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Table 1Comparison of women with urinary frequency and urgency with those without frequency and urgency.^a

	Frequency (n = 765)	No frequency (n = 1479)	OR (95% CI)	P value	Urgency (n = 857)	No urgency (n = 1387)	OR (95% CI)	P value
Drinks tea or coffee								
Both	477 (62.3)	845 (57.1)	1.2 (1.0–1.2)	0.01	541 (63.4)	704 (50.7)	1.6 (1.4–2.0)	<0.001
Tea	162 (21.2)	492 (33.2)	0.5 (0.4–0.6)	<0.001	199 (23.3)	435 (31.4)	0.6 (0.5–0.7)	<0.001
Coffee	97 (12.6)	87 (5.8)	2.3 (1.7–3.1)	<0.001	83 (9.73)	77 (5.5)	1.8 (1.3–2.5)	<0.001
Uses mug for beverage	607 (79.3)	1211 (81.8)		0.6	706 (82.7)	1013 (73.0)		0.2
Drinks >5 mugs tea	291 (38.0)	505 (34.1)		0.07	202 (23.6)	314 (22.6)		0.5
Drinks ≥10 mugs tea	116 (15.1)	198 (13.3)		0.02	41 (4.8)	15 (1.2)	4.1 (3.1–7.2)	<0.001
Use >2 tea bags	39 (5.1)	60 (4.0)		0.02	61 (7.15)	36 (2.6)	2.6 (1.7–4.1)	<0.001
Drinks ≥6 cups/mugs of coffee per day	56 (7.0)	31 (2.0)	3.6 (2.3–5.7)	<0.001	57 (3.1)	28 (2.02)	3.7 (2.3–5.8)	<0.001
Use >3 spoonfuls of coffee	11 (1.4)	5 (0.3)	4.3 (1.4–12.4)	0.003	11 (1.28)	6 (0.4)	3.1 (1.2–8.4)	0.01
Drink ≥1 glass of alcohol per week	272 (35.5)	418 (28.2)	1.4 (1.1–1.6)	<0.001	299 (35.0)	363 (26.1)	1.5 (1.2–1.8)	0.002
Drinks ≥2 liters of fluid per day	211 (27.5)	196 (13.2)	2.4 (0.3–0.4)	<0.001	150 (17.5)	243 (19.2)		0.3
Bothered by frequency symptom	368 (48.1)	44 (2.97)	28.9 (20.7–40.3)	<0.001				

^a Values are given as number (percentage) unless otherwise indicated.

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Twinning of obstetric and gynecological societies in Tanzania and the Netherlands

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This report describes the collaboration between the Association of Gynaecologists and Obstetricians of Tanzania (AGOTA) and the Working Party on International Safe Motherhood and Reproductive Health (www.safemotherhood.nl), a committee of the Dutch Society for Obstetrics and Gynaecology (NVOG) and the Netherlands Society for Tropical Medicine and International Health. The collaboration between the two societies ran from 2006–2012 and was inspired by FIGO's Saving Mothers and Newborns projects, but was not implemented under FIGO's umbrella nor was funding provided by FIGO. Funding for the collaboration was provided by NVOG and several civil society organizations.

From 1998 onward, several programs were instituted under FIGO's Safe Motherhood and Newborn Health project, all using a twinning mechanism whereby an active member society was paired with a member society in a country with high rates of maternal and newborn mortality. Although the projects have proven successful in involving health professionals, the project model was not without flaws or challenges. The work was largely undertaken by health workers already engaged

in full time jobs and, therefore, the country projects relied heavily on volunteerism [1].

The twinning cooperation agreement between AGOTA and NVOG was signed in 2006 and covered a 5-year period; in 2010 it was extended for 2 years, until the end of 2012. The aim of the program was to increase women's access to quality obstetric care.

Kilwa District was chosen as a pilot district for improving the quality of maternal health services. The most important activity was organizing training in lifesaving skills in emergency obstetric care. The first training session was conducted in Dar es Salaam in 2007 and 24 senior obstetric healthcare workers (gynecologists, midwives, and nurses) were trained. From 2008, 7 training sessions were organized in Kilwa District and 135 healthcare workers (80%) were trained [2–4]. The training materials were left at Kilwa Hospital and management was encouraged to organize refresher courses.

A new maternity ward was built and the operation theatre was rehabilitated at Kilwa Hospital. For rural health centers and dispensaries, medical supplies and equipment were purchased to facilitate health workers to use their new skills and knowledge.

An exchange program for residents training in obstetrics and gynecology was organized. Between 2008 and 2012, 5 Tanzanian residents visited the Netherlands for a 4 to 6-week period to become familiar with different aspects of gynecological and obstetric care in the Netherlands. Unfortunately, the exchange remained unidirectional. Several Dutch residents had wanted to go to Tanzania; however, logistic problems concerning working permits and the hesitation of Dutch supervisors to give permission eventually turned out to be impassable barriers.

It is difficult to evaluate the program because it lacked a structured approach. A situational analysis and needs assessment were not well done and there was no plan of activities. Outcome indicators were not defined.

The exchange program for residents was evaluated positively by all people involved. The residents who came to the Netherlands have continued to play an important role in fighting poor neonatal and maternal

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health in Tanzania. Collaboration between Dutch and Tanzanian gynecologists in research projects is an example of the positive outcomes.

Efforts to improve maternal health services in Kilwa have also been evaluated positively. However, upgrading of skills and training is not sufficient. Supportive supervision and monitoring and development of local capacity are needed to create real impact [5].

It was recognized early on in the program that increasing the institutional capacity of AGOTA was an important goal. For professional associations to take an active part in strengthening the health system, they must first be healthy and sustainable themselves [6]. For that reason AGOTA received financial support for organizing annual scientific conferences. However, increasing the institutional capacity of AGOTA lagged behind, and ownership and subsequent sustainability of the program have not developed sufficiently.

Several lessons were learned that will help the design of future collaboration projects. Insufficient attention was paid to the organizational capacity development of AGOTA, and obstetricians and gynecologists are not automatically adequately skilled and equipped to manage development programs.

Situational analysis and needs assessment should be done in an early phase of the collaboration to ensure a plan of activities and a clear process. Outcome indicators should be defined. Data should be collected and analyzed to monitor progress. Time constraints of both Dutch and Tanzanian obstetricians, all involved in (more than) full time jobs, have negatively influenced running the projects. If financial means were available, paid program managers could play an important role.

In summary, the twinning program between AGOTA and NVOG has certainly been a positive experience for all people involved.

However, to achieve a sustainable program with higher impact, a structured approach with proper data collection and analysis before and after the program and more emphasis on development of the capacity of professional associations are needed.

NVOG no longer provides financial support for the twinning program. The Working Party will continue to work together with other partners, aiming to improve maternal and neonatal health services worldwide. Accepting high levels of maternal and neonatal mortality and morbidity, a scandal of our time, is not an option.

Conflict of interest

The authors have no conflicts of interest.

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Fallopian tube invasive molar disease

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Only about 1% of all pregnancies in the UK are ectopic. The presence of hydatidiform moles varies worldwide from 1% in Southeast Asia to 0.05% in the USA, making the combined incidence of ectopic molar pregnancy somewhere between 0.01% and 0.00005% [1]. Tubal invasive molar disease is extremely rare, with only 3 cases reported in the literature [2].

A 20-year-old woman (G2, P1) presented at the emergency room with severe low abdominal pain 8 weeks and 4 days after her last

menstrual period. The patient had had a term vaginal delivery 2 years previously. There was no significant medical history. On examination, the patient's pulse was 88 beats per minute and her blood pressure was 98/63 mm Hg. A urine pregnancy test was positive. Transabdominal ultrasound revealed an empty endometrial cavity with cul-de-sac fluid and a left adnexal mass. Beta human chorionic gonadotropin (β -hCG) level was 6984 mIU/ML. The patient underwent laparoscopy and salpingectomy for a left ampullary ectopic pregnancy. An obvious bleeding site in the tube was seen. The pathology report identified a tubal invasive mole and tubal rupture (Fig. 1). Weekly quantitative β -hCG titers were performed until 3 successive β -hCG levels were negative.

Gestational trophoblastic disease (GTD) is characterized by an abnormal proliferation of trophoblasts during pregnancy, including complete and partial hydatidiform moles, invasive moles, placental-site trophoblastic tumors, and choriocarcinomas. The last 3 are malignant and are termed gestational trophoblastic neoplasia (GTN) [3].

Tubal invasive molar pregnancy is confirmed by strict histopathologic criteria, along with the presence of hydropic chorionic villi accompanied by trophoblastic proliferation, destruction of smooth muscle, and vesicle invasion into the tubal wall. If the diagnosis is in doubt, a ploidy evaluation using DNA flow cytometric analysis can be done to differentiate gestational trophoblastic tumors from non-gestational germ cell tumors [3,4].

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