The below data dictionary is for the EA1141 analysis dataset: "ea1141_year0_tomolesions_outcome.sas7bdat".

This dataset contains one record per reported lesion for participants with a positive Year 0 Tomo screen, and is unique by SUBJECT_DE and TOMO_LESIONNUM_YR0. **Participants without a Year 0 Tomo screen or with a negative Year 0 Tomo screen (Final BIRADS 1-2) DO NOT appear in this data set.** There are a total of 72 variables contained in this dataset.

Variable name	**Variable definition**	**Code Table/Values** 'Num' signifies numeric variable 'Char' signifies character/text variable Otherwise, variables are numeric with coded values as indicated
Year 0 Tomo lesion-specific variables and recommendation variables [15 variables]		
SUBJECT_DE	De-identified case number (numeric).	Num
TOMO_LESIONNUM_YR0	Year 0 Tomo lesion number [taken from LES_NUM from the Tomosynthesis YR-0 Lesions form, and the corresponding lesion number element in the Final Management, Needle Biopsy Pathology, Surgical Biopsy Pathology and BIRADS 3 6-month FUP forms] (character).	Char ($400.) Possible values are: "T0-1" "T0-2" "T0-3"
TOMO_LESIONBREAST_YR0	Breast of reported lesion [taken from BRST from the Tomosynthesis YR-0 Lesions form] (numeric, code table).	.M=Missing 1=Right breast 2=Left breast
TOMO_LESIONVIEWSSEEN_YR0	What views was lesion seen on? [taken from LES_SEEN_VIEWS from the Tomosynthesis YR-0 Lesions form] (numeric, code table).	.M=Missing 1=2D 2=Tomosynthesis 3=Both 2D and Tomosynthesis
TOMO_LESIONSEENUS_YR0	Was lesion seen on ultrasound? [taken from LES_SEEN_ULTRA from the Tomosynthesis YR-0 Lesions form] (numeric, code table).	.M=Missing 0=No 1=Yes 2=Ultrasound not performed for this lesion
TOMO_LESIONLOCATION_YR0	Location of lesion [taken from LES_LOC_1 from the Tomosynthesis YR-0 Lesions form] (numeric, code table).	.M=Missing 1=Quadrant axillary tail 2=Central/Subareolar region 3=Lower-inner quadrant 4=Lower-outer quadrant

		5=Upper-inner quadrant 6=Upper-outer quadrant 7=Subareolar
TOMO_LESIONCLOCK_YR0	Clock position of lesion [taken from CLOCK_POS from the Tomosynthesis YR-0 Lesions form] (numeric).	1-12 .M=Missing
TOMO_LESIONDISTNIPPLE_YR0	Distance of lesion from nipple [taken from DIST_NIPPL from the Tomosynthesis YR-0 Lesions form] (numeric, code table).	.M=Missing 1=Anterior 1/3 2=Middle 1/3 3=Posterior 1/3
TOMO_LESIONFINDINGTYPE_YR0	Finding type [taken from TP_FINDING from the Tomosynthesis YR-0 Lesions form] (numeric, code table).	.M=Missing 1=Architectural distortion 2=Calcification(s) 3=Mass 4=Asymmetry/Focal asymmetry 5=Mass and calcifications 6=Distortion and calcifications
TOMO_LESIONMAXDIAM_YR0	Greatest diameter of lesion (cm) [taken from MAX_DIAM_1 from the Tomosynthesis YR-0 Lesions form] (numeric).	Num .M=Missing
TOMO_LESIONBIRADS_YR0	Lesion BIRADS [taken from BIRADS-3_5 from the Tomosynthesis YR-0 Lesions form] (numeric, code table).	3=3:Probably Benign 4=4:Suspicious Abnormality 5=5:Highly Suggestive of Malignancy
TOMO_LESIONREPORTEDMRI_YR0	Was the lesion also reported as BIRADS 3, 4, or 5 on the MRI blinded reading? [taken from LES_RP_MRI_READ_YN from the Final Management – Tomo Lesions form located in the Visit 1 folder] (numeric, code table).	0=No 1=Yes
TOMO_LESIONREPORTEDMRI NUM_YR0	Corresponding Year 0 MRI lesion number [taken from LES_NUM_MR from the Final Management – Tomo Lesions form located in the Visit 1 folder] (character). ***NOTE: This variable is only populated if TOMO_LESIONREPORTEDMRI_YR0=1. Otherwise, it is .N.***	Char ($400.) .N=N/A Possible values are: “M0-1” “M0-2” “M0-3” “M0-4”

TOMO_LESIONREC_YR0	Recommendation for lesion [taken from REC_DBT from the Final Management – Tomo Lesions form located in the Visit 1 folder] (numeric, code table).	1=Stereotactic-guided core biopsy 2=Ultrasound-guided core biopsy 3=MR-guided core biopsy 4=Surgical biopsy 5=6-month follow-up 99=Other
TOMO_LESIONREC_OTHERSPEC_YR0	Recommendation for lesion, other specify [taken from REC_DBT from the Final Management – Tomo Lesions form located in the Visit 1 folder] (character). ***NOTE: This variable is only populated if TOMO_LESIONREC_YR0=99. Otherwise, it is .N.***	Char ($400.) .N=N/A
Year 0 Tomo BIRADS 3 6-month FUP variables [7 variables]		
TOMO_LESION6MONTHFUP_YR0	Was 6-month FUP imaging performed? [taken from _6_MTH_FU_IMAG_YN_V2 from the BIRADS 3 Follow-up form located in the Visit 1 folder] (numeric, code table).	.N=N/A (6-month FUP imaging was not recommended for the lesion in question) .F=Form not yet submitted 0=No 1=Yes
TOMO_LESION6MONTHREAS_YR0	Reason 6-month FUP imaging was not performed? [taken from _6_MTH_FU_IMAG_NOT_PERF_V2 from the BIRADS 3 Follow-up form located in the Visit 1 folder] (numeric, code table).	.N=N/A (6-month FUP imaging was not recommended for the lesion in question, or 6-month FUP imaging was performed) .F=Form not yet submitted 1=Patient refused completion of the follow-up 2=Patient failed to return for follow-up, reason unknown 3=Denied by insurance 4=Patient withdrew consent 5=Biopsy performed instead – patient or referring physician preferred biopsy instead of follow-up 6=Biopsy performed instead - radiologist recommended biopsy

		7=Tomo lesion was not seen on MRI, and so was not followed at 6 months
		8=Patient deceased
TOMO_LESION6MONTHDATE_YR0_YYYY TOMO_LESION6MONTHDATE_YR0_DAYS	Date of 6-month FUP imaging [taken from _6_MTH_FU_IMAG_DT_V2 from the BIRADS 3 Follow-up form located in the Visit 1 folder] (numeric, date). ***NOTE: Per HIPAA standards, for each date, the exact date is not given. Instead, two variables are supplied, one giving the year, and one giving days since the baseline date.***	Num .N=N/A (6-month FUP imaging was not recommended for the lesion in question, or 6-month FUP imaging was not performed) .F=Form not yet submitted
TOMO_LESION6MONTHMODALITY_YR0	Imaging modality used for 6-month FUP imaging [taken from the variables _2D_MAMMO_V2, TOMO_V2, ULTRA_V2, MRI_V2, OTH_IMAG_MODL_V2 from the BIRADS 3 Follow-up form located in the Visit 1 folder] (numeric, code table).	.N=N/A (6-month FUP imaging was not recommended for the lesion in question, or 6-month FUP imaging was not performed)
		.F=Form not yet submitted
		1=2D mammography
		2=Tomosynthesis
		3=Ultrasound
		4=MRI
		5=2D mammography and Tomosynthesis
		6=2D mammography, Tomosynthesis, and Ultrasound
		7=Tomosynthesis and Ultrasound
		8=2D mammography and Ultrasound
		9=Ultrasound and MRI
TOMO_LESION6MONTHOUTCOME_YR0	BIRADS recommendation based on 6-month FUP imaging for the lesion that was followed [taken from OUTCOME_V2 from the BIRADS 3 Follow-up form located in the Visit 1 folder] (numeric, code table).	.N=N/A (6-month FUP imaging was not recommended for the lesion in question, or 6-month FUP imaging was not performed)
		.F=Form not yet submitted
		1=1:Negative
		2=2:Benign
		3=3:Probably Benign
		4=4:Suspicious Abnormality

TOMO_LESION6MONTHBIOPSY_YR0	If BIRADS 4 or 5, or if biopsy was done instead, what type of biopsy was recommended/done? [taken from BIRADS_4_5_V2 and _6_MTH_FU_BX_V2 from the BIRADS 3 Follow-up form located in the Visit 1 folder] (numeric, code table).	.N=N/A (6-month FUP imaging was not recommended for the lesion in question, or 6-month FUP imaging was not performed, or new BIRADS was 1-3) .F=Form not yet submitted 1=Needle biopsy (FNAB or core needle biopsy) 2=Surgical biopsy
Year 0 Tomo Core needle biopsy variables [20 variables]		
TOMO_CORE_YR0	Was a core needle biopsy performed? [taken from WAS_BIOP_SURG_PERF from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table).	.N=N/A (Core biopsy was not recommended for the lesion in question) .F=Form not yet submitted 0=No 1=Yes
TOMO_COREREAS_YR0	Reason core needle biopsy was not performed? [taken from REAS_CORE_NDL_BX_NOT_DONE from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_CORE_YR0=0:No.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was performed) .F=Form not yet submitted 1=Surgical biopsy was performed instead of core needle biopsy 2=Patient refusal 3=Patient did not return 4=Medical contraindications 5=Changed by radiologist to BIRADS 3 6=Lesion resolved/benign 9=Lesion could not be visualized at time of biopsy – patient returned to annual screening
TOMO_COREDATE_YR0_YYYY TOMO_COREDATE_YR0_DAYS	Date of core needle biopsy [taken from SURG_DT from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, date). ***NOTE: Per HIPAA standards, for each date, the exact date is not given. Instead, two variables are supplied, one giving the year, and one giving days since the baseline date.***	Num .N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed) .F=Form not yet submitted

TOMO_CORETYPE_YR0	Type of needle biopsy [taken from TP_PROC from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table).	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed) .F=Form not yet submitted 1=Core needle biopsy 2=Vacuum-assisted biopsy 3=Aspiration – fluid discarded
TOMO_COREGUIDE_YR0	Method of image guidance [taken from IMAG_GUIDE_METHOD from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table).	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed) .F=Form not yet submitted 1=Ultrasound 2=Stereotactic prone 3=Stereotactic upright 4=Mammographic 5=MRI 6=No image guidance 98=Unknown 99=Other
TOMO_COREPATH_YR0	Pathology/Cytology results [taken from PATH_CYT_RESULTS from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: For case 248152, the T0-1 lesion noted for type of needle biopsy on the Needle Biopsy Pathology form that an aspiration was done and the fluid discarded. Per the study investigator, this is a benign finding. For this instance, TOMO_COREPATH_YR0=1 and TOMO_COREPATH_BENIGN_YR0=23.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed) .F=Form not yet submitted 1=Benign 2=Benign with atypia or high-risk lesion 3=Malignant
TOMO_COREPATH_BENIGN_YR0	If benign, pathology/cytology entity from the most significant lesion [taken from PATH_BENIGN from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_COREPATH_YR0 in(1,2); otherwise, it is set to .N.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not benign) .F=Form not yet submitted 1=Fibroadenoma 2=Fibrosis 3=Fibrodenomatoid

		4=Usual ductal hyperplasia
		5=Duct ectasia
		6=Sclerosing adenosis
		7=Fibrocystic changes
		8=Apocrine metaplasia
		9=Fat necrosis
		10=Papilloma without atypia
		11=Abscess
		12=Lymph node
		13=PASH
		14=Tubular adenoma
		15=Complex sclerosing lesion/radial scar
		16=Atypical ductal hyperplasia
		17= Atypical lobular hyperplasia
		18=Classic LCIS
		19=Atypical papilloma
		20=Columnar alteration with atypia
		21=Columnar cell changes
		22=Flat epithelial atypia (FEA)
		23=Aspiration – fluid discarded
		99=Other
TOMO_COREPATH_BENIGN_OTH_YR0	If benign, pathology/cytology entity from the most significant lesion, other specify [taken from PATH_BENIGN from the Needle Biopsy Pathology form located in the Visit 1 folder] (character). ***NOTE: This element is only populated if TOMO_COREPATH_BENIGN_YR0=99; otherwise, it is set to .N.***	Char ($400.) .N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not benign) .F=Form not yet submitted
TOMO_COREPATH_MALIG_YR0	If malignant, pathology/cytology entity from the most significant lesion [taken from PATH_MALIGNANT from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_COREPATH_YR0=3; otherwise, it is set to .N.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not malignant)
		.F=Form not yet submitted
		1=Invasive (infiltrating) ductal carcinoma
		2=Invasive lobular carcinoma

		3=Invasive with mixed ductal/lobular features
		4=DCIS
TOMO_COREPATH_GRADE_YR0	Grade of cancer [taken from GRADE from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_COREPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not malignant)
		.F=Form not yet submitted
		1=Low (Grade I)
		2=Intermediate (Grade II)
		3=High (Grade III)
		99=Grade cannot be assessed/not reported
TOMO_COREPATH_DCPATTERN_YR0	Ductal carcinoma pattern [taken from PATTERN_DCIS from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_COREPATH_MALIG_YR0=4:DCIS; otherwise, it is set to .N.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not DCIS)
		.F=Form not yet submitted
		1=Cribform
		2=Comedo
		3=Mixed
		4=NOS
		5=Solid and cribriform with comedonecrosis
		6=Solid
		99=Unknown
TOMO_COREPATH_INVASPATTERN_YR0	Invasive pattern [taken from PATTERN from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_COREPATH_MALIG_YR0 in(1,2,3), i.e. invasive; otherwise, it is set to .N.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not invasive)
		.F=Form not yet submitted
		.M=Missing
		1=Tubular
		2=Colloid/mucinous
		3=Medullary
		4=Micropapillary
		5=NOS
		6=Unknown

TOMO_COREPATH_DIFF_YR0	Differentiation [taken from DIFFNTION from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_COREPATH_MALIG_YR0 in(1,2,3), i.e. invasive; otherwise, it is set to .N.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not invasive) .F=Form not yet submitted 1=Well differentiated 2=Moderately differentiated 3=Poorly differentiated
TOMO_COREPATH_VASCULAR_YR0	Was vascular or lymphovascular or angiolymphatic invasion present? [taken from VASC_LYMPH_INV_CNCR from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_COREPATH_MALIG_YR0 in(1,2,3), i.e. invasive; otherwise, it is set to .N.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not invasive) .F=Form not yet submitted 0=No 1=Yes
TOMO_COREPATH_ER_YR0	ER status [taken from ADDTL_TST_ER from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_COREPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not malignant) .F=Form not yet submitted 1=Positive 2=Negative 3=Weak 4=Not performed
TOMO_COREPATH_PR_YR0	PR status [taken from ADDTL_TST_PR from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_COREPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not malignant) .F=Form not yet submitted 1=Positive 2=Negative 3=Weak 4=Not performed

TOMO_COREPATH_HER2_YR0	HER2 status [taken from ADDTL_TST_HER2 from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_COREPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not malignant) .F=Form not yet submitted 1=Positive 2=Negative 3=Weak 4=Not performed
TOMO_COREPATH_KI67_YR0	Ki67 status [taken from ADDTL_TST_KI67 from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_COREPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not malignant) .F=Form not yet submitted 1=Positive 2=Negative 3=Weak 4=Not performed
TOMO_COREPATH_SURG_YR0	Was a surgical biopsy recommended? [taken from SURG_BX_REC from the Needle Biopsy Pathology form located in the Visit 1 folder] (numeric, code table).	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed) .F=Form not yet submitted 0=No 1=Yes
Year 0 Tomo Surgical biopsy variables [28 variables]		
TOMO_SURG_YR0	Was a surgical biopsy performed? [taken from WAS_BIOP_SURG_PERF from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table).	.N=N/A (Surgical biopsy was not recommended for the lesion in question) .F=Form not yet submitted 0=No 1=Yes

TOMO_SURGREAS_YR0	Reason surgical biopsy was not performed? [taken from REAS_BIOP_SURG_NOT_DONE from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURG_YR0=0:No.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was performed) .F=Form not yet submitted 1=Medical contraindications 2=Patient refusal 3=Core needle biopsy performed instead 4=Patient and surgical oncologist decision not to excise 5=Patient did not return
TOMO_SURGREAS6MO_YR0	If a surgical biopsy was not performed, was 6-month FUP recommended? [taken from _6_MTH_FU_PERF_YN from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURG_YR0=0:No.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was performed) .F=Form not yet submitted 0=No 1=Yes
TOMO_SURGDATE_YR0_YYYY TOMO_SURGDATE_YR0_DAYS	Date of surgical biopsy [taken from SURG_DT from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, date). ***NOTE: Per HIPAA standards, for each date, the exact date is not given. Instead, two variables are supplied, one giving the year, and one giving days since the baseline date.***	Num .N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed) .F=Form not yet submitted
TOMO_SURGTYPE_YR0	Type of surgical procedure [taken from TP_PROC_SURG_BX from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table).	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed) .F=Form not yet submitted 1=Excisional biopsy for diagnosis 2=Excision of high-risk lesion on needle biopsy 3=Lumpectomy for cancer 4=Mastectomy

TOMO_SURGLOCALIZE_YR0	Was localization performed prior to surgery [taken from LOCAL_PRIOR_SURG from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table).	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed) .F=Form not yet submitted 0=No 1=Yes
TOMO_SURGLOCALIZETYPE_YR0	Type of localization [taken from LOCAL_TP from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This variable is only populated if TOMO_SURGLOCALIZE_YR0=1:Yes; otherwise, it is set to .N.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or localization was not performed) .F=Form not yet submitted 1=Ultrasound 2=Mammographic grid 3=Stereotactic 4=MRI 5=No image guidance 98=Unknown 99=Other
TOMO_SURGPATH_YR0	Pathology results [taken from PATH_CYT_RESULTS from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table).	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed) .F=Form not yet submitted 1=Benign 2=Benign with atypia or high-risk lesion 3=Malignant
TOMO_SURGPATH_BENIGN_YR0	If benign, pathological entity from the most significant lesion [taken from PATH_BENIGN from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_YR0 in(1,2); otherwise, it is set to .N.***	.N=N/A (Core biopsy was not recommended for the lesion in question, or core biopsy was not performed, or pathology was not benign) .F=Form not yet submitted 1=Fibroadenoma 2=Fibrosis 3=Fibrodenomatoid 4=Usual ductal hyperplasia 5=Duct ectasia 6=Sclerosing adenosis 7=Fibrocystic changes

		8=Apocrine metaplasia 9=Fat necrosis 10=Papilloma without atypia 11=Abscess 12=Lymph node 13=PASH 14=Tubular adenoma 15=Complex sclerosing lesion/radial scar 16=Atypical ductal hyperplasia 17= Atypical lobular hyperplasia 18=Classic LCIS 19=Atypical papilloma 20=Columnar alteration with atypia 21=Columnar cell changes 22=Flat epithelial atypia (FEA) 99=Other
TOMO_SURGPATH_BENIGN_OTH_YR0	If benign, pathological entity from the most significant lesion, other specify [taken from PATH_BENIGN from the Surgical Biopsy Pathology form located in the Visit 1 folder] (character). ***NOTE: This element is only populated if TOMO_SURGPATH_BENIGN_YR0=99; otherwise, it is set to .N.***	Char ($400.) .N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not benign) .F=Form not yet submitted
TOMO_SURGPATH_MALIG_YR0	If malignant, pathological entity from the most significant lesion [taken from PATH_MALIGNANT from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_YR0=3; otherwise, it is set to .N.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant) .F=Form not yet submitted 1=Invasive (infiltrating) ductal carcinoma 2=Invasive lobular carcinoma 3=Invasive with mixed ductal/lobular features 4=DCIS

TOMO_SURGPATH_DIAM_YR0	If malignant, largest diameter of the carcinoma (cm) [taken from DIAM_MALIGNANT from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric). ***NOTE: This element is only populated if TOMO_SURGPATH_YR0=3; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	Num .N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant) .F=Form not yet submitted .M=Missing
TOMO_SURGPATH_GRADE_YR0	Grade of cancer [taken from GRADE from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant) .F=Form not yet submitted 1=Low (Grade I) 2=Intermediate (Grade II) 3=High (Grade III) 99=Grade cannot be assessed/not reported
TOMO_SURGPATH_DCPATTERN_YR0	Ductal carcinoma pattern [taken from PATTERN_DCIS from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_MALIG_YR0=4:DCIS; otherwise, it is set to .N.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not DCIS) .F=Form not yet submitted 1=Cribform 2=Comedo 3=Mixed 4=NOS 5=Solid and cribriform with comedonecrosis 6=Solid 99=Unknown
TOMO_SURGPATH_INVASPATTERN_YR0	Invasive pattern [taken from PATTERN from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_MALIG_YR0 in(1,2,3), i.e. invasive; otherwise, it is set to .N.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not invasive) .F=Form not yet submitted .M=Missing 1=Tubular 2=Colloid/mucinous

		3=Medullary
		4=Micropapillary
		5=NOS
		6=Unknown
TOMO_SURGPATH_DIFF_YR0	Differentiation [taken from DIFFNTION from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_MALIG_YR0 in(1,2,3), i.e. invasive; otherwise, it is set to .N.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not invasive)
		.F=Form not yet submitted
		.M=Missing
		1=Well differentiated
		2=Moderately differentiated
		3=Poorly differentiated
TOMO_SURGPATH_VASCULAR_YR0	Was vascular or lymphovascular or angiolymphatic invasion present? [taken from VASC_LYMPH_INV_CNCR from the Surgical Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_MALIG_YR0 in(1,2,3), i.e. invasive; otherwise, it is set to .N.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not invasive)
		.F=Form not yet submitted
		.M=Missing
		0=No
		1=Yes
TOMO_SURGPATH_ER_YR0	ER status [taken from ADDTL_TST_ER from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant)
		.F=Form not yet submitted
		.M=Missing
		1=Positive
		2=Negative
		3=Weak
		4=Not performed
TOMO_SURGPATH_PR_YR0	PR status [taken from ADDTL_TST_PR from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant)
		.F=Form not yet submitted
		.M=Missing

		1=Positive
		2=Negative
		3=Weak
		4=Not performed
TOMO_SURGPATH_HER2_YR0	HER2 status [taken from ADDTL_TST_HER2 from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant)
		.F=Form not yet submitted
		.M=Missing
		1=Positive
		2=Negative
		3=Weak
		4=Not performed
TOMO_SURGPATH_KI67_YR0	Ki67 status [taken from ADDTL_TST_KI67 from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant)
		.F=Form not yet submitted
		.M=Missing
		1=Positive
		2=Negative
		3=Weak
		4=Not performed
TOMO_SURGPATH_CHEMO_YR0	Did the patient have neoadjuvant chemotherapy prior to surgery? [taken from PT_NEOADJ_CHEMO from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant)
		.F=Form not yet submitted
		0=No
		1=Yes
TOMO_SURGPATH_LYMPHBIOP_YR0	Did the patient have a preoperative axillary lymph node biopsy? [taken from PT_PREOP_BX from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant)
		.F=Form not yet submitted
		0=No
		1=Yes

TOMO_SURGPATH_LYMPHINVOL_YR0	Was there histological evidence of lymph node involvement? [taken from HIST_LYMPH_NODE from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_LYMPHBIOP_YR0=1:Yes; otherwise, it is set to .N.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant, or preoperative axillary lymph node biopsy was not performed) .F=Form not yet submitted 0=No 1=Yes
TOMO_SURGPATH_SENTINEL_YR0	Was a sentinel node biopsy performed at the time of surgery? [taken from SENT_BX_SURG_YN from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_YR0=3:Malignant; otherwise, it is set to .N. However, it is completed for both DCIS and invasive cancers.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant) .F=Form not yet submitted 0=No 1=Yes
TOMO_SURGPATH_DISS_YR0	Was axillary dissection performed at the time of surgery? [taken from AXILL_DISS_SURG_YN from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_SENTINEL_YR0=1:Yes; otherwise, it is set to .N.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant, or sentinel node biopsy was not performed) .F=Form not yet submitted 0=No 1=Yes
TOMO_SURGPATH_EXTRACAP_YR0	Was there evidence of extracapsular nodal extension? [taken from EXTR_CAPS_NODES from the Surgical Biopsy Pathology form located in the Visit 1 folder] (numeric, code table). ***NOTE: This element is only populated if TOMO_SURGPATH_SENTINEL_YR0=1:Yes; otherwise, it is set to .N.***	.N=N/A (Surgical biopsy was not recommended for the lesion in question, or surgical biopsy was not performed, or pathology was not malignant, or sentinel node biopsy was not performed) .F=Form not yet submitted 0=No 1=Yes 99=Unknown

Year 0 Tomo Final lesion outcome variables [2 variables]		
TOMO_LESIONOUTCOME_YR0	Final lesion outcome/resolution [taken from above derived variables] (character).	Char ($400.) .M=Data element missing .F=Lesion outstanding/ unresolved
TOMO_LESIONOUTCOMEDETAIL _YR0	Final lesion outcome/resolution – with detailed pathology for benign lesions and invasive lesions [taken from above derived variables] (character).	Char ($400.) .M=Data element missing .F=Lesion outstanding/ unresolved