Rajiv Gandhi Cancer Institute and Research Centre

# NewsLetter

Issue: August 2022 | Vol. XXVI | No. 8 | Price: 50 Paisa

## EDITORIAL

## EMOTIONAL INTELLIGENCE IN HEALTH CARE: A FELT NEED

Emotional intelligence (E.I) has been quoted as an attribute which can improve the quality of work, increase productivity and help in personal and organizational success. Interest in EI arose from Goleman's*'Emotional Intelligence: Why It Can Matter More Than IQ',* which convened that success depended more on the ability to understand and control emotions than on IQ.One of the most appropriate definitions of E.I. is "a set of abilities (verbal and non-verbal) that enable a person to generate, recognize, express, understand and evaluate their own and others' emotions in order to guide thinking and action and successfully cope with environmental demands and pressures".

It is stated that people with a high degree of emotional intelligence are usually motivated, highly productive, love challenges, and are very effective in whatever they do. People with empathy are good at recognizing the feelings of others, even when those feelings may not be obvious (as in case of patient care). Hence, empathetic people are usually excellent at managing relationships, listening, and relating to others. Various models have been developed to measure E.I.; the most commonly quoted is the Golemans original model which outlines five main E.I constructs – self-awareness, self-management, social skills, empathy and two core emotional competencies –personal competence and social competence. EI skills are grounded in personal competence, upon which depend the skills for social competence, including social awareness and relationship management.

### EI AND PATIENT CARE

***"More than prescriptions, medicine involves communication, tolerance, flexibility, listening, hard work and a passion for the practice."***

Most complaints about doctors relate to poor communication and not their clinical competence. Improving communication in health care is a current area of interest in policy and practice. Models of E.I.emphasize on insights into one's own and others' emotions and this might be an explanation for why some practitioners appear to be better at delivering patient centered care. Further, assessing and discriminating patient's emotions could impact the quality and accuracy of history taking and diagnosis. Additionally, if clinicians are able to understand patients' emotional reactions to prescribed treatments or lifestyle advice they may be better able to understand why some treatments are more or less acceptable to some patients.

Healthcare professionals must attend to varying levels of health literacy in patients and families and face many challenges – challenges in communication including the exchange of information, building of a relationship and repo, engaging in shared decisions or challenges due to limited time and resources, and multiple documentation requirements.

Many health care systems around the world are emphasizing on more patient-centered care. By being empathetic, improving interactions and relationships with patients, healthcare professionals and administration, one can implement the principles of the patient-centeredness, which can significantly influence patient outcomes and overall success of an organization.

### EI AND HEALTHCARE LEADERS

"***All effective leaders are united by one essential feature-a high level of development of emotional intelligence***".

As per Daniel Goleman it is emotional intelligence and not IQ or technical skills that distinguish great leaders from merely good ones. There is positive correlation between E.I, leadership, communication, interpersonal skills and effectiveness of a team. By being skilled in E.I. healthcare leaders can understand, engage and motivate their team. These skills are essential for dealing well with conflict and creating workable solutions to complex problems in healthcare. The leader's E.I. skills strongly impact the culture of the organization.

Skills required for healthcare leaders to succeed generally fall into two categories: hard and soft skills .For physicians in particular, but also for many other healthcare leaders, "hard skills" are the technical skills traditionally emphasized in training. The "soft skills" are strategic skills which include interpersonal and communication skills and emotional intelligence. These, until recently, have received far less attention in formal training for either medicine, nursing or healthcare administration.

As defined by Reuven Bar-On, a pioneer researcher in the field of E.I., emotional intelligenceis,***"an array of non-cognitive (emotional and social) capabilities, competencies, and skills that influence one's ability to succeed in coping with environmental demands and pressures".*** Needless to say healthcare and public health are fields fraught with environmental demands and pressures with which leaders must endlessly cope.

Promoting one's own emotional intelligence can have an impact on the E.I.skills and behaviors of co-workers and team members' .Though, use of logic and reason in decision making and interaction are important, so is the recognition that humans are primarily emotional animals.

As aptly stated by Stein and Book, ***"regardless of how brainy we may be, if we turn others off with abrasive behavior, are unaware of how we are presenting ourselves or cave in under minimal stress, no one will stick around long enough to notice our high IQs".***

To conclude, contemporary healthcare has new challenges which require new strategies to cope with them. Emotional intelligence is a valid strategy and can address some of those challenges well. Strategies that facilitate strong E.I. skill development could prove exceptionally helpful to healthcare workers and leaders a like.It is general agreement that ***E.I. skills are a felt need.*** Health care workers must undergo training to enhance their EI abilities along with clinical skills to perceive patients' emotions and manage them better, which will lead to better patient care outcome and improve the doctor-patient relationship.

**Guest Editor**
**Dr. Anila Sharma**
Sr. Consultant, Pathology Department, RGCIRC, Delhi

## WHAT IS NEW IN 5TH EDITION WHO-FGT

The WHO classification of tumours are a system specific fascicles, also commonly known as WHO blue books. The fifth edition of WHO blue books are revised & updated edition, under the leadership of Dr. Ian Cree. The aim is to provide a classification and a set of international standards which underpin the diagnosis of tumour worldwide.

The new classification emphasized on key molecular events that resulted in the discovery of new tumour types and in refinement to the categorization of common neoplasm like endometrioid carcinoma.Importance is given to integrated morphological-molecular approach, with conventional pathology retaining its pivotal role in interpretation.

The specific organ wise updates of female genital tract WHO are reviewed below;Ovary:The histotype diagnosis is retained from 4th edition, with five main types of ovarian carcinoma having different risk factors, genetics,precursor lesions, immunophenotype, response to therapy and clinical outcome. Few changes in present edition include; reintroduction of mixed carcinoma category. Though rare, it is usually seen in background of endometriosis with clear cell and emdometrioid type. Rare ovarian carcinoma variants added includes mesonephric-like carcinoma and de-differentiated carcinoma (Endometrioid + undifferentiated carcinoma). Carcinosarcoma is now considered as carcinoma variant, rather than true mesenchymal and epithelial tumour. Seromucinous carcinoma has been removed, but is now included as morphological variant of emdometrioid carcinoma.

For non-epithelial ovarian neoplasm, category of gynandroblastoma(Male+ female differentiation) has been reintroduced. Information regarding underlying molecular abnormality in sex-cord stromal tumours, such as FOXL2 mutations in adult granulosa tumours.

Tumours of Peritoneum and Fallopian tube: Well differentiated papillary mesothelioma has been renamed as “well differentiated papillary mesothelial tumour”, to signify its benign clinical course.The primary peritoneal HGSC which is exceedingly rare needs fallopian tube origin to be ruled out first. The origin of most extra uterine HGSCs as fallopian tube (FT) fimbrial end is accepted, and detailed recommendations how to designate the site of origin is outlined in 5th edition.

Another clarification is in regard to multiple HGSC, it was previously thought that they could arise at multiple sites through some form of the “Field effect.” However it is now convincingly proven that HGSC at multiple sites are clonal, with one site representing the primary and others being metastatic.

Tumors of uterine corpus: Two new morphologic types of endometrial carcinoma included are mesonephric-like-carcinoma and mucinous carcinoma intestinal type(changed to mucinous carcinoma-gastric type). Serous intraepithelial carcinoma is excluded from the classification, because such lesions, even in absence of any invasion may shed malignant cells and metastasize. The morphologic classifications is thus left unchanged, barring above mentioned changes.Molecular classification based on TCGA(the cancer genome atlas), whose four subtypes [POLEmut, MMRdp53abn, and no specific molecular profile], correspond to molecular subtypes identified on basis of genomic architecture.Four molecular subtypes are more reproducible than morphologic classification, &can be assigned on biopsy specimen to aid in initial treatment planning, provide prognostic information and predict response to treatment.This classification is particularly useful in prognostication of grade 3 endometrioid adenocarcinoma.(PROTEC-3 trial). Table 1 gives detailed Molecular classification of endometrial carcinoma.The POLEmut category is important, as these tumour have a favourable prognosis despite having high risk pathological features. Hence clinical trials are ongoing for de-escalating treatment. The p53abn has high levels of somatic copy number alteration just like ovarian HGSC, howevever association with BRCA 1&2 is less likely. The presence of Her2 amplification and HRD make them amenable to targeted therapy. They however respond better to Combined Chemo-radiation. The NSMP category contains hormone positive tumours and encompasses most conventional endometrioid carcinoma. MMRd category is amenable to check point inhibitors in metastatic setting. They have poorer prognosis outside lynch syndrome associated carcinoma. Thus this classification finds place in many international treatment guidelines like NCCN.

| | POLE-ultramutated EC | MMR-deficient EC | p53-mutant EC | NSMP EC |
|---|---|---|---|---|
| **Associated molecular features** | > 100 mutations/Mb, SCNA very low, MSS | 10-100 mutations/Mb, SCNA low, MSI | < 10 mutations/Mb, SCNA high, MSS | < 10 mutations/Mb, SCNA low, MSS, 30-40% with CTNNB1 mutations |
| **Associated histological features** | Often high-grade, ambiguous morphology with scattered tumour giant cells, prominent TILS | Often high-grade, prominent TILS, mucinous differentiation, MELF-type invasion, LVSI | Mostly high-grade with diffuse cytonuclear atypia; glandular and solid forms exist | Mostly low-grade with frequent squamous differentiation or morule, absence of TILS |
| **Diagnostic tests** | NGS/Sanger sequencing / hotspot analysis includes p.Pro286Arg, p.Val411Leu, p.Ser297Phe, p.Ala456Pro, and p.Ser459Phe | MMR-IHC: MLH1, MSH2, MSH6, and PMS2; MSI assay; NGS | p53-IHC: mutant-like staining | MMR-proficient, p53-wildtype, and pathogenic POLE variant absent |
| **Associated clinical features** | Younger age at presentation | May be associated with Lynch syndrome | Advanced stage at presentation | Higher body mass index |
| **Prognosis** | Excellent | Intermediate | Poor | Intermediate to excellent |

**Table 1: Molecular classification of endometrial cancers**

The other recommendation pertains to synchronous low grade endometrioid carcinoma of the endometrium and ovary are clonally related, with endometrial being the primary carcinoma.

Mesenchymal tumours are better defined using molecular perturbations. 2020 WHO now includes molecularly defined entities like; High-grade endometrial stromal sarcomas associated with YWHAE- NUTM2A/B or BCOR genetic abnormalities, undifferentiated sarcomas associated with SMARCA4 mutation, Sarcomas associated with NTRK rearrangements. This will result in diminution of the category of undifferentiated sarcomas.

Cervical and lower genital tract epithelial neoplasm:Squamous & Adenocarcinoma are divided into HPV associated and independent, clear, mesonephric and gastric type included in later. The classification across lower genital tract sites is harmonized, including for vaginal and vulvar carcinoma. In vagina no HPV- independent lesion is defined. p16 immunostaining or HPV testing is required for this categorization. (Table 2A, 2B)

There is no difference in treatment between HPV-associated and HPV-independent tumours as of today. There is no evidence that an HPV-independent squamous precursor lesion exists, and squamous intraepithelial lesions are therefore grouped into a single, HPV-associated, category. Thus, Squamous are all HPV associated whereas adenocarcinoma are divided into HPV associated and independent.

**Table 2A. Comparison of the 2014 and 2020 World Health Organization (WHO) classifications of cervical squamous cell carcinoma**

| WHO 2014 | WHO 2020 |
|---|---|
| Squamous cell carcinoma, usual type | Squamous cell carcinoma, |
| Keratinising type | HPV-associated |
| Non-keratinising type | Squamous cell carcinoma, |
| Papillary type | HPV-independent |
| Basaloid type | Squamous cell carcinoma, NOS |
| Warty type | |
| Verrrucous type | |
| Squamotransitional type | |
| Lymphoepithelioma-like type | |
| HPV, Human papillomavirus; NOS, not otherwise specified. | |

**Table 2B. Comparison of the 2014 and 2020 World Health Organization (WHO) classifications of cervical adenocarcinoma**

| WHO 2014 | WHO 2020 |
|---|---|
| Endocervical adenocarcinoma, usual type | HPV-associated cervical adenocarcinoma (includes several subtypes; see text) |
| Mucinous carcinoma, NOS | HPV-independent cervical adenocarcinoma |
| Mucinous carcinoma, gastric type | Gastric type |
| Mucinous carcinoma, intestinal type | Mesonephric type |
| Mucinous carcinoma, signet ring cell type | Clear cell type |
| Villoglandular carcinoma | Other adenocarcinomas |
| Mesonephric carcinoma | |
| Serous carcinoma | |
| Clear cell carcinoma | |
| Endometrioid carcinoma | |
| HPV, Human papillomavirus; NOS, not otherwise specified. | |

Trophoblastic tumours: 5th edition WHO, Tabulates the different categories of trophoblast and the benign and malignant lesions arising from each category.The category of gestational trophoblastic neoplasms (GTNs) has been expanded to include mixed trophoblastic tumour. Diagnosis of molar and non-molar pregnancies has been given a more detailed description.Exaggerated placental site reaction and placental site nodule/plaque (PSN) are classified as tumour-like lesions (in the 4th edition, these were grouped as non-neoplastic lesions)

**Conclusion:** The new WHO classification addresses numerous issues and incorporates recent developments in the field. However because of large number of authors, some inconsistencies have crept in the text. The WHO has released the erratum to take care of some of these issues.

The online version with Whole slide images is a welcome change in this series.

**References:**

1. WHO Classification of tumours series, 5th edition; vol.4, 2020
2. Cree, I A, White, V A, Indave, B I & Lokuhetty, D Revising the WHO classification: female genital tract tumours; (2020) Histopathology 76, 151–156.
3. McCluggage, WG. Progress in the pathological arena of gynecological cancers. Int J Gynecol Obstet. 2021; 155(Suppl. 1): 107– 114
4. McCluggage WG, Singh N, Gilks CB. Key changes to the World Health Organization (WHO) classification of female genital tumours introduced in the 5th edition (2020). Histopathology. 2022 Apr;80(5):762-778.

**Dr. Gurudutt Gupta**
Sr. Consultant & Head – Histopathology, RGCIRC, Delhi

Date of Printing: 25th August 2022

Date of Publishing: 30th August 2022

Posted at: Ashok Vihar, Head Post Office, Delhi - 110052
Register with Registrar of Newspaper Under No.68797/1998
Postal Department Registration No. DL(N)/004/2021-23
Licensed to Post without Prepayment Under No.: "U"(DN)-162/2022-23

## PARENT SUPPORT GROUP MEET ("UMANG")


The Department of Pediatric Hematology & Oncology organized a Parent Support Group ("Umang") Meeting on the Saturday, 23rd July 2022 with the theme of **"Nutrition during Cancer Treatment"**.

Ms. Kajal Jaiswal, Child Life Specialist, coordinated an interactive session involving forty-eight children with their parents currently undergoing treatment in Pediatric Hematology & Oncology Department.

The session involved a quiz on nutrition with children and their families, and an interactive session with Dr. Gauri Kapoor and the Dietician emphasizing do's & don'ts during cancer treatment. This was followed by refreshment and gift distribution for all kids. Overall it was a grand success.

## PALLIATIVE CARE: THE NEED OF THE HOUR

The demand of Palliative Care is increasing day by day as statistics reveal that a huge number of cancer patients still get diagnosed in advanced stage. Data suggests that a large number of "Palliative Care Specialists" will be needed to cater this massive outbreak of cancer pain patients who will be requiring palliation at some point of time in their disease trajectory. In view of this, 2 days Conference (CME plus workshop) on "Cancer Pain Interventions & Palliative Care" was conducted at Gandhinagar Hospital, Jammu in collaboration with Indian Association of Palliative Care (IAPC). The CME was inaugurated by Directorate of Health Services, Jammu.

The theme of the conference was **"There is always hope in Palliative Care"**. The faculty members of Premier Institutes from India participated in the Conference for this noble cause to train delegates from various states. Dr Sunny Malik (Consultant In-Charge,Department of Pain and Palliative Medicine, Rajiv Gandhi Cancer Institute, Niti Bagh, Delhi) also shared his experiences and knowledge of "Cancer pain management and Palliative Care"with the delegates. Live cases of minimally invasive pain and spine interventions (MIPSI) were demonstrated and relayed from Operation theatre to the Conference Hall. Jammu's first procedure of Cooled Radiofrequency ablation was also done during this Conference by the Faculty from Rajiv Gandhi Cancer Institute and Research Centre, Delhi.




To:

If undelivered please return to:
Rajiv Gandhi Cancer Institute and
Research Centre, D-18, Sector - 5,
Rohini, Delhi - 110085

Printed and Published by Mr. Pramod Maheshwari on behalf of Indraprastha Cancer Society and Research Centre and printed at R. R. Enterprises, 18 - A, Old Gobind Pura Ext., Street No. 2, Parwana Road, Delhi - 110051, Tel: +91- 8447494107, Published from Rajiv Gandhi Cancer Institute and Research Centre, D - 18, Sector - 5, Rohini, Delhi - 110085

**Editor: Dr. A. K. Dewan**