clude a infrasound heterogeneous structure with internal echogenic echoes with irregular margins, often infiltrating the adjacent tissues. Although ultrasound check cannot detect the peritoneal endometriotic implants, the use of transvaginal sonography today is useful in investigation of pelvic structures, to determine the coexistence of pelvic disease. With earlier study by Wolff and colleagues showed that 25% of women with endometriosis in laparotomy scar after cesarean section coexisted a pelvic disease. Computed tomography and particularly magnetic resonance imaging outweigh ultrasound as it is able to provide valuable information on the location, depth, extent of damage and the possible infiltration of adjacent tissues from ectopic endometriotic area.

Unlike imaging, the aspiration biopsy with thin needle (Fine Needle Aspiration – FNA) can be a valuable and reliable diagnostic tool in the investigation of palpable masses in the abdominal wall. The method can distinguish ectopic endometrium from other pathologies included in the differential diagnosis of endometriosis of the abdominal wall and contribute to timely and accurate preoperative diagnosis, in order to achieve the most appropriate therapeutic approach design disease.

The treatment of endometriosis of the abdominal wall depends on the severity of symptoms and the age of the patient. Wide surgical resection of ectopic endometriotic outbreak remains the treatment of choice, even for repeated recurrent lesions. It is usually curative, and also ensuring the confirmation of diagnosis. Intraoperatively, it is necessary to thorough cleaning of adjacent tissue damage in order to minimize the chances of relapse of the disease. If the symptoms are mild and the patient is to gestate in the near future, the surgical removal of the lesion should be carried out during cesarean. Contrary to the surgical treatment, administration of hormonal preparations as first treatment appears to offer only temporary relief of symptoms. The role of conservative treatment in endometriosis of the abdominal wall is combined with surgical resection of the area in those cases of suspected excision of the lesion on unhealthy limits in order to avoid the increased risk of relapse. The role of conservative treatment in endometriosis of the abdominal wall is combined with surgical resection of the area in those cases of suspected excision of the lesion on unhealthy limits in order to avoid the increased risk of relapse.

Finally, new therapeutic techniques that intend to reduce vascularization of ectopic endometrial tissue have been proposed and expected future to expand the available therapeutic options for the effective treatment of endometriosis, especially pelvic form of the disease.

The prognosis of endometriosis of the abdominal wall is usually good. Immediately after surgery most patients report relief of their symptoms. Postoperative monitoring to determine Ca125 is necessary. The Ca125 a recurrence rate of the disease, and malignancy, as reported in the international literature in recipient tumor masses endometriotic origin in surgical scars after gynecological surgeries or cesarean.

**Conclusion**

Endometriosis of the abdominal wall is generally iatrogenic. It is a rare form extra pelvic endometriosis in the differential diagnosis which should include all