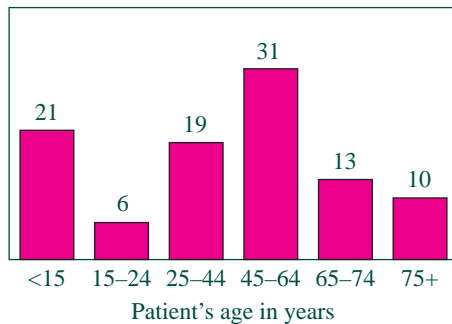
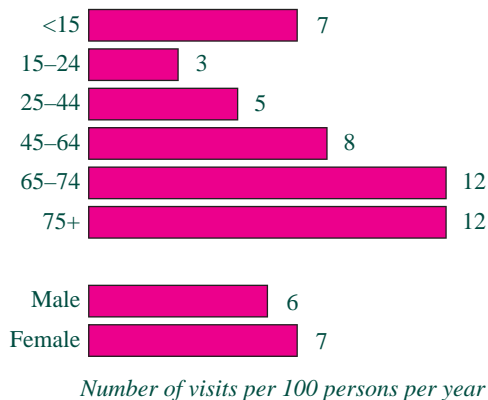


In 2009, there were an estimated 20 million visits to nonfederally employed, office-based otolaryngologists in the United States. One-fifth of the visits were made by persons under 15 years of age.

Percent distribution of office visits by patient's age: 2009



Annual office visit rates by patient's age and sex: 2009. The visit rate was not different for males and females.



Primary expected source of payment included:

- Private insurance — 73%
- Medicare — 21%
- Medicaid — 11%
- No insurance¹ — 2%

The major reason for visit was:

- New Problem — 35%
- Chronic problem, routine — 28%
- Pre- or post-surgery/injury follow-up — 17%
- Chronic problem, flare-up — 15%
- Preventative care — 4%

The top 5 reasons given by patients for visiting otolaryngologists were:

- Postoperative visit
- Earache or ear infection
- Hearing dysfunction
- Plugged feeling in ear
- Nasal congestion

The top 5 diagnoses were:

- Otitis media and eustachian tube disorders
- Other diseases of the respiratory system
- Other disorders of the ear and mastoid process
- Disorders of external ear
- Chronic sinusitis

Medications were provided or prescribed at 65 percent of office visits. The top 5 generic substances utilized were:

- Levothyroxine
- Omeprazole
- Aspirin
- Fluticasone nasal
- Montelukast

For more information, contact the Ambulatory Care Statistics Branch at 301-458-4600 or visit our Web site at <www.cdc.gov/namcs>.

¹ No insurance is defined as having only self-pay, no charge, or charity visits as payment sources.

THE IMPORTANCE OF NAMCS DATA

Otolaryngology

NAMCS data are widely used in research studies appearing in nationally recognized medical journals, including *JAMA*, *Journal of the American Board of Family Practice*, and *Archives of Internal Medicine*. Here are just a few recent publications using NAMCS data:

Smith WM, Davidson TM, Murphy C. Regional variations in chronic rhinosinusitis, 2003–2006. *Otolaryngol Head Neck Surg*. 141(3):347–52. Sep 2009.

Valderas JM, Starfield B, Forrest CB, Sibbald B, Roland M. Ambulatory care provided by office-based specialists in the United States. *Ann Fam Med*. 7(2):104–11. Mar–Apr 2009.

Morgan PA, Strand J, Ostbye T, Albanese MA. Missing in action: care by physician assistants and nurse practitioners in national health surveys. *Health Serv Res*. 42(5):2022–37. Oct 2007.

Sharp HJ, Denman D, Puumala S, Leopold DA. Treatment of acute and chronic rhinosinusitis in the United States, 1999–2002. *Arch Otolaryngol Head Neck Surg*. 133(3):260–5. Mar 2007.

Ferris TG, Kuhlthau K, Ausiello J, Perrin J, Kahn R. Are minority children the last to benefit from a new technology? Technology diffusion and inhaled corticosteroids for asthma. *Med Care*. 44(1):81–6. Jan 2006.

Altman KW, Stephens RM, Lyttle CS. Changing Impact of Gastroesophageal Reflux in Medical and Otolaryngology Practice. *Laryngoscope*. 115(7):1145–1153. Jul 2005.

Ladd E. The use of antibiotics for viral upper respiratory tract infections: an analysis of nurse practitioner and physician prescribing practices in ambulatory care, 1997–2001. *J Am Acad Nurse Pract*. 17(10):416–24. Oct 2005.

Niemcryk SJ, Joshua-Gotlib S, Levine DS. Outpatient Experience of Patients with GERD in the United States: Analysis of the 1998–2001 National Ambulatory Medical Care Survey. *Dig Dis Sci*. 50(10):1904–8. Oct 2005.

Linder JA, Bates DW, Lee GM, Finkelstein JA. Antibiotic treatment of children with sore throat. *JAMA*. 294(18):2315–22. Nov 2005.

Rutschmann OT, Domino ME. Antibiotics for upper respiratory tract infections in ambulatory practice in the United States, 1997–1999: does physician specialty matter? *J Am Board Fam Pract*. 17(3):196–200. May–Jun 2004.

Leader S, Kohlhase K. Recent trends in severe respiratory syncytial virus (RSV) among US infants, 1997 to 2000. *J Pediatr*. 143(5 Suppl):S127–32. Nov 2003.

The complete list of publications using NAMCS data, which includes hundreds of articles and reports, is available on our Web site.

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