OCCR NewsFlash

Oklahoma Central Cancer Registry

November 2010

Fall Issue

New Consultant for OCCR

By Leslie Dill

OCCR is very excited to announce that we have a new consultant for the hospitals in the western region of Oklahoma, a position formerly filled by Bonnie Connelly prior to her retirement. Amanda Moran joined our staff November 1, 2010. A graduate of East Central University in Ada, OK, Amanda has a Bachelor's of Science in Health Information Management. She became a Registered Health Information Administrator while working as a HIPAA Privacy/Security Officer for McCurtain Memorial Hospital in Idabel, OK . In 2005, Amanda moved to Oklahoma City, working as a cancer registrar for OU Medical Center from 2006-2010. It was during this time that she became a Certified Tumor Registrar. Amanda has also worked as a consultant for Summit Medical Center in Edmond and as a release of information specialist at Deaconess Hospital in Oklahoma City.

OCCR welcomes Amanda and looks forward to utilizing her experience and knowledge. Amanda can be contacted at (405) 271-9444, ext 57138 or AmandaM@health.ok.gov.

RMCDS Corner

By Paula Marshall, BBA, CTR

Conversion! Conversion! Conversion! If you have completed all 2009 diagnosed cases and submitted them to the OCCR, you are ready for conversion. Your system must be converted to V12 before you start abstracting 2010 diagnosed cases. An email was sent to all RMCDS users in June, 2010, with procedures for converting your RMCDS system. The first item of business is to complete the Appendix A and fax or email to Larry Derrick at RMCDS. You will be contacted by RMCDS and they will set up a time with you or your IT to convert your system. Don't delay with your conversion because 2010 cases are due now to the OCCR. Contact Paula if you have any questions.

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OCCR Update

We have converted our database to V12 and everything seems to be going smoothly. We will continue to undergo some testing before we start processing the 2010 data received from our reporters. If you have a question or concern regarding whether your data was received, please contact Paula Marshall. We appreciate your patience during our conversion.

Instructions for Coding

By Beth Watwood, RHIA, CTR

OCCR recently participated in an NPCR audit performed by CDC in which the quality of a random sample of OCCR data was reviewed to determine where we may be lacking in providing education to facilities regarding casefinding and coding/ abstracting. During the reconciliation process, some common coding errors were identified. A list is provided below with instructions, examples and notes on a few of those topics.

Grade/Differentiation, *FORDS 2009 pg 96*
Instructions: **Code the grade or differentiation from the pathologic examination of the primary tumor, NOT the metastatic site.** For example: Liver biopsy reveals small cell carcinoma, Grade 2, metastatic from the lung.

Notes: Grade should be coded as 9 in this case, unless otherwise noted in the chart.
Do **NOT** code Grade to 2 in this scenario because the stated grade is associated with the metastatic site (liver) and not the primary site (lung).

Systemic/Surgery Sequence, *FORDS 2009 pg 183A*
Instructions: If none of the following surgical procedures was performed: *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, Surgical Procedure/Other Site,* then this item should be coded 0. For example: Needle biopsy of prostate only, followed by Radiation for Prostate Adenocarcinoma. Surgery not recommended.

Notes: Since no surgery was performed, Systemic/Surgery Sequence should be coded 0 in this case. It would not be appropriate to code 2 (treatment before surgery) unless you know that the patient had surgery after treatment. Coding 0 indicates that either no surgery was performed OR that no treatment was provided. In this instance, it would indicate that no surgery was performed.

> ***"Code the grade or differentiation from the pathologic examination of the primary tumor, NOT the metastatic site."***

Date First Course Treatment, *FORDS 2009 pg 129*
Instructions: Record the earliest of the following dates: *Date of First Surgical Procedure, Date Radiation Started, Date Systemic Therapy Started*, or *Date Other Treatment Started*. For example: Needle biopsy left lung, performed 02/18/2007 revealing small cell carcinoma. Left lung resection performed 03/02/2007.

Notes: Date of First Course Treatment in this scenario is 03/02/2007. Needle biopsy is **NOT** considered a treatment modality for this site. It is not appropriate to code a needle biopsy date for Date First Course Treatment, unless it is a primary site where a biopsy is considered *excisional* and would be coded under Surgical Procedure. FORDS 2009, pg 26, states that "a treatment plan describes the type(s) of therapies intended to modify, control, remove, or destroy proliferating cancer cells". FORDS 2009, pg 130, further indicates "Do not record the date of *incisional*, core, or fine needle biopsies as the date of first course of treatment."

OCCR Required Site Specific Factors (SSFs) for Cases Diagnosed 2010

By Paula Marshall, BBA, CTR

NPCR is requiring all SSFs needed to derive SEER Summary Stage 2000 and additional SSFs related to prognostic factors for breast cancer cases. Cancer cases diagnosed on or after January 1, 2010 are required to be coded using the new Collaborative Stage Data Collection System (CSv2).

Below are the lists of CSv2 data items required by OCCR to derive SEER Summary Stage and additional SSFs.

2010 Required Input Items for **all sites:**

Item Name

CS Tumor Size
CS Extension
CS Tumor Size/Ext Eval
CS Lymph Nodes
Regional Nodes Positive
Regional Nodes Examined
CS Met at DX

The electronic PDF files of the current CS manual (for 2010 cases) can be downloaded from this link:

http://cancerstaging.org/cstage/manuals/index.html. There are three links there, each listed under the "Coding Instructions" heading at the top of the page. Save this website to your desktop for easy access when coding 2010 cases.

Site Specific Factor	Primary Site/Histology
SSF1	Lung, pleura, and retinoblastoma
SSF2	Corpus Adenosarcoma, Corpus Carcinoma, Corpus Sarcoma
SSF3	Prostate
SSF25	Schema discriminator for select sites where information is needed to select the correct subgroup for deriving Summary Stage 2000

TABLE 1: Site Specific Factors needed to derive Summary Stage 2000

Site Specific Factor	Primary Site/SSF Definition
SSF1	Breast (ERA positive or negative)
SSF2	Breast (PRA positive or negative)
SSF8	Breast (IHC Value-shows whether or not the cancer cells have HER2 receptors and/or hormone receptors on their surface)
SSF9	Breast – HER2 IHC Test Interpretation
SSF10	Breast – HER2 FISH Value
SSF11	Breast – HER2 FISH Test Interpretation
SSF12	Breast – HER2 CISH Value
SSF13	Breast – HER2 CISH Test Interpretation
SSF14	Breast – HER2 Result of Other/Unknown Test

TABLE 2: Additional Site Specific Factors for Breast

2010 Hematopoietic and Lymphoid Neoplasm

By Delores Greene, CTR

The interactive Hematopoietic and Lymphoid Database (Hematopoietic DB) has been developed to provide registrars with new rules and guidelines for determining case reportability, number of primaries, and coding primary site histology and grade for hematopoietic and/or lymphoid neoplasms. The new Hematopoietic DB, which can be copied to any computer desktop, will enable registrars to accurately identify hematopoietic or lymphoid neoplasms as well as correctly and consistently abstract and code cases. Registrars will have the ability to query any final differential or provisional diagnosis in the Hematopoietic DB. After identifying the condition, the diagnostic or confirmatory test will be listed under "definitive diagnosis" for each neoplasm. This will provide information needed to search the medical record for specific diagnostic test results. Tables have been created to show obsolete terms, histology lineage, new histology terms and codes along with NOS terms and codes and a lymph node/lymph node chain reference table.

For cases diagnosed January 1, 2010 and later, the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* and the *Hematopoietic Database* **replace** the following:

The February 2001 *Single Versus Subsequent Primaries of Lymphatic* and *Hematopoietic Diseases* table (FORDS Manual pgs. 241-246)

Abstracting and Coding Guide for the Hematopoietic Diseases, 2002 (red book)

Previous casefinding and Reportable Neoplasm lists for hematopoietic neoplasms (ICD-9-CM and ICD-10). (ICD-O 3rd Edition; purple book).

To reiterate: starting with 2010 hematopoietic and lymphoid neoplasm cases, use ONLY the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual.*

For quick reference, a shortcut can be placed on the desktop.

The Hematopoietic and Lymphoid Database must be downloaded from the SEER website: http://seer.cancer.gov/tools/heme/. The *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual* is embedded in the Hematopoietic Database. **Use the instructions and rules within the Manual first. The Hematopoietic DB is used when the rules specifically instruct you to refer to the DB or when you have used all of the rules in the manual.**

Before using either the manual or the Hematopoietic DB, complete the online training on the SEER website: http://seer.cancer.gov/tools/heme/training/. There are a total of 13 presentations and registrars are strongly encouraged to take advantage of this training, provided at no cost. NCRA has approved these presentations for continuing education units and each module ends with a test covering key concepts. After successful completion of each test, CEU Certificates may be printed.

Complete Casefinding

By Anne Pate, MPH

With the CDC audit of OCCR Data coming to a close, the OCCR wants to send out a reminder of the importance of complete case finding. One of the areas the CDC reviewed was case finding at each of the facilities by reviewing many sources of information including path reports, radiology reports and most importantly the facility's disease index. Casefinding is not complete unless a disease index review has been performed. The disease index report should include inpatient, outpatient, radiology, emergency room visits and lab reports. If these reports are reviewed quarterly and any missed cases investigated, it will assist each facility in reporting the number of expected cases and achieving compliance with much greater ease. The OCCR is held accountable by the federal government for the number of cases reported, and as such this accountability is passed on to each facility. Some of the efforts conducted at the OCCR to attempt to find all reportable cases include matching hospital discharge databases with our database to identify missed cases as well as conducting facility specific audits of the disease indexes. As usual, the staff of the OCCR is available to answer any questions and assist in learning these processes as needed.

Cancer Data Used Throughout the Health Department

By Becki Moore, M.S., Data Enhancement Coordinator, Health Care Information, Oklahoma State Department of Health

The Health Care Information (HCI) division is responsible for collecting, managing, and disseminating health-related data for OSDH. Within the responsibilities of HCI, staff has worked with the Cancer Registry data to ensure information is available to our partners by providing Cancer and cancer-related mortality statistics through the web-based data query system OK2SHARE. HCI staff geo-code the Cancer Registry data to provide spatial information related to diagnosis to allow for environmental analyses. In addition, the HCI-managed hospital-inpatient discharge data containing cancer diagnoses are provided to Cancer Registry staff for matching and enhancing the cancer data.

As the HCI division is growing to provide data matching services, staff has recently matched adolescent cancer and birth data for an OU Health Sciences Center, Epidemiology thesis project. The study will examine the relationship between cancer diagnoses and birth-related information including characteristics of the mother such as age, race, previous births, and pregnancy-related risk factors; and birth events including the location, weight, gender, and plurality. This study will provide valuable information related to adolescent cancer.

HCI staff looks forward to continuing with the collaboration with the Cancer Registry staff. As we continue to develop the Analytical Data Warehouse, the Cancer Registry data will be one of the first data sets linked with all of HCI data to provide a more comprehensive picture of the health of Oklahomans.

Edits Radar

By Paula Marshall, BBA, CTR

RX Summ-Systemic/Surg Seq

Description: Records the sequencing of systemic therapy and surgical procedures given as part of the first course of treatment.

Coding tips:

*Code the administration of systemic therapy in sequence with the **first** surgery performed.

*If none of the following surgical procedures were performed: *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, Surgical Procedure/Other Site*, then this item should be coded **0**.

*If the patient received both systemic therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, Surgical Procedure/Other Site*, then code this item **2-9**, as appropriate.

Example edit for Systemic/Sur Seq:

000244482-00 C505 POS=00278213

Systemic RX, Surgery, Systemic/Sur Seq (COC)

E: Conflict among Systemic RX, Surgery, and Systemic Sur Seq

RX Summ--Surg Prim Site (1567) = **24**

RX Summ--Scope Reg LN Sur (1569) = 0

RX Summ--Surg Oth Reg/Dis (1570) = 0

RX Summ--BRM (1589) = 00

RX Summ--Chemo (1585) = 00

RX Summ--Hormone (1587) = 00

RX Summ--Transplnt/Endocr (1583) = 00

RX Summ--Systemic/Sur Seq (1616) = **3**

This patient had surgery, but NO systemic treatment. The RX Summ--Systemic/Sur Seq is incorrect and should be coded to 0.

Systemic therapy includes the administration of chemotherapy agents, hormonal agents, biological response modifiers, bone marrow transplants, stem cell harvests, and surgical and/or radiation endocrine therapy.

RX Summ-Surg/Rad Seq

Description: Records the sequencing of radiation and surgical procedures given as part of the first course of treatment.

Coding tips:

*Surgical procedures include *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, Surgical Procedure/Other Site*. If all of these procedures are coded **0**, or it is not known whether the patient received both surgery and radiation, then this item should be coded **0**.

Continued on page 7

Coding tips, continued from page 6:

*If the patient received both radiation therapy and any one or a combination of the following surgical procedures: *Surgical Procedure of Primary Site, Scope of Regional Lymph Node Surgery, Surgical Procedure/Other Site,* then code this item **2-9**, as appropriate.

Example edit for Surg/Rad Seq:

000305612-00 C501 POS=00308080

Radiation RX, Surgery, Surg/Rad Seq (COC)

E: Conflict among Radiation RX, Surgery, and Surg/Radiation Seq

RX Summ--Surg Prim Site (1567) = **51**

RX Summ--Scope Reg LN Sur (1569) = 5

RX Summ--Surg Oth Reg/Dis (1570) = 0

RX Summ--Radiation (1572) = **1**

RX Summ--BRM (1589) = 00

RX Summ--Chemo (1585) = 00

RX Summ--Hormone (1587) = 00

RX Summ--Transplnt/Endocr (1583) = 00

RX Summ--Surg Rad/Seq (1616) = **0**

This patient had surgery and radiation after surgery. The RX Summ--Surg Rad/Seq is incorrect and should be coded to 3.

CS Tumor Size/Ext Eval

Description: CS Tumor Size/Ext Eval records how the codes for CS Tumor Size and CS Extension were determined, based on the diagnostic methods employed.

Bladder Schema - CS TS/Ext Eval

Note: According to AJCC, staging basis for transurethral resection of bladder tumor (TURBT) is **clinical** and is recorded as CS TS/Ext Eval "1" (not "3"). TURBT is coded as surgery, but is part of the clinical criteria, not pathological criteria for bladder. See *CD TS/EXT-Eval* note in the CS Manual.

Example edit for Bladder – CS TS/Ext Eval:

Edit: CS TS/Ext Eval, Surgery, Bladder Schema (CS)

E: Conflict among schema, RX Summ--Surg Prim Site (25), CS Tumor Size/Ext Eval (3]

Primary Site (540) = C679 Histologic Type ICD-O-3 (550) = 8130

Behavior Code ICD-O-3 = 3

RX Summ--Surg Prim Site (1567) = **20**

CS Tumor Size/Ext Eval (991) = **3**

CS Site-Specific Factor25 (1075) = 988

This patient had local tumor excision (TURB). The CS Tumor Size/Ext Eval is incorrect and should be coded to **1**.

Continued on page 8

Edits Radar, continued from page 7

Prostate Schema - CS TS/Ext Eval

Note: According to AJCC, staging basis for transurethral resection of prostate tumor (TURP) is **clinical** and is recorded as CS TS/Ext Eval "1" (not "3). TURP is coded under surgery, but is not considered definitive surgery for prostate and is part of the clinical criteria, not pathological criteria. See CS TS/EXT-Eval note 4 in CS Manual.

Example edit for Prostate – CS TS/Ext Eval:

CS TS/Ext Eval, Surgery, Prostate Schema (CS)

E: Conflict among schema, RX Summ--Surg Prim Site (22), CS Tumor Size/Ext Eval (4)

Primary Site (540) = C619

Histologic Type ICD-O-3 (550) = 8140

Behavior Code ICD-O-3 (554) = 3

RX Summ--Surg Prim Site (1567) = **21**

CS Tumor Size/Ext Eval (991) = **4**

CS Site-Specific Factor25 (1075) = 988

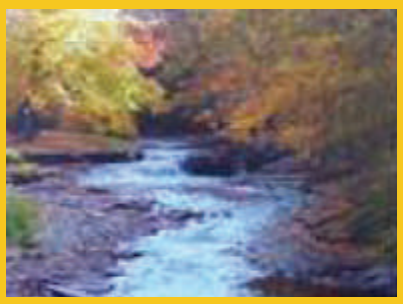
This patient had TURP. The CS Tumor Size/Ext Eval is incorrect and should be coded to **1**.

New Data Flag Items

By Paula Marshall, BBA, CTR

There are 126 new data items in V12 (effective January 1, 2010), which include twenty-two (22) new data flag items. As part of an initiative to standardize date fields, new fields were introduced to accommodate non-date information that had previously been transmitted in date fields. This flag explains why there is no appropriate value in the corresponding date field, i.e. Date of Diagnosis. Prior to V12 (through 2009 diagnosis), date fields included codes which provided information other than dates.

Numerical values 0, 8 and 9 are no longer valid as date variables. If a valid date value is provided in the date item, the date flag is left blank. When the date variable is completely unknown, the date flag must be entered. Depending on the type of unknown date, the date flag codes might vary, i.e. Date of Diagnosis Flag only has one code – *12. A proper value is applicable but not known (e.g., date of diagnosis is unknown)* and other date variables have several codes that are applicable.

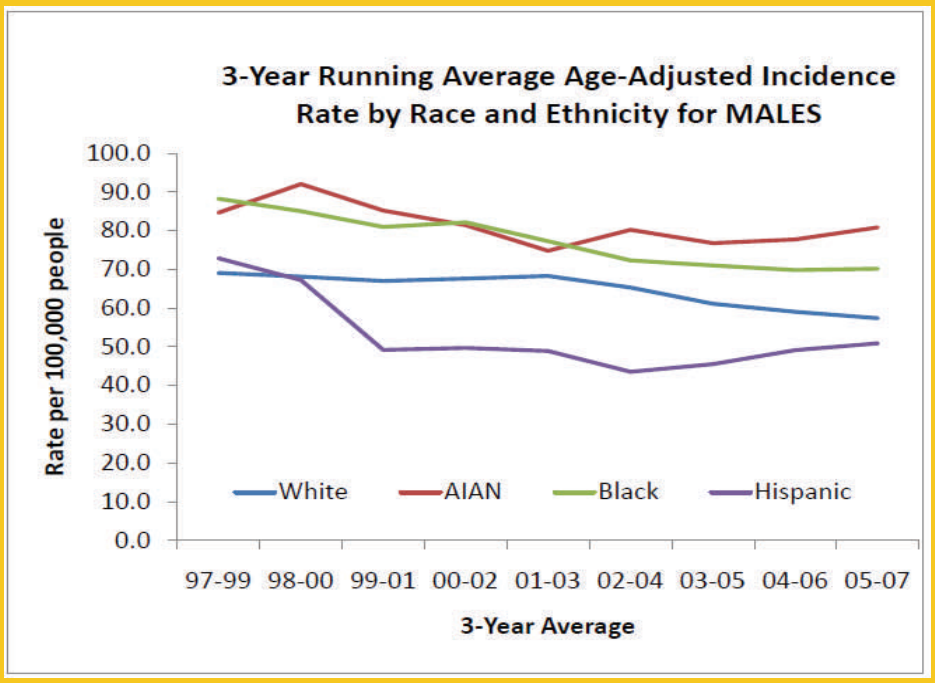


How Your Data is Used

By Anne Pate, MPH

Every five years, the Oklahoma Comprehensive Cancer Control Program publishes a State Cancer Burden that describes the incidence, mortality and risk factors for a number of different cancers to help identify areas of need throughout the state. Without each facility reporting high quality data in a timely manner, publication of the burden would not be possible. We have already published one burden statement and are in the process of developing and identifying the contents of the next one which should be published no later than June 2011. The following primary sites are being considered for the next burden statement: Lung, Breast, Prostate, Colorectal, Urinary Bladder, Non-Hodgkin Lymphoma, Melanoma, Kidney & Renal Pelvis, Uterine, Pancreas, and Cervical. Data from diagnosis years 1997 through 2008 will be included in this publication and any cancer registrars are encouraged to attend the Oklahoma Comprehensive Cancer Network meetings where this data will be presented. The next meeting will be in December (exact date to be determined). If you are interested in attending please contact Amy Nelson at AmyN@health.ok.gov or 405-271-4072.

One of the graphs recently presented at the Oklahoma Cancer Registrars Association meeting in Muskogee reflects some very positive trends in colorectal cancer incidence. It was determined that among males of all races and ethnicities, incidence has been on the decline in the past decade. The 3-year average declines as follows: 17% for White males, 4.5% for American Indian males, 20% for Black males, and 30% for Hispanic males.



Timeliness Awards

By Leslie Dill

Last issue, OCCR recognized the cancer registries of those hospitals who had met or exceeded the reporting timeline for data submission to the OCCR . Deaconess Hospital Cancer Registry should have been among those recognized, but was inadvertently missed. Congratulations for receiving this award and for a job well done!

OCCR had planned to recognize the ambulatory surgery center registrars who have also met or exceeded the reporting timeline in the this issue. However, due to staffing issues and preparation for NPCR data submission in December, these facilities will be announced in the Spring 2011 Issue.

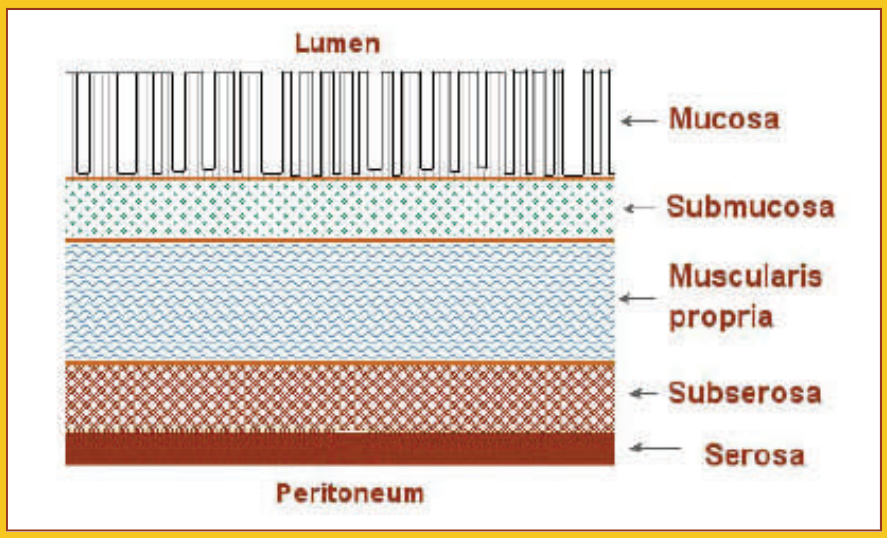
CS Extension for Colorectal Sites

By Beth Watwood, RHIA, CTR

When reviewing patient medical records, there are often different terms used synonymously by physicians and pathologists. Many times, CS Extension for colorectal sites is miscoded when anatomy is not reviewed or the registrar is not aware of synonymous terms used to describe the layers of the bowel wall. It is important that registrars understand anatomy in order to apply the appropriate CS extension code. Below is a helpful illustration from the SEER training site: http://training.seer.cancer.gov/colorectal/anatomy/layers.html showing the layers of the bowel wall. Notice the terms listed below that are often used synonymously for the different layers. For example, serosa may sometimes be referred to as the visceral peritoneum.

Layers of Bowel Wall

Lumen (interior surface of colon "tube")
Mucosa
Surface epithelium
Lamina propria or basement membrane—dividing line between in situ and invasive lesions
Muscularis mucosae
Submucosa—lymphatics; potential for metastases increases
Muscularis propria
Circular layer
Longitudinal layer—in three bands called taenia coli
Subserosa—sometimes called pericolic fat or subserosal fat
Serosa—present on ascending, transverse, sigmoid only (also called the visceral peritoneum)
Retroperitoneal fat (also called pericolic fat)
Mesenteric fat (also called pericolic fat)



Questions Sent to the CoC—I & R

By Delores Greene, CTR

Case #1 Question:
This case has a lymph node biopsy only, compatible with lung primary. No mention in medical record of which side involved. CT and Pet Scan only shows mediastinal, hilar, and cervical neck lymph nodes mostly on the left side. There are so many lymph nodes it is possible they can't see the primary tumor. Only slight mention of very small nodules left upper and right upper lung that do not light up.

Question: How do you code the multiplicity counter? There is no define statement of tumor and so it is unknown and we do not have that option to choose from. And 88 is not a good statement as "not applicable".

Answer: The response from the AJCC curator, SEER/MPH was: For now, code 99 is the appropriate code when there is no evidence of the primary site. For cases diagnosed 2011 plus, use code 00 for multiplicity counter when there is no evidence of the primary tumor.

Case #2 Question sent to NAACCR for Clarification following NAACCR Webinar presented on September 2, 2010 "Coding Pitfalls"

New Data Items in 2010 • Lymph-vascular Invasion (LVI) – Indicates whether LVI is identified in path report • LVI is the presence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels – May be an indicator of prognosis – Used by CS algorithm to map AJCC T for some primary sites

Case Scenario 8: • CT scan of chest showed large upper lobe lung mass invading pleura. Incisional biopsy positive for squamous cell carcinoma. Patient treated with radiation therapy. – Lymph-vascular Invasion = 8.

Question: After reviewing the FORDS information on this field why is this scenario coded to an 8 instead of 9?

Answer: This was taken from an I&R Question which has since been removed. The I&R has clarified to indicate that 9 is the correct answer.

Both of these questions address items required for CoC hospitals only.

If you have a question please email it to DeloresG@health.ok.gov. It will be researched and included in upcoming newsletters.

OCCR Required Treatment Variables

By Paula Marshall, BBA, CTR

- First Course Treatment
- Date First Course of Rx
- RX Summ-Treatment Status*
- RX Summ-Systemic/Surg Seq
- Reason For No Surgery
- Date Radiation Started
- Rad-Regional Rx Modality
- RX Summ-Surg/Rad Seq
- Reason for No Radiation
- RX Summ-Transplnt/Endocr

*New for 2010

Oklahoma State Department of Health
Creating a State of Health

Oklahoma Central Cancer Registry

Oklahoma State Department of Health
Chronic Disease Service
Cancer Prevention and Control Program
1000 NE 10th St., Room 1205
Oklahoma City, OK 73099

Phone: 405-271-9444
Fax: 405-271-6315

Visit us on the web:

http://occr.health.ok.gov

OCCR will be out of the office on the following dates:

Nov. 25-26, 2010

Dec. 23-24, 2010

Jan. 17, 2011

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Free NAACCR Webinars

By Leslie Dill

The following NAACCR webinars have been purchased by OCCR and will be presented in two locations: Deaconess Hospital in Oklahoma City and St. John Medical Center in Tulsa. All webinars are from 8-11 a.m. Please register in advance by emailing LeslieD@health.ok.gov or DeloresG@health.ok.gov.

12/2/2010	*Collecting Cancer Data: Liver and Biliary Tract*
1/6/2011	*Collecting Tumor Data: Brain and Central Nervous System*
2/3/2011	*Collecting Cancer Data: Testis*
3/3/2011	*Collecting Cancer Data: Bladder*
4/7/2011	*Collecting Cancer Data: Breast*
5/5/2011	*Collecting Cancer Data: Prostate*
6/2/2011	*Best Practices for Developing and Working with Survival Data*
7/7/2011	*Complete Case Identification and Ascertainment*
8/4/2010	*NAACCR Interoperability Activities and the Electronic Health Record*
10/7/2010	*Coding Pitfalls*

We acknowledge the Centers for Disease Control and Prevention (CDC) and the National Program of Cancer Registries (NPCR) for its support and the distribution of this newsletter under cooperative agreement #U58/DP000834-03 awarded to Oklahoma. Its contents are solely the responsibility of the authors and do not represent the official view of CDC.

This publication was issued by the Oklahoma State Department of Health as authorized by Dr. Terry Cline, Commissioner of Health. 500 copies were printed by OSDH in Nov 2010 at a cost of $870.00. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.