-grade squamous abnormality
	HS03.1	*High-grade (CIN NOS)*
	HS03.2	*High-grade (CIN II)*
	HS03.3	*High-grade (CIN III)*
	HS04	Squamous cell carcinoma
	HS04.1	*Squamous cell carcinoma (micro-invasive)*
	HS04.2	*Squamous cell carcinoma (invasive)*
	HSU	Unsatisfactory
	HSN	Not applicable

Collection and usage attributes

Guide for use	These codes represent a higher level coding system to which specific codes from State and Territory cervical screening registers can be mapped, in order to more accurately collate national data.
Collection methods	Pathology laboratories send histology results to State and Territory cervical screening registries, and these are either coded by each registry to their own histology coding sheets, or SNOMED codes are uploaded automatically. State and Territory cervical screening registries then use Appendix C 'Histology code concordances' to map the histology codes stored in their register to these codes. Note that unsatisfactory histology results are as defined in each state and territory

Data element attributes

Source and reference attributes

Origin	Australian Institute of Health and Welfare
Reference documents	State and territory Cervical Screening Registry histology coding sheets

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Histology (second) sub-set data element 2 Person—cervical (squamous) specimen analysis, histology code AANN

H6 Histology test—endocervical (glandular) histology cell analysis, code AAX[XXX]

Identifying and definitional attributes

Data element name	Endocervical (glandular) histology cell analysis
Definition	The histological analysis of an endocervical specimen (glandular/columnar cells of the endocervix) for the purpose of assessment of cancer or pre-cancerous changes.
Collection status	Essential

Value domain representational attributes

Representation class	Code
Data type	String
Format	AAX[XXX]
Maximum character length	6

Permissible values

Value	Meaning
HE01	Negative
HE02	Endocervical atypia
HE03	High-grade endocervical abnormality
HE03.1	*High-grade (endocervical dysplasia)*
HE03.2	*High-grade (adenocarcinoma in situ)*
HE03.3	*High-grade (mixed carcinoma in situ/ adenocarcinoma in situ)*
HE04	Endocervical adenocarcinoma
HE04.1	*Endocervical adenocarcinoma (microinvasive)*
HE04.2	*Endocervical adenocarcinoma (invasive)*
HE04.3	*Adenosquamous carcinoma*
HE04.4	*Carcinoma of the cervix (other)*
HEU	Unsatisfactory
HEN	Not applicable

Collection and usage attributes

Guide for use	These codes represent a higher level coding system to which specific codes from State and Territory cervical screening registers can be mapped, in order to more accurately collate national data.
Collection methods	Pathology laboratories send histology results to State and Territory cervical screening registries, and these are either coded by each registry to their own histology coding sheets, or SNOMED codes are uploaded automatically. State and Territory cervical screening registries then use Appendix C ‘Histology code concordances’ to map the histology codes stored in their register to these codes.

Data element attributes

Source and reference attributes

Origin	Australian Institute of Health and Welfare
Reference documents	State and Territory Cervical Screening Registry histology coding sheets

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Histology (second) sub-set data element 3 Person—endocervical (glandular) specimen analysis, histology code AANN

H7 Histology test—vaginal histology cell analysis, code {AAX[XXX]}

Identifying and definitional attributes

Data element name	Vaginal histology cell analysis
Definition	The histological analysis of a vaginal specimen for the purpose of assessment of cancer or pre-cancerous changes.
Collection status	Desirable

Value domain representational attributes

Representation class	Code
Data type	String
Format	{AAX[XXX]}
Maximum character length	6

Permissible values

Value	Meaning
HV01	Negative
HV02	Low-grade vaginal abnormality
HV03	High-grade vaginal abnormality
HV03.1	*High-grade (VAIN NOS)*
HV03.2	*High-grade (VAIN II)*
HV03.3	*High-grade (VAIN III)*
HV04	Squamous cell carcinoma
HV04.1	*Squamous cell carcinoma (micro-invasive)*
HV04.2	*Squamous cell carcinoma (invasive)*
HVU	Unsatisfactory
HVN	Not applicable

Collection and usage attributes

Guide for use	These codes represent a higher level coding system. At present, these histology codes are not mapped.
Collection methods	Pathology laboratories send histology results to State and Territory cervical screening registries, and these are either coded by each registry to their own histology coding sheets, or SNOMED codes are uploaded automatically.

Data element attributes

Source and reference attributes

Origin	Australian Institute of Health and Welfare
Reference documents	State and Territory Cervical Screening Registry histology coding sheets

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Histology (second) sub-set data element 4 Person—vaginal specimen analysis, histology code AANN

H8 Histology test—other or unspecified histology cell analysis, code {AAX[N]}

Identifying and definitional attributes

Data element name	Other or unspecified histology cell analysis
Definition	The histological analysis of a specimen from a gynaecological site other than the cervix, endocervix, or vagina, for the purpose of assessment of cancer or pre-cancerous changes to a woman's other gynaecological tissues.
Collection status	Desirable

Value domain representational attributes

Representation class	Code
Data type	String
Format	{AAX[N]}
Maximum character length	4

Permissible values

Value	Meaning
H_01	Negative
H_02	Low-grade abnormality
H_03	High-grade abnormality
H_04	Invasive / malignant
H_U	Unsatisfactory
H_N	Not applicable

Replace the _ symbol with the appropriate letter from the list, according to the site from which the specimen was collected, as follows.

Value	Site
F	Fallopian tube
L	Vulva
M	Endometrium
O	Ovary
U	Other or unspecified

For example, HM02 would refer to a histology specimen collected from the endometrium with a low-grade abnormality

Collection and usage attributes

Guide for use	These codes represent a higher level coding system. At present, these histology codes are not mapped.
Collection methods	Pathology laboratories send histology results to State and Territory cervical screening registries, and these are either coded by each registry to their own histology coding sheets, or SNOMED codes are uploaded automatically.

Data element attributes

Source and reference attributes

Origin	Australian Institute of Health and Welfare
Reference documents	State and Territory Cervical Screening Registry histology coding sheets

Relational attributes

Related metadata references	Supersedes *Standardised cervical screening data dictionary* Histology (second) sub-set data element 5 Person—other or unspecified gynaecological specimen analysis, histology code AANN

H9 Histology test—histology result, code {AA}

Identifying and definitional attributes

Data element name	Histology result (AIHW-derived)
Definition	Cervical histology result based on HS and HE codes as defined by the Australian Institute of Health and Welfare for national reporting purposes.
Collection status	Desirable

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	{AA}	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	HU	Unsatisfactory
	HN	Negative
	HL	Low-grade
	HH	High-grade
	HC	Cancer

Collection and usage attributes

Guide for use

Note that for the purposes of national reporting of cervical histology to the Australian Institute of Health and Welfare, categories are based only on HS and HE codes.

HU Unsatisfactory

An unsatisfactory histology result is defined as specified in each state or territory, since the entire pathology result is required to make an evaluation. For instance, the overall findings may be unsatisfactory, even if there are valid squamous and endocervical codes allocated, since a pathologist may code what can be observed, even in the case of an unsatisfactory sample. Hence it is not appropriate to define unsatisfactory histology using HS and HE codes.

Note, however, that if high-grade or malignant cells are seen in an otherwise unsatisfactory specimen, the histology result category should reflect the high-grade or malignant finding, rather than the unsatisfactory nature of the sample.

HN Negative

A negative histology result is defined as any histology test that is not unsatisfactory and where there is no evidence of HPV infection, intraepithelial pre-neoplasia, or intraepithelial neoplasia.

Note that there is no requirement for both squamous and endocervical components to be sampled and to be negative; a

histology result that only samples the squamous component and the squamous component is negative, or a histology result that only samples the endocervical component and the endocervical component is negative, are both counted as negative histology tests.

A negative histology result can therefore be represented as (H5 = HS01 & H6 = HE01) or (H5 = HS01 & H6 = HEN) or (H5 = HSN & H6 = HE01), although this may not reflect how negative histology is coded by cervical screening registers.

HL Low-grade

A low-grade histology result is defined as H5 = HS02 or H6 = HE02 (H5 cannot be >HS02 and H6 cannot be >HE02).

HH High-grade

A high-grade histology result is defined as H5 = HS03 or H6 = HE03 (H5 cannot be >HS03 and H6 cannot be >HE03).

HC Cervical cancer

A cervical cancer histology result is defined as H5 = HS04 or H6 = HE04.

Data element attributes

Collection and usage attributes

Collection methods: State and Territory cervical screening registers.

These are AIHW-derived definitions used for reporting purposes only and may differ from definitions used for other purposes. For the purposes of national reporting of cervical histology to the Australian Institute of Health and Welfare, categories are based only on HS and HE codes.

Source and reference attributes

Origin Australian Institute of Health and Welfare

Reference documents State and Territory Cervical Screening Registry histology coding sheets

HPV DNA test data elements

HPV DNA testing is a relatively recent development in cervical screening, and new HPV DNA test methods are being developed all the time. The data elements for HPV DNA testing reflect what is currently available, but allow for future development of these data elements as technologies change.

D1 HPV DNA test—laboratory accession number, identifier X[X(19)]

Identifying and definitional attributes

Data element name	Laboratory accession number for cervical HPV DNA test
Synonymous names	HPV DNA lab specimen ID HPV DNA lab record ID
Definition	A unique record identifier allocated by the cervical screening laboratory to a cervical specimen to distinguish it from all other specimens analysed by the laboratory.
Collection status	Essential

Value domain representational attributes

Representation class	Identifier
Data type	String
Format	X[X(19)]
Maximum character length	20

Data element attributes

Collection and usage attributes

Guide for use	Provided by Pathology Laboratories

Source and reference attributes

Origin	State and Territory cervical screening registers

D2 HPV DNA test—date of HPV DNA test, date DDMMYYYY

Identifying and definitional attributes

Data element name	Date of HPV DNA test
Synonymous names	HPV DNA collection date
Definition	The date when a specimen was collected.
Collection status	Essential

Value domain representational attributes

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

Collection and usage attributes

Guide for use	Laboratory receipt date (L2) can be used instead of test date (P2), if date of HPV DNA test is not known.

Data element attributes

Source and reference attributes

Origin	State and Territory cervical screening registers

D3 HPV DNA test—HPV DNA specimen site, code AN

Identifying and definitional attributes

Data element name	HPV DNA specimen site
Definition	The site from where a sample has been collected.
Collection status	Essential

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	AN	
Maximum character length	2	
Permissible values	**Value**	**Meaning**
	B1	Cervical
	B2	Vaginal *(with or without an intact cervix)*
	B3	Other gynaecological site
	B0	Not stated

Data element attributes

Source and reference attributes

Origin	State and Territory cervical screening registers

D4 HPV DNA test—HPV DNA sampling method, code {AN}

Identifying and definitional attributes

Data element name	HPV DNA sampling method
Definition	The method of sampling used to determine whether a specimen contains HPV DNA.
Collection status	Desirable

Value domain representational attributes

Representation class	Code	
Data type	String	
Format	{AN}	
Maximum character length	2	
Permissible values	Value	Meaning
	M1	LBC sample
	M2	Digene sampler
	M3	Self collect
	M8	Other
	M9	Not stated/Unknown

Data element attributes

Collection and usage attributes

Guide for use

Source and reference attributes

Reference documents

D5 HPV DNA test—HPV DNA test type, code ANN

Identifying and definitional attributes

Data element name	HPV DNA test type
Definition	The type of test used to determine whether a specimen contains HPV DNA.
Collection status	Essential

Value domain representational attributes

Representation class	Code
Data type	String
Format	ANN
Maximum character length	3

Permissible values

Value	*Meaning*
P01	*Digene Hybrid Capture II Assay*
P02	*Roche AMPLICOR HPV Test*
P03	*HGS High-Risk HPV detection kit*
P04	*Abbott RealTime High Risk (HR) HPV assay*
P05	*Cervista™ HPV HR*
P06	*Cervista HPV 16/18 assay*
P97	*PCR (not otherwise specified)*
P98	*Other*
P99	*Not stated/Unknown*

Data element attributes

Collection and usage attributes

Guide for use

The following are correct at time of preparation of this document; additional tests will be added as they become common.

P01 Digene Hybrid Capture II Assay

The second-generation nucleic acid hybridisation-based Digene Hybrid Capture II Assay (Digene Corporation) detects the presence of 13 high-risk HPV types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, and 68) and 5 low-risk HPV types (6, 11, 42, 43, and 44).

HC-II is approved for use by the Medical Services Advisory Committee following a histologically-confirmed high-grade cervical lesion.

P02 Roche AMPLICOR HPV Test

The polymerase chain reaction (PCR)-based Roche AMPLICOR HPV Test (Roche Molecular Systems) detects the presence of 13 high-risk HPV types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, and 68).

P03 HGS High-Risk HPV detection kit

The HGS High-Risk HPV detection kit (Human Genetic Signatures) uses nucleic acid simplification technology and detects the presence of 13 high-risk HPV types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, and 68).

P04 Abbott RealTi*me* High Risk (HR) HPV assay

The RealTime High Risk (HR) HPV assay (Abbott Molecular) is a qualitative in vitro polymerase chain reaction (PCR) assay that detects the presence of 14 high-risk HPV types (16,18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66 and 68).

P05 Cervista™ HPV HR

The Cervista HPV HR test (Hologic) uses a unique signal amplification technique to detect the presence of 14 high-risk HPV DNA types (16,18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66 and 68).

P06 Cervista HPV 16/18 assay

The Cervista HPV 16/18 assay (Hologic) uses a unique signal amplification technique to detect the presence of the two high-risk HPV types 16 and 18.

P97 Polymerase chain reaction (PCR)

Polymerase chain reaction (PCR) techniques identify individual HPV types and require only small amounts of DNA. A consensus PCR is generally performed which identifies several HPV types in one assay.

PCR is approved for use by the Medical Services Advisory Committee following a histologically confirmed high-grade cervical lesion.

Source and reference attributes

Submitting organisation

Australian Institute of Health and Welfare

Reference documents

Arney, A. and Bennett, K.M. (2010). Molecular Diagnostics of Human Papillomavirus: Cervista HPV HR and Cervista HPV 16/18. Laboratory Medicine. 2010;41(9):523-530.

Baleriola C, Millar D, Melki J, Coulsten N, Altman P, Rismanto N, & Rawlinson W (2008). Comparison of a novel HPV test with the Hybrid Capture II (hcII) and a reference PCR method shows high specificity and positive predictive value for 13 high-risk human papillomavirus infections. Journal of Clinical Virology 42: 22-26.

Huang S, Tang N, Mak WB, Erickson B, Salituro J, Li Y, Krumpe E, Schneider G, Yu H, Robinson J, Abravaya K. (2009). Principles and analytical performance of Abbott RealTime High Risk HPV test. J Clin Virol. 45 Suppl 1:S13-7.

Malloy C, Sherris J & Herdman C (2000). HPV DNA Testing: Technical and Programmatic Issues for Cervical Cancer Prevention in Low-Resource Settings, cited 25 May 2006, http://www.path.org/files/HPV-DNA-Testing-Issues.pdf

MSAC Report: The use of human papilloma virus testing to monitor effectiveness of treatment of high-grade intraepithelial abnormalities of the cervix, cited 9 June 2006 www.msac.gov.au/pdfs/reports/msacref12e.pdf.

Poljak M, Fujs K, Seme K, Kocjan BJ & Vrtačnik-Bokal E (2005). Retrospective and prospective evaluation of the Amplicor HPV test for detection of 13 high-risk human papillomavirus genotypes on 862 clinical samples. Acta Dermatoven APA 14: 147-152.

Soderlund-Strand A, Rymark P, Andersson P, Dillner J & Dillner L (2005). Comparison between the Hybrid Capture II Test and a PCR-based human papillomavirus detection method for diagnosis and posttreatment follow-up of cervical intraepithelial

neoplasia. Journal of Clinical Microbiology 43: 3260-3266.

Stevens MP, Garland SM, Rudland E, Tan J, Quinn MA 7 Tabrizi SN (2007). Comparison of the Digene Hybrid Capture 2 Assay and Roche AMPLICOR and LINEAR ARRAY Human Papillomavirus (HPV) tests in detecting high-risk HPV genotypes in specimens from women with previous abnormal Pap smear results. Journal of Clinical Microbiology 45: 2130-2137.

Relational attributes

Related metadata references Supersedes Cytology (first) sub-set data element 28 Person—HPV DNA test type, code AAN

D6 HPV DNA test—High-risk HPV DNA result, code AX

Identifying and definitional attributes

Data element name	High-risk HPV DNA result
Definition	An indication as to whether high-risk HPV DNA is detected in a specimen.
Collection status	Essential

Value domain representational attributes

Representation class	Code
Data type	String
Format	AX
Maximum character length	2

Permissible values

Value	Meaning
D0	No high-risk HPV DNA detected
D1	High-risk HPV DNA detected
DE	Equivocal result
DU	Unsatisfactory

Collection and usage attributes

Guide for use

The result needs to be considered in light of the HPV DNA detection method used.

The result code used should reflect only what is known about the result. For instance, if the test method used only detects the presence of high-risk types of HPV, then a negative result for this test should be coded as' P0 No high-risk HPV DNA detected'.

The strains of HPV DNA considered high risk (as at June 2006) are viral types: 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68, 73 and 82. An additional three types (23, 53 and 66) are considered probable high-risk.

Those strains of HPV DNA that are understood to be relatively low risk for the development of cervical cancer are 6, 11, 40, 42, 43 44, 54, 61, 70, 72, 81 and CP108.

See guide for use for 'V5 HPV DNA test—HPV DNA test, code AN' for information on specific strains identified by each test.

Data element attributes

Source and reference attributes

Reference documents

Lab Tests Online 2006. Cited 9 June 2006, www.labtestsonline.org.

NHMRC Screening to Prevent Cervical Cancer: Guidelines for the Management of Asymptomatic Women with Screen Detected Abnormalities, 2005, cited 9 June 2006 www.nhmrc.gov.aupublications.

MSAC Report: The use of human papilloma virus testing to monitor effectiveness of treatment of high-grade intraepithelial abnormalities of the cervix, cited 9 June 2006 www.msac.gov.au/pdfs/reports/msacref12e.pdf.

Relational attributes

Related metadata references	Supersedes Cytology (first) sub-set data element 27 Person—HPV DNA result, code N

D7 HPV DNA test—Low-risk HPV DNA result, code {AX}

Identifying and definitional attributes

Data element name	Low-risk HPV DNA result
Definition	An indication as to whether low-risk HPV DNA is detected in a specimen.
Collection status	Desirable

Value domain representational attributes

Representation class	Code
Data type	String
Format	{AX}
Maximum character length	2

Permissible values

Value	Meaning
W0	No low-risk HPV DNA detected
W1	Low-risk HPV DNA detected
WE	Equivocal result
WU	Unsatisfactory

Collection and usage attributes

Guide for use

The result needs to be considered in light of the HPV DNA detection method used.

The result code used should reflect only what is known about the result.

Those strains of HPV DNA that are understood to be relatively low risk for the development of cervical cancer are 6, 11, 40, 42, 43 44, 54, 61, 70, 72, 81 and CP108.

D8 HPV DNA test—HPV DNA genotyping status, code N

Identifying and definitional attributes

Data element name	HPV DNA genotyping status
Definition	Whether or not genotyping was performed on a specimen in which HPV DNA was detected.
Collection status	Aspirational; requires development

Value domain representational attributes

Representation class	Code	
Data type	Number	
Format	N	
Maximum character length	1	
Permissible values	Value	Meaning
	1	Genotyping performed
	2	No genotyping performed
	9	Not stated/Unknown

Data element attributes

Source and reference attributes

Origin	Australian Institute of Health and Welfare

D9 HPV DNA test—HPV DNA genotype test type, code ANN

Identifying and definitional attributes

Data element name	HPV DNA genotype test type
Definition	The type of test used to determine the specific genotype(s) of HPV DNA present in a specimen .
Collection status	Aspirational; requires development

Value domain representational attributes

Representation class	Code
Data type	String
Format	ANN
Maximum character length	3

Permissible values

Value	Meaning
G00	Not applicable (no test performed)
G01	Roche Linear Array HPV genotyping test
G08	Other
G99	Not stated/Unknown

Data element attributes

Collection and usage attributes

Guide for use

G1 Roche Linear Array HPV genotyping test

The polymerase chain reaction (PCR)-based Roche Linear Array HPV genotyping test (Roche Molecular Systems) is capable of detecting and distinguishing 37 individual genotypes of HPV, including 13 high-risk HPV types (16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, and 68), 5 low-risk HPV types (6, 11, 42, 43, and 44), and also 26, 40, 53, 54, 55, 61, 62, 64, 66, 67, 69, 70, 71, 72, 73, 81, 82, 83, 84, IS39, & CP6108.

Source and reference attributes

Submitting organisation	Australian Institute of Health and Welfare
Reference documents	

D10 HPV DNA test—HPV genotype, code X[XXXXX], X[XXXXX], X[XXXXX]

Identifying and definitional attributes

Data element name	HPV DNA genotype
Definition	The genotype/s of HPV detected in a specimen.
Collection status	Aspirational; requires development

Value domain representational attributes

Representation class	Code
Data type	String
Format	X[XXXXX], X[XXXXX], X[XXXXX]
Maximum character length	8

Collection and usage attributes

Guide for use	X[XXXXX] represents the number of the HPV genotype detected, with the format allowing for up to three HPV genotypes to be recorded in the one sample. Unused genotypes in the format should not be left blank. Data items should be separated by commas, without any spaces For instance data for a woman with types 16 and 18 would be represented by 16,18,- or 16,18,0.

Data element attributes

Source and reference attributes

Origin	Australian Institute of Health and Welfare

Follow-up data elements

F1 Follow-up—27 month reminder letter sent, code N

Identifying and definitional attributes

Data element name	27 month reminder letter sent
Definition	Whether a 27 month reminder letter has been sent from a cervical screening register to a woman.
Collection status	Essential

Value domain representational attributes

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

Permissible values

Value	Meaning
1	27 month reminder letter sent
2	27 month reminder letter not sent
9	Not stated/Unknown

Collection and usage attributes

Guide for use

Follow-up and reminder letters are sent by cervical screening registries to both woman and practitioners to provide a safety net for women.

The 27 month reminder letter is sent 27 months after a woman's negative Pap test, if the cervical screening register has not received notice that the woman has had a repeat Pap test within that time, and has not received information that the woman has had a hysterectomy or died, or become no longer an active client on the cervical screening register.

This data item specifies whether a letter was sent directly to women, and is required for Indicator 2.2, which measures the proportion of women who are re-screened within 3 months of being sent a 27 month Pap test reminder letter.

Data element attributes

Source and reference attributes

Origin	Australian Institute of Health and Welfare

F2 Follow-up—date letter sent, date {DDMMYYYY}

Identifying and definitional attributes

Data element name	Date letter sent
Definition	The date when the 27 month reminder letter was sent to a woman.
Collection status	Conditional

Value domain representational attributes

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

Collection and usage attributes

Guide for use	Follow-up and reminder letters are sent by cervical screening registries to both woman and practitioners to provide a safety net for women. The 27 month reminder letter is sent 27 months after a woman's negative Pap test, if the cervical screening register has not received notice that the woman has had a repeat Pap test within that time, and has not received information that the woman has had a hysterectomy or died, or become no longer an active client on the cervical screening register. This data item specifies the date when the 27 month reminder letter was sent to women, and is required for Indicator 2.2, which measures the proportion of women who are re-screened within 3 months of being sent a 27 month Pap test reminder letter.

Data element attributes

Collection and usage attributes

Collection methods

Source and reference attributes

Origin	State and Territory cervical screening registers

Relational attributes

Related metadata references

4 Performance indicators

The effectiveness of the National Cervical Screening Program (NCSP) has been monitored since 1996–1997 using performance indicators that cover what were originally defined as essential aspects of the program by the then National Screening Information Advisory Group, in conjunction with the Australian Institute of Health and Welfare (AIHW) and state and territory program and data managers, with additional input from other experts in the field. Because it was recognised that changes to incidence and mortality—the ultimate aim of the program—would not be realised for a considerable length of time, indicators that could be measured in the shorter term and could monitor progress towards these longer term aims were initiated. For all reporting periods between 1996–1997 and 2007–2008, the indicators covered participation, early rescreening, low-grade abnormality detection, high-grade abnormality detection, incidence of cervical cancer, and mortality from cervical cancer.

In 2009, a working group reviewed the original indicators, and considered additional essential aspects of the current NCSP and cervical screening environment. After this review process, the working group agreed to a set of performance indicators that would allow the program to be monitored optimally in the face of changes to cervical cancer and cervical screening, including the introduction of new *Guidelines for the management of screen detected abnormalities in asymptomatic women* (NHMRC 2005) by the National Health and Research Council (NHMRC) on 1 July 2006 and the commencement of the National HPV Vaccination Program from 1 April 2007.

In August 2009, an expert advisory group was established to review the performance indicators proposed by the working group to ensure that these indicators would allow optimal monitoring of the important components of the NCSP. The expert advisory group considered the proposed performance indicators to be comprehensive and useful for monitoring the NCSP and, after several alterations were made to the data specifications, endorsed the performance indicators as described in this technical paper in September 2009.

The expert advisory group was comprised of the following experts, all of whom had particular knowledge of cervical screening:

- Ms Jennifer Muller (Senior Director, Cancer Screening Services, Queensland Dept of Health)
- Associate Professor Marion Saville (Executive Director, Victorian Cytology Service)
- Associate Professor Dorota Gertig (Director, Victorian Cervical Cytology Register)
- Dr Mark Clements (Research Fellow, National Centre for Epidemiology and Population Health, Australian National University)
- Dr Bronwen Harvey (Medical Advisor, Commonwealth Department of Health and Ageing).

The expert advisory group considered the proposed performance indicators to be comprehensive and useful for monitoring the NCSP and, after several alterations were made to the data specifications, endorsed the performance indicators in September 2009.

Later in 2009, the indicators were endorsed by the then-named Australian Population Health Development Principal Committee Screening Subcommittee. These made their debut in *Cervical screening in Australia 2008–2009*.

National performance indicators for the National Cervical Screening Program

Performance indicators

The 7 NCSP performance indicators are as follows:

- Indicator 1 Participation
- Indicator 2 Rescreening
- Indicator 3 Cytology
- Indicator 4 Histology
- Indicator 5 Cytology-histology correlation
- Indicator 6 Incidence
- Indicator 7 Mortality

Performance indicators specifications

The following pages comprise definition, rational, and data specifications for the NCSP performance indicators.

Indicator 1 Participation

Identifying and definitional attributes

Data element type Performance indicator

Definition Percentage of women screened through the National Cervical Screening Program in a two-, three- or five-year period for the target age group 20–69.

The participation indicator measures the proportion of the population covered by the cervical screening programs. Women aged 20–69 are actively targeted to participate in cervical screening by recruitment initiatives at the state and territory level. Higher participation in cervical screening means that more women with precancerous abnormalities can be detected and treated, which is necessary for achieving the overall aim of reducing incidence and mortality from cervical cancer.

While the definition of participation is for the target age group 20–69, data are collected for the following age groups: <20, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50-54, 55–59, 60–64, 65–69, 70–74, 75–79, 80–84, and 85+.

Participation is measured over a two-year period in line with the current recommended screening interval. In addition, participation is measured over a three- and five-year period to evaluate participation outside the recommended screening interval, as well as allowing limited comparisons between Australia's screening program and screening programs in countries with three- or five-year screening intervals.

Two-year participation is measured by remoteness area and socioeconomic status to allow the program to better assess who in the population are participating in cervical screening, so that recruitment initiatives can be better tailored to those who are under-represented.

Remoteness area is coded using the Australian Statistical Geography Standard (ASGS), which is defined using the Accessibility/Remoteness Index for Australia (ARIA). ARIA is a measure of the remoteness of a location from the services provided by large towns or cities. A higher ARIA score denotes a more remote location. The five classes of the ASGS classification are: Major cities of Australia, Inner regional Australia, Outer regional Australia, Remote Australia, and Very remote Australia.

Socioeconomic status is coded according to the Index of Relative Socioeconomic Disadvantage (IRSD). The IRSD is one of the socioeconomic indexes for areas (SEIFA indexes) developed by the Australian Bureau of Statistics to categorise geographic areas according to their social and economic characteristics. The IRSD relates to the average disadvantage of all people living in a geographic area. This index of socioeconomic status divides areas into five quintiles, in which the first quintile corresponds to the least disadvantaged and the fifth quintile corresponds to the most disadvantaged.

Collection and usage attributes

Formula	$\frac{\text{Number of women screened}}{\text{ABS ERP adjusted for proportion of women who have had a hysterectomy}}$
Numerator	The number of individual women screened during a 24-month, 36-month or 60-month period by age group.
Source	State and territory cervical screening registers
Data collection	*National cervical cancer prevention data dictionary version 1*
Data elements	A1 Client identifier A7 Date of birth T1 Type of test C2 Date of cytology test C3 Specimen site C6 Endocervical (glandular) cytology cell analysis
Numerator Specifications	• Count is of individual women, not tests. • Count is the woman's first screening episode in the reporting period. • Only includes cytology tests (T1=C) where C3 = B0 or B1 and C6 ≠ E-. • Excludes women who have opted off the register. • Excludes vault smears. • Remoteness area assigned using residential postcode (A15) at the time of test. • Socioeconomic status category assigned using residential postcode (A15) at time of test.
Denominator	The number of women resident in each state and territory, geographic region, socioeconomic status and Australia, using Australian Bureau of Statistics estimated resident female population (ERP) as at 30th June averaged over the relevant two-, three- or five-years by age group, adjusted for the proportion of women who have had a hysterectomy.
Source	ABS Estimated Resident Population National hysterectomy fractions derived from the AIHW National Morbidity Hospitals Database

Administrative attributes

Source document	Developed for the *National cervical cancer prevention data dictionary version 1*
Source organisation	National Cervical Screening Program

Indicator 2 Rescreening

2.1 Early rescreening

Identifying and definitional attributes

Data element type Performance indicator

Definition The proportion of women re-screened, by number of re-screens, during a 21-month period following a negative cytology test for women in the target age group 20–69.

Context The National Cervical Screening Program seeks to maximise the reduction in mortality from cervical cancer within a cost-effective framework. Compliance with the recommended screening interval is important in maintaining both the effectiveness of the Program and its cost efficiency. Early rescreening, outside the NHMRC Guidelines, does not increase the effectiveness of the program but utilises resources that would be more effective if used to increase population coverage.

This indicator tracks over a period of 21 months a cohort of women from all states and territories who had a negative cytology test result in February in the first year of the 2-year monitoring period, to determine the extent of early re-screening within the National Cervical Screening Program.

Women who have had an abnormality in the preceding 36 months are excluded, as are cytology tests that are a valid repeat of an unsatisfactory cytology test, since rescreening within 21 months in these contexts is valid.

It is not possible to know if there was a clinical reason for early rescreening, such as symptoms, which would also be valid.

Collection and usage attributes

Formula

$$\frac{\text{Number of women with a negative cytology test result in the index month who had a repeat cytology test within the 21 months following this negative cytology test}}{\text{Number of women with a negative cytology test result in the index month who have not had a cytological or histological abnormality within the preceding 36 months.}}$$

The numerator is a subset of the denominator. Note that not all the data elements specified in the denominator are restated in the numerator.

Numerator The number of women screened in the index period with a negative cytology test result (who have not had a cytological or histological abnormality within the preceding 36 months), who had a specific number of repeated screens (0, 1, 2, 3, 4, 5 or more, also without a cytological or histological abnormality within the preceding 36 months)), and where the repeat screen is not a valid repeat of an unsatisfactory test, tracked for 21 months after the initial screen.

Source State and territory cervical screening registers

Data collection *National cervical cancer prevention data dictionary version 1*

Data elements

A1 Client identifier

T1 Type of test

C2 Date of cytology test

C3 Specimen site

C5 Squamous cytology cell analysis

C6 Endocervical (glandular) cytology cell analysis

H5 Squamous histology cell analysis

H6 Endocervical (glandular) histology cell analysis

Numerator specifications

- Includes cytology tests that occur in the 21 months (640 days) following the index test (0 days < C2 – C2 (index test) <= 640 days).
- Only includes cytology tests (T1=C) where C3 = B0 or B1 and C6 ≠ E-.
- Only includes cytology tests that do not have an immediately preceding cytological result of unsatisfactory ((C5 = SU & C6 = EU) or (C5 = SU & C6 = (E0 or E1))).
- Only includes women who have not had a cytological (T1=C) or histological (T1=H) abnormality within the preceding 36 months (1096 days) of their index negative cytology (C2 (index)).
- Excludes women who have opted off the register.
- Excludes vault smears.

- Abnormalities include:

Abnormal squamous cytology

C5 = S2 Possible low-grade intraepithelial lesion

C5 = S3 Low-grade intraepithelial lesion

C5 = S4 Possible high-grade intraepithelial lesion

C5 = S5 High-grade intraepithelial lesion

C5 = S6 High-grade intraepithelial lesion with possible microinvasion/invasion

C5 = S7 Squamous carcinoma

Abnormal endocervical cytology

C6 = E2 Atypical endocervical cells of uncertain significance

C6 = E3 Possible high-grade endocervical glandular lesion

C6 = E4 Adenocarcinoma *in situ*

C6 = E5 Adenocarcinoma *in situ* with possible microinvasion/invasion

C6 = E6 Adenocarcinoma

Abnormal squamous histology

H5 = HS02 Low grade squamous abnormality

H5 = HS03.1 High grade squamous abnormality, CIN NOS

H5 = HS03.2 High grade squamous abnormality, CIN II

H5 = HS03.3 High grade squamous abnormality, CIN III

H5 = HS04.1 Squamous cell carcinoma, microinvasive

H5 = HS04.2 Squamous cell carcinoma, invasive

Abnormal endocervical histology

H6 = HE02 Endocervical atypia

H6 = HE03.1 High-grade endocervical abnormality, endocervical dysplasia

H6 = HE03.2 High-grade endocervical abnormality, adenocarcinoma *in situ*

H6 = HE03.3 High-grade endocervical abnormality, mixed carcinoma *in situ*/adenocarcinoma *in situ*

H6 = HE04.1 Endocervical adenocarcinoma, microinvasive

H6 = HE04.2 Endocervical adenocarcinoma, invasive

H6 = HE04.3 Adenosquamous carcinoma

H6 = HE04.4 Carcinoma of the cervix (other)

Denominator

The number of women screened in the index period aged 20–69 with a negative cytology test result (who have not had a cytological or histological abnormality within the preceding 36 months).

Source

State and territory cervical screening registers

Data collection

National cervical cancer prevention data dictionary version 1

Data elements

A1 Client identifier

A7 Date of birth

T1 Type of test

C2 Date of cytology test

C3 Specimen site

C5 Squamous cytology cell analysis

C6 Endocervical (glandular) cytology cell analysis

C7 Other/non-cervical cytology cell analysis

H5 Squamous histology cell analysis

H6 Endocervical (glandular) histology cell analysis

Denominator Specifications

- Count is of individual women, not tests.
- Count is all women with a negative cytology test (T1 = C) with C3 = B0 or B1 and C5=S1 & C6 = (E0 or E1) & C7≠ O3 with C2 in the index month. This negative cytology test is the index test.
- Index month is February.
- If a woman has more than one negative cytology test in the index month, the woman's first negative cytology test is the index test.
- Only includes women aged 20–69 at the time of test of the index test (C2 (index)).
- Only includes women who have not had a cytological (T1=C) or histological (T1=H) abnormality within the preceding 36 months (1096 days) of their index negative cytology (C2 (index)).
- Excludes women who have opted off the register.
- Excludes vault smears.

- Abnormalities include:

Abnormal squamous cytology

C5 = S2 Possible low-grade intraepithelial lesion

C5 = S3 Low-grade intraepithelial lesion

C5 = S4 Possible high-grade intraepithelial lesion

C5 = S5 High-grade intraepithelial lesion

C5 = S6 High-grade intraepithelial lesion with possible microinvasion/invasion

C5 = S7 Squamous carcinoma

Abnormal endocervical cytology

C6 = E2 Atypical endocervical cells of uncertain significance

C6 = E3 Possible high-grade endocervical glandular lesion

C6 = E4 Adenocarcinoma *in situ*

C6 = E5 Adenocarcinoma *in situ* with possible microinvasion/invasion

C6 = E6 Adenocarcinoma

Abnormal squamous histology

H5 = HS02 Low grade squamous abnormality

H5 = HS03.1 High grade squamous abnormality, CIN NOS

H5 = HS03.2 High grade squamous abnormality, CIN II

H5 = HS03.3 High grade squamous abnormality, CIN III

H5 = HS04.1 Squamous cell carcinoma, microinvasive

H5 = HS04.2 Squamous cell carcinoma, invasive

Abnormal endocervical histology

H6 = HE02 Endocervical atypia

H6 = HE03.1 High-grade endocervical abnormality, endocervical dysplasia

H6 = HE03.2 High-grade endocervical abnormality, adenocarcinoma *in situ*

H6 = HE03.3 High-grade endocervical abnormality, mixed carcinoma *in situ*/adenocarcinoma *in situ*

H6 = HE04.1 Endocervical adenocarcinoma, microinvasive

H6 = HE04.2 Endocervical adenocarcinoma, invasive

H6 = HE04.3 Adenosquamous carcinoma

H6 = HE04.4 Carcinoma of the cervix (other)

Administrative attributes

Source document	Developed for the *National cervical cancer prevention data dictionary version 1*
Source organisation	National Cervical Screening Program
Comments	Although women with an abnormality in the preceding 36 months have been removed, it should be noted that this will not remove women with a previous high-grade histology result who did not have a test of cure who are undergoing annual screening according to the previous NHMRC Guidelines that advised these women to have annual Pap tests *ad infinitum*.

Indicator 2 Rescreening

2.2 Rescreening after 27 month cervical screening register reminder letter

Identifying and definitional attributes

Data element type	Performance indicator
Definition	The proportion of women rescreening within 3 months of the 27 month cervical screening register reminder letter for women in the target age group 20–69.
Context	This indicator gives an indication of the proportion of women for whom the 27 month reminder letter is a prompt to rescreen. A lower proportion of women who rescreen within 3 months of receiving this letter could indicate either that this letter was not an effective prompt to rescreen, or a lower capacity of primary health services that provide the cervical screening service to women.

Collection and usage attributes

Formula	$\frac{\text{Number of women who had a cytology test within 3 months of being sent a 27 month reminder letter}}{\text{Number of women who were sent a 27 month reminder letter}}$ The numerator is a subset of the denominator. Note that not all the data elements specified in the denominator are restated in the numerator.
Numerator	The number of women who had a cytology test within 3 months of being sent a 27 month reminder letter.
Source	State and territory cervical screening registers
Data collection	*National cervical cancer prevention data dictionary version 1*
Data elements	A1 Client identifier T1 Type of test C2 Date of cytology test F2 Date letter sent
Numerator Specifications	• Count is of individual women, not tests. • Includes cytology tests (T1=C) that occur in the 3 months (92 days) following the 27 month reminder letter (0 days < C2 –F2 <= 92 days). • Excludes women who have opted off the register.
Denominator	The number of women who were sent a 27 month reminder letter.
Source	State and territory cervical screening registers
Data collection	*National cervical cancer prevention data dictionary version 1*
Data elements	A1 Client identifier

A7 Date of birth

F1 27 month reminder letter sent

F2 Date letter sent

Denominator Specifications

- Count is of individual women, not tests.
- Count is all women who were sent a 27 month reminder letter in the 12-month period.
- Only includes women aged 20–69 at the time the letter was sent (F2).
- Excludes women who have opted off the register.

Administrative attributes

Source document Developed for the *National cervical cancer prevention data dictionary version 1*.

Source organisation National Cervical Screening Program

Indicator 3 Cytology

Identifying and definitional attributes

Data element type Performance indicator

Definition Proportion of cytology test results in each result category in a 12-month period for the target age group 20–69.

Context This indicator provides a breakdown of cytology performed, by cytology report categories for squamous and endocervical component, using the categories defined by the National Cervical Cytology Coding Sheet.

The primary screening tool of the National Cervical Screening Program is cervical cytology, using the Papaniculoau smear (or 'Pap test'). The annual reporting of squamous and endocervical cytology result categories by year and by age allows trends in cytology results to be monitored.

Data are collected for the following age groups: <20, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50-54, 55–59, 60–64, 65–69, 70–74, 75–79, 80–84, and 85+.

Collection and usage attributes

Formula

$$\frac{\text{Number of cytology test results in each squamous and endocervical result category in a 12-month period}}{\text{Number of cytology test results in the same 12-month period}}$$

Numerator Number of cytology test results in each squamous and endocervical result category in a 12-month period.

Source State and territory cervical screening registers

Data collection *National cervical cancer prevention data dictionary version 1*

Data elements

A1	Client identifier
A7	Date of birth
T1	Type of test
C2	Date of cytology test
C3	Specimen site
C5	Squamous cytology cell analysis
C6	Endocervical (glandular) cytology cell analysis

Numerator Specifications

- Count is of individual tests, not women.
- Only includes cytology tests (T1=C) where C3 = B0 or B1 and C6 ≠ E-.
- Excludes women who have opted off the register.
- Excludes vault smears.
- Cytology reporting categories are as follows:

  Unsatisfactory cytology

  Unsatisfactory = ((T1 = C) & (C3 = B0 or B1) & ((C5 = SU & C6 = EU) or (C5 = SU & C6 = (E0 or E1)))

Negative cytology

Negative = ((T1 = C) & (C3 = B0 or B1) & ((C5 = S1 & C6 = (E0 or E1)))

No endocervical component

No endocervical component = ((T1 = C) & (C3 = B0 or B1) & (C6 = E0))

Squamous cytology

S2 Possible low-grade intraepithelial lesion = ((T1 = C) & (C3 = B0 or B1) & (C5 = S2) & (C6 ≠ E-))

S3 Low-grade intraepithelial lesion = ((T1 = C) & (C3 = B0 or B1) & (C5 = S3) & (C6 ≠ E-))

S4 Possible high-grade intraepithelial lesion = ((T1 = C) & (C3 = B0 or B1) & (C5 = S4) & (C6 ≠ E-))

S5 High-grade intraepithelial lesion = ((T1 = C) & (C3 = B0 or B1) & (C5 = S5) & (C6 ≠ E-))

S6 High-grade intraepithelial lesion with possible microinvasion/ invasion = ((T1 = C) & (C3 = B0 or B1) & (C5 = S6) & (C6 ≠ E-))

S7 Squamous carcinoma = ((T1 = C) & (C3 = B0 or B1) & (C5 = S7) & (C6 ≠ E-))

Endocervical cytology

E2 Atypical endocervical cells of uncertain significance | = ((T1 = C) & (C3 = B0 or B1) & (C6 = E2))

E3 Possible high-grade endocervical glandular lesion = ((T1 = C) & (C3 = B0 or B1) & (C6 = E3))

E4 Adenocarcinoma *in situ* = ((T1 = C) & (C3 = B0 or B1) & (C6 = E4))

E5 Adenocarcinoma *in situ* with possible microinvasion/invasion = ((T1 = C) & (C3 = B0 or B1) & (C6 = E5))

E6 Adenocarcinoma = ((T1 = C) & (C3 = B0 or B1) & (C6 = E6))

Denominator Number of cytology test results in the same 12-month period.

Source State and territory cervical screening registers

Data collection *National cervical cancer prevention data dictionary version 1*

Data elements

A1	Client identifier
A7	Date of birth
T1	Type of test
C2	Date of cytology test
C3	Specimen site
C6	Endocervical (glandular) cytology cell analysis

Denominator Specifications

- Count is of individual tests, not women.
- Includes all cytology tests (T1= C) where C3 = B0 or B1 and C6 ≠ E-.
- Excludes women who have opted off the register.
- Excludes vault smears.

Administrative attributes

Source document	Developed for the *National cervical cancer prevention data dictionary version 1*.
Source organisation	National Cervical Screening Program

Indicator 4 Histology

4.1 Histology

Identifying and definitional attributes

Data element type
Performance indicator

Definition
Proportion of histology results in each squamous and endocervical result category in a 12-month period for the target age group 20–69.

Context
This indicator provides a breakdown of histology performed, by histology report categories for squamous cells and endocervical component, using the categories defined by the *National cervical cancer prevention data dictionary version 1*.

Histology is the primary diagnostic tool of the National Cervical Screening Program. It is performed when cytology results suggest that an abnormality is present, as per the recommendations set out in the NHMRC *Guidelines for the management of women with screen detected abnormalities* (NHMRC 2005), but may also be performed for other reasons.

The annual reporting of squamous and endocervical histology result categories by year and by age allows trends in histology results to be monitored.

Data are collected for the following age groups: <20, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50-54, 55–59, 60–64, 65–69, 70–74, 75–79, 80–84, and 85+.

Collection and usage attributes

Formula

$$\frac{\text{Number of histology test results in each squamous and endocervical result category in a 12-month period}}{\text{Number of histology test results in the same 12-month period}}$$

Numerator
Number of histology tests in each squamous and endocervical result category in a 12-month period.

Source
State and territory cervical screening registers

Data collection
National cervical cancer prevention data dictionary version 1

Data elements

A1	Client identifier
A7	Date of birth
T1	Type of test
H2	Date of histology test
H3	Specimen site
H5	Squamous histology cell analysis
H6	Endocervical (glandular) histology cell analysis

Numerator Specifications

- Count is of individual tests, not women.
- Excludes colposcopies.
- Excludes women who have opted off the register.
- Histology reporting categories are as follows:

Negative histology

Negative = ((T1 = H) & (H3 = B0 or B1) & (H5 = HS01 & H6 = HE01) or (H5 = HS01 & H6 = HEN) or (H5 = HSN & H6 = HE01).

Squamous histology

HS02 Low-grade squamous abnormality = ((T1 = H) & (H3 = B0 or B1) & (H5 = HS02))

HS03.1 High-grade squamous abnormality: **CIN NOS** = ((T1 = H) & (H3 = B0 or B1) & (H5 = HS03.1))

HS03.2 High-grade squamous abnormality: **CIN II** = ((T1 = H) & (H3 = B0 or B1) & (H5 = HS03.2))

HS03.3 High-grade squamous abnormality: **CIN III** = ((T1 = H) & (H3 = B0 or B1) & (H5 = HS03.3))

HS04.1 Squamous cell carcinoma: **microinvasive** ((T1 = H) & (H3 = B0 or B1) & (H5 = HC04.1))

HS04.2 Squamous cell carcinoma: **invasive** ((T1 = H) & (H3 = B0 or B1) & (H5 = HC04.2)

Endocervical histology

HE02 Endocervical atypia = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE02))

HE03.1 High-grade endocervical abnormality: **endocervical dysplasia** = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE03.1))

HE03.2 High-grade endocervical abnormality: **adenocarcinoma *in situ*** = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE03.2))

HE03.3 High-grade endocervical abnormality: **mixed carcinoma *in situ*adenocarcinoma *in situ*** = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE03.3))

HE04.1 Endocervical adenocarcinoma: **microinvasive** = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE04.1))

HE04.2 Endocervical adenocarcinoma: **invasive** = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE04.2))

HE04.3 Adenosquamous carcinoma = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE04.3))

HE04.4 Carcinoma of the cervix (other) = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE04.4))

Denominator Number of histology test results in the same 12-month period

Source State and territory cervical screening registers

Data collection *National cervical cancer prevention data dictionary version 1*

*Data element*s

A1	Client identifier
A7	Date of birth
T1	Type of test
H2	Date of histology test
H3	Specimen site

Denominator Specifications

- Count is of individual tests, not women.
- Includes all histology tests (T1=H) where (H3 = B0 or B1).
- Excludes colposcopies.

- Excludes women who have opted off the register.

Administrative attributes

Source document	Developed for the *National cervical cancer prevention data dictionary version 1*.
Source organisation	National Cervical Screening Program

Indicator 4 Histology

4.2 High-grade abnormality detection

Identifying and definitional attributes

Data element type

Performance indicator

Definition

Detection rate of histological high-grade intraepithelial abnormalities per 1,000 women screened in a 12-month period for the target age group 20–69.

Context

The detection of high-grade abnormalities is an indicator of program performance. High-grade abnormalities have a greater probability of progressing to invasive cancer than do low-grade lesions. Therefore, one of the aims of the National Cervical Screening Program is to set a screening interval that detects most of these lesions before they progress and become invasive.

High-grade abnormalities of the cervix include cervical intraepithelial neoplasia (CIN) that has been graded as moderate (CIN II) or severe (CIN III), or for which the grade has not been specified, as well as endocervical dysplasia and adenocarcinoma *in situ*.

Detection of high-grade abnormalities provides an opportunity for treatment before cancer can develop, thus the NCSP aims to detect high-grade abnormalities in line with its broader aim to reduce the incidence of cervical cancer.

Data are collected for the following age groups: <20, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50-54, 55–59, 60–64, 65–69, 70–74, 75–79, 80–84, and 85+.

Collection and usage attributes

Formula

$$\frac{\text{Number of women with a high-grade intraepithelial abnormality detected by histology in a 12-month period}}{\text{Number of women screened in the same 12-month period}}$$

Numerator

Number of women with a high-grade intraepithelial abnormality detected by histology in a 12-month period

Source

State and territory cervical screening registers

Data collection

National cervical cancer prevention data dictionary version 1

Data elements

A1	Client identifier
A7	Date of birth
T1	Type of test
H2	Date of histology test
H3	Specimen site
H5	Squamous histology cell analysis
H6	Endocervical (glandular) histology cell analysis

Numerator Specifications

- Count is of individual women, not tests.

- Includes women with a histology test (T1=H) where H3 = B0 or B1 and H5 = HS03.1 or HS03.2 or HS03.3 or H6 = HE03.1 or HE03.2 or HE03.3 in the 12-month reporting period.
- Includes women with a high-grade histology result even if they have a histology result of cancer in the 12-month reporting period.
- Excludes colposcopies.
- Exclude women who have opted off the register.

Denominator Number of women screened in the same 12-month period

Source State and territory cervical screening registers

Data collection *National cervical cancer prevention data dictionary version 1*

*Data element*s

A1	Client identifier
A7	Date of birth
T1	Type of test
C2	Date of cytology test
C3	Specimen site
C6	Endocervical (glandular) cytology cell analysis

Denominator Specifications

- Count is of individual women, not tests.
- Count the woman's first screening episode in the reporting period.
- Only include cytology tests (T1 = C) where C3 = B0 or B1 and C6 ≠ E-
- Exclude women who have opted off the register.
- Exclude vault smears.

Administrative attributes

Source document Developed for the *National cervical cancer prevention data dictionary version 1*.

Source organisation National Cervical Screening Program

Indicator 5 Cytology-histology correlation

Identifying and definitional attributes

Data element type Performance indicator

Definition The correlation between a woman's cytology prediction and histology finding where the histology is performed within the six months following the cytology.

Context The National Cervical Screening Program uses cervical cytology as its screening test, with cells sampled from the uterine cervix using the Pap test. Cervical cytology, like other screening tests, is not intended to be diagnostic. Rather, screening aims to identify people who are more likely to have a cervical abnormality or cervical cancer, and therefore require further investigation from diagnostic tests – histology in the case of cervical screening.

In order to understand the characteristics of the screening test, it is useful to compare the results of screening tests performed with the "truth". In reality, it is not possible to do this absolutely for cervical screening, since a large number of cervical cytology tests will not indicate the need for diagnostic follow-up. However, correlating the cervical cytology tests that are followed up with histology still provides an informative – if incomplete – measure of the accuracy of cervical cytology.

In this indicator, all cervical cytology that is followed up by histology, where this histology occurs in the 6-month period following cytology, will be correlated to the most serious histology result within this 6-month period. This correlation will allow a measure of the accuracy of squamous and endocervical (glandular) cytological predictions of squamous and endocervical histology findings.

Relational and representational attributes

Formula

$$\frac{\text{Number of histology tests in each result category (where histology is within 183 days of cytology)}}{\text{Number of cytology tests in each result category}}$$

This formula is applied cell by cell for each cytology and histology result, such that the number of tests in each histology reporting category that corresponds with each cytology reporting category is reported in a grid.

Numerator Number of histology tests in each result category within 183 days of a cytology test in a 12-month period.

Source State and territory cervical screening registers

Data collection *National cervical cancer prevention data dictionary version 1*

Data elements

A1	Client identifier
A7	Date of birth
T1	Type of test
C2	Date of cytology test

H2 Date of histology test

H3 Specimen site

H5 Squamous histology cell analysis

H6 Endocervical (glandular) histology cell analysis

Numerator Specifications

- Correlation is based on the test, not the woman.
- Includes the most serious histology test within 6 months (183 days) of cytology test
- Only includes histology tests (T1=H) where H3 = B0 or B1.
- Only includes women aged 20–69.
- Excludes unsatisfactory histology.
- Excludes colposcopies.
- Excludes women who have opted off the register.
- Histology reporting categories are as follows:

  Squamous histology

  HS01 Negative = ((T1 = H) & (H3 = B0 or B1) & (H5 = HS01))

  HS02 Low-grade squamous abnormality = ((T1 = H) & (H3 = B0 or B1) & (H5 = HS02))

  HS03.1 High-grade squamous abnormality: **CIN NOS** = ((T1 = H) & (H3 = B0 or B1) & (H5 = HS03.1))

  HS03.2 High-grade squamous abnormality: **CIN II** = ((T1 = H) & (H3 = B0 or B1) & (H5 = HS03.2))

  HS03.3 High-grade squamous abnormality: **CIN III** = ((T1 = H) & (H3 = B0 or B1) & (H5 = HS03.3))

  HS04.1 Squamous cell carcinoma: **microinvasive** ((T1 = H) & (H3 = B0 or B1) & (H5 = HS04.1))

  HS04.2 Squamous cell carcinoma: **invasive** ((T1 = H) & (H3 = B0 or B1) & (H5 = HS04.2)

  Endocervical histology

  HE01 Negative = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE01))

  HE02 Endocervical atypia = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE02))

  HE03.1 High-grade endocervical abnormality: **endocervical dysplasia** = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE03.1))

  HE03.2 High-grade endocervical abnormality: **adenocarcinoma *in situ*** = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE03.2))

  HE03.3 High-grade endocervical abnormality: **mixed carcinoma *in situ*adenocarcinoma *in situ*** = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE03.3))

  HE04.1 Endocervical adenocarcinoma: **microinvasive** = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE04.1))

  HE04.2 Endocervical adenocarcinoma: **invasive** = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE04.2))

  HE04.3 Adenosquamous carcinoma = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE04.3))

  HE04.4 Carcinoma of the cervix (other) = ((T1 = H) & (H3 = B0 or B1) & (H6 = HE04.4))

Denominator	Number of cytology tests each result category that are followed, within 183 days, by histology
Source	State and territory cervical screening registers
Data collection	*National cervical cancer prevention data dictionary version 1*
Data elements	A1 Client identifier A7 Date of birth T1 Type of test C2 Date of cytology test C3 Specimen site C5 Squamous cytology cell analysis C6 Endocervical (glandular) cytology cell analysis
Denominator specifications	• Correlation is based on individual cytology tests, not the woman. • Includes all cytology tests in the 12-month reporting period followed by a histology test within 183 days. • Only includes cytology tests (T1=C) where C3 = B0 or B1 and C6 ≠ E-. • Only includes women aged 20–69. • Excludes unsatisfactory cytology. • Excludes women who have opted off the register. • Excludes vault smears. • Cytology reporting categories are as follows: **Squamous cytology** **S1** Negative = ((T1 = C) & (C3 = B0 or B1) &(C5 = S1) & (C6 ≠ E-)) **S2** Possible low-grade intraepithelial lesion = ((T1 = C) & (C3 = B0 or B1) & (C5 = S2) & (C6 ≠ E-)) **S3** Low-grade intraepithelial lesion = ((T1 = C) & (C3 = B0 or B1) & (C5 = S3) & (C6 ≠ E-)) **S4** Possible high-grade intraepithelial lesion = ((T1 = C) & (C3 = B0 or B1) & (C5 = S4)& (C6 ≠ E-)) **S5** High-grade intraepithelial lesion = ((T1 = C) & (C3 = B0 or B1) & (C5 = S5) & (C6 ≠ E-)) **S6** High-grade intraepithelial lesion with possible microinvasion/ invasion = ((T1 = C) & (C3 = B0 or B1) & (C5 = S6) & (C6 ≠ E-)) **S7** Squamous carcinoma = ((T1 = C) & (C3 = B0 or B1) & (C5 = S7) & (C6 ≠ E-)) **Endocervical cytology** **E0** No endocervical component = ((T1 = C) & (C3 = B0 or B1) & (C6 = E0)) **E1** Negative = ((T1 = C) & (C3 = B0 or B1) & (C6 = E1)) **E2** Atypical endocervical cells of uncertain significance = ((T1 = C) & (C3 = B0 or B1) & (C6 = E2))

E3 Possible high-grade endocervical glandular lesion = ((T1 = C) & (C3 = B0 or B1) & (C6 = E3))

E4 Adenocarcinoma *in situ* = ((T1 = C) & (C3 = B0 or B1) & (C6 = E4))

E5 Adenocarcinoma *in situ* with possible microinvasion/invasion = ((T1 = C) & (C3 = B0 or B1) & (C6 = E5))

E6 Adenocarcinoma = ((T1 = C) & (C3 = B0 or B1) & (C6 = E6))

Administrative attributes

Source document	Developed for the *National cervical cancer prevention data dictionary version 1*.
Source organisation	National Cervical Screening Program

Indicator 6 Incidence

Identifying and definitional attributes

Data element type	Performance indicator
Definition	Incidence rate of cervical cancer (squamous, adenocarcinoma, adenosquamous and other cervical cancer) per 100,000 estimated resident female population in a 12-month period for females of all ages and for the target age group 20–69.
Context	This indicator measures the incidence rates of all cervical cancers by histological type in women in Australia.

Collection and usage attributes

Formula

$$\frac{\text{Number of new cases of cervical cancer in a 12-month period}}{\text{ABS ERP for the same 12-month period}}$$

Numerator	The number of new cases of cervical cancer
Source	AIHW Australian Cancer Database
Numerator specifications	• All cervical cancer is defined as ICD10 code C53. • Carcinoma is defined as ICD10 code C53 and 8010 ≤ ICDO3 code ≤ 8380 or 8382 ≤ ICDO3 code ≤ 8576. • Squamous cell carcinoma is defined as ICD10 code C53 and 8050 ≤ ICDO3 code ≤ 8078 or ICDO3 code 8083,8084 . • Adenocarcinoma is defined as ICD10 code C53 and ICDO3 code 8140,8141,8230,8231,8260,8261,8262,8263,8310,8380,8382,8383,8384,8576 or 8190 ≤ ICD03 code ≤ 8211 or 8440 ≤ ICD03 code ≤ 8490 or 8570 ≤ ICDO3 code ≤ 8574. • Adenosquamous carcinoma is defined as ICD10 code C53 and ICDO3 code 8560. • Sarcoma is defined as ICD10 code C53 and 8800 ≤ ICDO3 code ≤ 8811 or 8840 ≤ ICDO3 code ≤ 8921 or 9040 ≤ ICDO3 code ≤ 9044 or 9120 ≤ ICDO3 code ≤ 9133 or 9540 ≤ ICDO3 code ≤ 9581 or ICDO3 code 8830,8990,8991, 9150. • Other and unspecified cervical cancer is defined as ICD10 code C53 and ICDO3 code not equal to those specified for carcinoma or sarcoma. • Aboriginal and Torres Strait Islander cancer incidence calculations are restricted to New South Wales, Queensland, Western Australia and the Northern Territory.
Denominator	The number of women in that particular age group, using Australian Bureau of Statistics estimated resident female mid-year population
Source	ABS Estimated Resident Population

Indicator 7 Mortality

Identifying and definitional attributes

Data element type	Performance indicator
Definition	Mortality from cervical cancer per 100,000 estimated resident female population in a 12-month period for women of all ages and for the target age group 20–69.
Context	Cervical cancer is one of the few cancers for which there is an efficacious screening test for detection of precursors of the disease. Most deaths due to cervical cancer are potentially avoidable (Marcus & Crane 1988). The objective of the National Cervical Screening Program is to reduce this mortality rate. Changes in mortality rates will not be evident for a number of years following an improvement in the participation rates. Therefore, the effectiveness of this measure needs to be viewed in the longer rather than the shorter term.

Collection and usage attributes

Formula

$$\frac{\text{Number of deaths from cervical cancer in a 12-month period}}{\text{ABS ERP for the same 12-month period}}$$

Numerator	The number of deaths from cervical cancer
Source	AIHW National Mortality Database
Numerator specifications	• Cervical cancer is defined as ICD9 code 180 for years 1982–1996 and ICD10 code C53 for years 1997–current. • Based on year of death, apart from the most recent year that is based on year of registration of death. • Aboriginal and Torres Strait Islander cancer mortality calculations are restricted to New South Wales, Queensland, Western Australia, South Australia and the Northern Territory.
Denominator	The number of women in that particular age group, using Australian Bureau of Statistics estimated resident female mid-year population
Source	ABS Estimated Resident Population

Appendix A: Data and the cervical screening registries

The following flowchart (Figure A1) describes the way in which data are received by the cervical screening registries. Note that this is a generic diagram, with each jurisdiction having slight differences in the way data are received and compiled.

Note that this flowchart only covers the flow of data to the cervical screening registers; it does not include clinical pathways.

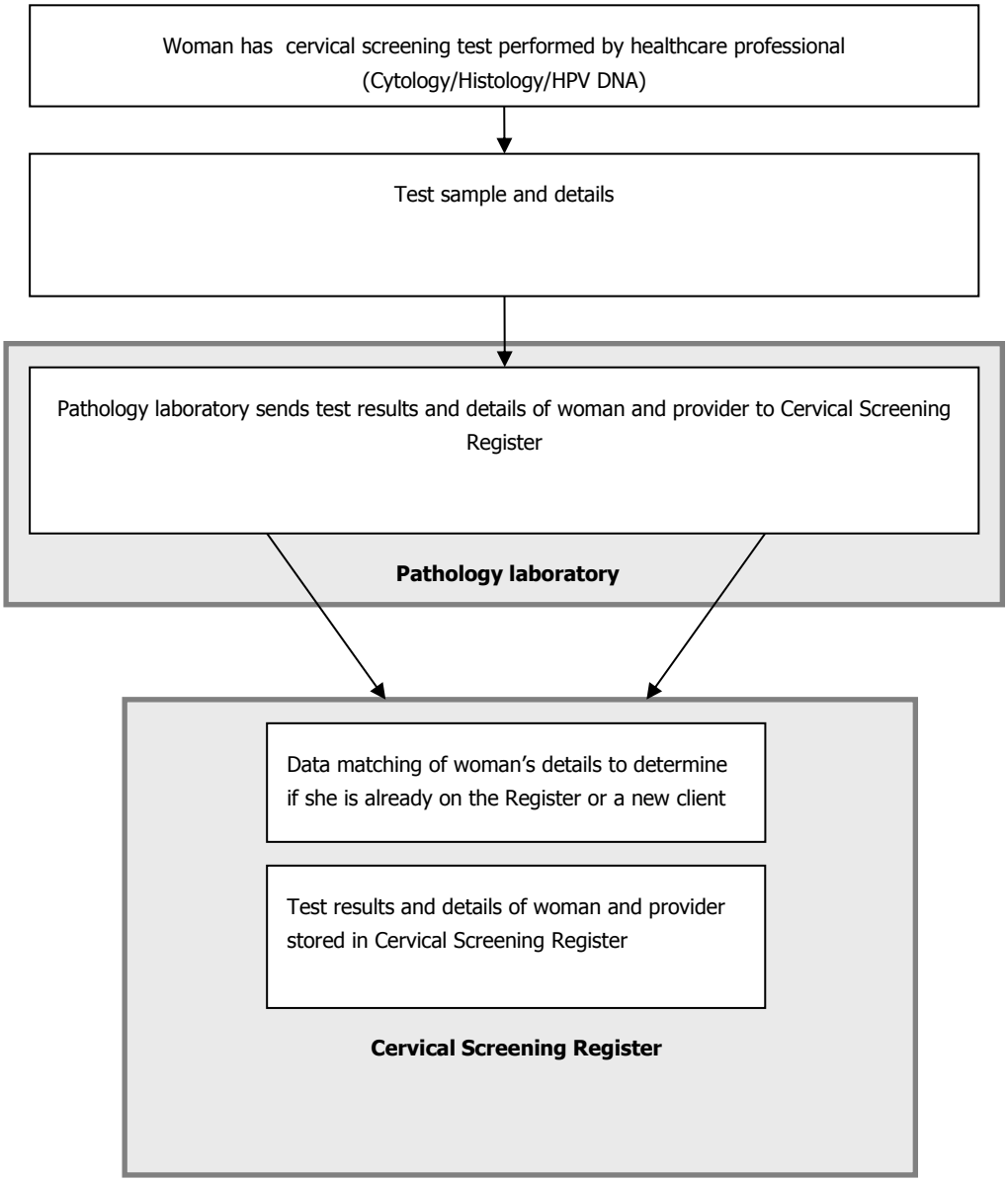


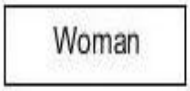
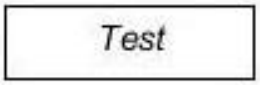
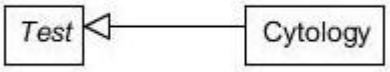
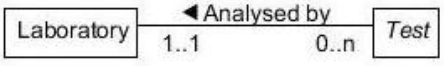
Figure A1: Generic flowchart showing the way in which data are received by the cervical screening registries

Appendix B: Class diagrams

In order to better model the relationships, the data elements have been categorised into object classes. The object classes are very similar to the data element sections identified in this document (see Chapter 3) but are more in line with the standards used by the AIHW. In addition, domain or object class diagrams have been added in order to show the most important relationships between the object classes.

The table below (Table B1) outlines the descriptions associated with object classes that are interlinked to represent data relationships.

Table B1: Object classes

Object classes	Description
	A class: a named collection of data elements representing a class of real world objects e.g. clients.
	An abstract class (note the italics): a class that is a generalisation of some more specific classes. E.g. a Test is a generalisation of the specific types of cytology, histology, and HPV DNA tests. Abstract classes need not exist independently of the specific classes.
	Generalisation/specialisation: a relationship between two classes that shows one is a generalisation of the other. Alternatively, the latter is a specialisation of the former. E.g. The Cytology class is a specialisation of the Test class i.e. Cytology is a type of Test.
	Association: a relationship that indicates that one class is associated with another. The relationship can indicate the cardinality (multiplicity) of the association in each direction. The relationship can also be named and have an arrow indicating in which direction the name is to be read. E.g. a Test is analysed by at least 1 and at most 1 Laboratory. A Laboratory analysed possibly 0 and at most n Tests. Common cardinalities are: 0..1, 1..1, 0..n, & 1..n although any range is possible. "n" need not be replaced by a specific number in which case it means "many".

Listed below are the class definitions and how they relate to the current data elements:

Woman

Class elements relating to the woman (excluding address details). Reflected within the following data element sections:

- Woman A1 to A10
- Woman A21 to A25

Laboratory

Class elements relating to the laboratory. Reflected within the following data element sections:

- L1—Pathology laboratory
- L2—Laboratory receipt date

Cytology

Class elements relating to a cytology test. Reflected within the following data element sections:

- Cytology—C1 to C9

Histology

Class elements relating to a histology test. Reflected within the following data element sections:

- Histology—H1 to H9

HPV DNA

Class elements relating to an HPV DNA test. Reflected within the following data element selections:

- HPV DNA—D1 to D10

HPV vaccination

Class elements relating to a single HPV vaccination episode. Reflected within the following data element selections:

- V4—HPV vaccination episode date
- V5—HPV vaccine dose

Vaccination (course)

Class elements related to a linked set of vaccination episodes (see abstract class definitions below). Reflected within the following data element selections:

- V1—HPV vaccine type
- V2—HPV vaccination status
- V3—HPV vaccination completion date

27 month reminder letter to women

A class of elements related to the 27 month reminder letter to a woman. Reflected within the following data element selections:

- F1—Reminder letter sent
- F2—Date letter sent

Address

Class elements related to address details. Reflected within the following data element sections:

- Woman A11 to A15 : Residential Address
- Woman A16 to A20 : Mailing Address
- Provider B7 to B11 : Provider Requesting Test Address

Practice

Class elements related to practice details (exc. address). Reflected within the following data element selections:

- B1—Medicare provider number (Provider requesting test)
- B3 & B15—HPI-O (Provider requesting test / Provider collecting test)
- B6—Practice Name (Provider requesting test)

Provider

Class elements related to provider details. Reflected within the following data element selections:

- B2 & B14—HPI-I (Provider requesting test / Provider collecting test)
- B4—Family Name (Provider requesting test)
- B5—Given Names (Provider requesting test)
- B12—Occupation (Provider collecting test)
- B13—Identifier (Provider collecting test)

Figure B1: Class diagram: Woman and Events

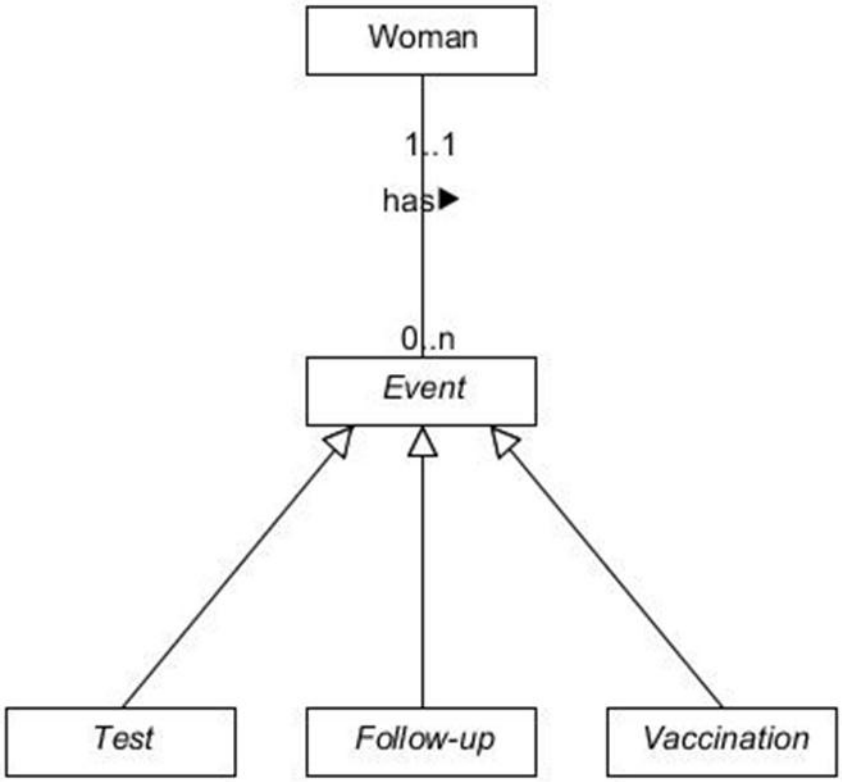


Figure B2: Class diagram: Tests

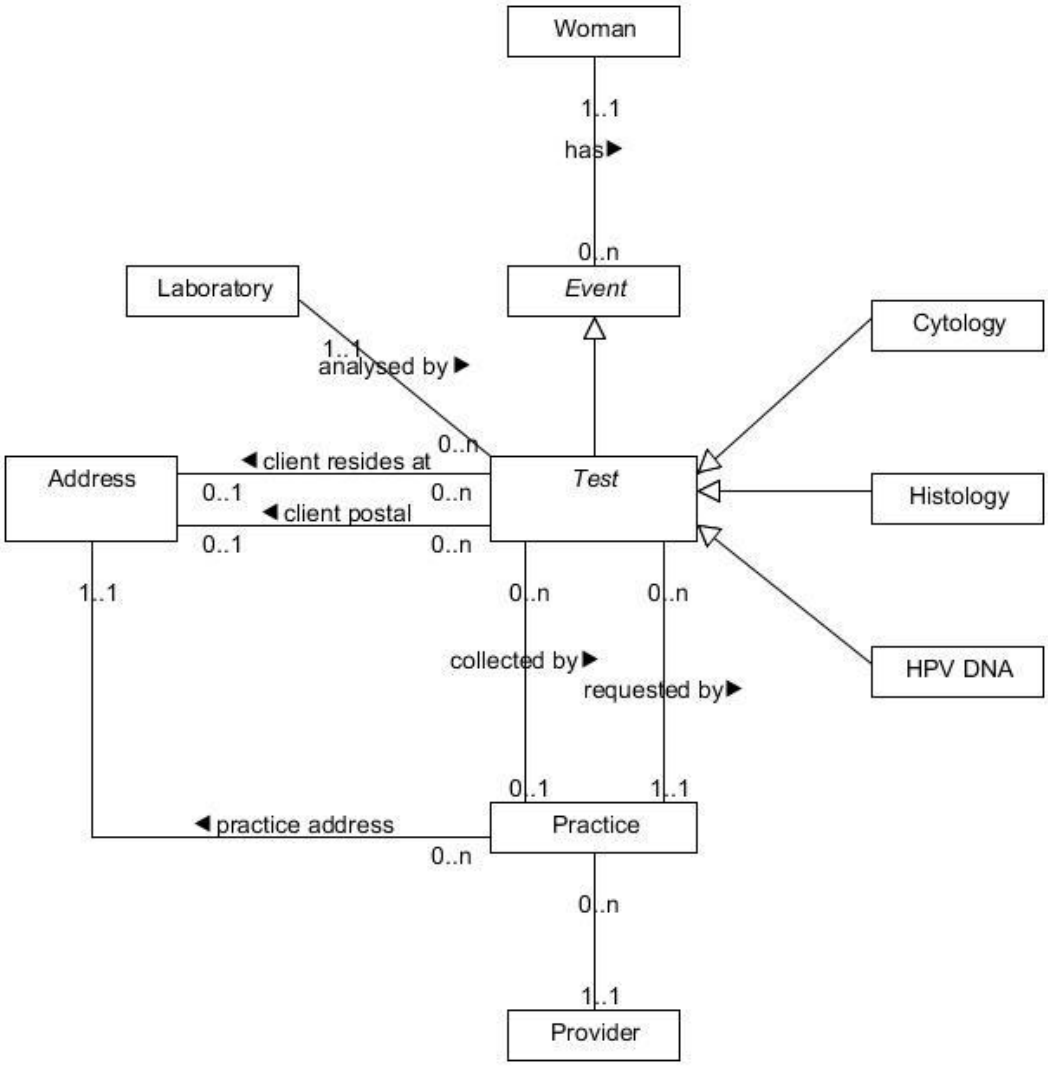


Figure B3: Class diagram: Follow-up

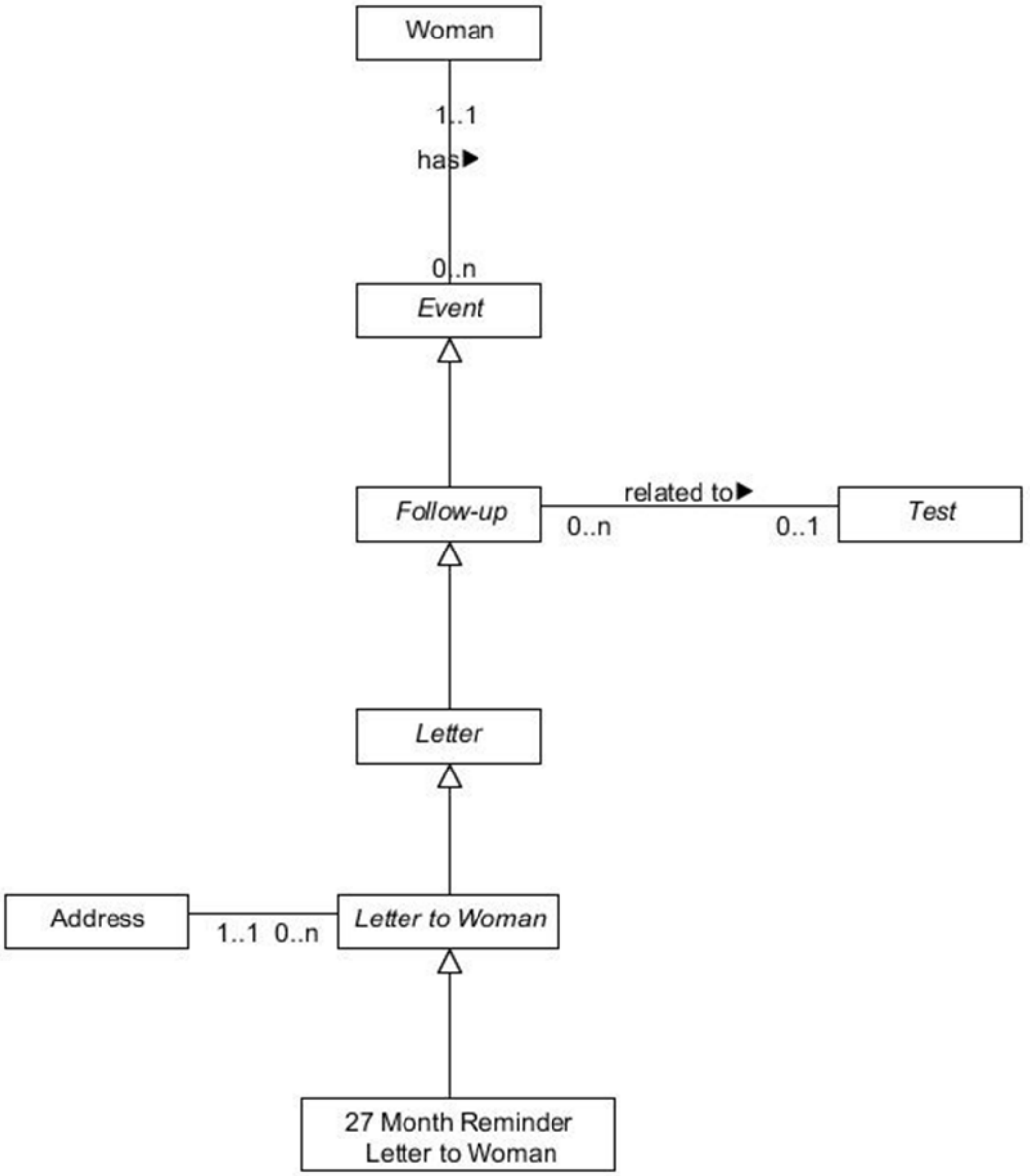
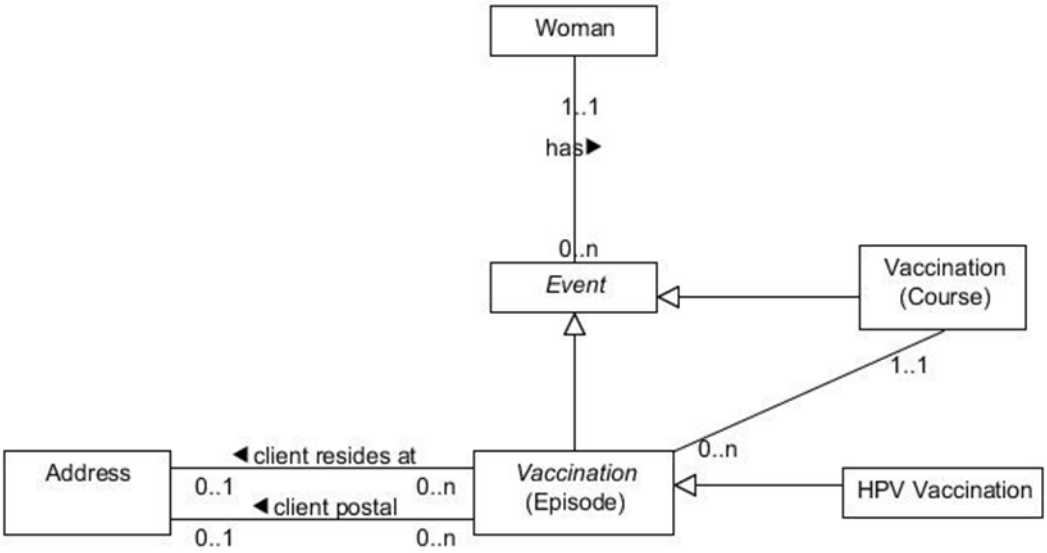


Figure B4: Class diagram: Vaccinations



Appendix C: Definition of 'opt off' in the National Cervical Screening Program

Women are able to 'opt off' the cervical screening register. A woman may do this at the time of her Pap test or related cervical test by electing not to have her results forwarded to the Register, or she may do this post registration. The following describes what 'opt off' means in terms of data implications for each state and territory. It should be appreciated that these decisions are largely a function of the over-arching health department policies that exist within each jurisdiction.

Table C1: Opt off

States and territories	Data implications of opt off
New South Wales	An opt-off test cannot be linked to a woman's existing record in the register. Her existing register record remains active. The woman's record is de-identified, which means her identifying details including names, address and DOB are removed from her record. Her existing register record is inactivated and her previous tests in the record are de-linked. The NSW PTR retains her test results for statistical purposes.
Victoria	The woman's record is deleted from the database.
Queensland	The woman's record is removed from the Register; she will not appear in any statistics.
Western Australia	Western Australia enables a woman to 'opt off' the Register, and also to specify that a test is 'not for register'. The woman's identifying details are changed to 'withdrawn'. DOB, suburb, postcode and test are kept on the register for statistical purposes.
South Australia	TBA
Tasmania	Tasmania legislatively enables a female to 'opt off' the Register, and also to specify that a test is 'not for register'. The woman's identifying details are changed to 'deleted' including address details. All comments on her Register entry are deleted, but test results remain to allow reporting. Women must specify at each test that the result is 'not for register'. These results are not sent by pathology laboratories to the Register.
Australian Capital Territory	The woman's demographics are de-identified; her screening data remain for statistical purposes
Northern Territory	An opt-off test result will not be sent to the Register. The woman's identity related data and test results are removed. Date of birth and initial letters of first name and surname are kept for statistical reasons. She is marked permanently inactive.

Appendix D: Histology code concordances

Although cytology results are coded consistently across states and territories using the national Cervical Cytology Coding Sheet, state and territory cervical screening registries each have their own histology coding sheets for the coding of histology results, which means that there are no nationally consistent histology codes.

The histology result codes that have been developed in this document are therefore only useful if each state and territory cervical screening registry is able to map their histology result codes to this higher level coding system. This Appendix therefore comprises concordances of histology result codes for each state and territory, to allow this mapping to occur.

There are three histology data elements that require concordances. These are: H4 Histology test—procedure used for obtaining specimen for histological analysis; H5 Histology test—cervical (squamous) cell analysis; and H6 Histology test—endocervical (glandular) cell analysis. For each of these data elements, the state and territory histology result codes for each permissible value are listed.

New South Wales

H4 Histology test—procedure used for obtaining specimen for histological analysis

HP01: Biopsy

The following codes signify that the specimen was obtained by biopsy

SNOMED International

P103000 Excision, NOS/Resection, NOS/Incision and removal, NOS/Extirpation, NOS/Ablation, NOS/Abscission, NOS

P103002 Complete excision/complete incision and removal

P103100 Biopsy, NOS

P103101 Excisional biopsy

P103102 Incisional biopsy

P103112 Punch biopsy

P103122 Fine needle biopsy, NOS/Aspiration biopsy, NOS/Fine needle aspiration biopsy, NOS

P183400 Cervical biopsy, NOS

P183425 Punch biopsy of cervix

P183460 Endocervical biopsy

HP02: Endocervical curettage

The following codes signify that the specimen was obtained by endocervical curettage

SNOMED International

P103150 Curettage, NOS/Curettement, NOS

P103151 Dilation and curettage

P183314 Diagnostic aspiration curettage of uterus/Aspiration curettage of endometrium/Endometrial biopsy by suction

P750600 Diathermy, NOS/ Physical medicine diathermy treatment to one area

HP03: LLETZ/LEEP loop biopsy

The following codes signify that the specimen was obtained by LLETZ/LEEP loop biopsy

SNOMED International

P103126 Loop electrosurgical excision procedure, NOS LEEP

P183423 Loop electro excision of cervix, LEEP procedure of cervix

HP04: Cone biopsy

The following codes signify that the specimen was obtained by cone biopsy

SNOMED International

P183420 Cone biopsy of cervix, NOS/Conization of uterine cervix/Cone biopsy of cervix without dilation and curettage, without repair

P183422 Excision of cervix by electroconization

HP05: Polypectomy

The following codes signify that the specimen was obtained by polypectomy

SNOMED International

P103210 Polypectomy, NOS

HP06: Subtotal hysterectomy

The following codes signify that the specimen was obtained by hysterectomy, but it is not specified as to whether the hysterectomy was total or subtotal

SNOMED International

P183350 Hysterectomy, NOS

HP07: Hysterectomy

The following codes signify that the specimen was obtained by hysterectomy

SNOMED International

P183353 Total hysterectomy with removal of both tubes and ovaries /Bilateral hysterosalpingo-ovariectomy

P183356 Total hysterectomy with unilateral removal of tube and ovary

P183360 Vaginal Hysterectomy

HP09: Amputated cervix

The following codes signify that the specimen was obtained by amputated cervix

P183440 amputation of cervix/Cervicectomy / Trachelectomy / Excision of cervical stump / Hysterotracheletomy

HP10: Not disclosed

No codes for this jurisdiction

H5 Histology test—cervical (squamous) cell analysis

Note that all negative and unsatisfactory histology codes have been allocated to cervical (squamous) cell analysis, and not repeated for either endocervical (glandular) or vaginal cell analysis. This is due to the nature in which New South Wales receives histology results from laboratories, which does not readily allow differentiation between cervical (squamous) and endocervical (glandular) results from these categories.

HS01: Negative cervical specimen

The following histology codes signify that a cervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

SNOMED International

Topography code for the cervix and:

M00100U Normal tissue, NOS/Normal tissue morphology, NOS/Normal appearance of tissue, NOS

M00110 No pathological diagnosis/No pathologic finding/No abnormality seen/No diagnostic abnormality

M09410 No evidence of neoplasm/No evidence of tumour

M09460 Negative for tumour cells

D771510 Cervicitis, NOS

D771512 Acute cervicitis

D771514 Chronic cervicitis

D771520 Cervicitis with erosion

D771522 Cervicitis with ectropion

D771524 Chronic cervicitis with erosion

D771526 Chronic cervicitis with ectropion

D771550 Nabothian gland cyst/Nabothian follicles/Naboth’s follicles/Nabothion cyst

D772000 Endometriosis, NOS

D772106 Endometriosis of cervix

D775722 Squamous metaplasia of cervix

D775784 Mucous polyp of cervix

D775788 Cyst of cervix

M11600 Radiation injury, NOS/radiation effect on tissue, NOS

M11620 Radiation injury with inflammation

M11640 Radiation injury with fibrosis/Radiation injury with proliferation/Radiation fibromatosis

M38000 Ulcer, NOS/Ulceration, NOS/Ulcerative lesion, NOS/Ulcus, NOS

M38350 Superficial ulcer/Erosion/Superficial ulceration

M40000 Inflammation, NOS/Inflammatory reaction, NOS/Inflammatory cell infiltration, NOS/Inflammatory infiltration, NOS/Leucocytic infiltrate, NOS

M40100 Exudative inflammation, NOS/Inflammatory exudate, NOS

M40750 Ulcerative inflammation, NOS/Erosive inflammation, NOS

M41000 Acute inflammation, NOS/Acute inflammatory reaction, NOS/Acute inflammatory cell infiltration, NOS/Polymorphonuclear leucocyte infiltration, NOS

M41100 Acute exudative inflammation, NOS/Acute inflammatory exudate

M41400 Acute membranous inflammation, NOS/Acute inflammatory membrane, NOS/Acute pyogenic membrane, NOS

M41602 Pus, NOS

M41610 Abscess/Acute abscess

M42000 Subacute inflammation, NOS/Acute and chronic inflammation, NOS/Active chronic inflammation, NOS/Subacute inflammatory cell infiltration, NOS/Subacute inflammatory cell infiltrate, NOS

M43000 Chronic inflammation, NOS/Chronic inflammatory reaction, NOS/Chronic inflammatory cell infiltration, NOS

M43020 Follicular inflammation, NOS

M43060 Plasma cell inflammation, NOS/Plasma cell infiltration, NOS/Plasmacytic infiltrate, NOS

M43750 Chronic ulcerative inflammation, NOS/Chronic erosive inflammation, NOS

M44000 Granulomatous inflammation, NOS/Granuloma, NOS/Histiocytic granuloma/Epithelioid granuloma

M45020 Granulation tissue

M60000 Normal cytology/Normal cellular morphology

M67050 Inflammatory atypia

M67051 Mild inflammatory atypia

M67052 Moderate inflammatory atypia

M68020 Estrogen effect, NOS

M68070 Progesterone effect present

M71000 Hypertrophy, NOS/Enlargement, NOS

M72000 Hyperplasia, NOS/Cellular hyperplasia/Hypercellularity

M72020 Secondary hyperplasia/Reactive hyperplasia/Compensatory hyperplasia

M72040 Polypoid hyperplasia

M72120 Basal cell hyperplasia/Reserve cell hyperplasia

M72160 Acanthosis, NOS

M72600 Hyperkeratosis, NOS/Keratosis, NOS/Excessive cornification/Skin callus/Callosity/Keratoma/Tyloma/Tylosis

M72760 Benign squamous keratosis

M72830 Leukoplakia, NOS

M72860 Keratoacanthoma, NOS/Localized keratoacanthoma

M73000 Metaplasia, NOS

M73200 Epithelial metaplasia, NOS/Epithelialisation, NOS

M73220 Squamous metaplasia/Epidermoid metaplasia/Epidermalisation

M73230 Keratin pearl formation/Epithelial pearl

M73260 Transitional cell metaplasia

M76000 Proliferation, NOS

M76800 Polyp, NOS

M76810 Fibroepithelial polyp/Fibroepithelial papilloma/Fibrous polyp/Skin tag/Acrochordon

M76820 Inflammatory polyp/Pseudopolyp, NOS/Inflammatory pseudopolyp

M78000 Fibrosis, NOS/Fibroplasia, NOS/Fibrous repair/Desmoplasia/Fibrous thickening

M78060 Scar, NOS/Scar tissue/Cicatrix

M78290 Healing scar

M78400U Adhesion, NOS

M79900 Regeneration, NOS

M81400 Adenoma, NOS

M82100 Adenomatous polyp, NOS/Polypoid adenoma

M84700 Mucinous cystadenoma, NOS/Mucinous cystoma/Pseudomucinous cystadenoma, NOS

HS02: Low-grade squamous abnormality

The following histology codes signify a low-grade squamous abnormality

SNOMED International

Topography code for the cervix and:

DE32A00 Disease due to Papilloma virus, NOS
DE32A10 Papovavirus infection subgroup A, NOS
DE32A20 Condyloma acuminatum/Venereal wart/Anogenital wart
L35600 Papillomavirus, NOS/Papillomavirus group, NOS/Papovavirus, NOS
L35610 Human papillomavirus group, NOS
L35620 Human papillomavirus, NOS/Warts virus/Verruca vulgaris virus
L35621 Human papillomavirus type 1
L35622 Human papillomavirus type 2
L35623 Human papillomavirus type 3
L35624 Human papillomavirus type 4
L35625 Human papillomavirus type 5
L35626 Human papillomavirus type 6
L35627 Human papillomavirus type 7
L35628 Human papillomavirus type 8
L35629 Human papillomavirus type 9
L36210 Human herpes simplex virus, NOS/HSV/Herpes virus, NOS
L36212 Human herpes simplex virus type 2
M01000U Morphologic abnormality, NOS/Morphologic alteration, NOS/Morphologic change, NOS/Abnormal tissue appearance, NOS
M67000 Cytologic atypia, NOS/Atypical cell present, NOS
M67001 Mild cytologic atypia
M67010 Squamous cell atypia
M67011 Mild squamous cell atypia
M67012 Moderate squamous cell atypia
M67013 Severe squamous cell atypia
M67016 Low grade squamous intraepithelial lesion/CIN 1
M67090 Koilocytotic atypia, NOS/Koilocytosis, NOS
M67091 Mild koilocytotic atypia
M67092 Moderate koilocytotic atypia
M67093 Severe koilocytotic atypia
M72005 Atypical hyperplasia
M73225 Atypical squamous metaplasia
M80500 Papilloma, NOS
M80520 Squamous cell papilloma/Squamous papilloma/Keratotic papilloma
M80600 Papillomatosis, NOS

HS03: High-grade squamous abnormality

The following histology codes signify a high-grade squamous abnormality

HS03.1: High-grade (CIN NOS)

SNOMED International

Topography code for the cervix and:

D775720 Dysplasia of cervix

M67015 Squamous intraepithelial lesion, NOS/SIL

M67060 Atypia suspicious for malignancy/Suspect cell present

M67200 Dyskaryosis

M74000 Dysplasia, NOS/Acquired dysplasia, NOS

M80001 Neoplasm, uncertain whether benign or malignant/Neoplasm, NOS/Tumour, NOS/Unclassified tumour, uncertain whether benign or malignant

HS03.2: High-grade (CIN II)

No codes for this jurisdiction

HS03.3: High-grade (CIN III)

SNOMED International

Topography code for the cervix and:

M67017 High grade squamous intraepithelial lesion/High grade SIL/CIN II/CIN III

M80102 Carcinoma in situ, NOS/Intraepithelial carcinoma, NOS

M80702 Squamous cell carcinoma in situ, NOS/Epidermoid carcinoma in situ, NOS/Intraepidermal carcinoma, NOS/Intraepithelial squamous cell carcinoma

M80762 Squamous cell carcinoma in situ with questionable stromal invasion/Epidermoid carcinoma in situ with questionable stromal invasion

M80772 Intraepithelial neoplasia, grade III, of cervix, vulva and vagina

HS04: Squamous cell carcinoma

The following histology codes signify an invasive or malignant result

HS04.1: Squamous cell carcinoma (microinvasive)

SNOMED International

Topography code for the cervix and:

M80763 Squamous cell carcinoma, microinvasive

M80773 Microinvasive squamous cell carcinoma, described as FIGO state 1A1

M80783 Microinvasive squamous cell carcinoma, described as FIGO state 1A2

M80873 Microinvasive squamous cell carcinoma, described as FIGO state 1A1

M80883 Microinvasive squamous cell carcinoma, described as FIGO state 1A2

HS04.2: Squamous cell carcinoma (invasive)

Note: There is inconsistency with how the term metastatic is used by pathology laboratories. Metastatic cancers should only be included if they are primary cervical cancers that have metastasised elsewhere, not if they are primary cancers from other sites that have metastasised to the cervix or endocervix.

SNOMED International

Topography code for the cervix and:

M80003 Neoplasm, malignant/Tumour, malignant, NOS/Malignancy/Cancer/Unclassified tumour, malignant/Blastoma, NOS

M80103 Carcinoma, NOS/Epithelial tumour, malignant

M80123 Large cell carcinoma, NOS

M80213 Carcinoma, anaplastic, NOS

M80523 Papillary squamous cell carcinoma/Papillary epidermoid carcinoma

M80703 Squamous cell carcinoma, NOS/Epidermoid carcinoma, NOS/Squamous carcinoma/Squamous cell epithelioma

M80713 Squamous cell carcinoma, keratinising, NOS

M80723 Squamous cell carcinoma, large cell, nonkeratinising/Squamous cell carcinoma, nonkeratinising, NOS/Epidermoid carcinoma, large cell, nonkeratinising

M80733 Squamous cell carcinoma, small cell, non-keratinising/Epidermoid carcinoma, small cell, nonkeratinising

M80743 Squamous cell carcinoma, spindle cell/Epidermoid carcinoma, spindle cell

M80753 Adenoid squamous cell carcinoma/Pseudoglandular squamous cell carcinoma

HSU: Unsatisfactory specimen

The following histology codes signify that a cervical specimen is unsatisfactory

SNOMED International

Topography code for the cervix and:

M00001 Morphology unknown

M00003U Morphology not assigned in SNOMED

M09005 Specimen less than optimal for diagnosis/Specimen less than optimal for interpretation

M09010 Specimen unsatisfactory for diagnosis/Specimen insufficient for diagnosis/Specimen inadequate for diagnosis

M09011 Insufficient tissue for diagnosis/Insufficient material for diagnosis/Scant cellularity on smear

M09030 Artifact, NOS/Morphologic artifact, NOS

M09150 Tissue lost in processing

HSN Not applicable

No codes for this jurisdiction

H6 Histology test—endocervical (glandular) cell analysis

Note that all negative and unsatisfactory histology codes have been allocated to cervical (squamous) cell analysis, and not repeated for either endocervical (glandular) or vaginal cell analysis. This is due to the nature in which New South Wales receives histology results from laboratories, which does not readily allow differentiation between cervical (squamous) and endocervical (glandular) results from these categories.

HE02: Endocervical atypia

The following histology codes signify Endocervical atypia

SNOMED International

Topography code for the cervix and:
M67020 Columnar cell atypia
M67030 Glandular cell atypia
M67031 Mild glandular cell atypia
M67032 Moderate glandular cell atypia
M67033 Severe glandular cell atypia

HE03: High-grade endocervical abnormality

The following histology codes signify a high-grade endocervical abnormality

HE03.1: High-grade (endocervical dysplasia)

No codes for this jurisdiction

HE03.2: High-grade (adenocarcinoma in situ)

SNOMED International

Topography code for the cervix and:
M81402 Adenocarcinoma in situ

HE03.3: High-grade (mixed carcinoma in situ/adenocarcinoma in situ)

SNOMED International

Topography code for the cervix and:
M85602 Adenosquamous carcinoma in situ/Mixed adenocarcinoma and squamous cell carcinoma in situ/Mixed adenocarcinoma and epidermoid carcinoma in situ

HE04: Endocervical adenocarcinoma

The following histology codes signify endocervical adenocarcinoma (includes adenosquamous carcinoma and carcinoma of the cervix (other))

HE04.1: Endocervical adenocarcinoma (microinvasive)

No codes for this jurisdiction

HE04.2: Endocervical adenocarcinoma (invasive)

SNOMED International

Topography code for the cervix and:

M81403 Adenocarcinoma, NOS

M82603 Papillary adenocarcinoma

M83103 Clear cell adenocarcinoma, NOS/Clear cell adenocarcinoma, mesonephroid/Clear cell carcinoma

M83803 Endometrioid carcinoma

M83823 Endometrioid adenocarcinoma, secretory variant

M83833 Endometrioid adenocarcinoma, ciliated cell variant

M83843 Adenocarcinoma, endocervical type

M84803 Mucinous adenocarcinoma/Mucinous carcinoma/Colloid adenocarcinoma/Colloid carcinoma/Gelatinous adenocarcinoma/Gelatinous carcinoma/Mucoid adenocarcinoma/Mucoid carcinoma/Mucous adenocarcinoma/Mucous carcinoma

M84813 Mucin-producing adenocarcinoma/Mucin-producing carcinoma/Mucin-secreting adenocarcinoma/Mucin-secreting carcinoma

M85703 Adenocarcinoma with squamous metaplasia/Adenoacanthoma

HE04.3: Adenosquamous carcinoma

SNOMED International

Topography code for the cervix and:

M85603 Adenosquamous carcinoma/Mixed adenocarcinoma and squamous cell carcinoma/Mixed adenocarcinoma and epidermoid carcinoma

HE04.4:Carcinoma of the cervix (other)

SNOMED International

Topography code for the cervix and:

M80203 Carcinoma, undifferentiated, NOS

M80413 Small cell carcinoma, NOS/Reserve cell carcinoma/Round cell carcinoma

M82403 Carcinoid tumour, NOS/Carcinoid, NOS

M82463 Neuroendocrine carcinoma

M89803 Carcinosarcoma, NOS

M82003 Adenoid cystic carcinoma/Cylindroma, NOS/Adenocarcinoma, cylindroid type/Adenocystic carcinoma

Victoria

H4 Histology test—procedure used for obtaining specimen for histological analysis

HP01: Biopsy

The following codes signify that the specimen was obtained by biopsy

1 Target punch biopsy
4 Random punch biopsy

HP02: Endocervical curettage

The following codes signify that the specimen was obtained by endocervical curettage

0 Endocervical curettage

HP03: LLETZ/LEEP loop biopsy

The following codes signify that the specimen was obtained by LLETZ/LEEP loop biopsy

9 LLETZ/LEEP loop biopsy

HP04: Cone biopsy

The following codes signify that the specimen was obtained by cone biopsy

2 Cone biopsy

HP05: Polypectomy

The following codes signify that the specimen was obtained by polypectomy

7 Polypectomy

HP06: Subtotal hysterectomy

The following codes signify that the specimen was obtained by subtotal hysterectomy

10 Sub-total hysterectomy

HP07: Hysterectomy

The following codes signify that the specimen was obtained by hysterectomy

3 Hysterectomy

HP09: Amputated cervix

The following codes signify that the specimen was obtained by amputated cervix

11 Amputated cervix

HP10: Not disclosed

No codes for this jurisdiction

H5 Histology test—cervical (squamous) cell analysis

HS01: Negative cervical specimen

The following histology codes signify that a cervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

1100 Normal cervical epithelium
1101 Atrophic cervical epithelium
2109 Cervix - benign lesion

HS02: Low-grade squamous abnormality

The following histology codes signify a low-grade squamous abnormality

2106 Cervix - HPV
2118 Cervix - possible low-grade squamous abnormality +/- HPV
4105 Cervix - mild dysplasia +/- HPV
4111 Cervix - low-grade squamous abnormality +/- HPV

HS03: High-grade squamous abnormality

The following histology codes signify a high-grade squamous abnormality

HS03.1: High-grade (CIN NOS)

4104 Cervix - dysplasia +/- HPV
4112 Cervix - possible high grade squamous abnormality +/- HPV
4113 Cervix - high grade squamous abnormality +/- HPV

HS03.3: High-grade (CIN II)

4106 Cervix - moderate dysplasia +/- HPV

HS03.3: High-grade (CIN III)

4107 Cervix - moderate/severe dysplasia +/- HPV
5100 Cervix - severe dysplasia/carcinoma in situ +/- HPV
5101 Cervix - carcinoma in situ +/- HPV
5118 Cervix - squamous carcinoma in situ with questionable microinvasion +/- HPV

HS04: Squamous cell carcinoma

The following histology codes signify an invasive or malignant result

HS04.1: Squamous cell carcinoma (microinvasive)

5102 Cervix - microinvasive carcinoma +/- HPV

HS04.2: Squamous cell carcinoma (invasive)

5103 Cervix - squamous cell carcinoma +/- HPV

HSU: Unsatisfactory specimen

0100 Non-diagnostic biopsy (unsatisfactory)

HSN: Not applicable

No codes for this jurisdiction

H6 Histology test—endocervical (glandular) cell analysis

HE01: Negative endocervical specimen

The following histology codes signify that an endocervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

2102 Endocervical polyp/hyperplasia

HE02: Endocervical atypia

The following histology codes signify Endocervical atypia

2112 Endocervix - possible low-grade abnormality +/- HPV
4805 Endocervix - mild dysplasia +/- HPV
4811 Endocervix - low-grade glandular abnormality +/- HPV
4814 Cervix - possible low grade mixed adenosquamous abnormality +/- HPV
4815 Cervix - low grade mixed adenosquamous abnormality +/- HPV

HE03: High-grade endocervical abnormality

The following histology codes signify a high-grade endocervical abnormality

HE03.1: High-grade (endocervical dysplasia)

4804 Endocervix - dysplasia +/- HPV
4806 Endocervix - moderate dysplasia +/- HPV
4812 Endocervix - possible high-grade glandular abnormality +/- HPV
4813 Endocervix - high grade glandular abnormality +/- HPV
4816 Cervix - possible high grade adenosquamous abnormality +/- HPV
4817 Cervix - high grade adenosquamous abnormality +/- HPV

HE03.2: High-grade (adenocarcinoma in situ)

4807 Endocervix - moderate/severe dysplasia +/- HPV
5114 Endocervix - adenocarcinoma in situ
5115 Endocervix - adenocarcinoma in situ & HPV
5119 Endocervix - adenocarcinoma in situ with questionable microinvasion +/- HPV

HE03.3: High-grade (carcinoma in situ/adenocarcinoma in situ)

5117 Cervix - mixed adenosquamous/carcinoma in situ

HE04: Endocervical adenocarcinoma

The following histology codes signify endocervical adenocarcinoma (includes adenosquamous carcinoma and carcinoma of the cervix (other))

HE04.1: Endocervical adenocarcinoma (microinvasive)

5116 Endocervix - microinvasive adenocarcinoma

HE04.2: Endocervical adenocarcinoma (invasive)

5106 Endocervix – adenocarcinoma
5107 Cervix - embryonal/clear cell carcinoma*

HE04.3: Adenosquamous carcinoma

5105 Cervix - mixed adenosquamous carcinoma

HE04.4: Carcinoma of the cervix (other)

5104 Cervix - small cell carcinoma
5108 Cervix - other malignant lesion*

HEU: Unsatisfactory specimen

No codes for this jurisdiction

HEN: Not applicable

No codes for this jurisdiction

*may include tumours of non-epithelial origin

Queensland

H5 Histology test—cervical (squamous) cell analysis

Note that all negative and unsatisfactory histology codes have been allocated to cervical (squamous) cell analysis, and not repeated for endocervical (glandular) cell analysis. This is due to the nature in which Queensland receives histology results from laboratories, which does not readily allow differentiation between cervical (squamous) and endocervical (glandular) results from these categories.

HS01: Negative cervical specimen

The following histology codes signify that a cervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

SNOMED International

Topography code for the cervix and:
M00100 Normal tissue morphology, NOS
M00100U U normal tissue, NOS
M00110 No pathologic diagnosis
M00120 Normal cellular morphology
M09410 No evidence of neoplasm
M09450 No evidence of malignancy
M33400 Cyst, NOS
M37000 Haemorrhage, NOS
M38000 Ulcer, NOS
M40000 Inflammation, NOS
M41000 Acute inflammation, NOS
M42000 Subacute inflammation, NOS
M42100 Acute and chronic inflammation, NOS
M43000 Chronic inflammation, NOS
M54000 Necrosis, NOS
M58000 Atrophy
M67055 Post-radiation cytologic changes without dysplasia
M72480 Microglandular hyperplasia
M72600 Hyperkeratosis, NOS
M73000 Metaplasia, NOS
M73220 Squamous metaplasia
M74470 Parakeratosis, NOS
M76500 Endometriosis, NOS
M76800 Polyp, NOS
M76810 Fibroepithelial polyp
M83400 Nabothian cyst
M88900 Leiomyoma, NOS

SNOMED 2

Topography code for the cervix and:
M00100 Normal tissue morphology, NOS
M00110 Normal microscopic morphology
M00120 Normal cellular morphology
M09450 No evidence of malignancy
M33400 Cyst, NOS
M37000 Haemorrhage, NOS
M38000 Ulcer, NOS
M40000 Inflammation, NOS
M41000 Acute inflammation, NOS
M42000 Subacute inflammation
M42100 Acute and chronic inflammation, NOS
M43000 Chronic inflammation, NOS
M54000 Necrosis, NOS
M58000 Atrophy, NOS
M67055 Post-radiation cytologic changes without dysplasia
M72480 Hyperplasia, microglandular
M72600 Hyperkeratosis, NOS
M73000 Metaplasia, NOS
M73220 Metaplasia, squamous
M74030 Parakeratosis, NOS
M76500 Endometriosis, NOS
M76800 Polyp, NOS
M76810 Polyp, fibroepithelial
M83400 Nabothian cyst
M88900 Leiomyoma, NOS

HS02: Low-grade squamous abnormality

The following histology codes signify a low-grade squamous abnormality

SNOMED International

Topography code for the cervix and:
M67000 Cytologic atypia, NOS
M67010 Squamous cell atypia
M67016 Low grade intraepithelial lesion (CIN 1)
M67056 Post-radiation cytologic changes with dysplasia
M67090 Koilocytotic, NOS
M69790 Koilocytotic atypia (HPV)
M72005 Atypical hyperplasia
M74001 Dysplasia – mild
M74430 Dyskeratosis, NOS
M76700 Condyloma, NOS
M76720 Condyloma acuminatum
M80500 Papilloma, NOS (except papilloma of bladder M81201)

SNOMED 2

Topography code for the cervix and:
M67016 CIN I
M67056 Post-radiation cytologic changes with dysplasia
M67090 Koilocytotic atypia
M69700 Atypia, cytologic, NOS
M69710 Squamous cell atypia
M69790 Koilocytotic atypia
M72005 Hyperplasia, atypical
M74006 Dysplasia - mild (CIN 1)
M74010 Dyskeratosis, NOS
M76700 Condyloma, NOS
M76720 Condyloma acuminatum
M80500 Papilloma, NOS (except Papilloma of urinary bladder M81201)

HS03: High-grade squamous abnormality (HSIL)

The following histology codes signify a high-grade squamous abnormality (HSIL)

HS03.1: High-grade (CIN NOS)

SNOMED International

Topography code for the cervix and:
M67015 Squamous intraepithelial lesion, NOS
M74000 Dysplasia, NOS

SNOMED 2

Topography code for the cervix and:
M67015 Squamous intraepithelial lesion, NOS
M74000 Dysplasia, NOS

HS03.2: High-grade (CIN II)

SNOMED International

Topography code for the cervix and:
M74002 Dysplasia – moderate

SNOMED 2

Topography code for the cervix and:
M67017 CIN II
M74007 Dysplasia - moderate (CIN 2)

HS03.3: High-grade (CIN III)

SNOMED International

Topography code for the cervix and:
M67017 High grade intraepithelial lesion (CIN2/3)
M74003 Dysplasia - severe
M80001 Neoplasm, uncertain whether benign or malignant
M80102 Carcinoma in situ, NOS
M80702 Squamous cell carcinoma in situ, NOS
M80762 Squamous cell carcinoma in situ
M80772 Intraepithelial neoplasia, grade III, of cervix, vulva and vagina

SNOMED 2

Topography code for the cervix and:
M74008 Dysplasia - severe (CIN 3)
M80001 Neoplasm, uncertain whether benign or malignant
M80102 Carcinoma in situ, NOS
M80702 Squamous cell carcinoma in situ, NOS
M80762 Squamous cell carcinoma in situ with questionable stromal invasion
M80772 CIN III

HS04: Squamous cell carcinoma

The following histology codes signify an invasive or malignant result

HS04.1: Squamous cell carcinoma (microinvasive)

SNOMED International

Topography code for the cervix and:
M80763 Squamous cell carcinoma, microinvasive

SNOMED 2

Topography code for the cervix and:
M80715 Microinvasive squamous cell carcinoma
M80763 Squamous cell carcinoma, microinvasive

HS04.2: Squamous cell carcinoma (invasive)

SNOMED International

Topography code for the cervix and:
M80003 Malignancy, NOS
M80009 Neoplasm, malignant, uncertain whether primary or metastatic
M80103 Carcinoma, NOS
M80513 Verrucous carcinoma, NOS
M80703 Squamous cell carcinoma, NOS
M80713 Squamous cell carcinoma, keratinising, NOS
M80723 Squamous cell carcinoma, non-keratinising large cell type

SNOMED 2

Topography code for the cervix and:
M80003 Neoplasm, malignant
M80009 Neoplasm, malignant, uncertain whether primary or metastatic
M80103 Carcinoma, NOS
M80513 Verrucous carcinoma, NOS
M80703 Squamous cell carcinoma, NOS
M80713 Squamous cell carcinoma, keratinising, NOS
M80723 Squamous cell carcinoma, large cell, non-keratinising type

HSU: Unsatisfactory specimen

The following histology codes signify that a cervical specimen is unsatisfactory

SNOMED International

Topography code for the cervix and:
M09000 Specimen unsatisfactory for diagnosis
M09010 Specimen unsatisfactory for diagnosis
M09011 Insufficient tissue for diagnosis
M09100 No tissue received

SNOMED 2

Topography code for the cervix and:
M09000 Insufficient tissue for diagnosis
M09010 Tissue insufficient for diagnosis
M09100 No tissue received

HSN: Not applicable

No codes for this jurisdiction

H6 Histology test—endocervical (glandular) cell analysis

Note that all negative and unsatisfactory histology codes have been allocated to cervical (squamous) cell analysis, and not repeated for endocervical (glandular) cell analysis. This is due to the nature in which Queensland receives histology results from laboratories, which does not readily allow differentiation between cervical (squamous) and endocervical (glandular) results from these categories.

HE02: Endocervical atypia

The following histology codes signify endocervical atypia

SNOMED International

Topography code for the cervix and:
M67020 Columnar cell atypia
M67030 Glandular cell atypia

SNOMED 2

Topography code for the cervix and:
M69720 Columnar cell atypia

HE03: High-grade endocervical abnormality

The following histology codes signify a high-grade endocervical abnormality

HE03.1: High-grade (endocervical dysplasia)

SNOMED International

No codes for this jurisdiction

SNOMED 2

No codes for this jurisdiction

HE03.2: High-grade (adenocarcinoma in situ)

SNOMED International

Topography code for the cervix and:
M81402 Adenocarcinoma in situ

SNOMED 2

Topography code for the cervix and:
M81402 Adenocarcinoma in situ

HE04: Endocervical adenocarcinoma

The following histology codes signify endocervical adenocarcinoma (includes adenosquamous carcinoma and carcinoma of the cervix (other))

HE04.1: Endocervical adenocarcinoma (microinvasive)

SNOMED International

No codes for this jurisdiction

SNOMED 2

No codes for this jurisdiction

HE04.2: Endocervical adenocarcinoma (invasive)

SNOMED International

Topography code for the cervix and:
M81403 Adenocarcinoma
M81443 Adenocarcinoma, intestinal type
M83103 Clear cell adenocarcinoma
M83803 Endometroid carcinoma

SNOMED 2

Topography code for the cervix and:
M81403 Adenocarcinoma, NOS
M81443 Adenocarcinoma, intestinal type
M83103 Clear cell adenocarcinoma, NOS
M83803 Endometroid carcinoma

HE04.3: Adenosquamous carcinoma

SNOMED International

Topography code for the cervix and:
M85603 Adenosquamous carcinoma

SNOMED 2

Topography code for the cervix and:
M85603 Adenosquamous carcinoma

HE04.4: Carcinoma of the cervix (other)

SNOMED International

Topography code for the cervix and:
M80413 Small cell carcinoma, NOS

SNOMED 2

Topography code for the cervix and:
M80413 Small cell carcinoma, NOS

Western Australia

H4 Histology test—procedure used for obtaining specimen for histological analysis

HP01: Biopsy

The following codes signify that the specimen was obtained by biopsy

T1 Punch biopsy of cervix (for specimens with B1 at data element T1)
T7 Vaginal biopsy (for specimens with B2 at data element T1)

HP02: Endocervical curettage

The following codes signify that the specimen was obtained by endocervical curettage

T2 Endocervical curettage

HP03: LLETZ/LEEP loop biopsy

The following codes signify that the specimen was obtained by LLETZ/LEEP loop biopsy

T3 Large loop excision of TZ

HP04: Cone biopsy

The following codes signify that the specimen was obtained by cone biopsy

T4 Cone biopsy

HP05: Polypectomy

The following codes signify that the specimen was obtained by polypectomy

TP Cervical polyp

HP06: Subtotal hysterectomy

The following codes signify that the specimen was obtained by subtotal hysterectomy

TS Subtotal hysterectomy

HP07: Hysterectomy

The following codes signify that the specimen was obtained by hysterectomy

T6 Hysterectomy

HP09: Amputated cervix

The following codes signify that the specimen was obtained by amputated cervix

TA Amputated cervix

HP10: Not disclosed

The following codes signify that the procedure by which specimen obtained was not disclosed

T0 Not disclosed

H5 Histology test—cervical (squamous) cell analysis

HS01: Negative cervical specimen

The following histology codes signify that a cervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

S1 Native squamous epithelium: squamous metaplasia; immature squamous metaplasia with or without inflammatory or reactive changes; atrophy and
W1 Wart virus absent

HS02: Low-grade squamous abnormality

The following histology codes signify a low-grade squamous abnormality

S2 Atypia. Atypical immature squamous metaplasia
S2 Atypia. Atypical immature squamous metaplasia and
W2 Equivocal HPV
S3 HPV effect and
W3 Human papillomavirus
S4 Mild dysplasia (CIN 1)

HS03: High-grade squamous abnormality

The following histology codes signify a high-grade squamous abnormality (HSIL)

HS03.1: High-grade (CIN NOS)

No codes for this jurisdiction

HS03.2: High-grade (CIN II)

S5 Moderate dysplasia (CIN2)

HS03.3: High-grade (CIN III)

S6 Severe dysplasia (CIN3)

HS04: Squamous cell carcinoma

The following histology codes signify an invasive or malignant result

HS04.1: Squamous cell carcinoma (microinvasive)

S7 Micro-invasive squamous cell carcinoma

HS04.2: Squamous cell carcinoma (invasive)

S8 Invasive squamous cell carcinoma

HSU: Unsatisfactory specimen

The following histology codes signify that a cervical specimen is unsatisfactory

SØ Unsatisfactory for evaluation
WU Due to unsatisfactory nature of the biopsy, no assessment has been made

HSN: Not applicable

The following histology codes signify that a cervical specimen analysis result is not applicable

S- Not applicable (no squamous epithelium collected)
W- Not applicable (no squamous epithelium collected)

H6 Histology test—endocervical (glandular) cell analysis

HE01: Negative endocervical specimen

The following histology codes signify that an endocervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

E1 Normal, inflammatory or reactive changes, endocervical polyp
E2 Mild nuclear changes (probably reactive)

HE02: Endocervical atypia

The following histology codes signify endocervical atypia

No codes for this jurisdiction

HE03: High-grade endocervical abnormality

The following histology codes signify a high-grade endocervical abnormality

HE03.1: High-grade (endocervical dysplasia)

E3 Endocervical dysplasia

HE03.2: High-grade (adenocarcinoma in situ)

E4 Adenocarcinoma in situ

HE04: Endocervical adenocarcinoma

The following histology codes signify endocervical adenocarcinoma or adenosquamous carcinoma

HE04.1: Endocervical adenocarcinoma (microinvasive)

E5 Microinvasive adenocarcinoma

HE04.2: Endocervical adenocarcinoma (invasive)

E6 Invasive adenocarcinoma

HE04.3: Adenosquamous carcinoma

E7 Adenosquamous carcinoma (cervix)

HE04.4: Carcinoma of the cervix (other)

E8 Carcinoma of cervix (other)

HEU: Unsatisfactory specimen

The following histology codes signify that an endocervical specimen is unsatisfactory

EU Due to unsatisfactory nature of biopsy no assessment has been made

HEN: Not applicable

The following histology codes signify that an endocervical specimen analysis result is not applicable

E- Not applicable

South Australia

H4 Histology test—procedure used for obtaining specimen for histological analysis

HP01: Biopsy

The following codes signify that the specimen was obtained by biopsy

T1 Biopsy of cervix (for specimens with B1 at data element T1)
T5 Vagina (for specimens with B2 at data element T1)

HP02: Endocervical curettage

The following codes signify that the specimen was obtained by endocervical curettage

T2 Endocervical curettage/ T2 Endometrial curettage

HP03: LLETZ/LEEP loop biopsy

The following codes signify that the specimen was obtained by LLETZ/LEEP loop biopsy

T3 Large loop excision of TZ (Lletz/Leep)

HP04: Cone biopsy

The following codes signify that the specimen was obtained by cone biopsy

T4 Cone biopsy

HP05: Polypectomy

The following codes signify that the specimen was obtained by polypectomy

TP Cervical polyp

HP06: Subtotal hysterectomy

The following codes signify that the specimen was obtained by subtotal hysterectomy

TS Subtotal hysterectomy

HP07: Hysterectomy

The following codes signify that the specimen was obtained by hysterectomy

T7 Hysterectomy

HP09: Amputated cervix

The following codes signify that the specimen was obtained by amputated cervix

TA Amputated cervix

HP10: Not disclosed

The following codes signify that the procedure by which specimen obtained was not disclosed

T0 Not disclosed

H5 Histology test—cervical (squamous) cell analysis

HS01: Negative cervical specimen

The following histology codes signify that a cervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

S1 Normal squamous and metaplastic epithelium; atrophy

HS02: Low-grade squamous abnormality

The following histology codes signify a low-grade squamous abnormality

S1 Normal squamous and metaplastic epithelium; atrophy and
W2 Equivocal HPV
S1 Normal squamous and metaplastic epithelium; atrophy and
W3 Human papillomavirus
S2 Mild squamous atypia, falling short of dysplasia and including HPV or suggestive of HPV
S3 CIN I (mild dysplasia)

HS03: High-grade squamous abnormality

The following histology codes signify a high-grade squamous abnormality

HS03.1: High-grade (CIN NOS)

S6 CIN NOS

HS03.2: High-grade (CIN II)

S4 CIN II (moderate dysplasia)

HS03.3: High-grade (CIN III)

S5 CIN III (severe dysplasia/carcinoma in situ)

HS04: Squamous cell carcinoma

The following histology codes signify an invasive or malignant result

HS04.1: Squamous cell carcinoma (microinvasive)

S7 Micro-invasive squamous cell carcinoma

HS04.2: Squamous cell carcinoma (invasive)

S8 Invasive squamous cell carcinoma

HSU: Unsatisfactory specimen

The following histology codes signify that a cervical specimen is unsatisfactory

O3 Unsatisfactory specimen for diagnosis

HSN: Not applicable

The following histology codes signify that a cervical specimen analysis result is not applicable

S0 Not applicable
W0 Not applicable

H6 Histology test—endocervical (glandular) cell analysis

HE01: Negative endocervical specimen

The following histology codes signify that an endocervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

E1 Normal; inflammatory or reactive changes; endocervical polyp

HE02: Endocervical atypia

The following histology codes signify endocervical atypia

E2 Minor non specific change

HE03: High-grade endocervical abnormality

The following histology codes signify a high-grade endocervical abnormality

HE03.1: High-grade (endocervical dysplasia)

E3 High-grade endocervical dysplasia/Adenocarcinoma in situ

HE03.2: High-grade (adenocarcinoma in situ)

E4 Adenocarcinoma in situ

HE04: Endocervical adenocarcinoma

The following histology codes signify endocervical adenocarcinoma (includes adenosquamous carcinoma and carcinoma of the cervix (other))

HE04.1: Endocervical adenocarcinoma (microinvasive)

E5 Microinvasive adenocarcinoma

HE04.2: Endocervical adenocarcinoma (invasive)

E6 Invasive adenocarcinoma

HE04.3: Adenosquamous carcinoma

E7 Adenosquamous carcinoma (cervix)

HE04.4: Carcinoma of the cervix (other)

No codes for this jurisdiction

HEU: Unsatisfactory specimen

The following histology codes signify that an endocervical specimen is unsatisfactory

O3 Unsatisfactory specimen for diagnosis

HEN: Not applicable

The following histology codes signify that an endocervical specimen analysis result is not applicable

E0 Not applicable

Tasmania

H4 Histology test—procedure used for obtaining specimen for histological analysis

HP01: Biopsy

The following codes signify that the specimen was obtained by biopsy

T2 Punch biopsy of the cervix

HP02: Endocervical curettage

The following codes signify that the specimen was obtained by endocervical curettage

T3 Endocervical curettage

HP03: LLETZ/LEEP loop biopsy

The following codes signify that the specimen was obtained by LLETZ/LEEP loop biopsy

T4 Large loop excision of TZ

HP04: Cone biopsy

The following codes signify that the specimen was obtained by cone biopsy

T5 Cone biopsy

HP05: Polypectomy

The following codes signify that the specimen was obtained by polypectomy

T12 Endocervical polyp

HP06: Subtotal hysterectomy

The following codes signify that the specimen was obtained by subtotal hysterectomy

T13 Sub-total hysterectomy

HP07: Hysterectomy

The following codes signify that the specimen was obtained by hysterectomy

T7 Total hysterectomy

HP09: Amputated cervix

The following codes signify that the specimen was obtained by amputated cervix

T 11 Manchester Repair (Amputated Cervix)

HP10: Not disclosed

The following codes signify that the procedure by which specimen obtained was not disclosed

T1 Not disclosed

H5 Histology test—cervical (squamous) cell analysis

HS01: Negative cervical specimen

The following histology codes signify that a cervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

S1 Native squamous epithelial; squamous metaplasia; immature squamous metaplasia with or without inflammatory or reactive changes; atrophy
S1 Native squamous epithelial; squamous metaplasia; immature squamous metaplasia with or without inflammatory or reactive changes; atrophy and
W1 Wart virus absent
S2 Atypia

HS02: Low-grade squamous abnormality

The following histology codes signify a low-grade squamous abnormality

S3 HPV effect and
W2 Equivocal HPV
S3 HPV effect and
W3 Human papillomavirus
S4 Mild dysplasia (CIN1)

HS03: High-grade squamous abnormality

The following histology codes signify a high-grade squamous abnormality (HSIL)

HS03.1: High-grade (CIN NOS)

No codes for this jurisdiction

HS03.2: High-grade (CIN II)

S5 Moderate dysplasia (CIN2)

HS03.3: High-grade (CIN III)

S6 Severe dysplasia/CIS (CIN3)

HS04: Squamous cell carcinoma

The following histology codes signify an invasive or malignant result

HS04.1: Squamous cell carcinoma (microinvasive)

S7 Microinvasive squamous cell carcinoma

HS04.2: Squamous cell carcinoma (invasive)

S8 Invasive squamous cell carcinoma

HSU: Unsatisfactory specimen

No codes for this jurisdiction

HSN Not applicable

No codes for this jurisdiction

H6 Histology test—endocervical (glandular) cell analysis

HE01: Negative endocervical specimen

The following histology codes signify that an endocervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

E1 Normal; inflammatory or reactive changes; endocervical polyp/hyperplasia
E2 Mild nuclear changes (probably reactive)

HE02: Endocervical atypia

The following histology codes signify endocervical atypia

No codes for this jurisdiction

HE03: High-grade endocervical abnormality

The following histology codes signify a high-grade endocervical abnormality

HE03.1: High-grade (endocervical dysplasia)

E3 Endocervical dysplasia

HE03.2: High-grade (adenocarcinoma in situ)

E4 Adenocarcinoma in situ

HE04: Endocervical adenocarcinoma

The following histology codes signify endocervical adenocarcinoma (includes adenosquamous carcinoma and carcinoma of the cervix (other))

HE04.1: Endocervical adenocarcinoma (microinvasive)

E5 Microinvasive adenocarcinoma

HE04.2: Endocervical adenocarcinoma (invasive)

E6 Invasive adenocarcinoma

HE04.3: Adenosquamous carcinoma

E7 Adenosquamous carcinoma (cervix)

HE04.4: Carcinoma of the cervix (other)

E8 Carcinoma of cervix (other)*

*may include tumours of non-epithelial origin

HEU: Unsatisfactory specimen

No codes for this jurisdiction

HEN: Not applicable

The following histology codes signify that an endocervical specimen analysis result is not applicable

E0 Not applicable

Australian Capital Territory

H4 Histology test—procedure used for obtaining specimen for histological analysis

HP01: Biopsy

The following codes signify that the specimen was obtained by biopsy

T2 Punch biopsy of the cervix

HP02: Endocervical curettage

The following codes signify that the specimen was obtained by endocervical curettage

T3 Endocervical curettage
T6 Endometrial curettage

HP03: LLETZ/LEEP loop biopsy

The following codes signify that the specimen was obtained by LLETZ/LEEP loop biopsy

T4 Large loop excision of TZ

HP04: Cone biopsy

The following codes signify that the specimen was obtained by cone biopsy

T5 Cone biopsy

HP05: Polypectomy

The following codes signify that the specimen was obtained by polypectomy

T12 Endocervical polyp

HP06: Subtotal hysterectomy

The following codes signify that the specimen was obtained by subtotal hysterectomy

T13 Sub-total hysterectomy

HP07: Hysterectomy

The following codes signify that the specimen was obtained by hysterectomy

T7 Total hysterectomy

HP09: Amputated cervix

The following codes signify that the specimen was obtained by amputated cervix

T 11 Manchester Repair (Amputated Cervix)

HP10: Not disclosed

The following codes signify that the procedure by which specimen obtained was not disclosed

T0 Not disclosed

H5 Histology test—cervical (squamous) cell analysis

HS01: Negative cervical specimen

The following histology codes signify that a cervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

S1 Native squamous epithelial; squamous metaplasia; immature squamous metaplasia with or without inflammatory or reactive changes; atrophy
S1 Native squamous epithelial; squamous metaplasia; immature squamous metaplasia with or without inflammatory or reactive changes; atrophy and
W1 Wart virus absent
S2 Atypia

HS02: Low-grade squamous abnormality

The following histology codes signify a low-grade squamous abnormality

S3 HPV effect and
W2 Equivocal HPV
S3 HPV effect and
W3 Human papillomavirus
S4 Mild dysplasia (CIN1)

HS03: High-grade squamous abnormality

The following histology codes signify a high-grade squamous abnormality (HSIL)

HS03.1: High-grade (CIN NOS)

S9 Possible high grade abnormality

HS03.2: High-grade (CIN II)

S5 Moderate dysplasia (CIN2)

HS03.3: High-grade (CIN III)

S6 Severe dysplasia/CIS (CIN3)

HS04: Squamous cell carcinoma

The following histology codes signify an invasive or malignant result

HS04.1: Squamous cell carcinoma (microinvasive)

S7 Microinvasive squamous cell carcinoma

HS04.2: Squamous cell carcinoma (invasive)

S8 Invasive squamous cell carcinoma

HSU: Unsatisfactory specimen

The following histology codes signify that a cervical specimen is unsatisfactory

No codes for this jurisdiction

HSN Not applicable

The following histology codes signify that a cervical specimen analysis result is not applicable

S0 Not applicable
W0 Information not available (no squamous cells collected)

H6 Histology test—endocervical (glandular) cell analysis

HE01: Negative endocervical specimen

The following histology codes signify that an endocervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

E1 Normal; inflammatory or reactive changes; endocervical polyp/hyperplasia
E2 Mild nuclear changes (probably reactive)

HE02: Endocervical atypia

The following histology codes signify endocervical atypia

No codes for this jurisdiction

HE03: High-grade endocervical abnormality

The following histology codes signify a high-grade endocervical abnormality

HE03.1: High-grade (endocervical dysplasia)

E3 Endocervical dysplasia

HE03.2: High-grade (adenocarcinoma in situ)

E4 Adenocarcinoma in situ

HE04: Endocervical adenocarcinoma

The following histology codes signify endocervical adenocarcinoma or adenosquamous carcinoma

HE04.1: Endocervical adenocarcinoma (microinvasive)

E5 Microinvasive adenocarcinoma

HE04.2: Endocervical adenocarcinoma (invasive)

E6 Invasive adenocarcinoma

HE04.3: Adenosquamous carcinoma

E7 Adenosquamous carcinoma (cervix)

HE04.4: Carcinoma of the cervix (other)

E8 Carcinoma of cervix (other)

HEU: Unsatisfactory specimen

No codes for this jurisdiction

HEN: Not applicable

The following histology codes signify that an endocervical specimen analysis result is not applicable

E0 Not applicable

Northern Territory

H4 Histology test—procedure used for obtaining specimen for histological analysis

HP01: Biopsy

The following codes signify that the specimen was obtained by biopsy

T1 Punch biopsy of the cervix (for specimens with B1 at data element T1)
T8 Vaginal biopsy (for specimens with B2 at data element T1)

HP02: Endocervical curettage

The following codes signify that the specimen was obtained by endocervical curettage

T2 Endocervical curettage (incl endometrial curettage with cervical component)

HP03: LLETZ/LEEP loop biopsy

The following codes signify that the specimen was obtained by LLETZ/LEEP loop biopsy

T3 LLETZ/LEEP

HP04: Cone biopsy

The following codes signify that the specimen was obtained by cone biopsy

T4 Cone biopsy

HP05: Polypectomy

The following codes signify that the specimen was obtained by polypectomy

T5 Endocervical polyp

HP06: Subtotal hysterectomy

The following codes signify that the specimen was obtained by subtotal hysterectomy

T7 Sub-total hysterectomy

HP07: Hysterectomy

The following codes signify that the specimen was obtained by hysterectomy

T6 Total hysterectomy

HP09: Amputated cervix

No codes for this jurisdiction

HP10: Not disclosed

The following codes signify that the procedure by which specimen obtained was not disclosed

T0 Not disclosed

H5 Histology test—cervical (squamous) cell analysis

To code for this site, NT specimen code must be one of: T1, T2, T3, T4, T5, T6 or T7 only

HS01: Negative cervical specimen

The following histology codes signify that a cervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

S1 Native squamous epithelial; squamous metaplasia; immature squamous metaplasia with or without inflammatory or reactive changes; atrophy; hyperkeratosis or parakeratosis
S2 Atypia; Atypical immature squamous metaplasia; HPV effect and
W1 Wart virus absent

HS02: Low-grade squamous abnormality

The following histology codes signify a low-grade squamous abnormality

S2 Atypia; Atypical immature squamous metaplasia; HPV effect and
W2 Equivocal HPV
S2 Atypia; Atypical immature squamous metaplasia; HPV effect and
W3 Human papillomavirus
S3 Mild dysplasia (CIN1)

HS03: High-grade squamous abnormality

The following histology codes signify a high-grade squamous abnormality (HSIL)

HS03.1: High-grade (CIN NOS)

S6 High grade CIN (level not determined)

HS03.2: High-grade (CIN II)

S4 Moderate dysplasia (CIN2)

HS03.3: High-grade (CIN III)

S5 Severe dysplasia (CIN3)/Carcinoma in situ

HS04: Squamous cell carcinoma

The following histology codes signify an invasive or malignant result

HS04.1: Squamous cell carcinoma (microinvasive)

S7 Microinvasive squamous cell carcinoma

HS04.2: Squamous cell carcinoma (invasive)

S8 Invasive squamous cell carcinoma

HSU: Unsatisfactory specimen

The following histology codes signify that a cervical specimen is unsatisfactory

H0 Unsatisfactory

HSN: Not applicable

The following histology codes signify that a cervical specimen analysis result is not applicable

S0 Not applicable (or information not available)

H6 Histology test—endocervical (glandular) cell analysis

To code for this site, NT specimen code must be one of: T1, T2, T3, T4, T5, T6 or T7 only

HE01: Negative endocervical specimen

The following histology codes signify that an endocervical specimen analysis result is negative (for the purposes of assessment for cancer or pre-cancerous changes)

E1 Normal; inflammatory or reactive changes; normal endocervical polyp
E2 Mild nuclear changes (probably reactive)

HE02: Endocervical atypia

The following histology codes signify endocervical atypia

No codes for this jurisdiction

HE03: High-grade endocervical abnormality

The following histology codes signify a high-grade endocervical abnormality

HE03.1: High-grade (endocervical dysplasia)

E3 Endocervical dysplasia

HE03.2: High-grade (adenocarcinoma in situ)

E4 Adenocarcinoma in situ

HE04: Endocervical adenocarcinoma

The following histology codes signify endocervical adenocarcinoma (includes adenosquamous carcinoma and carcinoma of the cervix (other))

HE04.1: Endocervical adenocarcinoma (microinvasive)

E5 Microinvasive adenocarcinoma

HE04.2: Endocervical adenocarcinoma (invasive)

E6 Invasive adenocarcinoma

HE04.3: Adenosquamous carcinoma

E7 Adenosquamous carcinoma (cervix)

HE04.4: Carcinoma of the cervix (other)

E8 Carcinoma of cervix (other)

HEU: Unsatisfactory specimen

The following histology codes signify that an endocervical specimen is unsatisfactory

H0 Unsatisfactory

HEN: Not applicable

The following histology codes signify that an endocervical specimen analysis result is not applicable

E0 Not applicable

Appendix E: Change management protocol: request for change

National cervical cancer prevention data dictionary version 1

Request for change

To be completed by person requesting change

Date of endorsement

Person requesting change

Name: Position:

Requested change

Reasons for requesting change

To be completed by Cancer and screening unit, Australian Institute of Health and Welfare

AIHW comment on requested change

Other data elements or definitions affected

Recommendation

☐Endorse ☐Do not endorse

The National Cervical Screening Program aims to reduce incidence, morbidity and mortality from cervical cancer in Australia. The National cervical cancer prevention data dictionary is an assemblage of data elements used by the National Cervical Screening Program, developed by the Australian Institute of Health and Welfare in partnership with state and territory and Commonwealth components of the National Cervical Screening Program to support its aim of achieving national consistency in data reporting through promoting standardisation and comparability of data across the jurisdictions.