



ASCP Teleconferences & Live Webcasts Program Requirements

ASCP has been offering continuing education audioconferences for over 25 years. The following ASCP Teleconferences Program Requirements were developed based on input from our customers during this time. Please help us meet the needs of our customers by observing these criteria as you develop your program. Your time and cooperation are very much appreciated!

Program Criteria	Requirement
Program length:	<ul style="list-style-type: none"> ❖ Minimum of 45-50 minutes of lecture material ❖ Availability for a short Question & Answer segment following lecture
Supplementary program materials for participants:	<ul style="list-style-type: none"> ❖ PowerPoint slide presentation <ul style="list-style-type: none"> – Minimum of 15 slides – Maximum of 40-50 slides preferred – Presentation with embedded images preferred ❖ Supplemental handout (see pg. 4 for handout format options) <ul style="list-style-type: none"> – Minimum of 5-10 pages preferred – Include recent references unless already in the slides
Program materials submission date:	7 weeks before the date of your program
Copyright permission documentation:	Written permission(s) to use previously published material obtained from publishers/authors should be submitted to ASCP with the program materials

Please see the following pages for a more complete discussion of ASCP Teleconferences program materials.

Please call 312-541-4983 if you have any questions.



ASCP Teleconferences & Live Webcasts Program Materials Guidelines

ASCP Teleconferences are live audio presentations – in essence, a lecture over the telephone. Program materials enhance the audioconference educational experience by supplementing the verbal presentation with information that reinforces the lecture content. Two types of program materials are required:

- ❖ **Presentation slides** for projection
- ❖ **Supplemental handout** for notes and reference later

ASCP staff will convert the final draft of your program materials into **PDF file format** before distribution to registered sites.

Presentation Slide Guidelines ...

- Registered sites receive presentation slides in PDF file format to project for attendees during your lecture. Participants prefer slides that are image-intensive.
- Participants are not permitted to use your material for other purposes without your consent.

Purpose of presentation slides:

- Provides focus and clarity for important points
- Makes the presentation more interesting
- Increases retention of content

Criteria for development of presentation slides:

- Submit slide presentation no later than **7 weeks before your program date**.
- Submit slides in **Microsoft PowerPoint file via e-mail**. For large files, contact ASCP for **FTP** upload instructions. Alternatively submit on **CD-ROM**.
- Plan sufficient material for a **45-50 minute lecture; minimum of 15 slides**.
- A **maximum of 40-50 slides per session** is recommended which ensures ability to present slides within 45-50 minutes without rushing. Too many slides result in

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lecture exceeding 60 minutes - participants typically have one hour to attend programs.

- **Photos and other images** are **encouraged** to enhance clarity of content.
- If using **photos of patients** or images of actual patient data, facial features and other patient identification information should be **blocked out**.
- Make **tables and graphs simple** and **easy to read**.
- Place **complex/text-heavy tables/graphs** in your supplemental **handout**.
- Use a **white background with dark lettering**. If possible, use slide presentation template provided (**see resources section below**).
- **Avoid too much text** in slides as they will be hard to read. Place detail into your handout and use the slides to introduce the concept.
- Introduce key concepts with **title slides** (slides showing concept title only).
- **Obtain permission** for copyrighted material - ASCP cannot pay for the use of previously published images (**see resources section below**).
- Include **program objectives** slide using those from original planning guide.
- Include a **personal photo** to build rapport with your audience (optional).

Resources to assist in developing presentation slides:

- **Attachment B:** Microsoft PowerPoint File & Image Formatting Tips
- www.ascp.org/tcresources: Access to ASCP Slide Presentation Template
- **Attachment A:** Sample permission request verbiage for copyrighted material

After ASCP staff receives your slides:

- ASCP staff will insert an **ASCP logo slide** as the first slide in the presentation.
- ASCP staff will insert a **notice of disclosure slide** as the 2nd slide.
- ASCP staff will insert a **program objectives slide** **if** you do not include one.
- ASCP staff will **add slide numbers** in lower right-hand corner of each slide.
- A **draft** will be e-mailed to you in PDF format for your **review and approval**.
- A **final approved version** will be emailed to you – please use this version to **present your live teleconference**.



Supplemental Handout Material Guidelines ...

Registered locations receive an electronic file copy of the supplemental handout which for review during and after your lecture. **Participants prefer handouts that supplement the verbal and visual presentations.**

Purpose of supplemental handout:

- Captures and supplements all main points of lecture
- Explains visual images in more detail
- Eliminates need for extensive note-taking
- Serves as take-home document for later review and refresher
- Provides recent references for participants to research the topic more thoroughly

Supplemental handout format options:

Please include a **list of recent references** with one of the following handout options:

1. **Annotated slide key format (see Attachment C):** Using Word, add slide numbers in left margin and supplemental info for each slide to the right. Supporting images, charts, etc. may also be included. You can use the slide presentation template provided (**see resources section below**).
2. **PowerPoint slide notes & images format (see Attachment D):** You can add supplemental information for each slide in **PowerPoint** using the 'Notes' feature; then **import** slide images and notes into a Word document.
3. **Paragraph-style format (see Attachment E):** Supplemental material is organized in paragraphs with no references to slide numbers. Supporting images, charts, etc. may also be included.
4. **PowerPoint slide images only format (see Attachment F):** If you choose not to format the handout using one of the above options, ASCP staff will generate this type of handout using your PowerPoint file and append your list of references.

Criteria for development of supplemental handout:

- Submit handout material no later than **7 weeks before your program date**.
- Submit handout material in **Microsoft Word** file **via e-mail** (unless using option 4 handout above).
- Use a **minimum** of **5-10 pages** to a **maximum** of **15-20** pages.

Please call 312-541-4983 if you have any questions.



- **Include recent references** at the end of your handout, unless already included in the slides.
- **Obtain permission** for copyrighted material (**see resources section below**).
- **Graphs, charts, tables, etc.** in the body of handout or as appendices are **encouraged**.
- Include **complex or text-heavy charts** too small for use in your slides in the handout instead.
- **Do not** submit a **written narrative** of your lecture as a supplemental handout.

Other supplemental material (optional):

You may submit additional supplemental material if desired. Some examples include:

- Journal articles related to the content (Please note **permission requirements** by publishers – ASCP cannot pay distribution fees for the use of previously published journal material.)
- Calculation-based worksheets (i.e., Microsoft Excel) related to the content
- Examples of forms, job aids, etc. related to the content
- Procedures, SOP's, flowcharts, etc. related to the content

Resources to assist in developing supplemental handout:

- **Attachments C – F:** Examples of supplemental handout formats
- **www.ascp.org/tcresources:** Access to ASCP Supplemental Handout Template
- **Attachment A:** Sample permission request verbiage for copyrighted material

About ASCP Copyright ©...

ASCP will copyright all materials used in its continuing education programs, unless the materials are already copyrighted or unless the owner of the materials directs otherwise. This is done by the Society for the benefit of the faculty member(s) so that materials are not used by others without proper permission. **The faculty member maintains all literary rights, and may use the material without restriction.** Conversely, ASCP will not permit other usage of the Society copyrighted materials without the faculty member's permission and will transfer the copyright to the author when appropriate upon request.



Attachment A

Using Copyrighted Material...

It is the faculty member's responsibility to obtain written permission to use previously published material. If a figure, table, photograph, or any other type of material is excerpted from another publication, the original source must be acknowledged, and the copyright holder's written permission to reproduce the material must accompany your materials. Permission is required of all such materials, regardless of author or publisher, unless the material is in the public domain. Use of previously published material is at the discretion of the faculty member(s). However, ASCP is unable to reimburse fees charged by a publisher or author (i.e. user fees) for the right to reproduce materials. Sample verbiage for permissions request is provided below.

Sample verbiage for letter or email requesting permission to use material:

Dear Editor:

I am preparing material for an educational program on <title of program> for the American Society for Clinical Pathology and request permission to use the following in handout materials to be distributed to pathologists and technologists who register for the conference:

<insert specifics regarding text or figure>

Full credit to the author and publisher will be given.

Since the presentation material must be completed by <insert date before ASCP **deadline**>, your prompt response to this request would be greatly appreciated. If permission is granted, please sign below and return this form.

Permission granted by:

Publisher:

Date:

Sincerely,
(Your name)

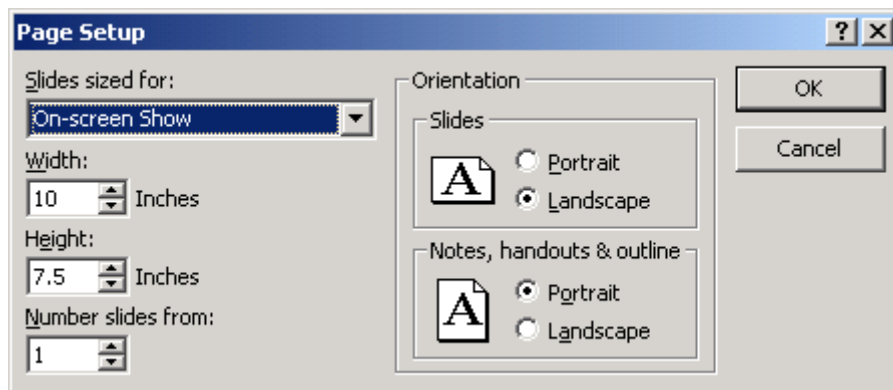


Attachment B

Microsoft PowerPoint File & Image Formatting Tips...

1. Page Setup:

The page setup in PowerPoint should be set to **On-Screen Show with Landscape orientation** which is the default setting. If you have an existing presentation already setup in the 35mm Slides format, changing to the On-Screen format will compress pictures and other objects to fit the new format. If this is the case, we recommend that the format not be changed.



2. Fonts:

Please select one of the common fonts for your slide text such as **Arial, Times, Times New Roman, Helvetica, Tahoma, or Palatino**. Because ASCP Teleconferences staff will need to work with your slide presentation file, using common fonts will ensure uniformity of text style when saving the final version.

3. Slide Backgrounds:

We ask that you use a **plain white background with dark-colored text (black, dark blue, or purple)** as the background format for slides. This combination provides good legibility for presentation slides. Avoid the use of red and green color combinations for participants who may be color blind. We discourage the use of colored and/or patterned backgrounds for two reasons: a white background is more printer-friendly for participants needing to print out the slides; and the use of patterns in the background can make slides distracting and hard to read.



4. Scanned Images and Artwork:

Scanned photographic images should be scanned at **180 to 200 dpi** (pixels per inch) at the size you are placing them within PowerPoint's page (11.5 X 7.5). Resolution greater than 200 dpi does not significantly increase image quality.

5. Photographic Images from Digital Cameras:

When creating digital images for importing into PowerPoint, the pixel limit should be **2250 pixels x 1500 pixels at 72 dpi**. Digital cameras should be set to produce **JPEG files (.jpg) at a medium compression** setting. Resolution should be set at a medium or normal quality setting. Note: If you plan to modify or enhance your digital camera images with photo editing software before importing the images into PowerPoint, the camera should be set to produce TIFF files (.tif). Once edited, they should be re-saved as JPEG images and then imported into your PowerPoint presentation.

6. Slide Boundaries:

Keep text and graphics away from the lower edges of the slide frame to allow room for the slide numbering to show, most notably in the lower right-hand corner.



Attachment C

Example Handout – Annotated Slide Key Format:

(Note: original length of handout has been reduced to facilitate printing)

Preanalytical Variables in Chemistry

Slide 1: **ASCP Logo**

Slide 2: **Disclosures**

Slide 3: **Title of Teleconference**

Slide 4: **Audioconference Objectives**

Provide an understanding of factors that influence preanalytical variables in chemistry. Discuss the relationship between safety legislation and the preanalytical phase, as well as preanalytical variables that the lab can and can not control. We define the preanalytical phase as the time from test ordering until sample analysis; this can be affected by biologic factors and technical factors.

Slide 5: **OSHA Legislation**

Needlestick Safety and Prevention Act – November 6, 2000
Revises and builds on the Bloodborne Pathogen Standard promulgated by OSHA.

The Needlestick Safety and Prevention Act (Pub. L 106-430) was passed because of the need for federal protection for healthcare workers against needlestick injuries. This act authorized federal OSHA to revise the 1991 bloodborne pathogen (BBP) standard. Provisions of the new law require changes to an institution's current Exposure Control Plan. These include the addition of two new terms, "Sharps with Engineered Sharps Injury Protections" and "Needleless Systems", and the modification of "Engineering Controls." Engineering controls refer to controls that isolate or remove the BBP hazard from the work place and include devices with engineered sharps injury protection and needleless systems.¹ Laboratories were required to be in compliance by April 18, 2001.



Attachment C: Example handout – annotated slide key

Employers are required to use engineering and work practice controls that eliminate occupational exposure, or reduce it to the lowest feasible extent, through a comprehensive program.

Slide 6:

Safety Trends

In March 2000, the Centers for Disease Control (CDC) estimated that depending on the device and procedure involved, 62% - 88% of sharps injuries could potentially be prevented by using safety-engineered medical devices. Since 1991, when the BBP standard was issued, there has been a substantial increase in the number and variety of effective engineering controls available.¹ “Safer medical devices” are designed so that the worker’s hand(s) remain behind the needle as it is covered. These include needles that retract, blunt or otherwise shield the sharp point or edge after use.²

Safety-engineered products designed to reduce risk of percutaneous injury related to blood collection include:

- **shielded, self-blunting, or retracting needles for vacuum tube phlebotomy sets**
- **plastic vacuum specimen tubes with shielded caps**
- **shielded, self-blunting, or retracting winged blood collection sets**
- **retracting finger/heelstick lancets**
- **blood gas syringes with a hinged needle recapping device and shielded tip caps**
- **unbreakable plastic capillary tubes for hematocrit determinations**

Additional information about safety-engineered devices are available at:

www.med.virginia.edu/~epinet

www.tdict.org

Additionally, a glass to plastic tube conversion has reduced tube breakage and biohazard risk. Preanalytical variables related to glass or plastic tubes are: platelet clumping, micro-clots and increased fibrin due to insufficient mixing of tubes. These errors can cause instrument obstruction, down time and erroneous results. Proper training and collection technique can prevent preanalytical errors from occurring.



Attachment C: Example handout – annotated slide key

Slide 7:

Relation Between Safety and Preanalytical Errors

With the proliferation of safety-engineered products, training in the use of these products is required for proper use and protection. Attention must be given to safety-engineered device usage, needle disposal and patient care. These tasks may distract the collector's attention away from proper specimen handling techniques.

Additionally, mixing is a critical step for proper product performance of plastic tubes. Laboratories that switch from glass to plastic will eliminate glass breakage issues; however, the importance of mixing cannot be stressed enough to reduce and/or avoid preanalytical errors. Training in the use of safety-engineered devices creates a perfect opportunity to train and reinforce specimen handling techniques.

Slide 8:

Relation Between Safety and Preanalytical Errors, Four key points to success:

1. College of American Pathologists (CAP) Requirements
 - The CAP requires proof that newly incorporated tubes in the lab were properly evaluated. This requirement is found in the Checklist Question: Gen.40520, which states: " The laboratory should evaluate its specimen containers to ensure that they do not contribute to analytic interference in the assays to be performed. This may be done through some combination of direct testing by the laboratory, review of the clinical literature, and evaluation of information from manufacturers. 'Inertness' of blood collection containers and specimen-contacting transfer devices and aliquot tubes cannot be assumed, as materials within these containers may lead to erroneous test results with medical consequences. Further, over or underfilling vacuum tubes may lead to error." ³

Attachment D: Example handout – Imported PowerPoint slide notes & images

Attachment D

Example Handout – PowerPoint Slide Notes and Images Format:

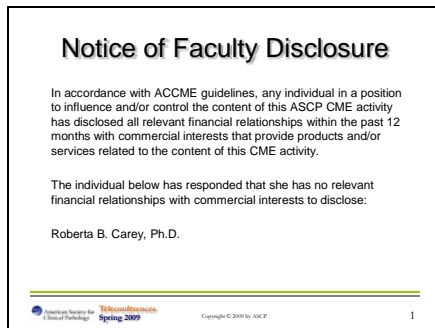
(Note: original length of handout has been reduced to facilitate printing)

Slide 0



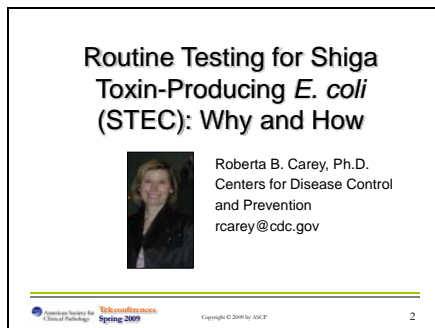
ASCP logo slide

Slide 1



Notice of disclosures of commercial relationships/interest by the presenter.

Slide 2



Title of today's lecture.

Attachment D: Example handout – Imported PowerPoint slide notes & images

Slide 3

Program Objectives

1. Identify the principal clinical and public health reasons for STEC testing
2. Explain the clinical laboratory's role in detecting and reporting STEC
3. Use the newest guideline for STEC testing to improve laboratory practices
4. Discuss the sensitivity of detecting STEC by culture and toxin assays

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Objectives for this program that we will cover today.

Slide 4

New Guideline for STEC

- "Recommendations for Diagnosis of Shiga Toxin-Producing *Escherichia coli* by Clinical Laboratories" (MMWR R&R)
- Authored by representatives from CDC, APHL, ASM, public health labs, commercial reference labs, academic medical centers
- Aimed at clinical and public health labs and the clinicians
- 104 references to support recommendations

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This is the title of the new guidelines for clinical laboratories, public health laboratories and clinicians with the supporting evidence for the recommendations from the literature and CDC experience.

Slide 5

Background

- *E. coli* that produce Shiga toxin (Stx) = STEC
 - 100 different STEC serotypes
 - O antigen= lipopolysaccharide
 - H antigen= flagellar
 - *E. coli* O157:H7 most commonly reported
- Shiga toxins similar to toxin produced by *Shigella dysenteriae* type 1
 - Stx1 and Stx2

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Throughout this presentation we will refer to the group of Shiga toxin producing *E. coli* as STEC. There are many different serotypes of pathogenic *E. coli* based on their cellular (O) antigen and flagellar antigen (H). More importantly *E. coli* makes two Shiga toxin types 1 and 2.



Attachment D: Example handout – Imported PowerPoint slide notes & images

Slide 6

Brand Identity Problem

- *E. coli* O157:H7
- *E. coli* O157
- STEC
- Enterohemorrhagic *E. coli* (EHEC)
- Verocytotoxigenic *E. coli* (VTEC)
- Stx+ *E. coli*

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Unfortunately there has been confusion about what to name this microorganism. We will use STEC to be inclusive of all *E. coli* producing Shiga toxin, not just *E. coli* O157:H7.

Slide 7

Epidemiology

- STEC causes ~100,000 illnesses/yr
 - 3200 hospitalizations, 91 deaths
- Approximately 8% of people with O157 STEC develop hemolytic uremic syndrome (HUS)
 - Thrombocytopenia
 - Hemolytic anemia
 - Kidney failure
- Non-O157 STEC just as virulent
 - Virulence linked to production of Stx2

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This slide provide some numbers on the severity of disease caused by STEC. HUS is the most severe consequence of this infection and has severe clinical hallmarks as described on the slide.

Slide 8

Transmission

- Occurs year round but especially summer
- Occurs in persons of all ages, but most common in children <5 yr
 - risk for HUS highest in this age group
- Occurs by consumption of undercooked ground beef, unpasteurized juice, raw milk and produce (spinach), contaminated water
- Low infectious dose (<100 organisms)

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Outbreaks are more common in warm weather, but transmission occurs all year round. Children are especially susceptible, and they do have the highest risk for HUS. These strains of *E. coli* are normal flora in animals, and animal waste can contaminate produce that is eaten raw. STEC are very effective pathogens, because like *Shigella* very few organisms are needed to cause disease. *Salmonella* requires 100,000 organisms to cause illness, but *E. coli* can do this with less than 100.

Attachment E

Example Handout – Paragraph-Style Format:

(Note: original length of handout has been reduced to facilitate printing)

Breast Biopsy Interpretation

Breast core needle biopsy (CNB) is currently the diagnostic procedure of choice for evaluating breast lesions. Compared to fine needle aspiration biopsy (FNAB), it provides a much detailed morphologic evaluation of the lesion in question without significant increase in complications related to the procedure. If the lesion is benign and the findings are concordant with radiographic findings, an open surgical procedure can be avoided. However, if the lesion is malignant appropriate planning (such as sentinel lymph node mapping) could be performed before definite surgical excision.

Diagnosis of breast lesions on core biopsy requires an understanding of breast cancer screening procedures, breast anatomy, and patient clinical presentation. The anxiety associated with a breast core biopsy mandates that a Pathologist maintains a 24 hours turn around time for each case. Although, this can be achieved for majority of cases, some requires additional procedures, such as deeper levels, obtaining additional clinical history and immunohistologic assays for definite diagnosis and therefore cannot be completed in 24 hours. For these cases, it is important to remember that a correct diagnosis is better than a fast diagnosis.

Patients undergo breast core biopsy generally due to one of the 3 main reasons:

- 1) Presence of a mass or mass-like lesion either clinically palpable or diagnosed on imaging.
- 2) Presence of suspicious calcifications on screening mammography.
- 3) Nipple discharge or skin/nipple changes.

The obvious concern for the patient and the radiologist/clinician is the presence of a malignant lesion. Not all mammographically detected lesions/changes are biopsied. Radiologists use a method of scoring called Breast Imaging and Radiologists Scoring (BI-RADS) system to assess if the lesion identified on imaging requires a biopsy.¹ Any lesion with a score of 4 is biopsied. The biopsy techniques and imaging modalities used by radiologists vary and is generally dependent on the type of lesion, most suitable method for visualization, and patient related factors.²⁻⁸ Calcifications are most obvious on screening mammograms and are amenable to stereotactic core biopsy. A mass lesion is generally best seen under ultrasound (US) guidance. US guided core biopsy offers several advantages over stereotactic biopsy. US is a real time procedure, i.e. it is possible to follow the motion of the biopsy needle as it moves through the breast tissue. Since it does not require breast compression, US guided core biopsy procedure may

Attachment E: Example handout – Paragraph-style

be more comfortable to the patient. US guided biopsy is faster, cheaper, avoids ionizing radiation and allows biopsy of areas hard to reach (under the arm or close to the chest wall) via stereotactic biopsy. Some difficult to see lesions are generally more obvious under magnetic resonance imaging (MRI).⁹ MRI is also used in some high risk patients to detect early lesions.^{10,11} Some breast centers have also started using bilateral breast MRI after the diagnosis of invasive cancer to exclude the possibility of multifocal disease, although the significance of this practice is currently debated. MRI guided core biopsies are more cumbersome than other methods and requires administration of gadolinium and therefore cannot be performed in pregnant patients.

The type of biopsy devices used may also vary by the type of imaging technique employed to perform the procedure. The vacuum assisted devices (VAD) have largely replaced automated large core (ALC) devices for stereotactic and MRI guided biopsies, but ALC devices are still used for US guided core biopsies. A VAD offer several advantages over ALC devices. VAD allows single insertion of the needle to obtain large amount of tissue which results in more accurate diagnosis and less false negatives. To further reduce the underestimation of disease, total removal devices (TRD) have recently been introduced that can be used under stereotactic or US guidance. This biopsy system requires an 8 mm skin incision and removes an intact portion of breast tissue preserving the architecture of the lesion.² More experience is required for its diagnostic and therapeutic use.

The pathology examination begins with the review of clinical history and indication for the core biopsy. The lesions identified on the core biopsy can be grouped into 3 main categories:

- 1) Benign lesions that do not require follow up surgical excision.
- 2) Benign or atypical lesions that require surgical excision.
- 3) Malignant lesions.

The management of the latter (malignant lesions) often requires a referral to the surgeon for appropriate management. However, recently more and more patients are receiving neo-adjuvant chemotherapy even for smaller tumors. Therefore, referral to oncologist is also common, and from pathology perspective, it makes more sense to do the receptor studies on all invasive breast carcinomas diagnosed on CNB.

The diagnoses of benign lesions that do not require follow up surgical excision are a relief to the patient and it is important for both the Pathologist and Radiologist to make sure that their findings are concordant. If there is discordance between pathology and radiographic findings, an excision is recommended. The benign lesions that do not require surgical excision include fibrocystic changes, ductal epithelial hyperplasia,¹² columnar cell changes,¹³⁻¹⁵ sclerosing adenosis,¹⁶ incidental pseudoangiomatous stromal hyperplasia, fibroadenoma,^{17,18} collagenous spherulosis,¹⁹⁻²¹ duct ectasia,^{22,23} fat necrosis,^{24,25} radiation related changes/atypia.²⁶⁻²⁹ The table 1 summarizes the clinical presentation, pathologic and clinical significance of these benign lesions.

Attachment E: Example handout – Paragraph-style

Table 1: Lesions that do not require surgical excision

Benign Lesions	Usual Clinical Presentation	Pathologic and/or Clinical Significance
Fibrocystic Changes	Cyst or mass (benign papillary apocrine metaplasia); abnormal calcifications.	Benign findings help explain the clinical abnormality; look carefully for calcium oxalate crystals if calcifications are not obvious at first glance.
Ductal Epithelial Hyperplasia	Incidental; mass-like lesion with florid hyperplasia.	Not to confuse with atypia or malignancy; florid hyperplasia has slight increase in relative risk (1.5-2.0) of developing invasive malignancy but excision is not required.



Attachment F: Example handout – Slide images only

Attachment F

Example Handout – PowerPoint Slide Images Only Format:

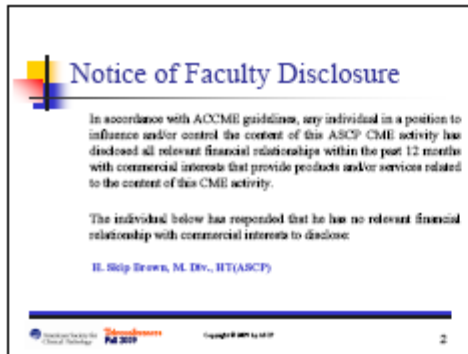
(Note: original length of handout has been reduced to facilitate printing)

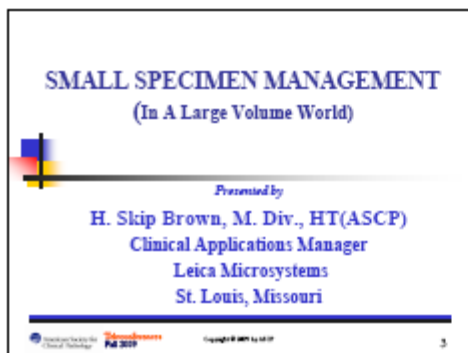
SMALL SPECIMEN MANAGEMENT(In A Large Volume World)

H. Skip Brown, M. Div., HT(ASCP)

9/11/2009









Attachment F: Example handout – Slide images only

COURSE OBJECTIVES

- Examine the shifting trend in anatomic pathology toward small specimen biopsies
- Evaluate microtechniques used with small tissue specimens
- Demonstrate small specimen microtomy techniques including optimal knife angles
- Review the imperative of effective communications, particularly between the embedder and the microtomeist

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