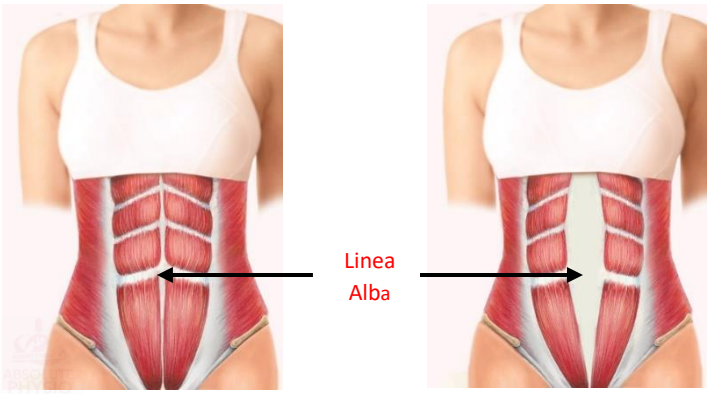
Diastasis doesn't have to be disastrous

If you have been following this week's Pelvic Roar campaign, you will know that it featured *Diastasis Recti*, the medical term given to the separation of the outer most abdominal muscles. An often feared and misunderstood condition and one that causes debacle across social media platforms as a result of conflicting information and the high prevalence of non-evidence-based products and services that are marketed to women seeking answers.

On the contrary to the infinity of inadequate information out there, some degree of separation at the *linea alba* (the connective tissue in between the 2 muscle bellies of the rectus abdominus – see illustration below) is **completely normal** towards the end of pregnancy. If you think about it, this separation serves a purpose and enables a woman's body to facilitate a growing baby. Pretty awesome, huh?

Normally this natural widening resolves itself in the weeks following delivery, however, in approximately 1/3 of postnatal women, the separation can remain. The reasons for this remain largely unknown. Some hypotheses include genetic predisposition, lifestyle and activities during and after having a baby e.g. constipation, repetitive lifting of young children and inappropriate abdominal loading exercises.



While diastasis is not life threatening, it can have a negative impact upon a woman's wellbeing. Mental health can be significantly affected with negative body image and lower self-esteem as a result of how the abdominal separation looks and makes you feel. Abdominal function can be reduced particularly in rotational movements and activities requiring rectus abdominis strength. There is also some research suggesting an increased risk of women with diastasis developing pelvic floor dysfunction such as pelvic organ prolapse.

So, what is the answer??? First and foremost, we need **LOTS** more research and studies investigating this condition. There is no conclusive consensus or one size fits all answer to the management of Diastasis. The following proforma has been developed using the best evidence to date and should be considered with every woman presenting with abdominal separation to guide a holistic approach to individualised assessment and management:

Person – what is your journey with diastasis to date? How does it make you feel? What are your expectations for rehabilitation? Do you want to function better? Do you want to feel stronger at your 'core'? Or is how it looks your main concern and goal? Finding out your relationship with diastasis is key to designing a rehabilitation program that aims to achieve *your* goals and also to evaluate whether your *expectations* are likely to be achieved via conservative rehabilitation or not.

Posture – Could Diastasis be influencing your posture or could posture be influencing your diastasis? While there are no *"perfect postures"* being able to move through a variation of postures is key to normal movement. Slumped or slouched postures can be adopted in subconscious attempts to hide our bellies but did you know that such postures are linked to negative confidence and lower feelings of self-efficacy? If you are already not feeling great about your tummy then slumped postures are unlikely to help. How we hold ourselves can also influence how we breathe. We will discuss the importance of breathing further down.

Patterns – Some women with Diastasis develop compensatory strategies where they over use alternative abdominal muscles e.g. the obliques. Our bodies are very intelligent and will always ensure function is maintained as best as possible by bringing in other muscles that may not usually carry out a specific role. While this is clever, it is beneficial to address some of these compensatory strategies to ensure they are not encouraging rib flare – which can encourage ongoing abdominal separation. Continuous gripping at the abdominal muscles may also have an impact upon the pelvic floor muscles and their function.

Respiration – We all know that breathing is essential for life, but did you know that the diaphragm, abdominal wall and pelvic floor muscles function in synergy with each other. This means that technically, an issue or dysfunction with one can encourage an issue or dysfunction at another. On the positive, it also means that we can address issues or dysfunction at all three using the function of the other two muscles. Encouraging good awareness of how we breathe, and the ability to vary how we breathe, e.g. doing some diaphragmatic breaths rather than natural costal breaths, can be beneficial for normalising function at both the abdominal and pelvic floor muscles. Breathing also plays an important role in intra-abdominal pressure regulation. Normal everyday activities alter the level of intra-abdominal pressure in our abdomen, e.g. a cough, sneeze, or opening our bowels will increase the intra-abdominal pressure. Excessive intra-abdominal pressure may put unnecessary strain on the *linea alba* encouraging diastasis. Therefore, being able to utilise how we breathe to regulate and manage intra-abdominal pressure is an important strategy.

Ribcage – An important component in breathing (discussed above), the ribcage expands outwards and elevates as we breath in and reduces and descends as we breath out. The ribcage naturally moves up and outwards during pregnancy to facilitate room for the growing baby. In some women it does not naturally return to pre-pregnancy position and remains somewhat flared. Due to the attachments of the abdominal muscles to the ribcage, ongoing flaring can encourage ongoing abdominal separation. Exercises that encourage control and depression of the ribs may help.

Load – Rehabilitation of any muscle groups or injuries involves appropriate loading at the appropriate time. This is no different for Diastasis. Progressing to the maximum load that you can achieve without losing control of intra-abdominal pressure or lumbo-pelvic stability (indicated by visual signs of 'doming', 'bulging' or 'sinking' at the midline during abdominal effort or arching and flaring at the ribs to achieve more stability) is key to progressing abdominal strength and function. Loading appropriately also demonstrates beneficial response in reducing inter-recti distance and depth at the diastasis. Your goals for loading need to be specific to your over-all aim. The type of sport or activity you wish to get back to needs to be considered and there is no right or wrong activities in the same way as there are no right or wrong exercises. A rehab program which challenges all the main muscle groups in multiple planes of movement is advisable. With the majority of women seeking help for Diastasis being new mums with young babies and children to look after, we need to ensure rehab assists women in becoming strong and fit for purpose in all the daily tasks required of them.

Defect – Women with Diastasis are also at risk of hernias e.g. umbilical hernia. Umbilical hernia's are not to be feared and are quite prevalent in pregnant and postpartum women, i.e. they don't just occur with Diastasis. While they are low risk for strangulation and therefore often not treated at all, it is important that if you think you may have a hernia, to seek advice from your GP or Consultant. While all modes of deliveries are absolutely normal, it is also important to consider scar tissue in terms of a defect. Scar tissue may present at the perineum in women who undergo vaginal delivery, or in the lower abdomen for women who have had a caesarean section. Mobilising scar tissue is important to ensure that the connective tissue mobilises/slides/glides freely and to ensure that there is no hypersensitivity associated with that area which may impact upon its function. No matter what type of delivery women have it can be associated with traumatic memories of the delivery experience. Touching and mobilising perineal or caesarean section scars helps the overall healing process including overcoming traumatic associations with that delivery. Positive affirmations and thoughts while you mobilise the tissue is key, with understanding and appreciation for how amazing our bodies are in what they undergo during childbirth and how resilient and versatile they are in their recovery. If trauma is something that is ongoing it can be beneficial to speak with your GP or care provider to arrange a birth debrief. How you feel and think about this area can impact on its function which in turn may impact upon the rehabilitation of Diastasis.

Overall, Diastasis should be considered as an absolutely normal component of pregnancy. Rehabilitation is only indicated if excessive separation is ongoing or if you find that your abdominal function remains compromised. The proforma described above, **PPP-RR-LD**, helps you consider different components that can be important in the overall recovery of Diastasis. Seek referral to a pelvic health physiotherapist if you need further guidance on your recovery.

References

Donnelly, G. (2019) Diastasis rectus abdominis: physiotherapy management. *Journal of Pelvic, Obstetric and Gynaecological Physiotherapy* Spring (124) Pp.15-19.

Hills, N. F., Graham, R. B., and McLean, L. (2018) Comparison of trunk muscle function between women with and without diastasis recti abdominis at 1 year postpartum. *Physical Therapy* 98(10), pp.891-901.

Mota, P., Pascoal, A., Carita, A. and Bø, K. (2015). Prevalence and risk factors of diastasis recti abdominis from late pregnancy to 6 months postpartum, and relationship with lumbo-pelvic pain. *Manual Therapy*, 20(1), pp.200-205.