Project Details	
Name	BC Bladder Data Dictionary
Organisation(s)	UHS

Versioning	
Version	v0.1 (DRAFT)
Version Notes	

Cohort	
Inclusion Criteria	Diagnosis of muscle invasive (T>1) urothelial (ICD-O-3 morphology codes: 8120, 8130) bladder cancer (ICD-10 C67) diagnosed during study period; Non-metastatic (M0) disease at high risk of recurrence T2-T4a or N+; Received radical resection surgery following primary diagnosis; Patients with a minimum of 6-months of continuous enrolment post index or confirmed death within the follow-up period time frame.
Exclusion Criteria	Aged <18; Missing TNM stage; Missing morphology; Prior malignancy active within the previous 3 years from the index date.

Metadata	
Template Version	v1.1
Tables	13
Columns	167
Issues	None

Table	Description	CHECKS
CONCEPT	Standard vocabulary table containing clinical codes, terms, and concept definitions	
CONDITION_OCCURRENCE	Patient diagnoses, medical conditions, and clinically recorded problems	
DEATH	Records of patient death status, including relevant dates where available	
DEMOGRAPHICS	Patient demographic information such as age, sex, ethnicity, and related attributes	
DRUG_EXPOSURE	Records of patient medication prescribing, dispensing, or administration	
DRUG_STRENGTH	Reference information describing the strength and dosage form of drugs	
EPISODE	Groups of related healthcare activity linked to a period of care	
EPISODE_EVENT	Links between care episodes and the clinical events within them	
MEASUREMENT	Laboratory tests, numeric clinical results, and other measured values	
OBSERVATION	Clinical observations, findings, and other recorded patient information	
PERSON	Core patient-level details and identifiers used across the dataset	
PROCEDURE_OCCURRENCE	Records of surgical, diagnostic, or clinical procedures performed	
VISIT_OCCURRENCE	Patient healthcare encounters, including admissions, appointments, and visits	

Table	Column	Order	Data Type	Length	Vocabularies	Enumerations	Primary Key	Foreign Key Target	Column Description	CHECKS
CONCEPT_DESCRIPTIONS	COLUMN_NAME	1	Text	64					Name of the column in the concept descriptions table	OK
CONCEPT_DESCRIPTIONS	CONCEPT_ID	2	Integer	64					Unique identifier for the concept	OK
CONCEPT_DESCRIPTIONS	DESCRIPTION	3	Text	207					Human-readable description of the concept	OK
CONCEPT_DESCRIPTIONS	TABLE_NAME	4	Text	64					Name of the table where this concept is used	OK
CONDITION_OCCURRENCE	BC_DATE_TYPE	1	Text	19					Whether the reported date is the date the comorbidity was diagnosed or documented	OK
CONDITION_OCCURRENCE	BC_START_DATE_MISSING_TYPE	2	Float						Indicator of how the start date is missing (unknown, not applicable, etc.)	OK
CONDITION_OCCURRENCE	CONDITION_CONCEPT_ID	3	Integer						Standardized concept ID for the comorbidity condition	OK
CONDITION_OCCURRENCE	CONDITION_END_DATE	4	Float						End date of the comorbidity condition	OK
CONDITION_OCCURRENCE	CONDITION_OCCURRENCE_ID	5	Integer	64					Unique identifier for the comorbidity occurrence record	OK
CONDITION_OCCURRENCE	CONDITION_SOURCE_CONCEPT_ID	6	Float						Source concept ID for the comorbidity	OK
CONDITION_OCCURRENCE	CONDITION_SOURCE_VALUE	7	Text	62					Original comorbidity code/value from the source system	OK
CONDITION_OCCURRENCE	CONDITION_START_DATE	8	Date						Date when the comorbidity was diagnosed or first documented	OK
CONDITION_OCCURRENCE	CONDITION_STATUS_CONCEPT_ID	9	Float						Concept ID indicating the status of the condition (active, resolved, etc.)	OK
CONDITION_OCCURRENCE	CONDITION_STATUS_SOURCE_VALUE	10	Float						Original status value from source system	OK
CONDITION_OCCURRENCE	CONDITION_TYPE_CONCEPT_ID	11	Integer						Concept ID for the type of condition occurrence	OK
CONDITION_OCCURRENCE	PERSON_ID	12	Integer						Unique pseudonymized identifier for the patient	OK
CONDITION_OCCURRENCE	STOP_REASON	13	Float						Reason why the condition was stopped or resolved	OK
CONDITION_OCCURRENCE	VISIT_DETAIL_ID	14	Float						Identifier linking to the visit detail where condition was recorded	OK
CONDITION_OCCURRENCE	VISIT_OCCURRENCE_ID	15	Float						Identifier linking to the visit where condition was recorded	OK
DEATH	CAUSE_CONCEPT_ID	1	Float						Concept ID for the cause of death	OK
DEATH	CAUSE_SOURCE_CONCEPT_ID	2	Float						Source concept ID for the cause of death	OK
DEATH	CAUSE_SOURCE_VALUE	3	Float						Original cause of death value from source system (ICD10 code or text)	OK
DEATH	DEATH_DATE	4	Date						Date of death of the subject	OK
DEATH	DEATH_TYPE_CONCEPT_ID	5	Float						Concept ID for the type of death record	OK
DEATH	PERSON_ID	6	Integer	64					Unique pseudonymized identifier for the deceased patient	OK
DEMOGRAPHICS	BC_ABSTR_DATE	1	Date						Date when the data for the study was abstracted from the patient records	OK
DEMOGRAPHICS	BC_COUNTRY_SUBDIVISION	2	Text	6					Country subdivision (e.g., region, county) of the patient	OK
DEMOGRAPHICS	BC_DEATH_RECORD_CHECKED	3	Text	5					Indicator of whether the death record was checked	OK
DEMOGRAPHICS	BC_DEATH_RECORD_DATE	4	Float						Date when the death record was checked or retrieved from the national death registry	OK
DEMOGRAPHICS	BC_LAST_CONTACT_DATE	5	Date						Date of the subject last contact with the treating provider	OK
DEMOGRAPHICS	BC_SOURCE_LAST_CONTACT_DATE	6	Text	15					Last contact date from the source system	OK
DEMOGRAPHICS	PERSON_ID	7	Integer	64					Unique pseudonymized identifier for the patient	OK
DRUG_EXPOSURE	BC_CLINICAL_TRIAL	1	Text	3					Whether the treatment was administered as part of a clinical trial (Y/N)	OK
DRUG_EXPOSURE	BC_END_DATE_MISSING_TYPE	2	Float						Indicator of how the end date is missing	OK
DRUG_EXPOSURE	BC_START_DATE_MISSING_TYPE	3	Float						Indicator of how the start date is missing	OK
DRUG_EXPOSURE	DAYS_SUPPLY	4	Float						Number of days the medication is expected to last until resupply or end of medication	OK
DRUG_EXPOSURE	DOSE_UNIT_SOURCE_VALUE	5	Text	7					Original unit of measurement for the drug dose from source system	OK
DRUG_EXPOSURE	DRUG_CONCEPT_ID	6	Integer						Standardized concept ID for the drug	OK
DRUG_EXPOSURE	DRUG_EXPOSURE_END_DATE	7	Float						Date when the patient ended the drug administration	OK
DRUG_EXPOSURE	DRUG_EXPOSURE_ID	8	Integer	64					Unique identifier for the drug exposure record	OK
DRUG_EXPOSURE	DRUG_EXPOSURE_START_DATE	9	Date						Date when the patient started the drug administration	OK
DRUG_EXPOSURE	DRUG_SOURCE_CONCEPT_ID	10	Float						Source concept ID for the drug	OK
DRUG_EXPOSURE	DRUG_SOURCE_VALUE	11	Text	29					Original drug name/code from the source system	OK
DRUG_EXPOSURE	DRUG_TYPE_CONCEPT_ID	12	Integer						Concept ID for the type of drug exposure	OK
DRUG_EXPOSURE	LOT_NUMBER	13	Float						Lot number of the medication administered	OK
DRUG_EXPOSURE	PERSON_ID	14	Integer						Unique pseudonymized identifier for the patient	OK
DRUG_EXPOSURE	QUANTITY	15	Float						Quantity of drug administered per supply	OK
DRUG_EXPOSURE	REFILLS	16	Float						Number of refills for the medication	OK
DRUG_EXPOSURE	ROUTE_CONCEPT_ID	17	Float						Concept ID for the route of administration	OK
DRUG_EXPOSURE	ROUTE_SOURCE_VALUE	18	Text	13					Original route of administration from source system (e.g., intravenous, oral)	OK
DRUG_EXPOSURE	SIG	19	Text	56					Signatures/instructions for the medication (prescription directions)	OK
DRUG_EXPOSURE	STOP_REASON	20	Float						Reason for treatment discontinuation (e.g., adverse event, completed, ongoing)	OK

DRUG_EXPOSURE	VERBATIM_END_DATE	21	Float		End date as recorded verbatim from clinical notes	OK
DRUG_EXPOSURE	VISIT_DETAIL_ID	22	Float		Identifier linking to the visit detail where medication was administered	OK
DRUG_EXPOSURE	VISIT_OCCURRENCE_ID	23	Float		Identifier linking to the visit where medication was administered	OK
DRUG_STRENGTH	AMOUNT_UNIT_CONCEPT_ID	1	Integer		Concept ID for the unit of the drug amount	OK
DRUG_STRENGTH	AMOUNT_VALUE	2	Float		Numeric value of the drug amount	OK
DRUG_STRENGTH	BOX_SIZE	3	Float		Number of units in a box/package of the medication	OK
DRUG_STRENGTH	DENOMINATOR_UNIT_CONCEPT_ID	4	Float		Concept ID for the denominator unit (for concentration ratios)	OK
DRUG_STRENGTH	DENOMINATOR_VALUE	5	Float		Numeric value of the denominator (for concentration ratios)	OK
DRUG_STRENGTH	DRUG_CONCEPT_ID	6	Integer	64	Concept ID for the drug this strength applies to	OK
DRUG_STRENGTH	INGREDIENT_CONCEPT_ID	7	Integer	64	Concept ID for the active ingredient	OK
DRUG_STRENGTH	INVALID_REASON	8	Float		Reason if the concept is marked as invalid	OK
DRUG_STRENGTH	NUMERATOR_UNIT_CONCEPT_ID	9	Float		Concept ID for the numerator unit (for concentration ratios)	OK
DRUG_STRENGTH	NUMERATOR_VALUE	10	Float		Numeric value of the numerator (for concentration ratios)	OK
DRUG_STRENGTH	VALID_END_DATE	11	Date		Date until which this drug strength record is valid	OK
DRUG_STRENGTH	VALID_START_DATE	12	Date		Date from which this drug strength record is valid	OK
EPISODE	BC_START_DATE_MISSING_TYPE	1	Float		Indicator of how the start date is missing for the episode	OK
EPISODE	EPISODE_CONCEPT_ID	2	Integer		Concept ID for the type of episode	OK
EPISODE	EPISODE_END_DATE	3	Float		End date of the episode	OK
EPISODE	EPISODE_ID	4	Integer	64	Unique identifier for the episode	OK
EPISODE	EPISODE_NUMBER	5	Float		Sequence number of the episode for a given patient	OK
EPISODE	EPISODE_OBJECT_CONCEPT_ID	6	Integer		Concept ID for the object of the episode (e.g., a condition or procedure)	OK
EPISODE	EPISODE_PARENT_ID	7	Float		Parent episode ID if this episode is nested within another	OK
EPISODE	EPISODE_SOURCE_CONCEPT_ID	8	Float		Source concept ID for the episode	OK
EPISODE	EPISODE_SOURCE_VALUE	9	Text	62	Original episode value from source system	OK
EPISODE	EPISODE_START_DATE	10	Date		Start date of the episode	OK
EPISODE	EPISODE_TYPE_CONCEPT_ID	11	Integer		Concept ID for the type of episode	OK
EPISODE	PERSON_ID	12	Integer		Unique pseudonymized identifier for the patient	OK
EPISODE_EVENT	EPISODE_EVENT_FIELD_CONCEPT_ID	1	Integer		Concept ID for the field within the episode event	OK
EPISODE_EVENT	EPISODE_ID	2	Integer	64	Identifier linking to the parent episode	OK
EPISODE_EVENT	EVENT_ID	3	Integer	64	Identifier linking to the specific event within the episode	OK
MEASUREMENT	BC_DATE_MISSING_TYPE	1	Float		Indicator of how the measurement date is missing	OK
MEASUREMENT	BC_DATE_TYPE	2	Text	19	Indicates if the date is sample withdrawal date, test performed date, or result documented date	OK
MEASUREMENT	MEASUREMENT_CONCEPT_ID	3	Integer		Standardized concept ID for the lab/molecular pathology test	OK
MEASUREMENT	MEASUREMENT_DATE	4	Date		Date of the lab/molecular pathology test	OK
MEASUREMENT	MEASUREMENT_DATETIME	5	Date		Date and time of the lab/molecular pathology test	OK
MEASUREMENT	MEASUREMENT_EVENT_ID	6	Float		Identifier linking to the measurement event	OK
MEASUREMENT	MEASUREMENT_ID	7	Integer	64	Unique identifier for the measurement record	OK
MEASUREMENT	MEASUREMENT_SOURCE_CONCEPT_ID	8	Float		Source concept ID for the measurement	OK
MEASUREMENT	MEASUREMENT_SOURCE_VALUE	9	Text	84	Original test name/code from the source system	OK
MEASUREMENT	MEASUREMENT_TYPE_CONCEPT_ID	10	Integer		Concept ID for the type of measurement	OK
MEASUREMENT	MEAS_EVENT_FIELD_CONCEPT_ID	11	Float		Concept ID for the field within the measurement event	OK
MEASUREMENT	OPERATOR_CONCEPT_ID	12	Float		Concept ID for the comparison operator (<, >, =) used with the numeric result	OK
MEASUREMENT	PERSON_ID	13	Integer		Unique pseudonymized identifier for the patient	OK
MEASUREMENT	RANGE_HIGH	14	Float		Higher bound of the reference range for normal results	OK
MEASUREMENT	RANGE_LOW	15	Float		Lower bound of the reference range for normal results	OK
MEASUREMENT	UNIT_CONCEPT_ID	16	Float		Concept ID for the unit of the measurement result	OK
MEASUREMENT	UNIT_SOURCE_CONCEPT_ID	17	Float		Source concept ID for the unit of measurement	OK
MEASUREMENT	UNIT_SOURCE_VALUE	18	Text	9	Original unit of measurement from source system	OK
MEASUREMENT	VALUE_AS_CONCEPT_ID	19	Float		Concept ID for the type of value (numeric, string, concept)	OK
MEASUREMENT	VALUE_AS_NUMBER	20	Float		Numeric result for the lab/molecular pathology test (can include operator < or > or range)	OK
MEASUREMENT	VALUE_SOURCE_VALUE	21	Text	20	Original qualitative or text result from source system	OK
MEASUREMENT	VISIT_DETAIL_ID	22	Float		Identifier linking to the visit detail where measurement was performed	OK
MEASUREMENT	VISIT_OCCURRENCE_ID	23	Float		Identifier linking to the visit where measurement was performed	OK
OBSERVATION	BC_DATE_MISSING_TYPE	1	Float		Indicator of how the observation date is missing	OK
OBSERVATION	OBSERVATION_CONCEPT_ID	2	Integer		Standardized concept ID for the observation	OK

OBSERVATION	OBSERVATION_DATE	3	Date		Date of the observation	OK
OBSERVATION	OBSERVATION_EVENT_ID	4	Float		Identifier linking to the observation event	OK
OBSERVATION	OBSERVATION_ID	5	Integer	64	Unique identifier for the observation record	OK
OBSERVATION	OBSERVATION_SOURCE_CONCEPT_ID	6	Float		Source concept ID for the observation	OK
OBSERVATION	OBSERVATION_SOURCE_VALUE	7	Text	89	Original observation value from source system	OK
OBSERVATION	OBSERVATION_TYPE_CONCEPT_ID	8	Integer		Concept ID for the type of observation	OK
OBSERVATION	OBS_EVENT_FIELD_CONCEPT_ID	9	Float		Concept ID for the field within the observation event	OK
OBSERVATION	PERSON_ID	10	Integer		Unique pseudonymized identifier for the patient	OK
OBSERVATION	PROVIDER_ID	11	Float		Identifier for the healthcare provider who recorded the observation	OK
OBSERVATION	QUALIFIER_CONCEPT_ID	12	Float		Concept ID for a qualifier of the observation value	OK
OBSERVATION	QUALIFIER_SOURCE_VALUE	13	Float		Original qualifier value from source system	OK
OBSERVATION	UNIT_CONCEPT_ID	14	Float		Concept ID for the unit of the observation value	OK
OBSERVATION	UNIT_SOURCE_VALUE	15	Float		Original unit from source system	OK
OBSERVATION	VALUE_AS_CONCEPT_ID	16	Float		Concept ID for the type of value (numeric, string, concept)	OK
OBSERVATION	VALUE_AS_NUMBER	17	Float		Numeric result for the observation	OK
OBSERVATION	VALUE_AS_STRING	18	Float		String value for the observation (e.g., race, ethnicity, smoking status)	OK
OBSERVATION	VALUE_SOURCE_VALUE	19	Text	89	Original value from source system	OK
OBSERVATION	VISIT_DETAIL_ID	20	Float		Identifier linking to the visit detail where observation was recorded	OK
OBSERVATION	VISIT_OCCURRENCE_ID	21	Float		Identifier linking to the visit where observation was recorded	OK
PERSON	ETHNICITY_CONCEPT_ID	1	Integer		Standardized concept ID for the patient ethnicity	OK
PERSON	ETHNICITY_SOURCE_CONCEPT_ID	2	Float		Source concept ID for ethnicity	OK
PERSON	ETHNICITY_SOURCE_VALUE	3	Float		Original ethnicity value from source system	OK
PERSON	GENDER_CONCEPT_ID	4	Integer		Standardized concept ID for the patient sex/gender	OK
PERSON	GENDER_SOURCE_CONCEPT_ID	5	Float		Source concept ID for gender	OK
PERSON	GENDER_SOURCE_VALUE	6	Text	1	Original gender value from source system (M/F)	OK
PERSON	PERSON_ID	7	Integer	64	Unique pseudonymized identifier for the patient	OK
PERSON	PERSON_SOURCE_VALUE	8	Text	70	Original patient identifier from source system	OK
PERSON	RACE_CONCEPT_ID	9	Integer		Standardized concept ID for the patient race	OK
PERSON	RACE_SOURCE_CONCEPT_ID	10	Float		Source concept ID for race	OK
PERSON	RACE_SOURCE_VALUE	11	Text	23	Original race value from source system	OK
PERSON	YEAR_OF_BIRTH	12	Integer		Year of birth of the subject as YYYY	OK
PROCEDURE_OCCURRENCE	BC_DATE_MISSING_TYPE	1	Float		Indicator of how the procedure date is missing	OK
PROCEDURE_OCCURRENCE	MODIFIER_CONCEPT_ID	2	Float		Concept ID for a modifier of the procedure	OK
PROCEDURE_OCCURRENCE	MODIFIER_SOURCE_VALUE	3	Float		Original modifier value from source system	OK
PROCEDURE_OCCURRENCE	PERSON_ID	4	Integer		Unique pseudonymized identifier for the patient	OK
PROCEDURE_OCCURRENCE	PROCEDURE_CONCEPT_ID	5	Integer		Standardized concept ID for the procedure/surgery	OK
PROCEDURE_OCCURRENCE	PROCEDURE_DATE	6	Date		Date when the surgery or procedure was performed	OK
PROCEDURE_OCCURRENCE	PROCEDURE_END_DATE	7	Date		End date of the procedure (if applicable)	OK
PROCEDURE_OCCURRENCE	PROCEDURE_OCCURRENCE_ID	8	Integer	64	Unique identifier for the procedure occurrence record	OK
PROCEDURE_OCCURRENCE	PROCEDURE_SOURCE_CONCEPT_ID	9	Float		Source concept ID for the procedure	OK
PROCEDURE_OCCURRENCE	PROCEDURE_SOURCE_VALUE	10	Text	137	Original procedure name/code from source system (e.g., OPCS-4 code)	OK
PROCEDURE_OCCURRENCE	PROCEDURE_TYPE_CONCEPT_ID	11	Integer		Concept ID for the type of procedure occurrence	OK
PROCEDURE_OCCURRENCE	QUANTITY	12	Float		Quantity associated with the procedure	OK
PROCEDURE_OCCURRENCE	VISIT_DETAIL_ID	13	Float		Identifier linking to the visit detail where procedure was performed	OK
PROCEDURE_OCCURRENCE	VISIT_OCCURRENCE_ID	14	Float		Identifier linking to the visit where procedure was performed	OK
VISIT_OCCURRENCE	ADMITTED_FROM_CONCEPT_ID	1	Float		Concept ID for where the patient was admitted from	OK
VISIT_OCCURRENCE	ADMITTED_FROM_SOURCE_VALUE	2	Float		Original admission source from source system	OK
VISIT_OCCURRENCE	BC_END_DATE_MISSING_TYPE	3	Float		Indicator of how the visit end date is missing	OK
VISIT_OCCURRENCE	BC_START_DATE_MISSING_TYPE	4	Float		Indicator of how the visit start date is missing	OK
VISIT_OCCURRENCE	DISCHARGED_TO_CONCEPT_ID	5	Float		Concept ID for where the patient was discharged to	OK
VISIT_OCCURRENCE	DISCHARGED_TO_SOURCE_VALUE	6	Float		Original discharge location from source system	OK
VISIT_OCCURRENCE	PERSON_ID	7	Integer		Unique pseudonymized identifier for the patient	OK
VISIT_OCCURRENCE	PRECEDING_VISIT_OCCURRENCE_ID	8	Float		Identifier for the preceding visit for this patient	OK
VISIT_OCCURRENCE	VISIT_CONCEPT_ID	9	Integer		Concept ID for the type of visit (inpatient, outpatient, ED, etc.)	OK
VISIT_OCCURRENCE	VISIT_END_DATE	10	Date		End date of service for the encounter	OK
VISIT_OCCURRENCE	VISIT_OCCURRENCE_ID	11	Integer	64	Unique identifier for the visit occurrence record	OK

VISIT_OCCURRENCE	VISIT_SOURCE_CONCEPT_ID	12	Float		Source concept ID for the visit type	OK
VISIT_OCCURRENCE	VISIT_SOURCE_VALUE	13	Text	89	Original visit type code from source system (e.g., LOINC/SNOMED CT)	OK
VISIT_OCCURRENCE	VISIT_START_DATE	14	Date		Start date of service for the encounter	OK
VISIT_OCCURRENCE	VISIT_TYPE_CONCEPT_ID	15	Integer		Concept ID for the type of encounter (ED, inpatient, outpatient, pathology, imaging)	OK

Table	Column	Code	Name	Description	CHECKS
				No enumerations supplied in source CSV.	

Data Type	Description
Text	Free text (string)
Integer	Numerical (Integer)
Float	Numerical (Decimal)
Date	Date (date only)
Timestamp	Datetime (including time)
File	Whole file for upload