

Mammography form: completion instructions

1. Surname and forenames

- pre-printed on the form
- if the name has changed, cross out the old names and write the new names on the form
- if empty, write according to the information given

2. Identity code

- pre-printed on the form
- if empty, write according to the information given

Note: It is important that the code follow the National Population Coding Procedure.

3. Mother tongue

- pre-printed on the form
- if empty, tick the correct alternative

4. Address

- pre-printed on the form
- if changed, cross out the old address and write the new address on the form
- if empty, write according to the information given

5. Invitation year

- pre-printed on the form
- if empty, write down the year when the invitation was received

Note: The invitation year is the year during which the mammography was organised for the invitee's age group.

6. Inviting municipality

- pre-printed on the form
- if empty, write according to the information given

7. Visit municipality (i.e., new domicile)

- often empty, because the invitation and visit municipality are normally the same; if a person has changed her domicile after getting the invitation to a screening, the new domicile is written here

8. Suggested date for a visit

- pre-printed on the form
- if empty, write the date of the visit
- if a reminder has been sent, tick the appropriate box

Note: The suggested date for a visit should be written down also for non-participants.

Note: The mailing date of the invitation letter can also be sent to the Mass Screening Registry. It is in the same place as the suggested day for a visit.

9. Randomisation code

- pre-printed on the form – the code cannot be changed

10. Telephone number

- write according to the information given

11. Screening centre

- pre-printed on the form
- if empty, write the name of the centre

12. Preliminary information

Ask and write down:

- the number of previous mammograms and the date of the latest mammogram
- the number of previous clinical mammograms and the date of the latest clinical mammogram
- the use of hormonal therapy
- the symptoms during the previous two months
- the findings
- the year of any earlier breast cancer diagnosis

Mark the findings on the picture, using symbols beside the picture.

13. Mammography

Write down:

- the mammography device (tick the appropriate box)
- the date for the test
- the number of projections (usually 2)
- the total number of exposures – i.e., the total number of successful and failed images
- the amount of radiation (mGy, integer) in the front image from either of the breasts; tick also the method of measurement: 'skin dose' or 'glandular dose'
- the findings of the first radiologist (0–5) dx and (0–5) sin
- the findings of the second radiologist (0–5) dx and (0–5) sin
- whether consensus reading is performed (tick dx and/or sin)
- the result of the consensus reading (0–5) dx and/or (0–5) sin
- referral for further examinations (tick dx and/or sin)
- the date and signature of the radiographer and the radiologists

Note: The findings of the first and second radiologist are written down only after separate reading has been performed.

Additional information

All necessary additional information concerning the preliminary examinations or the mammography can be written down here.

14. Additional mammograms

Write down:

- the date (if a person refused to participate or for some other reason did not participate, tick 'not done')
- the type and projections of the images dx and/or sin (e.g., tick 'Craniocaudal extra image', 'Oblique extra image', 'Side extra image', etc.)
- the findings (0–5) dx and/or sin
- the shape, calcification, and structure of the findings and lesion parameters dx and/or sin
- the referral for the additional further examinations (tick dx and/or sin)
- the signature of a radiographer or a radiologist

15. Additional further examinations

Write down:

- the date of additional further examinations (if a person refused to participate or for some other reason did not participate, tick 'not done')
- the finding of ultrasound dx and/or sin (0–5)
- the finding of pneumocystograph y dx and/or sin (0–5)
- the cyst puncture dx and/or sin (x = examination done)
- the galactography dx and/or sin (x = examination done)
- the palpable change dx and/or sin (tick 'yes' or 'no')
- the radiological find (0–5) dx and/or sin: summary for all radiological findings
- the finding of fine needle biopsy (FNB) from the breast dx and/or sin (0–5)
- the finding of fine needle biopsy (FNB) from the axilla dx and/or sin (0–5)
- the signature of the radiographer or the radiologist

16. Core needle biopsy (CNB)

Write down:

- the date of core needle biopsy (if a person refused to participate or for some other reason did not participate, tick 'not done')
- the pathologic–anatomical diagnosis for CNB (PAD) dx and/or sin (ICD-O/SNOMED; see Annex 1)
- the signature of the radiographer or the radiologist

17. Further measures

Write down:

- the date for the referral for surgical procedures
- the breast (tick the box for dx and/or sin)
- the hospital to which the person will be sent
- the number of months after which another control mammography test will be done

18. Surgical procedures

Write down:

- the date for the primary operation (not PNB) (if a person refused to participate or for some other reason did not participate, tick 'not done')
- the codes for the primary operation dx and/or sin (see Annex 2)
- the codes for any subsequent operations (same tumour) dx and/or sin (see Annex 2)

19. Histological response

Write down:

- the final pathologic–anatomical diagnosis (PAD) dx and/or sin (ICD-O/SNOMED; see Annex 1)
- other PAD – e.g., from axillary nodes – dx and/or sin (ICD-O/SNOMED; see Annex 1)
- the number of metastatic and examined sentinel nodes dx and/or sin
- the number of metastatic and examined axillary nodes dx and/or sin
- the diameter in the histological specimen (mm) dx and/or sin
- pTNM dx and/or sin (T = primary tumour, N = regional nodes, M = distant nodes; see Annex 3)
- stage dx and/or sin (0, 1, 2A, 2B, 3A, 3B, or 4; see Annex 4)
- grade dx and/or sin (1, 2, or 3; see Annex 5)
- one focus dx and/or sin (tick the box), connected to PAD of the breast
- multifocal dx and/or sin (tick the box), connected to PAD of the breast

ANNEX 1: PAD – BREAST CODES, ICD-O/SNOMED

BENIGN	MALIGNANT
41740 Abscessus	81403 Adenocarcinoma
85060 Adenoma of the nipple	82003 Adenocarcinoma, cylindroid
85040 Adenoma papillare intracysticum	84803 Adenocarcinoma, mucinous
74220 Adenosis (scleroticans)	82003 Adenoid cystic ca.
49060 Scar	84013 Apocrine adenocarcinoma
35400 Atheroma	82803 Ca. acidophilicum
58000 Atrophia	82003 Ca. adenocysticum
55400 Calcification(s)	81403 Ca. adenomatosum
49060 Cicatrix	80213 Ca. anaplasticum
33400 Cysta	84013 Ca. apocrinic
90201 Cystosarcoma phyllodes	83103 Ca. clarocellulare
32100 Ductectasia	84803 Ca. colloidal
74000 Dysplasia	82013 Ca. cribriforme
35400 Epidermal cyst	85003 Ca. ductale (invasivum)
54110 Fat necrosis	85413 Ca. ductale + Paget's disease
90100 Fibroadenoma	82803 Ca. eosinophilicum
74220 Fibroadenosis	80102 Ca. in situ
74320 Fibrocystic disease	85002 Ca. intraductale (in situ)
74320 Fibrosclerosis	85202 Ca. lobulare in situ
49000 Fibrosis	85203 Ca. lobulare (invasivum)
44140 Foreign body reaction	80203 Ca. maledifferentiatum
37100 Haematoma	85103 Ca. medullare
37100 Haemorrhagia	85123 Ca. medullare, with lymphoid stroma
72000 Hyperplasia	*80106 Ca metastaticum
72100 Hyperplasia lobularis	84803 Ca. mucinosum
72000 Hyperplasia lymphoid (armpit)	82603 Ca. papillare
80000 Benign tumour	80502 Ca. papillare in situ
88500 Lipoma	81413 Ca. scirrhosum
54110 Liponecrosis	82113 Ca. tubulare
40000 Mastitis	80103 Carcinoma, Ca. invasivum
43000 Mastitis chronica	83103 Clear cell adenocarcinoma, NOS
74320 Mastopathia (cystica, chronica, etc.)	83103 Clear cell carcinoma
54110 Necrosis adiposa	85013 Comedocarcinoma
00100 Normal breast tissue	90203 Cystosarcoma phyllodes malignum
85040 Papilloma intracysticum	85003 Ductal adenocarcinoma, NOS
85030 Papilloma intraductale	85003 Ductal carcinoma, NOS
85050 Papillomatosis intraductalis	82803 Eosinophil adenocarcinoma
74320 Radial scar	82803 Eosinophil carcinoma
44210 Sarcoidosis	85003 Infiltrating duct adenocarcinoma
74220 Sclerosing adenosis	85003 Infiltrating duct carcinoma
80000 Tumor benignum	85203 Infiltrating lobular carcinoma, NOS
22300 Polymastia, ectopic breast tissue	85002 Intraductal carcinoma, noninfiltrating, NOS
	85202 Lobular carcinoma, noninfiltrating
	95903 Lymphoma malignum NOS (many. subtypes)
	84803 Mucoïd adenocarcinoma
	84803 Mucous carcinoma
	85403 Paget's disease
	85413 Paget's disease + infiltrating carcinoma
	82603 Papillary adenocarcinoma, NOS
	88003 Sarcoma (etc.) (many subtypes)
	81413 Scirrhous adenocarcinoma
	82113 Tubular adenocarcinoma

* *Metastatic lesions in the breast are registered with this code regardless of the site of the primary tumour.*

When the fifth number is 0 or 1, the tumour is benign.

When the fifth number is 2 (in situ), 3 (malignant), or 6 (metastatic, originating from somewhere else), the tumour is malignant.

ANNEX 2**OPERATION CODES**

The most frequently used Nordic codes:

<u>Definition</u>	<u>Code</u>
Biopsy of mammary gland	HAA10
Excision of lesion of mammary gland	HAB00
Excision of lactiferous duct	HAB20
Excision of mamilla or areola	HAB30
Wedge excision of mammary gland	HAB40
Other partial excision of mammary gland	HAB99
Subcutaneous mastectomy with preserv. of mamilla	HAC10
Subcutaneous mastectomy with excision of mamilla	HAC15
Total mastectomy	HAC20
Radical mastectomy	HAC25
Other mastectomy	HAC99
Reconstruction of breast using graft or flap	HAE10
Excision of local recurrence of breast cancer	HAF00
Repair after excision of local recurrence of breast cancer using graft or flap	HAF10
Block dissection of axillary lymph nodes	PJD52
Excision of axillary lymph nodes	PJD42

ANNEX 3pT Primary tumour

The pathological classification requires examination of the primary carcinoma with no gross tumour at the margins of resection. A case can be classified as pT if there is only a microscopic tumour in a margin. The tumour size is a measurement of the invasive component. If there is a large in situ component and a small invasive component, the tumour is classified according to the invasive component.

pTX Primary tumour cannot be assessed, **code X**

pT0 No evidence of primary tumour, **code 0**

pTis Carcinoma in situ, **code IS**

- ductal carcinoma in situ (Tis DCIS)
- lobular carcinoma in situ (Tis LCIS)
- Paget's disease of the nipple with no tumour (Tis Paget)

pT1 Tumour 2 cm or less in greatest dimension, **code 1**

- microinvasion in greatest dimension ≤ 0.1 cm (T1mic), **code 1m**
- more than 0.1 cm but not more than 0.5 cm (T1a), **code 1a**
- more than 0.5 cm but not more than 1.0 cm (T1b), **code 1b**
- more than 1 cm but not more than 2 cm (T1c), **code 1c**

pT2 Tumour more than 2 cm but not more than 5 cm, **code 2**

pT3 Tumour more than 5 cm, **code 3**

pT4 Tumour of any size with direct extension to chest wall (= ribs, intercostal muscles, serratus anterior muscles, no pectoralis muscle) or skin, **code 4**

- extension to chest wall (T4a), **code 4a**
- oedema (including peau d'orange), or ulceration of the skin of the breast, or satellite skin nodules confined to the same breast (T4b), **code 4b**
- T4a and T4b together (T4c), **code 4c**
- inflammatory carcinoma (diffused brawny induration of the skin with erysipeloid edge, usually with no underlying mass) (T4d), **code 4d**

Dimpling of the skin, nipple retraction, or other skin changes (except those in T4b or T4d) may occur in pT1, pT2, or pT3 without affecting the classification.

pN Regional lymph nodes

The pathological classification requires resection and examination of at least the low axillary lymph nodes (level I). Such resection will ordinarily include six or more lymph nodes. If the lymph nodes are negative but the number ordinarily examined is not met, classify as pN0.

pNX Regional lymph nodes cannot be assessed (not removed for study or previously removed), **code X**

pN0 No regional lymph node metastasis, **code 0**

pN1 Metastasis in 1–3 ipsilateral axillary lymph nodes, **code 1**

- metastasis in 1–3 axillary lymph nodes, including at least one larger than 2 mm in greatest dimension (N1a), **code 1a**
- internal mammary lymph nodes with microscopic metastasis detected by sentinel node dissection but not clinically apparent, **code 1b**
- metastasis in 1–3 axillary lymph nodes and internal mammary lymph nodes with microscopic metastases detected by sentinel lymph node dissection but not clinically apparent, **code 1c**

pN2 Metastasis in 4–9 ipsilateral axillary lymph nodes, or in clinically apparent ipsilateral internal mammary lymph node(s) in the absence of axillary lymph node metastasis, **code 2**

- metastasis in 4–9 axillary lymph nodes, including at least one that is larger than 2 mm, **code 2a**
- metastasis in clinically apparent internal mammary lymph node(s), in the absence of axillary lymph node metastasis, **code 2b**

pN3 Metastasis in 10 or more ipsilateral lymph nodes, **code 3**

- metastasis in 10 or more axillary lymph nodes (at least one larger than 2 mm) or metastasis in infraclavicular lymph nodes, **code 3a**
- metastasis in clinically apparent internal mammary lymph node(s) in the presence of positive axillary lymph node(s); or metastasis in more than three axillary lymph nodes and in internal mammary lymph nodes with microscopic metastasis detected by sentinel lymph node dissection but not clinically apparent, **code 3b**
- metastasis in supraclavicular lymph node(s), **code 3c**

pM Distant metastases

MX Distant metastasis cannot be assessed, **code X**

M0 No distant metastasis, **code 0**

M1 Distant metastasis, **code 1**

ANNEX 4

STAGE

International Union Against Cancer (UICC) 2002. TNM Classification of Malignant Tumours. Sixth Edition. Wiley-Liss, New York.

STAGE	pT	pN	pM	CODE
Stage 0	Tis	N0	M0	0 (0)
Stage I	T1	N0	M0	1 (I)
Stage IIA	T0-1	N1	M0	2A, 2 (IIA, II)*
	T2	N0	M0	2A, 2 (IIA, II)*
Stage IIB	T2	N1	M0	2B, 2 (IIB, II)*
	T3	N0	M0	2B, 2 (IIB, II)*
Stage IIIA	T0-2	N2	M0	3A, 3 (IIIA, III)**
	T3	N1-2	M0	3A, 3 (IIIA, III)**
Stage IIIB	T4	Any N	M0	3B, 3 (IIIB, III)**
	Any T	N3	M0	3B, 3 (IIIB, III)**
Stage IV	Any T	Any N	M1	4 (IV)

* If code 2A or 2B (IIA or IIB) is not available, code 2 is accepted (II).

** If code 3A or 3B (IIIA or IIIB) is not available, code 3 is accepted (III).

ANNEX 5

HISTOPATHOLOGICAL GRADING

<u>Definition</u>	<u>CODE</u>
G1 Well differentiated	1 (I)
G2 Intermediately differentiated	2 (II)
G3 Poorly differentiated	3 (III)