

may achieve greater short-term structural improvements than “exercise + abdominal support” (Skoura et al., 2024; Du et al., 2025). In addition, both conventional abdominal training and hypopressive training may produce positive effects on IRD within 6 weeks, although differences exist between resting and contraction conditions, and multiparous women may experience greater benefits (Table 1) (Soto-González et al., 2024).

Table 1 Mean (SD) of Inter-Rectus Distance (mm) measured 2 cm (AB2) and 5 cm (AB5) above the umbilicus

Probe Location	Group	Moment 1 (Week 0)	Moment 2 (Week 6)	Probe Location	Group
		RT Mean (SD)	AC Mean (SD)	RT Mean (SD)	AC Mean (SD)
AB2	Conventional	21.5 (8.99)	23.42 (9.20)	17.03 (7.94)	18.79 (8.31)
	Hypopressive	20.81 (8.46)	21.23 (8.68)	19.31 (7.46)	19.62 (7.83)
AB5	Conventional	20.97 (9.89)	16.44# (8.15)	19.03* (10.95)	17.30 (9.95)
	Hypopressive	22.04 (9.31)	20.21 (7.67)	21.38 (10.32)	17.95**# (9.42)

Table caption: * The mean difference is significant ($p < .05$) between week 0 and week 6; # The mean difference is significant ($p < .05$) between RT and AC

However, short-term findings are limited by considerable heterogeneity across studies. Variations in intervention frequency, training dosage, participant characteristics, measurement methods, and follow-up duration, along with small sample sizes and high risk of bias in many studies, require cautious interpretation of the evidence despite generally favorable trends. This suggests that short-term improvements do not necessarily translate into sustained long-term benefits. Long-term evidence remains limited, but available data suggest that structural and functional improvements may be maintained when rehabilitation is combined with continued training, behavioral modification, or comprehensive management strategies. Early randomized trials have shown that abdominal support combined with exercise can improve body image and trunk flexion strength at 6-month follow-up. For patients with severe DRA and poor response to conservative treatment, the “training-operation-rehabilitation (TOR)” model has demonstrated significant improvements in functional impairment and quality of life at 1 year postoperatively, with no obvious recurrence, indicating promising long-term outcomes for integrated approaches in refractory cases (Janiszewska et al., 2025). However, mild to moderate DRA may also exhibit natural recovery within the first postpartum year, which complicates interpretation of long-term effects of low-intensity or poorly controlled interventions (Beamish et al., 2024).

6 Current Limitations in Research

6.1 Lack of standardized diagnostic criteria and assessment methods for DRA

Despite increasing research attention, there is still no consensus on the diagnostic criteria and assessment methods for diastasis recti abdominis (DRA), which has become a major barrier to study comparability, evidence synthesis, and clinical translation. Most studies rely on inter-recti distance (IRD) as the primary diagnostic indicator; however, thresholds for defining “abnormal” separation vary considerably. Different studies use cut-offs such as ≥ 2.0 cm, ≥ 2.5 cm, ≥ 28 -30 mm, or criteria based on fingerbreadths, body proportions, or population norms, with measurement sites ranging from above, at, or below the umbilicus, and assessment conditions including rest, light curl-up, or muscle activation (Skoura et al., 2024). This variability in definitions and thresholds contributes to substantial heterogeneity in prevalence estimates, severity classification, and reported treatment effects, making cross-study comparisons difficult.

In addition to diagnostic thresholds, assessment methods themselves show considerable heterogeneity. Measurement tools include finger palpation, calipers, ultrasound, and, less commonly, CT and MRI. Although ultrasound is increasingly regarded as a reliable reference method, its measurement process involves multiple technical factors, such as probe pressure, breathing control, body positioning, selection of measurement sites, and repetition, which are not yet fully standardized and may introduce systematic error. Meanwhile, finger-width palpation, although simple and widely used, has only moderate reliability and is more suitable for identifying the presence of DRA rather than detecting subtle changes in IRD, potentially masking clinically meaningful improvements (Skoura et al., 2024). In response, some countries have proposed standardized pathways, for