CONCLUSION
The risk of the complete mole to progress to a gestational trophoblastic neoplasia is around 15-20%. This percentage can be higher in high-risk patients (levels of BHCG > 100000, maternal age < 40, background of previous mole). Patients with non-metastatic disease (stage I) can be treated initially with methotrexate in monotherapy, obtaining cure rates close to 80-90%. In case of resistance to treatment like ours, treatment with Actinomycin D or even the MAC protocol should be initiated (polychemotherapy with Methotrexate, Actinomycin D and Cyclophosphamide)

Hysterectomy should also be considered when the uterus has significant involvement by the tumor, to prevent or treat bleeding and perforations, or because of the risk of infection. Under these circumstances, surgery may shorten the duration of chemotherapy treatment in patients with resistance to monotherapy.

CASE REPORT
A 36-year-old patient diagnosed with abortion was suspected of having a hydatidiform mole with a BHCG level of 91752 mUI. Vacuum curettage was performed by aspiration without incidents. The anatomy reported complete hydatidiform mole.

In later controls of BHCG, the values were initially checked down to 111, but subsequently it started again with elevation of them until 13390.
Ultrasound was performed visualizing an intramiometrial image on the posterior side of about 23 mm Doppler positive. Normal ovaries. Brain, chest and abdomen TC were normal.

A pelvic MRI was requested and reported uterine varices, being more numerous in the thickness of the posterior wall, where in addition an image of 6 mm of greater signal in T2 was observed, indeterminate.

After analyzing the complementary tests, a low-risk post-molar gestational trophoblastic neoplasia was diagnosed, stage I of the FIGO (disease confined to the uterus), and therefore required a single chemotherapeutic agent (methotrexate 0.4 mg / Kg for 5 days).

Subsequently, he continued with biweekly methotrexate treatment (50 mg x m2). 2 doses were administered.
Initially, the levels of BHCG were reduced to 432, but in the last control, it stabilized and even increased.

A new ultrasound examination was performed, confirming an increase in the size of the positive Doppler intramyometrial image (37x21 mm). Ovaries presented bilateral hemorrhagic follicles, probably tecaluteinic cysts.
On suspicion of resistance to treatment to Methotrexate, it was decided to start treatment with biweekly Actinomycin D and propose a simple abdominal hysterectomy.