NHS
Cheshire and Merseyside

Clinical Commissioning Policy

Diastasis (divarication) of the Recti Repair

Category 1 Intervention - Not routinely commissioned

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Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
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1. Introduction

1.1 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

1.2 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined in Appendix 1.

1.3 At the time of publication, the evidence presented per procedure/treatment was the most current available.

2. Purpose

2.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

3. Policy statement

3.1 Diastasis (divarication) of the recti repair is not routinely commissioned.

4. Exclusions

4.1 Patients with coexistent ventral hernia are considered to be out of scope of this policy.

5. Rationale

5.1 A systematic review identified no randomised controlled trials (RCTs) for the surgical correction of diastasis recti. The review reported a very high rate of complications including seroma, haematoma, minor skin necrosis, wound infections, post-operative pain, nerve damage and recurrence.

5.2 A 2nd systematic review of the surgical management found the overall quality of published studies was low to moderate with limited scientific power

5.3 Because of the low-quality evidence for both safety and efficacy, it was concluded surgical correction should not routinely be commissioned.

6. Underpinning evidence

6.1 Diastasis of the recti (the rectus abdominis muscles) is the thinning and widening of the line down the middle of the tummy (linea alba) which allows part of the underlying abdomen to bulge through. Divarication means splitting in two, which is a word used sometimes in place of diastasis. With diastasis, the muscles separate and weaken, so the midline bulges when intra-abdominal pressure is increased but the fascia (underlying layer) remains intact. This is unlike a hernia, which is a hole in the fascia which lets tissue and organs poke through and has the potential to become strangulated if the organs/tissue cannot return into the abdomen.

6.2 Diastasis of the recti is a common problem, particularly after pregnancy. There is a scant knowledge on the prevalence, risk factors, prevention or management of the Diastasis of the recti abdominus[1] Prenatal exercise is not associated (positively or negatively) with diastasis recti[1]. Women are at risk of developing persistent symptomatic diastasis recti abdominus which may have a detrimental effect on their physical function and quality of life[3], although the extent to which women with the diastasis suffer low back pain or pelvic floor dysfunction has been found to be no different to a comparison group with diastasis[4]. In the majority of women, diastasis of the recti resolves naturally, without treatment in the months after the delivery of the baby[1].

6.3 Diastasis recti can also occur in men and women who have not been pregnant, often due to rapid changes in weight, but also commonly caused by improper exercise technique and weightlifting.

6.4 Indication for surgical repair of the Diastasis of the recti is based on cosmetic or functional impairment

6.5 There is a lack of consensus on the preferred treatment of this condition; physiotherapy and surgical intervention and are the most frequently reported treatments. Although numerous studies confirm the positive influence of exercises on reducing the inter-recti distance no generally acceptable protocol of therapeutic exercises has been formulated so far. It has not been assessed which abdominal exercises are the most effective[1]. Operative repair is controversial, with some authors stating that the decision should be based on the size of the gap <3cm)[5], with others6 stating that decision should be influenced primarily by the size of the protrusion rather than the gap.

6.6 A systematic review in 2011 identified no Randomised Controlled Trials for surgical correction of the diastasis. Although the 7 non-controlled studies that were found reported high satisfaction following surgery[3], there was a very high rate of complications, commonly seroma, but also haematoma, minor skin necrosis, wound infections, dehiscence, post-operative pain, nerve damage and recurrence, the rate of which can be as high as 40%[7]. A 2017 systematic review[8] of general surgical (as opposed to plastic surgery) repairs and physiotherapy found that the overall quality of published studies was low-to moderate, combined with limited scientific power since only five prospective studies were included, of which only two were Randomised Controlled Trials (RCTs). The primary outcome for surgical studies was recurrence rate, secondary outcomes were complication rate within 30 days, and patient satisfaction. Some studies reported no recurrence, others had relatively high levels of post-operative complications such as seromas (as previously).

6.7 The primary outcome for physiotherapy studies was the effect of the treatment on the gap - the Inter Rectus Distance (IRD) - measured in a relaxed state, and these authors found no literature reporting improvement with intervention[8]. There is another review of physiotherapy interventions however, which reported reductions in IRD, but the research was poor quality[9].

6.8 Surgery can be laparoscopic or open, standard hernia repair type or plication (folding) of one of the layers of fascia, and most commonly using mesh. No clear difference was found between any of the techniques[8]. The plication techniques can leave a surplus of skin directly after surgery, undesirable from a cosmetic perspective[10], but not of concern if the intent is improved trunk function. Open procedures carry the risk of later abdominal hernias.

6.9 A study of repair associated with small midline hernias mentioned that open repair with preperitoneal placement of mesh without approximation of the rectus fascia, i.e. not bringing the two sides of the gap together (resembling a bridged repair) leads to fluctuating cosmetic results, since protrusion of the tummy may still be present after mesh placement[11].

6.10 It is worth mentioning that the difference between diastasis recti and ventral hernia is important, but they may coexist. When that is the case, it would be out of scope of this policy – it would be a hernia repair, and would be treated if it met the criteria for repair, i.e. if it were symptomatic; a case report was found which treated these coexisting conditions successfully[12].

References

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7. Force

7.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

8. Coding

8.1 **Office of Population Censuses and Surveys (OPCS)**
T28 Other repair of anterior abdominal wall
T51 Excision of fascia of the abdomen
T57 Other operations on fascia,
T573 Repair of fascia,
T578 Other specified other operations on fascia
T579 Unspecified other operations on fascia
All in conjunction with Z92.6 Abdomen NEC

9. Monitoring And Review

9.1 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

9.2 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

10. Quality and Equality Analysis

10.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

Appendix - Core Objectives and Principles

Objectives

The main objective for having healthcare commissioning policies is to ensure that:

- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

Principles

This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

Core Eligibility Criteria

There are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

Cosmetic Surgery

Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

A summary of Cosmetic Surgery is provided by NHS Choices. Weblink:
http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and
http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

Diagnostic Procedures

Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

Clinical Trials

The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

Clinical Exceptionality

If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy.